PLEASE NOTE CHANGE DATE/TIME

SHADOW HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

26 October 2012

11.30 am

Committee B, Civic Centre
Victoria Road, Hartlepool

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, Cleveland Fire Authority.

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 10 September 2012 and 1 October 2012

4. **MATTERS ARISING FROM MINUTES**

5. **ITEM FOR INFORMATION**

   5.1 Clear and Credible Plan – Verbal Update
   5.2 CCG Authorisation – Verbal Update
   5.3 Update on Health Watch – Verbal Update
   5.4 NHS Emergency Planning Arrangements – post 2013 – Verbal Update

PLEASE NOTE CHANGE DATE/TIME

6. **ITEMS REQUIRING DECISION**

6.1 Deciding Priorities for Health and Wellbeing in Hartlepool (*Specialty Registrar in Public Health, NHS Tees) (attached)*

7. **ITEM FOR DISCUSSION**

7.1 Cold Kills presentation – Director of Public Health and Head of Public Health Intelligence
7.2 Minimum Unit Pricing for Alcohol Presentation – Director of BALANCE

8. **FUTURE AGENDA ITEMS**

9. **ANY OTHER BUSINESS**

SHADOW HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

10th September 2012

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

The Mayor, Stuart Drummond - In the Chair

Statutory Members

Councillors: Councillors: Cath Hill (Deputy Mayor) (Children's and Community Services Portfolio Holder)
John Lauderdale (Adult and Public Health Services Portfolio Holder).

Jill Harrison, Assistant Director, Adult Social Care
Louise Wallace, Assistant Director, Health Improvement

Non Statutory Members: -

Alan Foster, Chief Executive, North Tees and Hartlepool NHS Foundation Trust
David Turton, District Manager, Cleveland Fire Authority

In attendance as substitute:-

David Brown as substitute for Martin Barkley, Tees, Esk and Wear Valley NHS Foundation Trust
Denise Ogden as substitute for Dave Stubbs, Hartlepool Borough Council
Iain Caldwell as substitute for Keith Bayley

Also Present:

Ian Wolstenholme, Local Authority & Criminal Justice Partner Liaison Officer, Cleveland Police Authority
Tracy Woodall, VCS representative
Andy Graham, Public health registrar

Officers: Amanda Whitaker, Democratic Services Team Manager

82. Apologies for Absence

Councillor Paul Thompson, Finance and Corporate Services Portfolio Holder, Sally Robinson, Assistant Director, Prevention, Safeguarding and Specialist Services, Chris Willis, Chief Executive, NHS Hartlepool
Nicola Bailey, Acting Chief Executive
Keith Bayley, HVDA
Martin Barkley, Chief Exec, Tees and Esk Valley NHS Trust
Simon Featherstone, Chief Exec, North East Ambulance Service
Dr Paul Pagni, Clinical Commissioning Group
Dave Stubbs, Director of Regeneration and Neighbourhoods

83. Declarations of interest by Members

None

84. Minutes of the meeting held on 30th July 2012

Confirmed

85. Public Health Funding Response

Further to minute 79, the Director of Public Health advised that a response had been submitted to the Department of Health, from the Local Authority and through NHS routes, expressing concern at the implications of a potential for a reduction in Public Health funding. A response had been submitted also from the Association of North East Councils in terms of the implications for the region.

Decision

The update was noted.

86. Health and Wellbeing Consultation

Further to minute 80, the Director of Public Health provided an update on the consultation process for the Joint Health and Wellbeing Strategy. It was noted that the consultation included an online survey and a health priorities exercise which was being conducted at various locations in the town. A face the public event had also been held. Elected Members of the Council had been contacted in relation to ward priorities and features had been included in the local press.

Following the conclusion of the consultation period, outcomes would be considered. A report would be submitted to the next meeting of the Shadow Board proposing a process for identifying priorities for health and wellbeing in Hartlepool, on which to base the Hartlepool Joint Health and Wellbeing Strategy. Reports would be submitted also to various other decision making bodies.

Decision

The update was noted.

87. Local Government Association Offer to Health and Wellbeing Boards

Further to minute 76, the Director of Public Health referred to an opportunity for Shadow Board Members to attend a Health and Wellbeing Board Simulation Event in Manchester on 26 September.

Whilst recognising that statutory guidance had not yet been received, issues relating to development of the Board were discussed.

Decision

The update was noted.

88. Clinical Commissioning Group Authorisation Process

It was noted that apologies had been submitted on behalf of Clinical Commissioning Group (CCG) representatives who were unable to attend the meeting due to unforeseen circumstances. An update was, therefore, provided by the Director of Public Health on the CCG Authorisation Process. A number of senior appointments had been made nationally. As reported to the last meting of the Shadow Board, Cameron Ward had been appointed to the Durham and Tees Local Area Team and staffing structures were expected to be announced in due course.

A copy of the draft Clear and Credible Plan would be submitted to the next meeting of the Shadow Board to ensure consistency with the Joint Health and Wellbeing Strategy.

Decision

The update was noted.

89. Interaction between Shadow Board and Police Commissioners Officer

Ian Wolstenholme, Local Authority & Criminal Justice Partner Liaison Officer, presented a report which highlighted the opportunities and requirements of the office of the Police and Crime Commissioner to work

with and pay regard to Health and Wellbeing Boards. The report set out areas of commonality and identified areas of partnership working. In view of the complexity of funding structures, the advantages of joint commissioning and partnership working were highlighted. It was concluded that participation with the Health and Wellbeing structure could play a pivotal role in informed service provision.

Members of the Shadow Board sought clarification on issues which had been highlighted by the report. Concern was expressed regarding the potential implications of the allocation of funding streams to Police and Crime Commissioners. The Shadow Board was advised that in relation to the Early Interventions Grant, only the element of the grant relating to youth offending would be allocated to Police and Crime Commissioners. In terms of Community Safety Partnership Funding, the Mayor explained the current approach to allocation of funding.

Decision

The update was noted.

90. Stay Safe and Warm Campaign 2012-2013

Details of the Stay Safe and Warm Campaign 2012-2013 had been circulated to members of the Shadow Board. Jill Harrison, Assistant Director, Adult Social Care provided further details of the Campaign at the meeting. The Scheme was led by Cleveland Fire Brigade and supported by local statutory members of the Teeswide Safeguarding Vulnerable Adults Board. The annual campaign aimed to raise awareness of the dangers faced by people who struggled to keep warm during the cold months and to highlight the help and support available to them. Case Studies had shown some excellent case studies and benefits to those who had used the service.

It was highlighted that although this year's campaign would commence on 3 October 2012 and operate until 31 March 2013, Cleveland Fire Brigade would offer assistance with heating and fire safety matters throughout the year.

Board Members spoke in support of the Campaign. Discussion took place regarding the availability of resources to support the Campaign and the potential increase in demand arising from changes in the benefits system. Board Members noted that link with hospital discharges had been established previously and was currently being considered with Trust community staff.

Following a suggestion made at the meeting, a link to the Campaign with free cavity wall and loft installation initiatives would be considered.

It was noted that a report would be submitted to the next meeting of the

Shadow Board relating to the Cold Weather Plan.

Decision

That further update reports on the Campaign be submitted to the Shadow Board.

91. Regional Assurance Framework

The Director of Public Health provided the Shadow Board with assurances in relation to attendance at regional group meetings for the workstream on Health and Wellbeing Boards across the North East. The Shadow Board agreed that the Director should continue to complete surveys on behalf of the Board.

Decision

The update was noted.

92. Health Protection Agency Annual Report

The Director of Public Health highlighted the production of the Health Protection Agency Annual Report. Reference was made to the presentation which had been made by Health Protection Agency at a previous meeting of the Shadow Board when key health protection issues had been discussed.

Decision

The update was noted.

93. Joint Strategic Needs Assessment (JSNA)

(i) JSNAs and Joint Health and Wellbeing Strategies – Draft Guidance – Proposals for Consultation

(ii) Presentation by Director of Public Health on JSNA Refresh

Proposals for consultation, produced by the Department of Health, had been circulated to members of the Shadow Board. The statutory guidance explained duties and powers for Health and Wellbeing Boards in relation to JSNAs and Joint Health and Wellbeing Strategies. The document included a number of consultation questions. It was noted that the consultation was running from 31 July 2012 to 28 September 2012. The Board agreed that there was nothing new for Hartlepool processes in the Guidance that justified forwarding a response from the Shadow Board. However colleagues were urged to continue to consider the JSNA as part of their work.

The Director of Public Health provided a demonstration of the web based JSNA (www.teesjsna.org.uk). Members of the Shadow Board acknowledged that details included on the site would be fundamental to developing the Joint Health and Wellbeing Strategy together with the outcomes of the current consultation exercise. It was recognised, therefore, that it was essential for the Board to take ownership of the website and to ensure information was updated regularly.

Decision

The update was noted.

94. Mental Health and Wellbeing
(i) Mental Health and Social Care
(ii) Mental Health and Health Services
(iii) Voluntary Sector Perspective

Jill Harrison, Assistant Director, Adult Social Care made a presentation on mental health services from a social care perspective. The Board was advised of key issues and was informed that Hartlepool has a 40% greater need in relation to mental illness compared to England. In 2010, 2,274 people had accessed secondary mental health services compared to 5.2% for the North East and 5.1% for England. The number of people with mental illness is predicted to remain at similar levels over the next 15 years but would increase by 30% for dementia and depression in older people. It was highlighted that mental ill health was linked with inequality and deprivation (Marmot 2010). It was noted also that Hartlepool has higher than average levels of long-term unemployment, deprivation, drugs use and alcohol related harm.

In terms of data specifically relating to Hartlepool, Members of the Board were advised that 700 people were on mental health registers with serious mental illness and approximately 2,200 were accessing secondary mental health services. There were 9,000 people with common mental disorders and 1,030 people with dementia. The Child and Adult Mental Health Service (CAMHS**)** had received 600 referrals in 2011 which was a 7% increase from 2010. Other key data for Hartlepool was highlighted including percentage in settled accommodation (80%), employment (8.7%), residential/nursing placements (43) and personal budgets. It was noted that Hartlepool Borough Council contributed approximately £2 million and Tees Esk and Wear Valley Trust contributes approximately £4million including direct inpatient services. Average allocated spend for mental health per head is £216 (compared to England average of £182). Improving Access to Psychological Therapies was well used with a recovery rate of 79%. The Assistant Director concluded her presentation with details of the focus on JSNA 2012-2014 in terms of mental health services.

Following the presentation Board Members discussed issues which had been raised including clarification of the reference to 'recovery rate'. The potential impact of changes to the benefits system, in terms of mental health, was highlighted together with the possibility of a role for the Police Commissioner in terms of commissioning mental health services.

The Shadow Board also received a presentation from David Brown, Tees Director of Operations, on key issues affecting mental health services from a NHS provider perspective. The presentation covered background information in relation to the geographic spread of the Tees, Esk and Wear Valleys Trust, the services provided and facts and figures relating to population, employment and finance affecting the Trust. The presentation also included details of the 2012/13 Operating Framework for the Trust in terms of the Financial Framework and Service Issues. The top 10 priorities for the Monitor Plan were highlighted. In summary, key issues were identified including improving quality of services, patient experience, patient outcomes, GP feedback, staff morale and development, meeting expectations of stakeholders and reducing costs. Discussion followed in relation to issues associated with patients not attending appointments.

The Voluntary Sector perspective was presented by Iain Caldwell from Hartlepool and East Durham Mind. The current context for the voluntary sector was set out in terms of issues associated with Any Qualified Provider, Multiple competing providers, reduction in funding grants, Social Care dis-investment and the establishment of the Clinical Commissioning Group. The impact on the voluntary sector of strategic partnerships, mergers and takeovers was presented together with the impact of the reduction in 'informal partnerships', the closure of small to medium voluntary sector, management of risks and the change of culture from patients/clients to customers. Further impacts were highlighted in terms of innovation, business approach and identification of new funding streams. Board Members were also advised of details of World Health Mental Health Day and highlighted that an event had been organised to take place at the Historic Quay on 10th October. In response to clarification sought from a Board Member, Mr Caldwell clarified the event aimed to raise awareness of mental health issues, launch new initiatives, provide details on availability of services and raise the profile of mental health issues.

The risks for small voluntary groups were highlighted and the view was expressed regarding the potential for groups to act as a consortium. Concerns were expressed that specialist services could potentially be lost which are not picked up elsewhere.

The Shadow Board was advised that mental health collaboration commenced that week to improve dementia services. The importance of working together was highlighted together with crisis intervention issues.

Decision

The presentations were noted.

95. Future Agenda Items

It was agreed that the dementia initiative should be included on a Shadow Board agenda early in the new year.

The meeting concluded at 11.55 a.m.

CHAIR

SHADOW HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

1 October 2012

The meeting commenced at 9.00 am in the Civic Centre, Hartlepool

Present:

Dr Paul Pagni, Clinical Commissioning Group - In the Chair

Statutory Members: -

Councillors: Cath Hill (Deputy Mayor) (Children's and Community Services Portfolio Holder)
John Lauderdale (Adult and Public Health Services Portfolio Holder).

Nicola Bailey, Acting Chief Executive
Dave Stubbs, Director of Regeneration and Neighbourhoods
Jill Harrison, Assistant Director, Adult Social Care
Louise Wallace, Assistant Director, Health Improvement
Christopher Akers-Belcher, Hartlepool LINK Co-ordinator

Non Statutory Members: -

Alan Foster, Chief Exec, North Tees and Hartlepool NHS Foundation Trust
Martin Barkley, Chief Exec, Tees and Esk Valley NHS Trust

Also Present:

Dr Andy Graham, Public Health Registrar
Ali Wilson, NHS Tees / Clinical Commissioning Group
Sarah Bowman, Acting Consultant in Public Health

Officers: -

Catherine Frank, Performance and Partnerships Manager
David Cosgrove, Democratic Services Team

96. Apologies for Absence

The Mayor, Stuart Drummond, Councillor Paul Thompson (Finance and Corporate Services Portfolio Holder), Margaret Wrenn, Hartlepool LINK Chair, Chris Willis, Chief Executive, NHS Hartlepool, Nicola Fairless, Chief Executive, North East Ambulance Service

97. Declarations of interest by Members

None.

98. Minutes of the meeting held on 10 September 2012

Deferred to the next meeting of the Board.

99. Draft Health and Wellbeing Strategy (*Director of Public Health*)

The Director of Public Health and the Acting Consultant in Public Health presented to the Board the Draft Hartlepool Joint Health and Wellbeing Strategy 2013-2018. Copies of the draft strategy document were tabled at the meeting. The draft strategy would also be considered by the Clinical Commissioning Group (CCG) and Cabinet; Cabinet would also refer the strategy to Scrutiny.

The document presented to the meeting contained feedback from the recent eight-week consultation period and a further paper was tabled at the meeting setting out the responses received during the consultation process. The consultation feedback had influenced the key strategic priorities and objectives and the document also reflected the Council's adoption of the Marmot Principles.

A further report would be submitted to the Board meeting scheduled for 22 October which would look to the establishment of the key priorities.

Board Members noted that the consultation feedback was heavily weighted towards prioritising key services to children. Officers indicated that this outcome could be expected when some of the consultation venues were children's centres but it was also a clear outcome from other consultation venues as well. It was also noted that there was a high level of response prioritising parenting skills. There was also comment made that tackling issues around employment had the knock-on effect of dealing with many of the issues surrounding child poverty and they should not be ignored in any targeting of priorities towards improving children's start in life.

The Board also discussed the general issue a round budget constraints and the effect these may have on the implementation of the finalised strategy. The strategy had a five-year lifespan yet none of the partner organisations that would be delivering the strategy had knowledge of their budgets much beyond the next two years. It was understood that the local authority funding would be ring-fenced for the first two years but what would happen after that was still unknown. The Acting Chief Executive indicated that indicative budgets would be available in early December but definitive budgets would not be known until mid-February.

The reflection of the Marmot Principles was welcomed and while the consultation outcomes were quite clear, what was not known was how these would/could affect the operation of services. The full range of services would still need to be delivered and there would need to be further 'conversations' with the public in how that service delivery and their priorities could align.

The Board welcomed the draft strategy document and the Director of Public Health thanked the officers involved in the development of the document and the consultation exercise. The next meeting would look to the identification of priorities for the next stages of the strategy's development

Decision

That the Draft Hartlepool Joint Health and Wellbeing Strategy 2013-2018 be received.

The meeting concluded at 9.45 a.m.

CHAIR

6.1

SHADOW HEALTH AND WELL BEING BOARD REPORT

HARTLEPOOL BOROUGH COUNCIL

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

Subject: DECIDING PRIORITIES FOR HEALTH AND WELLBEING IN HARTLEPOOL

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1. PURPOSE OF REPORT

1.1 This paper proposes a process for identifying priorities for health and wellbeing in Hartlepool, on which to base the Hartlepool Joint Health and Wellbeing Strategy.

2. BACKGRO UND

2.1 The Hartlepool Joint Health and Wellbeing Strategy is currently being drafted, ready for completion by December 2012. The Strategy will outline the strategic priorities for improving the health and wellbeing of the Hartlepool population and reducing inequalities in health and wellbeing. The Strategy is being based on the Joint Strategic Needs Assessment (JSNA). The JSNA assesses, at a strategic level, the level of need in the population, the evidence for effective interventions and current service provision. It then makes recommendations at a strategic level for ensuring services meet the needs of the population.

2.2 The public and service users are being consulted on their views regarding priorities for health and wellbeing in Hartlepool. This process has been described in a previous paper to the Shadow Health and Wellbeing Board (Consultation Process for the Hartlepool Joint Health and Wellbeing Strategy). The consultation process is using a range of methods (including public surveys, consultation events and attendance at various meetings and forums) and will run until October 2012.

2.3 In order to ensure maximum impact on health and wellbeing in Hartlepool within the available resources, the outcomes of the JSNA and the consultation process will need to be assimilated and considered alongside each other. The

Hartlepool Shadow Health and Wellbeing Board will then need to define the priorities it will focus on, to develop its work programme.

2.4 This paper summarises the literature and experience from other areas, in deciding priorities for the Health and Wellbeing Board; and proposes a way forward for the prioritisation process in Hartlepool.

2.5 This paper reflects the NHS Confederation's recommendations on developing and running a prioritisation process[1]:

Step 1: Agree principles to underpin priority setting and factors to be considered
Step 2: Develop and establish priority setting structures and processes
Step 3: Consider how to approach a range of issues related to key relationships with stakeholders
Step 4: Produce key policy documents
Step 5: Develop tools to aid decision making, and make decisions

(Steps 1-3 are covered here, Step 4 will be the next step, and Step 5 is addressed in this paper through a draft proposed decision-making tool).

As the CCG's plans should reflect the Joint Health and Wellbeing Strategy, the CCG and its plans should also reflect the process used for prioritisation for the Strategy and underlying work programme. CCG health improvement plans should be informed by the priorities identified in the Joint Health and Wellbeing Strategy.

3. EVIDENCE BASE

3.1 Why use prioritisation tools?

3.1.1 A brief review of the available literature has been carried out, searching for guidance on Health and Wellbeing Strategy development and prioritisation methods (e.g. the LGA, ANEC and the NHS Confederation); and reviewing the experience of Boards in other areas. A summary of the findings follows.

3.1.2 Increases in demand, developments in technology and medicines, demographic changes, reduced resources and greater public expectation, means it is not possible to provide all potential services. It is therefore increasingly important that decisions are not based on intuitive methods, incomplete information or in conflict with strategic goals. A robust, transparent and evidence-based framework should be used for prioritisation and decision-making, to make explicit the impact on health when decisions are made to provide resources for some areas and not for others[2,3]. There is no national guidance on the prioritisation method that should be used, however the benefits commonly cited for using prioritisation tools are[2]:

- Align resources to agreed strategies and policies that improve the overall health and wellbeing of the population and improve the quality of services

- Ensure competing needs are given a fair hearing
- Enable consideration across pathways and discussion of disparate service areas and systems
- Provide better value for money
- Be operationally more efficient
- Increase public and patient confidence
- Add legitimacy to decision making
- Help achieve financial balance
- Meet the requirements of good corporate governance
- Be underpinned by a sound evidence base wherever possible

3.2 Principles

3.2.1 The importance of a clear, robust and principle-based framework is commonly recognised. The Royal College of General Practitioners have adopted the 'accountability for reasonableness' framework4 for a fair process of setting priorities in healthcare resource allocation:

- Publicity of decisions and their rationale
- Relevance (rationale for decisions based on evidence and relevant reasons, accounting for how the organisation provides value for money and meets varied health care needs
- Mechanism for revision of policies and appeals of decisions
- External or self-imposed mechanisms for regulation of the above

3.2.2 Organisations[2] may adopt the principle that new developments should not be invested in, unless they are clearly more effective, improve patient experience and health outcomes, and are at least equal in value for money to existing services or interventions. There is an opportunity cost to all service provision i.e. spend on a particular service means no spend, or less spend, on other services. The prioritisation framework should be developed within the agreed ethical framework of the Health and Wellbeing Board and its partners. A significant measure of informed judgement will be used by the panel, therefore agreement on this underpinning framework is important.

3.3 Prioritisation process

3.1 The approach taken by a range of areas has been reviewed (including Hackney[5], Harlow (Essex)[6], Birmingham). All are similar, broadly involving:

- A summary of the key issues, based on the JSNA
- The summary is shared with key stakeholders. Revisions are made as appropriate.
- A meeting is convened bringing together key stakeholders to:
    a. Score the identified issues against a set of agreed criteria / questions
    b. Review the current Profile / JSNA priorities against the outcome of the scoring
    c. Propose a long list of priorities

- A stakeholder meeting is convened to review decision-making and identify a short-list of priorities
- Agreement of revised priorities by Shadow Health and Wellbeing Board, Cabinet and CCG
- Priorities inform the development of the Joint Health and Wellbeing Strategy

3.4 Prioritisation tools

3.4.1 A task and finish group of the Shadow Health and Wellbeing Board may be established to drive the work forward, as in Bath. The Board for Bath allocated potential priorities to groups and rated them according to 'importance' and 'do-ability' - **Appendix I** sets out the detail as a case study.

3.4.2 Birmingham are matching local population needs, as identified in the JSNA, to the Marmot recommendations and prioritised on how closely they meet the recommendations. They will then be further scored and ranked in how far they help to achieve the Public Health Outcomes Framework. A formal ranking matrix will then be used for potential priorities that fall outside of the Marmot Framework, or to reprioritise under each Marmot theme if there are too many.

3.4.3 In their framework for allocating resources to health care, the Betsi Cadwaldr University Local Health Board (North Wales) aim to use limited resources to do as much good as possible (maximising health – and any other justifiable - benefit), whilst being fair. They acknowledge that sometimes it may be justifiable to do less good overall in order to be fair e.g. when targeting resources at a deprived group.

3.4.4 The NHS Confederation has reviewed a range of tools e.g. paired comparison analysis (generally used for ten choices or less), nominal group approaches (involving discussions to reach a consensus) and scoring mechanisms7. All have advantages and disadvantages – consensus approaches generate a more acceptable list, whereas scoring ensures each participant has equal weight in the process. Box 1 outlines the factors included in most scoring mechanisms.

3.4.5 In considering the economic aspect of prioritisation, Ruta et al.[7] state that singular decision-making (i.e. based on the issue in question alone, without accounting for all services) is inappropriate, and propose the use of PBMA (Programme Budgeting and Marginal Analysis). It proposes the following flow of questions:

- What are the total resources available?
- On which services and these resources currently spent?
- Which services are candidates for receiving more or new resources (and what are the costs and potential benefits of this)?
- Can any existing services be provided as effectively but with fewer resources, so releasing resources to fund items on the growth list?

- If some growth areas still cannot be funded, are there any services that should receive fewer resources, or even be stopped, because greater benefits would be reached by funding the growth options as opposed to the existing service?

Box 1: Factors considered in most scoring mechanisms

• The nature of the health gain	• Clinical risks
• Confidence in the clinical evidence	• Service risks
• The number of individuals benefiting	• Quality issues
• Cost effectiveness / value for money	• Cost
• The need to redress inequalities and inequities of access	• Legislation and direction from the Secretary of State
• Accessibility	• Patient choice
• National priorities	
• Stated local priorities	

As with all tools, the outputs are an aid to decision-making rather than a substitute for it. That said, it would be expected that any changes following discussion and negotiation, would be minimal.

4. THE PROPOSED PRIORITISATION PROCESS FOR HARTLEPOOL

4.1 Proposed principles

4.1.1 Proposed principles on which to base the prioritisation process are:

- The Health and Wellbeing Board is the mechanism through which major investment and disinvestment decisions are taken
- The Board will base its decisions on the Department of Health guidance that the Strategy: '… should prioritise the issues requiring the greatest attention, avoiding the pitfalls of trying to take action on everything all at once. They will not be a long list of everything that might be done; they will focus instead on key issues that make the biggest difference'[3].
- It may sometimes be justifiable to do 'less good overall' in order to be fair e.g. when targeting resources at a deprived group[2,3].
- Open, timely and robust communications will be a core element of the decision-making process

4.2 Proposed prioritisation process

4.2.1 It is proposed the following approach is used for Hartlepool (reflecting that outlined in Box 1):

- A long-list of potential priorities is drafted from the JSNA outcomes, together with the outcomes of the consultation process and informed by the key Marmot policy areas
- The priorities are grouped according to whether they will address: statutory requirements, short-term Board goals, or long-term Board goals
- A task-and-finish group is established to develop / refine the prioritisation tool if necessary
- The task-and-finish group use the prioritisation tool to generate a list of potential priorities for consideration by the Health and Wellbeing Board
- The suggested priorities are used to construct the Joint Health and Wellbeing Strategy
- The Strategy is intended to outline the direction and priorities for the medium- and long-term. Priorities should be reviewed when the Strategy is reviewed, to allow sufficient time to enable delivery against the priorities set. Sub-groups of the Shadow Health and Wellbeing Board will have the delegated responsibility deliver their elements of the Strategy work programme

4.3 Proposed prioritisation tool

It is proposed that a scoring mechanism is used, based on the criteria in **Box 1**, and the case studies from Bath (**Appendix I**) and Wales (**Appendix II**), with scoring criteria and weighting agreed by the Health and Wellbeing Board. Where possible, it would be beneficial to incorporate PBMA techniques to understand cost effectiveness relative to other proposed priorities. **Appendix III** proposes a prioritisation tool for Hartlepool, for discussion.

5. RECOMMENDATIONS

5.1 The Hartlepool Shadow Health and Wellbeing Board is asked to consider the proposed principles, process and tool for prioritisation in Hartlepool and agree next steps.

6. REASONS FOR RECOMMENDATIONS

6.1 An agreed, robust and open approach to prioritisation will be important in deciding and communicating priorities for health and wellbeing in Hartlepool.

7. BACKGROUND PAPERS

1. NHS Confederation (2007) PROCESS REF: Priority setting: an overview. http://www.nhsconfed.org/Publications/Documents/Priority%20setting%20an%20overview.pdf

2. NHS Wales: http://www.wales.nhs.uk/sitesplus/861/opendoc/192080
3. Department of Health JSNAs and joint health and wellbeing strategies – draft guidance (Jan. 2012) http://healthandcare.dh.gov.uk/files/2012/01/JSNAs-and-joint-health-and-wellbeing-strategies-draft-strats.pdf
4. Daniels and Sabin (2007) Setting Limits Fairly – Can we Learn to Share Medical Resources? A short summary was published in the BMJ (Daniels and Sabin, 2008)
5. NHS East London and the City: Hackney and the City of London (www.hackney.gov.uk)
6. Harlow: www.vaef.org.uk/documents/MicrosoftWord-Invitationtoattend.pdf
7. NHS Confederation (2008) Priority setting: strategic planning. http://www.nhsconfed.org/Publications/Documents/Priority%20setting%20strategic%20planning.pdf

8. CONTACT OFFICER

Sarah Bowman (Specialty Registrar in Public Health, NHS Tees)
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Email: sarah.bowman@northteespct.nhs.uk

Louise Wallace (Assistant Director of Health Improvement, NHS Hartlepool / Hartlepool Borough Council)

APPENDICES

Appendix I: Case study - Prioritisation process used by Bath Shadow Health and Wellbeing Board

Bath (http://democracy.bathnes.gov.uk/documents/s12515/Appendix%201.pdf) devised a prioritisation framework based on that used for its housing strategy. The draft principles it worked to were:

- Prevent ill health
- Promote equality, health and wellbeing
- Improve service quality
- Deliver best value
- Provide leadership and champion health and wellbeing

A task group was formulated to consider the framework and work up priorities. The process:

Stage 1 – **Allocates potential priorities** into 'groups'
Group 1: statutory responsibilities
Group 2a: contributes to longer-term Board ambitions and / or sustainability (e.g. from JSNA)
Group 2b: contributes to shorter-term Board ambitions and / or sustainability (e.g. from JSNA)
Group 3: doesn't fit any of the groups (not a priority)

Stage 2 – **Refinement**: this is a set of 'check' questions to ensure that the potential priority is in the right group and is the right level of aspiration:

a) What justifies the allocation of the potential priority to this group?

b) Is the potential priority being considered the minimum we need to do, or the maximum we might aspire to? Where does the appropriate balance lie in the current circumstances?

c) Are there opportunities to shape the potential priority to fit better with the Board's ambitions?

d) Have timing and sustainability been considered in looking at the potential priority?

e) Have achievability issues been considered in looking at the potential priority?

Stage 3 – **Evaluate** relative priority within a group – this is a mechanism for considering the overall benefits of each potential priority and mapping them in order in the group. Criteria were used to determine 'importance' and 'do-ability' and weighted scoring undertaken to calculate a percentage. These were plotted on the

prioritisation map. The threshold for selection will depend on the overall affordability / capacity. To ensure validity of the process, there needs to be consistency of scoring, which is likely to require some moderation by the task group. A number of people should be involved.

Relative prioritisation criteria

a) Importance – how important is the potential priority in comparison to all other potential priorities under consideration?

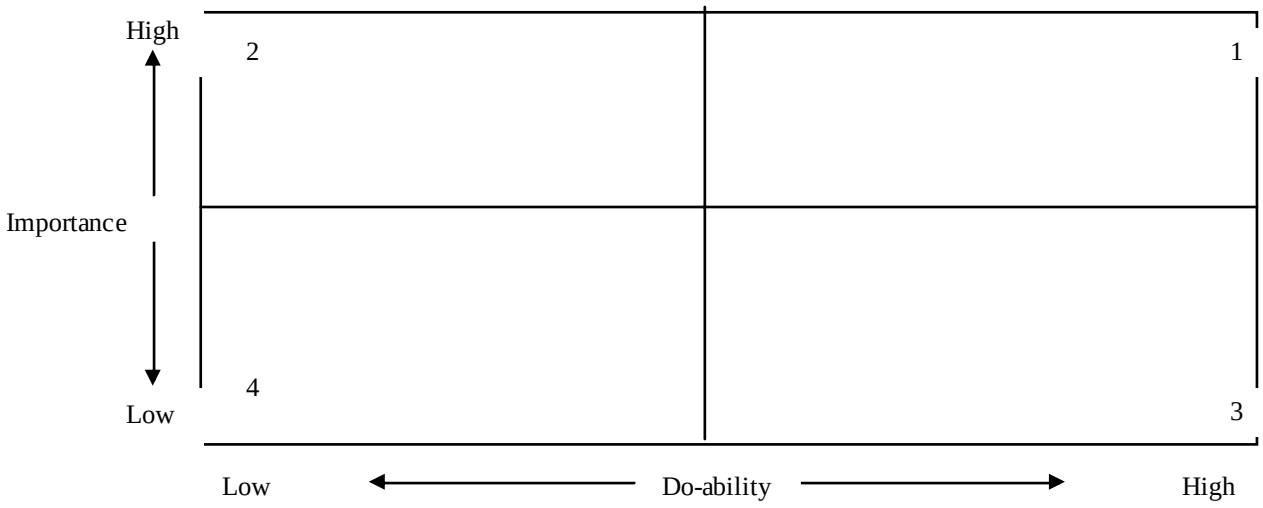
Element	Key 'importance' considerations	Max.
Local priority	To what extent would the potential priority take forward the Board's overall ambitions to: Prevent ill health (20) Promote equality, health and wellbeing (15) Improve service quality (20) Deliver best value (20) Provide leadership and champion health and wellbeing (5)	80
External drivers	To what extent is there pressure for change from other people or organisations (e.g. the public, stakeholders)? To what extent is there pressure for change nationally? Are there wider community benefits (e.g. education attainment, environmental) that rely on us delivering this?	20

b) Do-ability – how easy is it to deliver the potential priority in comparison to all other potential priorities under consideration?

Element	Key 'do-ability' considerations	Max.
Stakeholders / market capacity	To what extent are key stakeholders within the local health and wellbeing community supportive of this potential priority? What is the likely reaction of local people / groups and politicians to this potential priority (e.g. Overview and Scrutiny Committee; LINkS)	15

Service and change management	To what extent does this potential priority represent a complex service change, including workforce change? To what extent would it require other political / organisational agreement? How easy would this be to achieve? Would this potential priority affect the viability of other services? Is the market capable of delivering the potential priority (is there a market capacity issue)?	35
Resources required	Would this potential priority require additional financial investment? (Is this available to the Board?)	30
Consequences	What is the level of risk of failure to complete / deliver the potential priority?	10
Good practice evidence	Is there an evidence base for effective intervention on this topic?	10

Prioritisation map



Stage 4 – is a final check on **affordability** (both financial and management capacity).
Risk was a key consideration (the associated risk of 'doing' or 'not doing' the potential priority). Inequality was also a key consideration.

Appendix II: Prioritisation tool used by the Betsi Cadwaldr University Local Health Board

The tool simply uses a set of questions:

- Does it work?
    - (Clinical) effectiveness
    - Health gain (life expectancy, healthy life expectancy, quality of life and risk factors)
- Does it add value to society?
    - Strategic fit
    - Population and individual impact (balance between needs of a group of patients and that of the wider community)
    - Health inequities
- Is it at a reasonable cost to the public?
    - Affordability
    - Cost effectiveness
- Is it the best way of delivering the service?
    - Alternative services
    - Impact on services elsewhere
    - Workforce implications
    - Geography (transport, rural isolation)

Appendix III: Proposed tool for Hartlepool

Importance

Element	Key 'importance' considerations	Max.
Local priority	To what extent would the potential priority take forward the Board's overall ambitions to: Prevent ill health (20) Promote equality and equity (10) Provide health and wellbeing gain (life expectancy, healthy life expectancy, quality of life and risk factors) (15) Improve service quality (10) Deliver best value (cost effectiveness and affordability) (20) Provide leadership and champion health and wellbeing (5)	80
External drivers	To what extent is there pressure for change from other people or organisations (e.g. the public, stakeholders)? To what extent is there pressure for change nationally? Are there wider community benefits (e.g. education attainment, environmental) that rely on us delivering this?	20

Feasibility

Element	Key 'do-ability' considerations	Max.
Stakeholders / market capacity	To what extent are key stakeholders within the local health and wellbeing community supportive of this potential priority? What is the likely reaction of local people / groups and politicians to this potential priority (e.g. Overview and Scrutiny Committee; LINkS)	15

Service and change management	To what extent does this potential priority represent a complex service change, including workforce change? To what extent would it require other political / organisational agreement? How easy would this be to achieve? Would this potential priority affect the viability of other services? Is the market capable of delivering the potential priority (is there a market capacity issue)? Are there geographical issues? (rural isolation, transport etc.) To what extent would this potential priority support patient choice?	35
Resources required	Would this potential priority require additional financial investment? (Is this available to the Board?)	30
Consequences	What is the level of risk of failure to complete / deliver the potential priority? (clinical risk, service risk)	10
Good practice evidence	Is there an evidence base for effective intervention on this topic?	10