Health and Wellbeing Board
North Yorkshire

Agenda

Meeting: Health and Wellbeing Board

Venue: The Garden Rooms at Tennants, Leyburn, DL8 5SG

(location plan attached)

Date: Friday 27 November 2015 at 10.30 am

Recording is allowed at County Council, committee and sub-committee meetings which are open to the public, please give due regard to the Council's protocol on audio/visual recording and photography at public meetings, a copy of which is available to download below. Anyone wishing to record is asked to contact, prior to the start of the meeting, the Officer whose details are at the foot of the first page of the Agenda. We ask that any recording is clearly visible to anyone at the meeting and that it is non-disruptive. http://democracy.northyorks.gov.uk

Business

No	Agenda Item	Action	Document/ Page Nos	Suggested Timings
1	Apologies for Absence	**To note**	-	10.30-10.35
	Standard Items			
2	Minutes of the meeting held on 30 September 2015	**To approve**	1-10	
3	Public Questions or Statements Members of the public may ask questions or make statements at this meeting if they have given notice to Patrick Duffy of Democratic Services *(contact details below)* no later than midday on Monday 23 November 2015, three working days before the day of the meeting. Each speaker should limit themselves to 3 minutes on any item.	**To note**	-	

Enquiries relating to this agenda please contact Patrick Duffy Tel: 01609 534546
Fax: 01609 780447 or e-mail patrick.duffy@northyorks.gov.uk (or 0800 220617 after office hours)
Website: www.northyorks.gov.uk

	Members of the public who have given notice will be invited to speak:- • at this point in the meeting if their questions/statements relate to matters which are not otherwise on the Agenda (subject to an overall time limit of 30 minutes); • when the relevant Agenda Item is being considered if they wish to speak on a matter which is on the Agenda for this meeting.			
4	**Part 1: Safeguarding Adults Board and Safeguarding Children Board** **Part 2: Healthwatch and Cloverleaf**	**Presentation**	**11**	**10.35-11.15**
	<u>Strategy</u>			
5	**Joint Health & Wellbeing Strategy 2015-2020** Sponsor: Wendy Balmain	**To approve**	**12 to 40**	**11.15-11.20**
6	**Commissioning for Military Populations across North Yorkshire** Sponsor: Debbie Newton	**To accept**	**41 to 53**	**11.20-11.35**
7	**Future in Mind: Transforming Support for Children and Young People's Mental Health and Wellbeing** Sponsor: Janet Probert	**To accept**	**54 to 60**	**11.35-11.45**
8	**Healthy Weight, Active Lives Strategy 2009-2020** Sponsor: Lincoln Sargeant	**To approve**	**61 to 63**	**11.45-11.50**
9	**North Yorkshire Winter Health Strategy 2015-2020** Sponsor: Lincoln Sargeant	**To approve**	**64 to 86**	**11.50-12.00**
	<u>Assurance</u>			
10	**System Resilience and Winter Preparedness in North Yorkshire** Sponsors: Amanda Bloor and Richard Webb	**To accept**	**87 to 93**	**12.00-12.10**
11	**Better Care Fund (BCF) Evaluation** Sponsor: Wendy Balmain	**To accept**	**94 to 101**	**12.10-12.20**
12	**Health Protection Assurance Statement** Sponsor: Lincoln Sargeant	**To accept**	**102 to 108**	**12.20-12.25**

13	**Partnership Protocol with Safeguarding Boards** Sponsor: Elaine Wyllie	**To approve**	**109 to 114**	**12.25-12.30**
	<u>Information Sharing</u>			
14	**Draft Notes of North Yorkshire Delivery Board Meeting (8 October 2015)**	**To note**	**115 to 118**	
	<u>Other Items</u>			
15	**Work Programme/Calendar of Meetings 2015/2016**	**To approve**	**119 to 121**	
16	**Other business which the Chairman agrees should be considered as a matter of urgency because of special circumstances**			

Barry Khan
Assistant Chief Executive (Legal and Democratic Services)

County Hall
Northallerton

Date: 19 November 2015

Notes:

Members are reminded of the need to consider whether they have any interests to declare on any of the items on this agenda and, if so, of the need to explain the reason(s) why they have any interest when making a declaration.

The relevant Democratic Services Officer or the Monitoring Officer will be pleased to advise on interest issues. Ideally their views should be sought as soon as possible and preferably prior to the day of the meeting, so that time is available to explore adequately any issues that might arise.

North Yorkshire Health and Wellbeing Board

Membership

County Councillors (3)		
1	WOOD, Clare (Chairman)	Executive Member for Adult Social Care and Health Integration
2	CHANCE, David	Executive Member for Stronger Communities and Public Health
3	SANDERSON, Janet	Executive Member for Children and Young People's Services
Elected Member District Council Representative (1)		
4	FOSTER, Richard	Craven District Council Leader
Local Authority Officers (5)		
5	FLINTON, Richard	North Yorkshire County Council Chief Executive
6	WEBB, Richard	North Yorkshire County Council Corporate Director, Health & Adult Services
7	DWYER, Peter	North Yorkshire County Council Corporate Director, Children & Young People's Service
8	WAGGOTT, Janet	Chief Officer District Council Representative
9	SARGEANT, Dr Lincoln	North Yorkshire County Council Director of Public Health
Clinical Commissioning Groups (5)		
10	RENWICK, Dr Colin	Airedale, Wharfedale & Craven CCG
11	PLEYDELL, Dr Vicky	Hambleton, Richmondshire & Whitby CCG
12	BLOOR, Amanda (Vice-Chairman)	Harrogate & Rural District CCG
13	HAYES, Dr Mark	Vale of York CCG
14	COX, Simon	Scarborough and Ryedale CCG
Other Members (3)		
15	JONES, Shaun	NHS England NY & Humber Area Team
16	CARLISLE, Sir Michael	Chairman, Healthwatch
17	BIRD, Alex	Voluntary Sector Representative
Co-opted Members (2) – Voting		
18	BARKLEY, Martin	Mental Health Trust Representative (Chief Executive, Tees, Esk and Wear Valleys NHS Foundation Trust – Mental Health Services)
19	CROWLEY, Patrick	Acute Hospital Representative (Chief Executive York Teaching Hospital NHS Foundation Trust)
Substitute Members		
	COULTHARD, Adele	Tees, Esk and Wear Valley NHS Foundation Trust
	WARREN, Julie	NHS England NY & Humber Area Team
	ITA, David	Healthwatch
	TOLCHER, Dr Ros	Harrogate and District NHS Foundation Trust
	NEWTON, Debbie	Hambleton Richmondshire & Whitby CCG

Notes:

1. The Health and Wellbeing Board is exempt from the requirements as to political balance set out in Sections 15-16, Schedule 1 Local Government Housing Act 1989
2. The Councillor Membership of the Board is nominated by the Leader of the Council. In the event that the number of portfolio holders responsible for health and well related issues increases, the additional portfolio holders will also be a Member of the Board.
3. All members of the Health and Wellbeing Board or any sub committees of the Health and Wellbeing Board are voting Members unless the Council decides otherwise.

Health and Wellbeing Board
North Yorkshire

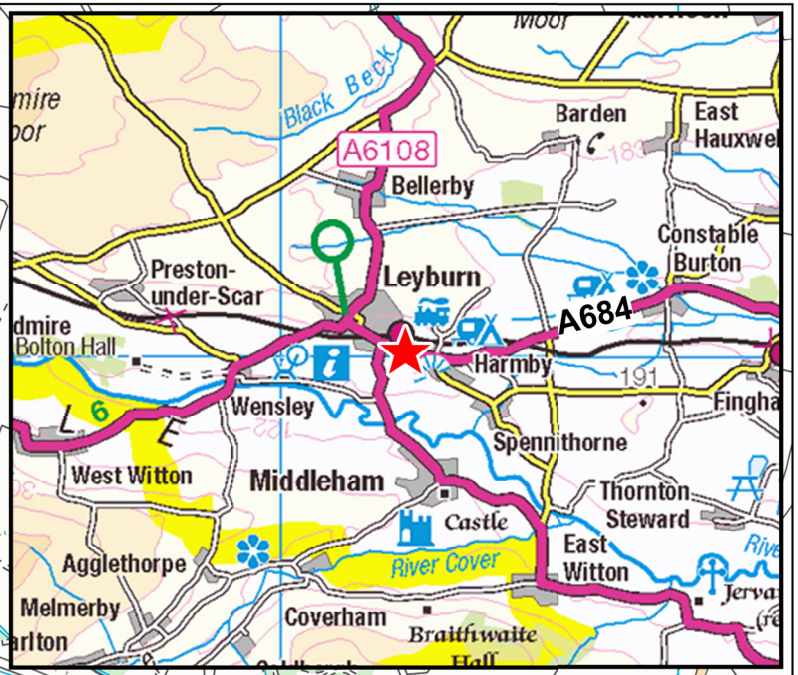
These ground rules are about Team North Yorkshire Health and Wellbeing Board and should apply within and outside of Board meetings. They were adopted by Board members in June 2015.

We have made a commitment that when working together we will treat each other with **respect**, with **openness and honesty**. We will make sure that there is **equality – everyone is of equal value in the room.** We will **contribute and take part, committing to listen and ask questions of each other**, **checking that what we heard is what was intended**. We believe **it is good to be passionate**, and we know that constructive **challenge is helpful in getting us to a better place**. We must **voice disagreement, otherwise silence implies consent** but recognise that this should be done **with respect** to other points of view. **We shouldn't expect the same sort of challenge in the public arena.**

We have a responsibility to model exemplary behaviour, inside and outside of the HWB meetings, as Board members we should **give and accept support** and **bring collective experience and knowledge to this Board**. **Our discussions need to focus on added value and outcomes** and we must **take responsibility for our decisions.** We should ensure that we **communicate and cascade to our respective audiences and organisations.**

We believe that we should **continually strive to be better and** wear our **team badges - Team North Yorkshire** with pride.

Tennants Auctioneers
Auction Centre
Harmby Road
Leyburn
DL8 5SG



North Yorkshire County Council

North Yorkshire Health and Well-being Board

Minutes of the meeting held on Wednesday 30 September 2015 at 2.00 pm at The Rosewood, Herriots Hotel, Skipton, BD23 1RT

Present:-

Board Members	Constituent Organisation
County Councillors	
County Councillor Clare Wood **(Chairman)**	North Yorkshire County Council Executive Member for Adult Social Care & Health Integration
County Councillor David Chance	North Yorkshire County Council Executive Member for Stronger Communities & Public Health
County Councillor Janet Sanderson	North Yorkshire County Council Executive Member for Children & Young People's Service
Local Authority Officers	
Richard Flinton	North Yorkshire County Council Chief Executive
Richard Webb	North Yorkshire County Council Corporate Director – Health & Adult Services
Dr Lincoln Sargeant	North Yorkshire County Council Director of Public Health
Janet Waggott	Ryedale District Council Chief Executive
Clinical Commissioning Groups	
Dr Colin Renwick	Airedale, Wharfedale & Craven CCG
Dr Vicky Pleydell	Hambleton, Richmondshire & Whitby CCG
Amanda Bloor (Vice Chairman)	Harrogate & Rural District CCG
Simon Cox	Scarborough & Ryedale CCG
Andrew Philips (informal substitute)	Vale of York CCG
Other Members	
Gillian Laurence (substitute)	NHS England NY & Humber Area Team
Sir Michael Carlisle	Chairman, North Yorkshire Healthwatch
Alex Bird	Voluntary Sector (North Yorkshire and York Forum)
Co-opted Members (voting)	
Adele Coulthard (substitute)	Mental Health Trust Representative Tees Esk & Wear Valleys NHS Foundation Trust

In Attendance:-
County Councillor Jim Clark (Chair, Scrutiny of Health Committee); David Ita (Healthwatch); and Janet Probert (Partnership Commissioning Unit)

North Yorkshire County Council officers: Wendy Balmain, Kathy Clark, Gavin Halligan-Davis, Anne-Marie Lubanski, Gail McCracken and Elaine Wyllie (NYCC Health & Adult Services), Kate Arscott and Jane Wilkinson (NYCC Legal & Democratic Services), Sarah Parvin (Business Support).

4 members of the public

Copies of all documents considered are in the Minute Book

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110. Apologies for absence

Apologies for absence were submitted by Pete Dwyer (North Yorkshire County Council Corporate Director, Children & Young People's Service), Dr Mark Hayes (Vale of York CCG), Julie Warren (NHS England), Martin Barkley (Mental Health Trusts) and Patrick Crowley (Acute Hospitals).

111. Minutes

Resolved -

That the Minutes of the meeting held on 3 June 2015 be approved as an accurate record.

112. Public Questions or Statements

Notice had been given of three contributions, two of which were related to item 7, Mental Health Strategy, and were taken under this agenda item.

Mr James Monkfield asked whether the Health and Wellbeing Board had any plans to include military input within its membership. He expressed concerns about increasing numbers of ex-servicemen with health and mental health issues, whose families do not feel equipped to support them. He expressed specific concerns in relation to services in the Craven area.

In response, the Chair and Members of the Board acknowledged the importance of this issue and indicated that a specific paper on military health was due to be presented at the Board's next meeting. It was also noted that specific reference was made to the needs of military families and veterans in the mental health strategy, which was included on the agenda for this meeting.

In terms of the membership of the Board, it was noted that there was limited discretion as to who could be appointed. With regard to services in the Craven area, Colin Renwick agreed to speak to Mr Monkfield outside the meeting and provide him with contact details.

113. Presentation on Falls Prevention

Considered -

A presentation by Gail McCracken, Falls Co-ordinator, regarding Falls Prevention, related to the Joint Health and Wellbeing Strategy theme: Live Well and Age Well.

Gail McCracken outlined the scale of the issue, with around 42,000 falls each year in North Yorkshire, and around 50% of admissions to hospitals to care homes related to falls. She referred to the human cost in pain, distress and loss of confidence leading to the risk of future falls and potentially to isolation, depression and loss of independence.

A fall was defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground or an object below knee level. A distinction was made between a fall and a collapse due to an acute medical problem. It was stressed that it was not inevitable that people would fall as they got older.

Gail outlined the work being undertaken through Better Care Fund (BCF) funding including a Falls Pathway group and an implementation plan with 12 objectives. It was the intention to make widespread use of opportunities to identify those at risk; to support providers of care to have systems in place to prevent and manage falls; and to ensure access to the full range of interventions to meet different levels of need and risk. Current levels of provision varied across the county.

In summary the ambition was to make a difference through:

- An agreed screening tool for all agencies to use
- An agreed minimum data set for assessments
- Quality standards for providers
- A full range of exercise group provision
- Greater capacity in statutory teams
- Involvement of the voluntary sector
- Greater awareness from the public and agencies

The key issues raised in discussion were:

- The arrangements for assessing projects such as this within the time limited funding period, and the impact on future sustainability of new initiatives. It was noted that the Transformation Boards were the appropriate forum for considering such matters and the use of transitional funding to extend Innovation Fund projects to gather further evidence.
- The need for greater publicity around falls prevention, although recognising the excellent information available on the Age UK website, and the intention to include information on the County Council's website
- A role for the Delivery Board to monitor progress

Resolved -

That the presentation be noted.

114. Joint Health and Wellbeing Strategy

Considered -

The report by Amanda Bloor, Chief Officer, Harrogate and Rural District CCG, bringing the draft Joint Health and Wellbeing Strategy before the Board following consultation with the public and wider partners. Following approval by the Board the strategy will be used as the overarching framework for ensuring delivery of the Board's priorities.

Amanda Bloor outlined the developments that had taken place since the June meeting of the Board, and reported on the feedback from consultation and how this had been reflected in changes to the draft. In particular the Board needed to consider a proposal that a separate theme on 'dying well' be added to the strategy.

The importance of the section on measurement was highlighted in terms of the partnership holding itself to account and demonstrating to the public that the strategy was being delivered. Further work was required in this area. Wendy Balmain, Assistant Director Integration, NYCC Health and Adult Services, indicated that it was planned to broaden the remit of the Better Care Fund performance function to encompass this role.

It was proposed that the next Health and Wellbeing Board Development Session should focus on implementation of the strategy. Members were advised that this session needed to be deferred from the original date of 26 October due to the number of apologies received. It was agreed to reschedule the Development Session to Monday 14 December.

Following discussion, the inclusion of a separate theme on 'dying well' was supported. It was agreed that the necessary changes to the text to implement this should be drafted in consultation with the Chairman and Vice Chairman. A final version of the strategy would then be brought back to the next meeting of the Health and Wellbeing Board to be signed off.

In reference to the earlier public question, it was also agreed that explicit reference should be made in the final document to the health and wellbeing of the military and veterans.

The Chair placed on record the Board's thanks to Amanda Bloor as sponsor for the Strategy, to Wendy Balmain and Elaine Wyllie from Health and Adult Services, and to all others involved, including consultation participants, for their contribution to producing the final draft strategy.

Resolved -

(a) That the work undertaken by the task and finish group in producing the final draft strategy and the support of partners in seeking/providing feedback throughout the consultation be acknowledged.

(b) That the feedback received throughout the consultation and the changes approved made within the strategy document be received and noted.

(c) That the changes necessary with regard to the suggestion of including a separate theme on 'dying well' be agreed, and that a revised draft of the text be circulated for comments prior to being reported back to the next meeting of the Health and Wellbeing Board for sign off.

(d) That the design concept be approved in principle.

(e) That the intention that strategies/work programmes are clearly linked to the Joint Health and Wellbeing Strategy outcomes be supported.

(f) That the use of some of the rescheduled Board development session on 14 December 2015 to further develop the five elements described in the strategy for measuring success be supported.

115. 2015 Annual Report of the Direct of Public Health for North Yorkshire

Considered -

The report of the Director for Public Health for North Yorkshire presenting the Annual Report of the Director for Public Health for North Yorkshire 2015, "The health of our children: Growing up healthy in North Yorkshire".

In presenting his third annual report, Dr Lincoln Sargeant reminded the Board that he had adopted a thematic approach to these reports. This year's report focused on the journey from birth to early adulthood and chimed with the Starting Well theme of the Joint Health and Wellbeing Strategy considered under the previous agenda item.

The report considered how all partners can work together to remove or reduce the barriers and obstacles that some children face through no fault of their own. Resilience was a key feature of the report.

The Health and Wellbeing Board was asked to receive the report and to consider the actions that Members can take to implement the recommendations contained in the annual report, which related to the following areas:

(a) Child Poverty
(b) 0-5 Healthy Child Programme
(c) Parenting Programmes
(d) Childhood Obesity
(e) PSHE in Schools
(f) Maximise opportunities for Future in Mind

Members strongly welcomed the report and noted that it would also be presented to the various constituent organisations of this Board, as well as to the Children's Trust Board.

Lincoln Sargeant confirmed that the public health team was working with colleagues in Children and Young People's Services to look at updating the child poverty assessment measures.

Resolved –

That the Annual Report of the Director for Public Health for North Yorkshire 2015 "The health of our children: Growing up healthy in North Yorkshire" be received and that the recommendations in the report be noted.

116. Mental Health Strategy

Considered -

The joint report of Dr Vicky Pleydell, Hambleton, Richmondshire and Whitby CCG and Richard Webb, Corporate Director - Health and Adult Services, presenting the final draft of the Mental Health Strategy for North Yorkshire.

At this point in the meeting the two public contributions related to the Mental Health Strategy were taken.

Nigel Ayre, City of York Councillor, welcomed the document. He spoke of his experience of working in the mental health field and endorsed the sentiments expressed in the strategy as well as commending the consultation and engagement with service users and stakeholders that had taken place. He identified two key challenges for delivery of the strategy: the importance of early intervention and the potential of the voluntary sector to play a key role. He also raised his concern about the precarious funding position of the local Mental Health Forums and sought a commitment from Health and Wellbeing Board members to do everything possible to ensure these forums continued to operate.

Mr Ian Fulton endorsed the previous speaker's comments and asked the Board "Will the Mental Health Strategy Implementation Plan include closer connection between various other services, particularly where mental illness is the pre-cursor to drug and

alcohol dependency, where there is either a misdiagnosis of mental illness which is really a personality disorder matter which is not adequately dealt with by psychiatry also or where presentations to psychiatric professionals are misdiagnosed when they are perhaps a condition on the autistic spectrum which psychiatry doesn't deal with. How will various strategies be connected which are separate but when misdiagnosis of mental illness means that the person doesn't get treatment as psychiatry does not recognise conditions which are outside its sphere of expertise?"

The Chair thanked both speakers for their positive endorsement of the work undertaken in developing the strategy.

Janet Probert, Director of the Partnership Commissioning Unit, and Kathy Clark, Assistant Director Commissioning, NYCC Health and Adult Services, presented the strategy and outlined the further work that had been undertaken since the initial draft strategy was presented to the Board in June 2015. The Board was now asked to approve the strategy for implementation, and to agree the arrangements for holding partners to account for delivery.

The report identified twelve initial joint actions, which were intended to be realistic and achievable within current resources. In common with the Joint Health and Wellbeing Strategy, the mental health strategy set out an ambition for the right level of specialist support and general community support. There was a focus on outcomes and new models of care to achieve value added for those with mental health challenges. An implementation plan with clear timescales would be developed over the next 3 months and would be included on the website.

In response to the issues raised by the speakers, the clear commitment to a consistent and strong conversation involving users, the voluntary sector and professionals was stressed. In particular Amanda Bloor confirmed that the Harrogate & Rural District CCG was looking at alternative approaches to supporting the local Forum.

The economic case for mental health and the impact on the economy of working days lost was highlighted.

Members of the Board welcomed the document and the work that had gone in from all involved, including service users, to develop it to this stage. It was noted that all CCGs have committed additional funding to mental health issues, reflecting the collective ambition and commitment.

In discussing the future accountability and reporting arrangements, it was acknowledged that further thought needed to be given to how the Health and Wellbeing Board itself could have meaningful discussions on the progress of this and other strategies. It was noted that this would be considered as part of the Board Development Session on 14 December.

Resolved -

(a) That the Strategy be approved.

(b) That information about the Strategy is developed to coincide with World Mental Health Day (10 October 2015).

(c) That the monitoring arrangements for delivery be agreed as set out in paragraph 5.2 of the report, which will then report to the Delivery Group of the Health and Wellbeing Board.

117. Tobacco Control Strategy

Considered -

The report of Dr Lincoln Sargeant, Director of Public Health for North Yorkshire, presenting the North Yorkshire Tobacco Control Strategy and implementation plan, asking the Board to endorse the actions that member organisations can make that will contribute to the vision 'to inspire a smoke free generation' and asking the Board to agree to formally launch the Strategy.

In introducing the report, Lincoln Sargeant emphasised that smoking was still the single greatest cause of preventable deaths in North Yorkshire. The smoking cessation service had recently been retendered and a new provider engaged with a more aggressive approach. As most people start to smoke in their teens there was a particular emphasis on working with children and young people.

Mr James Monkfield asked why chewing tobacco was not addressed in the strategy. It was confirmed that the strategy focused on cigarette smoking as this was the area of highest use, and that similarly pipe and cigar smoking were not included.

The Board welcomed the clarity of the strategy.

Resolved -

That the North Yorkshire Tobacco Control Strategy and implementation plan be approved for launch throughout October.

118. Strategy for Meeting the Needs of Children, Families and Adults with Autism in North Yorkshire 2015-2020

Considered -

The report of the Corporate Director - Health and Adult Services and the Director of the Partnership Commissioning Unit, seeking the Board's approval of the Strategy for meeting the needs of children, families and adults with autism in North Yorkshire 2015-2020, to be published in October 2015, and also seeking the Board's approval to publish a brief document specifically for people with autism and the wider public, stating the overall ambitions for supporting people with autism in North Yorkshire up to 2020. This would be circulated to the Board for information when it was produced.

Mr Ian Fulton asked about progress on autism diagnostic assessments for adults and when a more local service would be available. In response it was confirmed that the service was being re-commissioned on a more local basis.

Anne-Marie Lubanski, Assistant Director Care & Support, NYCC, and Janet Probert, Director of the Partnership Commissioning Unit, introduced the strategy. They outlined the further work and inclusive consultation that had been undertaken in developing the strategy since the earlier draft presented to the Board. Once the strategy was approved an implementation plan would be devised. It was also highlighted that the consultation had raised the need for a much shorter user friendly version of the strategy and the Board's endorsement was sought for this approach.

It was emphasised that the strategy is all-age, and that it had been endorsed by District Councils and the Police. The Board also thanked the Scrutiny of Health Committee for its input. Examples of work on safe places involving the Police and railways were quoted.

The Board welcomed the strategy and the engagement work that had taken place in its development. Against a national record of high cost and variable quality of autism services it is a challenge to bring this provision into the mainstream and control costs. There is also a challenge in terms of awareness raising in the workplace as more people are recognised as having autism, and more people with autism are in work.

Resolved -

(a) That the consulted draft strategy (market position statement) for meeting the needs of children, families and adults with autism in North Yorkshire 2015-2020 including the easy read version, policy framework document and the equality impact assessment is approved by the Health and Wellbeing Board to be published on 1 October 2015.

(b) That the Health and Wellbeing Board grants approval for a 4-page strategy document designed by people with autism and NYCC/PCU staff to be published which gives accessible and clear information about North Yorkshire's ambitions for autism between 2015-2020.

119. Better Care Fund Performance

Considered -

The report of Wendy Balmain, Assistant Director Integration, NYCC Health and Adult Services, updating the Board on the first two quarterly Better Care Fund (BCF) reporting periods up to 30 June 2015 and considering progress implementing the BCF plan.

The report highlighted that performance reporting is heavily weighted towards reducing non elective admissions (NEAs) to hospital and this is the only metric that attracts performance payment. The report looked in detail at delivery against that metric but recognised that BCF delivery is interdependent with other health and social care transformation programmes and performance reducing NEAs is a system responsibility. The Chair reminded the Board of the collective responsibility of Board members towards this matter.

In debating the report, Members referred to the difficulty in measuring the impact of changes in a very short period of time, and also the anomalies with two different national data systems being employed. Those CCGs showing some improvement in reducing non electives shared some of their experience. It was acknowledged that this was a challenging area, and the Board noted that the Transformation Boards would be undertaking more detailed evaluation in order to inform a clearer understanding of progress for reporting back to the Health and Wellbeing Board. NHS England was also asked for feedback on specific queries that had been raised with them, and it was agreed that this would be followed up outside the meeting.

Resolved -

(a) That it be noted that the quarterly performance reports will be shared with the North Yorkshire Delivery Board and Commissioner Forum in the first instance. These groups will continue to develop and monitor BCF implementation to provide assurance to HWB members about progress.

(b) That it be noted that North Yorkshire BCF performance is below target for reducing NEAs after the first two quarters.

(c) That it be noted that the Board will receive a report on progress evaluating BCF schemes from local Transformation Boards in November 2015 including implications for 2016/17 planning.

120. Annual Reports

The annual reports of the North Yorkshire Safeguarding Adults Board, North Yorkshire Safeguarding Children Board, North Yorkshire Healthwatch and North Yorkshire NHS Complaints Advocacy Service were presented to the Board for noting.

Members were informed that a representative from each of the organisations had been invited to attend the next meeting on 27 November 2015, in order to ensure that the Board can consider the key messages for its own work from these annual reports.

Resolved -

That the annual reports of the North Yorkshire Safeguarding Adults Board, North Yorkshire Safeguarding Children Board, North Yorkshire Healthwatch and North Yorkshire NHS Complaints Advocacy Service be noted.

121. North Yorkshire Delivery Board Meeting Notes

Considered -

The Committee received for information the draft notes of the meeting of the North Yorkshire Delivery Board held on 9 July 2015.

Resolved -

That the draft notes of the North Yorkshire Delivery Board meeting held on 9 July 2015 be noted.

122. Forward Work Plan/Work Programme

Considered -

Members were invited to comment upon and approve the content of the Board's future work programme.

The Board noted that the Health and Wellbeing Board Development Session scheduled for 26 October 2015 had been postponed to 14 December 2015.

It was agreed that the next meeting of the Health and Wellbeing Board on 27 November 2015 would be held in Leyburn.

Resolved -

That the Forward Plan is noted and approved and decisions made during the meeting and recorded in the minutes be incorporated.

123. Delegated Approval - Future in Mind

Considered -

The joint report of Janet Probert, Director of Partnership Commissioning and Pete Dwyer, Corporate Director - Children and Young People's Service providing the Health and Wellbeing Board with an outline of Future in Mind, a summary of the work

undertaken to develop the Transformation Plan including engagement with key partners and the project timetable, seeking delegated authority from the Board to sign off the Transformation Plans within the prescribed timeframe.

It was noted that this matter was also due to be considered by the Children's Trust Board on 10 October 2015.

Resolved -

(a) That the report be noted.

(b) That the Chair, in consultation with the CCG appointed representative authority, be delegated to sign off the Transformation Plan prior to its submission to NHS England on 16 October 2015.

The meeting concluded at 4.40pm

KA

Health and Wellbeing Board
North Yorkshire

NORTH YORKSHIRE HEALTH AND WELLBEING BOARD

27 November 2015

Presentation: ***"What are the significant issues arising from the work of [the organisation] that impact on the health and wellbeing of people living in North Yorkshire and what issues do the HWB need to be sighted on?"***

- Part 1: Safeguarding Adults Board (Jonathan Phillips) and Safeguarding Children Board (Pete Dwyer)
- Part 2: Healthwatch (David Ita) and Cloverleaf (Bob Carter)

1. Purpose

1.1 To provide an opportunity for members of HWB to gain an understanding of the work and the key issues relating to the HWB from the following stakeholders:

- Safeguarding Boards
- Healthwatch
- Cloverleaf

2. Background

2.1 The Board received the organisations' annual reports at its meeting on 30 September 2015.

2.2 The Board agreed to have a substantive agenda item to consider the question posed in the presentation.

3. Required from the Board

3.1 The Board is asked to:

Receive the presentations from stakeholders and fully engage in a discussion on the issues identified.

Elaine Wyllie
Head of Integration
12 November 2015

Health and Wellbeing Board
North Yorkshire

NORTH YORKSHIRE HEALTH AND WELLBEING BOARD
Joint Health and Wellbeing Strategy 2015-2020
27 November 2015

1. Purpose

1.1 To bring the final Joint Health and Wellbeing Strategy (JHWS) before the Board for approval.

2. Background

2.1 The Board received an updated draft strategy at its meeting on 30 September 2015 which reflected feedback from a range of stakeholders including: those who use services; HWB member organisations; NYCC Health Overview and Scrutiny Committee; County Homelessness Group; Woodlands Trust; NYCC Transport Planning Office and a number of district councils.

2.2 The Board agreed to add a theme focused on 'Dying Well' to the strategy with the final strategy being brought to the 27 November meeting before implementation.

3. Next Steps

3.1 Following consideration by the Board an action plan will be produced to take forward implementation. Easy Read and Plain English versions of the document will also be finalised.

3.2 In accordance with the Board's terms of reference, the Strategy will be referred to the Council for approval as part of the Council's Policy Framework.

3.3 The HWB development day on 14 December 2015 will provide an opportunity for members to consider the ways in which the successful delivery of the outcomes described in the strategy can be measured.

4. Required from the Board

4.1 The Board is asked to:

Approve the final Strategy.

Wendy Balmain
Assistant Director Integration
12 November 2015

Health and Wellbeing Board
North Yorkshire

Joint Health and Wellbeing Strategy 2015 - 2020

Signatories to the North Yorkshire Joint Health and Wellbeing Strategy are

Age Concern - representing the voluntary sector

Airedale, Wharfedale and Craven Clinical Commissioning Group

Craven District Council - representing District Council members

Hambleton, Richmondshire and Whitby Clinical Commissioning Group

Harrogate and Rural District Clinical Commissioning Group

healthwatch North Yorkshire

NHS England

North Yorkshire County Council

Ryedale District Council - representing District Council officers

Scarborough and Ryedale Clinical Commissioning Group

Tees, Esk and Wear Valleys NHS Foundation Trust

Vale of York Clinical Commissioning Group

York Teaching Hospital NHS Foundation Trust

York Teaching Hospital NHS Foundation Trust - representing acute hospital providers

The organisations that are signatories to this strategy have made a commitment to work together to support local systems to achieve continuous health and wellbeing improvements for the population of North Yorkshire.

Contents

Foreword

The North Yorkshire Health and Wellbeing Board is made up of partner organisations from across the county. We understand that there are diverse and complex communities within North Yorkshire and recognise the strong sense of local identity that this brings. We have a history of working together to develop healthier, stronger communities in our county and are well placed to tackle the next stage in partnership not only with each other but, more importantly, with those people who use services and the individuals or groups that provide direct support and care to others.

In 2013 we produced our first health and wellbeing strategy, which took into account what local people and our partners told us they thought our priorities should be. This updated document reflects on the progress we have made so far and outlines what we need to adapt to take into account changing local and national health priorities, as well as managing our reduced budgets. It also takes into account the findings of the latest Joint Strategic Needs Assessment (JSNA), and what local people have told us really matters to them for their long term health and wellbeing.

This updated strategy gives us an opportunity to restate our commitment to improving health and wellbeing as well as setting out how we want to continue to improve services. The five themes of: Connected Communities; Start Well; Live Well; Age Well and Dying Well describe how we intend to maintain the momentum we have built up in delivering our ambition to ensure that people in all communities in North Yorkshire have equal opportunities to live full and active lives from childhood to later years.

County Councillor Clare Wood

Executive Member for Adult Social Care and Health Integration
North Yorkshire County Council

Chairman of North Yorkshire Health and Wellbeing Board

Amanda Bloor

Chief Officer
Harrogate and Rural District Clinical Commissioning Group

Vice Chairman of North Yorkshire Health and Wellbeing Board

Why are we updating the strategy?

We want our strategy to make a difference, rather than being a document on a shelf. That's why we have taken this opportunity to bring it up to date so that people living in North Yorkshire continue to have access to great services which take account of:

- the latest evidence from our Joint Strategic Needs Assessment (JSNA)
- changes in national policy, local ambition and people's expectations
- listening to local people about what's important to them for their long term health and wellbeing and using feedback to shape our services

There are many changes taking place across North Yorkshire all the time that have an impact on our health and wellbeing, and there is always more to do. This document won't describe every change that is taking place, but it has been developed to help us stay focused on achieving those things that are most important for local people. It will help us make a difference by reducing variations in health and care outcomes across the county.

We know that if we do this, we will be making a positive and lasting impact on the health and wellbeing of people and communities in North Yorkshire.

You can see some of the things that people have said recently in the "What people have told us they want from this strategy" sections which appear throughout this document.

Why do we need to change?

- People in North Yorkshire are living longer than ever before. That means we all have the potential to enjoy more years of healthy, active life from childhood right into old age by helping ourselves and our families to live well. But it also means that we may need more help as we get older, to age well and be as healthy and independent as we can be through to the end of our lives.
- Not all the communities in North Yorkshire are as healthy as we'd like them to be. Life expectancy for men living in Scarborough, for example, can vary by as much as 11 years between the richest and poorest areas of the district. We are seeing widening variations in obesity between children living in affluent and deprived neighbourhoods. We want to reduce the gaps as part of our strategy to make North Yorkshire healthier and happier.
- There are more demands on the money available to the health and care system than in the past. This means all organisations need to plan carefully about how to spend the North Yorkshire pound. By doing that together, and using new technology wisely, we believe we can deliver better value for money and do more with the resources we have at our disposal.

The North Yorkshire Joint Strategic Needs Assessment (JSNA) contains more information on the current health and wellbeing of North Yorkshire communities. You can download a copy at www.nypartnerships.org.uk/jsna.

How does this fit into the national picture?

Since 2012 there have also been some big changes in the priorities for health and wellbeing at national level. As the largest county in England, it's not surprising that these are all highly relevant to North Yorkshire.

The most important of these include:

- Working with people throughout their lives to prevent the need for longer term care and making sure people are in control of the choices made about their care and their lives.
- Making sure children's services work together to help every child have the best start in life.
- A new focus on ways in which local health and social care organisations can work together so that peoples experience of care is more integrated.
- A new focus on care delivered in or close to people's homes with fewer people being admitted to hospital.

What is this strategy really about?

Working together to make North Yorkshire healthier and happier

This strategy really is important. It is a shared agreement between each partner organisation in the Health and Wellbeing Board with, and for, people of all ages living in North Yorkshire. It is about what we can and want to change.

Those of us who commission health and social care have a legal responsibility to make sure that our commissioning plans are guided by this strategy, and the Health and Wellbeing Board has a responsibility to ensure that this happens.

Health and wellbeing is about more than health and social care services. Every aspect of public life - education, childcare, housing, employment, the quality of the local environment, and the type of community we live in - can affect our health and wellbeing at any point through our lives. We understand this and want to help and encourage everyone to be aware of the impact of their actions on health and wellbeing, and to take account of this strategy when they plan to make changes.

Part of our job is to ensure that we all work well together so that we can achieve the best possible outcomes for local people and communities. We have a responsibility to make sure that our individual plans all face the same way and that when we invest the North Yorkshire pound we invest it wisely.

Understanding the strategy

What we plan to do

To help us concentrate on the most important things for North Yorkshire's health and wellbeing, we have agreed on five key themes to help us organise our work. These themes will sometimes overlap and will be relevant to all age groups.

- Connected communities
- Start well
- Live well
- Age well
- Dying well

We set out why each of our themes is important, what we hope to achieve - 'our outcomes' - and the changes you can expect to see, on pages 8 to 15.

Getting the whole system working better

To really make change happen we want to improve the ways in which the whole health and care system works together in North Yorkshire. We think that a focus on four things which, if we get them right, will help all organisations to achieve better outcomes for local people and communities:

- A new relationship with people using services
- Workforce
- Technology
- Economic prosperity

We explain more about these and why we think they are important on pages 6 to 19.

How we want things to happen

There are some guiding principles that we have adopted which organisations and people who receive services can use as a checklist when we develop new services. This will help build services that are more personal, joined up and equal across North Yorkshire. Our principles are:

- Recognise where things are different
- Tackle issues early
- Joining things up to make life simpler
- Making a positive contribution
- Keep people safe
- Spending our money wisely

We explain more about these and how we will use them into practice on pages 20 to 23.

Outcomes

We want North Yorkshire to be a place where communities flourish, people shape services and have control of their lives

Connected communities

Why is it important?

North Yorkshire people live longer, healthier lives compared to England as a whole, but there are significant variations between districts, communities and population groups.

For example, a girl born in Hambleton today can expect to live for 2.5 years longer than the average for England, but a girl born in Scarborough can expect to live for 0.5 years less. This variation has grown bigger over the last 10 years.

People with severe mental health problems often have poorer physical health too.

Strong local communities have been proved to be effective in supporting people to make healthy choices. They also help people cope with, and recover from, adverse events like illness, economic pressures and even extreme weather.

It prevents individuals feeling lonely and isolated which, in turn, reduces depression and anxiety.

Volunteering has benefits for both the volunteer and for those they help. Voluntary organisations are a vital part of connected communities - they provide things that other parts of the system can't, and their experience of working locally is a valuable resource.

Technology is a key asset for communities, helping to support local business opportunities, providing everyone with better ways of communicating with the outside world, and providing new solutions to self- manage our care.

What have people told us that they want from this strategy?

"To belong to a vibrant, caring community and to have access to health services when I need them."

'Recognise the importance that access to woodland and natural green space can have in improving wellbeing'

"To have options and resources available which reduce social isolation. To be able to feel confident attending a medical appointment and understand what's been said, what actions are required and what treatment is needed"

What changes can you expect to see?

By 2020, you can expect to see:

- Vibrant and self-reliant communities in all parts of North Yorkshire, with local people and organisations working together to develop community libraries, community transport services and activities for all age groups.
- Dementia friendly communities where people living with dementia and their families feel supported and confident and a part of their local area.
- Recognition and provision for our military communities, veterans and their families' needs as part of their local health and care services.
- Improvements in technology in rural areas, for businesses and homes, and increased access to technology for children and young people from disadvantaged communities.
- More opportunities for volunteering for people of all ages, and more people taking up these opportunities.
- A stronger link between work programmes across health and social care that make it clearer for people to see how things are connected, for example Stronger Communities, Living Well and local Transformation Board plans.

Outcomes

- Ensuring education is our greatest liberator
- Helping all children enjoy a happy family life
- A healthy start through healthy lifestyles

Start well

Why is it important?

There are over 130,000 children and young people aged 0-19 in North Yorkshire - and this number is growing.

Most North Yorkshire children already get a good start in life, but in a large and diverse county, there is still some who don't experience all the good things we would hope for. This may be for a range of reasons such as rural isolation, poverty, urban deprivation, disability or family breakdown. We need to make sure that these children's needs are spotted early and that they and their families receive the help they need from birth.

It's vital that every child has an excellent education to maximise their life chances - we know that this is a major factor in health and wellbeing throughout life. That includes a positive, safe experience throughout school and college as well as wider educational work to encourage children and young people to make healthy choices about their lifestyle.

Emotional and mental health and wellbeing is important at all ages. We need to support children and young people to be mentally and emotionally healthy. This doesn't just mean the 16,000 or so under-19s who have a recognised mental health disorder. We know that low self-esteem and anxiety can make daily life difficult, and we want to make sure every young person has a source of help when they need it.

What have people told us that they want from this strategy?

"keeping children and young people safe and ensuring that children and young people are safe from drugs/alcohol and unsafe sex."

What changes can you expect to see?

By 2020, you can expect to see:

- A higher percentage of babies who are breast fed and a higher percentage of children who receive immunisations and vaccinations.
- More children and young people making healthy choices, exercising regularly and eating well.
- A lower percentage of children who are obese or overweight.
- Fewer children and young people taking part in unhealthy, unsafe or risky behaviour - smoking or taking drugs, self-harming, unsafe sex - or becoming the victims of physical, mental or sexual abuse.
- An increase in the level of mental wellbeing amongst children and young people.
- A reduction in the gap in educational attainment between those children who receive free school meals and those who don't.

You can find out more about the work taking place to support children and young people from 'Young and Yorkshire'.
www.northyorks.gov.uk/youngandyorkshire

Outcomes

- People are emotionally resilient and experience good mental health
- Everyone has the opportunity to have a healthy body and a healthy mind
- People are active, involved and can be free from isolation and loneliness

Live well

Why is it important?

North Yorkshire people are healthier, and live longer, than the average for England. But there is still work to do to reduce the number of people affected by conditions that can be prevented or delayed. Heart disease, stroke and cancer account for the greatest proportion of deaths within North Yorkshire. Many of these illnesses can be avoided if everyone is helped to make positive lifestyle choices.

The risk of social isolation and loneliness is greater for people living in rural communities, especially (but not exclusively) amongst older people and those with a disability or long term illness - and people who are socially isolated are more likely to die prematurely.

Being in good employment increases mental and physical health and wellbeing. We need to maximise local opportunities for economic and job development, including apprenticeships and graduate opportunities for the young people who are our future workforce.

The quality of our home is another major factor in health and wellbeing. For example, fuel poverty and cold homes are major contributors to poor winter health. We need to ensure that there is an affordable supply of North Yorkshire homes that have a positive impact on health and wellbeing.

The York, North Yorkshire and East Riding Strategic Housing Partnership has produced a Housing strategy. You can find out more about it at www.nycyerhousing.co.uk

What have people told us that they want from this strategy?

Good clear communication so we can make healthy choices. Better awareness/training for people who support us about how we can live a happy and healthy life…

"Having easier access to fitness centres, lowering costs of fitness centres. More information on healthy choices."

What changes can you expect to see?

By 2020, you can expect to see:

- Fewer people saying that they feel socially isolated in their local communities.
- More people receiving personal budgets for their care, to give them choice and control over their lives.
- More people helped to self-manage their own care at home or through local community hubs.
- Fewer hospital admissions and lower premature death rates from heart disease, stroke and cancer, with the biggest improvements in the most deprived areas of the county.
- Improved employment opportunities, including rural areas and particularly for young people and those people who often face most barriers in the labour market - for example people with mental health issues, people with autism and people with disabilities.
- A higher proportion of young people taking up apprenticeships in North Yorkshire.
- Fewer people living in poor quality or inappropriate housing, or living in fuel poverty.
- More people with autism will have access to a diagnostic pathway to support and help improve their health, wellbeing and independence.
- A greater range of options for accessing exercise and fitness services.

Outcomes

- People can make choices to self-manage their care to help them stay independent for longer
- Carers are supported to live their own life

Age well

Why is it important?

North Yorkshire people are living longer these days - more than a year longer, on average, than ten years ago. That means more active older people in good health, but also more people (especially the very old) living with on- going conditions such as arthritis, dementia, heart problems or osteoporosis.

We expect there to be a third more people aged 85 plus by 2021 compared to 2011.

The number of families caring for loved ones continues to rise, with the sharpest rises amongst those providing the highest levels of care. The number of carers over 65 is increasing above any other age group

Care and support for older people takes up the greatest share of resources in the NHS and social care. So it's important to get this right - and if we make services work well together for older people, we can be confident that they can work well together for everyone else, too.

People can feel in control of their lives and are able to, make decisions and choices for themselves and be valued as part of a community.

What have people told us that they want from this strategy?

What changes can you expect to see?

By 2020, you can expect to see:

- More health and social care staff working together across local GP surgeries and primary health care centres to support older people in the local community.
- New community hubs offering advice, access and care to people receiving services and those who care for them.
- More carers feeling that they can have a life outside caring.
- Improved the way people can choose, buy and fit equipment and Telecare so that they can stay independent for longer.
- A range of options in place that help people to keep their independence for longer. For example, intermediate care and reablement services.
- Fewer older people entering nursing or residential homes for long term care.
- More Extra Care housing available to people across North Yorkshire.
- A greater range of support options for people in their last years of life.
- More people receiving support for themselves and their families at the end of life, with more people dying at home or in the place that they choose.

Outcomes

- Individuals are supported and encouraged to prepare for and plan their last days
- All individuals, their carer's and families' experience good end of life care

Dying well

Why is it important?

In North Yorkshire, although most people would prefer to die in their own home, around half die in hospital. The proportion dying at home will increase, but because of a rise in the death rate, the actual numbers dying in hospital will also increase

There has been a substantial shift towards the idea of patient choice, with people increasingly likely to question treatment plans for themselves and their relatives

Death and dying is now beginning to be debated more openly. Nevertheless it still seems to be the case that, in practice, the discussion of death as an inevitable and, in some cases, imminent aspect of life is regarded as morbid and thus avoided. Even with people suffering from terminal conditions, it is common for there to have been no discussion with patients, their consultants or GPs, relatives, and carers, about preparing for dying

Hospital cannot offer the individual the same comfort and familiarity that they might find if they were able to die in their own homes and in their own bed, surrounded by the people that they love, particularly when hospitals are long distances from the communities in which they and their friends and families live

To consider and address psychological and spiritual care needs and recognise these are as important as meeting physical needs

To provide support for the individual to live as actively as possible until death and to help family and friends cope during the person's illness and in bereavement

Encouraging conversations around quality of life, how and where a person might want to be cared for, as well as financial issues helps to make sure the wishes of the person dying are being adhered to

If family know about the dying person's wishes it can help them if they ever have to make decisions about care and can help to remove some of the stress from a very difficult situation

Exploring options for hospice care which can provide care for the dying and support for the family provided in a person's own home or elsewhere

To consider how bereavement support is provided to grieving friends and relatives

What have people told us that they want from this strategy?

"Dying well is very important for all ages and providing support to friends and relatives should have greater prominence from all organisations"

What changes can you expect to see?

By 2020, you can expect to see:

- A greater range of support options for people in their last years of life
- More people receiving support for themselves and their families at the end of life
- More people dying at home or in the place that they choose
- Greater numbers of trained staff and carers with deeper understanding about the range of issues in end of life care
- Breaking down barriers about how dying, death and bereavement are discussed
- Adoption of new and emerging best practice and principals around end of life care (Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020 - www.endoflifecareambitions.org.uk)
- End of life care to be planned in an effective and sensitively appropriate way, and for staff to be adequately trained

Getting the whole system working better

A new relationship with people who use services

We want to develop a new relationship with people who use services and the communities they live in. We recognise that people are part of a community and that we need to build on the strong relationships that are already in place locally to get the best outcomes we can for everyone.

Health and wellbeing services, by their very nature, are often needed most by those in our society that are the most vulnerable and we recognise that we have a statutory duty to help people in this situation. We also understand that people might find themselves in need of help because of a particular set of circumstances and it is important that we organise services in a way that makes it easy to get help whenever it is needed by a person, or their carer.

We want people to have a bigger say over their own care and how they manage their lives, no matter what their health and care needs might be. For people to be able to do this it is important that there is easy access to good information and advice that helps people make informed choices about their care. Getting this right means that, as our needs change, we can look after ourselves and each other for longer and that we can get the right help at the right time from others.

We want to work with people to do things differently and in a more joined up way. We also want to make it easy for people to tell us what they want from services and how we are doing in delivering services.

What have people told us that they want from this strategy?

"I think one of the hardest things for policy makers is to understand the variety of differing complex situations people find themselves in at various stages in their lives, and particularly in later life. So the point in the strategy about developing relationships with service users seems to me to be very important."

"That the professionals communicate effectively with each other, that there are supportive local services, that I am treated as an equal in my care"

As well as having more input into decisions about the sort of care people might receive, we want people to have direct control of the money available to support their care. We are already doing some of this through personal budgets for both health and care, but we expect to see more people using these budgets to self- manage their care.

Workforce

To deliver good health and wellbeing services we need a skilled, motivated and flexible workforce. Health and social care organisations don't always find it easy to recruit and retain staff to work locally - we need to help to change that. We know that nursing staff in care homes and some community hospitals is an area of particular pressure. We are working with organisations who provide care and our education partners to develop the workforce of the future and to attract and retain quality nursing staff so that people can be confident in the care that they receive.

North Yorkshire health and care organisations are working with local people to redesign the health and care system. This includes developing new models of care which will help people access more services in the community that join up health and social care. This will mean staff from different organisations will need to learn new skills so that people using services have a better experience of care.

Some of the ways we can make this happen are through:

- Creating new roles that offer exciting career choices in health and social care.
- More local opportunities for people to develop their skills in health and social care sectors, as well as in education and other children's services.
- More opportunities for people to return to work after a break or after retiring from a full time role.
- Better opportunities for people who have experienced poor mental health to access paid employment.

Technology

Technology is now a fundamental part of every aspect of our lives. The way we access and share information, interact with each other and use services all relies on technology working well and in a way that suits our lives. We want to help organisations to talk to each other more easily so that people can use technology to find out more about health and social care.

We want to help people take responsibility for self-managing their care and technology has a role to play in offering easy ways to access advice and information. There are now many ways to keep in touch and we want to maximise these opportunities for the people who use services.

Technology can be a key asset for communities, helping to support local business opportunities, improving educational experiences across all age groups, providing everyone with better ways of communicating with the outside world, and offering the opportunity to learn from others. We also need to ensure that children are protected from the potential pitfalls of technology especially where this might compromise the personal safety of young people or increase their likelihood of exploitation.

We want to work with partners and the wider community to make sure we are making the best use of the technology that is available to us and our communities.

What have people told us that they want from this strategy?

Economic prosperity

Our successful tourism sector gives us a special sense of the importance of our local communities and heritage. We want to encourage ourselves and our partners to think more creatively about how we can use these assets and the things that are best about North Yorkshire to find new ways in which they can contribute to health and wellbeing.

Creating a supportive environment for businesses is good for the health and wellbeing of the communities around them. For individuals, we know that an increase in income leads to an increase in psychological wellbeing and a decrease in anxiety and depression. For providers, having a vibrant market that offers good opportunities for them to develop their business means that they are more likely to invest in the local area which, in turn, will attract a workforce that delivers high quality care.

Growing our existing businesses and inspiring enterprise is part of the long term strategy for North Yorkshire. Health and social care organisations are major employers in North Yorkshire and play an important part in the economy, not only in supporting us to stay well, but by offering a wide choice of employment opportunities. This helps local people stay local and it also helps North Yorkshire attract new talent so that we can achieve outstanding quality-improving health and care.

Our principles for making these changes real

We will always use these principles when developing plans, commissioning services and delivering care to check that we are keeping our promises in this strategy.

1) Recognise where things are different…

- So that we respond to differences between local communities
- So that we prioritise the people and place that need things most
- So that we take full advantage of the different assets in urban and rural communities

Every community in North Yorkshire has a different range of resources and assets that can contribute to improving health and wellbeing. Our role is to help support people at every stage in life to use those assets wisely and well, in the way that suits the local community best.

We also need to make sure that we target our improvements on the people and communities that need it most. Although North Yorkshire is relatively prosperous overall, pockets of deprivation exist both in towns and rural areas where improving health and wellbeing can have a really significant effect, and which we need to make priorities for new investment.

2) Tackle issues early…

- By investing more in local services so that we prevent illness in the first place for all age groups
- So that you have more opportunities to access local care and support that can nip problems in the bud

Keeping healthy and well, and tackling ill health in its early stages is much better than trying to deal with things once they have become more serious.

We all know what we should be doing to increase our chances of staying healthy for longer - stopping smoking, cutting down on alcohol, avoiding drugs, keeping our weight down, taking more exercise - but it's much easier to do them when there is a local source of help and support.

3) Joining things up to make life simpler…

- So that you only have to tell your story once
- So that you can trust local services to work together effectively
- So that you get the response that meets your needs, not what's convenient for different organisations
- So that there's less waste caused by duplication

Many of the old organisational barriers that stopped services working together are being broken down. We want to make the most of these opportunities to do things differently - when it makes sense locally. This will mean increased integration between health and social care services as well as between county and district councils or NHS services and the voluntary or independent sectors.

4) Make a positive contribution…

- So that you're inspired and enabled to take responsibility for your health and wellbeing and the decisions about your care are shared between the person and the professional
- So that you have opportunities to support the health and wellbeing of others in your community

These days we hear a lot about the importance of being able to live independently - and having control over our lives is good for our health and wellbeing. You can take responsibility for your own health and wellbeing through lifestyle changes, or by having more control about how you use services - for example by managing your own medication, or having a personal budget to spend on the care you need.

But we also depend on each other to live our lives well. The greatest assets we have in North Yorkshire are the people of North Yorkshire. We want everyone to feel able to make a positive contribution to the health and happiness of your local community - whether that's as an employer, an employee, a volunteer, or just by being a good neighbour.

5) Keep people safe…

- So that you can feel safe and secure in your local community, your school and your family home
- So that you can be confident that you will be treated with dignity and respect
- So that you know we take a 'zero tolerance' approach to any form of abuse

Feeling safe in and around your own home is an important part of your overall sense of wellbeing. We will encourage organisations to make safety a priority when they plan and deliver services, particularly where these relate to children, people with disabilities,, those with dementia, and other vulnerable groups.

We also know that you expect high standards whenever you use public services. Everyone who uses services - and everyone who works in them - has the right to be treated with dignity and without being abused and is responsible for treating other people in the same way.

6) Spend money wisely…

- So that we invest in things you can be confident will deliver good value
- So that we improve the quality of services for the long term
- So that we make the most of the North Yorkshire pound

Value for money is always important, but especially at a time when demands on services are growing and budgets are under pressure. Part of our role is to make sure that what we do spend is spent wisely, on things that we know make a real long term difference.

What do we expect from the Health and Wellbeing Board?

- To make a difference and to improve health and wellbeing
- We will support each other to tackle problems together
- We will respect local differences
- We will look for ways in which we can work together
- We will stay focused on the strategy
- We will be ready to listen and take hard decisions together when necessary - and stick to them

What do we expect from local communities?

- They will value positive contributions from everyone, whoever they are and at all stages of their life
- They will support people to make healthy choices and live well throughout their lives
- They will speak up about the needs of local people including those who are at risk of being marginalised or in particular need, especially where this relates to children and young people, and other groups who might not ordinarily be able to speak up for themselves

What do we expect from people living in North Yorkshire?

- You will take on more responsibility for your own health and wellbeing
- You will make more healthy choices to improve your health and wellbeing
- You will look out for other people in your community
- You will ask for help when you need it
- You will speak up when things go wrong

How will we measure our success?

We will develop an action plan to include the following elements

Dashboard – key statistical data monitored regularly by the Health and Wellbeing Board

Exception reporting – statistical data or information that is escalated to the Health and Wellbeing Board requiring action and review

Theme discussions – an in depth review of progress against our four themes to encourage positive challenge and action.

Peer review – an evaluation by a group of Health and Wellbeing Board representatives to improve and enhance performance and share learning.

Letting you know how we're doing

Every quarter…

We hold Board meetings to look at progress on this strategy and to discuss ideas about how we can best improve health and wellbeing in North Yorkshire. Meetings are held in public, and papers are available the County Council's website **http://democracy.northyorks.gov.uk/committees.aspx?commid=27**

Every year…

We will publish a report on what has been achieved, and what impact it has had on health and wellbeing in North Yorkshire.

We hold a range of events across North Yorkshire to bring people together to talk about what's important to their health and wellbeing. Look out for details in your local newspaper, or check on the website at **http://www.northyorks.gov.uk**

How can you get involved?

Find out more

While this strategy sets out how we will organise our work and some of the biggest changes we expect you to be able to see by 2020, it can't cover all the changes that are planned for your local area.

If you want to find out more, you can contact North Yorkshire HealthWatch, who can signpost you to information about what's being planned for your local area.

Contact them by phone: **01904 621631**

By email: **healthwatchny@nbforum.org.uk**

Website: **www.healthwatchnorthyorkshire.co.uk**

Twitter: **@HealthwatchNY**

Help us implement this strategy

We won't always get things right first time and we need and value your help to tell us what's working and what we could do better.

We therefore pledge to continue to talk to you and to listen to see if the strategy is making a difference.

Contact us

You can tell us what you think about the strategy by emailing your views to **jsna@northyorks.gov.uk** or writing to:

JSNA, North Yorkshire House, Scalby Road,Scarborough YO12 6EE

If you would like this information in another language or format please ask us.
Tel: **01609 780 780** email: **customer.services@northyorks.gov.uk**

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Health and Wellbeing Board
North Yorkshire

HEALTH & WELLBEING BOARD

Friday 27 November 2015

Commissioning for military populations across North Yorkshire

1 Purpose of the Report

1.1 Military personnel, veterans, reservists and their families comprise an important population across North Yorkshire.

1.2 The purpose of this paper is to demonstrate why effective support for this population is so important and to strengthen the process of effective joint working to achieve better health outcomes.

2. Introduction

2.1 All Serving Armed Forces are registered with Ministry of Defence (MoD) Defence Medical Services (DMS) Medical Centres. Across England, approximately half are concentrated in four areas (Devon, Hampshire, Wiltshire and North Yorkshire).

2.2 There are multiple commissioners in any health and social care economy, but the armed forces health commissioning system is a particularly complex landscape. Interfaces between different commissioner responsibilities within the system require ongoing and strong partnership working to understand where commissioning responsibilities along care pathways start and stop. The continual population movement associated with military centres add another layer of complexity.

3. Our Population

3.1 Serving members of the Armed Forces, Reservists, Veterans, and all of their families, all form part of a larger Armed Forces Community.

- **Serving Armed Forces** – Nationally, approximately 140,000 people (9.9% female), all of whom are registered with the MoD DMS Medical Centres in England. There are approximately 13,600 Serving Personnel (SP) registered

across the 9 Medical Centres within North Yorkshire County Council (NYCC). The majority are based at Catterick Garrison. *(See Table 1)*

- **Their families** – i.e. spouses / partners and dependant children and adults. There are 127 DMS medical centres in England of which 21 are GP training practices and can provide primary care for dependants. Most dependants register with NHS GP Practices and are the responsibility of CCGs but approximately 15,000 are registered with DMS Medical Centres in England and are the responsibility of NHS England. Three of those 21 training medical centre practices are located within NYCC where approximately 3,000 dependants have chosen to register with them. *(See Table 1)*

- **Veterans** – A Veteran is defined, in the Armed Forces Covenant, as anyone who has been a member of the serving Armed Forces for a day or more. There are approximately 4.6 million veterans in the UK (4 million in England). All should be registered with NHS GP Practices and are the responsibility of CCGs. Due to difficulties in defining the veteran, and in many cases a reluctance of the veteran to identify themselves, the veteran group is largely hidden within the general population.

- **Reservists** – Reservists are civilians who are called in to the serving Armed Forces from time to time for particular tours of duty. Reservists are regarded as members of the Armed Forces while mobilised. When not mobilised, reservists should be regarded as veterans when accessing NHS care.

Table 1: MoD DMS Population within North Yorkshire by CCG

CCG	Medical Centre (MC)	Service	SP	Families
HRW	Catterick Garrison MC	Army	5300	1700
HRW	Catterick Infantry Training Centre MC	Army	2900	
HRW	Topcliffe MC	Army	600	
HRW	Leeming MC	RAF	1815	900
SR	Fylingdales MC	RAF	80	
H&RD	Dishforth MC	Army	500	
H&RD	Harrogate Army Foundation College MC	Army	1300	
H&RD	Ripon Claro MC	Army	800	
VoY	Linton-on-Ouse MC	RAF	340	440

3.2 Age profile

Members of the Armed Forces are typically younger and fitter than the general population. 50% of this population is aged under 30 which is in comparison with 35% of the England population. 81% of this population is aged under 40, compared with 47% of the England population. 17% of the England population is aged 65 or over, by comparison, none of the reported SP population is aged more than 65.

3.3 Rebasing

While there will be moves in and out of the NYCC area and fluctuating numbers, current planned Unit moves and British Forces Germany withdrawal plans will have no projected overall impact on total regional numbers in 15/16 and 16/17. Although still a small number, the most significant population change will be at Dishforth where there will be eventually be around 200 SP moving to the base which is approximately a 40% net increase in the population.

3.4 Statutory commissioning responsibilities

MoD DMS commission and provide primary care services for their registered population similar to those provided by NHS primary care. The Regional Rehabilitation Unit at Catterick Garrison provides physiotherapy and group rehabilitation for general musculo-skeletal conditions that support rehabilitation delivered in the majority of their primary care facilities. Catterick Garrison also provides a Community Mental Health service which also provides regionally-based occupational psychological support for service personnel. The MOD commissions some additional secondary care services e.g. fast-track access to diagnostic imaging and orthopaedic surgery for specified orthopaedic conditions and inpatient mental health care services.

Since 1st April 2013 NHS England has been responsible for commissioning secondary care and community services for Serving Personnel (SP), including mobilised reservists, and those families registered with a MoD DMS practice in England. (Those stationed overseas who return to England to receive health services are also the responsibility of NHS England). NHS England are also responsible for commissioning specialised services, including specialist limb prosthesis and rehabilitation services for veterans. NHS England works closely with local Clinical Commissioning Groups (CCGs) who have specific duties for the commissioning for Reservists, when not mobilised, Veterans and Armed Forces Families (except those registered with DMS practices).

Bespoke services for veterans, such as veterans' mental health services, will be commissioned by CCGs either individually or collectively. CCGs must also ensure serving members of the Armed Forces and their families (where registered with DMS Medical Centres) will have full access to Out of Hour and emergency care services. CCGs also need to consider the needs of serving personnel transitioning out of the Armed Forces, particularly when they have been wounded, injured, or are sick and where continuing health care assessments are required.

A brief high level summary of NHS commissioning responsibility for these populations is shown in *Table 2*.

Table 2: High level NHS commissioning responsibilities

Population	Responsible Commissioner
Serving Personnel, Mobilised Reservists	NHS England
Families – with a DMS practice	NHS England
Families – with an NHS practice	CCGs
Reservists – not mobilised	CCGs
Veterans	CCGs

3.5 The Health and Social Care Act 2012 made Local Authorities responsible for improving the health of their population and for commissioning certain public health services such as smoking cessation, sexual health, substance misuse treatment and the Healthy Child Programme. The Public Health team at NYCC has led on a number of strategies and public health service commissioning that are relevant to military personnel and their families. These services work closely with CCG and NHS commissioned services.

4. Health needs of our military populations

4.1 There is an increasing evidence base around the specific health needs of military populations. The North Yorkshire Joint Strategic Needs Assessment (JSNA) describes a range of key health issues relating to military personnel, their dependants and veterans.

4.2 Service personnel

The MoD produces an annual report on the Health of the Armed Forces, key themes from the 2013 report include:

- Health promotion – smoking cessation, oral health and alcohol misuse
- Musculoskeletal (MSK) problems
- Mental health

There is low prevalence of long-term conditions but a higher incidence of trauma and orthopaedic injury. Combat-related injuries aside, Armed Forces healthcare needs can usually be met by standard NHS services.

4.3 Families and Dependants

Whilst the children of service personnel have been shown to gain pride, identity and belonging from their parents' career, they are also exposed to some unique situations and challenges which non-armed forces children are less likely to face. The Royal Navy and Royal Marines Children's Fund have researched the needs of armed forces children and have concluded that: "we are sitting on a ticking time bomb of problems for service children which will only get worse if they are not addressed immediately, in a holistic manner, by all involved".

The report identified ten main challenges which service children face above and beyond those of their peers:

- Stresses and strains on children while their parents are away.
- Impact of living in a temporary one-parent or no-parent family.
- Influence of the media.
- Adjustments to family life when the parent returns.
- Impact of moving homes, schools and communities.
- Stigma of being viewed as a 'military brat'.
- Dealing with bereavement.
- Dealing with parental illness or injury.
- Dealing with divorce and family breakdown.
- Living with special educational needs (SEN) and/or a disability.

Locally, a health needs assessment was undertaken in 2010 to examine the health needs of children and families in Catterick Garrison. This did not identify any significant physical health differences between service children and non-service children locally. However, service children were around a fifth less likely to achieve a 'good' level of social and emotional development in the Early Years Foundation Stage curriculum than their peers across North Yorkshire. In areas such as literacy and communication their scores were similar or better. Factors influencing the social and emotional functioning were identified to be younger mothers, parents who might have had poor parenting themselves, frequent mobility, loss of extended family networks and lack of 'mature heads' amongst the service community.

Amongst older children, some clear differences in risk taking behaviours were highlighted in the School Health Behaviour Questionnaire in 2010. At 11 years old, service children reported higher levels of smoking, drinking alcohol, being bullied and having had an accident requiring clinic or hospital treatment than their non-service peers. At 12 and 15 years old, the differences were even more marked. 50% of service children reported having had an alcoholic drink in the last week compared to 35% of their civilian counterparts. This trend was also evident in relation to questions about smoking, taking drugs and risky sexual behaviour."

4.4 Veterans

Though military service is often seen as a job for life, less than one fifth of personnel actually serve for a full career of 22 years. Of those leaving in 2011/12, nearly half had served less than six years, including a significant number of Early Service Leavers who depart before they complete training. The average length of Service, for those that do complete training, is nine years. Despite the public perception, the health data for Service Leavers demonstrates that the overwhelming majority (92%) of them depart in good health and transition successfully. This is due in large part to the high level of physical fitness required and the extensive level of health monitoring and protection in place. Research findings indicate that veterans have similar health needs and experiences to the rest of the adult population with the same implications on resources for both health and adult social care. For veterans over 65 years old (the largest veteran group at 60% of the total), mobility, independent living and social isolation were the main concerns.

- Very few “post 9/11” veterans experiencing significant adversity related to their time in Service or consuming healthcare resources at a rate any different to the rest of the community.
- The existing generation of UK military personnel (both serving and ex-Service) have higher rates of alcohol use compared to the general population.
- Alcohol problems, depression and anxiety disorders are the most frequent mental health issues for ex-Service personnel.
- Similar rates of mental illness are found for ex-Service personnel and their still serving equivalents, which are broadly similar to the general population.
- Military personnel with mental health problems are more likely to leave their Service over a given period compared to those without these problems, and are at higher risk of poorer outcomes post-Service.
- Those who leave military service due to mental ill-health are a minority and are at increased risk of social exclusion (e.g. unemployment and homelessness) and continuing poor health.
- The overall suicide rate for UK ex-Service personnel is similar to the general population, but younger male ex-Service personnel (under the age of 24 years) have higher rates of suicide than their general population equivalent.
- Early Service Leavers are at higher risk for adverse outcomes such as suicide, mental health problems and risk-taking behaviours (e.g. heavy drinking, suicidal thoughts) compared to longer serving veterans.
- Studies on delayed-onset PTSD are based on small samples and mostly retrospective and should be treated with caution.
- Poor mental health outcomes are associated with deployment to Iraq or Afghanistan for personnel with pre-Service vulnerabilities, those exposed to high levels of combat and Reservists compared with Regulars.
- The North Yorkshire JSNA identifies specific issues in relation to veterans concerning the risk of homelessness. Estimates suggest that nationally around 6% of the homeless population may be ex-forces.

4.4 Nepalese Community

The North Yorkshire census shows a population of 758 Nepalese in Richmondshire, excluding serving Gurkha soldiers. The population is ageing as ex Gurkha soldiers and families can now settle in the UK and senior citizens come over to join their families. This population has a range of health and social needs, in part due to communication difficulties arising from language barriers and literacy levels. These can translate into difficulties in the utilisation of medication and hence health outcomes. There are also

challenges in relation to engaging with the community, cultural issues linked to health and social care and evidence of mental health issues.

5. Commissioning plans for the Armed Forces Community

5.1 NHS England's vision is to obtain the best health benefit from the available resources by commissioning high quality, safe and effective care for the Armed Forces Community in accordance with the *Armed Forces Covenant* and the *NHS Constitution*. The commissioning focus for the armed forces and those families registered with a DMS practice is to improve health outcomes ensuring equity and consistency in the provision of health services.

5.2 Armed Forces Covenant

It is recognised that military personnel put themselves in harm's way in the service of their country, risking injury or death in the course of their duty. Successive governments have recognised the debt society owes to its Armed Forces, their families and veterans, and most recently Society's obligations were set out in the *Armed Forces Covenant*, a framework for the duty of care the United Kingdom owes its Armed Forces and now included within the principles of the NHS Constitution.

In terms of healthcare, the key principle is that the Armed Forces Community should experience no disadvantage in accessing timely, comprehensive and effective healthcare. They will also receive bespoke services in some agreed areas for their particular needs or combat-related conditions including, for instance, specialist limb prostheses and rehabilitation.

5.3 Current NHS England commissioning priorities

<u>Delivering better care through the digital revolution:</u>

- increase use of E-referrals, including advice and guidance functionality, within DPHC
- increase the use of telemedicine as an alternative to face to face care where appropriate;
- increase access to national screening programmes
- link DMS systems to Child Health Information Systems

<u>Co-ordinated access to musculoskeletal pathway:</u>

- improved use of E-referrals and its functionality within DPHC for access to secondary / tertiary referral for MSK conditions
- re-design MSK pathways to make best use of recognised good practice in rehabilitation

<u>Improved access to mental health services:</u>

The Ministry of Defence (MoD) commission bespoke inpatient and community mental health services for their service personnel. NHS England commission prescribed specialised mental health services for the population in England, including an inpatient Post Traumatic Stress Disorder (PTSD) service specifically for Serving Personnel. Further planned service improvements are to:

- improve care co-ordination on service discharge

- improve signposting to appropriate mental health services including crisis services
- improve choice of recognised good practice and evidence based services for mental health

Wounded, Injured and Sick leavers (WIS) to have an agreed health plan:

- Work with the MoD to ensure that all WIS service leavers leave with a personal health plan;
- empower patients to take to take more control of their long term health and direct them to the most appropriate professional under the primary care team to manage their routine needs.

6. National co-commissioning plans for dependants / veterans

6.1 The following priority areas reflect NHS England co-commissioning intentions for veterans and their families.

6.2 Mental Health Services

Recommendations made by Andrew Murrison MP in the MoD published report *Fighting Fit: A mental health plan for servicemen and veterans (2010)* led to:

- Establishment of ten regionally based community veterans' mental health pilot services. NHS England commission Humber NHS Trust to provide a specialist veteran mental health service (expires September 2016) and the *Yorkshire and Humber Veterans Outreach Service* is delivered across Yorkshire and the Humber.
- *Big White Wall* – a national online psychological veterans mental health support service. (Commissioned by Department of Health.)

6.3 To further support CCGs in their overall commissioning responsibility for this population, NHS England are undertaking a review and engagement programme to establish the type of services which should be commissioned into the future and the commissioning arrangements for them. In light of significant research and the recently published Forces in Mind Trust: '*Call to mind, a framework for action'*, procured providers will be developing and testing 3 interim pilot service models (Oct 2015 – Mar 2016)

- Veterans who have a dual diagnosis relating to mental health and substance misuse (particularly alcohol)
- An outpatient PTSD Programme for moderate to severe PTSD as an alternative to an inpatient Programme
- Hard to reach veteran groups, especially early service leavers (<6 years' service)

6.4 Military amputees

On 27 October 2011 the Department of Health published "*A better deal for military amputees".* The report by Dr Andrew Murrison MP was in response to concerns from service charities and some Serving Personnel who have been seriously injured, and the recommendations made were for the NHS to

provide prosthetic services to the same standard as the Defence Medical Service at Headley Court.

6.5 Scheme of Equivalence for Medical Devices

Currently there is no formal mandate to the NHS to match medical devices other than prosthetics i.e. those that are issued by the MoD to Serving Personnel. The medical device received by veterans from the NHS may be different to that issued to them whilst they were serving. This is a specific issue for veterans requiring wheelchairs, orthoses and hearing aids. NHS England are working with the MoD to establish a scheme of equivalence for a range of medical devices over the next five years.

7. Commissioning primary health care for the families, dependants and veterans of Catterick Garrison

7.1 Hambleton, Richmondshire and Whitby CCG has worked with the main practices which provide the most significant proportion of services to military families, dependants and veterans linked with Catterick Garrison to better understand the population numbers, the observed local health needs, and the associated additional workload. Harewood Medical Practice in particular has undertaken some more detailed audits and analyses. The main emerging issues are below.

7.2 Patient numbers

One of the early findings is that this patient group are not routinely recorded as such within GP practice systems, which can make them difficult to identify and have wider needs met. One of the early areas of work to start better supporting these different patient groups will be to record patients in these categories using Read coding. In the meantime, approximately 3000 family members, 2000 veterans and 400 members of the Nepalese community have been identified as registered across the 2 GP practices in closest proximity to the Garrison.

7.3 Identified health and service needs of dependants

All the emerging evidence suggests that dependants of military families have higher levels of health need, in line with the issues identified through the NY JSNA and other evidence bases, leading to a higher level of presentation at local practices.

By the nature of the job, military personnel are recruited from various parts of the country and then based in a Garrison. As such virtually the whole community has moved away from their extended family and then become more dependent upon health services. This is with particular relevance to young mums with children. A snap-shot audit by Harewood Medical Practice indicated they saw their patients 6.34 times a year on average against a national norm of 5.5. Service personnel spend a significant part of the year training away from the base, often abroad, and also are sent on tours of duty abroad. As such the families become the equivalent of single parent families but are not recorded on statistics as such and therefore not reflected through in population weightings. This situation also has an effect on their families.

There are greater numbers of presentations for anxiety or depression / low mood associated with the stress of service personnel being deployed, and a greater prevalence and presentation for issues relating to obesity. This is evidenced in an audit undertaken by Harewood Medical Practice which showed the average number of appointments per annum for patients with depression was 11 for Harewood compared to 6 nationally. For obese patients the Harewood rate was 12 compared to 7 nationally. The health needs locally are reinforced by the military policy of basing families in Catterick Garrison who have special health needs, such as cerebral palsy and autistic spectrum disorders as well as other special needs, particularly for children but also other dependants too. This is done on the basis there are good support systems in place here.

7.4 Patient registration / deregistration of dependants

The turn-over associated with military families is particularly high. Military personnel are frequently expected to change location to a different base and their families and dependants may re-locate to join them. In many cases these patients come from abroad (and potentially military medical practices which operate in different ways to the NHS) making the administrative processes more difficult. For example Harewood Medical Practice had a turn-over of 236 new registrations per 1000 population per annum, whereas an example GMS practice was found to have a turn-over rate of only 69 per 1000 population, i.e. 3.4 times lower. Turn-over has a significant workload associated with it. Each registration involves a new patient consultation with a GP, administration and note summarising of approximately 25 minutes, and further administration and costs associated with deregistration.

7.5 Veterans

Discussions with the practices concerned have highlighted that there is more variability associated with the health care needs of veterans and to what extent they require targeted support through their local GP practice through an additional commissioned service. Being the largest military base in the UK in close proximity to an attractive area of the country with some cheap housing available within the vicinity of the Garrison, there are significant numbers of veterans and their families who decide to stay or retire in the area. In addition, some veterans also like to stay around the Garrison area so as to maintain a continued contact with the military. While there is a significant veteran population associated with the two practices in closest proximity to the Garrison, it should be noted that it is likely that smaller numbers of veterans are likely to registered at many or all of the practices in the CCG to different extents.

Many veterans will present in a pattern no different from the average patient. The issues of registration / deregistration will also not apply. However, there will be a cohort of veterans who may have additional and persisting health needs arising from their period of duty, particularly in connection to mental health.

Vulnerable Veterans and Adult Dependants Service (VVADS) is a bespoke Improving Access to Psychological Therapies (IAPT) service based at

Catterick Garrison. It specialises in working with veterans and dependants of serving personnel providing access to evidence based treatment for those who are experiencing common mental health difficulties and is provided by Tees, Esk and Wear Valley NHS Foundation Trust.

In particular, the MOD has built and set up in the Garrison a new centre (the Beacon) where 30 veterans can live for periods up to 18 months. These are ex-military personnel with health issues arising from their time in the forces; this covers non-physical issues like Post Traumatic Stress Disorder and other mental health problems. These are very demanding and chaotic group of patients who require significant input. There is also a centre recently opened (Phoenix House Recovery Centre, also based in the Garrison) by Help for Heroes with support from the British Legion, which is a short stay (up to a week) facility for military personnel, current and past, who have suffered physical and mental injuries in the line of duty.

7.6 Nepalese community

A proportion of these are military dependants as well as veterans and therefore the Armed Forces Covenant applies. The rest are extended families who have come to live here, mostly parents who therefore are elderly. They have significant chronic and often undiagnosed health problems like hypertension and diabetes which have a higher incidence in Asian populations. There are significant language problems. Harewood has employed a Nepalese receptionist as a supernumerary post two mornings a week in an effort to facilitate supporting these patients.

8. Future action through the Health and Wellbeing Board (HWB)

8.1 This paper makes a case for concerted commissioning collaboration and planning between partners to assess and address the health and service needs of military personnel, families and veterans.

A number of key areas of work have already been initiated.

8.2 Enhanced Service for primary healthcare for military families and veterans

Hambleton, Richmondshire and Whitby CCG are working with their two Personal Medical Services practices which are in closest proximity to Catterick Garrison to develop and design a new enhanced service for this patient group. The work in 2015/16 will focus on identifying and quantifying the population and their health needs, with a view to describing a more detailed service specification for future years.

8.3 Healthy Towns expression of interest (EoI) for Catterick Garrison

Local authorities, health and military bodies led by Richmondshire DC submitted an expression of interest to the NHS Healthy Towns initiative. This EoI is seeking to promote modern health services across the whole of Catterick Garrison and in support of the wider rural hinterland. It also seeks to support healthy design on a major strategic site.

It is important to note that the specific health commissioning challenges of the military population are set in wider North Yorkshire communities. Catterick Garrison is a rather unusual town for North Yorkshire and has coalesced over the past 100 years to include the villages of Colburn, Scotton and Hipswell as well as a number of military facilities. The military Catterick Garrison comprises several sites including the main site, Marne Barracks at Catterick Village and Alanbrooke Barracks, Topcliffe. The town's population of about 15,000 people includes the largest number of military personnel and their families in the county, about 10,500 who are also part of the wider community in Richmondshire.

The age/sex mix of the military population is unusual since overall it remains about the same as personnel and their families move through their military careers. It is younger than the surrounding population and heavily skewed towards younger men. Military families are also not typical of the wider population because they are all younger and with children. The 2011 Census shows that the average household size of military families is about 3.5 compared with 2.3 in the wider population. The military population also brings with it an unusual mix of people particularly recruits from the Commonwealth including the West Indies, Pacific nations and Nepal. Dependants and, increasingly veterans are adding to this mix.

The substantial presence of this military population in Richmondshire therefore reduces the average age and masks local economic conditions because personnel are fully employed. The risk is that not only does it bring a range of specific health care issues, but it may also obscures those of the local population to some extent. The EoI recognises the close relationship of all communities in Catterick Garrison and aims to develop shared local and military health services through the redevelopment and regeneration of existing facilities.

8.5 Engaging with the Nepalese Community

North Yorkshire County Council is in the initial scoping stages of conducting an assessment of the health needs of the Nepalese community living in North Yorkshire. The aim is to establish whether these needs differ significantly from the rest of the County population, as well as investigate whether barriers to services exist and if so, how these might be overcome.

The Public Health team will be working closely with members of the community, the voluntary sector, defence medical services, and CCGs to allow the input of key stakeholders and care professionals, as well as Nepalese residents. Initial findings suggest that nationality should be captured by primary care, allowing us to analyse information relevant to those from a Nepali background. Quantitative data relating to lifestyle, disease prevalence and uptake of services will hopefully be used alongside the findings of interviews and focus groups to develop our understanding of the experience of the Nepalese community living in North Yorkshire.

It is hoped this information will help to inform commissioning decisions and care provision across the County. It may also feed into future Joint Strategic

Needs Assessments, for example, those relating to veterans and the health of military personnel and their families.

8.6 Developing a strategic way forward

Due to the significant military population in its area, Hambleton, Richmondshire & Whitby CCG has agreed to be the commissioner representative for the North Yorkshire CCG's on the Armed Forces Network Group. Discussions have started to take place with members of the Defence Primary Healthcare team, with intent to work more closely together and to build relationships which will result in better health and social care for the community.

It is imperative that across North Yorkshire the partnership extends to the wider community including the County & District councils, Public Health, NHS England and the third sector. Although in the early stages the CCG are committed to building and delivering a plan that will improve the outcomes for the military population.

Partners from across the community attended a meeting with a member of NHS England recently to highlight the challenges and opportunities that currently exist across health and social care at Catterick Garrison. The meeting was positive and is the first step in forging joint working for the local population. The CCG recognises that the current commissioning landscape for armed forces personnel, families and veterans is confusing and fragmented. There is a need for a programme of work to be undertaken to ensure that commissioners and partners work in a joined up way to commission high quality, safe and effective care for the Armed Forces Community in accordance with the *Armed Forces Covenant* and the *NHS Constitution*.

9 Recommendations

9.1 This paper sets out a range of commissioning priorities both at local and national level. The Health and Wellbeing Board are asked to recognise the importance of this population and their associated health and social needs. The HWB is asked to prioritise this work programme and share the learning arising from the local initiatives at appropriate intervals.

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18 November 2015

Partnership Commissioning Unit
Commissioning services on behalf of:
NHS Hambleton, Richmondshire and Whitby CCG
NHS Harrogate and Rural District CCG
NHS Scarborough and Ryedale CCG
NHS Vale of York CCG

North Yorkshire Health and Wellbeing Board
27 November 2015

Report Title:	*Future in Mind*: transforming support for Children and Young People's Mental Health and Well-being
Report From:	Janet Probert, Director of Partnership Commissioning on behalf of the *Future in Mind* Transformation Plan Lead Commissioning Forum

1. INTRODUCTION

Future in Mind sets out a strong national vision and ambition for the delivery of mental health support for children and young people by 2020. 49 recommendations grouped into 5 themes set the direction, away from the existing health-led 4 tier structure to a model that clusters services around the child or young person, and emphasises prevention, and early support. The delivery mechanism is through the Local Transformation Plan, monitored by NHS England and the local Health and Well-Being Boards, to which is attached £1.3 million annually for 5 years to 2020 across North Yorkshire and York. Funding is on a Clinical Commissioning Group (CCG) footprint. The CCGs in North Yorkshire are: Harrogate and Rural District; Hambleton Richmondshire and Whitby; Scarborough and Ryedale, Vale of York CCG, Airedale Wharfedale and Craven and NHS Cumbria. These last two have only a small footprint in the County, but are involved in developing the Transformation Plan. The Plan is led in behalf of the 4 largest CCGs by the Partnership commissioning Unit, working with Local Authority colleagues. The funding formula for the Transformation Plans is based on population. Within the Vale of York CCG area, 64% of the population is resident in the City of York or the East Riding of Yorkshire, and their funding is apportioned between the local authority areas as circumstances require; the figures presented reflects the full funding allocation for the CCG.

This report:

- Outlines *Future in Mind*
- Explains the work undertaken to develop the Local Transformation Plan, and
- Sets out the priorities and actions proposed for inclusion in the Plan.
- Sets out the funding, governance and monitoring arrangements
- Sets out the implementation arrangements

2. FUTURE IN MIND

The report is produced jointly by the Departments of Health and Education. Its 49 recommendations are grouped into those deliverable without further investment (the majority), and those for which further investment or co-ordination with other initiatives is necessary (the minority). The Budget in March 2015 announced £1.25 billion funding for child and adolescent mental health over 5 years, and thus most recommendations are likely to be deliverable.

The **national ambition** is:

1. Children and young people will grow up confident and resilient so they can achieve their goals and ambitions
2. When children and young people need help they can find it easily, and be able to trust it
3. Help for children and young people will meet their needs as individuals and be delivered by people who care about what happens to that child
4. Children and young people are experts in their own care and will be involved in how mental health services are developed and delivered

To make the vision happen, there are **5 delivery themes**:

1. Promote resilience, prevention and early intervention
2. Improve access to effective support – a system without tiers
3. Care for the most vulnerable
4. Accountability and transparency
5. A well- developed workforce

On 3 August 2015 NHS England published guidance for the preparation of the Transformation Plans (see Section 3 below), and announced the funding to be allocated to each CCG for delivery.

The guidance also announced 3 priority areas for further potential investment and/or improved delivery in addition to the 5 themes outlined above:

1. Community Eating Disorder Service: this encompasses all support other than inpatient treatment, ranging from basic advice and information through to specialist clinic based therapies. There will be £384k pa across all 4 CCGs until 2020 to support this service.

2. Complete the roll-out of psychological therapies for children and young people (IAPT); these are therapies such as cognitive behaviour therapy, which have a strong track record in helping people to recover from or manage mental illness. All 4 North Yorkshire CCGs are now signed up to IAPT, with Vale of York CCG joining the regional collaborative in September 2015. It is therefore expected that the area will meet the commitment in *Future in Mind* to be fully covered by IAPT services by 2018.

3. Strengthen peri-natal mental healthcare: the subject area covers maternity care through to Health Visiting support, and separate guidance will be published about the expected standards and potential additional funding.

3. DEVELOPING THE TRANSFORMATION PLAN

The national ambition requires local leadership and ownership: all CCGs are required to publish a Local Transformation Plan to articulate the local offer. These Plans will cover the whole spectrum of services for children and young peoples' mental health and well-being, from health promotion and prevention work to support and interventions for those with existing or emerging health problem, or are transitioning between services.

The Plans were submitted to NHS England on 16 October 2015, and are currently being assured by NHS England. The Board Chair signed off the four Transformation Plans prior to submission; it was a condition of submission that the Board had had some oversight of the Plan proposals, and, in signing off the Plans, the Chair was assured that a report would be made to this meeting of the Board. Early feedback from NHS England indicates only minor amendments to the plan are required. They reflect the national ambition and have been developed in collaboration with children, young people and their families and with providers and commissioners.

Locally, work began on the Plan as soon as *Future in Mind* was published:

- Establishment of a Lead Commissioning Forum to oversee the project (see Section 4 below)
- Review of applicable strategies across all agencies: the Local Transformation Plan should align with and build on current strategies for emotional and mental health. The priorities articulated in the Plan reflect both the views of professionals and families and also the priorities in the Health and Well Being Strategy, *Growing Up in North Yorkshire*, and *Growing up Happy in North Yorkshire*. The North Yorkshire Mental Health Strategy, *Hope, Control and Choice* was in preparation during the development of the Transformation Plan, but the two documents are clearly aligned through the strategic themes and the priorities for action.
- Conversations with partner agencies, including service providers, Police, Youth Offending Teams, and Public Health colleagues in drafting a statement of readiness to implement the recommendations in *Future in Mind*
- Engagement with schools, both head teachers and SENCOs
- Engagement through the Discover! programme with a broad range of stakeholders including voluntary sector, young people and their families, Army Welfare, Department of Work and Pensions.

The outcome of the preliminary work was twofold; first to envision the future service:

By 2020, we will work together and share resources across North Yorkshire and York to make sure that children and young people…

- *Grow up confident and resilient and are able to achieve their goals and ambitions*
- *Can find help easily when they need it*
- *Receive help that meets their needs as individuals in a timely way*
- *Are fully involved in deciding on their support and more broadly how services are delivered and organised.*

Second was the identification of three priority areas for investment, in addition to the priority themes published by NHS England:

1. Prevention, promotion and early intervention
2. A system without tiers: easy access to appropriate help
3. Care for the most vulnerable children and young people

These themes are being worked into action plans that will deliver significant new levels of support for children and young people and those who work with them. All are keen to ensure this excellent new opportunity builds both on existing strategic priorities as expressed in Young and Yorkshire but also as a consequence results in new provision closely aligned with work to enhance the local integration and alignment of key services.

Prevention, promotion and early intervention

This is concerned with the value placed on recognising and promoting good mental health and emotional well-being, rather than focusing on illness. There must be an integrated partnership approach to defining and meeting needs across the full range of universal, targeted and specialist services:

- Promoting good mental well-being and resilience
- Preventing mental health problems from arising by taking early action with those at risk
- Early identification of need as problems emerge The main proposals for action are:
- Support throughout childhood from birth: subject to awaited guidance on peri-natal mental health care, working with the Healthy Child, and Health Visitor programmes and also within early years settings such as pre-school
- Whole system approach in schools: approaches involving building academic resilience
- Schools, GPs and others are equipped to support: named CAMHS links for all school clusters and allied GP surgeries to offer advice, support training and early therapies for individuals and groups.

A system without tiers: easy access to appropriate help

Current models of care have become overly rigid, dependent on the children and young people fitting the system of support, rather than services fitting the needs or changing needs of the child or young person. Frequently, children and young people have the option of specialist services which they do not need, or no service at all. The proposal is to move to a flexible needs based model: this allows agencies to jointly commission and deliver support to enable children and young people to move more easily into and between services and to make collaborative choices about what help best suits them.

This means that clearly structured access into services, and common understanding of how the ‘whole system’ functions is critical. The main proposals for action are:

- Single point of access into support: this will encompass a multi-agency triage to ensure that children and young people are offered the most appropriate support to suit their needs. It is proposed that within North Yorkshire a mental health worker be assigned to each Prevent Hub to advise, offer consultation to colleagues and onward referral to appropriate services. This will also ensure that high risk vulnerable groups are prioritised, allowing prompt decision making on interventions, advice and support.

- Invest in technologies to empower children and young people to access advice and early help in ways that are comfortable for them: there are technologies that offer web-based information, and incrementally, mediated discussion with professional support through to face to face support. Young people have expressed a strong preference for this approach, and have also stated they want to be able to access advice to help them support friends.

Care for the most vulnerable

Children and young people such as those in care, with complex needs, or in the Youth Justice system have greater vulnerability to mental illness, but often find it harder to access help and support. If access is readily available, then outcomes are improved for the individual and the potential costs to the public purse can be reduced.

The challenges are to ensure a clear sense of purpose across agencies in ensuring that appropriate care is always available. There are a number of models of care for vulnerable groups, such as Team Around the Child, and consultation and liaison models. Initiatives will be focused on work in schools.

In addition, the Plan details the approach towards establishing a community eating disorder service to meet the NHS national waiting time standards by 2020. There is very clear evidence that children and young people with eating disorders achieve better outcomes , both health and social/economic, if they can be treated in the community rather than in inpatient units. NHS data shows that across the four CCGs, there were 95 admissions to Tier 4 CAMHS inpatient units in 2014/15 of which 4 were primary presentations of eating disorder.

The national standard is that all urgent cases will commence treatment within five days, and non-urgent within fifteen days of referral. There are currently eating disorder clinics in Harrogate and York: both have a caseload of around 30-40 cases at any one time. The new community eating disorder service is structured on a footprint for the four main CCGs in North Yorkshire and York (750,000) population, and expects to carry a caseload of around 80 referrals a year. A proposal for the provision of the service has been submitted by Tees Esk and Wear Valley NHS Trust (TEWV), which is being considered.

How will we know we have succeeded?

The critical success factors for this ambitious project will be:

- Reduction in inappropriate referrals to specialist CAMHS services
- Measurement through pupil surveys that show more pupils feel supported and able to cope with adversity
- Measurement through staff surveys that show frontline staff are better informed and support and able to manage children and young people with difficulties
- Measurement that shows workforce generally is better aware of the issues surrounding emotional and mental well-being and able to respond appropriately to support children and young people

Detailed KPIs are being worked on.

4. FUNDING, GOVERNANCE AND MONITORING

Funding

Once assured, there will be £1.3 million pa across the 4 CCGs, with a proposed allocation as follows:

- £384K pa for Community Eating Disorder Service.
- Of the remaining £963k:
    - 60% on prevention, promotion and early intervention
    - 20% on easy access to appropriate support
    - 20% on support for vulnerable groups

The table below sets out the allocated funding announced by the NHS:

CCG	Eating disorder service and planning (annual)	Future in Mind funding (annual)
Hambleton Richmondshire and Whitby CCG	75,249	188,356
Harrogate and Rural District CCG	79,246	198360
Scarborough and Ryedale CCG	64,802	162,205
Vale of York CCG	165,536	414355
TOTAL	**384,833**	**963,276**

The funding is made available as follows:

- £384k in August 2015 for planning and Eating Disorders to be spent in the current financial year
- £900k to be paid on assurance of the Plan by NHS England: this is expected to be in November or December 2015, also to be spent in the current financial year
- £1.3 million in each subsequent financial year to 2019/20 encompassing the Eating Disorder allocation and general transformation funding.

Governance and monitoring

The whole project is directed by North Yorkshire & York Lead Commissioning Forum, comprising the Partnership Commissioning Unit (PCU) on behalf of the 4 CCGs, North Yorkshire County Council, City of York Council, Airedale Wharfedale and Craven CCG, NHS England and East Riding of Yorkshire Council: this has overseen the preparation of the Transformation Plan. Following submission, a Delivery and Implementation Group has been set up with the task of managing the delivery of the Plans.

The governance structure proposed in the Transformation Plans, subject to NHS England approval provides for oversight by the Health and Well-Being Board, which

will ensure that the Transformation Plans reflect and are reflected across all children and adolescent strategies.

NHS England will monitor the Plan against the financial and performance metrics adopted within the Plan structure.

The meeting will receive a verbal update on progress against the NHS assurance framework; it is hoped that the Plans will be approved by the end of November 2015, with publication in early December 2015

5. Conclusion

Future in Mind offers the opportunity for a fresh start to the whole approach for responding to the basic need of children and young people for good mental health and emotional well-being. By moving from a deficit model of treating illness to one built around developing and reinforcing that which is good and supportive in the lives of children and young people, it is intended that fewer will report negative feelings about their lives and be better equipped to manage adversity and challenge. For those children and young people who need support, the move to a system structured to provide early support appropriate for the individual should mean speedier recovery.

6. Recommendation

The Board is asked to note the report.

Health and Wellbeing Board
North Yorkshire

27 November 2015

Healthy Weight, Active Lives Strategy 2009 - 2020

1.0 Executive Summary

1.1 The purpose of this report is to obtain a mandate from the Health and Wellbeing Board for the re-write and re-launch of the Healthy Weight, Active Lives Strategy for North Yorkshire.

1.2 The current Healthy Weight, Active Lives Strategy can be accessed via the link http://www.northyorks.gov.uk/CHttpHandler.ashx?id=30345&p=0
The current Healthy Weight, Active Lives Strategy is for North Yorkshire and York, which was only applicable pre transition from primary care trusts to local authority.

2.0 Recommendation

2.1 It is recommended that the Health and Wellbeing Board consider the rationale for re-writing the Healthy Weight, Active Lives Strategy and agree the proposed process associated with this.

3.0 Report Details

3.1 **A Healthy Weight, Active Lives Strategy re-write - the rationale**
Based on the following reasons it is suggested that a re-write is required:

- The national and local obesity and physical activity data for adults and children and young people in the existing Strategy needs updating and re-structuring, using the recent JSNA Healthy Weight deep dive work completed.
- It is suggested the Strategy is revised to align the presentation of refreshed intelligence, the vision, and priorities with the refresh of the Joint Health and Wellbeing Strategy and other recently published Public Health strategies i.e. Tobacco Control Strategy.
- The focus of the Strategy needs to be on North Yorkshire therefore a joint North Yorkshire and York Strategy is not required- the content of the Strategy needs to reflect this.
- The Strategy priorities need assessing to ensure they are relevant to current need. A comprehensive engagement process will not only ensure priorities are (re-) established but will create the opportunity to establish stronger joint accountability and governance in relation to obesity.
- Obesity-related strategies and frameworks across the region include significantly more focus on physical activity and sustainable food than the current North Yorkshire and York Healthy Weight, Active Lives

Strategy. The vision and the aims of the Strategy need revising to reflect a balance with healthy eating and physical activity across a life course.

- The Strategy needs to have an increased focus on the wider determinants of health in order to reflect current Public Health practice.

3.2 A Project Group has been formed to oversee the process and has suggested the following project plan:

Milestone	Original timescale	Revised timescale
Obtain a mandate for the re-write of the Healthy Weight, Active Lives Strategy (from PH Business Team, HASLT, and the Health and Wellbeing Board)	July - October 2015	July – November 2015
Engagement (including stakeholder mapping, establishment of tools, engagement activity with stakeholders)	August – November 2015	August 2015 – end of January 2016
Reflection and development (including **draft framework/strategy and action plan** written for **30th April 2016**)	November 2015 – January 2016	February to end of April 2016
Consultation	April – May 2016	April to end of June 2016
Reflection and development	June – July 2016	July – September 2016
Framework/strategy launch	**August 2016**	**October 2016**
Implementation of action plan and establishment of working groups		October 2016 onwards

Please note that revised timescales have been amended since mandate has been obtained from the Public Health Business Team meeting and HASLT. A new milestone has also been added 'Implementation of action plan and establishment of working groups'.

The Project Group recognises the timescales are very challenging. The Health and Wellbeing Board will be provided with updates on any significant slippage and actions associated with this.

3.3 Engagement activity is imperative to ensuring the priorities relating to healthy weight and physical activity are relevant to the local residents; the outcomes of the engagement activity will shape the focus of the Framework/Strategy. The process of engagement will also further develop relationships with key stakeholders and promote a shared leadership for tackling obesity across

North Yorkshire. The Project Group are currently working through identifying stakeholder groups and agreeing the most appropriate methods tools for engaging with key groups. Stakeholder mapping is underway and initial contact will be made with key stakeholders to initiate the engagement process.

4.0 Framework

4.1 As part of the engagement activity, a framework has been proposed to ensure the outcome of a more action-focused document. This is being discussed with key stakeholders and the Yorkshire and Humber Obesity Network.

4.2 The framework promotes:

- 'taking action across the life course' (including pregnancy and first year of life, early years 1-4 years, childhood 5-10 years and 11-16 years, adulthood 17-59 years, older people 60+ years)
- 'taking action that is universally proportionate' – universal, targeted and specialist interventions

5.0 Next steps

5.1 The Project Group has undertaken a stakeholder mapping exercise and is making initial contact with some key partners. Decisions on the most appropriate methods of engagement and tools to be used have been agreed (one-to one interviews) amongst the Project Group. Stakeholder interviews are scheduled in the Project Group members' calendars.

5.2 A draft Strategy and action plan will be developed for consultation. The draft will be presented to the Health and Wellbeing Board for approval in order to launch the new Healthy Weight, Active Lives Strategy in October 2016.

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Presenter of Report: Lincoln Sargeant
Background Documents: None
Annexes: None

Health and Wellbeing Board
North Yorkshire

HEALTH & WELLBEING BOARD

27 November 2015

North Yorkshire Winter Health Strategy 2015-2020

1 Purpose of the Report

1.1 To present the draft North Yorkshire Winter Health Strategy building on the work of the JSNA Winter Health Deep Dive (Feb 2015)

1.2 The Health and Wellbeing Board are asked to endorse the approach and encourage member organisations to contribute to the vision 'to reduce fuel poverty and the adverse effects of cold weather'

1.3 To formally respond to the draft strategy during this 12 week consultation period winterhealthstrategyfeedback@northyorks.gov.uk

2 Background

2.1 The Seasonal Winter Health Strategic Partnership was established at the beginning of 2015 and began developing its strategy based on the JSNA deep dive on Winter Health. A multi-agency partnership event on Winter Health was held on 3rd June 2015 which included partners across North Yorkshire and helped to develop the overarching vision, aims, principles and the four key priorities.

2.2 The final strategy and implementation plan will be presented to confirm Health and Wellbeing Board support in February 2016 before a launch planned on 17th March 2016.

3 Implementation Plan

3.1 A draft implementation plan for the Strategy is being produced with 20 delivery partners and 10 key supporting partners. It will sit alongside the strategy and will identify key actions for each organisation under the four Key Strategic priorities.

3.2 For each of the Strategic priorities an outcomes framework to monitor progress against agreed indicators is being developed as part of developing the implementation plan. The Public Health team are doing work to establish the baseline for these indicators.

3.3 It is proposed that the Strategy Implementation Plan will be monitored by the North Yorkshire Seasonal Winter Health Strategic Partnership, chaired by Assistance Director Policy and Partnerships. This Group will also make recommendations for review of the Strategy should the need arise.

4 Recommendations

4.1 The Health and Wellbeing Board members are asked to consider and support the priorities in the strategy.

4.2 All members receiving the draft strategy are asked to respond to the consultation and commit their organisation as a signatory.

5 Appendices

5.1 Appendix 1 – North Yorkshire Winter Health Strategy

Rachel Richards
Public Health Consultant

Dr Lincoln Sargeant
Director of Public Health for North Yorkshire

11 November 2015

Health and Wellbeing Board
North Yorkshire

North Yorkshire's Winter Health Strategy 2015-20

Working together to reduce fuel poverty and the adverse health effects of cold weather for individuals, families and communities

Seasonal Winter Health Strategy 2015-2020

Foreword

Cold weather can have a significant and predictable impact on people's health. However, for the vast majority of people the real extent of the effects of the cold are not appreciated and few people realise it is largely preventable. The direct effects of winter weather such as icy roads and footpaths with the consequent accidents, slips and trips are well known. Fewer people realise the cold can increase the occurrences of heart attacks, respiratory and influenza related diseases resulting in deaths. In addition to this, there are the indirect effects of the cold including poorer mental health and wellbeing and other risks such as carbon monoxide poisoning from poorly maintained heating and domestic appliances.

Certain groups of people are at greater risk of the direct effects of the cold. For example, those over 75 years and families with children under 5 years. In North Yorkshire during the 2012/13 winter there were 431 excess winter deaths (EWDs). These are the number of excess deaths that occur between December and March each year. For every excess winter death it is estimated there are an additional eight emergency admissions to hospital.

The rate of Excess Winter Deaths across the whole of the UK is three times higher than other colder countries in Northern Europe. Although cold weather is clearly a factor in excess deaths, Scandinavian countries for example do not have the same pattern of excess winter deaths, giving a strong indication that this is a preventable situation. These countries have higher energy efficiency and housing standards and the population reacts differently to cold conditions.

The number of people indirectly affected by the cold in North Yorkshire is less easy to quantify. They may be referred through Health and Adult Social services or Children and Young Peoples Social Services because being too cold has impacted on them in some way. For example, people chose to move out of their rented property before winter because it is too cold, without realising they have become 'intentionally homeless'. Others cannot afford to heat the homes they live in and get into debt. Fuel poverty is a key priority for North Yorkshire's Health and Wellbeing and working together in partnership across the county with various organisations is one of the most effective ways of delivering changes.

We want to work together in partnership with each other, individuals and groups, including the independent and public sector to identify and provide support to reduce the number of vulnerable people in North Yorkshire whose lives are negatively affected by the cold.
We have a strong history of partnership working in North Yorkshire and are well placed with key partners to achieve the priority outcomes we have identified in this strategy. If we target our efforts jointly we can dramatically improve our local response to the increasingly recognised public health and social challenge of being too cold.

Cllr David Chance – Executive Member for Public Health North Yorkshire County Council

Contents

Glossary

CCG – Clinical Commissioning Groups
DECC – Department of Energy and Climate Change
EWD – Excess Winter Deaths
EPU – Emergency Planning Unit
GP – General Medical Practitioner
HWB – Health and Wellbeing Board
JHWS – Joint Health and Wellbeing Strategy
JSNA – Joint Strategic Needs Assessment
LA – Local Authority
NHS – National Health Service
NICE - National Institute for Health and Care Excellence
NYCC – North Yorkshire County Council
NYLRF – North Yorkshire Local Resilience Forum
PCT – Primary Care Trust
PHE – Public Health England
PCT – Randomised Controlled Trial
SWHSP – Seasonal Winter Health Strategic Partnership (North Yorkshire)
SRGs – System Resilience Groups

North Yorkshire Draft Seasonal Winter Health Strategy on a page

"We will improve and maintain health during winter months and prevent avoidable ill-health and Excess Winter Deaths by working together to reduce fuel poverty and the adverse health effects of cold weather for individuals, families and communities in North Yorkshire"

The ***seven strategic objectives*** we will adopt:

1. **EWDs** – *reduce preventable cold-related ill-health and Excess Winter Deaths (EWDs)*
2. **Vulnerable people** –*identify, support and improve the health of the most vulnerable groups*
3. **Services** – *reduce pressure on health and social care services*
4. **Fuel Poverty** – *reduce fuel poverty, the risk of fuel debt and/or disconnection from energy supplies*
5. **Influenza Immunisation** – *increase immunisation uptake rates across the population*
6. **Injury** – *reduce injury resulting from unexpected trips and falls*
7. **Hospital Admissions** – *reduce excess Emergency admissions to hospital*

Our ***four key priorities*** and ***the supporting outcomes:***

(1) General awareness raising: -

- Agree key messages on "Keep Warm, Keep Well, Keep Safe in winter" promoted across agencies in North Yorkshire consistently.
- Coordinate key messages and a single shared information resource.
- Increase awareness of preventable seasonal related ill-health and Excess Winter Deaths to members of the public.
- Increase seasonal influenza immunisation uptake rates.
- Increase awareness among communities and community leaders of ways to strengthen resilience to the impact of seasonal changes and cold weather.
- Increase awareness of impact of cold homes on health among frontline staff and professionals in the independent and public sector.
- Increase understanding of the links between fuel poverty and ill-health by supporting evaluated projects and research.
- Increase awareness among Landlords, Landowners and Homeowners.

(2) Identifying and supporting the most vulnerable (MV):

-Define the MV groups.
-Create ways to increase identification of the MV.
-Increase routes to reach those MV to the harmful effects of being cold.
-Utilise opportunities to target approaches based on the needs of the MV.
-Maximise current services provided to the MV increasing added value and diversity where needed.
-Increase number of programmes which support the delivery of prevention services in the community and provide consistent coverage when most needed. (e.g. increased uptake of influenza immunisations).
-Increase the range of opportunities for 'support services' to promote resilience in cold weather and community connectedness.
-Increase accessibility for all vulnerable groups to reach the support which most appropriately meets their needs.
-Increase initiatives which support people to reduce unnecessary fuel consumption and reduce fuel poverty.
-Develope opportunities to involve service users.

(3) Shared responsibility and making every contact count:

-Increase awareness across North Yorkshire among professionals and others (independent and public sector) to feel confident in giving advice and signposting service users, as well as neighbours, friends and family members.
-Increase training and awareness for staff working with vulnerable groups about the link between household temperature and effects on health and wellbeing so that it positively impacts on practice and improves services.
-Increase ability to refer individuals to appropriate services to improve their health and wellbeing in winter.

(4) Partnership commitment:

-Align priorities to achieve better health and wellbeing for the population of North Yorkshire especially in winter months.
-Create policies and plans which take into account the impact of winter / cold weather as part of the year-round planning and decision-making.
-Increase consideration of impact of winter on health across all sectors (including utilities, housing, service providers etc)
-Create stronger partnerships taking action in response to significant issues e.g. poor quality housing and fuel poverty.

Executive Summary

What is the context for this Strategy?
North Yorkshire County Council became responsible for population health outcomes under the terms of the Health and Social Care Act 2012 and has a duty to ensure plans are in place to protect the health of their populations including preparation for cold weather, snow and ice. There is a shared agreement between each partner organisation in the North Yorkshire Health and Wellbeing Board to work together to deliver change, reducing the impact of seasonal ill-health and ultimately reducing excess winter deaths (EWDs).

There is a North Yorkshire Health and Wellbeing Strategy 2013-2018 (2015 update) which has been developed jointly by partners across North Yorkshire and this work links into those priorities. This strategy also has links to:-

- the York North Yorkshire and East Riding Housing Strategy 2015 – 2021.
- The North Yorkshire Local Resilience Forum
- Local District Cold Weather Plans and CCG System Resilience Groups

What is the Purpose of the Strategy?
The North Yorkshire Health and Wellbeing Board is made up of partner organisations from across the County who understand the importance of working together across diverse and complex rural communities within North Yorkshire. This Strategy is about working together across the agencies to tackle the effects of the cold on people in North Yorkshire. We want our strategy to galvanise partners, statutory and non-statutory organisations, businesses and communities within North Yorkshire to work co-operatively to reduce the harms from the cold and help lift people out of fuel poverty. It is built on the latest data collected within the North Yorkshire Partnership Joint Strategic Winter Health Needs Assessment (JSNA), and uses the best evidence of what works where available, taking account best value (NICE Guideline NG6). See ***page 9*** for list of organisations involved.

How does this fit into the National Picture?
Since 2012 there have been a number of key strategic drivers nationally, including:-

- the governments Fuel Poverty Strategy Cutting the Cost of Keeping Warm (DECC, March 2015) which followed changes in legislation (December 2014) to increase the number of homes with Band C energy ratings by 2020;
- the full appraisal on “Excess Winter Deaths and morbidity; the health risks associated with Cold Homes” (NICE guidelines NG6, March 2015).
- “Protecting health and reducing harm from cold weather – local partnerships survey report” from Public Health England in November 2014 reporting on how agencies need to work together to achieve change

- the Public Health Outcomes Framework (2013) with specific indicators to reduce excess winter deaths (EWDs) and address fuel poverty;
- the NHS Five Year Forward View (October 2014) putting higher priority on prevention of ill-health and working in partnership with patients and communities
- the Cold Weather Plan for England 2014 (October 2014) report on protecting health and reducing the harm from cold weather from Public Health England.
- the NHS Outcomes Framework (2014-15) and the Adult Social Care (2014-15) include tackling health outcomes by improving the wider determinants of ill health and preventing avoidable early deaths which can be positively influenced by tackling cold, damp homes and fuel poverty.
- the Health and Social Care Act (2012) include duties for local authorities to ensure plans are in place to protect the health of their population including preparation for cold weather, snow and ice.

What about the North Yorkshire local Strategic Direction?

The NHS 5 year forward view plan and Social Care Strategies outlined the need for 'prevention' to reduce the number of people unnecessarily accessing services. In addition, local Housing Strategies and Transport Plans being developed in partnership with districts, businesses and communities across North Yorkshire all contribute to

- prevent people needing services and ensuring people are in control of the choices they make about their health and wellbeing
- ensure partners work together so that complex issues that affect health and wellbeing, like fuel poverty and cold homes, can be improved effectively
- focus on increasing people's awareness of the impact of choices they make on their health and wellbeing

How does this Strategy fit with Community Resilience in North Yorkshire?

The North Yorkshire Local Resilience Forum (NYLRF) is a multi-agency body set up to discharge the statutory obligations and duty of care required of identified agencies under the Civil Contingencies Act (2004). This key work consists of assessing risk in North Yorkshire and coordinating all agencies in their efforts to plan and mitigate potential impacts, such as snow and flooding, on our communities. This work is coordinated by the NYCC Emergency Planning Unit (EPU).

NYLRF is made up of key agencies (Police, Fire and Rescue, Ambulance and Health Agencies, Local Authorities) and other supporting agencies (Utility companies, Highways England, Network Rail etc.) with a shared responsibility for identifying vulnerability and supporting the resilience of local communities.

A key component in this work is the early sharing of information with colleagues and partner agencies to provide a coordinated well-informed response to major or critical

incidents and any emergency situation. This may include increased activity in emergency care due to seasonal pressures (e.g. increased hospital admissions due to winter illness such as influenza). Community engagement, communication and promotion of resilience at all levels is fundamental to the work of NYLRF and an established robust multi-agency structure is in place across North Yorkshire to deliver relevant messages to the public.
NYLRF fully support the strategic objectives of the North Yorkshire Winter Health Strategy.

What are System Resilience Groups (SRGs)?
System Resilience Groups (SRGs) link to the NHS Clinical Commissioning Groups (CCGs) with 5 SRGs covering the population of North Yorkshire. The SRGs membership includes the operational leads of the health and social care services.

They are responsible for:-

- Effective delivery of bespoke urgent care in their geographical area.
- Planning additional winter capacity for urgent and emergency care.

The SRGs report to NHS England and provide assurance and feedback to the NYLRF. SRGs make predictions about activity levels for NHS services during the year (e.g. elective care, emergency care, diagnostics) and report to NHS England nationally as well as to the NYLRF. This all year planning activity includes winter months. Work is also coordinated through the regional Urgent and Emergency Care network to support the delivery of the urgent and emergency care strategy.

Partnership working

A Shared Commitment to Improving Winter Health
In order to improve the outcomes for people relating to cold weather, and reduce the number of excess winter deaths and unnecessary admissions to health and social care we need to work in partnership across a number of agencies. There are many complex and interacting factors influencing the winter health outcomes. For example, the environment, housing conditions; income levels; vaccination status; age and general health and wellbeing.

These challenges mean that across North Yorkshire we need to be able to:-
- lead changes in a coordinated way
- communicate messages consistently and clearly
- build on and not duplicate the work of other agencies
- know the impact we are having on the health outcomes for people

To do this the North Yorkshire Health and Wellbeing Board delivery group established **A North Yorkshire Seasonal Winter Health Strategic Partnership** to develop and drive this strategy on behalf of the partners within North Yorkshire.

The North Yorkshire Seasonal Winter Health Strategic Partnership

The North Yorkshire Seasonal Winter Health Strategic Partnership (SWHSP) is a multiagency partnership leading and developing this strategy on behalf of North Yorkshire and linking to existing partnerships such as the Health and Wellbeing Board, Local Resilience Forum, Voluntary Sector and Housing Partnerships. Part of this work means finding the evidence; identifying and mapping where there are gaps in evidence and / or services and establishing new links where needed to achieve the overall vision. The North Yorkshire Seasonal Winter Health Strategic Partnership (SWHSP) meets quarterly and reports to the Delivery Board of the North Yorkshire Health and Wellbeing Board.

The Partnership's *Strategic Vision* *is:-*

" to improve and maintain health during winter months and prevent avoidable ill-health and Excess Winter Deaths by reducing the adverse impact of indoor and outdoor winter conditions on the populations health and wellbeing".

The Partnerships 7 Strategic Objectives are to:-

- Reduce preventable cold-related ill-health and Excess Winter Death (EWD) rates.
- Improve Health and Wellbeing among vulnerable groups.
- Reduce pressure on health and social care services.
- Reduce fuel poverty, the risk of fuel debt and/or being disconnected from energy supplies.
- Increase Influenza Immunisation Uptake Rates.
- Reduce injury resulting from accidents, trips and falls.
- Reduce excess Emergency admissions to hospital.

The SWHSP will develop an all year round strategic and systems-wide approach to achieve the above strategic goal and objectives in North Yorkshire through partnership and collaboration. This includes effective evidence based planning and coordinated working to implement a wide range of interventions that address the multiple problems of the most vulnerable in order to achieve measurable improvements in the objectives.

The first task of the partnership was to produce this jointly agreed Draft Seasonal Winter Health Strategy 2015-2020 and subsequently an implementation plan that reflects the evidence and includes the recommendations of NICE guidelines, the Fuel Poverty Strategy and elements of the Cold Weather Plan so that these align with other strategic and operational plans (see references at end of this document).

List of organisations involved in North Yorkshires Seasonal Winter Health Partnership

Who is involved?

- System Resilience Groups
- Clinical Commissioning Groups
- Local Health Resilience /Partnership groups
- Winter Weather groups – District Councils, including housing representation
- Capacity Planning Groups
- Mental Health Foundation Trust
- Harrogate and District NHS Foundation Trust;
- North Yorkshire County Council Adult Social Care;
- York NHS Trust;
- the Voluntary Sector elected through the VCSE Strategy Group North Yorkshire
- Yorkshire Ambulance Service NHS Trust.
- Healthwatch North Yorkshire;
- Children Young People Services

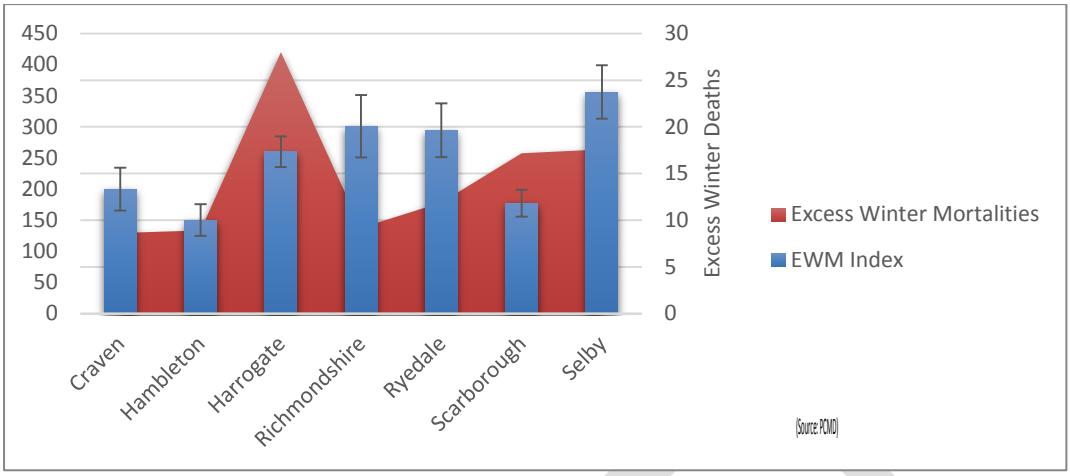
How big is the problem in North Yorkshire?

Every year in North Yorkshire there are hundreds of Excess Winter Deaths (EWDs). These deaths are calculated by comparing the number of deaths that occurred during the December to March winter period with the average number of deaths occurring in the preceding August to November and the following April to July.

- There are an estimated 431 Excess Winter Deaths each year in North Yorkshire (ONS 2012/13)
- The majority of winter deaths occur in people aged 75 and over
- For every Excess Winter Death it is estimated there are an additional 8 emergency admissions i.e. approx. 3,448 avoidable NHS hospital admissions

The following Figure 1 shows both excess winter mortality and the EWM Index by District. It demonstrates the large variation across North Yorkshire. Mortalities are relatively rare events and do not provide enough data in a single year to draw conclusions between districts in North Yorkshire geographies. The 5 year snapshot comparison between the districts shows Selby with the highest EWM Index and Craven with the lowest. Harrogate, with the highest population, has the largest number of excess winter mortalities.

Figure 1 North Yorkshire EWM Index and Excess Winter Deaths by District, 2009-2014 (EWM = winter deaths – average non-winter deaths)



Tackling winter health issues, particularly fuel poverty, cold damp homes and increasing the take-up of flu vaccinations, can make a significant contribution to reducing winter pressures on health and social care services and improve the health and wellbeing of the population.

Understanding the problem and building the case for action

Across North Yorkshire there is a growing older population, many of whom are living in rural areas with fixed incomes. This older demographic is important to consider, together with the quality of the housing stock in North Yorkshire which is also older and less energy efficient.

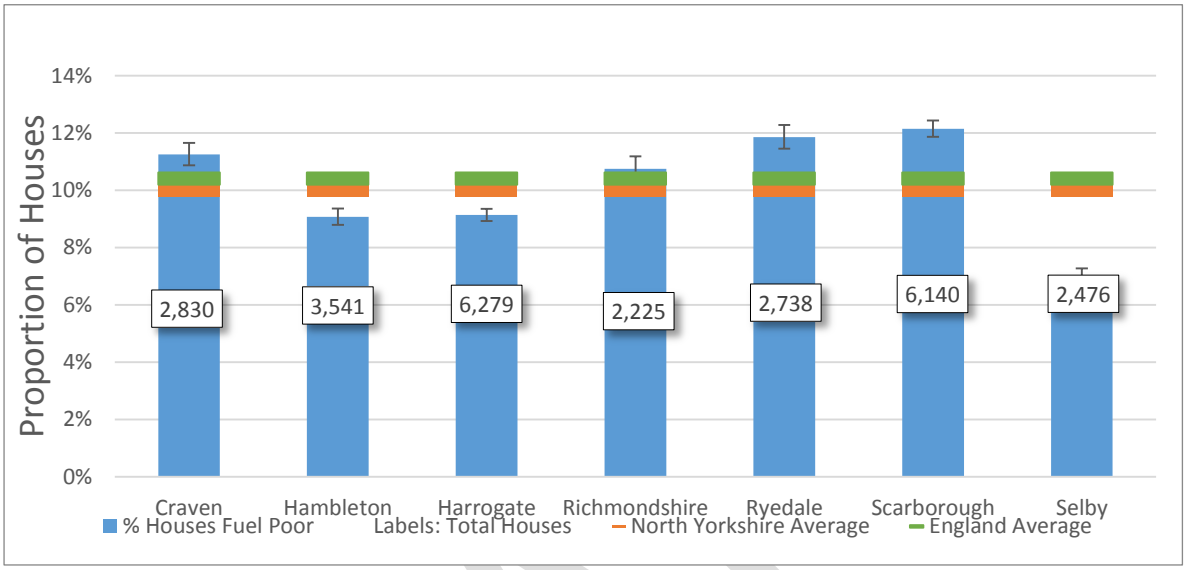
The impact of cold weather on health is estimated to cost the NHS £1.5bn a year[1] and over 18,000 people died prematurely last winter[2]. The excess cost of winter emergency admissions in the former North Yorkshire and York PCT area in 2010/11 was £3.7m. Excess emergency admissions to hospital from respiratory conditions alone in the same period cost £2.4m.

Fuel poverty is a potential causal factor of increased morbidity and mortality from winter weather. Figures 2 and 3 show the distribution of fuel poverty in households across North Yorkshire. The new (2013) definition of fuel poverty in England is measured on a low income, high costs basis. A household is considered to be in fuel poverty if:

- they have required fuel costs that are above average (the national median level) and
- were they to spend that amount they would be left with a residual income below the official poverty line.

Fuel poverty can be a useful indicator for areas where households struggle to heat their homes, but it does not necessarily describe the temperature of a household. Households with higher fuel poverty may have well heated homes, and conversely, a low fuel poverty household may have a poorly heated home.

Figure 2 - 2012 Fuel Poverty by District (source: DECC)



The extent of fuel poverty and cold homes are both major contributors to poor winter health. Fuel poverty is caused by three main factors:

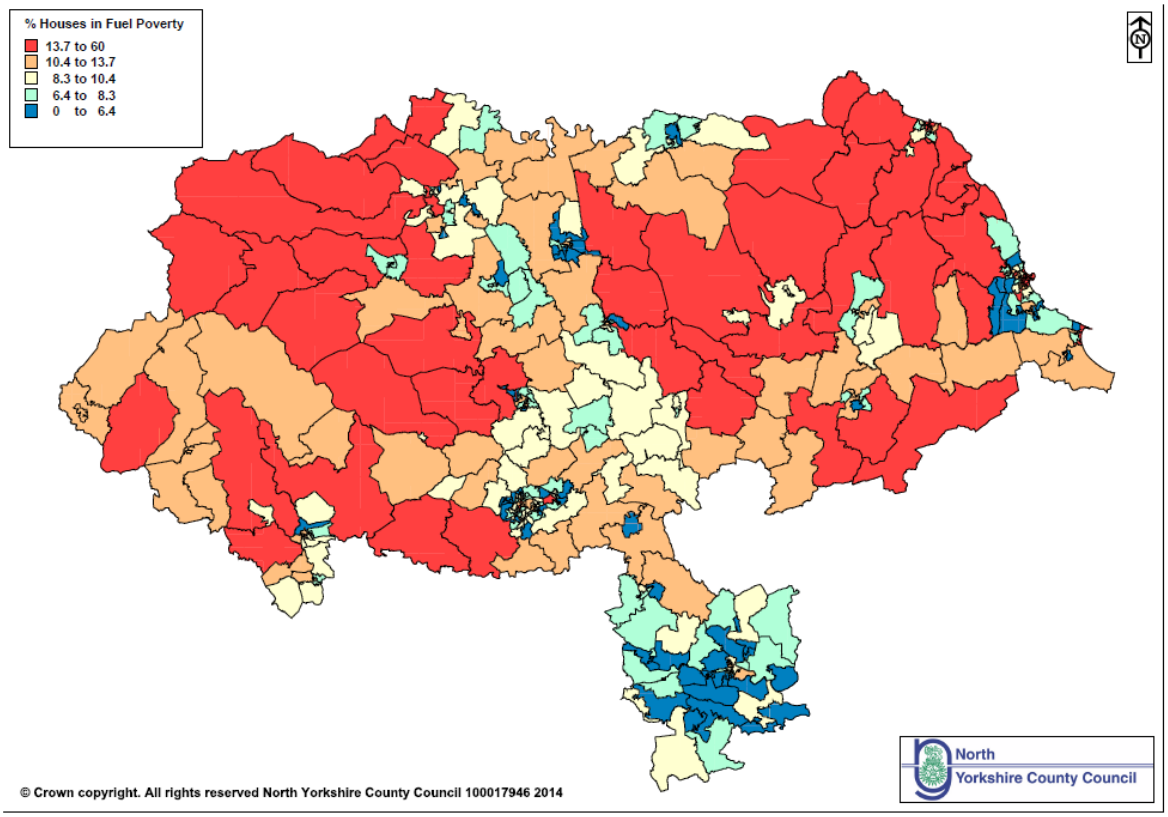
- inefficient homes,
- high energy costs and
- low incomes.

Improving the energy efficiency of housing has been shown to reduce health and social care costs and improve health and wellbeing.

In North Yorkshire, fuel poverty stands at 10%, that is **26,229 households**. Figure 3 shows the percentage of households in North Yorkshire in fuel poverty. Fuel poverty is more likely to occur in rural areas like North Yorkshire because housing tends to be older and more difficult to make energy efficient. Many homes have solid walls so are more difficult to insulate and a large proportion of homes are off the mains gas network, meaning higher costs for heating fuels. More generally in rural areas, there is a lower take up of benefits and energy advice and grants.

Figure 3 North Yorkshire Residents, % of Houses in Fuel Poverty 2010-2012, Low Income High Cost

(Source DECC)



Mortality and Morbidity

The impacts of fuel poverty and cold damp homes on health and wellbeing are felt most notably by vulnerable households, in particular older people, those living with chronic illness or disability and children.

Whilst fuel poverty and cold homes are factors in EWDs the scale of morbidity should not be underestimated. According to the Marmot Review Team, 'There is a strong relationship between cold temperatures and cardio-vascular and respiratory diseases, children living in cold homes are more than twice as likely to suffer from a variety of respiratory problems than children living in warm homes, mental health is negatively affected by fuel poverty and cold housing for any age group…'*The Health Impacts of Cold Homes and Fuel Poverty*'[1].

[1] See http://www.foe.co.uk/sites/default/files/downloads/cold_homes_health.pdf (2011)

The 'Hills Fuel Poverty Review' found that, "Thirty-four per cent of fuel poor households contain someone with a disability or long-term illness, 20% have a child aged 5 or under, and 10 per cent a person aged 75 or over.[2]

Cost to health of fuel poverty and cold damp homes

The Government has been working on a methodology to estimate and monetise change in Quality of Life Years (QALY) that result from improving energy efficiency of homes and the resultant financial value of the health savings per measure installed. For example below:-

Intervention	QALY saved per measure installed	Value of health saving per measure installed (£-Net Present Value)
Cavity Wall Insulation	0.049	£969
Solid Wall Insulation	0.036	£742
Replacement boiler	0.009	£224
Central Heating	0.012	£303

In addition, potential areas for cost savings locally include:

- Reduced GP consultations, out-of-hours calls, attendances at walk-in centres, district nurse visits and drug prescriptions.
- Reduced emergency department visits.
- Reduced inpatient admissions.
- Reduced social care service costs.

Recent research begins to quantify the Social Cost of cold homes (ref Journal of Public Health 21 Aug 2014 pp251-7) and NICE have undertaken work demonstrating some potential cost savings see NICE costing statement http://www.nice.org.uk/guidance/ng6/resources/costing-statement-6811741

[2] Fuel Poverty Advisory Group (for England) - 11th Annual Report 2012-13 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266350/fpag_11th_annual_report.pdf

Objective Details

Strategic Vision and Priorities

In order to deliver against the strategic vision and the 7 Strategic Objectives the following four key strategic priorities have been identified, based on the evidence in the NICE guidelines and the Fuel Poverty Strategy.

Four Key Strategic Priorities

1. **General awareness raising**
2. **Identifying and supporting the most vulnerable people**
3. **Shared responsibility and making every contact count**
4. **Partnership commitment**

1 - General awareness raising

This strategy recognises the need for a single source on information with clear and consistent messages that increases awareness among professionals and members of the public that this is a priority in the prevention of ill-health effects of winter. A North Yorkshire- wide awareness raising approach under the heading “Keep Well, Keep Warm, Keep Safe” in winter is being developed.

Outcomes

- Coordination of key messages and a single shared information resource
- Increased awareness of preventable seasonal related ill-health and Excess Winter Deaths to members of the public.
- Increased seasonal influenza immunisation uptake rates
- Increased awareness among communities and community leaders of ways to strengthen resilience to the impact of seasonal changes and cold weather.
- Increased awareness of impact of cold homes on health among frontline staff and professionals in the independent and public sector.
- Increased understanding of the links between fuel poverty and ill-health by supporting evaluated projects and research.
- Agreed key messages on “Keep Warm Keep Well Keep Safe in winter” promoted across North Yorkshire consistently as part of a multi-agency, partnership campaign

- Increased awareness among Landlords, Landowners and Homeowners.

2 – Identifying and supporting the most vulnerable

This strategy recognises that there are a wide range of people who are vulnerable to the cold, particularly in rural areas of North Yorkshire. Those most vulnerable to the cold need support to prevent ill-health, hospital admissions, social care interventions and excess winter deaths. For example, people living with a chronic medical condition such as heart disease, a disability, older people and families with children and young people. Sometimes, personal circumstances such as being socially isolated and unable to afford to keep warm, is enough to make someone vulnerable potentially leading to harm which could be avoided e.g. slips, trips and falls. This strategy will ensure that we recognise the needs of and provide support for the most vulnerable including the factors above and those on low incomes, by providing preventative approaches through early interventions and targeted awareness raising.

Outcomes

- Defined the most vulnerable groups in North Yorkshire
- Created ways to increase identification of the most vulnerable in North Yorkshire
- Increased routes to reach those most vulnerable to the harmful effects of being cold
- Utilised opportunities to target approaches based on the needs of the most vulnerable.
- Maximised current services provided to the most vulnerable increasing added value and diversity where needed.
- Increased number of programmes which support the delivery of prevention services in the community and provide consistent coverage when most needed. (e.g. increased uptake of influenza immunisations)
- Increased the range of opportunities for ‘support services’ to promote resilience in cold weather and community connectedness.
- Increased accessibility for all vulnerable groups to reach the support which most appropriately meets their needs.
- Increased initiatives which support people to reduce unnecessary fuel consumption and reduce fuel poverty.

- Developed opportunities to involve service users in the evaluation / design of interventions.

3 – Shared responsibility and making every contact count

This strategy recognises that everyone can be affected by cold weather (all ages, male and female) directly or indirectly. We are all responsible, whether we are parents, employees, neighbours and friends, for reducing preventable, cold-related ill-health and Excess Winter Deaths, especially if we live and /or work with those who are most vulnerable to the effects of the cold. This strategy encourages us all to take a shared responsibility across all services for all citizens and use the concept of 'making every contact count' to protect everyone from the adverse effects of cold weather.

Outcomes

- Increased awareness across North Yorkshire among professionals and others (independent and public sector) to feel confident in giving advice and signposting service users, as well as neighbours, friends and family members.

- Increased training and awareness for staff working with vulnerable groups about the link between household temperature and effects on health and wellbeing so that it positively impacts on practice and improves services.

- Increased ability to refer individuals to appropriate services to improve their health and wellbeing in winter.

4 – Partnership commitment

This strategy recognises the need to continue to work in partnership across many sectors including health, voluntary sector, councils and other agencies to deliver Joint Commissioning and effective and coordinated services.

Outcomes

- Aligned priorities to achieve better health and wellbeing for the population of North Yorkshire especially in winter months.

- Created policies and plans which take into account the impact of winter / cold weather as part of the year-round planning and decision-making.

- Increased consideration of impact of winter on health across all sectors (including utilities, housing, service providers etc)

- Created stronger partnerships taking action in response to significant issues e.g. poor quality housing and fuel poverty.

Partnership Communication

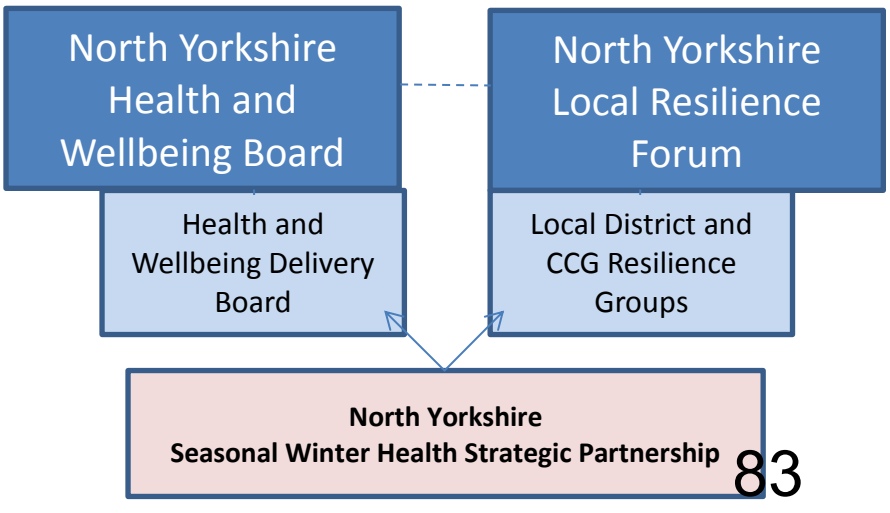
There is acknowledgment that plenty of good work is already being undertaken in localities across North Yorkshire by various agencies and we want to find ways to build on this and focus on addressing areas where more needs to be done and where there is the greatest impact locally. By working closely with partner agencies at the right scale and volume, we can ensure local action is well integrated, communicated, evaluated and effective.

Through signing up to this strategy the partnership is committed to communicating effectively not only with other agencies but also with members of the community. This includes:

- Delivering coordinated awareness raising with all members of the community
- Delivering targeted training to identified partner agencies
- Facilitating coordinated communication within and between partner agencies
- Promoting a consistent approach and key messages on seasonal winter health across all partner organisations in North Yorkshire.

Leadership and Governance

This overarching Strategy was commissioned and approved by the North Yorkshire Health and Wellbeing Board. Leadership at a "system" level will continue to be owned by this Board. However, some aspects of its delivery will rest with partner organisations. For example the responsibility for devising, delivering and monitoring the detailed actions that flow from healthcare service delivery in winter and relating to system capacity and resilience will be overseen by the Local Resilience Forum and the existing reporting arrangements to NHS England who will in turn be linking to the North Yorkshire Health and Wellbeing Board.



Measuring the Impact

The Seasonal Winter Health Strategic Partnership aims to prevent the adverse effects of winter on the population. Since winter health is a complex area due to the breadth of factors affecting the outcomes, attempts have been made to rationalise these and measure the complex winter health performance frameworks under three outcome domains - Population; Person: Community i.e. so that:-

1. **Population**
   The population does not suffer adverse health effects as a result of Seasonal Climatic Change

2. **Person**
   Across the county there is consistent affordable warmth

3. **Community**
   Communities have active networks to address Seasonal Climatic Change issues

Grouped under each of these 3 outcomes domains are a series of indictors relating the domain, the indicators are population level. Below the population indicator level the activity of the projects/schemes that are running across the county is captured demonstrating what is in progress to improve health and wellbeing.

Through ongoing discussion with partners, indicators will be developed around housing quality and the activity in voluntary sector groups, as the strategy and action plan sub-groups progress their work. Task and finish groups established will develop specific measures around the schemes of work, ultimately demonstrating progress against the population measures and therefore the overarching outcomes.
The intention is to engage all the partnerships involved in activities linked to this strategy to ensure that there are measurable outcomes linked to the SWHSPs 7 strategic objectives (***page 8***). For example, measureable impacts across North Yorkshire include:-

- Reducing preventable cold-related ill-health and Excess Winter Deaths (EWD)
- Improving Health and Wellbeing among vulnerable groups.
- Reducing pressure on health and social care services.
- Reducing fuel poverty, the risk of fuel debt and/or being disconnected from energy supplies.
- Increasing Influenza Immunisation Uptake Rates.
- Reducing injury resulting from accidents, trips and falls.
- Reducing excess Emergency admissions to hospital.

Equality Statement

This strategy recognises that winter cold weather can affect people regardless of age; ethnicity; religion or belief; disability; sexual orientation; gender. An equality impact assessment is being undertaken to inform the development of the plan and determine the impact on various groups and take appropriate action.

The North Yorkshire Seasonal Winter Health Strategic Partnership recognises that winter health issues, particularly fuel poverty, cold damp homes and poor take-up of flu vaccinations, can make a significant contribution to winter pressures on health and social care services.

Whilst older people and young children are predominantly the most at risk, it is important to note that there are other vulnerable groups such as the homeless and those in poor quality cold housing.

Products developed under this strategy and its implementation plan will be systematically reviewed using an Equality and Diversity Impact assessment to ensure they meet the needs of users and that mitigations and proactive action is in place to ensure no one within the identified protected characteristic groups are disadvantaged.

For comments on this draft strategy and feedback please email:-

Winterhealthstrategyfeedback@northyorks.gov.uk

Links to other Strategies, Related Documents and Guidance

HM Government "Cutting the cost of Keeping warm" A fuel poverty strategy for England URN 15D/062 (March 2015)

NICE National Institute of Health and Care Excellence Guideline "Excess winter deaths and morbidity and the health risks associated with cold homes" (5 March 2015)

Public Health England "Protecting health and reducing harm from cold weather – local partnerships survey report" (November 2014)

North Yorkshire Local Resilience Forum Multi-agency response arrangements (?Ref doc needed)

References

[1] NEA November 2014 http://www.nea.org.uk/Resources/NEA/Action%20for%20Warm%20Homes/documents/Letter%20to%20Prime%20Minister.pdf

[2] ONS November 2014 http://www.ons.gov.uk/ons/rel/subnational-health2/excess-winter-mortality-in-england-and-wales/2013-14--provisional--and-2012-13--final-/index.html

Health and Wellbeing Board
North Yorkshire

27 November 2015

System resilience and winter preparedness in North Yorkshire

1.0 Overview

1.1 The purpose of this paper is to provide assurance to the Health and Wellbeing Board that the health and social care economy across the county is as prepared and ready as it can be for the upcoming winter period.

1.2 The paper discusses the national, regional and local drivers to ensure systems are resilient and prepared for winter (as well as other periods of surges and pressures) within and across the health and social care system.

1.3 The paper considers what work is currently underway to reassure the Board that the system is prepared for the upcoming winter period.

2.0 National drivers (The Civil Contingencies Act (2004)[1])

2.1 The Civil Contingencies Act (2004) establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at the local level. The Act divides local responders into 2 categories, imposing a different set of duties on each.

2.2 Those in Category 1 are organisations at the core of the response to most emergencies (the emergency services, local authorities, NHS bodies). Category 1 responders are subject to the full set of civil protection duties.

2.3 Category 2 organisations (the Health and Safety Executive, transport and utility companies) are 'co-operating bodies'. They are less likely to be involved in the heart of planning work, but will be heavily involved in incidents that affect their own sector. Category 2 responders have a lesser set of duties - co-operating and sharing relevant information with other Category 1 and 2 responders.

2.4 Category 1 and 2 organisations come together to form 'local resilience forums'[2] (LRF).

3.0 Regional drivers

3.1 Local Resilience Forums (LRF's)

3.1.1 LRF's are based on police areas and help co-ordination and co-operation between responders at the local level. Therefore in this case, there is the North Yorkshire Local Resilience Forum.

[1] http://www.legislation.gov.uk/ukpga/2004/36/pdfs/ukpga_20040036_en.pdf

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/62277/The_role_of_Local_Resilience_Forums-_A_reference_document_v2_July_2013.pdf

3.1.2 The North Yorkshire Local Resilience Forum is not a legal entity, nor does a Forum have powers to direct its members. Nevertheless, the Civil Contingencies Act (2004) and the Regulations within provide that responders, through the Forum, have a collective responsibility to plan, prepare and communicate in a multi-agency environment.

3.1.3 This responsibility is best fulfilled where the LRF is organised as a collaborative mechanism for delivery equipped to achieve the mutual aims and outcomes agreed by the member organisations (partners), able to monitor its own progress and strengths, and active in identifying and developing necessary improvements.

3.2 Local Health Resilience Partnerships (LHRPs)

3.2.1. LHRP's have also been established. Their role is to deliver national Emergency Preparedness, Resilience and Response (EPRR) in the context of local risks. These bring together the health sector organisations involved in EPRR at the Local Resilience Forum level. Building on existing arrangements for health representation at LRFs, the LHRP will be a forum for coordination, joint working and planning for emergency preparedness and response by all relevant health bodies. The LHRPs' footprint will map to the LRFs. It will offer a coordinated point of contact with the LRF and reflect a national consistent approach to support effective planning of health emergency response.

3.3 Seasonal Winter Health Strategic Partnership

3.3.1 North Yorkshire County Council has established a seasonal winter health strategic partnership. This partnership is in the process of creating a North Yorkshire Seasonal Winter Health Strategy 2015-2020. This strategy aims for all partners to work together including individuals, groups, the independent and public sector to reduce fuel poverty and the adverse health effects of cold weather for individuals, families and communities, reducing excess winter deaths and to reduce the number of vulnerable people in North Yorkshire whose lives are negatively affected by the cold.

4.0 Local drivers

4.1 System Resilience Groups (SRG's)

4.1.1 In 2014, NHS England requested that each local area set up its own System Resilience Group[3]. These SRG's are to plan capacity and ensure that operational delivery across the health and social care system is coordinated, on-going and robust. From 2015, SRG's are

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/320224/Operational_resilience_and_capacity_planning_for_2014-15.pdf

responsible for ensuring the whole health and social care economy is resilient therefore includes both elective as well as urgent care[4].

4.1.2 The bringing together of urgent and elective care elements within one planning process underlines the importance of whole system resilience. It ensures that both parts of the system need to be addressed in order for local health and care systems to operate as effectively as possible in delivering year-round sustainable services for patients.

4.1.3 In North Yorkshire, there are 4 SRG's:

- Harrogate and Rural District SRG (HaRD SRG)
- Hambleton, Richmondshire and Whitby SRG (HRW SRG)
- Airedale, Wharfedale and Craven SRG (AWC SRG)
- York, Selby and Scarborough SRG (Y&S SRG)

4.1.4 Each SRG is chaired by a senior leader from the CCG(s) represented on the group. All local provider, commissioner, and social care organisations are members in the group. This allows for plans to be developed and agreed by representatives from across the health and social care system. SRGs can also have independent or voluntary sector representation. All care providers are represented such as ambulance services, mental health services, primary and community care providers as all have a key role in delivery.

4.1.5 SRG's have a responsibility for undertaking rigorous and analytical reviews of the drivers of system pressures. This allows solutions to these pressures to be developed with a collaborative approach. SRG's are to hold each other's partner organisations to account for actions resulting from internal review, with member organisations sharing intelligence and pooling resources where possible, to improve system delivery against agreed key performance indicators. These arrangements do not supersede accountabilities between organisations and their respective regulators. A final responsibility is for SRG's to undertake wider transformational changes in line with the Urgent and Emergency Care Review.

4.1.6 SRG's meet on a monthly basis, are accountable to NHS England and feed into both the LHRP and LRF.

5.0 Preparing for Winter 15/16

5.1 Lessons learnt

5.1.1 The key lesson learnt by health and care systems from last year is to ensure full preparedness well in advance to the onset of winter. Relationships formed as a result of managing operational pressures last year have remained in place allowing partners to maintain an open dialogue and build on the greater awareness of each other's problems. Linked to this is the recognition of the importance of locally determining

[4] https://www.england.nhs.uk/wp-content/uploads/2012/10/winter-readiness-letter-1516.pdf

how best to manage winter pressures such as when to escalate/de-escalate into control and command reporting structures. In recognition of this, there is now a common methodology in place across the HWB footprint (see 5.2.6).

5.1.2 Another key learning point has been the recognition of the importance of understanding the wider interdependencies across health and social care systems. SRG's in North Yorkshire have created linkages with wider geographical neighbours depending upon patient flow. For example the Harrogate and Rural District SRG has links with the Leeds SRG as a lot of the Harrogate patient's access services in the Leeds and Wetherby area. Similarly, the Hambleton, Richmondshire and Whitby SRG has links with Durham and Darlington due to patient flow upwards into South Tees. These 'cross border' links are particularly useful to resolve issues such as delayed transfers of care as these more informal networks give access to other services (such as Leeds City Council) who are responsible for approximately 50% of all HaRD SRG delayed transfers of care.

5.1.3 Pressure on the care home sector caused operational difficulties last year and remains an area of focus for NYCC with current occupancy levels across care homes remaining above 90% on average. The causal factors behind this relate to market pressures with some providers failing to deliver services, others reducing their bed base and some providers exiting the market. Similar challenges in the domiciliary care market add to the overall system pressure. The following actions have been taken to address these issues:

- Market position statement produced and shared with partners and providers – this is used to inform commissioning intentions as well as potential providers of the current picture across the HWB footprint.
- Multiple provider failures – Business continuity/communications plans reviewed to ensure effective links in place between operational and emergency planning teams.
- Acknowledgement that workforce challenges are a significant system issue affecting all partners – Simon Cox identified as sponsor for this issue on behalf of the Board.

5.2 <u>Assurance/current practice</u>

5.2.1 As part of the learning of being prepared earlier, NHS England requested each SRG to complete an assurance toolkit by the 30 September 2015. The most relevant element of this assurance process was the 'eight high impact interventions'. These eight high impact interventions are detailed in Table One.

High Impact Interventions	
1. No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.	2. Calls to the ambulance 999 service and NHS 111 should undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS111, ambulance services and out-of-hours GPs should be considered.
3. The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.	4. SRGs should ensure that the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.
5. Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate	6. Rapid Assessment and Treat should be in place, to support patients in A&E and Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.
7. Consultant led morning ward rounds should take place 7 days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.	8. Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

Table One: The Eight High Impact Interventions

5.2.2 At the time of writing this report, the SRG's across North Yorkshire had been assured by NHS England as being either fully or partially assured in relation to the eight high impact interventions.

5.2.3 Each SRG area has created a work plan to address any areas within the SRG assurance submission where full assurance was not achieved. Work plans are standing agenda items on the SRG agenda's until full assurance has been achieved. This approach is supporting the work undertaken to ensure the SRG's are as fully prepared for periods of surge and escalation as possible. SRG's have also set up risk registers to log the risks requiring mitigating input. These risk registers help to drive the work around obtaining full assurance.

5.2.4 Each SRG has 'tested' its resilience plans by conducting a table top exercise with all the partners present. These test scenarios have been a real success as have given assurance to NHS England and reassurance to the SRG's that partner plans align with one another and

that the partners are consistent in their use of escalation triggers and reporting criteria.

5.2.5 Each SRG lead (the CCG) is required to participate in weekly assurance calls with NHS England. These calls commenced w/c 2 November 2015. The calls focus on how pressures across the SRG are being mitigated, actions that have been taken and provide an opportunity for NHS England to offer place based support to help manage the pressures being experienced. It also allows each SRG to hear how what pressures other areas are experiencing. This helps to determine if similarities are occurring or if patterns/trends are emerging. These pressures can then be dealt with at regional level where appropriate to do so. An example of this is working with Yorkshire Ambulance Service around their workforce issues. This is a regional issue that the SRG's are working on collectively and feeding into wider regional footprints (Yorkshire and the Humber).

5.2.6 North Yorkshire Health and Adult Services (HAS) have recently updated its escalation plan to mirror the recently published guidance on NHS REAP levels, moving from a four level plan to a six level plan. The plan has been developed in conjunction with the Scarborough, York and East Riding SRG, but is the basis for action with the other SRGs across the county. As part of the overall Scarborough, York and East Riding SRG plan for monitoring escalation levels HAS contributes to the Urgent Care Monitoring dashboard on a weekly basis.

6.0 SRG Assurance

6.1 Following on from the SRG assurance toolkit submissions on 30 September 2015, a Tripartite (NHS England, Monitor and the Trust Development Agency) review is underway. Assurance levels will be fed back to each SRG and, where full assurance is not given, work plans and risk registers will be refreshed and monitored through the SRG to ensure full assurance is reached as soon as possible.

6.2 SRG's have been advised by the Met office/NHS England to anticipate a bad winter this year. This is due to the fact that we are expected to have severe cold weather including snow this year. The UK is also overdue an influenza pandemic. The SRG test scenario's as discussed in paragraph 5.2.4 have evidenced cold weather plans are robust across the SRG's, such as access to 4x4 vehicles, business continuity arrangements in place and communications strategies already underway. All SRG's will be at an event on the 19 November 2015 which is a table top exercise looking at testing plans to effectively manage a community outbreak of influenza. Local and national campaigns are already under way to encourage members of the public- especially at risk groups to have the flu vaccination.

7.0 Communications

7.1 As set out by NHS England and Public Health England, all regional and local winter communications follow the national communications toolkit. The same applies to the communications element as part of the seasonal winter health

strategic partnership (see 3.1.1). This joined up approach from national through to local ensures consistent, key and timely messages are given out by all the partners and is aimed at ensuring members of the public are clear about messages regarding winter.

8.0 Conclusion

8.1 The SRG's within North Yorkshire are prepared for winter with individual work plans, risk registers and support from NHS England to work towards full assurance. Partners are working in a closer, more co-ordinated way to manage system pressure, e.g. adoption of REAP methodology.

8.2 Lessons learnt from last year have been incorporated into the current work and a robust SRG assurance process has been undertaken, led by NHS England.

8.3 SRG's operate at a local level under national guidance and support. SRG's also come together across North Yorkshire (and wider such as the Yorkshire and the Humber region) to address issues that cut across all SRG's.

8.4 SRG's meet regularly and report to NHS England on a weekly basis during the winter period. Partners have built a greater level of understanding through regular communication and dialogue that has continued since last winter allowing formal procedures for winter to be put in place in a smooth and efficient manner.

8.5 Communications to partners, provider of health and care services and members of the public align to the national communications developed by NHS England and Public Health England. Partners recognise the interdependencies across the health and care system and are using the SRG forum to continue to develop local 'best practice' set out in the high impact changes.

8.6 SRG's across the county support the work the seasonal winter health strategic partnership are undertaking and will dovetail with this work.

9.0 Required from the Board:

9.1 The Board is asked to note and accept the details set out in the paper as part of the assurance framework across the HWB health and care system.

Health and Wellbeing Board
North Yorkshire

27 November 2015

Better Care Fund evaluation

1.0 Purpose of the report

1.1 This paper seeks to provide assurance to the North Yorkshire Health and Wellbeing Board (NYHWB) regarding the monitoring arrangements for the Better Care Fund (BCF).

2.0 Background

2.1 The NYHWB received a paper covering the first two quarters of the BCF reporting periods up to 30 June 2015. At that time the Board was asked to:

- Note that the level of performance against the Non Elective Admission target (NEA) was below plan at a North Yorkshire (NY) level
- Receive a report on the progress evaluating BCF schemes from local Transformation Boards in November 2015, including implications for 2016/17 planning

2.2 This report seeks to deliver this commitment within the context of the national reporting structures. This is supported by the BCF arrangements across the NYHWB footprint and at local Transformation Board level which, collectively, provide a framework for implementation of the BCF plan and evaluating progress on delivery.

3.0 National reporting

3.1 The BCF programme is routinely monitored at a national level through quarterly reports based on a HWB footprint. To date there have been two quarters of data submitted (May and August) with the third quarter due to be returned on 27 November 2015. Each submission has been a stocktake of progress to date against a set of questions supported by a free text narrative. More elements have been added to the template each quarter and the latest requirements comprise:

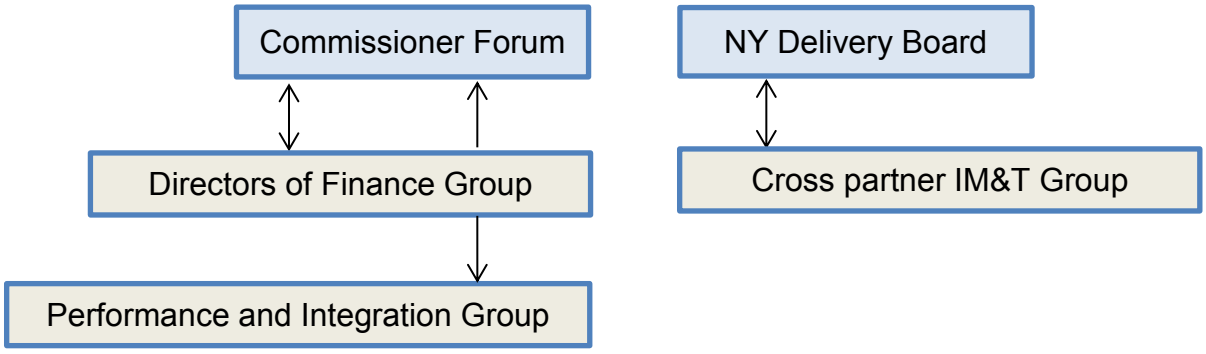
- Progress against the national conditions
- Budget arrangements
- Progress against NEA target and associated performance fund payment
- Income and expenditure against the plan
- Local metrics – additional integration metrics have now been added
- Preparations for BCF 16/17

3.2 To date, the emphasis nationally has been on delivery against the NEA target. As previously reported, there are some CCGs in NY that are achieving reductions in their individual NEA plan but this progress has not delivered at a NYHWB level. The overall performance at a NY level shows a slight improvement at 2.8% increase in non-elective admissions compared to 3% at the last reporting period (end June). The annual target for NYHWB is an 8.2% reduction which, given performance year to date, is unlikely to be achieved over the remaining 15/16 quarters.

3.3 As we move through 15/16 there has been a slight shift in focus nationally towards understanding the effect of transformation projects on the wider system. This reflects the fact that initiatives that have been invested in via BCF have been running for some time. Understanding the impact of any investment is necessary for a number of reasons: improving services for those receiving them; sharing learning across health and care systems; maximising resources and informing future commissioning plans.

4.0 NYHWB arrangements and activities

4.1 In line with the single NY BCF plan, all elements of the BCF national requirements are co-ordinated across the NY HWB footprint. This includes a range of forums which bring CCGs and NYCC together as part of the HWB substructures as follows:



4.2 As we move towards 16/17 the existing strong relationships across the health and care system will be critical in ensuring good communication flows between partners. The existing forums provide this platform for open discussions which has allowed partners to:

- Prepare and review the national quarterly submissions
- Support development of data sharing frameworks
- Establish co-location working between partner organisations
- Share learning between organisations
- Consider the developing integration agenda/potential new metrics
- Begin developing plans at transformation board level, and collectively, in readiness for 16/17

5.0 Local Transformation Boards: Progress Evaluating BCF

5.1 The following contributions have been developed by local Transformation Boards. They confirm that evaluation of schemes is underway, that different approaches have been taken and that evaluation will continue to be an iterative process to develop a fuller understanding of scheme impact and in particular the correlation with reducing NEAs. The outcomes of these reviews will inform planning for 2016/17 for which guidance is expected in December 2015.

5.2 Vale of York (VoY)

5.2.1 The key VoY schemes that sit within the boundary of North Yorkshire are the Selby Integrated Care Hub, a proportion of the Urgent Care Practitioner Scheme and a proportion of the Hospice at Home Scheme. The functions of the Mental Health Street Triage scheme have now been mainstreamed into the new mental health contract with Tees, Esk and Wear Valley Foundation Trust. All of the schemes have been monitored and demonstrate an impact on NEAs and emergency department attendances, albeit not at the scale planned.

5.2.2 Pressures elsewhere in the system often mask the impact of the specific schemes and a piece of work is being undertaken to address this. The quality impact of the schemes cannot be understated, particularly the impact of Hospice at Home, and the CCG are committed to continue to fund the schemes in North Yorkshire as long as the financial position allows it. The CCG continue to work closely with providers to develop more mature risk/share and risk/reward models and this approach is currently being tested with a draft funding model for the Selby Hub for the remainder of 15/16 and beyond

5.3 Scarborough & Ryedale (SR)

5.3.1 There has been investment in a number of schemes, some of which are local and some of which are pan North Yorkshire or partnership schemes across other CCG areas.

5.3.2 Local schemes include the Ryedale Community Response Team (Malton Hub), Hospice at Home/Care Home Link Nurse Scheme and a number of CCG funded posts supporting the North Yorkshire County Council Living Well programme. In addition Scarborough & Ryedale CCG (SRCCG) are contributing to wider schemes, in particular Improving Access to Psychological Therapies (IAPT) and Acute Hospital Psychiatric Liaison Service.

5.3.3 Schemes generally are not demonstrating the targeted reduction in NEAs, with a rise in NEAs across the CCG area. However, the overall rise is not as high as the non-mitigated rise predicted for this year. It has proved difficult to link the outputs of the schemes directly to effect on NEA rates due to the multifactorial nature of NEA variation. Work is also on-going to ensure that NEA recording is accurate.

5.3.4 Whilst the lack of effect against NEAs is disappointing, the wider impact (including qualitative) of the schemes should not be underestimated. The IAPT scheme, for example is showing such a significant improvement in access and recovery rates that local GPs are now referring at an un-precedented rate, which is in itself impacting on the scheme. All of the schemes are able to demonstrate quality improvements, and further work is needed to understand the value of this "quality premium".

5.3.5 SRCCG carried out a formal evaluation of the schemes in September 2015, but it was deemed too early to make decisions about continued investment at that stage. There will be further evaluation of the schemes in January 2016 to inform decisions on continued funding and potential commissioning decisions for the 2016/17 BCF.

5.4 Harrogate and Rural District (HaRD)

5.4.1 The HaRD schemes have in the main been implemented since April 2014, with the exception of the FAST response into Care Homes which has recently been reviewed and commissioned through a different approach. The summary below provides an update on the schemes:

- Care Home initiative - in reach team including FAST and supported by existing Community Geriatrician, increased Community Mental Health Care Home Liaison, GP practices linked to Care Homes. The FAST response team were linked to 4 Care Homes and this has now been expanded to all Care Homes and guidance communicated to GPs to be able to refer. Emergency admissions from Care Homes in 15/16 shows a similar number compared to 14/15. A significant change has been the number of deaths in hospital following an emergency admission from a Care Home showing lower numbers compared to previous two years.

- Mental Health Liaison Service is provided in Harrogate District Foundation Trust over 7 days from 8am to 8pm. In 15/16 emergency admissions for people with a mental health diagnosis has reduced compared to Q1 14/15.

- Community Stroke Team provides MDT specialist stroke rehabilitation supporting patients prior to discharge. A review has shown the average length of stay for stroke patients as 20.8 days, for those patients receiving community support the average is reduced to 15.9 days. Additional FAST response team is to focus on improvement or maintaining patient's independence and enable them to remain in their own home. The additional capacity has provided assessments for an additional 45 new patients per month. Supporting approximately 15 additional patients each month to remain at home and assumed a saving of 75 bed days per month.

- Voluntary Sector Schemes – 5 schemes have been commissioned that support carers, social prescribing, support at Home and Volunteers. All of the schemes are going through a formal evaluation through the SRG group and will continue to be reported.

5.4.2 The evaluation of the schemes in October 2015 evidenced full assurance for quality and impact of the schemes. The providers were each asked to provide additional evidence to provide assurance on the success factors including reduction in avoidable admissions and financial evaluation. Scheme evaluation will be completed on a quarterly basis to monitor delivery of services and evidence of investment. The reports will be presented at SRG and subsequently at Harrogate Health Transformation Board to consider future investment and continuation of schemes.

5.5 Airedale, Wharfedale & Craven (AWC)

5.5.1 There are currently 4 BCF commissioned schemes being delivered in the Craven area of North Yorkshire County Council. These schemes include:

- Assisted Technologies Service - Installation of telemedicine into 12 nursing and residential homes across Craven to provide 24/7 clinical support to residents and carers. Installation of 65 iPads into 65 patients' homes across Craven with COPD, Heart Failure and any other complex needs assessed on a case by case basis i.e. end of life, complex comorbidities.

- Care Home Quality Improvement Support Service - The service provides a dedicated support and liaison service to facilitate quality improvement in care delivered across the care homes in Craven.

- Specialist Community Nursing Service - Expansion of existing specialist community services in Craven to support people with long term conditions through comprehensive assessment and care planning.

- Craven Collaborative Care Team Enhancement - Further enhancement of the existing Craven Collaborative Care team to provide a multidisciplinary, multiagency intermediate care services with the aim of preventing avoidable admissions to hospital and long term care. Funding provided to enhance the capacity and capability within the team by 1 WTE Social Care Assessor, 1 WTE Physiotherapist, 1 WTE Advanced Nurse Practitioner (ANP), 0.5 WTE Mental Health Nurse and 4 WTE Community nurses, plus 0.4 WTE link Carers' Resource worker to ensure that the health and social care needs of patients are met in a timely manner.

5.5.2 As well as using data from the AWC Transformation and Integration Group (TIG) dashboard to assess impact across the system in Craven, a local Craven dash board has been developed, covering the 5 Craven practices participating in the 'Better Care Fund' schemes. It details various pertinent activities that would be expected to change as a measure of success of the various schemes. The report shows data for the previous 12 months prior to commencement of any pilots, and in order to make comparisons, data for the following 12 months after pilot start date. Regular monthly monitoring of these measures is taking place.

5.5.3 A separate (qualitative) evaluation framework is being agreed with providers and expected to be completed by mid-December.

5.6 Hambleton, Richmondshire and Whitby (HRW)

5.6.1 The HRW BCF evaluation completed in October 2015 provided assurance that all of the schemes partially meet their evaluation criteria specified through the North Yorkshire submission.

5.6.2 Whilst each individual's schemes impact on NEL Admissions cannot be evidenced directly through quantitative data it can be assumed to be a positive impact and effect on the current position at -3% (September 2015 source MAR). The impact at our main provider is even more significant with a current position of -6% on all emergency admissions and -10% ages 18-64. A recent rise in paediatric activity across the locality is offsetting some of the impacts on adults and older people.

5.6.3 All schemes are delivering increased activity levels and qualitative service improvements strengthening the localities service resilience and the Fit 4 the Future Transformation Programme. Provider feedback includes; improved GP and Partner relations, improved services for Patients and Carers and a real and ongoing commitment to continued service improvement.

5.6.4 All schemes are now fully operational. Mental Health schemes are meeting service targets, Discharge Facilitators are established as change agents to improve discharge processes and a GP Hospitalist model has been implemented and identified as a best practice as part of the Friarage wider transformation proposals. The successes include; reductions in Emergency Admissions with Mental Health Diagnosis, -23% reduction in emergency admissions due to falls, 24 hour support for palliative patients and reduced overnight admissions.

5.6.5 Schemes identified as enabling schemes without specific saving targets are also monitored against their outputs and our service resilience, impacts include a Model of Dementia provision now outlined to inform future commissioning intentions and a District Nursing Service at full capacity and fully engaged in the CCG's Primary Care Workforce transformation project.

5.6.6 The evaluation includes the significant risks of any service reduction at this point of full service delivery and investment and recommends no significant changes to schemes or existing funding arrangements. Scheme evaluation will remain on-going with a detailed evaluation exercise being completed every quarter to continually monitor delivery of services and prototype developments to justify the investment as a positive contribution and influence to the wider integration agenda.

6.0 Conclusion

6.1 Further work needs to be done to understand the implications of the BCF schemes (see Appendix 1 for summary of all new schemes) in all localities. Discussions with health and care colleagues have identified the need to develop mechanisms that will provide regular review of schemes, both in terms of quality and financial benefits.

6.2 The national move towards measuring impact of the BCF through new integration metrics is helpful in supporting the current direction of travel of NYHWB and the Joint Health and Wellbeing Strategy.

6.3 Partners have created an environment from which to build further transformation at local level which will become increasingly important as resources continue to be stretched.

7.0 Required from the Board:

7.1 The Board is asked to note and accept the details set out in the paper as part of the assurance framework across the HWB health and care system.

Wendy Balmain
Assistant Director of Integration
19 November 2015

Appendix A: New schemes identified in the BCF submission in 2014 by CCG

AWC	Craven Assistive Technology – Telemedicine	156,000
	Quality Improvement Support	105,000
	Craven Specialist Community Nursing (Intermediate Care)	200,000
	Craven Collaborative Care Team	413,000
	Elms 2	1,556
	Dementia navigator	6,085
	Craven equipment	22,464
	Harrogate ICES (Equipment Store)	33,626
	Equipment	135,000
	Community Services ACCT	6,500
	Young carers	3,414
	Carers resource/support schemes	1,611
	Carers resource	11,051
	Carers scheme children	123,000
	Crossroads	15,693
	Tissue viability service	52,000
	Primary enhanced care	255,000
	A & E liaison	46,000
	Palliative care nursing	56,000
	Phys therapies	30,000

HRW	Psychiatric Liaison Scheme	473,000
	Dementia Strategy	80,000
	Integrated START, Fast Response and Int Care	1,145,800
	Extended Whitby overnight nursing service	188,000
	Hospital case management	127,700
	H&R district nursing capacity	352,900
	Risk profiling and long term conditions	101,600
	Community Focused acute care	137,600
	Lifestyle Referral	50,000
	Community Navigators	0
	IAPT	205,000
	Carer Sitting Service	22,000
	Clinicial Skills Educator	0
	Telemedicine	115,000
	BCF support	73,400
	Dementia Navigator	16,648
	Equipment	275,178
	Falls	130,000
	Generic Workers	84,870
	Community support assistants	22,755
	Transport	20,997
	Advocacy - County contract	20,525
	Whitby cart	80,000
	St Johns shopping service	15,000
	Heriot Hospice Homecare support	25,856
	Young Carers	9,340
	Carers Resource/Support Scheme	5,449
	Carers Suppport Scheme/Resource	44,991
	Carers Resource	9,421
	Sitting Service	3,346
	End of Life Benefits Advisor HRW	39,106
	Fast Resonse	726,000
	Wheelchair services - hdft	309,384
	Heart Failure Nursing Support	68,267
	Respiratory Nursing Support	111,874
	Specialist Continence / & Nursing S	292,334

HaRD	Psychiatric Liaison Service	426,000
	Voluntary Sector Projects	200,000
	Clinical Assessment Team and Intermediate Care	1,895,000
	Care Home Support	251,000
	Dementia Navigator	19,033
	Equipment	389,848
	Transport	24,003
	Advocacy - County Contract from 11-12	23,464
	Cardiac re-ablement in community	69,042
	Recovery team str workers 1.5	36,973
	Recovery team admin	8,090
	Community Support Assistant	24,674
	Mental Health Crisis	13,551
	REACT	8,493
	Staion View rehabilitation	21,154
	Carers resource/support scheme	64,697
	Woodfield EMI respte	36,998
	Acorn Centre - Day care	11,195
	Claro - Day care	9,271
	Crossroads	17,981
	Fast Resonse	1,214,559
	Wheelchair services - hdft	372,533
	Heart Failure Nursing Support	85,515
	Respiratory Nursing Support	52,879
	Specialist Continence / & Nursing Support	336,047

S&R	Malton Care Hub	1,000,000
	Health Trainers	135,000
	Psychiatric Liaison	400,000
	Community Mental Health (IAPT)	300,000
	Smoking Cessation	100,000
	Nutrition in Care Homes	40,000
	Care Home Link Nurse (Linked to S&R_008_VS for delivery)	168,000
	Palliative Care Pathway	92,000
	Dementia Navigator	14,027
	- Intermediate Care	89,900
	Transport	17,690
	Advocacy - County contract from 11-12	17,292
	101 Prospect Mt Road - Rehab unit - Deputy Off	29,371
	101 Prospect Mt Road - Rehab unit - Care Assistant Hours	35,849
	Continence	221,708
	Early Supported Discharge	283,350
	Young Carers	7,869
	Carers Resource/Support scheme	33,827
	Carers Support Scheme / Resource	7,097
	Carers Resource	35,045
	Care watch	62,290
	Tissue Viability Services	51,685
	Fast Resonse	768,237
	Wheelchair services - hdft	414,236
	Heart Failure	101,527

VoY	St Leonard's Hospice at Home	170,000
	Selby Care Hub	550,000
	Street Triage service	125,000
	Urgent Care Practitioners	300,000
	Psychaitric Liaison	0
	Dementia Navigator	9,991
	Harrogate ICES (Equipment Store)	211,200
	Falls	149,343
	- Intermediate Care	13,540
	Generic Workers	5,130
	Community Support Assistants - Support Time/Recovery Worker	1,375
	Voyage - New Selby Sitting Scheme Feb 2012	28,552
	Transport	12,600
	Advocacy - County Contract from 11-12	12,316
	Young Carers	5,604
	Carers Resource/Support scheme	5,915
	Carers Support Scheme / Resource	4,868
	Carers Resource	2,719
	Carers Support Service	14,820
	Community rehabilitation	600,013
	Intermediate Care	325,000
	Tissue Viability Services	94,742
	Fast Resonse	593,982
	Wheelchair services - hdft	263,602
	Heart Failure Nursing Support	81,078
	Respiratory Nursing Support	27,022
	Specialist Cardiac Rehabilitation	83,374
	Specialist Continence / & Nursing Support	411,213

North Yorkshire County Council

Management Board/ Health and Wellbeing Board

27 November 2015

Health Protection Assurance Statement

Report of the Director of Public Health for North Yorkshire

1.0 Purpose

This paper presents a Statement of Assurance on Health Protection arrangements in North Yorkshire to ensure that residents are protected from health threats including major emergencies and describes the issues of concern regarding the plans in place to respond to incidents that present a threat to the public's health.

2.0 Background

In May 2014, North Yorkshire County Council agreed the proposal for a local Health Protection Assurance Group of representatives from relevant lead agencies and chaired by the Director of Public Health to meet 6-monthly to formally review health protection arrangements and agree Statements of Assurance for the Council and Health and Wellbeing Board.

The Council agreed to use the common health protection assurance framework which Directors of Public Health across North Yorkshire, York and the Humber have adopted for this purpose. The key elements of the framework are:

- Prevention
    - Vaccination and Immunisation
    - Screening – nationally defined and commissioned cancer and non-cancer programmes
    - Infection prevention and control (IPC) – usually within the health and care setting,
    - Environment, enforcement, trading standards, food, animal health, water, and health & safety
    - Drugs and substance misuse
    - Prevention of injury including Suicide prevention
    - Sexual health
- Emergency preparedness, resilience, and response (EPRR)
- Incidents and outbreaks of infectious diseases and environmental hazards
- Surveillance of infectious diseases and environmental hazards

The Health Protection Assurance Group met on 15th January 2015 and 22nd July 2015. Terms of Reference (attached) have been agreed.

3.0 Progress

The North Yorkshire Health Protection Assurance Group has reviewed its Terms of Reference to ensure it has clear aims and objectives that do not duplicate existing groups or partnerships that play a role in health protection assurance. This is especially important because organisations such as NHS England and Public Health England have reduced capacity and work across a larger area that North Yorkshire. As such Directors of Public Health from local authorities in North Yorkshire, York and the Humber have formed a regional Health Protection Assurance Group that meets quarterly. In addition the North Yorkshire and York Local Resilience Partnership and the North Yorkshire and Humber Local Health Resilience Partnership are key to EPRR aspects of Health Protection assurance.

Across North Yorkshire each year, there are over 100 outbreaks and incidents, 180 000 immunisation contacts and 210 000 screening contacts. These are managed efficiently and errors are extremely rare. However, on the rare occasion when there is a failure it is important that there is a clear understanding of the system so the appropriate actions can be taken quickly.

The Group has done work to map the infrastructure and plans in place to respond to outbreaks and incidents. This has included the role of environmental officers and how actions of Environmental Health Departments in our 7 districts are co-ordinated. Progress has also been made in specifying the role and agreeing the arrangements for commissioning of the Community Infection Control and Prevention team which is a major contributor to outbreak management.

In the past year, the county played host to the Tour de France. There has been valuable learning from this event that has been used in planning subsequent events such as the Tour of Yorkshire.

Further work is needed to develop and agree standards for the evidence required to provide assurance that health protection duties are being met to allow consistency across organisations and functions.

4.0 Current concerns

Organisational Restructures

The Group noted the risks associated with organisational restructures which can result in lack of clarity about roles, reduced capacity and disruption of relationships with other organisations that are important for planning and responding to threats to public health. The Group has been monitoring the impact of the NHS England restructure on EPRR arrangements. Public Health England Screening and Immunisations teams and Health Protection teams are under review and the impact of changes that arise from this review is not clear. The Commissioning Support Unit (CSU) is also going through changes and some health protection functions will be delivered by different organisations.

The Group was also aware of potential risks to district Environmental Health Departments as local government adjusts to reductions in their budgets. Environmental

Health Officers contribute to networks across district boundaries that ensure there is consistent planning and resilience in the response to issues. This sharing of expertise is under threat if numbers and skills decrease as districts focus increasingly only on statutory functions in the face of shrinking budgets. There is no mechanism in place to monitor capacity and skill mix in EHOs across all districts.

Screening programmes

Screening programmes in North Yorkshire are delivered by different NHS Trusts and commissioned and monitored by different NHS England and PHE teams. There is therefore a need to engage with several Screening Programme Boards to gain assurance. Limited capacity means that detailed work to understand variation in uptake of screening across the county does not get the priority needed.

Child Health Information System (CHIS)

Harrogate District Foundation Trust (HDFT) continues to provide the Child Health Information System (CHIS) for North Yorkshire. CHIS is important because data on immunisation uptake and other information that is important for protecting the health of children are collected and collated through this system. It is acknowledged that our CHIS offers only partial coverage of the full national specification of the service but recent quality visits and contract review processes have reflected improvements in this.

Next steps will involve work with HDFT to support an improvement plan; deadline for the plan completion is Autumn 2015, which will set out milestones towards the complete delivery of the full current service specification, with early priorities to be addressed during 2015/16. A revised national service specification is still in development and a decision on the future direction of CHIS services is expected in early 2016.

Given that the health visiting service and the Healthy Child Programme 5-19 are both provided by HDFT and commissioned by NYCC, there will be improvements brought about with these teams working together. In addition to this the NHS England regional team jointly procured immunisation services alongside the Healthy Child Programme 5-19. This will meet some of the outcomes and needs of such a system through the collection of the relevant information by the Healthy Child Programme practitioners.

Health care associated infections

New arrangements for monitoring HCAIs and sharing learning across the system are evolving but a coherent approach is still not in place. CCGs are working together to implement a robust system of assurance to replace previous arrangements with the CSU.

Avian flu

There have been recent outbreaks of avian flu in poultry farms in neighbouring counties and a few instances where avian flu was suspected but not confirmed in North Yorkshire. The Group recognises the need to check that we can respond to an outbreak and that the arrangements outlined in our plans are still relevant and

deliverable following significant changes to the public health system that occurred after these plans were agreed.

5.0 Conclusion

The Group has made progress in adopting a framework that defines the scope of functions that are reviewed and in mapping the organisations, groups and partnerships that make up the system for health protection.

Based on the evidence reviewed there is substantial assurance that plans and procedures are in place to protect the health of the public. However, a number of concerns have been identified for action.

6.0 Next steps

At the next meeting, the Group will agree revisions to the terms and conditions to outline the roles and responsibilities of members. The Group will also review the evidence required from lead organisations in order to assess how robust their health protection plans and arrangements are to respond to identified threats and risks. This will include capacity and skills to ensure delivery of plans. Increased clarity is needed on the criteria to be used to assess the level of assurance of plans and arrangements.

NHS England are in the process of planning a community outbreak exercise for North Yorkshire and the Humber in October 2015. The learning form this event will be used to update outbreak plans as relevant.

7.0 Recommendation

The Board are asked to note the report.

Dr Lincoln Sargeant

Director of Public Health

20 August 2015

North Yorkshire Health Protection Assurance Group
Terms of Reference

1. Aim

The aim of the Group is to provide assurance to North Yorkshire County Council and the North Yorkshire Health and Wellbeing Board about the adequacy of prevention, surveillance, planning and response with regard to health protection issues.

The Groups will assist the Director of Public Health, as the Chair, to discharge his/her responsibility for ensuring oversight of health protection in North Yorkshire, and in providing a strategic challenge to health protection plans/arrangements produced by partner organisations.

2. Accountability

The Group will be provide Statements of Assurance to North Yorkshire County Council and to the Health and Wellbeing Board with respect to health protection plans. It will produce an annual report on health protection issues for the Health and Wellbeing Board and will report other issues by exception.

3. Specific duties and functions

The Group will oversee health protection plans and arrangements in North Yorkshire through an agreed health protection assurance framework. This assurance framework will seek evidence that plans and arrangements meet the following criteria:

- Identification of key elements of health protection, with appropriate lead roles allocated to cover each element,
- Assessment of risks for each element of health protection and control measures in place, and
- Mechanisms to monitor health protection risks which should be reviewed on a regular basis, or at least annually.

The key elements of the framework include but are not restricted to:

- Prevention
    - Vaccination and Immunisation
    - Screening – nationally defined and commissioned cancer and non-cancer programmes
    - Infection prevention and control (IPC) – usually within the health and care setting,
    - Environment, enforcement, trading standards, food, animal health, water, and health & safety
    - Drugs and substance misuse
    - Prevention of injury including Suicide prevention
    - Sexual health

- Emergency preparedness, resilience, and response (EPRR)
- Incidents and outbreaks of infectious diseases and environmental hazards
- Surveillance of infectious diseases and environmental hazards

The Group will have key responsibilities to:

- Highlight concerns about significant health protection issues and the appropriateness of health protection arrangements in North Yorkshire, raising any concerns with the relevant commissioners and/or providers or, as necessary, escalating concerns to the Health and Wellbeing Board or relevant Chief Executives
- Provide an expert view on any health protection concerns on which the Council or Health and Wellbeing Board request advice from the Group
- Monitor local performance in addressing the key health protection issues in North Yorkshire
- Review significant areas of poor performance and to expect recovery plans to be in place
- Identify the need for, and review the content of, local plans relevant to significant health protection issues
- Make recommendations as to health protection issues that should be included in the local Joint Strategic Needs Assessment
- Consider the lessons identified from any serious incidents or outbreaks and to expect that learning from such incidents is embedded in future working practices

5. Membership

The membership of the Health Protection Assurance Group includes:

- Director of Public Health for North Yorkshire
- Consultant Public Health lead for sexual health commissioning (NYCC)
- Consultant Public Health lead for substance misuse commissioning (NYCC)
- Consultant Public Health lead for Screening and Immunisation (PHE)
- Consultant in Communicable Disease Control (PHE)
- Lead Officer for Infection Control Prevention commissioning (e.g Executive Nurse) on behalf of all CCGs
- Lead Director of Infection Prevention and Control on behalf of Provider Trusts
- Chief Environmental Health Officer representative on behalf of all Chief EHOs
- Head of Emergency Planning Unit (NYCC) representing secretariat of NYLRF
- Health Emergency Planning Officer (NHS England Area Team) representing LHRP secretariat

Members should be in a position to provide assurance on behalf of the organisation or partnership that they represent. Each member will be responsible for reporting back to their organisation or partnership on the work of the Group.

6. Nominated substitutes

Each member will nominate a named substitute with appropriate seniority and knowledge to attend and act in their absence.

7. Chair and vice chair

Chair: Director of Public Health for North Yorkshire.
Vice Chair: Deputy Director of Public Health or Consultant Public Health (NYCC)

8. Quorum

The quorum for the Group will be one half of its membership. Representation within that number must include the Chair or Vice-chair. A Statement of Assurance can only be made when a quorate Groups is able to review evidence pertaining to all key elements of the Health Protection Assurance Framework.

9. Secretariat and recording meetings

The secretariat will be provided by the Administrator to the Director of Public Health for North Yorkshire. The agenda and reports will normally be distributed no later than seven days before the meeting date. Members will be expected to submit evidence to support Statements of Assurance in their lead area in time to be circulated seven full days before the meeting date. All meetings will be formally minuted. The minutes will be circulated to all members and substitutes.

10. Frequency of meetings

The Board meets two times per year

11. Review

The Terms of Reference will be reviewed annually.

Health and Wellbeing Board
North Yorkshire

NORTH YORKSHIRE HEALTH AND WELLBEING BOARD

Partnership Protocol with Safeguarding Boards

27 November 2015

1. Purpose

1.1 To set out the relationship and working arrangements between the following Boards:

- North Yorkshire Health and Wellbeing Board (NYHWB)
- North Yorkshire Safeguarding Adults Board (NYSAB)
- North Yorkshire Safeguarding Children Board (NYSCB)

2. Background

2.1 The enclosed protocol has been developed in recognition of the need to have effective communication and engagement between the Boards. Section 5 of the paper sets out those elements which are of particular relevance to all three Boards and describes the opportunities presented by formalising the current working relationship between the Boards.

2.2 Section 6 of the protocol describes how the Boards will operationally co-ordinate some key activities. NYHWB received the two Safeguarding Boards' Annual Reports at its meeting on 30 September 2015.

3. Required from the Board

3.1 The Board is asked to approve the protocol.

Elaine Wyllie
Head of Integration
17 November 2015

1. The Partnership

1.1 This protocol sets out the relationship and describes the working arrangements that exist between the North Yorkshire Health and Wellbeing Board (NYHWB) and the Children and Adult Safeguarding Boards operating across North Yorkshire.

1.2 The role of the Safeguarding Children Board (NYSCB) and the Safeguarding Adults Board (NYSAB) in relation to the Health and Wellbeing Board is one of equal partners underpinned by this protocol. The protocol sets out the distinct roles and responsibilities of the Boards, the inter-relationships between them in terms of safeguarding and well-being and the means by which we secure effective co-ordination and coherence between the Boards.

1.3 The role of North Yorkshire County Council Scrutiny Committees, to scrutinise performance of safeguarding boards and to be consulted on for policy changes and related service design and commissioning intentions, remains unchanged, as does the governance of partner agencies to oversee and monitor respective agency contribution and performance to prevent and protect.

2. North Yorkshire Health and Wellbeing Board

2.1 The North Yorkshire Health and Wellbeing Board (NYHWB) was established consequent to the Health and Social Care Act 2012. The Board provides a forum where leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce variations in outcomes through a shared understanding of local need, agreed priorities and a collaborative approach to ensure services are commissioned and delivered in an integrated way.

2.2 The North Yorkshire Joint Strategic Needs Assessment (JSNA) informs and supports the development of a Joint Health and Wellbeing strategy (JHWS) which provides the Board with a framework of strategic influence regarding commissioning decisions across health, public health and social care. This enables a more effective and responsive local health and care system which connects to other key policy and decision making areas that impact on health and wellbeing such as housing, transport and education.

2.3 The NYHWB undertook a governance review in 2014. The review identified a number of actions, including the need to update the Joint Health and Wellbeing Strategy (JHWS). The governance review identified that close links with both Children's and Adults' Safeguarding Boards is essential to ensure that commissioning plans and service delivery incorporate key findings

from the Boards. The JHWS builds on this review and sets out that treating people with dignity and respect and keeping them safe and free from abuse is a core principle adopted by all HWB member organisations.

3. North Yorkshire Safeguarding Children Board (NYSCB)

3.1 Section 13 of the Children Act 2004 requires each Local Authority to establish a Local Safeguarding Children Board (LSCB) for their area. It specifies the organisations and individuals (other than the Local Authority) that should be represented on LSCBs.

3.2 Working Together to Safeguard Children (2013) provides guidance as to the role and responsibilities of LSCBs and the functions they undertake:

a) To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
b) To ensure the effectiveness of what is done by each such person or body for those purposes.

3.3 Safeguarding and promoting the welfare of children is defined as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.

3.4 A key objective in undertaking these roles is to enable children to have optimum life chances and enter adulthood successfully.

3.5 The role of an LSCB is to scrutinise and challenge the work of agencies both individually and collectively. The LSCB is not operationally responsible for managers and staff in constituent agencies.

4. North Yorkshire Safeguarding Adults Board (NYSAB)

4.1 The Care Act (2014) requires each Local Authority to establish a Safeguarding Adults Board for their area. Chapter 14 of the Care Act Statutory guidance (2014) provides guidance as to the role and responsibilities of Safeguarding Adults Boards (SABs) and the functions they undertake.

4.2 The main objective of a SAB is to assure itself those local safeguarding arrangements and partners act to help and protect adults in its area where they meet the criteria below.

- they have needs for care and support and
- they are experiencing, or at risk of, abuse and neglect; and
- as a result of those care and support needs they are unable to protect themselves from either the risk of or the experience of abuse or neglect.

4.3 The forms of abuse which the Board aims to prevent and address are: physical abuse, sexual abuse, psychological abuse, financial or material abuse, neglect or acts of omission, discriminatory abuse, organisational abuse, domestic violence, modern slavery and self-neglect.

4.4 The NYSAB has identified agreed objectives and priorities for its work which include clear policy, procedural and practice arrangements, mechanisms to secure co-ordination of activities between agencies, the provision of training and workforce development in support of safeguarding and quality assurance and performance management arrangements to test the effectiveness of safeguarding and the impact of the Board.

4.5 The role of a SAB is to scrutinise and challenge the work of agencies both individually and collectively. The SAB is not operationally responsible for managers and staff in constituent agencies.

5. Effective communication and engagement between the Boards

5.1 Safeguarding is everyone's business. As such, all key strategic plans whether they be formulated by individual agencies or by partnership forums should include safeguarding as a cross-cutting theme, to ensure that existing strategies and service delivery as well as emerging plans for change and improvement include effective safeguarding arrangements that ensure that all people of North Yorkshire are safe and their wellbeing is protected.

5.2 The Joint Health and Wellbeing Strategy is a key commissioning strategy for the delivery of services to children and adults across North Yorkshire and so it is critical that in developing, delivering and evaluating the strategy there is effective interchange between the North Yorkshire Health and Wellbeing Board and the two safeguarding boards.

5.3 'Working Together' 2013 outlines a number of statements intended to formalise the relationship between the Health and Wellbeing Board and the

local Safeguarding Boards, particularly in relation to the JSNA and the presentation of the Safeguarding Board Annual Reports.

5.4 The opportunities presented by a formal working relationship between the NYHWB and NYSCB/NYSAB can be summarised as follows:

- Sharing of strategic intelligence to inform commissioning decisions and/or provide assurance on significant issues
- Ensuring safeguarding is 'everyone's business', reflected in the public health agenda and related health strategies
- Consideration of the impact of the JHWB Strategy on safeguarding outcomes, and of safeguarding on wider determinants of health
- Providing a formal mechanism for mutual Board support and assurance of the health and social care system

6. Co-ordination between the Boards

6.1 In order to secure the opportunities identified above the following arrangements will operate to ensure effective co-ordination and coherence in the work of the three Boards:

- The two Safeguarding Boards' Annual Reports will be received by the NYHWB for:
  i. consideration in setting strategic commissioning plans
  ii. assurance of the system in relation to NYHWB partners' safeguarding arrangements
  iii. Updating NYHWB on performance against Business Plan objectives in the previous financial year.

- The JHWB Strategy will be received by NYSAB and NYSCB for:
  i. Consideration of any key safeguarding policies, emerging themes and implementation of best practice wherever possible
  ii. Consideration of the proposed priorities and objectives for the refreshed JHWB Strategy to ensure alignment to the Business Plans

- The NYCC Executive Officers in consultation with the Chairs for NYSCB and NYSAB will be the conduit for escalation of strategic issues that require consideration by NYHWB, or its substructure. This is a reciprocal arrangement between the three Boards and is the mechanism for action outwith the annual business planning cycle.

7. Relationships between the Safeguarding Boards and other partnership forums reporting to the Health and Wellbeing Board

7.1 The overarching strategic plan for North Yorkshire is the Community Plan. The partnership objectives of the Community Plan are overseen by a series of groups providing strategic leadership:

- Local Government North Yorkshire and York
- Chief Executives' Group – North Yorkshire and York
- Local strategic partnerships (District local authority level where these are in place)
- North Yorkshire Community Safety Partnership
- York Community Safety Partnership
- York, North Yorkshire and East Riding Local Enterprise Partnership
- North Yorkshire and York Local Nature Partnership

7.2 The NYHWB is a statutory committee of North Yorkshire County Council, it has a substructure to lead on delivering the key strategic strands to ensure the health and wellbeing needs of the local population are met. Key subgroups of the Board are:

- North Yorkshire Delivery Board
- North Yorkshire Commissioning Forum
- Local Transformation Boards

7.3 In the context of our aim to ensure that 'Safeguarding is Everyone's Business', there should be effective co-ordination and coherence in relation to safeguarding and wellbeing between the two Safeguarding Boards and the key strategic partnership forums as described above. The 2 Safeguarding Boards can ask any of these groups to consider a relevant aspect of safeguarding as can these groups request the Safeguarding Boards to consider and advise them.

Revised 17 November 2015

NORTH YORKSHIRE DELIVERY BOARD

Notes of a meeting held on 8 October 2015 at 2.00 pm
Boardroom, Sovereign House, York

Present:

Richard Webb (Vice Chair)	NYCC
Carolyn Bird (substitute)	NYCC
Anne-Marie Lubanski	NYCC
Dr Lincoln Sargeant	NYCC
Wendy Balmain	NYCC
Patrick Crowley	York Teaching Hospital NHS Foundation Trust
Adele Coulthard (substitute)	Tees, Esk & Wear Valleys NHS Foundation Trust
Rob Harrison (substitute)	Harrogate & District NHS Foundation Trust
Andrew Copley (substitute)	Airedale NHS Foundation Trust
Chris Newton (informal substitute)	South Tees NHS Foundation Trust
Wendy Scott	York Teaching Hospital NHS Foundation Trust
Dr Vicky Pleydell	Hambleton, Richmondshire & Whitby CCG
Anthony Fitzgerald (substitute)	Harrogate & Rural District CCG
Fiona Bell (informal substitute)	Vale of York CCG
Simon Cox	Scarborough & Ryedale CCG
Janet Probert	NHS Partnership Commissioning Unit
Alex Bird	Age UK - Voluntary Sector Representative
Mike Padgham (substitute)	Independent Care Group
Elaine Wyllie	NYCC
Gavin Halligan-Davis	NYCC
James Stroyan	NYCC
Kate Arscott	NYCC (Note taker)

Apologies:

Pete Dwyer	NYCC
Janet Waggott	Ryedale District Council - District Council Representative
Martin Barkley	Tees, Esk & Wear Valleys NHS Foundation Trust
Ros Tolcher	Harrogate & District NHS Foundation Trust
Bridget Fletcher	Airedale NHS Foundation Trust
Tricia Hart	South Tees NHS Foundation Trust
Sue Pitkethly	Airedale, Wharfedale & Craven CCG
Amanda Bloor (Chair)	Harrogate & Rural District CCG
Dr Mark Hayes & Rachel Potts	Vale of York CCG
David Ita	Healthwatch
Keren Wilson	Independent Care Group
Jenni Newberry	North Yorkshire Police & Crime Commissioner (Head of Partnerships & Commissioning)

	Richard Webb in the Chair	Action
1	**INTRODUCTION AND APOLOGIES** Richard Webb offered the Board's congratulations to Janet Probert on her appointment as Chief Officer at Hambleton, Richmondshire & Whitby CCG in place of Vicky Pleydell who will be retiring in November. The Board thanked Vicky for the passion and commitment she has brought to the role and wished her all the best in the future.	

2	**FEEDBACK FROM HWB 30/9/15** • Joint Health and Wellbeing Strategy: Noted that HWB had agreed to add a specific section on 'dying well' to the Strategy. Final draft will go back to HWB on 27 November to be signed off. • Better Care Fund: The paper to HWB was circulated, including the NY reporting framework. There were difficult issues for the partnership to tackle in regard to missing the Non-Elective Admissions target. All Transformation Boards are to evaluate existing investment in BCF schemes. Elaine Wyllie and Gavin Halligan-Davis will work with CCGs. HWB had recognised that it can take time to see results, but there is still a need for challenge to identify which schemes are delivering results. Confusion also exists between the 2 different national data sets (MAR and SUS) in use. • Mental Health Strategy: this was well received and signed off by HWB. There was good feedback from service users on the consultation. The next stage is to develop an Implementation Plan. • Autism Strategy: this was also well received and signed off by HWB. **Noted:** • **GH-D will be developing a dashboard for HWB to measure progress against implementation plans for the strategies agreed by the Board**	**WB/EW** **EW/GH-D** **JP/KC** **GH-D**
3	**PLACE FOCUS – HAMBLETON, RICHMONDSHIRE & WHITBY** Presentation by Vicky Pleydell on HR&W CCG progress against the Fit for the Future programme. VP's presentation outlined: • different priorities across the 3 distinct localities • programme objectives • governance framework for programme delivery • workstreams – urgent care, community care and capital developments • achievements to date • "soft stuff" • Challenges • Clinical summit to take place on 25 November 2015 Presentation by Ann-Marie Lubanski and James Stroyan (NYCC) on progress, challenge and opportunities across the HR&W area. The presentation outlined: • ASCOF indicators for the NYCC area • People receiving services from HAS in 2014/15 across North Yorkshire and HR&W in numbers • Examples of integration • Looking forward: challenges and opportunities, and new ways of working	

	• Delivering good outcomes for people **Noted:** • **A-ML to respond to Alex Bird direct on opportunities for voluntary sector to input to workshops**	**A-ML/A Bird**

4	**PLACE FOCUS – SCARBOROUGH & RYEDALE**
	
	Presentation by Simon Cox on S&R CCG's Health and Wellbeing Programme for the East Coast. SC's presentation outlined:
	• The ambition
	• The givens
	• The problem of comparing achievements with measurements
	• Objectives and actions for each of the three strategic themes:
	  o Acute care system
	  o Out of hospital care system
	  o Health improvement
	• The strategic programme	

5	**SEASONAL WINTER HEALTH STRATEGY** Lincoln Sargeant gave a presentation on the draft strategy. NYDB members indicated their support for the aims of the draft strategy, which will be reported to HWB in November. Alex Bird advised NYDB of a bid by Age UK in relation to winter health. **Agreed:** • **Alex Bird to provide details of the Age UK bid for circulation** • **LS to follow up possible input from the Fire Service** • **LS and team to take the draft strategy through SRGs** • **SRGs to report on winter resilience to HWB via Commissioner Forum**	**A Bird** **LS** **LS** **SRGs/CF**
6	**WORKFORCE** The Board considered how to progress work on the topic of workforce. Particular issues highlighted in discussion included the challenge of retaining staff in both health and care sectors across North Yorkshire. The discussion reflected on a number of causal socio-economic factors. It was recognised that it had proved challenging to take forward this piece of work alongside other priorities. It was agreed that it was important to understand and address local issues, but at the same time any work undertaken needs to add value and avoid duplicating work being carried out elsewhere. The development of a 'heat map' to understand the key challenges that need to be addressed was considered to be a helpful tool. **Agreed:** • **SC and WB to pull together the current position and frame a plan of work to report back to the next meeting**	**SC/WB**

7	**MENTAL HEALTH CRISIS CARE CONCORDAT** Janet Probert presented a report on the Mental Health Crisis Care Concordat governance arrangements, and an overview of work undertaken across the North Yorkshire and York localities. The paper was presented in response to a request at the previous NYDB meeting. JP emphasised the positive partnership work and engagement taking place. **Noted:** • **JP offered to provide additional information on request to Board members**	**JP**
8	**FORWARD PLAN** Elaine Wyllie will merge the forward plans for the Health & Wellbeing Board, NY Delivery Board and Commissioner Forum into a composite plan. Items to be included on the agenda for the January 2016 meeting: • Workforce • Joint Health & Wellbeing Strategy implementation (following the December HWB development session) • Place Focus – Vale of York • BCF 2016/17 Planning • Learning Disability –Impact of Fast Track Items to be included on the agenda for Commissioner Forum: • Syrian movement (will require NHSE input) • Winter resilience	**EW** **SC/WB** **WB** **MH/A-ML** **WB** **AC/JP**
9	**MINUTES OF LAST MEETING/MATTERS ARISING** Draft notes of NY Delivery Board held on 9 July 2015 – Agreed	
10	**DATE & TIME OF NEXT MEETING** 14 January 2016 at 2.00pm at Sovereign House, York	

Health & Wellbeing Board (HWB), Delivery Board (DB) and Commissioner Forum (CF)

WORK PROGRAMME/CALENDAR OF MEETINGS 2015/2016 - Updated 18 November 2015

Date	Meeting	Details	Item (contact)
Dec 2015	**Commissioner Forum** *Report Deadline Tuesday 2 December*	Time: 2.00pm Date: Thursday 10 December Venue: Sovereign House, York	<u>Strategy</u> • System planning: ECIP/transformation & integration plans/digital roadmaps/BCF planning/discharge to assess/winter resilience (Wendy Balmain) <u>Assurance</u> <u>Shared learning/information</u> • Syrian Refugees (to include Anne-Marie Lubanski/NHSE input) deferred from 10/11/15 • Smoking cessation (Lincoln Sargeant) deferred from 10/11/15
	HWB Development Session	Time: 10 am – 3 pm Date: Monday 14 December Venue: Dishforth Village Hall	Joyce Redfearn facilitating

Date	Meeting	Details	Item (contact)
Jan 2016	**Delivery Board** *Report Deadline Tuesday 5 January*	Time: 2.00pm Date: Thursday 14 January Venue: Sovereign House, York	<u>Strategy</u> • Place Review – Vale of York • Workforce update (Simon Cox) • JHWS: Issues/actions arising from 14/12/15 Development Session <u>Assurance</u> • Better Care Fund 2016/17 • Learning Disability –Impact of Fast Track (Janet Probert/PCU) <u>Information Sharing</u> • 2016/17 diary dates
Feb 2016	**Commissioner Forum** *Report Deadline Tuesday 2 February*	Time: 2.00pm Date: Thursday 11 February Venue: Sovereign House, York	<u>Strategy</u> • Learning Disability Strategy (Kathy Clark/Janet Probert) <u>Assurance</u> • BCF 16/17 including learning from Q2/Q3 and actions from local TBs <u>Information Sharing</u>
	Health & Wellbeing Board *Report Deadline Friday 12 February*	Time: 2.00 pm Date: Wednesday 24 February Venue: Selby Civic Centre	<u>Strategy</u> • JHWS Theme: Start Well – children and young people focus (Pete Dwyer) • North Yorkshire Winter Health Strategy 2015-2020 (Lincoln Sargeant) • System Plans • Workforce update (Simon Cox)

Date	Meeting	Details	Item (contact)
			• Ambition for Health Programme (Simon Cox) <u>Assurance</u> <u>Information Sharing</u> • Delivery Board notes
March 2016	**Commissioner Forum** *Report Deadline Tuesday 1 March*	Time: 2.00 pm Date: Thursday 10 March Venue: Sovereign House, York	
April 2016			
May 2016	**Health & Wellbeing Board** *Report Deadline Friday 22 April*	Time: 10.30am Date: Friday 6 May 2016 Venue: The Cairn Hotel, Harrogate	<u>Strategy</u> <u>Assurance</u> • Review of winter 2015/16 <u>Information sharing</u>

<u>2016/17 Health and Wellbeing Board dates</u>

Friday 15 July 2016

Wednesday 14 September 2016

Friday 25 November 2016

Wednesday 18 January 2017

Friday 17 March 2017