Notice of a public meeting of

Health Overview & Scrutiny Committee

To: Councillors Funnell (Chair), Doughty (Vice-Chair), Riches, Hodgson, Fraser, Richardson and Cuthbertson

Date: Wednesday, 24 October 2012

Time: 5.00 pm

Venue: The Guildhall, York

A G E N D A

1. Declarations of Interest (Pages 3 - 4)
At this point in the meeting Members are asked to declare any personal, prejudicial or disclosable pecuniary interests they may have in the business on the agenda. A list of general personal interests previously declared are attached.

2. Minutes (Pages 5 - 16)
To approve and sign the minutes of the meeting held on 12 September 2012.

3. Public Participation
At this point in the meeting, members of the public who have registered their wish to speak regarding an item on the agenda or an issue within the Committee's remit can do so. The deadline for registering is **Tuesday 23 October 2012** at **5.00pm**.

4. Attendance of NHS North Yorkshire, York Teaching Hospital NHS Foundation Trust & Vale of York Clinical Commissioning Group- Financial Status and Handover Process

The Chief Executives from York Teaching Hospital NHS Foundation Trust and NHS North Yorkshire and York will be in attendance at today's meeting along with the Chief Finance Officer from the Vale of York Clinical Commissioning Group. They will be discussing the Financial Status of NHS North Yorkshire and York and the handover process to the Vale of York Clinical Commissioning Group and some of the challenges that this will bring.

5. Update on Changes to the Urgent Care Unit (Pages 17 - 22)

This report provides the Committee with an update on the relocation of York's NHS walk in centre, formerly located on Monkgate, to the urgent care centre based in York Hospital's emergency department. It also outlines future involvement and engagement plans. The Deputy Operations Manager at York Teaching Hospital NHS Foundation Trust will be in attendance at the meeting to present the report.

6. Transition Update Report (Pages 23 - 110)

This report updates the Committee on the following;

- The Transfer of Public Health functions to the City of York Council
- The establishment of the City of York Health & Wellbeing Board
- The commissioning of Healthwatch for the City of York pursuant to the Health and Social Care Act 2012

7. Work Plan (Pages 111 - 114)

Members are asked to consider the Committee's updated work plan for the municipal year 2012/13.

8. Urgent Business

Any other business which the Chair considers urgent under the Local Government Act 1972.

Democracy Officer

Name- Judith Betts
Telephone- 01904 551078
E-mail- judith.betts@york.gov.uk

For more information about any of the following please contact the Democracy Officer responsible for servicing this meeting

- Registering to speak
- Business of the meeting
- Any special arrangements
- Copies of reports

Contact details are set out above

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Agenda Annex

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If you would, you will need to:

- register by contacting the Democracy Officer (whose name and contact details can be found on the agenda for the meeting) **no later than** 5.00 pm on the last working day before the meeting;
- ensure that what you want to say speak relates to an item of business on the agenda or an issue which the committee has power to consider (speak to the Democracy Officer for advice on this);
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Further information about what's being discussed at this meeting
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Holding the Cabinet to Account

The majority of councillors are not appointed to the Cabinet (39 out of 47). Any 3 non-Cabinet councillors can 'call-in' an item of business following a Cabinet meeting or publication of a Cabinet Member decision. A specially convened Corporate and Scrutiny Management Committee (CSMC) will then make its recommendations to the next scheduled Cabinet meeting, where a final decision on the 'called-in' business will be made.

Scrutiny Committees

The purpose of all scrutiny and ad-hoc scrutiny committees appointed by the Council is to:

- Monitor the performance and effectiveness of services;
- Review existing policies and assist in the development of new ones, as necessary; and
- Monitor best value continuous service improvement plans

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- All public agenda/reports can also be accessed online at other public libraries using this link http://democracy.york.gov.uk/ieDocHome.aspx?bcr=1

Agenda Item 1

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Agenda item 1: Declarations of interest.

Please state any amendments you have to your declarations of interest:

Councillor Doughty	Volunteers for York and District Mind and partner also works for this charity. Member of York NHS Foundation Teaching Trust.
Councillor Funnell	Member of the General Pharmaceutical Council Trustee of York CVS
Councillor Hodgson	Previously worked at York Hospital
Councillor Richardson	Frequent user of Yorkshire Ambulance Service due to ongoing treatment at Leeds Pain Management Unit. Member of Haxby Medical Centre Niece works as a staff district nurse for NHS North Yorkshire and York.
Councillor Riches	Council appointee to the governing body of York Hospital Member of UNITE

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City of York Council Committee Minutes

MEETING	HEALTH OVERVIEW & SCRUTINY COMMITTEE
DATE	12 SEPTEMBER 2012
PRESENT	COUNCILLORS FUNNELL (CHAIR), DOUGHTY (VICE-CHAIR), FRASER, HODGSON, RICHES AND RUNCIMAN (SUBSTITUTE)
IN ATTENDANCE	RACHEL BARBER (INDEPENDENT)
	JOHN BURGESS (YORK MENTAL HEALTH FORUM)
	KATHY CLARK (CITY OF YORK COUNCIL)
	ADAM GRAY (CITY OF YORK COUNCIL)
	RICHARD HARTLE (CITY OF YORK COUNCIL)
	MELANIE HIRD (LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST)
	ANDREW HOWARTH (LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST
	PETER GARBERT (YORK MIND)
	DAVID LEWIS (YORK MIND)
	DAVID SMITH (YORK MIND)
	JIM KHAMBATTA (NHS NORTH YORKSHIRE AND YORK)
	VINCE LARVIN (YORKSHIRE AMBULANCE SERVICE)
	JASON LEE (YORK TEACHING HOSPITAL NHS FOUNDATION TRUST)

NEIL WILSON (YORK TEACHING HOSPITAL NHS FOUNDATION TRUST).

GEORGE WOOD (YORK OLDER PEOPLES ASSEMBLY)

JOHN YATES (YORK OLDER PEOPLES ASSEMBLY)

JANE PERGER (YORK LINK)

APOLOGIES COUNCILLORS RICHARDSON AND CUTHBERTSON

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22. DECLARATIONS OF INTEREST

Members were invited to declare at this point in the meeting any personal, prejudicial or disclosable pecuniary interests, other than those listed on the standing declarations attached to the agenda, that they might have had.

Councillor Fraser declared a personal interest in the business on the agenda as a Council appointee to the York Hospital Board of Governors. He also declared a personal interest in the general remit of the Committee as a retired member of UNISON and Unite (TGWU/ACTS sections).

Councillor Doughty declared a personal interest as his partner had registered to speak at the meeting on behalf of York Mind.

23. MINUTES

RESOLVED: That the minutes of the meetings of Health Overview and Scrutiny Committee held on 23rd July 2012 and 6th August 2012 be approved and signed by the Chair as a correct record with the following amendment having been made to item 19 on 23rd July meeting:

'That the Association for Public Service Excellence (APSE) *has been* commissioned *by* the Council to conduct a study into how to get people involved in Public Health.

24. PUBLIC PARTICIPATION

It was reported that there had been four registrations to speak under the Council's Public Participation Scheme. Details are included under the relevant minute items.

25. LOCAL HEALTHWATCH YORK: PROGRESS UPDATE

Members considered a report which updated them on the progression from LINks (Local Involvement Networks) to Local HealthWatch by April 2013.

George Wood who had registered to speak on this item queried paragraph 9 of the report which appeared to suggest that there may be an alternative for the delivery of NHS Complaints Advocacy. Officers advised that this was not the intention.

Members queried paragraph 27 of the report which advised that there is a risk of challenge as to the validity of the Council's procurement and commissioning process if a HealthWatch contract is let without full and proper consultation. Officers advised that the appointment of a lay person will eliminate this risk.

Members noted a number of key dates as outlined at paragraph 7 of the report.

RESOLVED: That the report be noted.

REASON: To update the Committee on the latest progress towards establishing a HealthWatch.

26. INTRODUCTION FROM THE NEW DIRECTOR OF PUBLIC HEALTH (DPH) - CHALLENGES AND PRIORITIES FOR THE DPH

The Director of Public Health, Dr. Paul Edmondson Jones was in attendance at the meeting and gave a verbal report on the challenges and priorities in his role.

He advised that his key priorities for York are:

- Establishment of the Health and Wellbeing Board.
- The safe transition of Public Health to the Local Authority.
- Safe delivery of functions.
- Health improvements to the population of York and how this impacts on the Council.
- Health Protection issues such as the control of outbreaks of influenza.
- Supporting the NHS.

His challenges were highlighted as being as follows:

- Meeting and getting to know as many people as possible.
- The safe transition of Public Health to the Local Authority.
- Supporting the NHS – he acknowledged that the past few years had been financially challenging for the NHS in York and he will be looking at ways to redress the balance.

He also confirmed that he would be the lead person for the Health Overview and Scrutiny Committee.

RESOLVED: That Members noted the Director of Public Health's update.

REASON: To keep them informed on the Director for Public Health's key priorities and challenges.

27. PROGRESS BRIEFING ON THE MAJOR TRAUMA NETWORK

Members considered a briefing note which provided them with information on the Major Trauma Network arrangements for Major Trauma events in York and surrounding areas, the implementation plan, progress to date and the next steps in the process.

The Senior Commissioning Manager for NHS North Yorkshire and York Cluster, a Consultant for the Emergency Department at York Hospital and a representative from the Yorkshire Ambulance Service presented the briefing note to the Committee.

They outlined the following key points:

- The service changes are the result of major trauma service improvements across England.
- It is about the better use of existing resources and better communication between the NHS Trust and the Ambulance Service.
- Due to York being situated between Leeds and Hull, traumas that occur in the east of York will go to Hull, those in the west to Leeds. Traumas to the North will continue to go to York Hospital in the first instance.
- Due to issues with the accuracy of trauma data there has been a delay in phases 2 and 3 which are expected to take place in 2013.

Members queried a number of points including:

- The use of Leeds Hospital for paediatric traumas and the impact the recent closure of the children's coronary unit may have on the hospitals capacity to treat trauma patients.
- Paragraph 5.3 which advised that the funding of major trauma will be solely via payment by results. It was confirmed that this is the standard practice.

RESOLVED: That Members noted the report.

REASON: To keep them informed on improvements in and management of major trauma across Yorkshire and the Humber.

28. PROPOSAL TO REDESIGN OLDER PEOPLE'S MENTAL HEALTH SERVICES AND ENHANCE PROVISION OF COMMUNITY CARE AND SUPPORT

Members considered a report which presented proposals by Leeds and York Partnership NHS Foundation Trust on proposals to redesign older people's mental health services and enhance the provision of community care and support. Their report was attached at Annex A and Members were asked to consider whether the proposed redesign was a substantial variation to service.

John Yates from York Older Peoples assembly spoke to enquire how the proposed transformation of services from 'hospital to home' would affect domiciliary community services when older people are able to be returned back to their own homes, not care homes or nursing homes as this was not made clear in the text.

David Smith from York Mind spoke to advise that he agrees with the proposal in principle but had concerns about the changes which could mean that elderly individuals would be transferred from health to social care and the associated impacts. He advised that as the impact upon Council resources and budgets was unknown, then there should be further consultation.

The Associate Director, York and North Yorkshire Services from Leeds and York Partnership NHS Foundation Trust was in attendance and presented the paper to the Committee.

The Committee were advised that the main change to the services would be the establishment of a nursing home team to help prevent admissions from care homes to hospital and transfer between care homes. The team would also help to improve the pathway out of NHS inpatient services into residential and nursing homes, helping to prevent delayed discharge and therefore freeing up beds for those who needed them.

Members raised concerns about the cost implications to the Council should problems arise from the changes and the proposals to close Mill Lodge. They also raised concerns that not enough discussion had taken place between the Trust and Council Officers as to the implications behind the proposals. Members requested that a longer consultation period be undertaken to ensure that the public understands the changes and in order for further discussion to take place between the Council and the Trust.

In response to Members questions, it was advised that the changes were a reconfiguration of resources and that the service will continue, rather than it being a substantial change.

RESOLVED: (i) That Members agreed with Leeds and York Partnership NHS Foundation Trust that the proposed changes do not constitute a substantial variation of service.

(ii) That Members requested a longer consultation period of 2 months be undertaken.

(iii) That a report be brought back to the December meeting of Health Overview and Scrutiny Committee detailing the outcomes of the consultation and further information on the partnership and engagement between the Trust and City of York Council.

(iv) That the Clinical Commissioning Group Primary Care Trust and City of York Council Officers be invited to join the debate at the December meeting.

REASON: To ensure that the most appropriate consultation period is set for the proposed redesign of service.

29. 2012-13 FIRST QUARTER FINANCIAL & PERFORMANCE MONITORING REPORT FOR ADULT SOCIAL SERVICES

Members considered a report which analysed the latest performance for 2012/13 and forecasts the financial outturn position by reference to the service plan and budgets for all the relevant services falling under responsibility of the Director of Adults, Children and Education.

In relation to the report, Members had the following queries:

- Page 53 paragraph 13 – the overspend in Adult Transport. Officers confirmed that it is intended that there will be a review undertaken of how Adult Transport is provided.
- Page 58 paragraph 17 which referred to adults with learning disabilities in settled accommodation, and the figures on page 54 which showed that the target for quarter one had been missed. Officers advised that by the end of the quarter they would expect the target to be on track following the re-timetabling of reviews.
- Page 59 – the fall off in performance of the Occupational Therapy team. Officers advised that there had been some staffing issues due to the expectation that vacancies are not automatically filled.
- Members queried who decides which areas are monitored. Officers confirmed that it was a mixture of service plans and performance indicators set by the Department of Health which decided which areas are monitored.
- Members asked if there are better ways of forecasting performance in areas where there are big overspends. Members suggested the use of demographics. Officers advised that they are always looking at ways to improve projections and that overspends from previous years are still affecting the current figures, but they are confident of improvement.

RESOLVED: That Members noted the report.

REASON: To update the committee on the latest financial and performance position for 2012/13.

30. CONSULTATION ON LOCAL AUTHORITY HEALTH SCRUTINY

Members considered a report which presented to them a consultation document on Local Authority Health Scrutiny.

The document attached at Annex A contained the Government's proposed changes to health scrutiny in local authorities. These changes are further to changes already consulted on under the Health and Social Care Act 2012. The Scrutiny Officer outlined the consultation response attached at Annex B.

Members queried the response to question 7 which stated that many Councils have full council meetings every 2 months as it was thought that County Councils hold theirs every 3 months. The Scrutiny Officer agreed to look into this and amend if necessary.

RESOLVED: That Members agreed the draft response with the amendments highlighted above.

REASON: To respond to the national consultation on Local Authority Health Scrutiny.

31. CONSULTATION ON THE MANDATE TO THE NHS COMMISSIONING BOARD

Members considered a report which asked them to comment upon a consultation document on the Draft Mandate to the NHS Commissioning Board.

The Director of Public Health and Wellbeing introduced the report and advised that the proposals were part of NHS reforms which have resulted in the setting up of the NHS Commissioning Board (NHSCB).

The mandate to the NHSCB will be updated manually and is the means by which the Secretary of State for Health will retain ultimate responsibility for securing the provision of health services by setting clear objectives for the NHSCB.

The Consultation sought a response around six issues:

- The overall approach to the Mandate.
- The best way of assessing progress against the Mandate.
- The use of objectives based on the NHS Outcomes Framework.
- The principle of 'putting patients first'.
- The principle of 'broader contribution from the NHS'.
- The principle of 'effective commissioning'.

The Director for Public Health advised that the key aspect of the consultation response was the request for a statutory review of the Mandate in one years time.

RESOLVED: That Members considered and approved the response at Annex B.

REASON: To respond to the national consultation on the draft Mandate for the NHS Commissioning Board.

32. WORK PLAN FOR 2012-13

Members considered the Committee's updated work plan for the municipal year 2012/13.

The Scrutiny Officer advised that the workloads for the October and December meetings had been altered slightly to ensure an even distribution of work.

Members attention was drawn to the fact that an extra meeting may need to be scheduled for November and Democratic Services would advise accordingly.

RESOLVED: That following the changes be made to the Committee's work plan:

(i) That the progress update on Local HealthWatch York be moved to the December meeting of the Committee.

(ii) Report on the outcomes of the consultation into the closure of Mill Lodge (minute 28 refers).

(iii) Addition of a November meeting and the redistribution of items to allow time for the debate at the October meeting with NHS North Yorkshire and York and the Clinical Commissioning Group.

REASON: In order to keep the Committee's work plan up to date.

Action Required

1. To Update the Committee's Work Plan. TW

Councillor C Funnell, Chair

[The meeting started at 5.00 pm and finished at 7.30 pm].

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York Teaching Hospital NHS
NHS Foundation Trust

City of York Health Overview and Scrutiny Committee

Update on the Urgent Care Centre at York Hospital

Background

In April 2012, York's NHS walk in centre, formerly located on Monkgate, was relocated to form part of the urgent care centre based in York Hospital's emergency department.

This was an outcome of partnership work overseen by a multi-agency board (the Emergency and Urgent Care Board). Representatives of this board attended the meeting of the Overview and Scrutiny Committee in November 2011 to outline the rationale for creating an urgent care centre, how key stakeholders would be fully engaged in developing the proposals, and how the relocation of the walk in centre would be communicated to patients and the public.

The committee approved the plans, and representatives from the emergency and urgent care board agreed to update the committee at a future meeting.

The purpose of this paper is to provide the Overview and Scrutiny Committee with an update on the relocation and to outline future involvement and engagement plans.

Communications and engagement: relocating the walk in centre

A comprehensive communications and engagement plan, which was approved by the Overview and Scrutiny Committee, was implemented prior to the relocation of the walk in centre to help ensure that patients and local residents were aware of the proposals. Press releases were issued, gaining local media coverage, and information posters and flyers were distributed to key locations such as libraries and GP surgeries. Clear signage was put in place, both on the York Hospital site and at Monkgate.

Stakeholders were also written to informing them of the move, including other healthcare providers, MPs, and patient representative groups including the Local Involvement Network (LINk).

A project was undertaken to physically redesign the emergency department, particularly the reception and entrance area, in order to better integrate the walk in centre and make it easier to manage the flow of patients.

A full programme of patient and public involvement activity took place prior to the move, including a focus group of recent service users, the capturing of real-time feedback in the waiting room and a 24 hour observation session by Hospital Governors and LINk members.

No formal complaints relating to the move have been received and the majority of informal feedback has been positive. During the relocation some feedback was received regarding third parties whose information had not been updated and this was rectified wherever possible and where the Trust was aware that third parties were publishing information. We have had several pieces of positive feedback about the urgent care centre; the following are just some examples from patients:

“The whole consultation was very professional and conducted by a delightful nurse who is a true credit to her profession and your hospital (...) we were on our way in about one and a half hours from the start of the visit.”

“This morning at the ‘urgent treatment dept’ the treatment and courtesy was wonderful.”

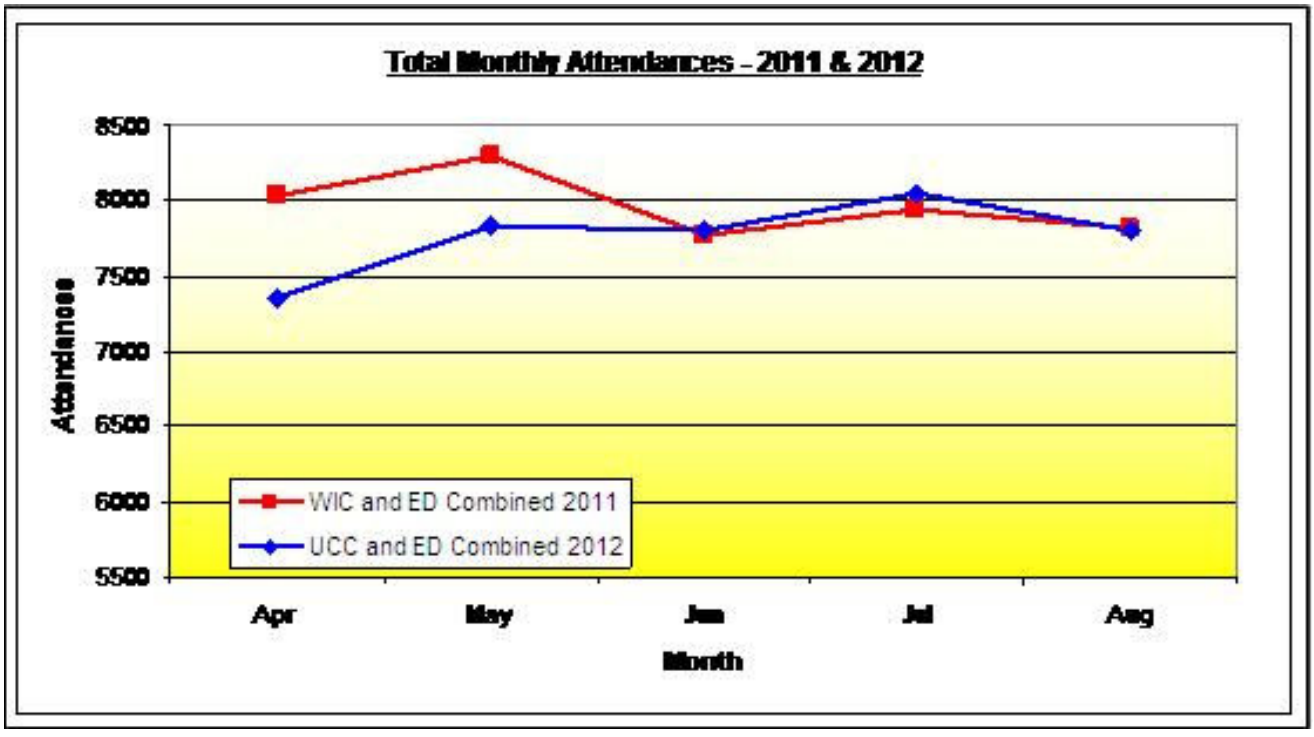
“My son was struggling to walk and his calf was badly swollen (...) I brought him to A&E at York and was seen within 20 minutes by the minor injuries nurse. I want to let you know that our experience in York was excellent!”

Activity in the emergency department and urgent care centre

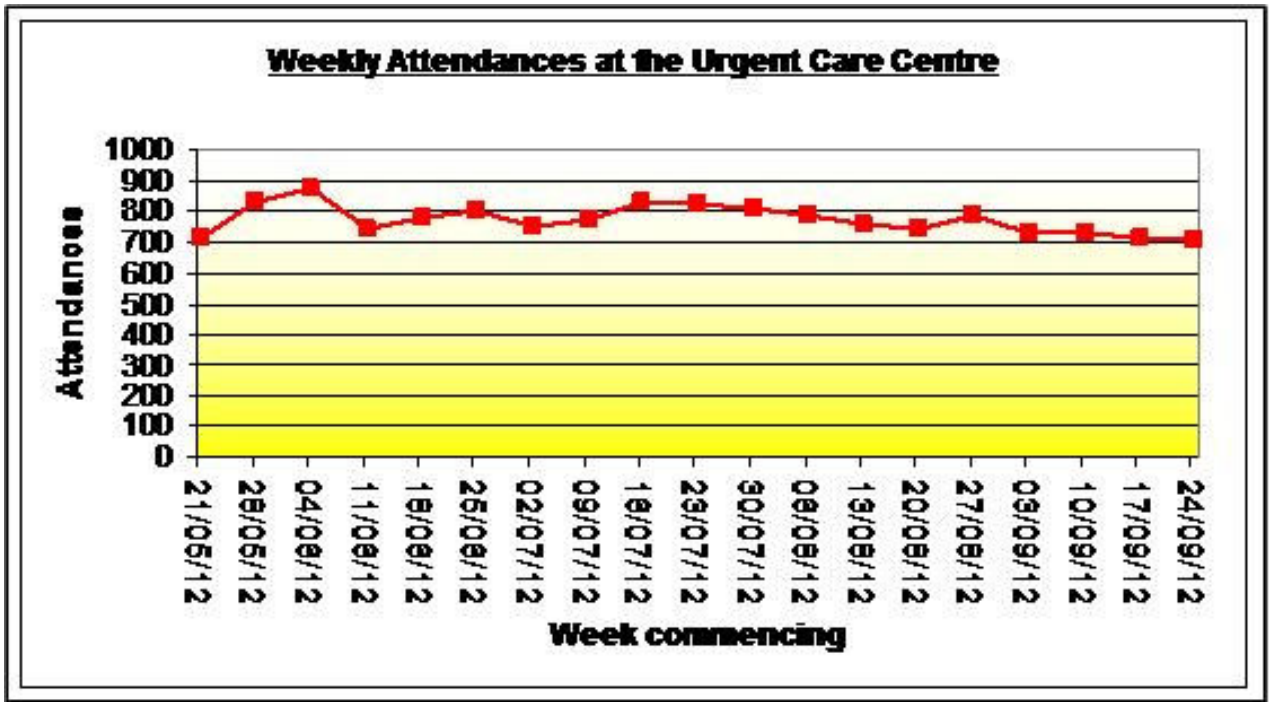
The walk in centre relocated on 18 April 2012.

The urgent care centre opened the same day, seeing both those patients who previously presented to Monkgate and those who were previously seen in the emergency department with minor injuries and illness.

It is possible to see from the chart below that when the total monthly attendances are compared between 2011 and 2012 there was an initial small dip in attendances but that since June these have been very similar. Due to a number of variables however it is not possible to ascertain the proportion of these that would have previously been walk in centre patients and make a reliable judgement on the proportion of activity that transferred.



The chart below shows the weekly attendances through the urgent care centre. Around 780 patients per week attend (around 111 per day) with an average time from arrival to discharge of 1hr 12mins.



Future plans

Partner organisations will continue to work together under the umbrella of the emergency and urgent care board to continue to improve services for patients, and to help ensure that the various parts of the system are working effectively together.

Membership of the communications and engagement subgroup of the Emergency and Urgent Care Board will be refreshed. The group will work together to develop social marketing campaigns to support areas of focus as identified by the Board, for example, educating the public and encouraging behaviour change in relation to how and when they access services, particularly where a primary care attendance, at the patient's GP surgery, is more appropriate.

The Trust will remain focused on engagement and involvement to help make improvements to services and to use patients' views to inform how services are delivered.

Opportunities for engagement have been sought, for example, the Directorate Manager for Emergency Medicine met with the LINk Patient Safety Group and the CVS Mental Health Forum, and will host a presentation for Foundation Trust members and the public about the urgent care centre on 31 October.

Now that the urgent care centre is established, plans to carry out a further observation study by the end of 2012 are being developed. This will again involve Hospital Governors and LINks members to determine how the urgent care centre feels for patients accessing it.

Another important mechanism for understanding patients' experience of our services is the introduction of the 'Friends and Family' test (FFT). In May 2012, the Prime Minister announced the introduction of the FFT to improve patient care and identify the best performing hospitals in England. The FFT will be implemented in all acute NHS Trusts from 1 April 2013 and will require that all adult inpatients and those attending (but not admitted from) the Emergency Department are given the opportunity to answer the question: "how likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment."

This will provide us with valuable insight in to what our patients feel about our services and provides an indicator which shows where things are working well or less well and how they are changing over time.

In summary

The Trust is pleased to report on what it considers to be the successful relocation of the walk in centre from Monkgate into the urgent car centre at York Hospital. Operationally the move went smoothly and user feedback is largely positive. The Trust, through the Emergency and Urgent Care Board and through patient feedback, will continually seek to keep the service model under review and seek to improve as necessary and appropriate.

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Health Overview and Scrutiny Committee **24 October 2012**

Report of the Director of Public Health & Wellbeing

An Update Report on the transfer of Public Health Functions to the City of York Council, the establishment of the City of York Health & Wellbeing Board and the commissioning of Healthwatch for the City of York

Summary

1. This report updates Members on:

- the transfer of Public Health functions to the City of York Council
- the establishment of the City of York Health & Wellbeing Board
- the commissioning of Healthwatch for the City of York

pursuant to the Health & Social Care Act 2012

Background

2. The 2010 White Paper "Healthy Lives, Healthy People" set out an ambitious vision for Public Health in the 21st Century based on an innovative approach to protecting and improving the health of everyone in England, led by Local Government.

3. The Health & Social Care Act 2012 subsequently set out those functions that would transfer to Local Authorities and how Local Government would be supported in its delivery of these new responsibilities by a new national body called Public Health (England).

4. The Health & Social Care Act 2012 also gave Local Authorities the responsibility to establish a Health & Well-being Board that should ensure that a comprehensive Joint Strategic Needs Assessment was undertaken and that a consequent Joint Health & Wellbeing Strategy should be developed to set out how health outcomes would be improved and health inequalities reduced in each local area.

5. The Health & Social Care Act 2012 also gave Local Authorities the responsibility to establish a local Healthwatch

Transfer of Public Health Functions

6. The new Public Health role for Local Authorities is set out in the Department of Health document *"The New Public Health Role for Local Authorities" (October 2012)* which is available online as a background paper to this report. The document sets out how upper tier and unitary authorities will take on these new responsibilities from 1st April 2013 to protect and improve the health of their populations, backed by a ring fenced budget and a specialist public health team led by a Director of Public Health.

7. Broadly speaking the Health & Social Care Act 2012 gives responsibility for Health Improvement to Local Authorities and Health Protection to the Secretary of State. However, many Health Protection functions will be delegated to Local Authorities to add to their already existing functions in this area. The Act specifically requires each Local Authority to appoint a Director of Public Health and gives the Secretary of State new powers to publish guidance to which the Local Authority must have regard; an example of this is the Public Health Outcomes Framework.

8. There are five functions that are to be specifically mandated – not to indicate in any way their relative importance – but to ensure that there is a need in these areas for a greater uniformity of provision and/or a need to ensure there is an effective local public health system. These five mandated or compulsory areas are:

- steps that need to be taken to protect the health of the population
- ensuring the local Clinical Commissioning Group gets appropriate Public Health support
- appropriate access to Sexual Health Services
- the National Child Measurement Programme
- NHS Health Check Assessments

9. In order to be able to take on these new responsibilities with effect from 1st April 2013, there are four key elements that need to be in place and are critical to transition. An update on each of these elements follows:

Director of Public Health (DPH).

- The DPH will be the Local Authority's lead adviser, will be a statutory chief officer and will have a number of statutory responsibilities that exactly mirror the corporate public health duties of their local authority with the exception of the requirement for the DPH to write an Annual Report and for the Local Authority to publish it. A full explanation of the Roles, Responsibilities and Context of Directors of Public Health was published this month by the Department of Health and is available online as a background paper to this report.

  Update: City of York Council appointed a Director of Public Health, Dr Paul Edmondson-Jones, who took up appointment on 20th August 2012.

Specialist Public Health Team.

- As a consequence of the transfer of Public Health functions from the NHS to Local Authorities, any staff undertaking those functions will also transfer. Locally, public health staff who are working at NHS North Yorkshire & York have been divided 75:25 between North Yorkshire County Council and City of York Council. It is anticipated that the Public Health Consultant and 3 specialist support staff that have been identified will be transferred by TUPE to City of York Council on 1 April 2013 but will start taking on their new responsibilities over the next few months. These staff will form part of the new Public Health Team in City of York Council.

  Update:
  The four "assigned" public health staff will begin to take on their new duties immediately although the formal TUPE transfer will be on 1 April 2013. Now that the DPH is in place and specialist staff "assigned" work can begin to determine the overall structure needed to deliver the functions. It is anticipated this will be agreed by 30 November 2012.

Contracts for Commissioned Services.

- There are currently a number of contracts with NHS Acute and Community Provider Trusts, Voluntary Organisations, GP practices and Pharmacies across the City. All these need to be transferred to the City of York Council by "novation" or assignment or new contracts need to be established.

This is not very straightforward as many NHS contracts cover a wide range of services and so the public health elements need to be "unbundled" from the rest of the contract. A small working group, led by the City of York DPH, has been established and comprises legal, contract and procurement staff from City of York Council, North Yorkshire County Council and NHS North Yorkshire and York.

Update:
The working group is confident that it will have established the exact service specification, activity details and costs for each of the current contracts by the end of November 2012 in order that the most appropriate new contracting mechanism can be identified. This will ensure that all contracts can be in place by 1st April 2013.

Ring-fenced Grant.

- In February 2012, the Department of Health published a report entitled "*Baseline Spending estimates for the new NHS and PH Commissioning Architecture*" and this is available online as a background paper to this report. This set out the minimum baseline allocation for City of York Council to be £5.620 Million, using 2011-12 as the base year for the calculation. That sum is intended to cover the safe transition of all existing contracts and staff to the Local Authority and to provide an element of resource to fund support functions. This works out at £26 per head of the population. Some technical adjustments will be made to this to take account of updated information and the final allocation for 2013-14 should be announced on or around 18 December 2012. We do not expect it to be less than £5.620 million. For the future, a better needs-based formula will be used, hopefully for 2014-15 and beyond, which should result in some small increase to the overall resource allocated to York.

Update:
The anticipated baseline allocation of £5.620 Million (or more) should adequately cover all existing contracts, staff costs and support costs after transfer of the Public Health Functions on 1st April 2013. A more definitive assessment will be done by 31 December 2012, assuming allocations are announced on or around 18 December 2012.

10. The responsibility to date for performance management of the transition has been the Strategic Health Authority on behalf of Department of Health. They visited York on 26 September 2012 and were extremely complimentary of our progress to date.

They summarised their findings as "There is a clear understanding of how public health will operate within the Council, including working across Directorates, DPH involvement in the senior management team – and through DPH direct accountability to the Chief Executive. You have a good grip of the issues to be resolved and we will be working with you on all aspects over the next few months". The lead responsibility for performance management has now transferred to the Local Government Association; it has issued a new stock-take that needs to be completed by 17 October 2012.

11. Overall, the transition appears to be going well and all actions are on schedule. There are still risks involved around contract transfer and staff transfer as well as an underlying risk that the baseline allocation will be insufficient to meet all the expected commitments. These risks will be monitored and mitigated on an on-going basis. A report is made regularly to the Corporate Management Team and to the appropriate Cabinet Members.

Health & Wellbeing Board

12. The Health & Wellbeing Board has been established in shadow format and has met several times, most recently on 3rd October 2012. It has reviewed the Joint Strategic Needs Assessment and it established a clear vision and five key priority areas which are:

- Making York a great place for older people to live
- Reducing Health Inequalities
- Improving Mental Health and intervening early
- Enabling all children and young people to have the best start in life
- Creating a financially sustainable local health and well-being system

13. A draft Health & Wellbeing Strategy was approved in October 2012 following initial consultation with over 200 stakeholders; a copy is available online as a background paper to this report. There will now be a further period of consultation across the City with the final Strategy expected to be approved by the Health & Wellbeing Board in January 2013. The Board will cease to be "in shadow" on 31 March 2013 and is expected to meet for the first time formally in June or early July 2013.

14. The Shadow Health & Wellbeing Board has established four Strategic Delivery Boards to take forward the first four priorities listed above. Chairs have been agreed for each one and the Boards are currently being set up. The most advanced of these is the one to "Ensure all Children and Young people have the best start in life" as this will be led by the current YorOK Board. The final priority area – financial sustainability – will be led by the Health & Wellbeing Board itself initially.

Healthwatch

15. There have been regular reports to Health Overview and Scrutiny Committee on HealthWatch and so the following few paragraphs are by way of update only.

16. Tender specification for HealthWatch was sent out on Wednesday 19th September. Organisations have 6 weeks to respond to the tender, which closes on 31st October. City of York Council is the first authority in the Yorkshire and Humber to go out to full tender. Most authorities are currently tendering the Pre-Qualification Questionnaire (PQQ) stage; however, we are doing both the PQQ and full tender simultaneously. Our tender is a single tender, including both HealthWatch and independent complaints advocacy services. Providers can bid for one of the services or both. So far, over 27 organisations have registered to view the tender.

17. Once the invitation to tender has expired, the assessment panel will begin a series of meetings, from 6th-15th November to review received tenders. The panel will be comprised of council officers and an independent panellist. It is anticipated that the organisations who responded to the tender will know the result of their bids by late November. We expect that from December the organisation awarded the tender will begin some development work alongside the current providers of these services, to prepare them for when the contract commences in April 2013.

Council Plan

18. The transfer of Public Health Functions to the City of York Council will help to support all the key themes of the Council Plan; indeed, one of the key aims of the transfer is that "local authorities should embed all these new public health functions into all their activities, tailoring local solutions to local problems".

Similarly, the five key priorities of the Health & Wellbeing Strategy for the City of York will complement and support all the key themes of the Council Plan.

Implications

19. There are a number of key implications for the Council outlined in this report around the transfer of Public Health functions, the establishment of a Health & Well-being Board and the procurement of Healthwatch. These have been outlined in the body of the report.

Risk Management

20. A number of risks have been identified. Mitigation has been taken for each risk and they are monitored carefully by Corporate Management Team.

Recommendations

21. Members are asked to note the Update Report and to comment as appropriate.

Contact Details

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Report Approved **Date:** 16 October 2012

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

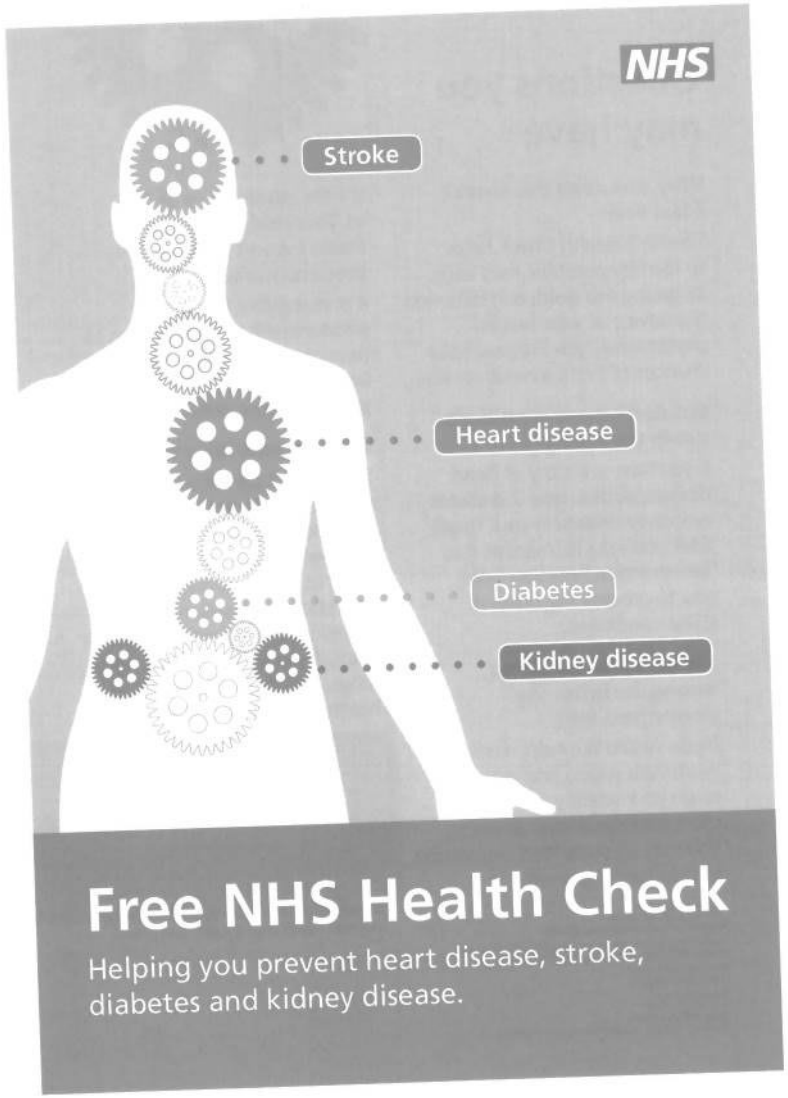
1. **The new Public Health Role of Local Authorities (DH 2012)**

2. **Directors of Public Health in Local Government (DH 2012)**

3. **Baseline spending estimates for the new NHS and Public Health Commissioning Architecture (DH 2012)**

4. **Draft Health & Well-being Strategy for the City of York (CYC 2012)**

CIRCULATED AT MEETING



Working together to improve your health

Everyone is at risk of developing heart disease, stroke, diabetes or kidney disease. The good news is that these conditions can often be prevented – even if you have a history of them in your family. Have your free NHS Health Check and you will be better prepared for the future and be able to take steps to maintain or improve your health.

Why do I need an NHS Health Check?

We know that your risk of developing heart disease, stroke, type 2 diabetes and kidney disease increases with age. There are also certain things that will put you at even greater risk.

These are:

- being overweight
- lack of exercise
- smoking
- high blood pressure
- high cholesterol.

Both men and women can develop these conditions, and having one could increase your risk of developing another in the future.

- In the brain a blocked artery or a bleed can cause a stroke.
- In the heart a blocked artery can cause a heart attack or angina.
- The kidneys can be damaged by high blood pressure or diabetes, causing chronic kidney disease and increasing your risk of having a heart attack.
- Being overweight and a lack of exercise can lead to type 2 diabetes.
- If unrecognised or unmanaged, type 2 diabetes could increase your risk of further health problems, including heart disease, kidney disease and stroke.

Even if you're feeling well, it's worth having your NHS Health Check now. We can then work with you to lower your chances of developing these health problems in the future.

What happens at the check?

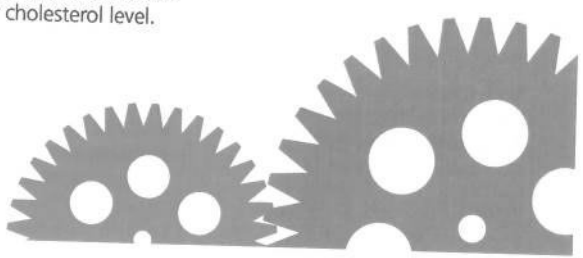
This check is to assess your risk of developing heart disease, type 2 diabetes, kidney disease and stroke.

- The check will take about 20–30 minutes.
- You'll be asked some simple questions. For example, about your family history and any medication you are currently taking.
- We'll record your height, weight, age, sex and ethnicity.
- We'll take your blood pressure.
- We'll do a simple blood test to check your cholesterol level.

What happens after the check?

We will discuss how we can support you to reduce your risk and stay healthy.

- You'll be taken through your results and told what they mean. Some people may be asked to return at a later date for their results.
- You'll be given personalised advice on how to lower your risk and maintain a healthy lifestyle.
- Some people with raised blood pressure will have their kidneys checked through a blood test.
- Some people may need to have another blood test to check for type 2 diabetes. Your health professional will be able to tell you more.
- Treatment or medication may be prescribed to help you maintain your health.



Questions you may have

Why do I need this check? I feel fine!

The NHS Health Check helps to identify potential risks early. By having this check and following the advice of your health professional, you improve your chances of living a healthier life.

But don't these conditions run in the family?

If you have a history of heart disease, stroke, type 2 diabetes or kidney disease in your family then you may be more at risk. Taking action now can help you to prevent the onset of these conditions.

I know what I'm doing wrong, how can the doctor help me?

If you would like help, we will work with you to find ways to reach your healthy weight, take more exercise or stop smoking. You may be prescribed medication to help lower your risk.

This leaflet is available in braille, audio, easy read and different languages. If you would like copies in one of these formats, please contact us:

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If I am assessed as being at 'low risk', does this mean I won't develop these conditions?

It is impossible to say that someone will or won't go on to develop one of these conditions. But taking action now can help you lower your potential risk.

Will everyone have this check?

This check is part of a new national scheme to help prevent the onset of these health problems. Everyone between the ages of 40 and 74 who has not been diagnosed with the conditions mentioned will be invited for a check once every five years. If you are outside the age range and concerned about your health, you should contact your GP.

For more information visit www.nhs.uk/nhshealthcheck or call the NHS Health Check helpline on 0845 850 9850

Calls cost a maximum of 5p per minute from a BT landline. Mobiles and other networks may vary. You may be charged a minimum cost per call.

Local NHS Health Check provider stamp here:

Directors of Public Health in Local Government

i) Roles, responsibilities and context

DH INFORMATION READER BOX

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HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

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Directors of Public Health in Local Government

i) Roles, responsibilities and context

Prepared by the Public Health England Transition Team

Part 1 of this guidance will be republished and updated in April 2013 under section 73A(7) of the NHS Act 2006 (inserted by section 30 of the Health and Social Care Act 2012) as guidance that local authorities must have regard to.

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1. Introduction

1.1 Public health practice made huge strides during the 20th century, transforming the living standards of millions and saving countless lives in the process. Yet real threats still linger and new ones emerge. Dealing with the avoidable mortality caused by, say, smoking or obesity as conclusively as cholera and typhoid were dealt with requires different ways of thinking and acting.

1.2 The 2010 white paper *Healthy Lives, Healthy People* set out an ambitious vision for public health in the 21st century, based on an innovative and dynamic approach to protecting and improving the health of everyone in England. The test that the white paper sets is clear – we will have succeeded only when we as a nation are living longer, healthier lives and have narrowed the persistent inequalities in health between rich and poor.

1.3 As the white paper proposed, and after a gap of almost 40 years, the Health and Social Care Act 2012 returned a leading public health role to local government. With it comes a sizeable proportion of the responsibility for rising to these challenges. In April 2013 unitary and upper tier authorities take over a raft of vital public health activity, ranging from cancer prevention and tackling obesity to drug misuse and sexual health services. Just as significantly, the reformed public health system gives local authorities an unprecedented opportunity to take a far more strategic role. They can now promote public health through the full range of their business and become an influential source of trusted advice for their populations, the local NHS and everyone whose activity might affect, or be affected by, the health of the people in their area.

1.4 Local government is ready, willing and able to take this on. To support it, every local authority with new public health responsibilities will employ a specialist director of public health (DPH) – appointed jointly with the Secretary of State for Health – who will be accountable for the delivery of their authority's duties. The post is an important and senior one. The DPH is a statutory chief officer of their authority and the principal adviser on all health matters to elected members and officers, with a leadership role spanning all three domains of public health: health improvement, health protection and healthcare public health.

1.5 Local authorities must take the action to improve public health that they decide is appropriate – it is not the job of central government to look

over their shoulders and offer unnecessary advice. Nevertheless, the statutory basis of the DPH role, its transfer to local government and the involvement of the Secretary of State mean that there is value in clear, informative guidance that establishes a shared understanding of how this vital component of the reformed system should work. This guidance is issued in that spirit.

1.6 It describes both the statutory and non-statutory elements of the DPH function, and sets out principles critical to their appointment, to delivery of an effective public health strategy and to other aspects of their relationship with their employer and the Secretary of State.

2. The role of the director of public health

2.1 The most fundamental duties of a DPH are set out in law and are described in the next section. How those statutory functions translate into everyday practice depends on a range factors that will be shaped by local needs and priorities from area to area and over time.

2.2 Nevertheless, there are some aspects of the role that define it in a more complete way than the legislation can, and that should be shared across the entire DPH community. All DsPH should:

- be the person who elected members and senior officers look to for leadership, expertise and advice on a range of issues, from outbreaks of disease and emergency preparedness through to improving local people's health and concerns around access to health services
- know how to improve the population's health by understanding the factors that determine health and ill health, how to change behaviour and promote both health and wellbeing in ways that reduce inequalities in health
- provide the public with expert, objective advice on health matters
- be able to promote action across the life course, working together with local authority colleagues such as the director of children's services and the director of adult social services, and with NHS colleagues
- work though local resilience fora to ensure effective and tested plans are in place for the wider health sector to protect the local population from risks to public health
- work with local criminal justice partners and police and crime commissioners to promote safer communities
- work with wider civil society to engage local partners in fostering improved health and wellbeing.

2.3 Within their local authority, DsPH also need to be able to:

- be an active member of the health and wellbeing board, advising on and contributing to the development of joint strategic needs assessments and joint health and wellbeing strategies, and commission appropriate services accordingly
- take responsibility for the management of their authority's public health services, with professional responsibility and accountability for their effectiveness, availability and value for money

- play a full part in their authority's action to meet the needs of vulnerable children, for example by linking effectively with the Local Safeguarding Children Board
- contribute to and influence the work of NHS commissioners, ensuring a whole system approach across the public sector.

3. Statutory functions of the director of public health

3.1 A number of the DPH's specific responsibilities and duties arise directly from Acts of Parliament – mainly the NHS Act 2006 and the Health and Social Care Act 2012 – and related regulations. Some of these duties are closely defined but most allow for local discretion in how they are delivered. This section summarises and explains the main legal provisions in effect from April 2013.

3.2 In general the statutory responsibilities of the DPH are designed to match exactly the corporate public health duties of their local authority. The exception is the annual report on the health of the local population – the DPH has a duty to write a report, whereas the authority's duty is to publish it (section 73B(5) & (6) of the 2006 Act, inserted by section 31 of the 2012 Act). The content and structure of the report is something to be decided locally.

3.3 Otherwise section 73A(1) of the 2006 Act, inserted by section 30 of the 2012 Act, gives the DPH responsibility for:

- all of their local authority's duties to take steps to improve public health
- any of the Secretary of State's public health protection or health improvement functions that s/he delegates to local authorities, either by arrangement or under regulations – these include services mandated by regulations made under section 6C of the 2006 Act, inserted by section 18 of the 2012 Act
- exercising their local authority's functions in planning for, and responding to, emergencies that present a risk to public health
- their local authority's role in co-operating with the police, the probation service and the prison service to assess the risks posed by violent or sexual offenders
- such other public health functions as the Secretary of State specifies in regulations (more on this below).

3.4 As well as those core functions, the Acts and regulations give DsPH some more specific responsibilities from April 2013:

- through regulations made under section 73A(1) of the 2006 Act, inserted by section 30 of the 2012 Act, the Department intends to

confirm that DsPH will be responsible for their local authority's public health response as a responsible authority under the Licensing Act 2003, such as making representations about licensing applications (a function given to local authorities by sections 5(3), 13(4), 69(4) and 172B(4) of the Licensing Act, as amended by Schedule 5 of the 2012 Act);

- if the local authority provides or commissions a maternity or child health clinic, then regulations made under section 73A(1) will also give the DPH responsibility for providing Healthy Start vitamins (a function conferred on local authorities by the Healthy Start and Welfare Food Regulations 2005 as amended)
- DsPH must have a place on their local health and wellbeing board (section 194(2)(d) of the 2012 Act).

4. Other relevant statutory provisions

4.1 The 2012 Act makes a number of other provisions that take effect from April 2013 and are directly relevant to DsPH. DsPH are made statutory chief officers of their local authority, and therefore holders of politically restricted posts, by section 2(6)(zb) of the Local Government and Housing Act 1989, inserted by Schedule 5 of the 2012 Act.

4.2 Under section 73A of the 2006 Act, inserted by section 30 of the 2012 Act:

- DsPH must be appointed jointly by their local authority and the Secretary of State (in practice Public Health England), although their subsequent employment relationship is with the local authority exclusively. There is more detail below on how the joint appointment process should work, and further information on best practice will be available is set out in part 2 of this guidance
- if the Secretary of State believes that a DPH is not properly carrying out any Secretary of State function that has been delegated to the local authority s/he can direct the authority to review the DPH's performance, to consider taking particular steps, and to report back. This power does not extend to the DPH's performance of the local authority's own health improvement duties
- a local authority must consult the Secretary of State before dismissing its DPH. The authority may still suspend its DPH from duty (following its standard rules and procedures) and the Secretary of State cannot veto its final decision on dismissal. An authority proposing dismissal for any reason should contact Public Health England for advice on how to proceed with the consultation. Public Health England will normally provide the Secretary of State's formal response within a maximum of 28 days.

5. Corporate and professional accountability

Corporate accountability

5.1 The DPH is an officer of their local authority and shares the same kind of corporate duties and responsibilities as other senior staff. To discharge their responsibility to their authority and deliver real improvements in local health the DPH needs both an overview of the authority's activity and the necessary degree of influence over it.

5.2 This may or may not mean that the DPH is a standing member of their local authority's most senior corporate management team. That should be determined locally, not least because the scope of the DPH role can also vary locally – for instance, where it is agreed that a DPH's role will extend beyond its core statutory responsibilities.

5.3 However, it does mean that there should be direct accountability between the DPH and the local authority chief executive (or other head of paid service) for the exercise of the local authority's public health responsibilities, and direct access to elected members.

5.4 DsPH should also have full access to the papers and other information that they need to inform and support their activity, and day to day responsibility for their authority's public health budget – although formal accountability will rest with the authority's accounting officer (usually the chief executive).

Professional accountability

Regulation and registration

5.5 Medical and dental public health consultants are regulated by the General Medical Council or the General Dental Council. Nurse, health visitor and midwife public health consultants are regulated by the Nursing and Midwifery Council. All public health consultants can also register with the voluntary UK Public Health Register.

5.6 To assure themselves of the continuing competence of their DPH, local authorities should ensure that s/he:

- undertakes a Faculty of Public Health continuing professional development programme
- maintains a portfolio of training that demonstrates competence with all aspects of public health accepted by the UK Public Health Register.

Revalidation

5.7 Medical revalidation is the process by which licensed doctors, including medical DsPH, regularly demonstrate that their skills are up to date and that they are fit to practise. Responsible officers in Great Britain (see below) make fitness to practise recommendations to the General Medical Council in respect of individual doctors. The Nursing and Midwifery Council has an equivalent process for nursing revalidation, and the UK Public Health Register is also establishing a revalidation process for its members.

Professional appraisal and continuing professional development

5.8 Continuing professional development (CPD) is an essential feature of the revalidation process for public health specialists. The overall aim of CPD is to ensure that those who work in the field develop and maintain the necessary knowledge, skills and attributes to practise effectively and work towards improving the health of the population. Local authorities should consider how best to meet these aims in respect of their DPH.

5.9 CPD is a professional obligation for all public health professionals and protected time for CPD is a contractual entitlement for directors transferring into local government on medical and dental contracts. In order to comply with the Faculty of Public Health's minimum standards for CPD all Faculty members must either submit a satisfactory CPD return annually or have been formally exempted by the Faculty from this requirement.

5.10 The UK Public Health Register expects all its registrants to participate in CPD, preferably as part of a formal scheme such as those operated by the Faculty of Public Health, the Chartered Institute of Environmental Health or the General Pharmaceutical Council.

5.11 For medical consultants subject to the General Medical Council revalidation process there is a requirement for annual medical appraisal to be undertaken as an integral part of the revalidation process. Local authorities should reassure themselves that they are in a position to deliver this requirement.

The role of responsible officers in relation to the director of public health

5.12 Responsible officers help to evaluate doctors' fitness and monitor their conduct and performance. The role of the responsible officer is to support doctors in maintaining and improving the quality of care they deliver, and to protect patients in those cases where doctors fall below the high standards set for them. Responsible officers are licensed doctors themselves, and as such must have their own responsible officer.

5.13 The Responsible Officer Regulations came into force on 1 January 2011 and apply to medically qualified DsPH. The regulations designate those bodies that are required to nominate or appoint a responsible officer for the purposes of medical revalidation – this includes local authorities that employ medically qualified staff. For those DsPH who are not medically qualified, arrangements should be in place for supporting the individual's professional practice through appropriate networks. Similarly, alternative arrangements should be made for any medically qualified members of the public health team who work under an non-medically qualified DPH.

5.14 Proposals on the responsible officer role in relation to local authorities and public health have been consulted on. The consultation responses are now being considered and the outcome will be reflected in draft regulations that will be published shortly.

6. Appointing directors of public health

General

6.1 From 2013 the Secretary of State for Health (and therefore Public Health England, which acts on the Secretary of State's behalf) has two general duties that apply to the joint appointment process:

- to promote the comprehensive health service (section 1 of the NHS Act 2006, as amended by section 1 of the 2012 Act)
- to promote local autonomy so far as that is compatible with the interests of the comprehensive health service (section 1D of the 2006 Act, inserted by section 5 of the 2012 Act).

6.2 Local authorities undertaking public health duties conferred on them by the 2012 Act are part of the comprehensive health service. This means that the Secretary of State may not normally intervene in decisions about matters such as the role or position within local authorities of DsPH, but must intervene - and ultimately may refuse to agree a joint appointment - if s/he has reason to believe that anything about an authority's proposals for the appointment of a DPH would be detrimental to the interests of the local health service.

Requirements for director of public health appointments

6.3 Local authorities recruiting a DPH should:

- design a job description that includes specialist public health leadership and an appropriate span of responsibility for improving and protecting health, advising on health services and ensuring that the impact on health is considered in the development and implementation of all policies
- make every effort to agree the job description with the Faculty of Public Health and the Public Health England regional director, ensuring in particular that it covers all the necessary areas of professional and technical competence
- manage the recruitment and selection process and set up an advisory appointments committee to make recommendations on the appointment to the leader of the local authority.

6.4 The advisory appointments committee should be chaired by a lay member, such as an elected member of the local authority (the cabinet member of the health and wellbeing board, for example). It should also normally include:

- an external professional assessor, appointed after consultation with the Faculty of Public Health
- the chief executive or other head of paid service of the appointing local authority (or their nominated deputy)
- senior local NHS representation
- the Public Health England regional director, or another senior professionally qualified member of Public Health England acting on his or her behalf
- in the case of appointments to posts which have teaching or research commitments, a professional member nominated after consultation with the relevant university.

The role of the Secretary of State and Public Health England

6.5 The relationship of the Secretary of State and the local authority in the joint appointment process is one of equals. The role of the Secretary of State is to provide additional assurance of the DPH's competency. Public Health England will advise the Secretary of State on whether:

- the recruitment and selection processes were robust
- the local authority's preferred candidate has the necessary technical, professional and strategic leadership skills and experience to perform the role - proven by their specialist competence, qualifications and professional registration.

6.6 In order to provide this assurance for the Secretary of State, Public Health England will:

- agree with the local authority and the Faculty of Public Health a job description that fits with the responsibilities of the DPH and sets out the necessary technical and professional skills required
- offer advice in relation to the recruitment and selection process, including the appointment of Faculty of Public Health assessors
- participate in the local advisory appointment committee
- confirm to the local authority the Secretary of State's agreement to the appointment.

6.7 Public Health England regional directors will work with local authorities in any area where there is a DPH vacancy to ensure a robust and transparent appointment process is established and a timescale for recruitment and appointment agreed. This should be completed within three months of a post becoming vacant.

6.8 If the regional director has concerns about the process or their involvement in it, s/he will seek to resolve these through negotiation with the local authority. They will be able to draw upon advice and dispute resolution support if it is required. It is important that the interaction between the regional director and the local authority is based on dialogue, collaboration and agreement.

6.9 The local authority has the primary role in recruiting people who will be under contract to it. However, there are clear joint considerations in processes for appointing a DPH. If, at the end of this procedure, the Secretary of State is not satisfied that an appropriate recruitment process has taken place and that the local authority preferred candidate has the necessary skills for the role, s/he will write to the lead member and chief executive of the council setting out in full the reasons for not agreeing the appointment and proposing steps to resolve the situation.

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Department of Health

The new public health role of local authorities

Introduction

The Health and Social Care Act 2012 received Royal Assent on 27 March 2012. This is a critical step in the transition towards the establishment of a new public health system. It is therefore timely to reaffirm the Government's vision for the new public health role in local authorities and to summarise the new legal framework for local government that underpins that vision.

This note sets out our vision for public health in local government and the new legal arrangements. It also sets out the implications for the role of the director of public health, although this is also the subject of separate and more detailed guidance in parts 1 and 2.

This note will primarily be of interest to local authority elected members and officers, and local public health teams, working within local government and supporting their local clinical commissioning groups.

The vision

Local leadership for public health will be at the heart of the new public health system. Upper tier and unitary authorities will take on new responsibilities to improve the health of their populations, backed by a ring-fenced grant and a specialist public health team, led by the director of public health. Upper tier authorities will be supported in this by the existing expertise within district councils – around environmental health, for example.

Local authorities should embed these new public health functions into all their activities, tailoring local solutions to local problems, and using all the levers at their disposal to improve health and reduce inequalities. They will create a 21st century local public health system, based on localism, democratic accountability and evidence.

Supporting local political leadership in improving health will be the director of public health and his or her team. The director of public health will be the lead officer in the local authority for health, and a statutory chief officer.

They will champion health across the whole of the authority's business, promoting healthier lifestyles and scrutinising and challenging the NHS and other partners to promote better health and ensure threats to health are addressed.

He or she will be a statutory member of the health and wellbeing board.

Contributing to the preparation of joint strategic needs assessments and the development of joint health and wellbeing strategies within the framework of the national Public Health Outcomes Framework, he or she should ensure a rigorous focus on local priorities and action across the life course to ensure a preventive approach is embedded in the local system.

The new local legal framework for public health

Broadly speaking, the Health and Social Care Act 2012 ("the Act") gives responsibility for health protection to the Secretary of State and health improvement to upper tier and unitary local authorities.

The Secretary of State will also delegate some health protection functions to local authorities. Local authorities will maintain responsibility for their existing health protection functions, many of which are exercised by lower tier and unitary authorities.

Section 12 of the Act inserts new section 2B into the NHS Act 2006 to give each relevant local authority a new duty to take such steps as it considers appropriate to improve the health of the people in its area. This section also gives Secretary of State a power to take steps to improve the health of the people of England – and it gives examples of health improvement steps that either local authorities or the Secretary of State could take, including giving information, providing services or facilities to promote healthy living and providing incentives to live more healthily.

Section 18 gives the Secretary of State the power to make regulations as to the exercise by local authorities of certain public health functions by inserting new section 6C into the NHS Act 2006. This means that the Secretary of State can require local authorities to carry out aspects of his health protection functions by taking certain prescribed steps. It also means that the Secretary of State can prescribe aspects of how local authorities carry out their health improvement function.

Upper tier and unitary local authorities are therefore taking on critical public health responsibilities. Section 30 then requires them, acting jointly with the Secretary of State, to appoint an individual who will be responsible for the local authority's new public health functions. That individual will be an officer of the local authority, and known as the director of public health.

This section also gives the Secretary of State the power to direct a local authority to investigate the conduct of a director of public health in relation to public health functions delegated from Secretary of State, and to report back (although the Secretary of State does not have the power to terminate the employment of a director of public health. The local authority as the employer does have this power, but must consult the Secretary of State before doing so).

Section 31 inserts a new section 73B into the NHS Act 2006, which gives Secretary of State the power to publish guidance to which the local authority must have regard.

Such guidance may include guidance as to the appointment of officers of the local authority to discharge its public health functions (for example, guidance on the involvement of the Secretary of State in the process of appointing directors of public health).

The Government will also publish the refreshed Public Health Outcomes Framework as guidance to which local authorities must have regard.

Under this same section, each director of public health is required to produce, and the relevant local authority to publish, an annual report. The Government has not further specified what the annual report might contain – this is very much a decision for individual directors of public health as to the issues they feel are important to raise.

Directors of public health will also be statutory members of health and wellbeing boards (section 194(2)(d) of the Act).

Schedule 5 of the Act amends the Local Government Act 1989 to add directors of public health to the list of statutory chief officers.

Finally, sections 35-37 set out new arrangements for consulting and making decisions on fluoridation schemes, which will become the responsibility of local authorities.

These duties mean that the local authority will have to take steps to ensure that it is aware of and has considered what the health needs of its local population are, and what the evidence suggests the appropriate steps would be to take to address those needs.

Local authorities will have considerable freedom in terms of how they choose to invest their grant to improve their population's health, although they will have to have regard to the Public Health Outcomes Framework and should consider the extant evidence regarding public health measures.

The Government intends to mandate a small number of steps and services, as follows:

- steps to be taken to protect the health of the local population
- ensuring NHS commissioners receive the public health advice they need
- appropriate access to sexual health services
- the National Child Measurement Programme
- NHS Health Check assessment.

These steps and services will be mandated through regulations made under new section 6C of the NHS Act 2006. Mandating steps and services in this way is not a means of indicating relative importance. Rather it reflects that there are some areas where a greater uniformity of provision is required (particularly health protection), or the fact that some steps are critical to ensuring there is an effective local public health system.

Mandating steps and services is also a means of ensuring that, where there is a legal duty on the Secretary of State which will be discharged in future by local authorities, this duty will be effectively discharged.

Implications for local authorities

As noted above, local authorities already have important and wide-ranging public health functions, for example under the Public Health (Control of Disease) Act 1984 (as amended). These will continue.

However, under the Act and the regulations listed above, local authorities will be taking on significant new public health functions.

The director of public health, as the lead officer for these new functions, will need to have specialist public health expertise, and access to specialist resources, spanning the three domains of public health, health improvement, health protection and healthcare public health (ie the population health aspects of NHS-funded clinical services).

The director and their specialist teams will also need access to appropriate information and evidence on which to base their advice, including detailed information on patterns of provision of health care if they are to advise local NHS commissioners and health and wellbeing boards.

Thus the director will have a critical role in defining the needs assessment which will drive commissioning, building on the assets of the local area. Directors of public health will support clinical commissioning so that it reflects the needs of the whole population.

They will also lead on health protection, ensuring that appropriate arrangements are in place, escalating concerns and holding local partners to account.

Additionally, as lead adviser on health to the local authority and a statutory chief officer, the director of public health will be an important official within the authority, influencing decisions across the range of the authority's business, as well as carrying out on the authority's behalf its new functions relating to public health.

To be effective, he or she will need to be an effective senior officer within the authority. This will call for considerable influencing skills and the ability to balance the need to be an advocate for public health and the requirement to respect the local democratic process.

Local authorities will lead the process of appointing directors jointly with the Secretary of State, which will help to ensure consistent appointment of people of the right calibre, with the right expertise and experience, in these key posts. The Government is publishing separate guidance on this process.

While the organisation and structures of individual local authorities are matters for local leadership, we are clear that these legal responsibilities should translate into the director of public health acting as the lead officer in a local authority for health and championing health across the whole of the authority's business.
This means that we would expect there to be direct accountability between the director of public health and the local authority chief executive (or other head of paid service) for the exercise of the local authority's public health functions, and that they will have direct access to elected members.

The new public health functions

Below we set out what the new functions mean for local authorities in each of the three domains of public health.

Health improvement

The key new duty for local authorities will be to take appropriate steps to improve the health of their population. This new duty complements much of the local authority's existing core business, and its strategic responsibility for stewardship of place.

It will normally be appropriate for a Cabinet Member to take the lead among elected members for this area and give it the appropriate political leadership at the local level.

The director of public health will support local political leaders in their ambitions to improve local health. We would expect that he or she will:

- contribute fully to rigorous and well-informed joint strategic needs assessments and joint health and wellbeing strategies
- take day-to-day management over the ring-fenced public health budget, thereby having responsibility and the resources to invest to improve health locally
- work more widely with wider partners to foster joint commissioning where appropriate and to inform wider strategies, for example around adult social care, children's services, transport, housing and leisure
- provide officers and elected members with appropriate advice, based on a rigorous appreciation of patterns of local health need, what works and potential returns on public health investment
- provide advice to partners more broadly (thus the local authority might wish to offer public health-related training courses).

She/he should have a particular focus on ensuring disadvantaged groups receive the attention they need, with the aim of reducing health inequalities.

When commissioning clinical services such as sexual health and drug and alcohol services directors of public health will need to ensure that providers have appropriate clinical governance arrangements in place that are equivalent to NHS standards.

Health protection

The Secretary of State will have the core duty to protect the health of the population in the new system.

However, the Government sees local authorities having a critical role at the local level in ensuring that all the relevant organisations locally are putting plans in place to protect the population against the range of threats and hazards.

This will link to, but be different from, their statutory responsibility for public health aspects of planning for emergencies within local authorities.

Most health protection incidents are contained locally. The director of public health, with Public Health England, should lead the initial response to public health incidents at the local level, in close collaboration with the NHS lead.

The NHS will determine, in the light of the impact on NHS resources and with advice from the director of public health, at what point the lead role will transfer, if required, to the NHS.

The director of public health should therefore:
- provide strategic challenge to health protection plans/arrangements produced by partner organisations
- scrutinise and as necessary challenge performance
- if necessary, escalate any concerns to the local health resilience partnership (LHRP)
- receive information on all local health protection incidents and outbreaks and take any necessary action, working in concert with Public Health England and the NHS. This may include, for example, chairing an outbreak control committee, or chairing a look back exercise in response to a sudden untoward incident
- contribute to the work of the LHRP, possibly as lead DPH for the area;
- provide the public health input into the local authority emergency plans.

To assist directors of public health in fulfilling this health protection role we recommend local areas consider setting up a health protection forum or committee, possibly linked to the health and wellbeing board, for example as a sub-committee of the board.

Such an arrangement would help ensure that all key organisations met regularly, shared information and planned effectively.

Healthcare public health
The Government intends to make regulations to require local authorities to provide public health advice to NHS commissioners.

The director of public health will therefore have the responsibility and funding for providing a core offer of public health advice to the NHS locally. NHS Commissioners will need to ensure that local authorities and health and wellbeing boards have access to the information they will need to advise them.

This arrangement provides an excellent opportunity for local authorities to build and maintain close links with clinical commissioners, complementing health and wellbeing boards.

She/he and their teams should therefore, for example:
- help to ensure that joint strategic needs assessments reflect the needs of the whole population
- support commissioning strategies that meet the needs of vulnerable groups
- support the development of evidence-based care pathways and service specifications
- contribute advice on evidence-based prioritisation policies
- produce as necessary health needs audits and health equity audits
- provide other specialist public health advice as required.

In delivering these functions directors of public health and their teams will benefit from the advice and support of Public Health England. Thus for example Public

Health England will provide data and evidence of what works in relation to the public health outcomes framework, provide specialist health protection services, and give advice on the population impact of health services.

Resourcing the team

The above description of the public health role within local authorities makes clear that there needs to be a specialist, experienced public health professional (the director of public health) supported by specialist public health resources with access to adequate information and evidence functions. The size of that resource will depend on a range of factors, not least the size and relative needs of the local population.

Conclusion

From April 2013 upper tier and unitary local authorities will provide local leadership for public health, underpinned by new statutory functions, dedicated resources and an expert public health team. Local political leadership will deliver a new focus on improving health and reducing health inequalities.

This new role will complement but also extend existing local authority functions in terms of maximising the wellbeing of citizens.

The director of public health will lead on delivering these public health functions for the local authority, supporting the political leadership.

She or he will have the overall role of advocating for the health of the population locally. This does not mean that the director of public health will have the accountability and resources to deliver all public health functions, but it does mean that they will need to be the lynchpin in the system – the person who knows how to access advice and resources, and support local elected members and officers in their work in promoting wellbeing across the local population.

To deliver this function successfully the director of public health will need to be a public health specialist, with highly developed technical skills, and with access to a range of public health expertise in their team. They will also need to be skilled at working in a political environment. In short, they will need to be public health change agents.

DH Department of Health

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Baseline spending estimates for the new NHS and Public Health Commissioning Architecture

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Baseline spending estimates for the new NHS and Public Health Commissioning Architecture

Prepared by
Department of Health
Resource Allocation team

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Summary

1.1. We have brought together two separate collections of 2010-11 Primary Care Trust spend that focused on public health and NHS Commissioning Board or Clinical Commissioning Groups to estimate how those resources would be deployed under the commissioning architecture proposed in the Health and Social Care Bill.

1.2. While these should be recognised as estimates at this stage, and further analysis is needed before 2013-14 allocations can be set, they do support initial planning by emerging Clinical Commissioning Groups and Local Authorities.

Introduction

1.3. At the moment over 80% of all NHS funding goes to primary care trusts (PCTs), who are then responsible for meeting health and public health needs. The government remains committed to real terms growth in health spending in each year of the current Parliament but the Health and Social Care Bill would create distinct responsibilities for commissioning different services. In particular:

- The NHS Commissioning Board (NHSCB) would commission a number of services, such as specialised services, primary medical services and dental services. The NHSCB budget was previously estimated to be in the region of £20bn. [1]
- Clinical Commissioning Groups (CCGs) would be responsible for commissioning most local services, by value, in particular hospital and community health services. We have previously estimated that they will control budgets of around £60bn.[2]
- The total spend on Public Health Services, including Public Health England (PHE), was estimated to be in excess of £4bn.[3]
- This also includes services provided or commissioned locally by local authorities (LAs), funded by a ring-fenced grant.

1.4. The Secretary of State would be responsible for setting the size of the budget available to NHSCB and PHE, as well as the size of the ring-fenced public health grants provided

[1] Transcript of oral evidence before Health Committee (HC 796-v): *Third Report into Commissioning*.
[2] Ibid 1
[3] *Healthy Lives, Healthy People* – Consultation on the Funding and Commissioning Routes for Public Health.

to LAs. NHSCB would determine the size of the budget available to each CCG, from within the total NHS commissioning budget.

1.5. The estimates described above were high level. But a good understanding of baseline spend is critical to a smooth transition to the new commissioning architecture. It is the starting point for decisions on how much funding should be available in different parts of the system and how that funding should be distributed locally. We therefore needed to go beyond these high-level estimates and during September we completed two major collections of information from PCTs: one focused on the public health system and one focused on NHSCB and CCG responsibilities.

1.6. In this paper, we bring the results of these collections together with information from accounts and other sources to provide the best available estimate of how spend by PCTs during 2010-11, adjusted to a hypothetical break-even position, would map on to the new commissioning architecture. Our analysis is broken down to regional and individual PCT level. When uplifted to 2012-13 levels these offer a first indicative estimate of local baselines, supporting planning and the further development of the commissioning architecture.

1.7. The analysis also gives us the first reliable estimate of the current spend in areas that would be the responsibility of the public health system. Adding spend from central budgets to the spend by PCTs in Table 1, and adjusting for spend we believe it has not been possible to separate from CCG spend, we estimate that during 2012-13 the NHS will spend £4.6bn on public health services[4]. Of this, about £2.2bn will be spent on services that would fall in the future within the responsibilities of local authorities. This paper includes our estimates of how this baseline spend is distributed across local authorities.

1.8. The information we have collected has also allowed us to estimate the size of spend on future CCG responsibilities, around £64.7bn, as well as estimates of the spend in some significant areas that NHSCB will directly commission. However, our analysis does not include some areas that are currently funded through Strategic Health Authorities, such as primary care in prisons.

1.9. The aggregate breakdown for England is shown in **Table 1**. The estimated breakdown of 2010-11 spend by PCT and Strategic Health Authority is presented in the accompanying Excel workbook,[5] while the estimated spend on public health in LA

[4] Corresponds to the Local Authorities, NHS Commissioning Board and Public Health England lines in Table 2.
[5] http://www.dh.gov.uk/health/2011/12/pct-allocations

areas (for relevant responsibilities) is shown in the Table at **Annex A**. The original data returns for each PCT are being placed on the Department of Health Website..[6]

[6] Ibid 4

Table 1: Estimated spend 2010-11 by PCTs by future commissioning architecture

	Source of data	£000s	Uplifted to 2012-13 £000s
CCG list based responsibilities			
Secondary and community care [1, 2]	(1) & (4)	52,124,374	
Out-of-hours primary care [1,2]	(1) &(4)	412,274	
Prescribing costs [1,2]	(1) & (4)	7,847,956	
Services currently commissioned through local enhanced services (excluding public health) [1,2]	(1)	392,663	
Total		60,777,267	63,984,056
CCG geographical responsibilities			
Secondary care for prisoners [3, 4, 9]	(1)	98,454	
Unregistered populations [3, 4]	(1)	310,538	
Charge exempt overseas visitors [3, 4]	(1)	39,495	
Non-rechargeable services [3, 4]	(1)	66,079	
Adjustment for transfer of responsibilities for termination of pregnancy, sterilisation and vasectomy	(4)	151,534	
Total		666,101	700,756
NHSCB direct commissioning			
Specialised services [5]	(1)	8,573,609	
Secondary dental care [5]	(1)	485,847	
GP services excluding local enhanced services and out-of-hours services[6]	(1),(2)	6,660,565	
General Dental Services (net of patient charges)	(2)	2,203,027	
General Ophthalmic Services	(2)	478,194	
Pharmaceutical Services (net of patient charges)	(2)	1,544,721	
Armed forces [5, 10]	(1)	23,257	
Other Primary Care	(2)	124,650	
Total		20,093,870	21,152,829
Public health system			
LA responsibilities	(3)	2,112,456	
Commissioned through NHSCB[7]	(3)	1,614,283	
PHE	(3)	17,828	
Total		3,744,567	3,941,912
Admin spend other than public health			
Admin[8]	(2)	2,717,671	
TOTAL		87,999,475	
Reconciliation to PCT Revenue Resource Limit for 2010-11			
Total resource Limit for 2010-11	(2)	90,335,595	
Less transfer to LAs for social care of people with learning disabilities	(2)	1,294,173	
Revised total resources		89,041,422	
Unattributed spend/income		-1,041,947	
% unattributed spend/income		-1.2%	

Sources:

(1) CCG focused returns
(2) Accounts
(3) Public health focused returns
(4) DH analysis

Notes:
1. Expenditure net of (ie after subtracting) income from other NHS organisations and other organisations. Includes spend from both recurrent allocations, non-recurrent allocations and inter authority transfers.
2. Each row in this group was adjusted by increasing spend if the surplus was higher at the end of 2010-11 than 2009-10, or deficits lower, and reducing spend if the surplus was lower or the deficit higher. Similar adjustments were made for net lodgements.
3. Expenditure net of (ie after subtracting) income from other NHS organisations and other organisations. Includes spend from both recurrent allocations, non-recurrent allocations and inter authority transfers.
4. Each row in this group was adjusted by increasing spend if the surplus was higher at the end of 2010-11 than 2009-10, or deficits lower, and reducing spend if the surplus was lower or the deficit higher. Similar adjustments were made for net lodgements.
5. Expenditure net of (ie after subtracting) income from other NHS organisations and other organisations. Includes spend from both recurrent allocations, non-recurrent allocations and inter authority transfers.
6. Gross expenditure. Excludes estimated purchase of public health from primary care. Includes non-GMS services, eg secondary care, from GPs. Non –GMS spend was £135m in England.
7. We estimate that a further £420m of expenditure is included in CCG spend estimates, due to the difficulty of separating spend on different areas commissioned through a single contract.
8. Gross expenditure.
9. Working assumption on future commissioning route.
10. Precise route for armed forces for discharging commissioning responsibilities in association with CCG contracts to be determined

1.10. This paper does not discuss the advice of the Advisory Committee on Resource Allocation (ACRA), nor 'pace-of-change' policy (but see the section on Next Steps on page 14).

1.11. Baseline spend estimates for CCGs and NHSCB do not include administrative costs; they refer only to programme spend. Where 2010-11 administrative costs are included in PCT breakdowns this is only to facilitate the reconciliation of our estimates against resource limits.

Collections

1.12. The principal sources for our estimates are the collections run between August and September 2011. These provided us with information around how the 2010-11 spend by PCTs would have been distributed under the new commissioning architecture. However, to build a complete picture of current spend we have had to combine these returns with other data sources. For instance the returns did not include information on the main primary care contract spend and so this has been estimated using accounts data. We are also aware of a limited number of areas where an alternative data source suggests that the returns may have underestimated or misattributed spend and where possible, we have approximated an adjustment. The effect of such adjustments has generally been to increase our estimates of the spend on public health.

Public Health

1.13. Public health 2010-11 spend information was collected twice during 2011: as part of the end of year audit and again in August/September, after working with PCT Directors of Finance and Directors of Public Health to improve the design of the return and the guidance. A key part of this second return was that we also asked local authorities to write to us with details of any areas of concern about the information PCTs were providing.

1.14. Our analysis suggests that the second collection was of significantly better quality. However, consistent with some of the feedback we received from local authorities, there were still areas where there may have been an underestimation of public health spend. This may be consistent with, for instance, the difficulty of disaggregating services currently commissioned through a single contract. We also had to correct for changes in the range of services included in the responsibilities of the public health system. To give the most reliable estimate of 2010-11 spend in the public health system we therefore made a number of adjustments to the returns. These are described in detail at Annex B, but they included:

- Correction of responsibility for abortion, sterilisation and vasectomy services. These were not separately identified in the returns but were part of a broader category. At the time of the collection they were proposed to be part of LA responsibilities. They are now initially expected to be part of CCGs' responsibilities. This reduced the total spend on public health services by around £150m.

- Some services were not included in the return but have been added to the specification of services to be delivered through the public health system subsequently. These have been estimated from other sources and add £168m to the total public health system spend[7].

- Imputing values where an unlikely zero value was reported. The returns included some services where zero spend was reported but we would expect all PCTs to be providing the service; it is also unlikely that the spend has been included in another category. In this case we have imputed the spend per head using the average of other PCTs in the same SHA. These add only around £34m to the total spend, suggesting that the returns are reasonably complete at least for high-spend categories.

- For a small number of services a reliable alternative estimate, or part estimate, exists. Where this suggests a significant error in the total spend, we adopted this estimate. This is a significant adjustment, mainly in the cost of screening, adding

[7] The £168m relates to services expected to be commissioned through the NHSCB .

approximately £430m to the total spend projected on to the public health system. We are unable to make a compensating correction to CCG spend estimates at a local level but as these services are expected to be commissioned through NHSCB this does not undermine this analysis as a tool for further planning.

1.15. For the relevant services, we have projected the spend on to LA areas to provide an estimate of baseline spend relevant to the ring-fenced public health grants. This is based on the proportion of registrations residing in each PCT's area living in each local authority.

1.16. The analysis discussed here focuses on revenue. Separate work is looking at the need for capital and we will make further updates at a later stage. However, local authorities' principal role will be as commissioners rather than providers of public health services, and so we would not expect their capital needs, typically, to be significant. This work also does not address the one-off costs of transition.

1.17. Most LAs highlighted one or more concerns about the information the PCT had returned to us. However, we do not believe, given the corrections suggested here, that most will have a large effect on the size of the ring-fenced grant.

1.18. Particular concerns included:

- 2010-11 was atypical because some policies had not been fully rolled out: this does not affect the accuracy of 2010-11 figures as a baseline spend estimate and all years would have suffered from this to some extent. This will need to be considered when confirming the size of the actual budget in 2013-14, along with potential for efficiency savings and the pressures in other parts of the comprehensive health service.
- Overheads costs have not been properly included: Most of the budget is for the commissioning of services from other bodies (such as sexual health services) and so do not require overheads. Other returns suggest that nationally public health's contribution to overheads is around £60m or 1½%. We therefore believe that any error on what is already a small component of the budget would not have a material effect on the size of the future ring-fenced grant.

CCGs and NHSCB

1.19. The second return focused on services that will in future be the responsibility of either CCGs or NHSCB. As CCGs have not yet been established we requested data at

practice level for future CCG commissioning responsibilities for their registered lists; we can then establish a baseline for whatever configuration of practice should ultimately be established. Spend on services that will be commissioned on the basis of CCGs' geographical areas (such as prison secondary care) or that will be the responsibility of NHSCB (such as specialised services) were collected at PCT level.

1.20. We asked PCTs to make an assessment of what the spend would have been in each area if they had been in balance in 2010-11, ie, no net change in their surplus or deficit position. This proved to be a technically difficult correction, where our own guidance could also have been clearer. We have therefore worked, in particular, with SHA clusters to understand the change in each PCT's position and then ensure that an appropriate adjustment is made; full details of this adjustment are at **Annex C**.

1.21. There were also uncertainties at the time of collection about which specialised services would be commissioned by NHSCB and that the available definitions of specialised services were not precise enough to get a good estimate of spend on these services. A comparison with HES data does suggest that in some areas specialised services spend has been underestimated, presumably with a compensating over-estimation in the estimates for CCGs' list based responsibilities. Since then the proposed scope of specialised services has increased further, making any under-estimation greater. In addition, some PCTs may have omitted from the returns spend on healthcare through pooled budgets arrangements with local authorities.

1.22. Many PCTs also reported difficulties in allocating spending on CCGs' list-based responsibilities to practices and so apportioned a significant amount of spending on a nominal population basis. Data at this level should therefore be used with caution.

Other information

1.23. To build a complete picture, our analysis also draws on information from accounts (for instance most spend on primary care services).

1.24. To test the validity of our estimates we have compared them with the PCTs' revenue resource limits. As some estimation has been required we do not expect a perfect reconciliation, but nationally we reconcile to 1.2% below the relevant revenue resource limit, and most PCTs are in the range 7% below to 2% above, although there are some outliers (the full range is 19% below - 6% above). This suggests that these estimates are generally robust and is testament to the high quality of information supplied by PCTs and SHAs.

Results of the analysis

1.25. The breakdown of each PCT's spend across the new commissioning architecture, and the reconciliation of our analysis against the relevant resource limit, is presented in the accompanying excel workbook. Non-NHS income has been deducted. Each PCT can be selected by entering its code. Aggregate information for SHAs can also be selected, or the aggregate position for England (by entering 'Eng'). Sub-totals have also been uplifted to approximate 2012-13 values using the relevant PCT recurrent allocation growth for 2011-12 and 2012-13, which is typically around 5¼%.

1.26. Each PCT's analysis also includes an estimated baseline for prospective CCGs in its area, based on future responsibilities for registered populations. All CCGs are shown that include one or more practice drawn from that PCT, and so some CCGs appear on more than one PCT's summary. CCGs whose proposed configurations have recently been rated as Amber or Green as part of the recent SHA risk assessment are included. CCGs whose proposed configurations were red-rated have been excluded unless SHAs have advised us that they are in the process of making minor adjustments to membership that they expect to deliver Amber or Green status. Unaffiliated practices have also been excluded.

1.27. The Table at Annex A shows the relevant part of the public health spend projected on to local authority areas. This is split between the different commissioning routes in Table 2 below. The detailed division of responsibilities between PHE and DH remains to be decided in some cases. Spend identified as 'Department of Health' includes a range of budgets that could also ultimately be held by PHE. However, it does not include the administration costs of public health functions currently within DH.

Table 2: Estimated 2010-11 public health spend (with adjustments to PCT survey)

Future commissioning route	Estimated baseline expenditure	Uplifted to 2012-13
Local Authorities	£2.1bn	£2.2bn
NHS Commissioning Board	£2.0bn	£2.2bn
Public Health England	£210m	£210m
Department of Health	£620m	£620m
Total	**£5.0bn**	**£5.2bn**

Notes:
1. Expenditure by PCTs has been uplifted in line with PCT recurrent allocation growth. Spend from central budgets in total has been assumed constant.. Central budgets includes grant-in-aid to organisations such as HPA..
2. These figures include the corrections discussed above and so do not necessarily match the values reported in Table 1.

Next steps

1.28. Understanding how 2010-11 spend projects on to the new architecture is an important step in implementing the transition proposed in the Health and Social Care Bill. But these figures do not necessarily represent the final budgets for 2013-14; these will need to take account of a number of other factors and final allocations for 2013-14 will be set later this year. We also expect to say more about ACRA's recommendations for how we should aim to distribute resources in the longer term in due course.

1.29. However, these do offer a sensible basis for initial planning, particularly when uplifted to 2012-13 values. In particular, we would not expect the LA public health ring-fenced grants to fall in real terms from the values in Annex A, other than in exceptional circumstances such as a gross error or following a technical adjustment with major consequences for budgets, such as a significant adjustment for NHS income, a change in planned responsibilities or a large shift in the incentive payment for drugs treatment. In particular, we may need to do further work to confirm the adjustment we have made to take account of abortion, sterilisation and vasectomy services initially being the responsibility of CCGs rather than LAs.

1.30. We are not planning to update the public health baseline described here through a repeat collection. However, where PCTs and LAs agree that significant errors have been made or our approach does not take sufficient account of local circumstances (such as how we project resources on to LA geographies) we will consider making appropriate updates.

1.31. For CCGs the position is more complex. Actual allocations will depend, for example, on the final configurations of CCGs and on final decisions on the balance of funding for nationally and locally commissioned services, both of which will be a matter for NHSCB. The likely underestimation of specialised and public health services has probably also led to an overestimation of CCG spend levels. Conversely, the addition of non-list based spend, estimated here for PCTs but not attributed to individual CCGs, would lead to an increase in the CCG baseline.

1.32. These and other uncertainties mean that CCG baselines need to be treated with caution. Nevertheless, we believe this analysis can be used for initial planning. We expect there to be a further collection of 2011-12 spend levels, not least to reflect GP practice changes, such as closures, mergers and new practices.

1.33. We would welcome feedback on our estimates, including updates to previously submitted information. These should be sent to allocations@dh.gsi.gov.uk. Any change to the data should be agreed by the PCT Cluster Chief Executive and Director

of Finance. For public health data changes, the relevant local authorities should also be involved.

1.34. In setting PCT allocations, we have adopted a process that includes estimating a long term aim for the most efficient distribution of resources, based on a formula set by an independent group of NHS managers, GPs and academics – currently the Advisory Committee on Resource Allocation (ACRA). The independence and influence of this group were praised in a recent Public Accounts Committee report on the use of allocation formulae in the public sector.[8]

1.35. During transition, the Secretary of State has asked ACRA to continue to provide advice, covering both allocations to CCGs and to LAs. They have completed their initial work and we are working through the implications of their recommendations, including a detailed comparison with the baseline spend estimated here. The full details of their recommendations and their implications are to be published in due course although we already know that there will be further work to do, such as considering how non-resident populations impact on the resources LAs need to provide public health services. We will welcome feedback on ACRA's recommendations.

1.36. It would however be too early to assess options for how quickly each area can be moved towards target; this will depend on the decisions about high level budgets that are not yet available. This will feed in to the final announcements of actual 2013-14 allocations for CCGs and local authority ring fenced grants, which are expected to be made around the end of the year.

[8] *Formula funding of Local Public Services*: Fifty-fifth Report of Session 2010-2012 – HOC 1502.

Annex A: Relevant public health baseline spend projected on to local authority areas

	2010-11			2012-13
Local Authority	Spend £000	Population* 1000s	Spend per head £	Spend £000
Hartlepool	7,300	91.3	80	7,685
Middlesbrough	14,136	142.4	99	14,872
Redcar and Cleveland	9,630	137.4	70	10,110
Stockton-on-Tees	11,318	192.4	59	11,914
Darlington	6,158	100.8	61	6,482
County Durham	40,755	510.8	80	42,905
Northumberland	10,419	312.0	33	10,969
Gateshead	13,806	191.7	72	14,496
Newcastle upon Tyne	17,348	292.2	59	18,213
North Tyneside	8,099	198.5	41	8,513
South Tyneside	11,400	153.7	74	11,970
Sunderland	18,508	283.5	65	19,468
North East	168,878	2,606.6	65	177,598
Halton	7,080	119.3	59	7,453
Warrington	7,520	198.9	38	7,917
Blackburn with Darwen	10,988	140.0	78	11,567
Blackpool	15,711	140.0	112	16,539
Cheshire East	10,181	363.8	28	10,704
Cheshire West and Chester	9,819	327.3	30	10,313
Bolton	15,126	266.5	57	15,924
Bury	5,778	183.8	31	6,082
Manchester	28,406	498.8	57	29,904
Oldham	8,854	219.8	40	9,306
Rochdale	11,836	205.2	58	12,460
Salford	13,507	229.0	59	14,220
Stockport	8,672	284.6	30	9,113
Tameside	8,857	216.9	41	9,324
Trafford	9,008	217.3	41	9,457
Wigan	17,712	307.6	58	18,646
Knowsley	14,478	149.1	97	15,202
Liverpool	32,537	445.2	73	34,159
St. Helens	10,533	177.4	59	11,088
Sefton	17,028	272.9	62	17,877
Wirral	21,207	308.8	69	22,264
Cumbria	11,979	494.4	24	12,611
Lancashire	43,626	1,169.3	37	45,891
North West	340,441	6,935.7	49	358,019
Kingston upon Hull, City of	19,154	263.9	73	20,164
East Riding of Yorkshire	7,058	338.7	21	7,430
North East Lincolnshire	8,344	157.3	53	8,762
North Lincolnshire	6,996	161.3	43	7,364
York	5,338	202.4	26	5,620
Barnsley	11,571	227.6	51	12,181
Doncaster	15,870	290.6	55	16,707
Rotherham	12,339	254.6	48	12,990
Sheffield	24,509	555.5	44	25,730

	2010-11			2012-13
Local Authority	Spend £000	Population* 1000s	Spend per head £	Spend £000
Bradford	23,971	512.6	47	25,225
Calderdale	6,679	202.7	33	7,013
Kirklees	18,511	409.8	45	19,487
Leeds	28,740	798.8	36	30,255
Wakefield	17,797	325.6	55	18,736
North Yorkshire	15,562	599.7	26	16,382
Yorkshire and the Humber	222,438	5,301.3	42	234,046
Derby	10,897	246.9	44	11,636
Leicester	16,075	306.6	52	16,995
Rutland	861	38.6	22	906
Nottingham	22,011	306.7	72	23,422
Derbyshire	30,736	763.7	40	32,357
Leicestershire	15,412	648.7	24	16,225
Lincolnshire	23,452	703.0	33	24,689
Northamptonshire	21,511	687.3	31	22,645
Nottinghamshire	28,446	779.9	36	29,946
East Midlands	169,400	4,481.4	38	178,820
Herefordshire, County of	6,324	179.3	35	6,657
Telford and Wrekin	7,383	162.6	45	7,773
Stoke-on-Trent	17,596	240.1	73	18,877
Shropshire	6,798	293.4	23	7,156
Birmingham	46,010	1,036.9	44	48,348
Coventry	13,479	315.7	43	14,150
Dudley	15,473	307.4	50	16,288
Sandwell	17,094	292.8	58	17,995
Solihull	7,336	206.1	36	7,723
Walsall	12,499	256.9	49	13,143
Wolverhampton	13,989	239.4	58	14,726
Staffordshire	27,675	831.3	33	29,472
Warwickshire	18,822	536.0	35	19,815
Worcestershire	21,291	557.4	35	22,414
West Midlands	231,769	5,455.2	42	244,538
Peterborough	5,617	173.4	32	5,897
Luton	6,909	198.8	35	7,273
Southend-on-Sea	4,944	165.3	30	5,205
Thurrock	4,977	159.7	31	5,240
Bedford	4,921	160.8	31	5,207
Central Bedfordshire	7,783	255.2	30	8,234
Cambridgeshire	14,391	616.3	23	15,150
Essex	37,416	1,413.0	26	39,616
Hertfordshire	21,113	1,107.5	19	22,227
Norfolk	26,692	862.3	31	28,493
Suffolk	23,283	719.5	32	24,511
East of England	158,046	5,831.8	27	167,051
City of London	1,355	11.7	116	1,422
Barking and Dagenham	10,485	179.7	58	11,019
Barnet	11,236	348.2	32	11,796

	2010-11			2012-13
Local Authority	Spend £000	Population* 1000s	Spend per head £	Spend £000
Bexley	4,435	228.0	19	4,669
Brent	15,247	256.6	59	16,007
Bromley	9,520	312.4	30	9,994
Camden	22,657	235.4	96	23,786
Croydon	16,222	345.6	47	17,078
Ealing	17,169	318.5	54	18,025
Enfield	9,847	294.9	33	10,367
Greenwich	13,521	228.5	59	14,195
Hackney	25,455	219.2	116	26,724
Hammersmith and Fulham	16,748	169.7	99	17,583
Haringey	13,935	225.0	62	14,630
Harrow	7,489	230.1	33	7,862
Havering	6,566	236.1	28	6,912
Hillingdon	10,653	266.1	40	11,184
Hounslow	8,744	236.8	37	9,179
Islington	19,877	194.1	102	20,867
Kensington and Chelsea	14,377	169.5	85	15,094
Kingston upon Thames	7,686	169.0	45	8,069
Lambeth	20,617	284.5	72	21,645
Lewisham	16,671	266.5	63	17,502
Merton	7,114	208.8	34	7,469
Newham	18,739	240.1	78	19,673
Redbridge	7,519	270.5	28	7,915
Richmond upon Thames	6,994	190.9	37	7,343
Southwark	17,448	287.0	61	18,368
Sutton	6,620	194.2	34	6,950
Tower Hamlets	27,756	237.9	117	29,139
Waltham Forest	8,145	227.1	36	8,550
Wandsworth	22,136	289.6	76	23,240
Westminster	25,816	253.1	102	27,102
London	448,798	7,825.2	57	471,360
Medway	9,882	256.7	38	10,403
Bracknell Forest	2,449	116.5	21	2,579
West Berkshire	3,925	154.0	25	4,132
Reading	3,942	154.2	26	4,150
Slough	2,778	131.1	21	2,925
Windsor and Maidenhead	3,078	146.1	21	3,240
Wokingham	4,139	163.2	25	4,357
Milton Keynes	5,459	241.5	23	5,747
Brighton and Hove	12,174	258.8	47	12,781
Portsmouth	14,123	207.1	68	14,868
Southampton	12,073	239.7	50	12,710
Isle of Wight	4,610	140.5	33	4,853
Buckinghamshire	7.624	498.1	15	8,026
East Sussex	20,302	515.5	39	21,318
Hampshire	26,829	1,296.8	21	28,244
Kent	34,669	1,427.4	24	36,484
Oxfordshire	19,906	648.7	31	20,899
Surrey	18,760	1,127.3	17	19,695
West Sussex	22,131	799.7	28	23,269

	2010-11			2012-13
Local Authority	Spend £000	Population* 1000s	Spend per head £	Spend £000
South East	228,851	8,523.1	27	240,677
Bath and North East Somerset	4,986	179.7	28	5,235
Bristol, City of	16,590	441.3	38	17,465
North Somerset	4,989	212.2	24	5,352
South Gloucestershire	4,692	264.8	18	4,940
Plymouth	8,008	258.7	31	8,430
Torbay	6,162	134.3	46	6,486
Bournemouth	6,139	168.1	37	6,460
Poole	5,172	142.1	36	5,442
Swindon	6,261	201.8	31	6,591
Cornwall	16,018	535.3	30	16,863
Isles of Scilly	64	2.1	30	67
Wiltshire	11,272	459.8	25	11,866
Devon	16,014	749.9	21	16,840
Dorset	10,640	404.8	26	11,201
Gloucestershire	14,919	593.5	25	15,704
Somerset	11,910	525.2	23	12,538
South West	143,834	5,273.7	27	151,478
England	2,112,456	52,234.0	40	2,223,588

Notes: * Office for National Statistics 2010 Mid-year estimates for 2010-11 spend per head, rounded to nearest 100.

Annex B: Technical adjustments to public health returns

Imputing reported zeros
While the second public health survey reduced the number of functions where some PCTs implausibly reported zero spend, some remained. To test the importance of the implausible zeros we imputed values based on the average spend per head for the other PCTs within the SHA.

This imputation raised the total spend only modestly (around £34m[9]), so we are confident that the coverage of the survey is reasonably complete in areas of significant spend. Imputed values have been retained in our analysis, although it has not been possible to make a compensating correction to the CCG focused returns.

Variability in per capita spend
While implausible reported zeros can be easily identified, it is less easy to identify implausibly high or low reported per capita spend (which might include simple data entry errors), as we would expect spend in some functions to vary markedly between PCTs, eg drugs treatment and prison public health.

For example, for alcohol misuse services, the PCT with the 10th highest spend per head reported a spend sixteen times higher per head than the PCT with the 10th lowest spend per head. This is a high range, but there is a high correlation between deprivation and high per capita spend. It was therefore not clear how plausible the reported spend is.

Comparisons with other data sources
For some public health functions we have alternative estimates of total spend. These include, amongst others: NAO reports and academic studies. Expenditure on a few functions was not covered in the collection and accounts data were used for these.

We have compared these with the total national spend for each function as reported in the PCT return and for the functions shown in Table B1 we believe other sources are more reliable than the PCT estimate.

Table B1: Alternative and additional estimates

Public Health Function	Reported spend	Alternative estimate	Source & discussion
Non-cancer screening	£128m	£404m	Professor Adrian Davis at the Royal Hampstead NHS Trust has produced an estimate of total national spend. It includes a number of estimates e.g. % of patients requiring services and some staff costs.
Cancer screening	£271m	£377m	There is an alternative estimate from the National Audit Office.

[9] Zero spend was imputed for: alcohol misuse, childhood immunisations, TD/IPV and HPV immunisation programmes; contraception additional service - GP contract; child health Information systems; preparedness, resilience and response for health protection incidents and emergencies; and PCT support for surveillance and control of infectious disease

QOF elements	-	£164m	Not included in survey. This is taken from accounts.
Seasonal flu and pneumococal immunisation programme	£117m	£151m	The alternative estimate is drawn from accounts figures and a survey drawn from GP systems. We would have expected PCT estimates to be at least this high, since the alternative does not cover all aspects of this programme. However, the alternative estimate may still be an underestimate.
Contraception additional service GP contract	£68m	£85m	Accounts information suggest this has been slightly underestimated.
Alcohol DES	-	£3.6m	Taken from accounts as it was omitted from the survey

If all of the above alternative and additional sources are accepted, the total public health system budget would be increased by approximately £600m, entirely in functions due to transfer to the NHS Commissioning Board (this corresponds to the £168m (QoF elements and alcohol DES) and £430m alternative sources cited in paragraph 1.14). These adjustments therefore do not affect the breakdown of PCT spend and no compensating adjustment has been made to CCG or NHSCB-focused returns.

Abortion, sterilisation and vasectomy services

Spend on abortion, sterilisation and vasectomy services was not separately identified in the returns but was part of a broader category. At the time of the collection they were proposed to be part of LA responsibilities. They are now expected to be part of CCG's responsibilities.

An estimate of spend on these services was made by multiplying activity levels by the most appropriate payment by result national tariffs. The national tariffs exclude the market forces factor for unavoidable costs due to location so the MFF for each PCT was also included.

Since the collection from PCTs, expenditure in the returns for preparedness, resilience and response for health protection incidents and emergencies, and part of the expenditure for PCT support for surveillance and control of infectious diseases has been included in the local authority figures. In the collection from PCTs they were not assigned to a future commissioning route as this was not known at the time.

Administration spend
So far we have concentrated on total outturn, ie, programme plus administration, as this will be the basis of grants to LAs. Feedback from PCTs suggests that there is a significant risk of misallocation of estimated spend between programme and administration in the collection. Our estimates of the breakdown of PCT spend therefore rely on other work mapping PCT functions and the resources they deploy on those functions.

Annex C: Technical adjustments to NHSCB and CCG focused returns

The estimated 2010-11 baseline expenditure for GP practices, and hence CCGs, needs to reflect PCT 2010-11 expenditure under a hypothetical situation that the PCT was in financial balance: a situation where there was no difference between the surplus/deficit at the end of 2009-10 and the end of 2010-11, and similarly no difference between the lodgements at the end of 2009-10 and the end of 2010-11.

PCTs were asked to submit data on this basis (i.e. corrected for surplus/deficit and lodgements) in September 2011. Due to difficulties with the guidance the corrections were not made uniformly or correctly by all PCTs. Therefore, in November 2011 SHAs were asked to resubmit or confirm data on surplus/deficit and lodgements for PCTs in their areas.

If a PCT runs an increase in its surplus (or decrease in its deficit) from the start to the end of the financial year, then its expenditure on health care services needs to be adjusted upwards (i.e. the value of the increase in surplus needs to be added to net expenditure). Similar logic applies to the changes in lodgements with the SHA. Correspondingly, if a PCT had a higher deficit at the end of the year than at the start of the financial year, the PCT should have scaled down spend. In order to assure the data was correctly adjusted a number of steps were taken.

Quality Assurance using accounts
We have compared the total net surplus/deficit reported in the collection with information from PCT accounts information collated by DH. There were many significant differences. In some cases there are good reasons for the differences, since part of the net surplus may have been attributed to activities not covered in the collection, such as primary care; but this factor is unlikely to explain the scale of many of the differences. This led us to request additional verifying information from SHAs.

Re-submission or confirmation of deficit/surplus and lodgements position
SHAs were asked to re-submit or confirm data on surplus/deficit and lodgements for PCTs in their areas. Where the subsequent collection suggests that this correction has not been applied in the way we anticipated a correction has been made. In cases where the sign of the correction was incorrect, this adjustment can be significant.

Adjustments to the data
Where the original deficit/surplus and lodgements corrections were either of the wrong sign or magnitude and / or no apportionment was made across expenditure categories and a number of steps were taken in different cases:

- removing the original PCT correction from the expenditure returns
- re-applying a proportion of the re-submitted correction, based on the proportion of the total PCT primary and secondary care expenditure covered by the returns (compared to the totals in accounts)
- re-apportioning the estimates of the relevant categories of spend to each GP practice, within a PCT, proportionately to the estimates of GP expenditure originally submitted by PCTs in September 2011.

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Improving Health & Wellbeing in York

Our joint strategy 2013-16

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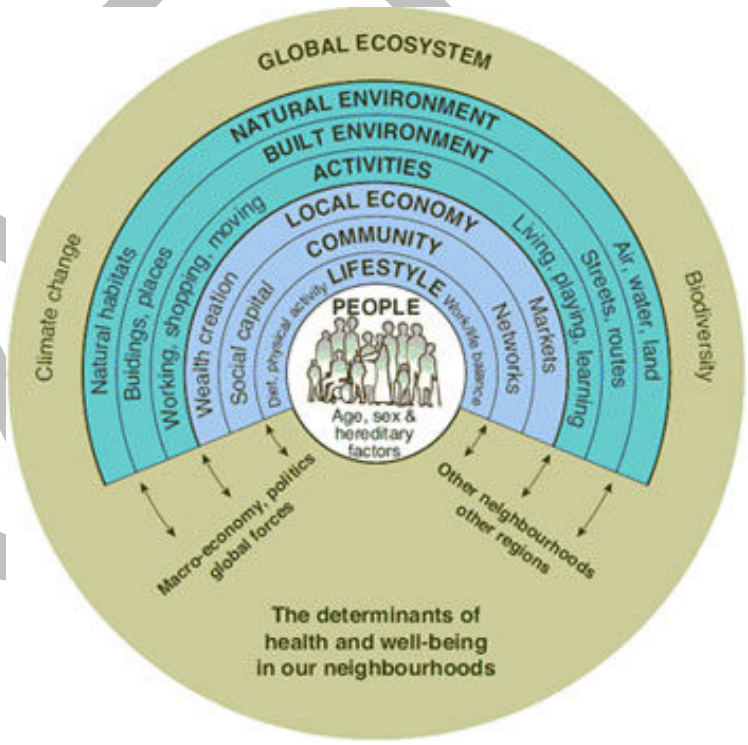
Foreword from the Chair of York's Health & Wellbeing Board

[To add for final version, including brief explanation of the Board]

Introduction and context

On the whole, people in York have a good standard of life. As residents, most of us can expect to be well educated, have access to good quality employment and, for the most part, live long, healthy and happy lives. However, this is not true for everyone, and there are still significant health and wellbeing challenges for the City including the significant differences in life expectancy between different some areas of the City and others, the growing needs of our ageing population and particular challenges around mental health and emotional wellbeing. Based on our understanding of the needs in York[1], this document sets out what we believe the priorities are for improving residents' health and wellbeing, and together, as key organisations and as a whole City, what we will do in practice to deliver these priorities.

Health and wellbeing is about more than illness and treatment. It is about being well physically, mentally and socially – feeling good and being able to do the things we need to do to live a healthy and fulfilled life. Many factors can affect this; for example, where we live, the surrounding environment, our income, how we interact with our local community and the lifestyle choices we make, all impact upon the level of our health and wellbeing (see diagram, right). It is therefore vital that we look not only at tackling the effects of ill health and wellbeing, but get in there early through addressing the wider causes, as well as championing good health and wellbeing.



Local authorities throughout the country are developing a Health and Wellbeing Strategy this year. In York we want to seize this opportunity and collaborate to develop a strategy that is both ambitious and meaningful, that is honest about the significant challenges we face but also affirms our commitment to pursuing what we believe is important. It should resonate with residents, affect what we do as organisations and ultimately, if indirectly, make a genuine difference to people in York.

[1] See Health & Wellbeing Needs in York: A Joint Strategic Needs Assessment

How have we developed our priorities and actions? What have we considered in making these decisions?

Our priorities and actions are the result of a combination of factors. The diagram below attempts to illustrate some of the most significant ones:

Our report, **Health and Wellbeing in York, Joint Strategic Needs Assessment 2012** (JSNA) was a comprehensive assessment of the health and wellbeing needs in the City. Our understanding of need is a foundational building block for deciding what we will do, so this has played a large in defining our principles and actions, and you will find evidence from this assessment scattered within each of the priority sections. The four main themes emerging from our JSNA were that:

- Our population is ageing and will place increasing demands on health and social care services
- Health and wellbeing inequalities exist in the city and must be tackled
- We need to know more about the mental health needs of our population

- We must intervene early and give children and young people the best possible start in life

As we know, these are very difficult economic times. Councils, health services and independent and voluntary sectors are facing tough decisions about how best use ever-decreasing funding and resource. An **Independent Review of Health Services in North Yorkshire and York** was published in 2011. It highlighted the precarious financial position of North Yorkshire & York Primary Care Trust which was overspending by several million pounds every year[2] and the additional efficiency savings required to meet the increased demand for services. The review made recommendations about how Health Services in North Yorkshire and York could manage this and operate within a sustainable financial framework while continuing to meet the health needs of the area. This document affirms and builds on the recommendations in the Review.

We also want to learn from **successful interventions and national research** relevant to the challenges we face in York. The report "Fair Society, Healthy Lives" (The Marmot Report) is extremely influential in developing an evidence-based approach to addressing the social determinants of health here in York. The report illustrates the relationships between social and economic status, poor health, educational attainment, employment, income, quality of neighbourhood and a variety of other measures accumulate throughout life. We fully support and commit to this holistic approach to tackling inequality and providing support across the life course.

Finally, and perhaps most importantly, in identifying what we should our priorities are and what we will do **we have listened to the experts within our City: our residents, community groups, frontline staff, management teams, elected Members and commissioners and provider across all sectors**. Over a number of months, we have asked what they felt would make the biggest difference to improve health and wellbeing in York and help us to achieve our priorities. 200 people were involved in discussing this using a variety of methods, from online questionnaires, to group workshops or one-to-one meetings. As a direct result of this input, suggested principles and actions have been developed. The Health & Wellbeing Board considered these suggested principles and actions and have indicated what they may want to commit to over the life of this strategy. These views have now been incorporated into this draft strategy.

[2] this annual overspend now falls to the Vale of York Clinical Commissioning Group to address

Our Vision

Our vision is for York to be a community where all residents enjoy long, healthy and independent lives, by ensuring that everyone is able to make healthy choices and, when they need it, have easy access to responsive health and social care services which they have helped to shape.

What will we do to achieve our vision?

To achieve our vision we will do many things, for many people, in different ways, through a number of organisations and approaches. However, we want to avoid the pitfalls of trying to take action on everything at once. Our strategy is not a long list of everything that might be done it instead focuses on key issues and actions that we can do together, which will make the biggest difference.

Although our strategy does not address every health and wellbeing related issue, that does not mean we will not continue to work to address them. We will, for example, still continue to strive towards providing excellent joined-up and personalised support for people with learning difficulties, to improve air quality through sustainable transport programmes, to champion the vital work of unpaid carers and to provide employment opportunities for those with long-term disabilities. However, so we can make a real difference, we will focus on a smaller number of issues that we believe are the most important to address at this current time. We want to develop more integrated approaches to benefit our residents' health and wellbeing, by working together better. We cannot achieve our priorities alone as separate organisations, we have to work together and do this better.

We have therefore agreed the following priorities, which will direct our strategy to improve health and wellbeing in York.

1. **Making York a great place for older people to live**
2. **Reducing health inequality**
3. **Improving mental health and intervening early**
4. **Enabling all children and young people to have the best start in life**
5. **Creating a financially sustainable local health and wellbeing system**

This strategy will explain the priority areas in more detail – why they are important, what our principles are for each and what we will do to achieve them.

Making York a great place for older people to live

Why is 'making York a great place for older people to live' important?

Older people make a huge contribution to the life of our city. Older people offer a significant benefit to business as experienced and committed workers and a growing contributor financially as customers of our local economy. Older people also at the heart of families and our communities, volunteering, caring, mentoring and supporting children and young people whilst we seek to build a society for all ages.

Older people already form a significant part of our community in York. Furthermore, due to people living longer, York's over-65 population is expected to increase by about 40% by 2020 and the number of people aged over 85 years is expected to increase by 60%. A growing number of these will also be living alone.

As we get older, we become increasingly vulnerable, are more at risk of social isolation, and are more likely to have complex health problems and high health and wellbeing needs. The JSNA estimates suggest that around 1 in 10 older people experience chronic loneliness'. Adverse affects on health can include increasing self destructive habits, increased likelihood of not seeking emotional support. It can affect immune and cardiovascular systems and can result in sleeping difficulties and can also severely affect people's mental health.'

The JSNA estimates that dementia will affect an additional 700 people in York within the next 15 years. Given the population projections and the increased incidence of dementia with increasing age, planning for potential need would be an appropriate strategy.

This means that there are ever increasing demands on health and social care services in York, and at a point when overall budgets are diminishing. If nothing is changed, the current system of support will quickly become vastly unaffordable. The JSNA specifically recommends that we provide community-based responses in responding to long term conditions and in preventing admissions to hospital and that we continue support for initiatives aimed at increasing levels of physical activity across the whole population and that priority is given to vulnerable groups.

Principles which will guide our work and resources to deliver this priority

- **Continue to respond to the needs of an increasing population of older people, ensuring strategies, plans and commissioning decisions across all partners take account of this demographic change and prioritise prevention work**. E.g. ensuring that homes and neighbourhoods are designed and adapted in a way which helps older people maintain their independence.
- **Shift the model of care away from one where people have to go to hospital, residential or nursing care to access treatment or support, to one where they can be supported in their own communities or remain at home wherever possible.** Despite patients repeatedly telling us they prefer to be treated this way, and the health and financial benefits of doing so, we do not underestimate the challenge of changing the system. A consequence of providing more treatment and care at home will be to reduce the number of beds that are needed in hospitals. We must reassure and remind people of the benefits of this approach in providing care closer to home. It will free up our hospitals to focus on providing care more efficiently to patients who require hospitals admission supported by better developed community health and social care services and thus avoid delays on discharge.

So together we will:

- Focus on making this happen, persevering at and prioritising this work
- Persist at overcoming barriers together, taking bold decisions where needed
- Trust patients and residents to understand the complex dilemmas we face and be involved in shaping solutions.

- **Support communities to develop their capacity, enabling them to address loneliness and social isolation older people may experience within their neighbourhoods.** In many ways is the best form of early intervention. For example, 10 minutes of contact a day could reduce the need for an older person needing to be admitted into hospital.
- **Recognise and promote the vital role of unpaid carers** who contribute so much to health and wellbeing in York. We will endeavour to provide support which genuinely makes carers' lives easier and lets them know we value their contribution.
- **Provide high quality care and support for people at the end of their lives and their carers,** including increasing choice and control over where people wish to die**.**
- **Jointly commission more voluntary sector services and support these interventions where there is evidence they have an impact and provide value for money.**

- **Improve the city's infrastructure so that older people have better access to social support and community services,** for example, we need good transport links so people can visit their friends and family or leisure facilities.
- **Dementia is a significant concern for older people. We will tailor our approach to working with people with dementia appropriately**, taking into account particular needs, not simply using standard pathways which may not be suitable.
- **Fully support Joseph Rowntree projects 'Dementia Without Walls' and 'Neighbourhood Approaches to Addressing Loneliness',** ensuring Health & Wellbeing Board organisations are actively responding to community need and applying the learning from these work programmes.
- **Make use of new technologies** which will help us develop creative solutions to addressing loneliness and social isolation.
- **We will support work that is already progressing**, specifically, creating state of the art facilities and accommodation for older people and increasing the take up of personalisation.

Over the next three years the Health and Wellbeing Board will:

1. **Set up Neighbourhood Care Teams across the City and explore other options which support people in their transition from hospital to home.**
   By Neighbourhood Care Teams we mean community teams which bring together NHS, local government, independent and voluntary sector providers around the 'neighbourhood' of a GP practice. The aim is to provide patient-centred, multi-disciplinary, integrated and streamlined care closer to a patient's home.
   - Specific attention should be given to embedding independent and voluntary sector organisations with these teams and ensuring there is coordination with neighbourhood working models in City of York Council.
   - They should be carefully evaluated as they are set up and if successful given long-term commitment, through pooling budgets across health and social care organisations, for example.
   - This will require de-commissioning acute provision and commissioning more community-based responses in responding to long term conditions and in preventing admissions to hospital.
   - To support this work, an Adult Commissioning Manager post should be jointly appointed between Vale of York Clinical Commissioning Group and the City of York Council, with a formal link to York Council for Voluntary Services.

2. **Develop an end of life policy across health and wellbeing partners, mapping current processes and re-commissioning.**
   - Include how those left behind should be supported as part of the policy. Ensure that GPs are supported to offer patients and their families / carers the best end of life pathway, which may mean staying at home to die peacefully.

3. **Provide weekly cross-sector case reviews for patients who have been in hospital over 100 days** *(Or other appropriate threshold)*
   - This will help identify if more effective support can be provided for these people and avoid unnecessarily long stays in hospital.
   - In order for this to be successful, staff attending meetings on behalf of organisations would need to be given the autonomy to make decisions about resource allocation and establish pragmatic solutions which work for individuals.
   - As well as using this process to provide more effective care and cheaper care for individuals, this should be used as learning environment to inform wider system change.

4. **Invest in services which support older people who are isolated to participate in the social groups or community activities that are available in York.**
   - Volunteers would support isolated individuals by accompanying them to the first few sessions of a group or activity, building up their confidence so they can participate in the longer term.
   - The promotion of these services by organisations on the Health and Wellbeing Board would enable more people to benefit from this type of support.
5. **Undertake a joint review of how medication is used and reviewed in residential and nursing care, promoting alternatives to medication where possible.**
6. **Deliver a joint communication campaign across organisations on the Health and Wellbeing Board focused on how to spot the early signs of dementia, how to respond and what support is available, and introduce specific dementia training and support for the health and wellbeing workforce.**
   - This would include having a single point of contact for the workforce to gain support and expertise to improve the care of those with dementia.
7. **Encourage care sectors to adopt the living wage and set timescales to reflect this in how we commission contracts.**
8. **Take a coordinated approach across sectors, to implement a single social prescribing programme which prescribes exercise, social activity or volunteering.**
   - This approach builds on existing programmes which recommend exercise and is recognised by health professionals.
   - Longer term we would like to embed this approach within Choose and Book.
9. **Work together to understand the factors that contribute to loneliness and what communities and organisations can do to alleviate this.**
   - Once we understand the issues and challenges and how they might we be addressed we will support the implementation of these initiatives.
10. **Develop an innovative inter-generational volunteering programme, working with the 'Volunteering York' partnership.**
11. **Develop a workforce strategy across care sectors for paid staff which supports joint workforce development initiatives.**
    - This will exemplify best practice around personalisation, showcase innovative work that has been initiated by proactive managers and help set up a paid carers providers network with opportunities for mentoring support

Reducing Health Inequality

Why is 'reducing health inequality' important?

The JSNA identifies that health inequalities are prevalent within York. The work of the Fairness Commission highlights the links between low income and poorer health outcomes.

People living in some areas of York can expect to live on average 10[3] years less than other York residents if they are male or 3.5 years less if they are female. We believe this is deeply unfair, and jars against our vision for *all* York residents to be able to enjoy long, healthy and independent lives.

There are clear links between other types of deprivation and poor health outcomes, so it is the same areas and communities where there are more people experiencing a range of issues, from substance misuse and unemployment to mental health problems and long-term health conditions.

To reduce health inequality therefore requires us to address both the causes and effects of these complex issues around deprivation in particular communities and areas of York. The JSNA recommends that we have a better understanding of how people access services, so we can ensure services are in the right place at the right time.

Smoking, alcohol use and obesity have a significant impact on the health of our residents. The JSNA recommends that established programmes aimed at reducing the smoking prevalence in York are maintained and built upon. Consideration should to be given to targeting specific groups, such as young people, pregnant women and routine and manual occupational groups.

[3] Figures rounded to nearest 0.5 years.

Principles which will guide our work and resources to deliver this priority

We will:

- Use the Marmot framework and its 6 domains as a holistic approach to reducing health inequalities across the life course.
- Consider the impact on health inequalities in every decision we make and every policy we develop, ensuring we do not widen the gap further.
- Allocate our resources to where they are needed most, particularly those areas or groups of people who suffer poorer health outcomes.
- As organisations, work in an integrated way with individuals and communities who suffer poorer health outcomes, understanding the complex and cross-cutting nature of issues relating to health inequality, many of which are rooted in wider social factors. We will endeavour to understand and address the key issue or issues which can act as a catalyst to improving broader outcomes, rather than trying to solve individual problems as separate organisations.
- Committed to supporting community based health and wellbeing programmes that work intensively with residents who experience lower health outcomes. In the longer term, we will assess the potential for community development approaches in improving health and wellbeing within neighbourhoods.
- Explore a range of options which take support and services where they are needed most, for example, more outreach work, or using the assets we have more flexibly to better meet local need.
- Take a smarter approach around communicating health and wellbeing messages with our residents. We will:
    - undertake joint campaigns across all partners
    - use our understanding of communities and individuals to target communication
    - adopt innovative marketing approaches which actively engage people
    - utilise health champions to go to places where older people are rather than expecting people always to come to us.
- We will work with and acknowledge the positive impact that existing partnerships and task groups are making in addressing health inequalities.
- Work with schools and children's centres to engage with parents, recognising the benefits of healthy food initiatives for families.
- Health and wellbeing are multi-faceted and complex concepts, therefore a range of approaches and interventions are required to address the determinants of health. This is reflected in our actions.

Over the next three years the Health and Wellbeing Board will:

1. **Invest in targeted health improvement programmes that offer bespoke interventions to our residents who experience lower health outcomes, for example, lone parents, homeless young people and care leavers.**
2. **Champion a joint approach to ameliorating complex, interlinked issues that a number of families experience in our city, through our work with troubled families.** We want to embed more health professional resource in the existing programme to support families with more specific health related issues.
3. **All organisations on the Health & Wellbeing Board will commit to timescales for implementing the Living Wage, and encourage others in the city to do the same.**
4. **Organisations on the Health and Wellbeing Board commit to running supported employment programmes within their organisations and if successful, encourage other organisations or businesses to follow.** We will also support volunteering programmes which offer that step up to employment and work which helps sustain people in employment or training. We absolutely recognise the benefits of employment and training on health and wellbeing.
5. **Invest in community based programmes which increase residents' income and/or reduce their expenditure, such as debt and benefits advice.** We support the recommendations in the Financial Inclusion Strategy and acknowledge that this work is continuing.
6. **Explore and identify opportunities where we can take services to residents who would benefit most from this support and share buildings. This includes:**

- The use of the Community Stadium as a hub for health and wellbeing and a base for outreach services, ensuring we reach people who experience lower health outcomes.
- The use of existing buildings within communities to join up, co-locate or extend services to increase flexibility and accessibility, for example, extending the range of support available from GP surgeries or using pharmacies to provide basic health checks and signposting.

7. **Undertake targeted work to investigate and address health behaviours and lifestyles in York, focused on smoking, alcohol use and obesity.**
8. **Establish a York model for tobacco control** (it is currently across both York and North Yorkshire).

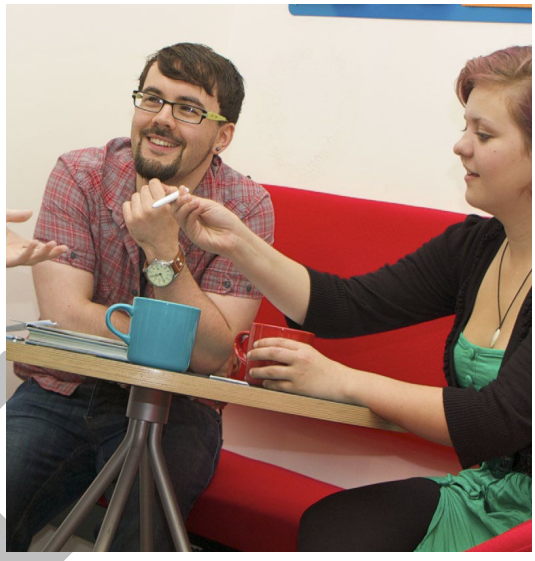
- This includes establishing a York Tobacco Alliance and implementing the NICE guidance 'Quitting smoking in pregnancy and following childbirth'.

9. **Adopt a joint approach to community development in deprived areas of York, where communities define their own issues and how they can address them.**

10. **Recruit health and wellbeing champions from within communities who experience poorer health outcomes, to signpost and offer advice.**

Improving mental health and intervening early

Why is 'improving mental health and intervening early' important?



It is estimated that at any one time there are around 25,000 York residents experiencing various kinds of mental health problems, ranging from anxiety and depression to severe and enduring conditions including dementia and schizophrenia. Furthermore, 10% of 5 to 15 year olds in York are estimated to have a diagnosable mental health disorder and, with people living longer, an increase in dementia is forecast.

Much of this can go under the radar, and we need to raise awareness and improve our understanding of the full range of mental health needs in the City.

Where possible, we want to be able to intervene early to address or prevent mental health problems and not just treat more severe conditions, as we know this is more cost-effective and better for the wellbeing of people in York.

The JSNA recommends that active consideration is given to joining up more closely the children's and adults' mental health agendas and work streams in order to support a closer focus on early intervention, prevention and transition. The JSNA also highlights the need to provide a range of comprehensive community based, early intervention support and services for individuals with mental health problems.

Housing has a significant impact on all our health and wellbeing. The JSNA specifically recommends that the housing needs of people with mental health conditions do need to be considered in the context of service planning and high quality provision.

Principles which will guide our work and resources to deliver this priority

- Seek to gain a better understanding of mental health needs in York, and the services that are currently available. We will make sure our services are fit for purpose and if necessary redesign them to better meet mental health needs locally.
- Look to raise the profile of mental health and remove the stigma attached to it.
- Ensure that when we plan services, this takes account of the mental health needs of the ageing population, with particular reference to social isolation, loneliness and the growing number of people with dementia.
- Endeavour to create supportive communities which enable good mental health; where people have regular contact with one another, friendships can be developed and people are there to support each other. This will help prevent people from developing mental health conditions or requiring services in the first place.
- Improve coordination between the broad range of mental health support available in York across sectors, and which draw from both medical and social models of health and wellbeing. Since we know that mental health conditions are often complex, long term and related to a range of factors, we will support the development of longer term support programmes and more joined-up working between services.
- Work together to join up children's and adult's mental health agendas to better support early intervention work and the transition between services.
- Support a model of early intervention and prevention where possible, providing and effectively referring to a range of alternative support (instead of medication or intensive interventions) for people with low-level mental health conditions. We acknowledge that there are different levels of mental health needs, and that different support and models of care should be used appropriately.
- Recognise that although the 'recovery model' can benefit those with mild or moderate mental health issues, there are approximately 400 people in the city with severe or enduring mental health conditions who need more intensive support.

Over the next three years the Health and Wellbeing Board will:

1. **Commit to an annual communication campaign for mental health: awareness of it, how to respond to it, and how to promote mental wellbeing.**

- As our understanding of mental health in the city increases, we can target these campaigns and work to bring in more partners from across sectors to increase their influence.

2. **Deliver a joint workforce programme for city employers for 'well at work': training for managers to increase awareness of mental health and stress.**
3. **Commission more mental health first aid training in York – either from the existing national programme or develop a local model.**
4. **Take a coordinated approach across sectors, to implement a single social prescribing programme which prescribes exercise, social activity or volunteering.**

- This approach builds on existing programmes which recommend exercise and is recognised by health professionals.
- Longer term we would like to embed this approach within Choose and Book.

5. **Introduce a Standardised Approach to Assessment (SAA) for Mental Health. All partners on the HWB agree to use the mental health recovery star for mental health recovery work.**

- This assessment could b a 'passport', following the service user to a range of services and reviews. This will avoid several different assessment tools being used every time someone uses a different service. It can be used by clinicians and non-clinicians.

6. **Across sectors, we will jointly map the support and pathways available for people with mental health conditions,** including thresholds and criteria, to identify opportunities for earlier intervention and reduced reliance on intensive support and re-commission where needed.
7. **Support schools to raise awareness of mental health to young people.**

- This includes bringing in mental health expertise to complement Personal, Health and Social Education within the curriculum and refining it so it is relevant young people's mental health issues, i.e. eating disorders and self-harm.

8. **Commission more community based support and services for individuals, especially early intervention and prevention work.**

- This includes: commissioning more counselling services and additional services to support 16-25 year olds. This will enable earlier intervention, and allow us to explore and address specific issues relating to young people moving into adulthood.

9. **Review our housing policy for people with a mental health condition, this includes looking at our housing stock options and how we can offer more flexible tenure options.**

10. **Provide a more fit for purpose Place of Safety for York and North Yorkshire.**

- We will increase multi-agency working to improve how agencies respond to those being detained under the Mental Health Act and agree a coordinated approach and policy for York.

Enabling all children and young people to have the best start in life

Early intervention and tackling inequality are the basis for enabling all children and young people to have the best start in life; there has been an increase in the number of children who are subject to formal child protection plans; an estimated 4,400 children were living in poverty in York in 2010; there is an attainment gap between children in York who are eligible to receive free school meals and those children who are not eligible.

As highlighted earlier in the document, each of our priorities will be taken forward by the designated partnership board. The YorOK partnership is developing this priority and they have set out how they will realise our ambitions through 'Dream Again', York's Strategic Plan for Children, Young People and their Families, 2013-2016

Principles which will guide our work and resources to deliver this priority

Eight ways in which we will work to help **all** children, young people and their families to live their dreams:

- **Striving for the highest standards**
  York already enjoys some of the highest educational and health outcomes of anywhere in the UK. But we are not complacent, and will continually strive for more. There should be no limits on the dreams and aspirations of any young person in York. This can only come about through positive partnerships with children, young people and their families; together with a skilled, confident and committed workforce.
- **Creating truly equal opportunities**
  We will work relentlessly to ensure that no child, young person or community is at a relative disadvantage, removing all traces of discrimination from our systems and our interactions – with a particular focus on the rising numbers of children from a BEM background, and on those questioning their sexuality. This principle is as much about celebrating the positive as it is about eliminating the negative.

- **Ensuring children and young people always feel safe**
  Safeguarding lies at the heart of all our work, as does ensuring that there are "arenas of safety" at home, at school and in the community. We will continue to make our procedures for raising concerns about a child as straightforward and as effective as possible. We will be sensitive to the possibilities of exploitation or extremism, and will continue to adopt a "zero tolerance" policy for bullying in any form.

- **Intervening early and effectively**
  We firmly believe in the principle of investing in "upstream" interventions to prevent costly "downstream" problems. This includes developing responsive mechanisms for supporting particularly vulnerable children, young people and families. It is also about programmes of public health to promote breastfeeding, exercise, healthy eating and good sexual health, whilst also preventing unwanted conceptions, and problems with drugs or alcohol.

- **Working together creatively**
  This is about working within and beyond the YorOK partnership to ensure that organisational demarcation never gets in the way of the best interests of children and young people in York. It's about sharing information, and pooling budgets, so as to develop better services. It's also about making best use of the changing organisational landscape in both education and health to promote the interests of young people.

- **Treating children as our partners: mutual respect and celebration**
  York has always prided itself on its capacity to involve young people. We need to ensure that all services continue to be fully responsive, and that young people's views are built into the design and delivery of services from the outset. We should lose no opportunity to celebrate their achievements. This principle is founded on respect for children's rights as enshrined in the UN Convention and recognition that with these rights also come responsibilities. We will continue to work closely with the Youth Council and with School Councils in this area.

- **Connecting to communities and to the rich culture of our great city**
  We need to see children as people who live within their communities and as future responsible citizens. York has such a rich heritage, and varied cultural life, and we need to ensure children and young people have multiple opportunities to connect with it. We also need to be sensitive to the fact that different communities have very different needs and aspirations, and that for some people their "community" may be their local area, whereas for others, it may have more to do with cultural identity.

- **Remembering that laughter and happiness are also important**
  It would negate the purpose of this principle to expand upon it further!

In addition, there are five specific priorities, based on evidence about where extra help is needed

- **Helping all York children enjoy a wonderful family life**
  We have always recognised that children are best brought up in their own family, however that is composed. Where that is not safely possible, we will seek always to ensure that high quality local alternative family settings are available. So we need to ensure we give extra help to any family experiencing particular difficulties, and to continue to support foster families, adoptive parents, and those parents who may be vulnerable in some way (including parents with learning difficulties).

- **Supporting those who need extra help**
  We already have evidence of differences in educational and health outcomes for looked after children compared with their peers and – despite some progress – in the attainment of pupils eligible for free school meals or the pupil premium. We also have concerns about the outcomes for young people from the traveller community and for young carers. Finally, we need to do more to help young people with a learning difficulty or disability to find employment after school or university. For all these groups, we need imaginative programmes of support and challenge.

- **Promoting good mental health**
  We need to do more work to understand the possible dimensions of the issue here, ie, what is actually needed, and to deliver a range of sensitive and professional services to support young people who have mental health issues. Young people are particularly keen for us to help to remove the stigma around poor mental health.

- **Reaching further: links to a strong economy**
  There are two particular areas where the needs of young people interact with the economic health of the city: child poverty, and young people not in education, training or employment (NEET). We need to expand our multi-agency, multi-faceted programme to tackle child poverty and to increase the number of apprenticeships across the city. The raising of the "participation age" during the lifetime of the plan will appear to have removed the problem of "NEET" young people under 18, but as a partnership, YorOK is just as concerned about young adults aged 18-25 who are without work or purposeful activity. We need to help all young people to be "work ready" and to encourage and support young entrepreneurs.

- **Planning well in a changing world**
  This priority recognises some particular uncertainties that we know we are going to have to face in the next plan period, for which we need to plan effectively. These include falling demand for secondary school places and, conversely, rising demand at primary level. We also face unprecedented pressures on our budgets, putting an added premium on ensuring that we spend every penny wisely and that we work together imaginatively to ensure that the total impact of our combined budgets is greater than

the sum of the parts. But there are also positives – the health reforms, and the changes to the education system, represent opportunities we should seize.

Cross-cutting Proposals

In addition to proposals under each of the priority areas, there are a number of proposals which, through taking a joint approach across all partners and needs, will make an impact all each of our priorities.

A key recommendation throughout the JSNA is that data collection is improved across the agreed priority areas within the Joint Health and Wellbeing Strategy. This will inform and influence how services are provided in the future, where from and for who, increasing the impact of what we commission and provide.

Over the next three years the Health and Wellbeing Board will:

1. **Undertake further research to share intelligence and get more of an insight into the health and wellbeing of those with the poorest health outcomes.**

- We need to increase our understanding of the following groups: looked after children, young people who leave care, carers including young carers, people who have disabilities, people with mental health needs, older people, offenders and people who misuse substances.

2. **Create a shared resource collating existing health and wellbeing information, joining up directories for activities / services / organisations in York, and designing appropriate ways of using this which is fit for purpose and user-friendly.**
3. **Create a health and wellbeing passport which is recognised by and used across all partners and sectors and integrate work around specific health passports. This is also relevant to the board's commitment to developing an end of life policy.**
4. **Deliver a joint workforce development programme across frontline staff of all partner organisations to 'Make Every Contact Count' and encouraging them to 'ask the next question', maximising opportunities to influence broader health and wellbeing outcomes.**
5. **Commission a joint engagement strategy to influence and coordinate our work between organisations across our five priorities.**

- This will enable us to engage with our residents and communities and individuals who use our services in the longer term.

6. **Create a joint campaigns plan, coordinating citywide health and wellbeing campaigns which often occur separately through individual organisations.**

- The proposal is to run a smaller number of more intensive campaigns that are coherent, coordinated, and focused on a significant issue related to our strategy. This will avoid disjointed messages and communication.

Creating a financially sustainable local health and wellbeing system

Why is 'creating a financially sustainable local health and wellbeing system' important?

In order to provide the services we do, and support the health and wellbeing of residents in York both in the short and long term, it is vital that we are able to do this effectively within the financial constraints we have.

Significantly reduced and further reducing public sector budgets, financially challenging times for individuals and increasing demands for a range of health and wellbeing services create a perfect storm for the health and wellbeing system in York to contend with. Taking into account increased demand, it is estimated that budget savings of around 20% will be required across health and local government by 2020.[4] To simply continue what we are doing, let alone additionally investing in our priorities or to make long-term savings, would be a major challenge.

All this, coupled with the urgent need to re-balance the York & North Yorkshire health system which is spending more than is available year on year, make this is a pivotal time to create a system which costs less overall but continues to provide excellent care, treatment, support and opportunities for our residents.

Nevertheless, we must remind ourselves that despite the challenges, there are still hundreds of millions of pounds across sectors to support and improve the health and wellbeing of individuals and communities in York – it is our responsibility to maximise what we do with this and invest it wisely.

[4] LGA Funding Outlook for Councils, 2012; King's Fund, 2011

Principles which will guide our work to deliver this priority

We will:

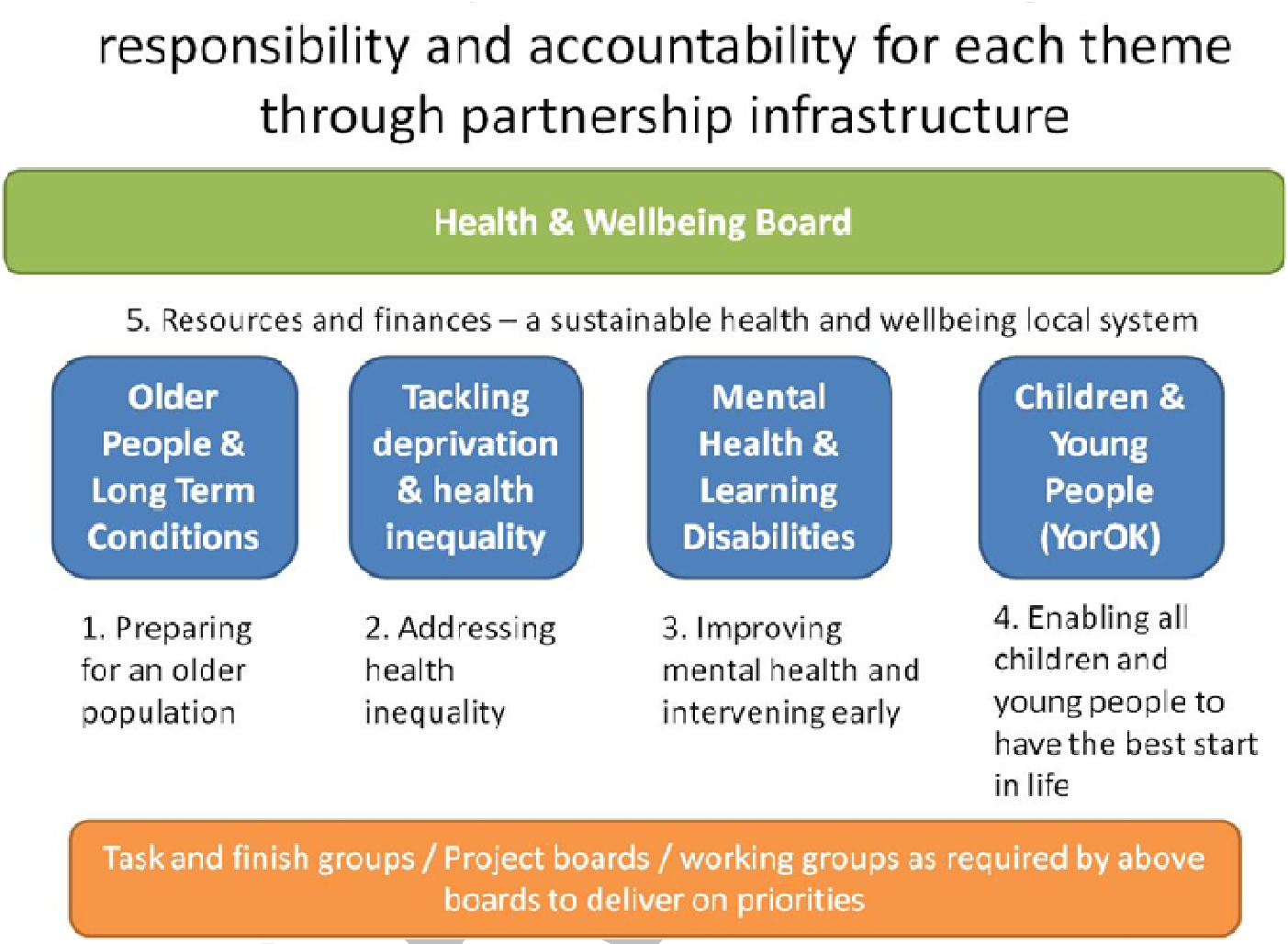
- **As the Health & Wellbeing Board, take ownership for the financial position of the whole health and wellbeing system in York, rather than the performance of individual organisations**. We will ensure we are investing in services that we know will have the biggest impact. We need to be aware of both the intended and unintended consequences of funding decisions we make and the impact of any subsequent service change. To help us make these decisions we will take a joint approach to budget consultation with residents and endeavour to communicate consistently about the overall financial position.
- **Maximise efficiencies between adult social care and health through jointly planning care pathways across sectors and integrating commissioning decisions more closely.** Where appropriate, we will explore opportunities for joint commissioning posts, pooled budgets or lead commissioning arrangements between City of York Council and Vale of York Clinical Commissioning Group to support this more integrated approach.
- **We will prioritise system change around care pathways for older people which are the most significant cost pressures and opportunities.** This will address a major strain and will release pressure on services so they are able to function better across the board, benefitting all our residents.
- **Shift the model of care away from one where people have to go to hospital, residential or nursing care to access treatment or support, to one where they are supported in their own communities or remain at home wherever possible and .**

  A consequence of providing more treatment and care at home will be to reduce the number of beds that are needed in hospitals and staffing and equipment costs accordingly. Patients prefer this model of care and this would also enable significant savings, avoiding reductions elsewhere. We must sensitively reassure and remind people of the benefits of this approach and the need to change. In order to make this system change, we will need to:
  - Create performance frameworks and contracts which reward this more financially sustainable model of care, and share risk appropriately
  - Commission primary, community and social care in a way where there is sufficient capacity to effectively support people closer to home who would have traditionally required hospital services. We will commission the best services possible, with openness to the possibility that this may not be from statutory providers.
  - Encourage the reduction of hospital referrals through GPs and nursing homes, highlighting other, more fit for purpose services, to refer on to.
  - Promote and encourage self-care where appropriate.
  - Be open with the public about the need for change, educating them in dilemmas we together face and trusting them to make decisions which benefit the whole population. We will work closely with local media, encouraging them act with social responsibility, to avoid publicity which could derail this collaborative approach.

- **Urge Central Government to adopt its plans for a financially sustainable model for paying for adult social care without delay.**
- **Allocate our resources to where they are needed most, particularly those areas or groups of people who suffer poorer health outcomes.**
- **Have a two-pronged approach to reviewing finance and resources – a whole system view but also assessing the effectiveness of our services on a case by case basis. This will give us more flexibility in allocating resource where it is needed and resolving cases where people are 'stuck in the system'.**
- **Maximise internal efficiencies through vacancy management and efficiency programmes across the Council and NHS.**
- **Take a shared approach to assets such as buildings and vehicles, maximising their use between partners, and selling or putting to other use assets we don't need as a result.**
- **Maximise the use of voluntary sector services where they provide excellent value for money and results.** We will stimulate a stronger market by supporting voluntary sectors organisations to work together or scale up to bid for larger contracts. We will tender contracts to enable voluntary sector organisations to be competitive against larger statutory or independent providers.
- **Trust patients and residents to understand the complex dilemmas we face and allow them to shape solutions, for example, through the Expert Patient Programme.**

6.

Delivering and monitoring the Strategy



There are 4 strategic delivery boards reporting to the York's Health and Wellbeing Board as illustrated above. While not the totality of their remit or work, these boards will take responsibility for delivering the various actions in the this strategy relating to their work area, which have been developed through consultation with various stakeholders including many members of the Boards themselves. It will be the responsibility of these boards to determine how each action will be taken forward in practice, with some actions perhaps requiring further scoping or definition. As part of their role, they will also consider other work required to meet the principles set out within this strategy, and establish a suitable joint performance framework to evaluate success.

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Health Overview & Scrutiny Committee Work Plan 2012/2013

Meeting Date	Work Programme
24th October 2012	1. **Verbal Item** - Attendance of NHS North Yorkshire, York Teaching Hospital NHS Foundation Trust & York and Vale of York Clinical Commissioning Group – Financial Status and Handover Process 2. Update on changes to the Urgent Care Unit at York Hospital 3. Transition Update 4. Workplan for 2012-13
27th November 2012	1. Final Report of End of Life Care Review 2. Verbal Report from Leeds & York Partnership NHS Foundation Trust (Mental Health Services) 3. Update Report on Proposed Changes to Children's Cardiac Services and Formation of a Joint Health Overview and Scrutiny Committee to respond to A National Consultation on Adult Cardiology Services 4. Update on Yorkshire Ambulance Service Patient Transport Services 5. Report from PCT – Merger of GP Surgeries 6. Workplan for 2012-13

19th December 2012	1. Results of Consultation on Closure of Mill Lodge (CCG, PCT, CYC to attend) 2. Health Watch Procurement Monitoring Report 3. Second Quarter CYC Finance & Performance Monitoring Report 4. Update on the Recent Review of Services for Homeless Patients at Monkgate Health Centre 5. The Local Account for Adult Social Care 6. Safeguarding Assurance report (to include care home monitoring and CQC Reports Summary) 7. Update Report on the Carer's Strategy and Update on the implementation of outstanding recommendations arising from the Carer's Scrutiny Review 8. Scoping Report – Personalisation Review 9. Workplan for 2012-13
16th January 2013	1. Health Watch Procurement Monitoring Report 2. Update on the North Yorkshire Review 3. Update on Implementation of the NHS 111 Service 4. Update from Leeds & York Partnership NHS Foundation Trust (Access to Talking Therapies/Improving Access to Psychological Therapy(IAPT)) 5. Scoping Report – Review into Community Mental Health Services in Care of Adolescents (particularly boys) 6. Workplan for 2012-13

20th February 2013	1. Health Watch Procurement Monitoring Report 2. Workplan for 2012-13
13th March 2013	1. Health Watch Procurement Monitoring Report 2. Third Quarter CYC Finance & Performance Monitoring Report 3. Workplan for 2012-13
24th April 2013	1. Health Watch Procurement Monitoring Report 2. Workplan for 2012-13

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