SHADOW HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

21st November 2011

at 2.00 p.m.

in Committee Room 'B'

MEMBERS: SHADOW HEALTH AND WELLBEING BOARD

Voting Members (statutory members)
Directly Elected Mayor, Executive Members of the Local Authority, Chief Executive of Local Authority, Representative of Clinical Commissioning Group, Chief Executive/Director of the PCT (transitional arrangements until 2013), Director of Public Health, Director of Child and Adult Social Services, HealthWatch Board Member, Representative of the NHS Commissioning Board, Patient Representative.
Non-Voting Members (non-statutory members)
Director of Regeneration and Neighbourhoods, North Tees and Hartlepool NHS Foundation Trust, Tees Esk and Wear Valley NHS Trust, Voluntary Sector Representative(s), North East Ambulance NHS Trust.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST**

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 10th October 2011

4. **MATTERS ARISING FROM MINUTES**

   4.1 Composition of Board – Verbal Update
   4.2 Member Development Needs – Verbal Update
   4.3 HealthWatch – Key Messages (*attached)*
   4.4 Association of North East Councils – Improving Health Task and Finish Group Report (*attached)*
   4.5 Future Meeting Dates (*attached)*

5. **ITEM FOR INFORMATION**

5.1 Operating Principles for Health and Wellbeing Board (*attached)*

6. **ITEMS REQUIRING DECISION**

6.1 Appointment of Vice-Chair
6.2 Update of Public Health Transition – Verbal Update
6.3 NHS Cold Weather Plan for England 2011/2012 – Protecting Health and Reducing Harm from Severe Cold (*attached)*
6.4 Framework – Draft Joint Health and Wellbeing Strategy (*Speciality Registrar in Public Health, NHS Tees) (attached)*

7. ITEM FOR DISCUSSION

7.1 Immunisation – Presentation by Paul Davidson, Director of Health Protection Agency, followed by Discussion.

6. ANY OTHER BUSINESS

SHADOW HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

10th October 2011

The meeting commenced at 2.00 pm in the Civic Centre, Hartlepool

Present:

The Mayor, Stuart Drummond - In the Chair

Statutory Members

Councillors: Robbie Payne (Deputy Mayor) (Finance and Procurement Portfolio Holder),
Gerard Hall (Adult and Public Health Services Portfolio Holder).
Cath Hill (Culture, Leisure and Tourism Portfolio Holder),
Hilary Thompson (Performance Portfolio Holder),

Jill Harrison, Assistant Director, Adult Social Care
Caroline O'Neill, Assistant Director, Performance and Achievement
Louise Wallace, Assistant Director, Health Improvement
Stephen Childs, Chief Executive, NHS Hartlepool
Christopher Akers-Belcher, Hartlepool LINK Co-ordinator
Margaret Wrenn, Hartlepool LINK Chair
Alison Wilson, Director of Commissioning and System Development, representing Clinical Commissioning Group.

Non Statutory Members: -

Carole Langrick, Deputy Chief Exec, North Tees and Hartlepool NHS Foundation Trust
Keith Bayley, Hartlepool Voluntary Development Agency
Dave Stubbs, Director of Regeneration and Neighbourhoods

Also Present:-

David Brown, Director of Operations as substitute for Martin Barkley, representing Tees, Esk and Wear Valley NHS Trust
Rachel Lonsdale, Business Planning and Performance Manager as substitute for Simon Featherstone, representing North East Ambulance Service

Councillors Cook, James, A Marshall, Richardson and Wells

Officers:
Sarah Bowman, Speciality Registrar Public Health, NHS Tees

Catherine Frank, Partnerships Manager
Amanda Whitaker, Democratic Services Team Manager

1. Apologies for Absence

Councillor Jonathan Brash (Housing and Transition Portfolio Holder), Chris Councillor Hargreaves (Transport and Neighbourhoods Portfolio Holder), Councillor Jackson (Regeneration and Economic Development and Skills Portfolio Holder), Councillor Simmons (Children's Services Portfolio Holder), Nicola Bailey, Acting Chief Executive, Martin Barkley, Chief Exec, Tees and Esk Valley NHS Trust, Simon Featherstone, Chief Exec, North East Ambulance Service, Dr Posmyk, Clinical Commissioning Group

2. Declarations of interest by Members

None

3. Minutes

None

4. Terms of Reference (*Assistant Director of Public Health)*)

The report set out the proposed Terms of Reference for the Shadow Health and Wellbeing Board. The introduction of the Shadow Health & Wellbeing Board had been agreed by Cabinet on 15th August 2011. In order to outline the structure, remit, membership and operation of the Board, a Terms of Reference had been prepared and was appended to the report for the Shadow Board's consideration.

The Mayor highlighted that it was necessary to elect the Vice-Chair of the Board. The Vice-Chair would be a representative of a different organisation than the Chair. The Mayor suggested, therefore, that partner organisations may wish to give this appointment some consideration in order that the appointment could be made at the next meeting of the Board.

Members referred to the composition of the Board and were keen to have the Board 'more balanced' in terms of representation. It was agreed that this should be considered in advance of the next meeting of the Board.

Decision

(i)The Terms of Reference, as appended to the report, were agreed.
(ii) That the appointment of the Vice-Chair be considered at the next meeting of the Board, together with the outcome of considerations regarding the composition of the Board.

5. Governance and Reporting Arrangements – Outcome of LSP Review, Children's Trust Boards Discussions and Safer Hartlepool Partnership

(*Assistant Chief Executive*)

The report summarised the recently agreed changes to Partnership arrangements in Hartlepool and outlined the links to this Shadow Health & Wellbeing Board. A review of partnership arrangements had been initiated by Hartlepool Borough Council's Cabinet following approval of the budget for 2011/12. Following wide consultation a new approach had been agreed by the Cabinet in July 2011 and this had seen a number of significant changes to the Partnership structure. The new partnership structure had been circulated, The report summarised the new structure and provided detail on the Strategic Partners Group, the Face the public events and the theme groups.

Board Members were requested to consider the following:-

- The Board's role within the Strategic Partners Group and the opportunity it presents for the discussion of strategic and cross-cutting issues that are important to the Borough.
- How the Board will utilise its Face the Public Event to engage with Ward Councillors, Neighbourhood Voices, members of special interest groups, the general public and the Voluntary and Community Sector.
- The links the Board needs to make and maintain with the other theme groups particularly on the SHP Team around the Household approach.
- The role of groups supporting the Board including the Children's Partnership.

Following presentation of the report, a Board Member referred to the positive and unique opportunities that the Board had to lead the way and influence in terms of public engagement on wider determinants on health.

It was highlighted also that in respect of strategic partners group, another key partner would be HealthWatch and it was agreed that their role on the group would be considered.

Decision

The report was noted.

6. Presentations by Partner's Organisation Update and Priorities

Presentations were made as follows:-

- Local Authority – presentation by Stuart Drummond, Elected Mayor

- Clinical Commissioning Group – presentation by Ali Wilson, Director of Commissioning & System Development (North)
- Public Health – presentation by Louise Wallace, Assistant Director, Health Improvement
- NHS Providers – presentation by Carole Langrick, Deputy Chief Executive
- Health Watch – Jill Harrison, Assistant Director, introduced a briefing note had been circulated which outlined the proposals by government to replace the Local Involvement Network with a local HealthWatch. Christopher Akers-Belcher, LINK Co-ordinator then provided further details in terms of moving forward and requested that prior to the next meeting a copy of the document he had prepared, on how HealthWatch would fit into structure, be circulated to Members of the Board.

Following the presentations, there was an opportunity to discuss and raise questions on issues arising from the presentations. During those discussions, Ali Wilson and Stephen Childs clarified that it was not yet certain how appointments of lay members on the Governing Body would be facilitated.

Decision

(i) That there would be an opportunity at the next meeting of the Board for presentations by other NHS Providers.

(ii) That prior to the next meeting of the Board, a copy of the HealthWatch document be circulated to all Board Members, together with copies of the presentations made by Partner Organisations.

7. Presentation on Joint Strategic Needs Assessment

The Assistant Director, Health Improvement advised Board Members that the Joint Strategic Needs Assessment brought together councils, NHS and other partners to develop common priorities for the improvement of local health and wellbeing. The process of undertaking the JSNA encouraged partners to work together to generate a shared picture of local needs, and then design systematic interventions that would meet these needs and produce better outcomes for local health.

The Assistant Director outlined the process of the review and gave a presentation highlighting the new web based JSNA. The JSNA would be managed through this Board.

Board Members sought clarification on the role of this Board, the timescale for completion of the JSNA and its utilisation by individual agencies.

Decision

The presentation was noted.

8. Proposed Process for developing Health and Well Being Strategy (*Speciality Registrar in Public Health, NHS Tees*)

The report proposed the process and set out the background in respect of developing the Hartlepool Joint Health and Wellbeing Strategy (JHWS). The Health and Social Care Bill (2011) currently established Health and Wellbeing Boards as statutory bodies responsible for encouraging integrated working and developing a Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy for their area.

In terms of timescales, the Board would need to carry out the JSNA, develop the Joint Health and Wellbeing Strategy and link these to commissioning plans in advance of Clinical Commissioning Groups (CCGs) and local authorities obtaining NHS commissioning and public health allocations from April 2013. CCGs are charged with developing and submitting their commissioning plans by December 2011. JSNAs are currently under development, with a deadline of March 2012 for JSNAs in all Tees locality. Therefore, the JHWS will be developed in parallel with the JSNA and CCG plans but should also evolve to incorporate the findings of these parallel processes.

It was noted that the process of Strategy development will need to be considered by the Board, including identifying:

- Strategy coordinator / author
- Key partners and communication channels
- Responsibility and process for high-level action planning, delivery, monitoring and Strategy launch, review / refresh

It was considered that it could also be helpful to review other strategies in early implementer sites and learn from their approach. A framework which could be helpful in considering the process of strategy development was set out in the report.

Concern was expressed in relation to the JSNA focussing on health and wellbeing when there were so many other aspects which should be considered. Reference was made to the potential implications of the health premium and it was highlighted that there would be a difficult balance for the Board to achieve. It has highlighted also that the Board needed to be clear on its outcomes and it was questioned whether that issue needed to be strengthened in the document.

The Mayor concluded discussions by referring to the work which was being undertaken by other partnerships and urged some caution that work was not being duplicated or taking a different direction to the work being undertaken by those partnerships.

Decision

The Board noted the suggested approach for developing the Joint Health and Wellbeing Strategy for Hartlepool.

9. Work Programme for the Board

In respect of the future work programme for the Board, Members wanted to maximise the work of the Board leading up to 2013. By way of an example, it was highlighted that Hartlepool had issues relating to immunisation rates and that all partners could contribute towards addressing those issues to ensure a collective impact which could be measured.

It was suggested also that each meeting of the Board be dedicated to one issue, whilst at the same time considering other issues previously highlighted including the development of a Strategy.

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10. Board Members Development Plan

With reference to a Development Plan for Board Members, it was suggested that consideration could be given to how the Board 'fitted into bigger picture' and where Board Members fitted in national context.

Board Members were advised that the Association of North East Councils had proposed a work programme which would be resourced regionally.

Decision

(i) That details of the work programme proposed by the Association of North East Councils be circulated to Board Members prior to the next meeting of the Board.
(ii) That Board Members give further consideration to the issue of their Development Plan.

11. Schedule of Future Meetings

This item was not considered by the Board.

The meeting concluded at 3.30 p.m.

CHAIR

HEALTHWATCH - KEY MESSAGES

HealthWatch in general

- Subject to the parliamentary passage of the Health and Social Care Bill, HealthWatch will be the new consumer champion for both health and adult social care
- It will exist in two distinct forms – Local HealthWatch, at local level, and HealthWatch England, at national level
- The duty to involve the public in the planning and development of health services, as set out in section 242 of the NHS Act, remains as before
- Updates on HealthWatch developments can be found on the DH website, LINks Exchange (www.lx.nhs.uk) and the CQC website
- People can engage in the development of HealthWatch through its online community by contacting healthwatch@nunwood.com

Local HealthWatch

What is it?

- Subject to the parliamentary passage of the Health and Social Care Bill, Local HealthWatch will be established in October 2012. Until then Local Involvement Networks (LINks) will continue to operate as usual
- A Local HealthWatch will be an independent organisation, able to employ its own staff and volunteers, so it can become the influential and effective voice of the public. It will have to keep accounts and make its annual reports available to the public
- The aim of Local HealthWatch will be to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality

What will it do?

- Local HealthWatch will have a seat on the new health and wellbeing boards, ensuring that the views and experiences of patients, carers and other service users are taken into account when local needs assessments and strategies are prepared, such as the Joint Strategic Needs Assessment (JSNA) and the authorisation of Clinical Commissioning Groups. This will ensure that Local HealthWatch has a role in promoting public health, health improvements and in tackling health inequalities
- Local HealthWatch will enable people to share their views and concerns about their local health and social care services and understand that their contribution will help build a picture of where services are doing well and where they can be improved
- Local HealthWatch will be able to alert HealthWatch England to concerns about specific care providers

- Local HealthWatch will provide people with information about what to do when things go wrong; this includes either signposting people to, or providing, advocacy for people who want to complain about NHS services

- Some signposting is currently provided by Primary Care Trusts (PCTs), as part of their Patient Advice and Liaison Services (PALS) responsibilities. Local HealthWatch will provide, or signpost people to, information about local health and care services and how to access them

- Local HealthWatch will provide authoritative, evidence-based feedback to organisations responsible for commissioning or delivering local health and social care services

- Local HealthWatch can help Clinical Commissioning Groups to make sure that services really are designed to meet citizens' needs

- Local HealthWatch will have to be inclusive and reflect the diversity of the community it serves. There is an explicit requirement in the Health & Social Care Bill that Local HealthWatch membership must be representative of local people and different users of services including carers

Local HealthWatch and LINks

- Local HealthWatch will evolve from existing LINks but with additional functions and powers

- Local HealthWatch will build on the good practice of LINks, establishing relationships with local authorities, Clinical Commissioning Groups (CCGs), patient representative groups, the local voluntary and community sector and service providers to ensure it is inclusive and truly representative of the community it serves

- In March 2011, the Department of Health (DH) published the *HealthWatch Transition Plan*, the first of a series of documents for local authorities and LINks. It can be found on the DH website

- Existing LINks will be supported to build their skills and maintain momentum through Action Learning Networks – which will identify and share best practice to help all LINks perform at the level of the best

Local HealthWatch pathfinders

- In August, the Department of Health announced that 75 HealthWatch pathfinders have been selected to test different approaches to the proposed Local HealthWatch functions. These are partnerships of local authorities, LINks and other relevant organisations

- The Local HealthWatch pathfinders will explore how best to champion patients' views and experiences, promote the integration of local services and improve choice for patients through advice and access to information

The role of local authorities

- Local HealthWatch will be funded by local authorities and held to account by them for their efficiency and effectiveness

- Subject to the passage of the Health & Social Care Bill, local authorities will have to have a Local HealthWatch organisation from October 2012, but will be free to choose how they commission it to achieve best value for money for their communities

- It is expected that local authorities will work in partnership with their existing LINk, voluntary groups and community organisations when designing their approach to commissioning Local HealthWatch

- Subject to the passage of the Health & Social Care Bill, local authorities will have to provide an advocacy service to people who wish to make a complaint about their experience of NHS care from April 2013. Local authorities will be able to commission the service from any provider including Local HealthWatch and may decide to provide it under the banner of Local HealthWatch

HealthWatch England

What is it?

- Subject to the parliamentary passage of the Health and Social Care Bill, HealthWatch England will be launched in October 2012

- HealthWatch England will be a national body that enables the collective views of the people who use NHS and adult social care services to influence national policy, advice and guidance

- It will be a statutory committee of the Care Quality Commission (CQC) with a Chair who will be a non-executive director of the CQC

- HealthWatch England will have its own identity within the CQC, but be able to use the CQC's expertise and infrastructure

- HealthWatch England will be funded as part of the Department of Health's grant in aid to the CQC

What will it do?

- HealthWatch England will provide leadership, guidance and support to Local HealthWatch organisations

- HealthWatch England will provide advice to the Secretary of State, NHS Commissioning Board, Monitor and the English local authorities and they must have regard to that advice

- HealthWatch England will be able to escalate concerns about health and social care services raised by Local HealthWatch to the CQC

- There will be a requirement for the CQC to respond to advice from HealthWatch England

- HealthWatch England will have a strong principle of continuous dialogue with Local HealthWatch, keeping communication lines open and transparent. This will facilitate HealthWatch England's responsibility to provide national leadership and support

- The Secretary of State for Health will be required to consult HealthWatch England on the mandate for the NHS Commissioning Board

- HealthWatch England will be required to make an annual report to Parliament

HealthWatch engagement and consultation

- There has been widespread engagement activity in support of the Government's White Paper and subsequent Health and Social Care Bill. As HealthWatch is amongst the proposed changes, the consultation has included existing LINks, patient organisations and the wider voluntary sector. Additionally, there have been regional events throughout 2010/11 specifically to facilitate discussion about the plans for HealthWatch

- To inform the development of HealthWatch, the CQC and Department of Health (DH) have jointly established the HealthWatch programme board and its advisory group. The minutes from the meetings of both of these groups are available on the CQC website and LINks Exchange

- The HealthWatch programme board provides strategic oversight and ensures readiness for the launch of both Local HealthWatch and HealthWatch England

- The HealthWatch advisory group provides expert guidance to the programme board so it can advise Ministers on the implementation of the Government's proposals for HealthWatch. The group also works alongside DH and CQC to look at practical ways of ensuring the transition to HealthWatch runs smoothly

- The advisory group has established a number of smaller task and finish (or sub-) groups to focus on specific issues such as securing the HealthWatch identity for HealthWatch England and Local HealthWatch, establishing what a good Local HealthWatch will look like and advising on the transitional arrangements from LINks to Local HealthWatch

- The CQC has set up an online community for anyone who is interested in HealthWatch to feed in their views (registration is via HealthWatch@nunwood.com). Views gathered from the online community will inform the HealthWatch programme board and its advisory group

- A full membership list for both the HealthWatch programme board and its advisory group, including sub-groups, can be accessed via the online community.

ASSOCIATION OF NORTH EAST COUNCILS

Association of North East Councils
Improving Health Task & Finish Group Report

Asscociation of North East Councils
Improving Health Task & Finish Group Report

Introduction

1. Task & Finish Groups (T&FGs) have proved to be an important way of working for the Association. They are a means of engaging the experience and expertise of elected members across the area, helping to shape thinking and unite behind actions and activity in support of local government's role. They allow members to undertake a rapid, time-limited, in-depth and non-bureaucratic examination of some of the key issues facing councils.

2. Task & Finish Groups focus on outcomes in terms of clear recommendations for action. Typically, outcomes can include:

    - identifying scope for working across local government and with partners;
    - identifying, disseminating and building on best practice;
    - getting key stakeholders to contribute to the debate and bring an external perspective to bear on the issue;
    - developing advocacy positions;
    - recommendations targeted at local authorities, partner organisations and government; and
    - adding value and making a difference – whether in terms of reducing costs, creating efficiencies, achieving cultural change etc.

3. Each Task & Finish Group report is presented to Leaders and Elected Mayors for approval and then widely disseminated.

4. Early in 2011, Association members considered proposals to set up Task & Finish Groups in a number of areas, one of which was around the wider impacts of health in the North East – having regard to the fact that the Government was embarking on a programme of reform to the National Health Service, as summarised below. This Group – the Improving Health Task & Finish Group – was consequently established. Its remit has been to consider the NHS reforms and other relevant evidence, and to make recommendations – to the 12 member authorities, Government, NHS bodies and other partners – as to how they can take advantage of the opportunities presented by the NHS reforms to improve health outcomes for the people and communities of the North East.

5. This report explains how the Task & Finish Group approached its role, and goes on to set out the Group's findings and recommendations.

Background - the NHS reforms

6. Reforming the NHS has been a significant – and sometimes controversial – element of the coalition Government's legislative programme. The Government's proposals are set out in a number of documents including:

    - two White Papers: *'Equity and Excellence: Liberating the NHS'* (July 2010) and *'Healthy Lives, Healthy People: our strategy for public health in England'* (November 2010);
    - a number of consultation papers on specific aspects of the above;
    - the Health and Social Care Bill, introduced into Parliament in January 2011; and
    - the Government's response to the report of the NHS Future Forum (June 2011) – the Forum had been established during a 'pause' in the passage of the Bill to carry out consultations on a number of expressed concerns.

7. The Government's proposals, as they now stand following the response to the NHS Future Forum, can be summarised as follows:

    - the Secretary of State will as now be accountable for the NHS, though rather than secure services directly, he will exercise his responsibility through his relationship with the bodies, such as the NHS Commissioning Board, to be established through the Bill;
    - Primary Care Trusts and Strategic Health Authorities will be abolished;
    - clinical commissioning groups (CCGs) will take responsibility for the bulk of NHS commissioning. They will be led by GPs but their membership will ensure involvement of patients, carers, the public and a wide range of health professionals. They will be under a duty to promote integrated services and will be required to operate in an open and accountable manner;

- local authority led Health and Wellbeing Boards (HWBs) will be responsible for promoting joint commissioning and integrated provision between health, public health and social care. They will lead the development of the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. They will also be involved as CCGs develop their commissioning plans and there will be an expectation, set out in statutory guidance, for the plans to be in line with the Health and Wellbeing Strategy;
- membership of HWBs will bring together locally elected councillors with the key commissioners in the area, including representatives of CCGs, directors of public health, children's services and adult social services and a representative of local HealthWatch. It will be for local authorities to determine the number of councillors on the HWB, and they will be free to insist on having a majority of elected councillors;
- the existing statutory powers of local authority scrutiny will continue to apply, and local authorities will still be able to challenge any proposals for the substantial reconfiguration of services;
- on the provider side, all acute trusts will become Foundation Trusts with greater freedoms, but will face competition from 'any qualified provider'. However, competition will be on the basis of quality not price, with safeguards against price competition and 'cherry-picking'. The core duty of the regulator, Monitor, will be to protect and promote patients' interests; and
- local authorities will take responsibility, alongside Public Health England, for improving the nation's health. They will be allocated a ring-fenced public health budget, with a 'health premium' for those authorities that achieve specified health outcomes.

8. The Task & Finish Group noted that there are still many 'unknowns', some of them significant. Government has still to publish its proposals on such key issues as the public health outcomes framework and funding regime; these are expected during the autumn, and will be a critical factor in determining whether local authorities are actually in a position to fulfil their ambitions. Government will also be issuing guidance, such as the statutory guidance on Joint Strategic Needs Assessments, which we have yet to see. There are also uncertainties about the roles of national bodies including the NHS Commissioning Board, Public Health England and Monitor and how they will impact on local authorities. In short, we are still in a period of transition. However, with local authorities already advanced in their preparations – in setting up their HWBs for example – we feel that it is essential to disseminate our recommendations as soon as possible, while there is an opportunity to influence new structures and working arrangements.

The Context for the North East

9. Health is a critically important agenda for the North East. Whilst great progress has been made on a number of issues, health inequalities still exist both between the North East and other regions, and between different parts of the North East. These inequalities manifest themselves in terms of:

    - the determinants of health, including housing, employment, education, the environment, alcohol, smoking, diet;
    - inequalities in access to some services; and
    - inequalities in outcomes such as life expectancy.

10. To give just a few examples:

    - the North East has the worst levels of deprivation and the lowest life expectancy in England;
    - it has the highest rate of early deaths from cancer; and
    - the North East's rates of smoking in pregnancy and breast feeding initiation are the worst in England.

11. However, much good work has been done:

    - in recent years, life expectancy has been rising faster in the North East than in any region except London;
    - cardiovascular disease has been falling more quickly than the national average; and
    - smoking prevalence has fallen dramatically since 2005.

12. There are also significant inequalities within the region – for example there are considerable differences between Northumberland and Middlesbrough in terms of male life expectancy, cardio-vascular heart disease and stroke, and cancer. But there is still much more to do, and a number of people who gave evidence to us pointed out that preventative spend has not been as significant as claimed.

13. The issue of health inequalities is not of course a new one. Professor Michael Marmot's significant report '*Fair Society, Healthy Lives*', published in February 2010, pointed out that the people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life. Marmot argued that health inequalities result from social inequalities, and that action on health inequalities requires action across all the social determinants of health. Delivering this would require action by central and local government, the NHS, the third and private sectors and community groups.

14. The case for change is clear but in an environment of resource reduction and tightening budgets, how might this happen? Will there be pressure on social care or other budgets, for example, to fill gaps? In an age of austerity, will this be possible, even if it is desirable? We return to this point later in our report.

15. The North East has long recognised the necessity of tackling these inequalities often through a collective effort between partners – in the health service, local government, the third sector and elsewhere. In 2008 regional partners agreed an ambitious strategy for health and wellbeing that aimed to make the health of the North East the best of any region in the country over the next 25 years. The Strategy – entitled *Better Health, Fairer Health* – was based on a number of principles including:

- improve health for all, achieve equal health where possible and ensure fairness always;
- add value to local and national action;
- move the North East further and faster in improving health; and
- address fundamental causes of health and wellbeing and their absence.

16. The strategy identified ten key themes for action:

- economy, culture and environment;
- mental health, happiness and wellbeing;
- tobacco;
- obesity, diet and physical activity;
- alcohol;
- prevention, fair and early treatment;
- early life;
- mature and working life;
- later life; and
- a good death.

Each of themes was taken forward by a inter-agency regional advisory group (RAG).

17. Particular mention should be made here of the approach that has been taken to tobacco and alcohol. The Fresh programme was established in 2005 as the UK's first dedicated office and programme for tobacco control. Its approach is one of *de-normalisation* – shifting the social norms around tobacco so that it becomes less desirable, less acceptable and less accessible. Outcomes to date in the North East include the furthest and fastest decline of smoking rates of any region in the country, from 29% in 2005 to 22% in 2009. Fresh is currently funded by the 12 Primary Care Trusts in the North East until March 2012, with a budget of £713,000 for 2011/12.

18. Balance, the North East Alcohol office, was set up in January 2009 to deliver a similar de-normalisation approach, calling for changes in the way alcohol is priced, promoted and sold and thus helping individuals to reduce their consumption. Like Fresh, it is funded by the 12 PCTs until March 2012, with a budget of £680,000 for 2011/12.

19. The future of the Regional Advisory Groups (which for tobacco and alcohol are linked to but separate from FRESH and BALANCE) is now under consideration, given the imminent removal of the regional tier in health service management (SHA, PHNE), which co-ordinated and provided support for this activity. There needs to be open and constructive dialogue with those who will be key players in the future; local authorities, Directors of Public Health, Clinical Senates/clinical networks, Public Health England and others, on agreeing a way forward – which we pick up later in the document.

Our approach

20. The membership of the Task & Finish Group included representation from all 12 local authorities in the North East, on a cross-party basis (a list of members is at Appendix A). We met three times. We worked closely with our health partners and throughout our deliberations we had the advice and support of Ian Parker, Chief Executive of Middlesbrough Council and Chris Willis, Transition Programme Director, NHS North East. At the second of our three meetings we had a panel discussion with senior NHS representatives from a variety of NHS organisations including commissioners and providers (also listed in Appendix A) which enabled us to explore the key issues in depth. At our third meeting we had a presentation from Kevin Rowan and Tom Ross of the Northern TUC on the Healthy Workplaces Project; more is said about this in paragraph 34. We are grateful to all those who contributed for making their time available. We were supported by ANEC staff Melanie Laws, Andy Robinson and Jonathan Rew.

21. Throughout our deliberations, members expressed a strong view that they wished to focus on how local authorities could use the opportunities presented by the NHS reforms to bring about improvements in health outcomes for the people and communities of the North East. These opportunities include:

- the lead role that local authorities will play in setting up and running Health and Wellbeing Boards;
- the strong role that HWBs will have in joining up health, public health and social care, as well as wider local authority services that impact on health, through the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy;
- the involvement of HWBs as clinical commissioning groups develop their commissioning strategies; and
- the return of public health functions to local government (alongside Public Health England) with a ring-fenced budget, and the location of Directors of Public Health with local authorities. (A list of the specific public health responsibilities assigned to local authorities is set out at Appendix B).

22. In considering how best to take advantage of these opportunities, the Group identified four key questions which it felt needed to be addressed. These questions are:

i) what are the key public health challenges for the North East, and how do we address them?
ii) how do we ensure the new structures – particularly the Health and Wellbeing Boards – can be made to work effectively?
iii) are there any 'must dos' (or must don'ts) that apply to every authority? and
iv) what are the opportunities for political leadership in improving health – for example, allocating resources, shaping the agenda, scrutiny?

23. Our conclusions on each of these questions are set out below.

Question 1: What are the key public health challenges for the North East and how do we address them?

24. We support the view that *Better Health, Fairer Health* remains valid in terms of its evidence base and its analysis of the public health challenges facing the North East. While the political landscape and the financial situation have changed since it was produced, our ambition to tackle the issues it identifies should not, and it would be useful for the 12 authorities to make a collective declaration of intent to work in our localities and where appropriate, collaboratively, to ensure that the population of the North East will have the best and fairest health and well being. We would see this declaration not as 'top down' but as something developed by the 12 authorities as a high-level statement of our collective vision to achieve the best and fairest health and wellbeing, while recognising that each authority has a different health profile and priorities.

25. However, it is one thing to identify the issues, another thing to prioritise them, especially in a period of financial constraint and when the future public health budget is far from clear. Some things are more complicated to deal with (eg: mental health). Equally, each local authority will have its own local priorities and will need to work out for itself both how it allocates its ring-fenced public health budget and to what extent it is able to bring

its mainstream budget to bear – although the strategic role of Health and Wellbeing Boards should ensure that their work is based on evidence and oversight of budgets to avoid budgets being used inappropriately to plug holes when funding should come from other sources.

26. Local authorities and health partners will also need to consider, in the light of all factors including finance, how the ambitions set out in *Better Health, Fairer Health* should be taken forward, by whom and at what spatial level. Though the final decision must rest with each local authority or principal partner, some collective discussion from a local authority perspective through ANEC would be very helpful. The role of Public Health England, clinical senates and networks in this respect is as yet unclear and needs also to be better understood before final decisions are made. Scarcity of resources (human and financial) will be a factor, and economies of scale will need to be taken into account.

27. We suggest that ANEC should consider holding a Health and Wellbeing summit to take forward key health issues and get councils, and elected members, thinking about them. It should also be considered whether there would be merit in having a permanent member group to take forward the health agenda. The Task & Finish Group approach has been valuable and effective in ensuring that attention is given at an early stage to health transition issues; to ensure that the health agenda retains a high priority into the future, there is a case for setting up a working group consisting of health lead members (possibly the Chairs of HWBs) from each of the 12 authorities. If such a group is set up it could prepare the declaration of intent referred to in paragraph 24.

28. We noted the achievements of Fresh and Balance in relation to tobacco and alcohol use and the cost-effectiveness of their approach which focuses on those areas which are best done once rather than 12 times. We also note that the current funding regime through the 12 Primary Care Trusts expires in March 2012. We would wish to see the current approach maintained, at least for the time being, so that when the responsibilities pass to local authorities, we have a 'steady state' position from which we can move forward and determine a way forward for the future.

29. On a separate but related point, it is sometimes suggested that some of the public health challenges facing the North East, for example those relating to alcohol, are a product of North East 'culture'. Without wishing to get into a philosophical debate about this, we would urge that to the extent that such a culture exists, it needs to be challenged; it must not be used as an excuse for doing nothing.

30. We therefore recommend:

- **that local authorities recognise the ambitions set out in *Better Health, Fairer Health* as a valid, current statement of themes that they will need to consider in discharging their public health functions;**
- **that ANEC should ensure that there is early discussion, through the Regional Chief Executives Group and the Leaders and Elected Mayors Group, of the scope for working at different spatial levels and in different ways to address critical issues, with the aim of achieving better value and making a greater impact through working collectively;**
- **that consideration should be given to holding a Health and Wellbeing summit for members, and to setting up a working group, to be hosted by ANEC and possibly consisting of the Chairs of the 12 HWBs, to take forward the health agenda;**
- **that a declaration of intent is developed and agreed by the 12 authorities, to seek to ensure that the population of the North East will have the best and fairest health and well being;**
- **that there is further discussion with local authorities on the roles of clinical senates and networks, Public Health England and the National Commissioning Board (and its 'outposts');**
- **that as part of this discussion, we would seek the retention by PCTs of funding in respect of FRESH and BALANCE so that a way forward can be determined for the future (so for this purpose PCTs should be asked to continue to fund them in 2012/13, and local authorities be recommended to support the initiatives, going forward); and**
- **where cultural issues might be responsible for some public health challenges (such as alcohol), this should not be used as an excuse to do nothing.**

31. One issue that was put to us strongly is the balance between acute services and public health – the importance of tackling the sources of ill health rather than spending money on treating illness. This is an issue that particularly affects the North East where the figures show that hospital use is the highest in the country. However, if we are going to reduce demand for services in hospitals, effective services in the community will be needed and this might also impact on hospital configuration in due course. The implications of this would need to be worked through in a collaborative way. It was reported to us that GPs are keen to do more in this respect but conflicts of interest arise in their role as provider as well as commissioner which have yet to be resolved. GPs need to ensure that they are working very closely with their council(s) when considering their role in the commissioning and provision of community services. Equally, all partners need to think carefully about their commissioning roles and ensure a joined up approach is taken – otherwise this could lead to destabilisation in the supplier/provider market which, apart from anything else, could lead to significant difficulties.

32. We note that management of long-term conditions has an important role to play in reducing pressures on the public health budget; this includes helping patients to manage their own conditions.

33. Local authorities will also need to think carefully about how they will use their wider responsibilities – such as employment, education, children's services, environment, housing and transport – to improve the health and wellbeing of their communities and achieve change at the local level. There is a great opportunity here for addressing the wider, social determinants of health but it will not happen automatically; local authorities will need to embed public health across all their services (see also the discussion on the role of Health and Wellbeing Boards).

34. Another role of local authorities that should not be overlooked is as the employer of a substantial workforce. In this context, we were greatly impressed by a presentation from Kevin Rowan and Tom Moss of the Northern TUC on the TUC's Healthy Workplaces project. The aim of the project is to improve public health by promoting wellbeing and health activities through workplaces; over 200 North East employers, and 250,000 employees, have been involved so far, mostly in the private sector. There have been some remarkable results, not least in reaching members of the workforce who do not normally engage with health services, enabling potentially threatening conditions to be picked up before they become serious. We would encourage member authorities, and their partner organisations, to consider adopting similar workplace health initiatives. They should also consider how their workforce, through their regular contacts with a wide range of individuals, can act as a resource to promote and improve the health of the community.

35. We considered the relationship of the HWB, as a committee of the council, to other partnerships and structures. We noted that the changes, particularly the creation of HWBs, present the opportunity for councils to review and refresh their approach to partnerships, including the LSP, should they wish to take it. The role of the HWB in relation to the Local Strategic Partnership will be important, as will the relationship to Children's Trusts. On the latter point, we consider that children's health is a vital issue. We noted that currently, most local authorities are retaining their Children's Trusts at least until their HWB is properly established. There is an opportunity here to eliminate duplication of roles within the local authority.

36. We recommend that local authorities:

- **work with health partners to examine the balance of resources between acute services, community services and public health;**
- **ensure that public health is embedded across all their services, using their wider responsibilities to improve the health and wellbeing of their communities, and reviewing where appropriate their approach to partnerships; and**
- **use their role as major employers to improve to improve the health of the community, by introducing workplace health initiatives and by considering how their workforce can promote health through their contacts with individuals.**

37. In addition, there are some critical areas where decisions and action by Government will impact on local authorities' ambitions for improving health outcomes. The first of these is finance: we do not yet know how the ring-fenced public health budget will be allocated between Public Health England and local government, and between individual local authorities (although we note that local authorities are being involved in the preparation of 'shadow' public health allocations for 2012/13, a helpful development). Further, while the principle of bringing other local authority services to bear on health is one that we support, this should not mean using mainstream budgets to remedy under-funding of the public health budget. Secondly, it is clear that national bodies including the NHS Commissioning Board, Public Health England and Monitor (and their outposts) will be major players; it is essential that they do not impose 'top down' approaches that hamper local authorities' ability to achieve their goals. Health and Wellbeing Boards will also need to develop working relationships with the new national bodies.

38. We recommend that these concerns are raised with the Government.

Question 2: How can we ensure the new structures – particularly the Health and Wellbeing Boards – can be made to work effectively?

39. We consider it is essential that each HWB thinks carefully about its purpose. The HWB should avoid becoming part of some bureaucratic process, a 'hoop' that has to be gone through; it needs to play a positive and proactive role, to make things happen, working with partners to shape and redesign services to meet the needs of its locality. It should ensure that it tackles the big issues that have real impact – it should not try to do everything itself.

40. It would be helpful if each HWB was at an early stage to set out its:

- values: what are the shared values that all members of the HWB bring to the table? (In this context it should be noted that the diagnostic tool for the establishment of clinical commissioning groups published by the Department of Health on 4 August makes reference to establishing values and behaviours as a key component of a CCG; read-across and consistency between the CCG's values and those of a HWB will be important);
- goals: What is our vision and what are our key objectives and goals? How do we tackle long-standing issues that have proved hard to address? and
- tasks: What do we need to do to achieve our objectives and who will do this?

41. These issues will be at the heart of a Health and Wellbeing strategy. They will also require strong political leadership (see below).

42. Crucially, the HWB should be a focus for **joining up commissioning and service provision** both within the local authority and with other partners and players who have an impact on health. The scope for exploring and developing integrated commissioning is something which could have potential too.

43. Following the report of the NHS Future Forum, it is clear that HWBs will be expected to be involved throughout the process as clinical commissioning groups (CCGs) develop their commissioning plans, and statutory guidance will set out the expectation that commissioning plans will be in line with the Health and Wellbeing Strategy. **We urge HWBs and CCGs to make the most of this opportunity – the process should ideally be one of co-production and not of checking, after the event, that the clinical commissioning plan is aligned with the HWB strategy.**

44. The Health and Wellbeing Board should have a key role in public and patient involvement: it should be the focus for engagement with the patient and community voice, involving them in the process of identifying local needs and developing the Health and Wellbeing Strategy. CCGs will clearly have an important role in understanding and addressing the health needs of their local population, but HWBs have the advantage of being able to take into account all factors influencing the health and wellbeing of people, and should look to address these through a cohesive approach. As part of this, the contribution that local councillors can make to this process as representatives of their local community will be critical, given the breadth of the role of a local councillor – we noted that councillors are often the only people who can see the whole system from top to bottom.

45. Further, the HWB will need to think through how it will engage with the voluntary and community sector (VCS). The VCS has a number of vital roles to play: in informing need through the Joint Strategic Needs Assessment, in developing the Health and Wellbeing Strategy and in delivery of a range of services. The VCS does of course comprise a very wide range of organisations and the HWB will need to give careful thought to how its voice can be heard and its contribution taken fully into account.

46. The role of scrutiny will also be important and, amongst other things, it will enable HWBs and their health partners to receive third party observations and advice on their important work.

47. One specific issue that each authority will want to address is how to ensure that the perspectives of provider organisations (both inside and outside the NHS) are available to its HWB as it shapes the health and wellbeing strategy. Authorities are approaching this in different ways, with some including provider representation in the membership of their HWB, others not. It is clearly a matter for each authority to decide its own approach – **the essential thing is that there is some mechanism for taking the provider perspective into account – including those providers who cross boundaries (this latter point could benefit from further consideration in the context of how HWBs work together in future).** Where there are any conflict of interest issues, these will need to be addressed through transparent governance mechanisms. Local authorities have scope to both commission and provide in almost every area of their activity and therefore this is nothing new. The key is that HWBs need to be a focus for joining up.

48. Given the commonality of health issues facing the North East, we feel that it is important that the 12 Health and Wellbeing Boards do not operate in isolation from each other; it is vital to share information, learning and good practice. It will also be important to consider how we use scarce resource (both money and people), looking at opportunities to share where it makes sense to do so. At the same time, we must avoid a bureaucratic structure of joint meetings simply for the sake of it. We suggest that ANEC should give further consideration as to how the 12 HWBs can work together most effectively and how it might help in this process.

49. Another issue that HWBs will need to consider is how they are going to work with those providers who operate on a wider base than a single local authority? Should they each have an individual relationship with the provider body in question, or should this be through some collective mechanism?

50. Those who submitted evidence to us noted that political leadership provided through ANEC is probably the only opportunity left to ensure that the area as a whole is able to take a strategic approach where required (and where economies of scale are helpful at that spatial level); for example, on issues such as aspects of health promotion and marketing, and other work. We pointed out that ANEC is a body of, and owned by, the local authorities. ANEC's political advocacy work is considered to be very valuable.

51. We recommend that:

- **each HWB should take some time to consider its approach - how it can play a positive, non-bureaucratic role, tackling the big issues that have real impact;**
- **HWBs should ensure that they are involved as co-producers with clinical commissioning groups of their commissioning plans;**
- **HWBs should ensure that they develop working relationships with national bodies including NHS Commissioning Board, Public Health England and their outposts, and with provider bodies that operate on a wider base than a single local authority;**
- **HWBs should play a key role in their area on involving the public in identifying local needs and developing the Health and Wellbeing strategy;**
- **each HWB should consider how it will engage with voluntary and community sector across the various roles that the VCS plays;**
- **as part of this, HWBs should ensure that the contribution of local councillors is actively sought, that arrangements for HealthWatch are made and engagement established;**
- **each local authority should ensure that the provider perspective is available to its HWB; and**
- **ANEC should be asked to further consider how the 12 HWBs can work together most effectively and its role in this agenda, going forward.**

Question 3: Are there any 'must dos' (or must don'ts) that apply to every authority?

52. In the previous sections we have set out a number of issues which we believe authorities should be addressing. It is worth re-emphasising here some key principles:

- local authorities should take a 'whole systems' approach to health, ensuring that the widest possible range of local authority functions contribute to improving health functions (this is the rationale for returning public health to local authority control);
- it is vital for local authorities and clinical commissioning groups in particular to develop strong, constructive relationships;
- local authorities should play a key role in facilitating relationships between NHS Trusts and CCGs;
- HWBs, CCGs and other partners should consider data and intelligence requirements and aim if possible to create a 'hub' or single point for partners to utilise so all are working to the same evidence base (where appropriate making use of existing resources, such as the North East Public Health Observatory);
- while recognising that health services and issues inevitably have a strong political dimension, authorities should as far as possible avoid allowing issues about structure to dominate their focus;
- acknowledging the important role of HealthWatch as a forum for local people to express their views on health issues, it is essential to engage local councillors, as the democratically elected representatives of local people, in identifying local health needs and drawing up strategies to meet them. Local councillors are ideally placed in this respect as they represent their communities on the breadth of issues which make up the determinants of health (see question 4);
- member development and capacity building will need to be an important priority – it will be essential to invest in developing members' capacity to deal with health issues; and
- local authorities should review where the HWB sits in relation to the Executive/Cabinet, with the aim of ensuring that it does not operate in isolation but is seen as fully part of the corporate decision-making processes of the authority.

Question 4: What are the opportunities for political leadership in improving health?

53. Local government is an equal partner in addressing health inequalities. Democratic accountability and political leadership are critical elements of the health reforms. We would see the role of political leadership as encompassing:

- providing leadership and vision;
- advocacy and challenge;
- working together, facilitating, developing relationships – including with CCGs – and between CCGs, Foundation Trusts and other partners;
- ensuring that structural inequalities are addressed;
- bringing the authority's mainstream services to bear on health;
- ensuring community engagement;
- ensuring that key issues are embedded into strategies, not just the health and wellbeing strategy but other relevant local authority strategies – and are followed up; and
- ensuring cross-boundary working where appropriate.

54. Under the Health and Social Care Bill as it currently stands, it is formally the responsibility of the Leader or Elected Mayor to nominate the local authority member(s) of the Health and Wellbeing Board. In addition, or instead, he/she may choose to be a member of the HWB. It goes without saying that this is an opportunity to secure appropriate high-level political representation on the HWB – if not by the Leader/Elected Mayor then through the Health and other portfolio holders (adults, children's services).

55. In any event the Leader/Elected Mayor will want to ensure that health issues are brought to Cabinet where appropriate and that links are made at Cabinet level between the Health and Wellbeing Strategy and other relevant strategies and partnerships – including the Local Strategic Partnership, if the local authority chooses to continue with it.

56. Local authorities will also want to consider the whole Council role in the health agenda. All areas of the council have a contribution to make. Again, the Leader/Elected Mayor will want to ensure that this consideration takes place.

Conclusions

57. We repeat our belief that health is a critically important agenda for the North East, and that the NHS reforms present local authorities with real opportunities to bring about improvements in health outcomes for the people and communities of the North East, provided the right conditions are in place: finance, resources and freedom from central control. Our role has been to consider how to make this happen. We feel that the important thing is to start by trying to understand where we want to be and to work back from there, looking at how we might achieve our goals and objectives. We have tried not to focus on structures for their own sake but to think about how the new structures – Health and Wellbeing Boards in particular – can work effectively, building strong partnerships, working at the appropriate spatial level and focusing on the key public health issues.

Appendix A

Membership of the Task & Finish Group

Members:

Councillor Nick Forbes (Chair)	Newcastle City Council
Councillor Florence Anderson	Sunderland City Council
Mayor Linda Arkley	North Tyneside Council
Councillor Jim Beall	Stockton on Tees Borough Council
Councillor Barry Coppinger	Middlesbrough Council
Councillor Kevin Dodds	Gateshead Council
Councillor Mary Foy	Gateshead Council
Councillor Pamela Hargreaves	Hartlepool Council
Councillor Eunice Huntington	Durham County Council
Councillor Liz Langfield	Newcastle City Council
Councillor Tristan Learoyd	Redcar & Cleveland Borough Council
Councillor Ian Lindley	Northumberland County Council
Councillor John McCabe	South Tyneside Council
Councillor Charles Rooney	Middlesbrough Council
Councillor Andrew Scott	Darlington Borough Council
Councillor Mel Speding	Sunderland City Council

Advisors:

Ian Parker	Chief Executive, Middlesbrough Council
Chris Willis	Regional Director – White Paper Transition, NHS North East
Melanie Laws	Chief Executive, Association of North East Councils
Andy Robinson	Head of Local Government Policy, Association of North East Councils
Jonathan Rew	Specialist Support Officer, Association of North East Councils

Participants in panel discussion:

Wendy Balmain	Deputy Regional Director Social Care and Partnerships, Public Health North East
Richard Barker	Director of Commissioning Development, NHS North East
Ken Bremner	Chief Executive, City Hospitals Sunderland NHS Foundation
Paul Hanson	Strategic Director of Community Services, North Tyneside Council
Professor Peter Kelly	Acting Regional Director of Public Health
Guy Pilkington	Chair, Newcastle Bridges Consortium (Pathfinder)
Colin Shevills	Director, Balance North East

Appendix B

Proposed public health responsibilities of local authorities

Subject to further engagement, the new responsibilities of local authorities will include local activity on:

- tobacco control;
- alcohol and drug misuse services;
- obesity and community nutrition initiatives;
- increasing levels of physical activity in the local population;
- assessment and lifestyle interventions as part of the NHS Health Check Programme;
- public mental health services;
- dental public health services;
- accidental injury prevention;
- population level interventions to reduce and prevent birth defects;
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions;
- local initiatives on workplace health;
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation programmes;
- comprehensive sexual health services;
- local initiatives to reduce excess deaths as a result of seasonal mortality;
- having a role in dealing with health protection incidents and emergencies, alongside Government departments and NHS bodies;
- promotion of community safety, violence prevention and response; and
- local initiatives to tackle social exclusion.

Appendix C

Summary of recommendations

Key public health challenges

1. Local authorities should recognise the ambitions set out in *Better Health, Fairer Health* as a valid, current statement of themes that they will need to consider in discharging their public health functions.

2. ANEC should ensure that there is early discussion, through the Regional Chief Executives Group and the Leaders and Elected Mayors Group, of the scope for working at different spatial levels and in different ways to address critical issues, with the aim of achieving better value and making a greater impact through working collectively.

3. Consideration should be given to holding a Health and Wellbeing summit for members, and to setting up a working group, to be hosted by ANEC and possibly consisting of the Chairs of the 12 HWBs, to take forward the health agenda.

4. A declaration should be developed and agreed by the 12 authorities of intent to work in our localities and where appropriate, collaboratively, to ensure that the population of the North East will have the best and fairest health and well being.

5. There should be further discussion with local authorities on the roles of clinical senates and networks, Public Health England and the National Commissioning Board (and its 'outposts').

6. As part of this discussion, we would seek the retention by Primary Care Trusts of funding in respect of FRESH and BALANCE so that a way forward can be determined for the future (and for this purpose PCTs should be asked to continue to fund them in 2012/13, and local authorities be recommended to support the initiatives, going forward).

7. Where cultural issues might be responsible for some public health challenges (such as alcohol), this should not be used as an excuse to do nothing.

8. Local authorities should work with health partners to bring about a shift in the balance of resources between acute services, community services and public health.

9. Local authorities should ensure that public health is embedded across all their services, using their wider responsibilities to improve the health and wellbeing of their communities, and reviewing where appropriate their approach to partnerships.

10. Local authorities should use their role as major employers to improve the health of the community, by introducing workplace health initiatives and by considering how their workforce can promote health through their contacts with individuals.

11. Government's attention should be drawn to concerns about (a) the allocation of the ring-fenced public health budget between Public Health England and local government, and between individual local authorities, and (b) the need to avoid 'top down' approaches by national bodies including the NHS Commissioning Board, Public Health England and Monitor.

Making the new structures work effectively

12. Each Health and Wellbeing Board should take some time to consider its approach – to think about how it can play a positive, non-bureaucratic role, tackling the big issues that have real impact, and to set out, at an early stage, its values, goals and tasks.

13. Health and Wellbeing Boards should ensure that they are involved as co-producers with clinical commissioning groups of their commissioning plans.

14. Health and Wellbeing Boards should ensure that they develop working relationships with national bodies including the NHS Commissioning Board, Public Health England and their outposts, and wider base than a single local authority.

15. Health and Wellbeing Boards should play a key role in their area on involving the public in identifying local needs and developing the Health and Wellbeing strategy.

16. As part of this, Health and Wellbeing Boards should ensure that the contribution of local councillors is actively sought, that arrangements for HealthWatch are made and engagement established.

17. Each Health and Wellbeing Board should consider how it will engage with the voluntary and community sector across the various roles that the VCS plays.

18. Member development and capacity building will be an important priority.

19. Each local authority should ensure that the provider perspective is available to its HWB.

20. ANEC should be asked to further consider how the 12 Health and Wellbeing Boards can work together most effectively and its role in this agenda, going forward.

'Must dos' (and must don'ts)

21. In addition to the other recommendations in this report, local authorities should keep in mind:

- the need to take a 'whole systems' approach to health, ensuring that the widest possible range of local authority functions contribute to improving health outcomes;
- the need to develop strong, constructive relationships with clinical commissioning groups in particular;
- their key role in facilitating relationships between NHS Trusts and CCGs;
- the need to consider, with partners, their data and intelligence requirements, with the aim of creating, if possible, a 'hub' or common evidence base for all partners to use, making use of existing resources where appropriate;
- the need to avoid allowing issues about structure to dominate their focus; and
- the importance of engaging local councillors in identifying local health needs and drawing up strategies to meet them.

Opportunities for political leadership

22. Local authority political leaders should recognise their key role in ensuring that their authority maximises the opportunities to improve health outcomes, through exercising the political leadership roles identified in paragraph 53.

23. In particular the Leader/Elected Mayor should ensure that health issues are brought to Cabinet where appropriate and that links are made at Cabinet level between the Health and Wellbeing Strategy and other relevant strategies and partnerships.

24. The Leader/Elected Mayor should also ensure that the authority considers the arrangements by which all areas of the Council can contribute to the health agenda.

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September 2011

ASSOCIATION OF
NORTH EAST COUNCILS

PROPOSED MEETING DATES –
SHADOW HEALTH AND WELLBEING BOARD

Monday 10 October 2011 – 2.00 pm – Committee Room B
Monday 21 November 2011 – 2.00 pm – Committee Room B
Monday 9 January 2012 – 2.00 pm – venue to be determined
Monday 20 Feb 2012 – 2.00 pm* - venue to be determined
Monday 2 April 2012 – 2.00 pm – venue to be determined.

* clashes with Adult and Community Services Scrutiny Forum at 2.00 pm

Royal College of General Practitioners

ADCS Leading Children's Services

RSPH Royal Society for Public Health Vision, Voice and Practice

NHS Confederation

Department of Health

nhsalliance

solace

5.1 Local Government Improvement and Development

Operating principles for health and wellbeing boards

Laying the foundations for healthier places

The partners

The following organisations jointly developed and endorse the operating principles for health and wellbeing boards contained in this paper.

The Association of Directors of Children's Services
www.adcs.org.uk

The Department of Health
www.dh.gov.uk

The Local Government Group
www.local.gov.uk

The NHS Alliance
www.nhsalliance.org

The NHS Confederation
www.nhsconfed.org

The Royal College of General Practitioners
www.rcgp.org.uk

The Royal Society for Public Health
www.rsph.org.uk/en/about-us/policy-and-projects/projects/health-and-wellbeing-boards-.cfm

Solace
www.solace.org.uk

The British Medical Association also contributed to the development of these principles.

Contents

Introduction and purpose

The Health and Social Care Bill 2011 currently establishes health and wellbeing boards as committees in upper-tier local authorities*, responsible for encouraging integrated working and developing Joint Strategic Needs Assessments and joint health and wellbeing strategies. The proposed health and wellbeing board membership includes:

- at least one councillor from the local authority
- the director of adult social services
- the director of children's services
- the director of public health
- a representative of the local HealthWatch
- a representative of each relevant clinical commissioning group
- other persons or representatives the local authority or health and wellbeing board thinks appropriate.

The director of public health will be the principal advisor on health and well-being to elected members and officials in the local authority.

National organisations representing the membership of health and wellbeing boards developed a set of principles for establishing the boards at an event in July 2011 (see page 12 for a full list of all participating organisations).

The resulting operating principles and accompanying narrative in this paper are designed to support the effective establishment and functioning of health and wellbeing boards. They are, we hope, a realistic and practical response to supporting health and wellbeing boards. They are neither perfect nor 'the end of the story', and this paper is not a definitive description of the legislation that will underpin health and wellbeing boards as there is a lot of potential for boards to operate effectively in different ways, driven by local needs, assets, relationships between partners, context and decisions. However, the principles are intended to help board members consider how to create really effective partnerships across local government and the NHS.

> 'The principles are intended to help board members consider how to create effective partnerships across local government and the NHS'

The operating principles can be used:

- flexibly at different levels
- during different stages of board development
- to guide new ways of working and local operating frameworks
- as a guide or a useful prompt to monitoring progress
- to support the development of local principles or standards by health and wellbeing boards themselves.

The principles can be used as part of a self-assessment process. They will not be used as a performance measure by the Department of Health, Public Health England or others, but health and wellbeing board members may find them useful in assessing the extent to which their boards are developing and working effectively.

*Although health and wellbeing boards will be set up as committees of local authorities, the Health and Social Care Bill 2011 has a clause that enables the disapplication of legislation that relates to those committees – such as legislation covering voting processes and terms of membership, among other issues. This recognises that health and wellbeing boards are unusual in comparison to normal s102 committees in having officers, clinical commissioning groups and local HealthWatch representatives sit on them.

Context

Health and wellbeing boards will be a key part of complex health and local government systems and contexts. Some of the issues they will face are outlined below.

Structures

Health and wellbeing boards will be established as committees of upper-tier local authorities. The way they will be structured is different from previous joint/partnership arrangements. As well as the intention to further develop effective working between upper-tier local authorities and health partners, it is hoped there will be opportunities for greater joint working across the tiers of local government as a result of the new system. Recognising the complexity of the system will be important to ensure that it is able to function effectively. Health and wellbeing boards should not be considered islands cut off from other areas. They will need to work with other health and wellbeing boards regionally and with the national structures such as the NHS Commissioning Board and Public Health England. They will also need to build credibility and trust with local communities.

Relationships

The success of health and wellbeing boards will depend on building constructive relationships between board members, the NHS, local government and partners, including the voluntary sector, communities and other bodies in lower-tier local authorities.

Funding

Resources are scarcer now than in recent years. A ring-fenced public health budget will be transferred to local authorities. The Government's comprehensive spending review to address the national budget deficit has resulted in substantial cuts to local authority budgets, and the NHS has to find 4 per cent efficiency savings each year until 2015. Health and wellbeing board members, local authorities and clinical commissioning groups will have to make difficult decisions about resources issues. Board members will need to work together to take collective responsibility for using limited resources to address the priority needs outlined in the Joint Strategic Needs Assessments and joint health and wellbeing strategies.

'There will be opportunities, through pooled budgets, to address key priorities such as families with complex needs. Local areas will be able to consider how best to use collective budgets across agencies to improve agreed outcomes'

Successful boards are likely to comprise of partners who do not withdraw from joint working to protect their own budgets or attempt to shift costs from one part of the system, which might significantly affect another part. Local areas will not be forced to pool budgets across local government and the NHS, but there will be opportunities, through pooled budgets, to address key priorities such as families with complex needs. Local areas will be able to consider how best to use collective budgets across agencies to improve agreed outcomes.

Methods for funding local areas may vary. Much funding comes through local government and the NHS, but some comes direct from central government and it may be difficult for health and wellbeing boards to influence this spending at a local level.

However, health and wellbeing boards can also seek to influence wider public spending locally. For example, tackling worklessness is an important part of improving health outcomes not only for individuals in employment but also for their wider family. As well as working with employers, health and wellbeing boards will have the opportunity to work with programme providers and Jobcentre Plus, who each have discretion to target resources at partnership working.

Outcomes

Outcomes linked to health and well-being priorities, as identified in the joint health and wellbeing strategy, are an integral part of each of the principles and should underpin the work of the health and wellbeing boards, in particular the commissioners of health, public health, well-being and social care. The boards should be focused on improving outcomes when setting strategies and making decisions. They should have a process for reviewing whether outcomes have changed as a result of agreed actions, taking into consideration the long-term nature of achieving many public health outcomes.

Broader determinants of health

Tackling health inequalities is a major priority for health and wellbeing boards. An approach that identifies needs and assets in the Joint Strategic Needs Assessment and the joint health and wellbeing strategy may be more effective in treating/preventing illness than one which focuses solely on needs. Addressing the structural, material and relational barriers to individuals and communities achieving their potential will significantly contribute towards tackling health inequalities. Health and wellbeing boards can lead this.

> ‘Addressing the structural, material and relational barriers to individuals and communities achieving their potential will significantly contribute towards tackling health inequalities’

Accountability

Although members of health and wellbeing boards will be formally accountable to different parts of the system, they will have a shared responsibility for developing and contributing to the delivery of the joint health and wellbeing strategy. Citizen involvement should be integral to the health and wellbeing board and seen as everybody’s business. Having councillors on the health and wellbeing board means that the actions boards take to achieve these aims will have some democratic legitimacy, but this is not the same as accountability.

Accountability of clinical commissioning groups will come through assessment by the NHS Commissioning Board, lay people on clinical commissioning group boards and duties to involve, consult and publish an annual report. Although clinical commissioning groups will be accountable to the NHS Commissioning Board for financial performance, quality of services, health outcomes and governance, they will also have a collective responsibility as members of the board for delivering their part of the joint health and wellbeing strategy.

Accountability of local authorities will come through their overview and scrutiny function and through local HealthWatch. Health and wellbeing boards in their entirety will be accountable to communities, service users and

overview and scrutiny committees. All board members will also have incentives to deliver on shared objectives to improve efficiency.

Self-assessment

These principles can be used as part of a self-assessment of progress. Self-regulation and improvement will be an important part of health and wellbeing boards' own governance systems and operational culture, such as how transparent, inclusive and accountable they are. Health and wellbeing boards will need to adopt a 'learning approach' to evaluate how well they operate, their collective impact on improving outcomes, and a process for identifying the most effective ways of sharing learning. Some health and wellbeing boards may find it useful to impact assess existing or new strategies, policies and service developments to ascertain how they impact upon the wider determinants of health.

Commissioning and provision of services

Health and wellbeing boards will have an opportunity to define and communicate locally what choice for health and public services means and what is possible. The Government said in its response to the NHS Future Forum report in June 2011 that health and wellbeing boards will act "as the vehicle for lead commissioning." Local areas will have to prioritise according to need. They might consider choice to be about having the best possible services available and accessible locally. Local communities' voices need to be heard and acted upon regarding the design, delivery and evaluation of services. Patient and public involvement through HealthWatch and other channels (such as clinical commissioning groups and overview and scrutiny) will be essential to ensuring high-quality and effective services are commissioned and delivered.

> 'Patient and public involvement will be essential to ensuring high-quality and effective services are commissioned and delivered'

Providers of services have specialist knowledge which is required when devising Joint Strategic Needs (and assets) Assessments and joint health and wellbeing strategies. While some health and wellbeing boards do not intend to directly commission services, others will have far more direct oversight of the commissioning of council services and of joint commissioning. Whatever they decide their role is in relation to commissioning, they will lead on strategy and governance issues relating to the joint health and wellbeing strategy. Furthermore, they will play a leading role in developing new, integrated ways of working across the NHS, public health, social care and the whole of local government to improve local health and well-being outcomes. Conflicts of interests for all parties need to be managed. Involving providers in key processes can be done in a variety of ways, for example, through a stakeholder forum, and will be important to improve the quality of services and outcomes.

The health and wellbeing board will need to think about how it ensures capacity building takes place. This could be in relation to enabling patient and public involvement to operate effectively, for example, through HealthWatch and other ways, how services respond to personalisation, or how the board can enable communities to build capacity in a 'Big Society'/community development context.

Operating principles

1. To provide collective leadership to improve health and well-being across the local authority area, enable shared decision-making and ownership of decisions in an open and transparent way

What success might look like	Prompts to assist with putting the principles into practice
Effective political and public leadership for health and well-being locally. Leaders: • take collective responsibility for engaging communities, professionals and patients, as well as public, private and voluntary sectors, to develop and deliver a shared vision for improving and protecting health and well-being • are working together in transparent, inclusive and accountable ways • take and communicate difficult decisions • learn lessons from past experience and the experience of others • oversee development of joined-up ways of working • develop a shared vision and agreed outcomes • agree a process for resolving disputes.	• Are strong governance procedures for the health and wellbeing board in place and operating well? • Is there a culture of transparency, trust, respect and understanding between health and well-being board members? • Is it clear how commissioning plans will address the Joint Strategic Needs (and assets) Assessment and achieve the outcomes of the joint health and wellbeing strategy? • Are health and wellbeing board members open and transparent about concerns, identifying potential conflicts straightaway and having ways of dealing with them? • Are health and wellbeing board members leading the culture changes required within the system? • Are difficult decisions, such as reconfiguration issues, being tackled and communicated clearly? • Are lessons being learnt from past local experiences and building on success of current partnership arrangements? • Are health and wellbeing board members applying good practice to join up ways of working between health and local government services? • Does the health and wellbeing board provide high-quality leadership so that health and well-being outcomes for the whole population are improved?

2. To achieve democratic legitimacy and accountability, and empower local people to take part in decision-making

What success might look like	Prompts to assist with putting the principles into practice
Health and wellbeing boards: • operate transparently • in partnership with HealthWatch, fully engage patients, service users and communities and the third, public and private sectors to influence the work of the board, in particular the Joint Strategic Needs (and assets) Assessment and joint health and wellbeing strategy • support communities to find their own solutions to improving and protecting health and well-being • demonstrate professional, clinical and democratic legitimacy for joint decisions.	• Is the health and wellbeing board operating openly, transparently and in accordance with the Nolan Principles of Public Life*? • Are there clear lines of accountability for health and wellbeing board members and partners? • Are the Joint Strategic Needs (and asset) Assessment and the joint health and wellbeing strategy and services being co-designed and commissioned in collaboration with and with engagement from communities as well as third, public and private sector organisations? • Are services and organisations involving people, including children and young people, in the planning and delivery of services? • Are relevant measures of success service user-generated? • Are individuals and communities being appropriately engaged in order to release capability and capacity to finding their own solutions to improve local health and well-being (bearing in mind that other parts of the system such as central government have a role to play at improving the public's health)? • Does the health and wellbeing board have a process to involve communities in evaluating whether it has been successful in delivering priority outcomes identified in the joint health and wellbeing strategy?

*Selflessness, integrity, objectivity, accountability, openness, honesty, leadership (see www.public-standards.gov.uk)

3. To address health inequalities by ensuring quality, consistency and comprehensive health and local government services are commissioned and delivered in the area

What success might look like	Prompts to assist with putting the principles into practice
Health and well-being outcomes are improving and health inequalities are reducing as a result of: • commissioning effective health and well-being services across the NHS and local government • addressing the wider determinants of health by including education, housing, transport, employment and the environment in the joint health and wellbeing strategy • influencing cross-sector decisions and services to have positive impacts on health and well-being. There is strong collaboration and partnerships and clear links between local statutory (such as local safeguarding boards) and non-statutory bodies (for example, children's trusts or voluntary group forums). The needs of unregistered patients and vulnerable groups are being addressed and there is a clear focus on children and young people as well as adults.	• Are health and well-being outcomes improving and health inequalities reducing? • Are there examples where local government and NHS services have joined-up working arrangements (such as the use of integrated commissioning arrangements or teams)? • Is it the norm for services and organisations to work together? • Are there clear links between statutory and non-statutory bodies? • Do service users experience services that are joined-up and that offer seamless and continuous care? • Are services timely and responsive to individual and community needs? • Are the needs of unregistered patients, vulnerable groups, children and adults being met? • Does the joint health and wellbeing strategy address the wider determinants of health (for example, a broader approach than simply health and social care services, working with wider partners particularly voluntary organisations) and place emphasis on prevention and early intervention? • Are equalities and human rights acts honoured and a quality equity audit carried out?

4. To identify key priorities for health and local government commissioning and develop clear plans for how commissioners can make best use of their combined resources to improve local health and well-being outcomes in the short, medium and long term

What success might look like	Prompts to assist with putting the principles into practice
The health and wellbeing board ensures the plans of local and regional commissioners are aligned to meet the agreed priorities in the joint health and wellbeing strategy. The Joint Strategic Needs Assessment is a meaningful, asset-based and high-quality process and the outputs provide the evidence to develop the joint health and wellbeing strategy. Decisions are based on research, public and patient input and robust evidence. Partners work together to jointly agree best use of resources. Resources are used effectively, fairly and sustainably. Relevant data and information is collected in order to measure progress. Action is taken when monitoring indicators show plans or initiatives are not working. Innovation and research is supported to improve current and protect future population health and well-being.	• Is the health and wellbeing board adaptive or responsive to change in, for example, demography, workforce requirements or level of resources available? • Do health and well-being partners work well together or operate individually? • Do health and wellbeing board partners have a shared understanding of what resources are available locally to improve health and well-being? Is there a consensus on how these resources can best be utilised to improve outcomes? • Are resources being used effectively and efficiently, ensuring value for money? • Are health and wellbeing board partners taking a flexible approach to allocating resources in support of whole systems thinking to improving health and well-being? • Are decisions driven by independent and robust evidence? • Were all health and wellbeing board members, local communities and external stakeholders meaningfully engaged in the Joint Strategic Needs (and assets) Assessment and joint health and wellbeing strategy processes? • Does the health and wellbeing board maintain an adequate balance between addressing immediate and longer term priorities for improving health and well-being outcomes, and reducing health inequalities? • Do all members of the health and wellbeing board have a shared understanding of the population health and well-being needs according to the Joint Strategic Needs (and assets) Assessments and are they committed to delivering the joint health and wellbeing strategy? • Does the health and wellbeing board monitor progress on outcomes and take action when indicators show plans or initiatives are not working? • Are research and innovative initiatives funded in your area? • Are initiatives and partnerships evaluated on their effectiveness and efficacy? • Does the health and wellbeing board have access to appropriately qualified, skilled and knowledgeable workforce to carry out its public health responsibilities?

Conclusion

Health and wellbeing boards are the vehicles by which the NHS, local government and local communities work together effectively to improve services and population health and well-being. They offer a real opportunity to address health inequalities by identifying priorities for health and local authority commissioning and by focusing resources on improving health and well-being outcomes.

These principles have been developed by the national organisations representing the proposed members of the health and wellbeing boards, and represent their shared commitment to making the new system work.

Health and wellbeing boards must be accountable to the local community. They must also empower local people to take part in decision-making.

Key to their success will be collective leadership and the way in which board members work together. Getting it right will lay the foundations for healthier communities and more sustainable public services.

For more information on the issues covered in this paper, contact Nicola Stevenson, Senior Policy and Research Officer, NHS Confederation at nicola.stevenson@nhsconfed.org

Further information

The following documents and links provide additional resources to assist with developing health and wellbeing boards.

Wistow G: *Integration this time? Liberating the NHS and the role of local government*. LGID, March 2011
www.idea.gov.uk/idk/aio/27388110

Where next for health and social care integration? NHS Confederation discussion paper, June 2010
www.nhsconfed.org/Publications/Pages/health-socialcare-integration.aspx

Bambra C, Blackman T, Hopkins T, Hunter DJ, Marks L, Perkins N: *Partnership working and the implications for governance: issues affecting public health partnerships*. NIHR, March 2011
www.sdo.nihr.ac.uk/projdetails.php?ref=08-1716-204

The NHS Constitution for England
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613

Accountability works. Centre for Public Scrutiny, 2010
www.cfps.org.uk/what-we-do/publications/cfps-general/?id=128

Board Assurance Prompt – Health and Wellbeing Boards, Good Governance Institute, September 2011
www.good-governance.org.uk/Downloads/2011%20Aug%20Health%20Well%20Being%20Board%20BAPMM.pdf

National learning sets to accelerate development of health and wellbeing boards
http://healthandcare.dh.gov.uk/learning-sets

Local Government Group, National Learning Network for Health and Wellbeing Boards
www.communities.idea.gov.uk/comm/landing-home.do?id=10113659

Health and wellbeing boards: making them work. The King's Fund
www.kingsfund.org.uk/current_projects/health_and_wellbeing_boards_making_them_work/health_and_wellbeing.html

The Joint Strategic Needs Assessment: a vital tool to guide commissioning. NHS Confederation, July 2011
www.nhsconfed.org/Publications/briefings/Pages/joint-strategic-needs-assessment.aspx

Acknowledgements

Representatives from the following national organisations attended the event in July 2011. We are grateful for their participation.

The Association of Directors of Adult Social Services

The Association of Directors of Children's Services

The Association of Directors of Public Health

The British Medical Association

The Centre for Public Scrutiny

The Department of Health

The Faculty of Public Health

The Family Doctor Association

The Local Government Group

The National Association of Links Members

The National Association of Primary Care

The National Quality Board

National Voices

The NHS Alliance

The NHS Confederation

Regional Voices

The Royal College of General Practitioners

The Royal Society for Public Health

We would also like to thank the representatives from the following local organisations who attended the event in July 2011. These representatives provided specific contributions in relation to their own local contexts which helped to frame discussions.

Bridgewater Community Healthcare NHS Trust

Knowsley Council

London Borough of Hammersmith and Fulham

NHS Hampshire

Operating principles for health and wellbeing boards

At an event held in July 2011, a number of national organisations developed a set of operating principles to support the effective establishment and functioning of health and wellbeing boards.

These operating principles are designed to be a realistic and practical response to supporting health and wellbeing boards. They are intended to help board members consider how to create really effective partnerships across local government and the NHS.

Further copies or alternative formats can be requested from:
Tel 0870 444 5841 Email publications@nhsconfed.org
or visit www.nhsconfed.org/publications

Stock code: BOK60047

From the Chief Medical Officer
Professor Dame Sally C Davies

Department of Health

6.3

Gateway clearance number: 16525

1 November 2011

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To SHA CEs, PCT CEs, LA CEs
Copied to see attached list

Re: NHS COLD WEATHER PLAN FOR ENGLAND – 2011/2012
Protecting Health and Reducing Harm from Severe Cold

This letter confirms the publication of the first national Cold Weather Plan (CWP) for England. This was referenced recently in Deputy NHS Chief Executive David Flory's September letter about Winter Preparedness and Planning. The CWP sets out the arrangements that will apply, and the actions that can be taken in advance of, and during, a spell of severe cold weather. The Plan can be accessed at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130564

Severe cold weather is a major public health challenge in this country. The effect of cold weather on health is one of the most significant, yet least recognised, factors causing death and illness in the country.

The CWP sets out a series of clear actions to be taken by the NHS, social care and other public agencies; professionals working with vulnerable people as well as by individuals and local communities to minimise the effects of severe cold weather on health.

The CWP will feel familiar to those associated with the national Heatwave Plan, which has been in existence for seven years. The CWP was also piloted over the last winter in certain parts of England.

The CWP is based on a severe cold warning system 'Cold Watch' which has been developed with the Met Office to alert key stakeholders to the likelihood of severe cold weather in different parts of the country so they can take appropriate action.

The purpose of the CWP is to enhance resilience in the event of severe cold weather. It is an important component of overall winter and emergency planning, as noted in David Flory's recent letter, and wider health promotion activity. It is being supported by a major new initiative, the Warm Homes, Healthy People fund with an aim to support Local Authorities and local partners to reduce death and morbidity in England

due to cold housing in the coming winter with further details to be announced in November 2011.

Why is cold weather an important health issue?

On average, 27,000 additional people die in England over the winter months because of cold weather when compared with other times of the year.
The death rate in England is far higher than that in comparable countries. With better preparation for cold weather, thousands of lives could be saved each year. It is also estimated that cold weather costs the NHS over £850 million, as a result of treating disease due to cold private housing.

The CWP focuses on the effects of cold weather on health. However, severe cold weather in winter is often accompanied by ice and snow, which can cause severe disruption to services and access to these services for patients, staff and the wider public. At a local level, the key will be to ensure that cold weather health planning is co-ordinated with other winter pressures planning – for example, to maintain transport and other infrastructure.

The aims of the Cold Weather Plan (CWP):

- To reduce winter mortality - reduce the yearly excess winter deaths, reduce disease and increase well-being through appropriate preparation and response to severe cold weather alerts. The CWP aims to raise public and professional awareness and trigger actions by those in contact with people known to be vulnerable to cold related illness and death. The CWP is primarily aimed at organisations, institutions and individuals who will interact with the most vulnerable in winter such as people with certain chronic health problems. It is also intended to mobilise civil society to help their neighbours, friends, relatives and themselves to protect against avoidable harm to health in winter.

- To reduce health system pressures - a secondary positive outcome is the potential for reduced pressures on the health and social care system during the busiest months of the year, through better anticipatory actions with vulnerable people.

The CWP draws attention to the dangers of cold weather to health and identifies a specific series of actions which can be taken in the preparations for winter and the response to a winter emergency. Our priority is to ensure that NHS and local authority public health and emergency planners take actions to reduce the impact of cold weather on health and to bring these actions into wider winter planning arrangements which already exist in all areas. Wider multi-agency Local Resilience Fora and emerging Health and Wellbeing Boards would also have a critical role in supporting the delivery of this Plan at a local level.

The CWP is also for local and voluntary groups and organisations, which play an important part in raising awareness and supporting vulnerable people in their homes during severe cold weather, ice and snow.

What does it include?

The CWP is supported by the Met Office's Cold Weather Alert Service. This is operated by the Met Office between **1st November and 31st March** and is divided into 4 levels depending on the risk of severe winter weather.

Each level provides recommended action and advice for: health and care services, the voluntary sector and individuals and families.

- We are also publishing today a separate volume of supporting information: **Making the Case: why public health cold weather planning is essential to health and well-being,** which gives an introduction to the basic science and facts and figures showing why cold weather can be deleterious to health.

The CWP is also being supported by the *Keep Warm Keep Well* information resources: these provide advice on staying warm over the winter and staying in touch with people who may be vulnerable during cold weather, including the elderly, in order to reduce illness and deaths. Adverts will run on local radio stations and a leaflet will be available to download at http://www.nhs.uk/Livewell/winterhealth/Pages/KeepWarmKeepWell.aspx

SHA clusters, Local Authorities and PCT clusters are asked to:

- take appropriate action to ensure the effective communication and dissemination of the CWP to key professional staff, organisations and local voluntary and community groups for implementation

- ensure that the core elements of winter planning are being managed locally. The key elements include:
  - long term strategic planning and winter preparedness
  - advance warning and advice during the winter months
  - communicating with the public
  - communicating with service providers
  - engaging the community

- ensure that the CWP is brought to the attention of all emerging Health and Wellbeing Boards or other appropriate local strategic health fora currently in operation; emerging clinical commissioning groups; and local resilience fora already in operation for implementation

- support primary and social care teams and emerging clinical commissioning groups in:
  - familiarising themselves with the CWP, and their roles in implementing it; and

- identifying individuals at particular risk, and taking steps as set out in the CWP to reduce it - this will involve collaboration with the voluntary sector and the Independent Care Home sector

- ensure independent care homes and hospitals and community nursing agencies are made aware of the Plan

- ensure NHS Trusts, including Mental Health Trusts, have assessed their ability to maintain ambient room temperatures at appropriate levels both day and night

- work with local authority housing and planning teams, and providers of social housing, to take account of long-term measures to reduce the impact of severe cold weather – especially working with health and social care partners who may be able to identify vulnerable clients and patients at risk from poorly heated and cold housing

- ensure that cold weather planning forms an integral part of wider multi-agency winter and emergency plans and procedures, and that those involved in their implementation, including Local Resilience Forums, are made familiar with it

A summary of key amendments and web-links to materials will be advertised via emergency planning routes and professional bulletins. However, you and copy recipients of this letter are asked to discuss the CWP, with those organisations and teams that need to start taking action as part of your overall winter preparedness work.

The effectiveness of the CWP will be reviewed in 2012 with a view to making improvements for future years. The evaluation process will include data monitoring, expert reviews, research, cross-departmental discussions and stakeholder engagement.

Yours ever,

Sally C Davies

PROFESSOR DAME SALLY C DAVIES
CHIEF MEDICAL OFFICER
CHIEF SCIENTIFIC ADVISER

Copied to:

Cabinet Office Civil Contingencies Secretariat
Care associations
- Carers UK
- ECCA
- National Care Association
- Registered Nursing Homes Association
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CQC CE
DCLG Resilience and Emergencies Division
Directors of Adult Social Services
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NHS Foundation Trusts CEs
NHS Regional Directors of Public Health
NHS Trust Medical Directors
PCT DPHs
PCT lead nurses
PCT Medical Directors
Professional bodies
- Community and District Nurses Association
- CPHVA
- RCGP
- RCN
- RCP
- RPSGB

NHS

Cold Weather Plan for England

Protecting health and reducing harm from severe cold

INFORMATION READER BOX

Policy	Estates
HR/Workforce	Commissioning
Management	IM & T
Planning	Finance
Clinical	Social Care/Partnership Working

Document purpose	Best Practice Guidance
Gateway reference	16525
Title	*Cold Weather Plan for England: Protecting health and reducing harm from severe cold weather*
Author	Department of Health
Publication date	1 November 2011
Target audience	PCT CEs, SHA CEs, Local Authority CEs
Circulation list	NHS Trust CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Directors of Adult SSs, Special HA CEs, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Voluntary Organisations/NDPBs, HPA CE, CQC CE, LA Directors of Housing and Planning, Professional Bodies (RCGP, RCP, RPSGB, RCN, CPHVA, Community and District Nursing Association), Care Associations (National Care Association, ECCA, Registered Nursing Homes Association and Carers UK), Domiciliary Care Organisations, Monitor, DCLG Resilience and Emergencies Division, Cabinet Office Civil Contigencies Secretariat
Description	The Cold Weather Plan for England is to be issued in November 2011 to raise both public and professional awareness of the effects of cold weather on health. The purpose of the plan is to enhance resilience in the event of severe cold weather. It is an important component of overall winter and emergency planning and wider health promotion activity.
Cross-reference	*Preparations for winter planning and reporting 2011/12* (29 September 2011)
Superseded documents	n/a
Action required	n/a
Timing	n/a
Contact details	Philip Gardiner Emergency Preparedness, Resilience and Response Department of Health Room 147, Richmond House London SW1A 2NS 020 7210 5352 philip.gardiner@dh.gsi.gov.uk
For recipient's use	

Prepared by the Department of Health and Health Protection Agency, in association with the Met Office

First published 1 November 2011
Published on the Department of Health website, in PDF format only
www.dh.gov.uk/publications

Contents

Foreword

Cold weather kills

This plan provides important guidance on how to reduce the impact that severe cold weather has upon health and, in doing so, will save lives. It builds on the *Annual Report of the Chief Medical Officer 2009* by my predecessor Sir Liam Donaldson, in which he called for a national Cold Weather Plan to address the issues of excess winter mortality.

The past two winters have had significant periods of severe and sustained cold weather. This has highlighted again the need to have effective plans in place to mitigate the effects of cold weather on health.

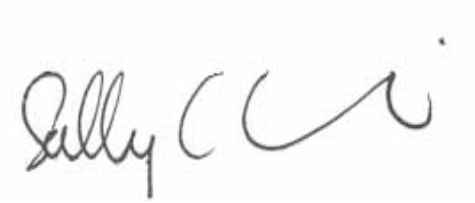
Every year mortality rises by 19% in the winter months in England. This amounts to an average of 27,000 'excess' winter deaths or about 1,560 more people per week dying between December and March compared with the rest of the year. In many northern European countries with much colder weather than ours a rise of such magnitude is not observed. Furthermore, many more people present to GPs and hospitals in winter with a range of cold weather-related conditions.

The majority of these deaths occur among older people, especially women, and those with underlying health problems; however, they are not people who would have died anyhow at that time. Most deaths are due to cardiac disease, strokes and respiratory problems, not hypothermia. It has been estimated that the annual cost to the NHS of treating winter-related disease due to cold private housing is over £850 million.

The purpose of this Cold Weather Plan is to reduce winter deaths by raising public awareness and triggering actions in the NHS, social care and other community organisations to support vulnerable people who have health, housing or economic circumstances that increase their risk. The plan is also intended to mobilise communities and civil society to help their neighbours, friends and relatives to protect against avoidable harm to health in winter.

Timely preventive measures can reduce this excess winter mortality. This plan draws on previous experience over the past few years in delivering the annual Heatwave Plan. The Heatwave Plan has successfully helped individuals, communities and authorities to prepare and plan for summer heatwaves and to reduce the impact of such events on those people who are most at risk.

We hope that this Cold Weather Plan will do the same to reduce excess winter deaths. As this is the first year of the Cold Weather Plan, we would value your comments on how you would like us to improve future editions of the plan.



Professor Dame Sally C. Davies
Chief Medical Officer
Chief Scientific Adviser
Department of Health

Executive summary

The Cold Weather Plan is a public health plan. It aims to prepare for, alert people to and prevent the major avoidable effects of winter on people's health, which claim around 27,000 lives each year.

The plan aims to do this by building on established national and local campaigns for winter health with a more co-ordinated approach. It recommends a series of steps to minimise the health impact of severe winter weather, to be taken by:

- the NHS, social care and other public agencies;
- professionals working with people at risk; and
- individuals and local communities.

Cold Weather Alert service

The plan will work through a system of cold weather alerts – linked to the existing winter weather warning system developed by the Met Office – which will trigger appropriate actions up to a major incident. This system is based on the established Heatwave Plan which has been in existence for seven years.

The Cold Weather Plan sets out actions at four Cold Weather Alert levels:

Cold Weather Plan levels	
Level 1	Long-term planning *All year*
	Winter preparedness programme *1 November–31 March*
Level 2	Severe winter weather is forecast – Alert and readiness *60% risk of severe cold in the following days*
Level 3	Response to severe winter weather – Severe weather action
Level 4	Major incident – Emergency response *Exceptionally severe weather or threshold temperatures breached for more than six days*

Level 1: Winter preparedness – long-term planning

Level 1 includes long-term strategic planning activities that can take place throughout the year. For example:

- **Health and social care services and professionals** should work with partner agencies to identify those most at risk from seasonal illness and to improve their resilience to severe winter weather.
- **Individuals and communities** should consider what they can do in advance to prepare for cold winter weather, such as insulating their homes and making sure that those at risk are receiving the benefits they are entitled to.

Level 1: Winter preparedness – general preparation

Level 1 also includes general winter preparations, running alongside seasonal activities such as the annual flu vaccination programme.

- **Health and social care services and professionals** should work with partner agencies to co-ordinate cold weather plans and support communities to help those at risk. They should also make plans to deal with a surge in demand for services, identify those at risk on their caseloads and encourage all staff to get their flu jabs.
- **Individuals and communities** should take steps to prepare for winter, such as: getting a flu jab if they are in a risk group; insulating their homes and protecting water pipes from freezing; looking out for vulnerable neighbours; and checking their entitlements and benefits.

Level 2: Severe winter weather is forecast

A Level 2 alert is triggered when there is a 60% risk of severe cold weather lasting at least 48 hours forecast to arrive within the next two or three days.

- **Health and social care services and professionals** should make sure that all those at risk have been identified and can be contacted. If visiting clients, they should check that their rooms are adequately heated. More general actions include implementing business continuity, communicating public media messages and making sure that all staff are aware of winter plans.
- **Individuals and communities** should stay tuned to the weather forecast and keep themselves stocked with food and medications, check room temperatures, keep an eye on people at risk and make sure that they are getting their benefits and entitlements.

Level 3: Response to severe winter weather

A Level 3 alert indicates that the severe winter weather forecast at Level 2 is now occurring, and is expected to impact on people's health and on health services.

- **Health and social care services and professionals** should activate plans to deal with a surge in demand for services and mobilise community and voluntary support. They should contact those at risk in person or by phone every day while the severe weather lasts and ensure that they are receiving their entitlements. Other actions include communicating public media messages to staff and ensuring that staff are in a position to help and advise clients.
- **Individuals and communities** should take immediate action to minimise the harmful effects of the weather, including: setting daytime room temperature to 21°C and bedroom night temperature to at least 18°C; dressing warmly and eating well; and checking on those you know are at risk.

Level 4: Major incident

A Level 4 alert indicates a major incident. It means that exceptional winter weather affects one or several parts of the country and is so severe that it creates widespread transport disruption and/or threatens the operation of health and social care services.

Level 4 alerts require a cross-government response at a national level. However, there are some actions that can be taken by the health sector, such as:

- continuing to take Level 3 actions during the emergency period;
- making sure that all local healthcare providers can continue to operate, for example by adequate clearing of snow and gritting to ensure safe emergency access; and
- risk appraisals on how the wider population, outside at-risk groups, is likely to be affected by the extreme conditions.

The plan and wider winter planning

The plan is part of a wider suite of measures that the Department of Health is taking to protect individuals and communities from the effects of severe winter weather and ensure continuity of services. It is also linked to the annual seasonal influenza vaccination programme and the 'Keep Warm Keep Well' campaign, as well as wider work on winter pressures and resilience which takes place in the NHS over the winter months.

The Cold Weather Plan provides strategic guidance and a framework which Local Resilience Forums, NHS, social care and other local organisations can incorporate into their winter planning arrangements. Most of the recommendations set out in the plan require co-ordinated action at a local level, although some incidents will require escalation. The plan is consistent with other emergency plans and duties under the Civil Contingencies Act 2004 to warn and inform the public before, during and after an emergency.

The Cold Weather Plan is being published today with a companion document *Making the Case: Why cold weather planning is essential to health and well-being*, which provides the most up-to-date research and evidence to act as an authoritative source of information for local organisations, communities and individuals.

Warm Homes, Healthy People fund: keeping people warm in winter

To support the aims of the Cold Weather Plan the Department of Health is establishing the **Warm Homes, Healthy People** fund for winter 2011/12.

This is a major new initiative to support local authorities and their local partners in reducing death and morbidity in England due to cold housing in the coming winter. Further details will be announced in November 2011.

Why the plan is needed

The extent of the problem

Although winter weather and snow can be fun, they are also associated with an increase in illnesses and injuries. Cold weather increases the risk of heart attacks, strokes, lung illnesses, influenza and other diseases. People slip and fall in the snow or ice causing serious injuries. Some groups are particularly susceptible to the effects of very cold weather, such as older people, the very young and people with pre-existing medical conditions. In most cases, simple preventive action could avoid illness and injury.

On average over the past three years, around 27,000 more people die in England over the winter months because of cold weather when compared with other times of the year. This is often referred to as 'excess winter deaths' or 'excess winter mortality'. Very severe weather can substantially add to this death toll. There were 34,000 'excess' deaths during the winter of 2008/09, compared with 23,800 in 2009/10.[1] In cold weather, many more people visit GPs and hospitals with a range of cold weather-related health problems.

Although there has been some improvement in the past decades with improving living conditions, mortality in England still does not compare well with the rest of Europe.[2] Other northern European countries perform better than England. For example, Finland – a much colder country – has around half the winter excess death rate of the UK. Likewise, those countries with the greatest excess mortality, such as Spain and Portugal, are also the ones with the mildest winters. This is largely because people in colder countries are better prepared for cold weather, with well-insulated, well-heated, energy-efficient homes and warm outdoor clothing. As the recent Marmot Review Team report *The Health Impacts of Cold Homes and Fuel Poverty* stated: 'Countries which have more energy efficient housing have lower excess winter deaths.'[3]

What is the purpose of the plan?

The purpose of the Cold Weather Plan is to avoid the adverse health effects of winter by raising public awareness and triggering actions by those in contact with people who are most at risk. This, in turn, could help to reduce pressures on the health and social care system in the busiest months of the year.

Who is the plan for?

The plan is primarily for health and social care services and other public agencies and professionals who interact with those most at risk from cold weather in winter. At-risk groups include older people, the very young and people with pre-existing medical conditions as well as those whose health, housing or economic circumstances put them at greater risk of harm from cold weather.

The plan is also intended to mobilise individuals and communities to help to protect their neighbours, friends, relatives and themselves against avoidable health problems in winter. As such, the broadcast media and alerting agencies may find this plan useful.

Health benefits

Many of the deaths and injuries due to cold weather are preventable. A number of local initiatives have already demonstrated that simple measures can improve people's health and lessen the impact on the NHS. Their success suggests that a national plan of preventive actions, education and co-ordinated responses could reduce both the health burden of winter weather and health inequalities across England.

Cost benefits

The annual cost to the NHS of treating winter-related disease due to cold private housing is over £850 million. This does not include additional spending by social services, or economic losses through missed work. A recent study showed that investing £1 in keeping homes warm saved the NHS up to 42 pence in health costs.[4]

Making the case

The Cold Weather Plan is supported by a separate volume of supporting information: *Making the Case: Why cold weather planning is essential to health and well-being* (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130564).

This sets out the supporting evidence on why cold weather can be harmful to health. It is also supported by a series of Information Guides published online which aim to provide an authoritative source of information about the effects of cold weather on health for:

- individuals, families and carers;
- community and voluntary sector organisations;
- health, social care and other community care professionals; and
- NHS, social care, and local authorities and other public sector organisations.

The plan and the Cold Weather Alert service were piloted over the last winter in certain parts of England and the plan has been extensively amended in light of this experience and comments received from a range of professional and community and social stakeholders.

Section 1

The Cold Weather Plan – a public health plan

The Cold Weather Plan sets out what should happen before and during severe winter weather in England. It spells out what preparations both individuals and organisations could make to reduce health risks and includes specific measures to protect at-risk groups.

The plan also provides good practice and advice on how to respond and what to do once severe winter weather has been forecast.

The plan focuses on the effects of cold weather on health. However, severe cold weather in winter is often accompanied by ice and snow, which can cause severe disruption to services and access to these services for patients, staff and the wider public. At a local level, the key will be how well cold weather health planning is co-ordinated with other winter pressures planning – for example, to maintain transport and other infrastructure.

For this reason, multi-agency Local Resilience Forums will have a critical role in supporting the delivery of this plan at a local level, working closely with the newly created Health and Wellbeing Boards.

The effectiveness of the plan will be reviewed in 2012 with a view to making improvements for future years. The evaluation process will include data monitoring, expert reviews, research, cross-departmental discussions and stakeholder engagement.

1.1 Essential elements of effective cold weather planning

The Cold Weather Plan depends on having well co-ordinated plans in place for how to deal with severe cold weather before it strikes, including the following essential elements.

1.1.1 Strategic planning

- Co-ordinated long-term planning between agencies to protect people and infrastructure from the effects of severe winter weather and thus reduce excess winter illness and death. It is anticipated that this could be led in the future by local Health and Wellbeing Boards.
- Strategic planning at national and local level to prepare for pressures on the health system such as pressure on staffing levels, high demand and disruption to services.
- Planning for the future impact of climate change on winter weather and the need to increase energy efficiency and reduce carbon emissions. The Government's Green Deal programme to provide energy efficiency measures (such as insulating homes) at no up-front cost starts in late 2012 and will be the most ambitious home improvement policy since World War II.

1.1.2 Advance warning and advice during the winter months

- A Cold Weather Alert service from 1 November to 31 March based on Met Office forecasts, which will trigger levels of response from the Department of Health and other organisations and groups.
- Advice and information from the Department of Health for the public and health and social care professionals, particularly those working with at-risk groups. This includes both general preparation for winter and more specific advice when severe weather is forecast.

1.1.3 Communicating with the public

- There are general duties under the Civil Contingencies Act 2004 to warn and inform the public before, during and after an emergency.
- Working with the media to get advice to people quickly, both before and during severe winter weather.
- Raising awareness of how cold weather affects health and what preventive action people can take, both throughout the year and during cold weather emergencies.
- Keep Warm Keep Well campaign materials are available online to help local organisations to communicate with the public every winter.

1.1.4 Communicating with service providers

- Helping GPs and district nurses to identify vulnerable patients on their practice lists by providing them with cold weather information and good practice.
- Ensuring that health and social care organisations and voluntary groups implement measures to protect people in their care and reduce cold-related illness and death in those most at risk.

- Ensuring that staff are fit and well and that service providers supply flu vaccination to front-line health and social care workers. This will reduce the risk of them passing the virus to vulnerable patients, staff and family members; and help to reduce the level of absenteeism in NHS and care services.

1.1.5 Engaging the community

- Providing extra help, where possible, to care for those most at risk, including isolated older people and those with a serious illness or disability. This could come from local authorities, health and social care services, the voluntary sector, communities and faith groups, families and others. This is determined locally as part of the person's individual care plan.
- Additional help to ensure that people are claiming entitlements to benefits should be signposted.

1.2 The Cold Weather Plan and existing winter planning

This Cold Weather Plan builds on existing measures taken by the Department of Health and the NHS to protect individuals and communities from the effects of severe winter weather.

These include:

- **Annual seasonal influenza (flu) vaccination programme** (www.dh.gov.uk/health/2011/10/winter-flu/) which aims to protect people from the harmful effects of flu and is offered, free of charge, to certain at-risk groups.
- **Pneumococcal vaccination programme** which aims to protect those people most at risk from pneumococcal disease which can cause meningitis, septicaemia and pneumonia.
- **Keep Warm Keep Well** – this provides advice on staying warm over the winter and checking on neighbours and relatives who may be vulnerable during cold weather, in order to reduce illness and deaths. www.nhs.uk/Livewell/winterhealth/Pages/KeepWarmKeepWell.aspx
- **NHS Choices** (www.nhs.uk) – the main NHS website provides reliable advice and guidance throughout the year on how to keep fit and well. It includes information on topics such as: keeping warm; the dangers of carbon monoxide poisoning; the importance of eating well; and the symptoms of flu.
- **NHS winter pressures reporting and winter resilience programmes** – these are plans made locally and nationally over the winter to help the NHS and local agencies to manage the demands placed on essential services so that they can continue to operate smoothly through severe winter weather.

- **Winterwatch** – this service, launched in 2010, provides information for service professionals and users about the current volume of activity in response to the winter pressures together with practical advice from the Chief Medical Officer to help to keep the public well. Winterwatch also includes regular data on A&E and ambulance activity and the weekly National Influenza Report from the Health Protection Agency (HPA). http://winterwatch.dh.gov.uk/
- **Excess Seasonal Deaths Toolkit** – this was produced by the Department of Health to help local communities to take a systematic approach to reduce the risk of seasonal excess deaths in older people. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115098.pdf
- **Excess Winter Deaths Atlas for England** – information about excess winter deaths produced in association with the Public Health Observatories. www.wmpho.org.uk/excesswinterdeathsinEnglandatlas/
- **Warm Homes, Healthy People fund: keeping people warm in winter –** this is a major new initiative to support local authorities in reducing death and morbidity in England due to cold housing in the coming winter. Further details will be announced in November 2011 (see Section 7).

The Cold Weather Plan will build on these measures by creating a co-ordinated, strategic approach supported by a new system of cold weather alerts to trigger action by those in contact with people who are at risk. We hope that the plan will be useful for communities and professionals, such as emergency responders in health and social care.

Section 2

The Cold Weather Alert service

The Met Office's National Severe Weather Warning Service already warns relevant organisations about a range of high-impact winter weather events, including heavy rain, heavy snow, strong winds, fog and widespread ice. This service operates year round across the UK.

Under the Cold Weather Plan, the new Cold Weather Alert service will add to this by recognising the potential impact of cold weather on health and triggering a co-ordinated response. Depending on the severity, duration and geographical spread of severely cold weather conditions, a series of escalating alerts will be issued up to a major incident (Level 4).

This service will run in England from 1 November to 31 March.

The Met Office will issue alerts up to Cold Weather Alert Level 3, while a Level 4 alert would be issued following cross-government consultation, in response to a particularly severe winter weather event.

The thresholds for what constitutes severe winter weather have been developed in consultation between the Met Office, Department of Health, Cabinet Office and other experts.

2.1 The Cold Weather Alert levels

The Cold Weather Alert service includes four alert levels as outlined in Figure 2.1 and described in further detail below. Cold weather alerts are issued by the Met Office on the basis of either of two measures: low temperatures or widespread ice/heavy snow. Often low temperature criteria are met at the same time as the ice and snow. However, sometimes one may occur without the other.

- **Level 1: Winter preparedness** – Level 1 is in force throughout the winter from 1 November to 31 March, with the seasonal flu vaccination programme starting on 1 October.
- **Level 2: Alert and readiness** – Level 2 is declared when the Met Office forecasts a 60% risk of severe winter weather in one or more defined geographical area in the days that follow. This usually occurs two to three days ahead of the event. A Level 2 alert would be issued when a mean temperature of 2°C is predicted for at least 48 hours, with 60% confidence, and/or widespread ice and heavy snow is forecast, with the same confidence.
- **Level 3: Severe weather action** – a Level 3 alert is issued when the weather described in Level 2 above actually happens. It indicates that severe winter weather is now occurring, and is expected to impact on people's health and on health services.
- **Level 4: Major incident** – a Level 4 alert indicates that many parts of the country are experiencing exceptionally severe winter weather and the conditions are affecting critical services. Such weather conditions are likely to have significant impacts not only on health, but also on other sectors and critical infrastructure. A cross-governmental response may be required.

The cold weather definitions from the Met Office are included at Annex 1.

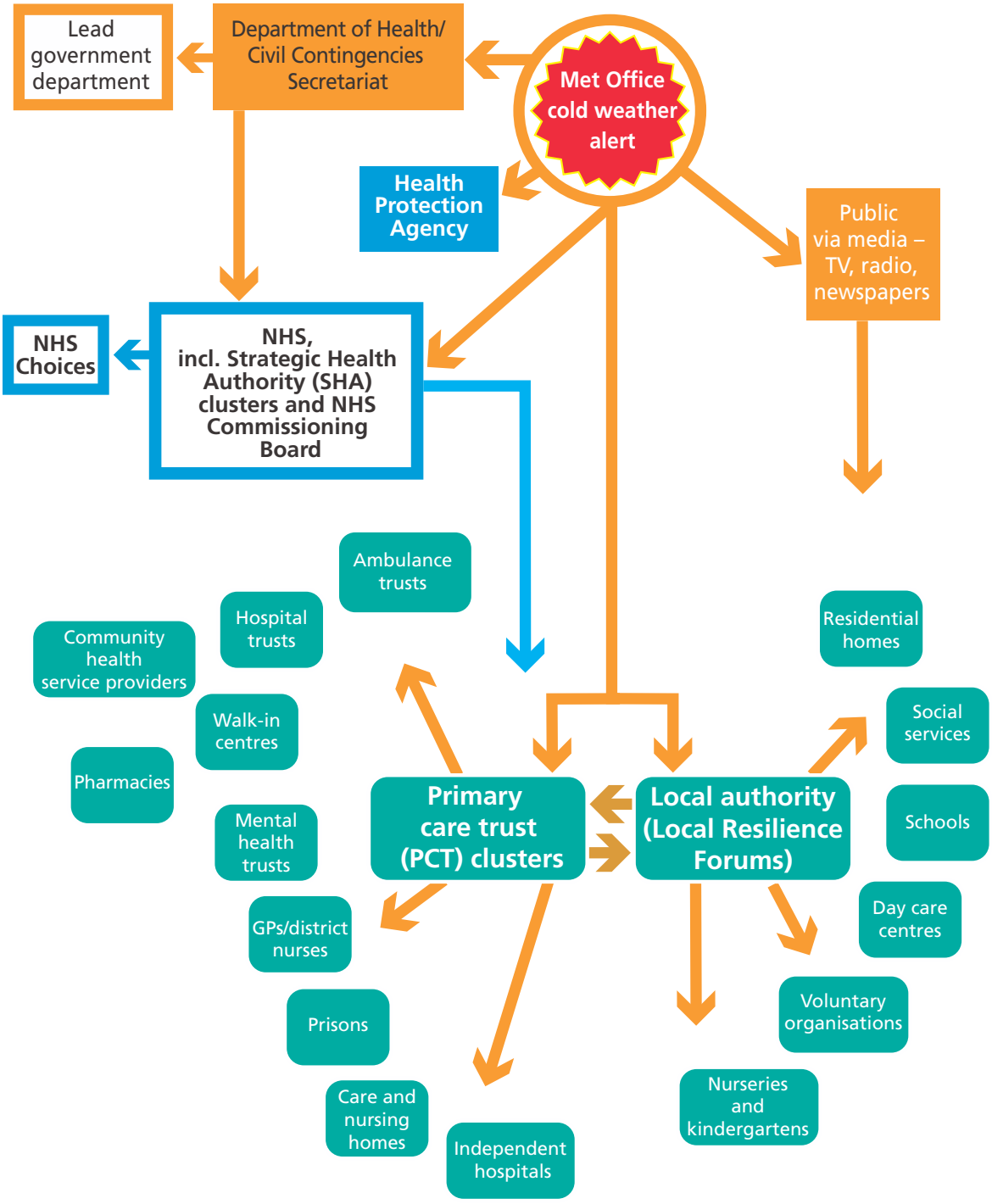
The issue of a cold weather alert should trigger a series of actions, as Figure 2.1 shows. It is a summary of the good practice guidance contained in the sections which follow.

Figure 2.1: Summary of Cold Weather Plan levels and actions

Alert trigger	Health, social care and local authorities	Community and voluntary sector	Individuals
Level 1 **Long-term planning** *All year*	**Organisations and professional staff:** Work with partner agencies to: • develop a shared understanding of excess winter deaths and what partners can do to reduce them • identify those most at risk from seasonal variations • improve winter resilience of those at risk • ensure that a local, joined-up programme is in place to support improved housing, heating and insulation • assess responses to climate change issues – a reduction in carbon emissions and preparing for the expected health impacts	• Develop a community action plan	• Insulate your home and protect water pipes from freezing • Check your entitlements to benefits and local grants
Level 1 **Winter preparedness programme** *1 November – 31 March*	**Organisations:** • Work with partner agencies to co-ordinate cold weather plans • Work with partners and staff on risk reduction awareness (e.g. flu jabs for staff), information and education • Support communities to help those at risk • Plan for a winter surge in demand for services **Professional staff:** • Identify those at risk on your caseload	• Develop community action plan	• Find good information about health risks • Check your entitlements and benefits • Get a flu jab if you are in a risk group • Insulate your home and protect water pipes from freezing • Look out for vulnerable neighbours
Level 2 **Alert and readiness** *60% risk of severe cold in the following days*	**Organisations:** • Communicate public media messages • Communicate alerts to staff and make sure that they are aware of winter plans • Implement business continuity **Professional staff:** • Identify those most at risk Check client's room temperature if visiting	• Keep an eye on people you know to be at risk	• Stay tuned into the weather forecast and keep yourself stocked with food and medications • Check ambient room temperatures • Make sure that you get any benefits to which you are entitled
Level 3 **Severe weather action**	**Organisations:** • Activate plans to deal with a surge in demand for services • Mobilise community and voluntary support As appropriate, contact those at risk (visit, phone call) daily • Communicate public media messages • Ensure that staff can help and advise clients **Professional staff:** • Signpost clients to appropriate benefits • Maintain business continuity	• Activate community action plan	• Clear pavements • Set daytime room temperature to 21°C • Set bedroom night-time temperature to at least 18°C • Dress warmly, eat well • Check those you know are at risk
Level 4 **Emergency response** **Exceptionally severe weather or threshold temperatures breached >6 days**	Level 4 alert declared by central Government Response likely to involve: • National government departments • Executive agencies • Public sector, including health sector • Voluntary sector At all levels	**NATIONAL EMERGENCY ACTION** Multi-agency response required and coordinated by central government	
At-risk groups Over 75 years old, frail, pre-existing cardiovascular or respiratory illnesses and other chronic medical conditions, severe mental illness, dementia, learning difficulties, arthritis, limited mobility		or otherwise at risk of falls, young children, living in deprived circumstances, living in houses with mould, fuel poor (needing to spend 10% or more of household income on heating home), elderly people living on their own, homeless or people sleeping rough, other marginalised groups	

Figure 2.2 below illustrates how cold weather alert messages should be cascaded throughout the local community and nationally as appropriate. Local Resilience Forums and health and social care organisations will want to develop this into a specific cascade system that is appropriate for their local area.

Figure 2.2: Typical cascade of cold weather alerts



Adapted from: Anthea Sanyasi, HPA Health Emergency Planning Adviser, London

Section 3

Responsibilities at Level 1 – Winter preparedness

Cold Weather Plan levels	
Level 1	**Long-term planning** ***All year***
	Winter preparedness programme ***1 November–31 March***
Level 2	Severe winter weather is forecast – Alert and readiness *60% risk of severe cold in the following days*
Level 3	Response to severe winter weather – Severe weather action
Level 4	Major incident – Emergency response *Exceptionally severe weather or threshold temperatures breached for more than six days*

Level 1 alerts run throughout the winter and indicate that people should be preparing for the possibility of severe weather and its effects on health. Everyone has a role to play in this, including individuals, health and social care professionals and a range of community and voluntary sector organisations.

Health and social care services have a particular responsibility to plan for cold weather in co-operation with government and other agencies, and to put measures in place to protect those most at risk. Therefore, Level 1 also includes long-term planning and prevention activities which can take place throughout the year.

3.1 Long-term planning

Preparing for cold weather should be a year-round activity. Long-term planning needs to encompass health improvement plans which can only be addressed jointly by partners in a multi-agency context.

Many of the factors that will help to protect and enhance the health of the population require action well before the winter. That is why long-term planning is needed, including year-round joint working between agencies to protect the population and infrastructure from severe winter weather and reduce excess winter illness and death.

To achieve this, long-term planning for cold weather should be included in health improvement plans agreed by local partner agencies including health, social care, local authorities and others – and be owned collectively by those partners. In the emerging new organisational structures for public health, consequent on proposed legislation, co-ordination should be provided by the local Health and Wellbeing Board with leadership coming from the local Director of Public Health.

3.1.1 A three-stage process for cold weather planning

The Department of Health publication *How to reduce the risk of seasonal excess deaths systematically in vulnerable older people to impact at population level*[5] sets out a variety of ways to reduce the risk of ill-health in cold weather. It also suggests a three-stage process which can be adopted for cold weather planning:

Prepare – develop a shared understanding of seasonal excess deaths and how partners can co-ordinate a systematic approach between agencies, for example through joint working arrangements, data sharing and agreed personal care plans.

Identify those people likely to be highly susceptible to seasonal variations, forming a shared register of those most at risk.

Systematically work to improve the resilience of vulnerable people to severe cold, for example by encouraging uptake of vaccination programmes, home insulation schemes and benefit entitlements.

These three stages should be co-ordinated with the cold weather alerts, and be responsive to the changes in cold weather conditions before and throughout the winter period.

3.1.2 Analysing different needs

A key part of this process is identifying and addressing the needs of different groups and communities, including marginalised and vulnerable groups. The local Joint Strategic Needs Assessment is an essential tool for this. Plans should take into account the different needs and concerns of those affected by cold weather, including cultural differences which can influence community-based responses to cold weather. An effective approach is one that seeks to:

- involve people from marginalised groups, service users and a range of community sources to plan and evaluate interventions and approaches; and
- collect and analyse local data that includes not only gender and age, but also other important demographic information to address social inequalities. Encouraging community engagement can help to draw a more accurate picture of need and community awareness of relevant issues.

3.1.3 Taking action

Some long-term responses to winter weather are directly within the control of the health sector, for instance planning for and delivery of seasonal flu immunisation programmes in the autumn.

Others, such as improved insulation and heating, or adaptations to reduce the risk of falls, are traditionally provided by local authority schemes or grants from other government departments or local sources. The health sector should be working in partnership with other agencies, especially local authorities, to help to promote schemes that provide assistance to householders.

For example, support and advice from a trusted source, such as a health or social care professional, could help vulnerable people to access the grant or assistance to which they are entitled. A more systematic, year-round focus on such activity could help to reduce health inequalities.

Behaviour change support, information and advice may also be effective, but needs long-term planning with consistent, sustained delivery of interventions over long periods of time. Even where support measures have been provided, many households, including the most vulnerable, often do not heat their homes to an adequate level for a variety of reasons. Information to promote appropriate behaviour and understanding of health risks needs to be provided not just in the coldest weather, but throughout the winter.

Long-term planning will also need to take into account the projected impacts of climate change (e.g. warmer, wetter winters, extreme weather events and cold snaps) and the need to increase energy efficiency and reduce carbon emissions in an attempt to mitigate those impacts.

At an individual level, we would urge people to consider improving the heating efficiency of their homes by installing better insulation and to find out whether they are entitled to grants and subsidies for home heating and insulation, and to 'shop around' to achieve the best prices for energy supply.

3.2 Level 1 alerts – actions and activities

The following measures can be taken in advance by individuals, communities, professionals and organisations to protect themselves against the effects of severe winter cold.

3.2.1 Individuals, families and carers

Consider how you can protect yourself and your family and friends from the effects of cold weather:

- Ensure that you can easily access information about cold weather and health (further information is given below and in the companion document to this plan, *Making the Case*).
- Make sure that you and your family members have received all appropriate vaccinations (influenza, pneumococcal, meningitis), particularly if you or they are in an at-risk group.
- Ensure that you have a room thermometer.
- Consider improving the heating efficiency of your home, including better insulation.
- Find out whether you are entitled to grants and subsidies for home heating and insulation.
- Check that home heating, radiators, boilers and electric heaters are serviced ahead of winter to reduce the risk of breakdowns during the cold weather.
- Have all gas, solid fuel and oil burning appliances (i.e. boilers, heaters and cookers) serviced by an appropriately registered engineer. Malfunctioning appliances can release carbon monoxide – a gas which at high levels will kill and at lower levels can cause health problems.
- Make sure that flues and chimneys are swept and checked for blockages and that there is adequate ventilation in rooms to allow appliances to work properly. Fit an audible carbon monoxide alarm which is EN50291 compliant, although fitting this type of alarm should not replace regular maintenance of appliances.
- Where the home is not connected to the mains gas network and heating oil or LPG is the main heating source, households should ensure that heating oil and gas are purchased early to avoid running out during periods of severely cold weather.
- Consider who might be at particular risk from cold weather among your family, neighbours and friends, and how you can help them to protect themselves against the ill-effects of cold weather (see examples of at-risk groups in Figure 3.1).
- Layer your clothing and wear shoes with a good grip if you need to go outside.

- Follow expert advice on protecting and insulating your water pipes against freezing (advice on pipe protection and what to do in the event of bursts is given by most water companies on their websites).

If you or your relative find your home uncomfortably cold or damp and are concerned that it may pose a health problem, you can seek advice from your local authority's environmental health department, who can undertake a Housing Health and Safety Rating System assessment (see box on page 27).

Figure 3.1: At-risk groups – examples of sub-categories, as well as living conditions and health conditions which may place people at risk

Over 75 years old
Frail
Pre-existing cardiovascular or respiratory illnesses and other chronic medical conditions
Severe mental illness
Dementia
Learning difficulties
Arthritis, limited mobility or otherwise at risk of falls
Young children
Living in deprived circumstances
Living in homes with mould
Fuel poor (needing to spend 10% or more of household income on heating home)
Elderly people living on their own
Homeless or people sleeping rough
Other marginalised groups

Advice for the public about winter warmth benefits

You may be able to get financial and practical help to heat your home. Help available includes Warm Front, and Warm Home Discount

The **Warm Front** scheme offers grants for heating and insulation improvements up to £3,500 or up to £6,000, if your home needs oil central heating, for private sector households in receipt of certain benefits. To find out if you qualify, call a Warm Front advisor free on 0800 316 2805 (lines are open Monday to Friday from 8am-6pm and Saturdays from 9am-5pm) or visit the Warm Front website (http://www.direct.gov.uk/en/Environmentandgreenerliving/Energyandwatersaving/Energygrants/DG_10018661).

The Warm Home Discount scheme is a four-year scheme that commenced in April 2011 to help low-income and vulnerable households with energy costs. There are two key elements to the scheme. The first is that a rebate of £120 may be paid, to those in receipt of Pension Credit guarantee credit only (not the savings element) on 11 September 2011, and who pay their own electricity bill to a participating supplier.

Those eligible need not apply. Limited data sharing between the Department for Work and Pensions and energy suppliers should enable rebates to be paid automatically in the majority of cases. If a consumer qualifies, but an automatic rebate can't be made, they'll receive a letter from the Government asking them to provide further information to a dedicated call centre. This information will be available on their electricity bill.

If a consumer is receiving the guarantee credit element of Pension Credit but not the savings credit element, please visit www.direct.gov.uk/warmhome for up to date information on the scheme.

The second element of the schemes requires participating electricity suppliers to provide additional rebates to a small number of groups who they class as vulnerable. For example people who are on a low income with a disability, long term illness or those with children. However, as suppliers have some discretion over who is included within this group, the actual criteria used will vary from supplier to supplier. Further information and contact email/telephone addresses for participating electricity suppliers is available at: www.decc.gov.uk/warmhome

Winter Fuel Payments from £100 to £300 for winter 2011/12 may be available if you were born on or before January 5 1951. If you receive State Pension or certain other benefits you should be paid automatically and don't need to claim. The payment is paid each winter and you don't need to reapply if your circumstances don't change.

If you don't currently receive a Winter Fuel Payment and think you may be eligible, you can find out more at www.direct.gov.uk/winterfuel or call 08459 151515 (8.30am-4.30pm Monday–Friday, textphone 0845 601 5613).

Cold Weather Payments are available to you if you receive Pension Credit and may be available to you if you receive certain benefits and are disabled or have a child who is disabled or under the age of five. To find out more about Cold Weather Payments visit www.direct.gov.uk/coldweatherpayment.

For more information and advice on your health and well-being in winter, visit NHS Choices on: www.nhs.uk/livewell/winterhealth/pages/keepwarmkeepwell.aspx

Additional information on help with heating costs is provided by charity organisations such as National Energy Action (www.nea.org.uk/useful-phone-numbers/), Citizens Advice (www.citizensadvice.org.uk or call 08444 111 444 or check your local bureau's contact details) and Age UK (www.ageuk.org.uk/money-matters/claiming-benefits/heating-benefits/ or call 0800 169 6565).

Housing Health and Safety Rating System (HHSRS)

This is the way in which local authorities assess homes under the Housing Act 2004. It is the basis for regulation of housing conditions. Anyone, including health professionals, can request that an assessment be made if they have concerns about how housing conditions could potentially affect someone's health.

The assessment is usually made by an environmental health practitioner who judges the risk based on the most vulnerable age group for any hazard identified, regardless of who is actually living there.

There are 29 potential hazards in the system: these include excess cold, excess heat, damp and mould, lead, carbon monoxide, noise, entry by intruders, falls associated with baths, falling on stairs, falling on the level, fire, electrical hazards, and crowding and space. Excess cold, damp and carbon monoxide are especially relevant to winter weather preparedness.

Depending on the severity of the hazards found, the housing authority can require that the landlord takes action to reduce the hazard. Alternatively, the assessment can be used as a basis for housing renewal assistance whereby the local authority can offer loans and grants from local resources depending on local prioritisation. For the most serious of hazards (Category 1) there is a duty on the authority to take action. For further information on the HHSRS please visit www.communities.gov.uk/documents/housing/pdf/150940.pdf

3.2.2 Community groups and voluntary sector organisations

- Develop a Community Action Plan to ensure that pavements and public walkways are cleared of snow and ice in the local community. This might include identifying local resources (snow clearing equipment and stocks of grit and salt) and rotas of willing volunteers to keep the community safe during inclement weather and to check on vulnerable or frail neighbours.
- Get in touch with other groups who will be holding workshops or directing members/clients to benefits advice.

3.2.3 NHS, social care and other community staff

- Find out what resources are available to you for raising awareness of the health risks associated with winter weather (for example, see the companion document to this plan, *Making the Case*).
- Identify individuals who are at particular risk from severe cold weather. These people are likely to be already receiving care from health and social services in the at-risk groups identified in this plan. Where many agencies are involved a key worker should oversee prevention/management arrangements, especially for frail elderly people living alone.
- Identify any changes to individual care plans for those in high-risk groups (see Figure 3.1 on page 25).
- Work with at-risk individuals, their families and carers to ensure that they are aware of the dangers of cold weather and how to keep warm. Help them to put simple protective measures in place, such as ensuring that they have

adequate warm clothing and receive warm meals every day, and that they are claiming the relevant benefits.

- Pharmacists have an important role in reminding people to have sufficient medication and help with preventive medicines management.
- Make sure that you get a flu vaccination.

3.2.4 Health, social care and local authority organisations

- Ensure that cold weather planning is brought into all aspects of winter weather planning within the NHS and social care organisations as well as with multi-agency Local Resilience Forums.
- Ensure that the actions in this plan are brought to the attention of relevant staff, and particularly that both organisations and staff are aware of all the guidance on minimising and coping with cold weather-related health risks.
- Ensure that your internal alert and cascade system is updated to receive the Cold Weather Alert service. People who will receive the alerts need to be aware of their own role and responsibilities for action when an alert is received.
- Ensure that you have a business continuity plan and an emergency plan for severe winter weather, including how to respond to a possible surge in activity and staffing pressures. Make sure that the plan is up to date with key emergency contacts identified.
- Consider who your partners may be in protecting the health of the local population against cold – these may include police and fire authorities and voluntary and community sector organisations.
- Consider how to best mobilise and engage community organisations and support the development of community action plans.
- Identify which local health, social care and voluntary sector organisations are themselves most vulnerable to the effects of severe winter weather.
- Ensure that all community staff who identify clients living in homes that are too cold know how to get assistance for their clients.
- Have a plan in place to provide influenza vaccination to all front-line staff and to encourage vaccination uptake.
- Explore and encourage the uptake of energy efficient, low-carbon solutions for insulating and heating of homes and social care and health institutions.
- Consider how your winter plans can help to reduce health inequalities and how they might target high-risk groups (as summarised in the box on page 29).
- Work out how your winter plans can target marginalised groups, including frail and isolated people, homeless people and travellers alongside careful consideration of the needs of black and ethnic minority groups.

- Implement the strategies recommended in the Department of Health publication *How to Reduce the Risk of Seasonal Excess Deaths Systematically in Vulnerable Older People to Impact at Population Level* (see box below).
- Work across all local authority teams to identify accident hotspots on the pavements or roads, advise on gritting priorities to prevent accidents in icy weather, and ensure access by utilities and other essential services.

How to reduce the risk of seasonal excess deaths systematically in vulnerable older people to impact at population level: A workbook for health and social care

The workbook, produced by the National Support Team for Health Inequalities, recommends a three-stage process for cold weather planning. Having prepared for winter (Stage 1) and identified those at risk (Stage 2), Stage 3 suggests systematically offering or implementing practical and effective interventions, including:

- assessment for affordable warmth interventions, including energy efficiency, household income and fuel cost;
- regular review of benefits entitlement and uptake;
- seasonal flu and pneumococcal vaccination;
- an annual medication review (every six months if taking four or more medicines);
- an annual medicines utilisation review and follow-up support to ensure that the patient is taking their medicine;
- implementation of a personal brief health interventions plan that includes advice and support on stopping smoking, sensible drinking, healthy eating, adequate hydration and daily active living;
- assessment and support programme to prevent falls;
- assessment for appropriate assistance technologies, e.g. alarm pendants to call for help; and
- help to develop a personal crisis contingency plan (e.g. including a buddy scheme, where there are no close friends or family, to watch for danger signs and provide someone to call).

Department of Health (2010) *How to Reduce the Risk of Seasonal Excess Deaths Systematically in Vulnerable Older People to Impact at Population Level*. Health Inequalities National Support Team 'How to' guide book 10. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115098.pdf

3.2.5 At national level

The Department of Health will make advice available to the public and health and social care professionals in affected areas as appropriate.

Preparations at this level will be the overall responsibility of the Department of Health and, in future, Public Health England in collaboration with the Met Office, the Health Protection Agency and NHS bodies, including NHS Direct/ NHS Choices.

A Level 1 alert will be sent by the Met Office to the agreed list of organisations supplied by the Department of Health, which will include the Cabinet Office as well as other central government departments.

The Met Office will continue to monitor and forecast temperatures in each area, including the likely duration of the period of severe winter weather.

The Department of Health, and in due course Public Health England, will look to develop new ways to monitor and analyse winter-related illnesses and deaths as close to real time as possible. It will also issue general advice to the public and healthcare professionals and will work closely with other national organisations that produce winter warmth advice to ensure maximum reach of the message.

Section 4

Responsibilities at Level 2 – Alert and readiness

Cold Weather Plan levels	
Level 1	Long-term planning *All year*
	Winter preparedness programme *1 November–31 March*
Level 2	**Severe winter weather is forecast – Alert and readiness** ***60% risk of severe cold in the following days***
Level 3	Response to severe winter weather – Severe weather action
Level 4	Major incident – Emergency response *Exceptionally severe weather or threshold temperatures breached for more than six days*

A Level 2 alert is triggered when there is a 60% risk of severe cold weather lasting at least 48 hours forecast to arrive within the next two or three days. The following actions should be taken by hospitals, care homes and communities to prepare for the potential impact on health.

4.1 Individuals, families and carers

- Consider how you can protect yourself and your family and friends, especially those most at risk. These include older people, the very young, and people with underlying medical conditions, including respiratory conditions such as asthma and chronic obstructive pulmonary disease (COPD) – see Figure 3.1 on page 25 for the full list.
- Actions to prepare for impending severe winter weather include:
  - Stay informed by tuning in to weather forecasts.
  - Take the weather into account when planning your activity over the following days. For example, avoid exposing yourself to cold or icy outdoor conditions if you are at higher risk of cold-related illness or falls.
  - Consider how you can access essential medication and groceries without putting yourself at risk, for example by getting supplies in early, having them delivered, or asking a friend or neighbour for help.
  - Check that the heating in your home is working properly, that your home is warm enough and that at least one room meets recommended room temperatures (see Table 5.1).

  - Consider whether any friends and family could benefit from some additional support during the cold snap.
  - Discuss with neighbours, community, friends and relatives about clearing snow and ice from in front of your house and public walkways nearby if you are unable to do this yourself.

4.2 Community groups and voluntary sector organisations

- Implement the Community Action Plan (see Level 1 actions).
- Keep an eye on vulnerable people you know.
- Encourage local residents to keep the pavements free of ice and snow.

4.3 NHS, social care and other community staff

- Make sure that all those at high risk from cold weather have been identified and that arrangements are in place to visit them and take appropriate action to protect them against severe winter weather.
- When visiting clients check room temperatures to ensure that clients are warm. Ensure that they have at least one room which meets recommended room temperatures (see Table 5.1).
- Also check that clients have supplies of food and medication and that they are claiming the benefits to which they are entitled.
- Remind clients of the action they can take to protect themselves from the effects of severe cold.
- Make sure that you are prepared for a potential influx of weather-related injuries and illnesses.
- Consider how the forecast weather conditions may impact on your work – for example, snow and icy roads delaying home visits.
- Get an influenza vaccination.

4.4 Health, social care and local authority organisations

- Make sure that NHS, social care and other community staff have implemented the agreed Cold Weather Plan and that they have identified vulnerable clients and are supporting them.
- Implement business continuity and emergency plans as required.
- Ensure that local resilience teams are aware of the new cold weather alerts.
- Communicate cold weather alerts to your staff, particularly those in community care.
- Make sure key partners, including all managers of care, residential and nursing homes, are aware of the alerts.
- Ensure that all key staff are aware of winter plans and arrangements and have access to relevant advice.

- Communicate public media messages on the weather.
- Provide a flu vaccination programme to all front-line staff and encourage staff to be vaccinated.
- Consider how to make best use of available capacity, for example by using community beds for at-risk patients who do not need an acute bed and enabling access to step down care and reablement.
- Provide guidance to community organisations to help them to mobilise their community action plans.
- Discuss road gritting arrangements with the local authority when snow or icy conditions are forecast. Consider plans to ensure access to critical health services, for essential deliveries and to prevent ice-related car and pedestrian accidents.

Hospitals, emergency departments, GP surgeries and other community health service providers

Cold-related illnesses and severe cold weather conditions may put particular pressure on hospitals, A&E departments and GP surgeries. If severe weather is forecast, they should consider the following actions to ensure that they can cope with demand and minimise disruption to services.

Staffing

- Consider deploying more clinical resources (medical, nursing and allied health) to deal with expected surges in demand.
- Consider accommodating key staff on site overnight if there is a risk that transport networks may be disrupted.
- Encourage relevant front-line staff to be vaccinated against flu.

Capacity

- Consider discharging inpatients, taking account of transport networks, to free up acute beds, and work with local authorities and other partners to make step down and reablement services available.
- Consider cancelling routine elective surgery and day case outpatient surgery to accommodate increased cold-related demand.
- Consider whether you will need more orthopaedic surgical capacity to deal with an expected increase in fall-related fractures.
- Consider scheduling extra ‘fracture clinics’ to cope with a possible surge in demand.
- Emergency departments should prepare for increased numbers of falls of elderly people. Extra occupational therapy and physiotherapy resources are likely to be required and there may be a higher workload for nurses.
- Consider postponing elective surgery that is likely to require critical care resources (Intensive Treatment Unit stay) to provide capacity for severe cold-related illness.

- Ease pressure on healthcare services by carefully selecting patients for hospital assessment and admission, and taking a co-ordinated approach to patient pathways to higher levels of care.
- Consider the impact on radiology departments, which may face an increased burden of medical and musculoskeletal imaging and need to work flexibly to cope with demand.
- Consider developing a triage mechanism for severe winter weather episodes.

Resources

- Ensure readily accessible supplies of warmed fluids, forced-air warming blankets and other warming equipment.
- Prepare for increased respiratory problems with stocks of nebulised medications and consider gathering non-invasive positive pressure ventilation (NIPPV) equipment for use.
- Ensure that departments are well stocked with plaster, splints, crutches and equipment required to manage any expected increase in fracture pathology.
- Consider whether you need to increase the frequency of routine pharmacy restocking to match increased hospital attendances and prescribing.

GP surgeries, walk-in health centres, community health service providers and other primary care facilities

- Consider how you can adapt your team's capacity to a possible surge in activity.
- Consider how you would deal with the potential consequences of disrupted transport links, including disrupted access to patients' homes and care homes and possible delays in pharmaceutical supplies.
- Encourage relevant front-line staff to be vaccinated against flu.
- Set up patient alert schemes which identify those at risk of cold homes.

Information gathering and support

- Work with ambulance crews to collect information about where accidents and falls are taking place to share with road, police and other organisations so that remedial action can be undertaken.
- Monitoring information from hospital A&E departments should be analysed and shared to identify specific reasons for A&E pressures (such as an increase in fractures or flu admissions) so that remedial and preventive action can be undertaken locally.

4.5 At national level

The Department of Health – and Public Health England in future – will make advice available to the public and health and social care professionals in affected regions via NHS Choices/NHS Direct, as well as on the Met Office, Health Protection Agency and Department of Health websites.

A Level 2 alert will be sent by the Met Office to the Cabinet Office as well as other central government departments which should then cascade the information through their own stakeholder networks and front-line communications systems.

Section 5

Responsibilities at Level 3 – Severe weather action

Cold Weather Plan levels	
Level 1	Long-term planning *All year*
	Winter preparedness programme *1 November–31 March*
Level 2	Severe winter weather is forecast – Alert and readiness *60% risk of severe cold in the following days*
Level 3	**Response to severe winter weather – Severe weather action**
Level 4	Major incident – Emergency response *Exceptionally severe weather or threshold temperatures breached for more than six days*

A Level 3 alert indicates that the severe winter weather forecast at Level 2 is now occurring, and is expected to impact on people's health and on health services. It should trigger the following actions by hospitals, care homes, local authorities, community organisations and individuals.

5.1 Individuals, families and carers

Families, friends and carers of people in high-risk groups, such as older people and those with respiratory conditions (see the full list in Figure 3.1 on page 25), should check on them regularly during the severe weather period.

There are a number of simple actions that those at risk can take to protect against the ill-effects of cold weather. These include the following.

5.1.1 During the day

- Avoid going outdoors unless necessary – but keep active and moving around indoors as much as you can.
- Keep your home at recommended indoor temperatures – see Table 5.1.
- If you cannot heat all your rooms, keep your living room warm throughout the day and heat your bedroom before going to bed.
- Set the timer on your heating to come on before you get up and switch off when you go to bed.
- In very cold weather, rather than turn the thermostat up, set the heating to come on earlier so that you will not be cold while you wait for your home to heat up.

5.1.2 During the night

- If you use a fire or heater in your bedroom during winter, open the window or door a little at night for ventilation.
- Keep your bedroom at recommended indoor night-time temperatures (see Table 5.1).
- Never use an electric blanket and hot water bottle together as you could electrocute yourself.
- If you have an electric blanket, check what type it is – some are designed only to warm the bed before you get in and should not be used throughout the night.
- Make sure that your electric blanket is safe by getting it tested every three years by an expert. The Fire Brigade and Trading Standards can test your electric blanket for safety. If buying a new electric blanket look for CE, BEAB or IMQ safety markings.

Table 5.1: Recommended indoor temperatures

Indoor temperature	Effect
21°C (70˚F)	Minimum recommended daytime temperature for rooms occupied during the day
18°C (65˚F)	Minimum recommended night-time temperature for bedrooms. No health risk, though may feel cold

Source: World Health Organization (1987) *Health Impact of Low Indoor Temperatures: Report on a WHO meeting*. Copenhagen: World Health Organization. Available at: http://tinyurl.com/3ghblbm

5.1.3 Dress warmly

- Wearing plenty of thin layers is warmer than one thick one.
- Put on a coat, hat, scarf, gloves and warm, non-slip shoes or boots when you go outside.
- Wear clothes made of wool, cotton or fleecy synthetic fibres.
- Stay warm in bed with bed socks, thermal underwear and a nightcap or headscarf.

5.1.4 Manage your energy use

- Shut and draughtproof outside doors.
- Draw your curtains at dusk to help to keep the heat generated inside your rooms.
- Make sure that your radiators are not obstructed by curtains or furniture.
- Boil only the water you need rather than filling the kettle completely.

- Do not use a gas cooker or oven to heat your home as this is inefficient and there is a risk of carbon monoxide poisoning.

More information is available from the Keep Warm Keep Well web page: www.nhs.uk/Livewell/winterhealth/Pages/KeepWarmKeepWell.aspx

5.2 Community groups and voluntary sector organisations

- Implement your winter emergency and business continuity plans.
- Make sure that you check the health status of vulnerable individuals regularly. If you visit, check that indoor temperatures remain at recommended levels (see Table 5.1), that individuals take warm meals and drinks regularly and that they wear adequate warm clothing. Also provide advice about the health effects of cold and preventive action.
- Take account of weather-related road conditions when planning home visits.
- Ensure that you are able to contact your colleagues and clients if visits need to be rearranged.

5.3 Health, social care and local authority organisations

5.3.1 Local health and social services

- Ensure strategic co-ordination of the likely surge in demand for primary and secondary care, and enquiries to social services.
- Ensure that staff are aware of cold weather health risks and are able to advise clients how to protect against them.
- Consider daily visits/phone calls for high-risk individuals living on their own who have no regular daily contacts.
- Provide guidance to community organisations to help them to implement local community action plans.
- Advise carers to contact the patient's GP if there are concerns about an individual's health.
- Ensure that all care home managers and domiciliary care providers have access to Department of Health advice.

5.3.2 Hospitals and care, residential and nursing homes

- Ensure that rooms, particularly living rooms and bedrooms, are kept warm (see Table 5.1).
- Ensure that patients and residents wear warm clothing that is appropriate to the temperature and weather conditions, indoors and outdoors.
- Identify particularly high-risk individuals (see Figure 3.1 on page 25 for the full list).
- Ensure that patients and residents take warm drinks and food regularly.

- Ensure that staffing levels will be sufficient to cover the anticipated period of severe weather.
- Repeat messages on risk and protective measures to staff.
- Mental health trusts and community teams should also ensure that visits or phone calls are made to check on high-risk individuals with severe mental illness who are living on their own or have no regular contact with a carer.

5.4 At national level

As per Level 2 arrangements, a Level 3 alert will be sent by the Met Office to the agreed list of organisations supplied by the Department of Health, which will include the Cabinet Office as well as other central government departments.

The Met Office will continue to monitor and forecast temperatures in each area, including the likely duration of the period of severe winter weather, the likely temperatures to be expected and the probability of other regions exceeding the Level 3 threshold.

The Department of Health will make advice available to the public and health and social care professionals in affected areas as appropriate.

Section 6

Responsibilities at Level 4 – Emergency action

Cold Weather Plan levels	
Level 1	Long-term planning *All year*
	Winter preparedness programme *1 November–31 March*
Level 2	Severe winter weather is forecast – Alert and readiness *60% risk of severe cold in the following days*
Level 3	Response to severe winter weather – Severe weather action
Level 4	**Major incident – Emergency response** ***Exceptionally severe weather or threshold temperatures breached for more than six days***

A Level 4 alert indicates a major incident. It means that exceptional winter weather affects one or several parts of the country.

Level 4 is reached when winter weather is so severe, prolonged or widespread that its effects are likely to extend outside health and social care, such as when it creates widespread transport disruption and/or where the operation of health and social care services is threatened.

A Level 4 alert would be declared nationally in a similar manner to that for a Level 4 heatwave. In the event of a major incident being declared, all existing emergency policies and procedures will apply. All Level 3 responsibilities must be maintained during a Level 4 incident.

Please note: This section sets out existing responsibilities during a major incident. However, this content is subject to change as a result of cross-government discussion this winter. The emerging role of the new national Public Health Service – Public Health England – could also have some impact on how a major incident is handled.

6.1 Cross-government response

- The decision to issue a Level 4 alert at national level will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat (Cabinet Office).
- In undertaking this assessment, the Civil Contingencies Secretariat would consult with a range of interested departments/agencies, including the

Department of Health emergency planning functions, the Met Office, the Department for Transport, and the Department for Communities and Local Government.

- In line with its approach to all major national incidents, the Cabinet Office would likely nominate a lead government department to co-ordinate the central government response in the event of a Level 4 alert being declared.
- Response arrangements will need to be necessarily flexible, in order to adapt to the nature of the challenge and other circumstances at the time, while applying good practice, including lessons learned from previous emergencies.

6.2 The health sector

- Health and social care services and local authorities should ensure that Level 3 actions continue during the emergency period.
- Measures should be taken to ensure that local healthcare providers that are most vulnerable to extreme winter conditions can continue to operate, for example adequate clearing of snow and gritting to ensure safe emergency access.
- During extreme conditions, it is not only high-risk groups that may be at risk. Therefore, further risk appraisals should be made as to how the wider population is likely to be affected.
- The Department for Communities and Local Government's Resilience and Emergencies Division will support the co-ordination of a cross-sector response to the period of extreme winter weather.

6.3 Potential wider impacts (including those that may have an impact on the health sector)

6.3.1 Transport infrastructure

- Motorways, trunk roads and smaller roads that lead to national or critical national infrastructure, including hospitals, will need clearing of ice and/or snow. The majority of this clearing will be by the spreading of salt. Given that the number of suppliers is limited, it is likely that arrangements for 'salting' the roads will be carefully co-ordinated through a national strategic salts plan.
- The Highways Agency will take responsibility for keeping traffic moving on motorways and trunk roads, whereas all other roads will remain the responsibility of the relevant local authorities. Traffic congestion has potentially serious consequences for those stranded in vehicles, particularly vulnerable people such as older people or young children.
- The rail network will be susceptible to ice on the rails and high levels of snow.
- Public transport networks are particularly at risk, with potential subsequent knock-on effects.
- Airlines require large supplies of de-icer to get planes ready to move. Runways need clearing of snow, but approach roads to all airports need to be clear to allow passengers and staff access to airports.

6.3.2 Power supplies

- In preparation for winter, National Grid carries out a 'what if' scenario-based analysis to determine the likely risks and consequences of infrastructure failure. The most recent exercise shows that unless there is an unlikely combination of unusually high gas demand combined with multiple infrastructure failure, all emergency requirements could be met through fuel switching, for example from gas to coal. Supplier companies are strongly incentivised to supply the fuel that their customers need.

6.3.3 Children's sector

- Some schools may have to close classrooms where conditions are too cold. Snow and ice may also disrupt staff and pupils' travel to school and make access to classrooms and playgrounds difficult or dangerous.
- Schools often close or send pupils home early in bad weather, sometimes putting a strain on childcare arrangements for working parents.
- It is for the headteacher of each school to decide whether or not to close their school in severe weather conditions, as they are best placed to make the decision taking account of the local conditions both inside and outside the school premises. Schools are kept open whenever it is safe to do so, once a risk assessment has taken place.
- Further information can be found at: www.education.gov.uk/schools/adminandfinance/emergencyplanning/a0069425/advice-on-severe-weather

6.3.4 Environment and agriculture

- Falling temperatures might require animals to be temporarily housed at farms, or they may be unable to get to markets and slaughterhouses.
- Milk-collecting tankers might be unable to reach farms.
- Freezing temperatures, snow and ice can disrupt the growth of plants and can delay planting.

6.3.5 Culture and sports

- Large numbers of outside entertainment events will be cancelled.
- Loss of revenue from sporting fixtures.

6.3.6 Water shortages

- Individual householders have a responsibility to protect their pipes against freezing and bursting as a result of cold weather. Advice on pipe protection and what to do in the event of bursts is given by most water companies on their websites.
- Water companies have plans in place to deal with failure in the supply of mains water or sewerage services. These plans are regularly reviewed and tested by the water companies and are independently certified every year.
- In the event of a loss of mains supply, water companies will supply water by alternative means such as in static tanks in the street, or bottled water. There is a requirement to provide not less than 10 litres per person per day, with special attention given to the needs of vulnerable people, hospitals and schools. Where an interruption to the piped water supply exceeds five days, the requirement rises to 20 litres per person per day.

Section 7

Warm Homes, Healthy People fund: keeping people warm in winter

To support the aims of the Cold Weather Plan the Department of Health is establishing the **Warm Homes, Healthy People** fund for winter 2011/12.

This is a major new initiative to support local authorities and their local partners in reducing death and morbidity in England due to cold housing in the coming winter. Further details will be announced in November 2011.

The Department of Health and other government departments already provide a range of advice and support to help individuals, families and carers to prepare for cold weather. However, the evidence that the annual cost to the NHS due to cold private housing is over £850 million is compelling. There is more that we can do to ensure the health of the most vulnerable. The Department of Health is therefore taking two immediate new steps:

- We will be providing additional financial support to the Department of Energy and Climate Change (DECC) of up to £10 million. This will be used to support Warm Front or other schemes to ensure that they help even more households vulnerable to fuel poverty in 2011/12.
- We will be inviting bids from local government and the charitable sector to access a new Warm Homes, Healthy People fund. Up to £20 million will be available in the first instance. We will be looking for innovative local proposals that address the public health consequences of cold housing for the most vulnerable in our communities, and where current available support is not getting through. We will be working closely with Age UK and other expert advisers on the design of this scheme.

Annex 1

Severe cold weather and cold weather service alerts – definitions

Cold weather alerts are issued by the Met Office on basis of the following weather events:

- low temperatures;
- widespread ice; and
- heavy snow.

Often low temperatures criteria are coincident with ice and/or snow. However, sometimes one event may occur without the other.

Definitions

Heavy snow – defined as snow falling at a rate of at least 2 cm per hour or more, expected for at least two hours. Geographic extent is not considered, and sometimes the event can be quite localised, but the Met Office will always try to indicate in the bulletin the areas that are affected.

Widespread ice – defined as when rain falls on to surfaces with temperatures at or below zero; or condensation occurs on surfaces at or below zero; or already wet surfaces fall to or below zero. The ice is usually clear and difficult to distinguish from a wet surface. It usually forms in sheets. Warnings are issued when any depth of ice is expected over a widespread area. Warnings will also be issued after snowfall when compacted snow is expected to cause an ice risk.

Widespread – indicates that icy surfaces will be found extensively over the area defined in the Met Office bulletin.

The Met Office issues all these alerts down to a county level, so either of the warnings above could be issued even if only one county was likely to be affected.

Acknowledgements

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Government departments across Whitehall have also contributed plans, expertise and commentary throughout the development of this plan.

The agencies and departments listed below were contacted during the course of the development of this plan. We are grateful for their assistance and input.

Department for Business, Innovation and Skills
Department for Communities and Local Government
Department for Culture, Media and Sport
Department for Education
Department for Environment, Food and Rural Affairs
Department for Transport
Department for Work and Pensions
Department of Energy and Climate Change
Department of Health
- Emergency Planning, Resilience and Response
- Health Improvement and Protection
- NHS Operations
- Office of the Chief Medical Officer

Health Protection Agency
Met Office
Ministry of Justice
Public Health England (launches in shadow form in 2012)

The delivery of this plan is closely linked in with a network of representatives from the Strategic Health Authority areas across England.

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Further reading

For a review of the evidence supporting this plan, see *Making the Case: Why cold weather planning is essential to health and well-being*, at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130564

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Produced in association
with the Met Office

Each winter there is an average of 27,000 extra winter deaths that could be avoided. The past two winters have seen significant periods of severe and sustained cold weather. This plan is intended to mobilise action to reduce winter deaths by a range of NHS, social care, community and voluntary organisations, as well as by individuals. For a review of the evidence supporting this plan, see *Making the Case: Why cold weather planning is essential to health and well-being*, at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130564

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SHADOW HEALTH AND WELL BEING BOARD REPORT

Report of: Sarah Bowman (Specialty Registrar in Public Health, NHS Tees)

Subject: FRAMEWORK - DRAFT JOINT HEALTH AND WELLBEING STRATEGY

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1. PURPOSE OF REPORT

1.1 This paper proposes the draft framework for the Hartlepool Joint Health and Wellbeing Strategy, to inform discussion at the shadow Health and Wellbeing Board meeting on 21st November 2011.

2. BACKGROUND

2.1 The proposed process for developing the Hartlepool Joint Health and Wellbeing Strategy (JHWS) was discussed and agreed at the shadow Health and Wellbeing Board meeting on 10th October 2011.

2.2 A task-and-finish group met on 3rd November to discuss the draft framework for the JHWS. The content of the draft framework is outlined in section 3 of this paper.

3. ISSUES FOR CONSIDERATION

3.1 Executive Summary

3.1.1 Summarising the vision, key aims, themes and actions in the strategy.

3.2 Foreword

3.2.1 By the Shadow Health and Wellbeing Board Chair.

3.3 Introduction

3.3.1 The JHWS is a high-level summary outlining how Hartlepool Borough Council, Hartlepool Clinical Commissioning Group and other key organisations will address health and wellbeing needs of Hartlepool and help reduce health inequalities. The Health and Social Care Bill (2011) currently establishes Health and Wellbeing Boards ('Boards') as statutory bodies responsible for encouraging integrated working and developing a Joint Strategic Needs Assessment[1] and Health and Wellbeing Strategy for their area. The JHWS is underpinned by the Joint Strategic Needs Assessment (JSNA) and together they will provide a foundation for strategic, evidence-based, outcomes-focused commissioning and planning for Hartlepool.

3.3.2 The JHWS will increase the opportunity for democratic accountability on joint health and social care issues and will outline the Health and Wellbeing Board's approach to:

- Promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health
- Support joint commissioning and pooled budget arrangements, where all parties agree this makes sense

3.3.3 It will be important to determine the scope of the Strategy and its resulting work programmes. Some areas of work will impact directly on health and wellbeing or act as clear 'wider determinants' of health and wellbeing. Others will link to the agenda but be outside the direct remit and influence of the Health and Wellbeing Board and its partner organisations. The purpose of the Strategy is to bridge health, Public Health and social care.

3.4 Vision

3.4.1 An agreed statement about 'where the Board wants to get to'. For example:

Improve health and wellbeing, reduce health inequalities and improve efficiency, through integrated working and focus on outcomes.

It may be helpful to summarise the scope, policy context, relationships and aims of the Strategy in a summary diagram[2].

3.5 Values and evidence base

3.5.1 'Values' describe the principles the Board will operate within, to implement the vision:

- Partnership working and increased integration
- Developed in the context of an oversight of budgets for health and wellbeing
- Focused on health and wellbeing outcomes
- Focused on prevention
- Based on evidence of need and evidence of what works

- Shared decision-making and priority-setting, in consultation with CCGs and other key groups
- Maximising the process of democratic accountability and developed in consultation with the public and service users

The evidence base for these core values could be set out in this section. For example the evidence base for integrated care[3] and for a focus on prevention.

3.6 Policy context – themes and principles

3.6.1 *Better Health, Fairer Health* (2008)[4] is the North East's vision and 25 year plan for improving Health and Wellbeing. It outlines ten themes:

- Economy, culture and environment
- Mental health, happiness and wellbeing
- Tobacco
- Obesity, diet and physical activity
- Alcohol
- Prevention, fair and early treatment
- Early life
- Mature and working life
- Later life
- A good death

3.6.2 The recent ANEC report[5] has recommended that all Local Authorities in the North East agree *Better Health, Fairer Health* as a common overarching vision for improving health and wellbeing. Its key themes form a useful overarching structure, within which localities could identify their own priorities. This approach would facilitate economies of scale across local authority areas where desired and appropriate.

3.6.3 In order to address the health and wellbeing needs of the population and tackle health inequalities, the JHWS should encompass and be embedded in the three 'domains' of Public Health practice: Health Protection, Health Services and Health Improvement[6]. This is important in identifying the roles of local authorities and Health and Wellbeing Board partner agencies e.g. CCGs, in discharging their responsibilities across the three areas.

3.6.4 In his *Strategic Review of Health Inequalities in England* (2010)[7], Prof. Sir Michael Marmot argues that fair distribution of health, well-being and sustainability will impact positively on the country's economic growth. He uses the finely graded nature of the relationship between socioeconomic gradient and both life expectancy and disability-free life expectancy, as the centre of his economic argument. Marmot highlights that social and economic inequalities are important causes of the gradient. In this context, he argues for action across all social determinants of health to reduce health inequalities. He also advocates that action to reduce the gradient should be universal but with a scale and intensity proportionate to the level of disadvantage.

3.6.5 The report outlines six priority policy areas, which also reflect the *Better Health, Fairer Health* themes. Marmot highlights early years interventions as the priority – in the context of a life-course approach, this may deliver the greatest benefits in health inequalities and economic terms.

3.6.6 Lastly, the JSNA for 2010[8] identified a series of commissioning intentions (***Appendix I***) to focus partners' activities in improving health and wellbeing and reducing health inequalities.

3.7 Strategic aims / priorities

3.7.1 The policy context can be used to develop overarching strategic aims / priorities for Hartlepool.

- Improve health and wellbeing and reduce inequalities
- Improve service integration
- Improve efficiency and balance the economy

(Source: NHS Leicestershire County & Rutland[9]).

3.7.2 Specific objectives define the priority areas for achieving each strategic aim. In order to prioritise strategic aims and objectives, it may be useful to agree a framework or mechanism. This could clarify the principles and the 'must-dos', and explicitly consider the evidence- and needs-base and political priorities.

3.7.3 It is important that the strategic aims and priorities are developed in consultation with the public and service users, through LINks membership on the Health and Wellbeing Board (and the development of HealthWatch), democratically elected member representation on the Board, and the consultation process (section 9). The seven Health and Wellbeing Board subgroups will be used as a focus for consultation on priorities. It is proposed the seven subgroups are mapped to existing groups to maximise structures already in place. A series of events will be planned in January – February 2012 to enable these prioritisation discussions, each beginning with the context of key evidence (facilitated through JSNA topic leads) and progress on key Public Health indicators.

3.7.4 The contribution of wider partner organisations to delivering the Strategy should be included e.g. the voluntary and community sector. The Strategy should also be developed with CCGs in the spirit of co-production to embed the Strategy in CCG plans from the outset and facilitate integrated commissioning, rather than aligning plans through a *post-hoc* checking mechanism. Through Local Authority structures and the ongoing wider transition agenda for Public Health, it will be important to embed health and wellbeing in the other relevant Local Authority strategies and services.

3.8 Objectives

3.8.1 The following structure is suggested for considering each objective[2]:

Objective Description of the issue Key outcome(s) (and the measure) Evidence base (what is the need and what works?) Priority actions

3.9 Measuring outcomes

3.9.1 It is important that the Strategy remains outcomes-focused and that these are appropriately measured. Though some process indicators will be necessary, the emphasis should be on measurement through outcome indicators for health and wellbeing e.g. Leicestershire County & Rutland[9]. Indicators will need to be developed in line with the Public Health Outcomes Framework and further details of the health premium.

3.10 Work programme

3.10.1 A work programme will be defined to agree timescales and organisational accountability for contributing towards outcomes. This should include a risk log for the implementing the Strategy.

3.11 Consultation

3.11.1 As outlined in section 5 partner, public and user involvement will be integral to the process of Strategy development. There will be consultation on the draft Strategy, according to statutory requirements and Local Authority processes. 'Face the Public' events will be used as an opportunity to consult on the draft strategy in June 2012 (which will also support parallel consultation on the draft JSNA). Haringey Shadow Health and Wellbeing Board has produced a consultation document which includes an example of a public consultation questionnaire[9].

3.12 Strategy ownership and review

3.12.1 The Strategy is owned by the Shadow Health and Wellbeing Board. It will be reviewed and refreshed following the completion of the new JSNA for Hartlepool and the release of further details on the shadow budgets and the health premium. Following its completion, it should be refreshed according to a defined schedule in line with JSNA, budget and planning cycles.

4. RECOMMENDATIONS

4.1 The shadow Health and Wellbeing Board is asked to consider the draft JHWS framework and proposed content.

5. REASONS FOR RECOMMENDATIONS

5.1 Discussion and agreement on the framework and content outline will enable a strategy to be developed in line with the Board's aims, expectations and requirements.

6. BACKGROUND PAPERS

1. Local Government Improvement and Development (April 2011) Joint Strategic Needs Assessment: A springboard for action. Available from: http://www.idea.gov.uk/idk/core/page.do?pageId=26995274

2. Haringey Council / NHS North Central London (2011) Haringey's Draft Health and Wellbeing Strategy 2012-2015: Consultation 20th September – 20th December 2011. Available from: http://www.haringey.gov.uk/health_and_wellbeing_consultation.pdf

3. Nick Goodwin and Judith Smith for The King's Fund / Nuffield Trust (2011) Developing a nation strategy for the promotion of integrated care: The evidence base for integrated care. Slide pack available from: http://www.nuffieldtrust.org.uk/our-work/projects/developing-national-strategy-promotion-integrated-care

4. NHS North East (2008) Better Health, Fairer Health. Available from: http://www.northeast.nhs.uk/your-health/regional-strategy/

5. Association of North East Councils (2011) Improving Health Task and Finish Report. Available from: http://www.northeastcouncils.gov.uk/global/assets/documents/asset20111011104927.pdf

6. Faculty of Public Health. Available from: www.fph.org.uk

7. Marmot report (2010) Strategic Review of Health Inequalities in England

8. Hartlepool Borough Council / NHS Hartlepool (2010) Hartlepool Joint Strategic Needs Assessment. Available from: http://www.teespublichealth.nhs.uk/Download/Public/1012/DOCUMENT/9574/Hartlepool%20JSNA%202010%20Reference.pdf

9. Dr. Peter Marks, NHS Leicestershire County & Rutland (06/09/11) Outcomes Framework 2011-12. Report of the Director of Public Health to the Shadow Health and Wellbeing Board. Copy available on request

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8. APPENDICES

Appendix I: Priority policy areas outlined in the Marmot report (2010)[7]:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

Appendix II: Commissioning intentions identified in the Hartlepool JSNA 2010[8]

Summary of Commissioning Intentions

CHILDREN & YOUNG PEOPLES HEALTH & WELLBEING

- Improve the quality of services for children and young people that enables them to enjoy their education, improve their well being, enrich their lives and raise aspirations.
- Ensure services are young person friendly implementing Your Welcome Standards across service providers.
- Continue to promote through a range of media the importance of vaccinations in protecting the health of children.
- Continue to promote the benefits of breastfeeding for mother and child and develop peer support approaches to support women to successfully sustain breastfeeding.
- Implement the recommendations of the Teenage Pregnancy National Support Team, ensuring the delivery of the 10 priority areas for action.

TRANSITION YEARS

- Continue to improve services for children and young people with physical disabilities and/or learning difficulties with a particular emphasis on the transition into adult services (health as well as social care).
- Continue to strengthen multi-agency working to ensure transitions are more person centered.
- Provide more support for children and young people who struggle with their schooling and develop better approaches to partnership working with parents.
- Strengthen participation of children and young people in the planning and decision making processes.
- Expand re-engagement programmes which support the most disaffected and disadvantaged young people.

SAFEGUARDING CHILDREN

- Work together with partners to ensure children, young people and vulnerable adults are kept safe from deliberate, neglectful or accidental harm and exploitation.
- Embed safeguarding standards into provider contracts to ensure providers meet local and national core standards.
- Develop a process that facilitates greater involvement within safeguarding of people who use services and their carers.
- Establish stronger links with between social care and health colleagues.

ADULTS & OLDER PEOPLE HEALTH & WELLBEING

- Increase the number of people who are "work ready" with the right skills to get local employment.
- Improve access to benefits advice and information for all.
- Support people to live healthier lives, in their own homes for as long as they want to be there through improving access to services and provision of specialist equipment.
- Ensure that services are commissioned which focus on prevention, early intervention and re-ablement, so that people are able to retain their independence for as long as they can.
- Improve transport to ensure easy access to services and to reduce social isolation.
- Ensure that recreation and leisure opportunities are accessible for older people to support them in maintaining their physical and emotional wellbeing.
- Make sure all carers have an assessment and are provided with breaks and the support they require.

SAFEGUARDING ADULTS

- Develop stronger links between commissioning and operational services.
- Develop a process that facilitates greater involvement within safeguarding of people who use services and their carers.
- Establish stronger links between social care and health colleagues in relation to safeguarding including GPs and all staff within integrated teams.
- Establish stronger links between the Care Programme Approach within mental health and the safeguarding framework.
- Develop closer working relationships between the Commissioned Services Team, the Safeguarding and Vulnerability Team and the Continuing Healthcare function.

Summary of Commissioning Intentions

CHOICES THAT THREATEN HEALTH - SMOKING

- Ensure easy access to stop smoking services so that everyone who smokes can easily find the support they need to stop - close and convenient to where they live or work.
- Ensure a whole health system approach to tackling smoking by developing service level agreements which require all health professionals to raise the issue of smoking through a brief intervention and refer to Stop Smoking Services for support.
- Ensure that referral to Stop Smoking Services is included in relevant care pathways and rehabilitation services for smoking related disease.
- Continue to promote the positive impact of stopping smoking in pregnancy, including offering rewards and incentives to support women to stop smoking.
- Help young people not to want to smoke and support those who want to stop smoking.
- Ensure all agencies work effectively to prevent under-age sales.
- Encourage families in Hartlepool to have smoke free homes.

CHOICES THAT THREATEN HEALTH – PHYSICAL INACTIVITY

- Support people to become more active as part of their everyday lives: linking services together and increasing physical activity opportunities across the town for all ages.
- Enhance and develop play spaces across the town.
- Develop an Olympic legacy for the town.
- Encourage children, young people and adults to include physical activity as their transport choice.
- Ensure the redevelopment of existing facilities is informed by people's needs and wants.

CHOICES THAT THREATEN HEALTH – NUTRITION

- Ensure all children and young people get the messages about making healthy choices to help them to improve their diet and increase uptake of exercise, therefore increasing the number who have a balanced weight.
- Continually improve access and effectiveness of community weight management services to help adults manage their weight effectively.
- Develop clear referral pathways for overweight and obese individuals.
- Deliver effective and efficient dietetic services for those who are morbidly obese.
- Increase easy access to fresh fruit and vegetables.

CHOICES THAT THREATEN HEALTH – DRUG & ALCOHOL

- Increase the capacity of treatment and support services, including criminal justice programmes.
- Increase integration of drug and alcohol services to ensure effective care coordination programmes for poly drug use.
- Increase training for non-substance specific services to increase screening and delivery of alcohol brief interventions.
- Improve support for family members, particularly children and young people affected by parental substance misuse.

CHOICES THAT THREATEN HEALTH – SEXUAL HEALTH

- Develop key partnerships with the new Accountable Provider for integrated Sexual Health Services to ensure synergy of commissioning.
- Develop risk taking behaviours board and thematic task group.
- Improve access and increase provision (particularly in areas of disadvantage) to meet the needs of all ages including young people, over 35s and minority groups.
- Increasing access to long acting reversible contraception (LARC).

Summary of Commissioning Intentions

CHOICES THAT THREATEN HEALTH – ORAL HEALTH

- Ensure timely local access to NHS dentistry for new patients, existing patients and those in need of urgent treatment.
- Address the imbalance of preventative services compared to treatment services to ensure that there is a greater focus on preventative care.
- Achieve waiting time targets for dental anaesthetic and orthodontic services.
- Address equity of access for vulnerable groups.
- Evaluate the effectiveness of the pilot oral cancer screening programme to inform future commissioning strategies.

CHOICES THAT THREATEN HEALTH – SICKNESS

- Reduce the number of people who develop diabetes, strokes and heart disease.
- Increase the number of people surviving at 5 and 10 years following a diagnosis of cancer.
- Reduce the number of people who develop a chronic respiratory disease.
- Increase the number of people who are screened for cancers and cardio vascular diseases through targeted campaigns and expansion of existing programmes.
- Increase the number of providers offering screening services.
- Support people with chronic respiratory diseases and other long term conditions to live healthier lives, manage their condition and retain their independence.
- Ensure that all adults aged 40-74 have a vascular risk assessment every 5 years.
- Continue to improve access to GP and primary care services including providing more services closer to people's homes.

PHYSICAL DISABILITIES

- Utilise more technology such as Telecare and Telehealth
- Develop a common assessment framework and share e-records across agencies
- Develop a centre for independent living
- Further develop personalised and individual budgets

AUTISTIC DISORDER SPECTRUM

- Increase the uptake of self directed care.
- Develop the workforce across a range of settings so that there is a greater understanding and knowledge of Autistic Spectrum disorder.
- Support and advise parents and carers, staff and educational and care staff in meeting the needs of children and young people with Autistic Spectrum disorder.

MENTAL HEALTH

- Improve access to psychological therapies
- Promote mental health and well being across the town
- Work in partnership across organisations to promote recovery

CARERS

- Provide services to carers who want to return to or maintain their education, training or employment
- Develop self Directed Assessment Questionnaire and Resource Allocation System so carers have greater choice over care and support and how positive outcomes are achieved

DEMENTIA

- Review and implement the intermediate model of care
- Develop Telecare (assistive technology) strategy
- Ensure all carers have an assessment and access to short breaks
- Progress the dementia advisor role

Summary of Commissioning Intentions

END OF LIFE
- Develop a palliative care register of all people approaching end of life for clinicians
- Develop services to meet people's needs on a 24 hours / 7 days a week basis
- Increase the number of people surviving cancer at 5 years through early detection and intervention
- Implement advanced care planning so carers are supported throughout the end of a patient's life and the subsequent period of bereavement

HEALTH AND SOCIAL CARE
- Provide housing aids and adaptation to help people to live independently in their own homes
- Provide services for people receiving intensive home care support
- Continue to promote immunisation and screening programmes to prevent and detect early disease
- Provide services to support people to live healthier lifestyles including stopping smoking and maintaining a healthy weight

VOLUNTARY AND COMMUNITY SECTOR
- Continue to implement the 'Compact' between statutory and voluntary agencies
- Strategically plan how the voluntary sector and statutory services can compliment each other and work together
- Identify new resources to lever into the town to continue this essential work

HOUSING
- Improve provision and access of suitable accommodation for young people
- Monitor the registered social landlords development for the provision of affordable rented accommodation in the town against needs of local communities
- Ensure all social rented accommodation meets Decent Homes Standard
- Develop the single persons supported housing scheme

ENVIRONMENT
- Continue to monitor air quality
- Reduce levels of underage and illicit tobacco sales
- Improve overall public satisfaction with cleanliness across the town
- Implement the Allotment Development Strategy

TRANSPORT
- Work with local transport providers to review routes, timetabling and costs
- Improve overall safety and security of the transport system
- Minimise impact of transport on air quality

COMMUNITY SAFETY
- Develop comprehensive sustainable alcohol treatment services
- Improve access to accommodation and support for people who misuse substances to support them in their recovery
- Improve parenting support and interventions
- Continue to focus on reducing anti-social behaviour

ECONOMIC DEVELOPMENT
- Work with local business communities to exploit new markets
- Seek to create sustainable jobs in difficult economic conditions
- Implement the child poverty action plan