HEALTH AND WELLBEING BOARD

Venue: **Town Hall, Moorgate Road, Rotherham S60 2TH**

Date: **Wednesday, 6th June, 2012**

Time: **1.00 p.m.**

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested in accordance with the Local Government Act 1972.

2. To determine any item which the Chairman is of the opinion should be considered as a matter of urgency.

3. Minutes of Previous Meeting (Pages 1 - 10)
   - and verbal update from the 2 workshops

4. Joint Health and Wellbeing Strategy (Pages 11 - 24)

5. Clinical Commissioning Group Authorisation
   - verbal update by Chris Edwards

6. Update on Healthwatch (Pages 25 - 41)

7. Communications

8. Date of Future Meetings 2012/13
   - Wednesday, 11th July at 2.00 p.m.
     26th September
     24th October
     29th November
     16th January, 2013
     27th February
     10th April

HEALTH AND WELLBEING BOARD
29th February, 2012

Present:-

Members:-	
Councillor Wyatt	**In the Chair**
Karl Battersby	Strategic Director, Environment and Development Services
Christine Boswell	RDaSH
Brian James	Rotherham Foundation Trust
Martin Kimber	Chief Executive, RMBC
Dr. David Polkinghorn	CCG
Dr. John Radford	Director of Public Health
Janet Wheatley	VAR
Sarah Whittle	NHSR/CCG
Officers:-	
Rebecca Achinson	NHS Rotherham
Laura Brown	RMBC
Miles Crompton	RMBC
Kate Green	RMBC
Tracy Holmes	RMBC
Simon Lister	Stop Smoking Service
Shona McFarlane	Director of Health and Wellbeing
Chrissy Wright	Strategic Commissioning Manager
Dawn Mitchell	Democratic Services, RMBC
Councillor Jack	Observer

Apologies for absence were received from Councillors Doyle and Lakin, Tom Cray, Joyce Thacker, Matt Gladstone, Dr. David Tooth, Alan Tolhurst and Chris Edwards.

S48. MINUTES OF PREVIOUS MEETING

Agreed:- That the minutes be approved as a true record.

S49. JOINT HEALTH AND WELLBEING STRATEGY

Kate Green, Policy Officer, reported that the Department of Health had recently published draft guidance on developing Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

The report submitted set out a timetable for developing the Strategy which hopefully would be produced by May, 2012 in advance of the national timeline of April, 2013 when Boards were due to take on their statutory responsibilities. Draft guidance had been published to enable local authorities and Clinical Commissioning Groups to incorporate jointly agreed actions based on identified need into their planning.

The work programme approved at the previous meeting set out the timeline for completion of specific tasks and decisions for the next 12 months. This also

provided milestones for self-assessment against specific criteria so that the Board could improve its effectiveness.

The JSNA would be the means by which local leaders worked together to understand and agree the needs, as well as 'assets', of local people and communities. Data, information and intelligence underpinned them as well as being an analysis and narrative of the evidence, presenting a picture of the local community and its health and social care needs.

Dr. Polkinghorn stressed the importance of agreeing and publishing a Strategy by May, 2012, or the Clinical Commissioning Group would not receive "signing off" of their Plan.

It was suggested that a special workshop style meeting be held in March to further discuss and agree priorities for the Strategy and Joint Strategic Needs Assessment to enable community engagement to take place before April.

Resolved:- (1) That a special meeting of the Board be held in March to agree the further work being undertaken on the JSNA and consider priorities for the Joint Health and Wellbeing Strategy.

(2) That a small working group comprising of officers from the local authority, Public Health and Clinical Commissioning Group meet regularly to align the different activities required.

S50. JOINT STRATEGIC NEEDS AASSESSMENT

Miles Crompton, Corporate Policy Team, gave the following powerpoint presentation:-

What is a Joint Strategic Needs Assessment (JSNA)?
- Statutory assessment of current and future needs
- Partnership between Council and NHSR
- Evidence base to guide:-
  Commissioning of Health and Social Care Services
  Health and Wellbeing Strategy
  Health and Wellbeing Board priorities
- 2008: First Rotherham JSNA
- 2010: Health White Paper confirmed duty
- 2010/11: Refresh of JSNA
- 2013: Central role and equal partnership – Council and CCG

Rotherham's Population
- Total population 254,600 (+2.6%)
  51% female 49% male
  Projected increase of 13,000 by 2020
- 22% children aged 0-17 (-9%)
- 23% older people aged 60+ (+14%)
- 16% on disability benefits (+17%)
- 7.5% BME (+86%)
- Life expectancy – Male 76.6/Female 80.7 years

Ageing Population: Implications for 2020

– Limiting long term illness	+5,580	+22%
– Mobility Impairment	+1,990	+26%
– Hearing Impairment (18+)	+5,120	+21%
– Obesity	+2,270	+20%
– Dementia	+860	+30%
– Depression	+800	+21%
– Incontinence	+1,660	+24%
– Diabetes	+1,200	+22%
– Falls	+2,730	+24%

Care Needs and Carers

- 17,400 need help with domestic tasks
- 14,200 need help with personal care
- 25% increase projected in both by 2020
- Estimated 35,000 carers, most aged 45-64 but 5,300 aged 65+ (+19% by 2020)
- Care gap increasing
  Adult children and non-relatives less inclined to provide informal care and fewer children
  Rising demand in care from spouses and the formal care sector

Ageing Households

- Household increase 2006-2031 (25 years)
- All ages +27,000
- One person +17,000 (+55%)
- 65+ +18,000 (8,000 living alone)
- 75+ +11,000 (6,000 living alone)
- Lone pensioners projected for 2031
  24,000 pensioners living alone (+51%)
  16,000 aged over 75 (+66%)
  11,000 over 75 with long term illness (+75%)

Children and Young People: Indicators relative to England
Rotherham was:-

- Average on Obesity and Tooth Decay
- Worse on Child Poverty, GCSE A*-C Maths and English, Smoking in Pregnancy, Breast Feeding Initiation, Physical Activity, Teenage Pregnancy, Key Stage 2 Level 4, Infant Mortality, A & E Admissions

Deprivation: Indices of Deprivation 2010

- Commissioned by Government
- 6 District Measures – 354 districts in 2007, 326 in 2010
- "Average of SOA Scores" – increased from 68th most deprived 2007 to 53rd 2010
- "Local Concentration" – increased from 60th in 2007 to 48th in 2010
- % of Rotherham in most deprived 10% of England up from 12% (2007) to 17% (2010)

Poverty

Child Poverty
- 2009: 13,665 children in poverty (23.3%)
- 2011 (est.): 13,800 in poverty (23.6%)
- 2012: 20% eligible for Free School Meals
  15.6% increase since 2009
- Most polarised form of deprivation

Pensioner Poverty
- 18,080 pensioners in Pension Credit households (35%)
- 11,238 pensioners in Guarantee Credit Households (22%)
- Low take-up – est. 21,000 households (60%) low income pensioners (13,000 or 37% Guarantee)

Health Indicators relative to England
Rotherham was:-
- Better on Hospital re. Self-Harm, new cases of TB, Road Injuries and Deaths
- Average on higher risk drinking
- Worse on Breast Feeding, Physical Activity, Obesity, Emergency Admissions, Teenage Conceptions, Smoking, Poor Diet, Drug Misuse, Hip Fracture 65+, Excess Winter Deaths, Life Expectancy, Cancer

Key Issues
- The impact of an ageing population
- Promoting healthy living – physical activity, diet and risk awareness (smoking and alcohol)
- Reducing the gap between healthy and actual life expectancy
- Increasing independence for people with long term conditions
- Increasing independence, choice and control for people suffering with dementia and new service development
- Preventative health and care strategies to save future care costs
- Reflecting the diversity of the learning disability population in services

Discussion ensued on the priorities for Rotherham:-

- Access to a good quality advice service in respect of poverty issues, Welfare Reform Act, mental health
- Influence of housing
- JSNA was agreement of the priorities – where should funding be invested to create the biggest impact
- The majority of health problems and inequalities stemmed from employment opportunities and wealth

Resolved:- That further work on the JSNA take place forming the basis for discussion at the special meeting to be held in March.

S51. HEALTH INEQUALITIES SUMMIT

John Radford, Director of Public Health, gave the following powerpoint presentation:-

Action and Next Steps

Session Plan
- Discussion on proposed actions
- Opportunity to develop the action plan

Aspiration
- Communities
- Look and Feel of Rotherham
- Health
- Skills for Life
- Cost of Living

Raising Aspirations
- Recognise what Rotherham had to offer and use the media to promote e.g. Clifton Park, Rotherham Shown, green spaces, play sites, walks etc.
- Refresh and extend the "Rotherham Ambassadors" Scheme – broaden involvement with communities

Look and Feel of Rotherham
- Planning to consider the health impact of all new applications and developments e.g. takeaways
- Develop a commercially viable, innovative and imaginative "Town Centre offer" e.g. early evening activities, café culture
- Develop a scheme to regulate private landlords

Rotherham Communities
- Develop an asset, skills and knowledge framework to fully utilise local potential in the 11 most deprived areas

Cost of Living
- Promote help with cost of living including credit unions, fuel/food co-operatives, housing and travel

Health
- CCG to make accessibility to services a priority for 2013

Skills for Life
- Develop and promote a skills training register identifying the "trigger points" for skills for life training linking to schools, colleges and job centres
- Increase the volunteering and apprenticeship programme/opportunities across Rotherham

Summary
- Actions need to make a difference
- Recurring theme of reducing short termism needs to be addressed
- Consultations need to result in action – "You said, We did"
- Energise communities – communities to be an active partner in service development and delivery e.g. Kimberworth Park

Discussion ensued on the presentation with the following issues raised/highlighted;-

- Should form part of the JSNA
- Hard to reach communities – how to raise their aspirations
- Health and Wellbeing Strategy wider than health
- Commissioning strategies would not be aimed at just health but delivering the whole health and wellbeing agenda
- Work on documents that linked together to ensure co-ordination

Resolved:- (1) That the presentation be noted

(2) That learning from the summit activity be built into the development of the JSNA and joint Health and Wellbeing Strategy.

S52. HEALTH AND WELLBEING BOARDS - LEARNING FROM EARLY IMPLEMENTERS

Kate Green, Policy and Scrutiny Officer, reported that the Local Government Improvement Development (LGID) had published a document, 'New Partnerships, New Opportunities', which pulled together 9 case studies of Health and Wellbeing Board Early Implementer areas where preparations were generally well advanced. The report submitted summarised the work undertaken by the case study areas and where it had been used to develop Rotherham's Board.

There were 5 stages outlined for developing a good Health and Wellbeing Board:-

Stage 1 Preparing for the Board
Rotherham had now agreed joint leads – Strategic Director for Neighbourhoods and Adult Services and the Chief Operating Officer of the Clinical Commissioning Group. A multi-agency working group was also being established to support the Board in developing the key areas of work required including the JSNA and Joint Strategy.

Stage 2 Forming the Board
Early Implementers reflected 2 main approaches in relation to Board membership – commissioner focused or mixed-membership approach.

Many had agreed to opt for the core statutory members in the first instance until the Board took on its statutory duties and then review membership. It may be that Rotherham wished to take this approach.

Stage 3 Work Programmes, Priorities and Commissioning
Rotherham had agreed a Board work programme based on a good practice toolkit and was to be implemented to inform agendas over the next 12 months.

The Board may wish to consider how it would manage the other business items alongside the more strategic items required.

Stage 4 Developing Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
A proposed timetable for further development of the local JSNA and JHWS had been put in place for the Board to consider.

Stage 5 Review, Performance and Looking Forward
The work programme included milestones for self-assessment against set criteria ensuring the Board's continued effectiveness and achievement.

The report also set out further development areas which the Board may wish to adopt or explore further.

Discussion ensued on the possibility of holding a stakeholder event as part of the JSNA and Health and Wellbeing Strategy. The importance of asset mapping was also stressed due to diminishing resources.

The Centre for Public Scrutiny had produced a paper on Achieving an Effective Health and Wellbeing Board. It was suggested that a meeting be held with them to discuss good practice.

It was reported that, in light of the delayed HealthWatch, the contract with LiNKS had been extended to carry out consultation on the JSNA.

Resolved:- (1) That the learning from the Early Implementer case studies and where it had been applied to the development of the Rotherham Board be noted.

(2) That a session at the May meeting of the Board take place to review the future directions of the Board and to consider best practice guidelines that were becoming available.

S53. HEALTH SCRUTINY WORK PROGRAMME

Kate Green, Scrutiny and Policy Officer, submitted, for information, the Health Select Commission work programme for January to July, 2012.

There were 2 items in the programme which the Commission wished to raise:-

- Scrutiny Review of Continuing Healthcare – there would be a requirement for NHS partners to be involved. The scope of the review was submitted for approval
- 19th April Health Select Commission meeting focussing on the Health and Wellbeing Board

The Chair and Vice-Chair of the Commission would like to invite Board representatives to attend the April meeting to discuss how they could complement the Board's work programme as well as building relationships between the Commission and Clinical Commissioning Group.

Resolved:- (1) That the Health Select Commission work programme be noted.

(2) That the areas of work which would require partner involvement and co-operation be noted, including the review of Continuing Healthcare.

(4) That the meeting of the Health Select Commission on 19th April be themed around the Health and Wellbeing Board and members of the Board be invited to attend.

S54. ROTHERHAM NHS STOP SMOKING SERVICE ANNUAL REPORT 2010-11

Simon Lister, Service Manager, Rotherham NHS Stop Smoking Service, presented the 2010-11 annual report.

RSSS was a specialist service that provided support for anyone who lived or worked in Rotherham. It provided one-to-one, drop-in, group and telephone support. Sessions were delivered in a number of venues across Rotherham during the day, evenings and Saturday mornings.

RSSS was commissioned by NHS Rotherham. The Service specification contained a number of very challenging objectives including:-

- Meet the specific 4 week quitter target (1,850 per annum)
- Meet the specific pregnant women 4 week quitter target (160 per annum)
- Achieve an average of 50% conversion rate
- Achieve 85% CO verification rate of clients who quit
- Support the achievement of the LES target (1,000 per annum)
- Contribute to the reduction of health inequalities by targeting specific groups

The Service specification had contained significant financial penalties should the Service not meet the 4 week quitter, pregnancy women 4 week quitter and conversion rate targets. The penalties had subsequently been removed.

The annual report contained detailed information on:-

- Service Objectives
- Performance Data
- Pregnant Women
- Primary Care and the Locally Enhanced Service
- Quit Shop
- Community Sessions
- Rotherham Hospital
- Telephone Service
- Patient and Public Engagement
- Staff Training and Development
- Challenges and Aspirations
- Aspirations

Discussion ensued with the following issues raised/highlighted;-

- Close work had taken place with the Midwifery Service and had undertaken flexible service delivery. They operated an opt-in service rather than opt-out service with all pregnant women receiving, as part of their clinical care, stop smoking advice
- Rotherham was the only area in the region that had a dedicated out of hours telephone service
- Although the number of pregnant women quitters had increased, Rotherham still had a very high percentage of smokers compared to the national average

Resolved:- That the report be noted.

S55. PREMIUM PHONE LINES IN GP PRACTICES

Dr. John Radford, Director of Public Health, reported on the use of 084 telephone numbers in Rotherham General Practices.

In December, 2009, the Secretary of State issued the "Directions to NHS bodies concerning the cost of telephone calls 2009". These mandated that, regardless of the telephone number being called, people should not pay more to call a NHS body than they would to make an equivalent call to a local telephone number. The directions did not expressly disallow the use of any particular telephone number ranges.

A recent review of Rotherham General Practice telephone numbers had been carried out and identified that many were using 0845 and 0844 telephone numbers. Calls to the numbers from a fixed line were charged at no more than a call to a local number. However, all calls, irrespective of the caller's provider or call plan, should be at the local rate and as such the continued use of 084 telephone numbers disadvantaged some patients who could not afford land lines and should be withdrawn.

Dr. Polkinghorn reported that, at a meeting held earlier in the week, there had been an undertaken given by all Rotherham GPs to migrate away from the 08 numbers. There would be a problem for some practices with large contracts.

Resolved:- That the report and decision by Rotherham GPs to migrate away from the 08 numbers be noted.

S56. ROTHERHAM'S OLYMPIC LEGACY PROJECT

Laura Brown, Corporate Improvement Officer, reported that working with Members and partners, the Council would deliver a programme of Olympic associated events and activities that would encourage people to live healthier lives, see more of Rotherham residents join clubs, volunteering and learning to coach and becoming more involved in social and cultural events.

The report highlighted progress to date in forging an Olympic partnership with the London Borough of Barking and Dagenham and the planning and initiating of a wide range of Olympic focussed events during 2012 as well as the Queen's Golden Jubilee.

Informal partnership working arrangements had been in place enabling the development of a joint events calendar. A draft Memorandum of Understanding had been drawn up which formalised the arrangements and focussed on aims, shared responsibilities and the partnerships structures. This was currently with Barking and Dagenham for review prior to final sign off by both authorities.

It was extremely important to encourage healthy lifestyles and cultural experiences, not only for 2012, but for years to come.

Any organisations that had planned events that could be linked to the

programme should notify Laura so they could be included in the promotional activities. It was hoped to have an Olympic page on the Council's website which would not only publicise events but also be a gateway to partners and their activities.

Rotherham's approach to the Olympics had been recognised by London 2012's Inspire programme. A revised application had been submitted in mid-January with confirmation received that the Council had been awarded the coveted Inspire Mark. This enabled the Inspire Mark to be included on marketing, subject to licence.

Resolved:- (1) That the report be noted

(2) That members of the Board consider areas of work/initiatives which could be linked to this wider project

S57. COMMUNICATIONS

The Chairman circulated, for information, a booklet produced by the LGA offering considerable support and resources to Health and Wellbeing Boards.

S58. DATE OF NEXT MEETING

Resolved:- (1) That a special meeting of the Board be held in March, 2012.

(2) That a further ordinary meeting be held on Wednesday, 11th April, 2012, commencing at 1.00 p.m.

ROTHERHAM BOROUGH COUNCIL - REPORT TO MEMBERS

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**6th June, 2012**
3.	**Title:**	**Joint Health and Wellbeing Strategy**
4.	**Directorate:**	**Resources**

5. Summary

This report presents the draft Joint Health and Wellbeing Strategy for Rotherham. It describes an outline of the process which has taken place in developing the strategy and seeks approval from the Board, prior to the document going out to public consultation and being used for Clinical Commissioning Group authorisation.

6. Recommendations

That HWBB members:

- **Discuss and consider the draft strategy being presented**

- **Subject to any amendments proposed by the Health and Wellbeing Board, agree for the strategy to be published for public consultation and to inform the authorisation process for the Clinical Commissioning Group**

7. Background

Joint Health and Wellbeing Strategies (JHWS) take the important step from assessing local needs and assets, which have been published in the Joint Strategic Needs Assessment (JSNA), to collectively addressing the underlying determinants of health and wellbeing.

In the context of the Health and Social Care Act, Health and Wellbeing Boards (HWBBs) will be responsible for ensuring a number of key pieces of work are undertaken and monitored, including gathering data through the JSNA, to developing a local strategy and commissioning plans.

The strategy presented here is the Rotherham HWBBs response to this requirement set out in the Act.

8. Proposals and Details

The JHWS for Rotherham sets out the key priorities that the local HWBB will deliver over the next three years to improve the health and wellbeing of Rotherham people.

The strategy presents a shared commitment to reduce health inequalities locally. It will be used to guide all agencies in Rotherham in developing commissioning priorities and plans and in tackling the major public health and wellbeing challenges present in our communities.

The strategy will sit within a set of documents which demonstrate the journey from gathering data, to understanding whether we are achieving our goals, these include:

- Joint Strategic Needs Assessment: our intelligence
- Health and Wellbeing Strategy: our vision and how we will achieve this
- Commissioning plans: funding and leadership
- Performance management framework: evaluating success.

Following a refresh of the JSNA towards the end of 2011, a series of workshops and officer task group meetings have taken place to develop the local strategy.

Health and Wellbeing Officer Group

Following agreement at the HWBB meeting in February, an officer group was established to support the work programme for the Board, in particular the development of the JHWS. This group was made up of officers from RMBC commissioning, policy and performance, colleagues from public health (NHS Rotherham) and the Clinical Commissioning Group (CCG), and chaired by the lead strategic director for health and wellbeing.

The officer group have supported and overseen two stakeholder workshops and have met regularly since March to develop the strategy.

Stakeholder Workshop 1 – 26 March

The purpose of the workshop was:

- For partners to agree the findings of the JSNA and its impact upon each organisation
- For partners to discuss and agree a 'shortlist' of strategic priorities over the next three years for consideration by the Health and Wellbeing Board
- For partners to agree a list of five strategic outcomes for the HWB to consider and agree

HWBB members and partners were presented with the headlines from the JSNA along with the outcomes from the local health inequalities consultation. Using this information, five strategic themes were agreed as an outcome of this first workshop which would form the basis of the local strategy, they were as follows:

1. Prevention and early intervention
2. Expectations and aspirations
3. Dependence to independence
4. Healthy Lifestyles
5. Long-term conditions
6. Poverty

Using these themes, the officer group developed them into 'strategic outcomes' which presented a desired state for what Rotherham should look like in three years.

HWBB Workshop 2 – 11 April

The second workshop provided an opportunity for partners to agree the 'outcomes' and wording used and use these to consider appropriate actions which would be required over the next three years to bring about step changes to reduce health inequalities in Rotherham.

The agreed 'outcomes' and final step changes are presented in the strategy attached as appendix A.

8.1 The Rotherham Strategy

The strategy presents the high-level plan for the HWBB. The document provides a clear picture of what we intend to do in Rotherham, it includes:

- The problem – why we need a strategy
- What we want to achieve – our vision and strategic outcomes
- What we will do – tackle the big issues presented in the JSNA
- How we will do it – specific actions which will bring about step changes over three years and who will be responsible for doing this

A life stage framework has been agreed as the basis of the strategy, subsequent action and performance monitoring. The life stages include:

- Starting well (age 0-3)
- Developing well (age 4-24)
- Working and living well (age 25-54)
- Ageing well (age 65+)

The document demonstrates how these life stages map across the five agreed outcomes and this has been presented in a matrix showing the lead and supporting agency for each area.

It is the intention for there to be a more detailed document which sets the context for the strategy and provides more information in terms of linkages with other areas of work, if this is felt necessary. This information could sit within a dedicated 'health and wellbeing' webpage, which also presents the set of documents which the strategy is part of.

8.2 Next Steps

The Health and Wellbeing Board are being asked to consider and approve the strategy presented with this report.

Following approval, the strategy will be used to inform the authorisation process for the Rotherham Clinical Commissioning Group.

It will also be necessary to begin a public consultation process. It is intended that this is done through the council and other partner websites and through the Local Involvement Network, as a follow up to the consultation they undertook on the JSNA. The standard timescale for consultation is 12 weeks and the board are asked to agree how they wish to pursue this.

HWBB Work Programme

The work programme which was presented and agreed by the Board in January will require continued development and evaluation to ensure the board is on target to achieving its goals and in becoming an exemplar board. Developing this strategy is part of that programme.

It is proposed that the health and wellbeing officer group continues to support this programme of work, which will include the continued monitoring and review process of the strategy.

9. Finance

There are no direct financial implications in relation to the content of this report.

10. Risks and Uncertainties

Having a jointly agreed strategy in place is essential to guide the work of the HWBB and ensure the key priorities are delivered on.

To effectively inform commissioning plans of all agencies there needs to be 'buy-in' from everyone involved and each agency needs to see where they fit into the bigger picture.

11. Policy and Performance Agenda Implications

The details in this report directly relate to the development of a local health and wellbeing strategy, which will be a requirement of the HWBB to publish from April 2013, although earlier implementation will ensure we are appropriately placed to tackle health issues locally and the CCG can seek authorisation.

12. Background Papers and Consultation

Rotherham JSNA 2011
http://www.rotherham.gov.uk/info/10016/council_documents/2102/joint_strategic_needs_assessment_2011

Rotherham Draft Joint Health and Wellbeing Strategy 2012-15

13. Contacts

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Rotherham Metropolitan Borough Council
Where Everyone Matters

NHS Rotherham

Rotherham Borough

Joint Health and Wellbeing Strategy 2012 – 2015

Introduction

The Rotherham Health and Wellbeing Strategy sets out the key priorities that the local Health and Wellbeing Board will deliver over the next three years to improve the health and wellbeing of Rotherham people.

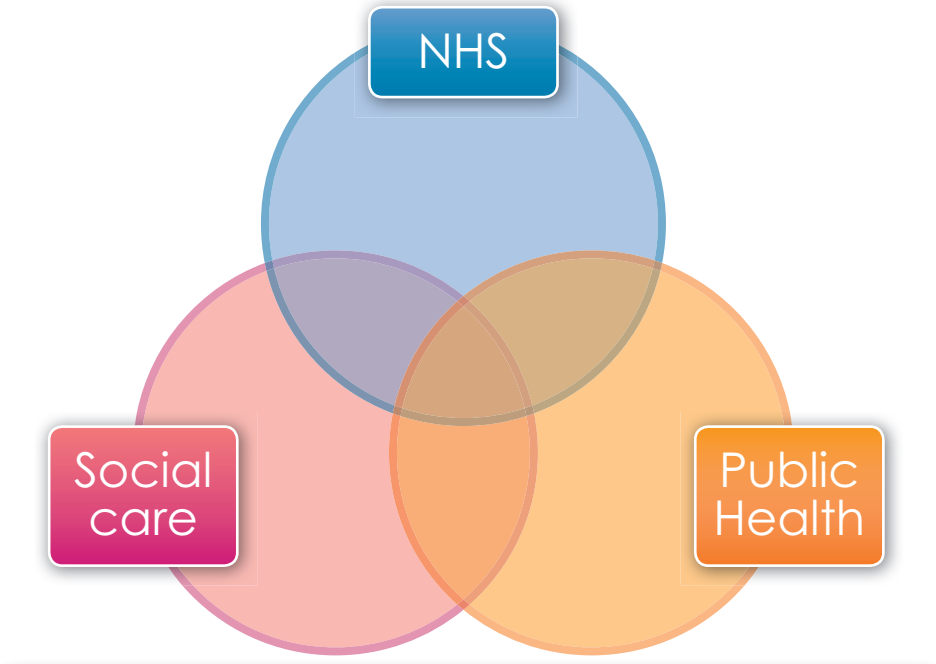
The document brings together the things that impact on people's health and wellbeing into a single, high-level framework. The strategy will be used to guide all agencies in Rotherham in developing commissioning priorities and plans in tackling the major public health and wellbeing challenges present in our communities. The document presents a shared commitment to ensure all Rotherham individuals and families are able to make positive choices to improve their physical, mental health and wellbeing, as well as helping to build strong communities. The strategy should also ensure that public services do everything we can to address the root causes of ill-health.

This strategy will sit within a set of documents which demonstrate the journey from gathering data, to understanding whether we are achieving our goals, these include:

- *Joint Strategic Needs Assessment: our intelligence*
- *Health and Wellbeing Strategy: our vision and how we will achieve this*
- *Commissioning plans: funding and leadership*
- *Performance management framework: evaluating success.*

Integrating Health and Social Care

There are obvious benefits from bringing together planning, funding, and delivery of health and social care. This is demonstrated through the publication of three frameworks of outcomes for the NHS, public health and adult social care. The diagram below shows how these frameworks overlap and how the Health and Wellbeing Board, and their joint priorities presented in this strategy, sit within the centre of this.



Why we need a strategy

Health Inequalities

Deprivation in Rotherham is higher than average and increasing. According to the Index of Multiple Deprivation in 2007, Rotherham ranked 68th most deprived district in England.

In 2010 we had moved to 53rd. Rotherham still ranks amongst the top 20% most deprived districts nationally. The biggest causes of deprivation in Rotherham remain Education and Skills, Health and Disability and Employment. Life expectancy is lower the England average, but there is also a large gap between the least and most deprived areas in the borough; 9.9 years for men and 5.9 for women. Health inequalities in Rotherham are generally worse than the England average and our statistical neighbours.

(source: Health Profile 2011, DH)

The Marmot Review of Health Inequalities ***'Fair Society, Healthy Lives'*** provides evidence that there is a bigger impact on the health for those living in deprivation. The review suggests that there needs to be a focus across different backgrounds as well as across the life course, with appropriate levels of help given to people from different backgrounds to reduce inequalities. It also presents the positive impact of employment for the health and wellbeing of working age people, particularly for an individual's mental health and wellbeing.

Life Course Framework

The Health and Wellbeing Board have agreed a life course framework, which has been adapted from the Marmot life course. The diagram below shows how the life course for this strategy links to the key points in people's lives:

Our Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) takes a comprehensive look at the health and social care needs of Rotherham. We refreshed and published our JSNA at the end of 2011, using factual information and evidence to identify needs.

Our JSNA has told us that the main determinants of health inequalities include deprivation and worklessness, attainment and skills, low birth-weight, infant mortality and mental health, as well as lifestyle factors such as poor diet, obesity, smoking and alcohol use, teenage pregnancy and low levels of physical activity. It also highlighted the ongoing concerns relating to the increased demands due to the ageing population and caring responsibilities, as well Rotherham's population is becoming more diverse and this poses challenges for service delivery.

Health Inequalities Consultation

To ensure that we fully understand the needs and demands of our local population, we have undertaken a comprehensive consultation on health inequalities with local people. This identified five themes: increased cost of living, quality health services, having the skills for life, Rotherham communities' assets and the look and feel of Rotherham, with an overarching theme of the raising aspirations of Rotherham people and communities.

The most common issues raised included:

- *Families felt challenges in their daily lives led to difficulties in prioritisation and a lack of long-term planning.*
- *Many felt trapped in a cycle of poverty with little prospect of escape.*
- *People felt that young people had poor skills for life and work.*
- *A welfare culture of dependency had become the norm for some people, which was also reflected in rising concerns about welfare reform and expected reductions in benefit.*
- *Low aspirations and expectations were evident across all age groups.*
- *There was little common identity in Rotherham, mainly in the outer areas of the Borough.*
- *Black and Minority Ethnic people still faced discrimination and negative perceptions from services.*
- *Older people often felt isolated and unsafe but also offered untapped potential to help others*
- *People identified the skills they had to offer, but found the opportunity to use them difficulty to find.*
- *People want clear, direct and simple messages on health to encourage people to make changes.*

What we want to achieve

Our Vision:

To improve health and reduce health inequalities across the whole of Rotherham.

Our 'Strategic Outcomes'

The Health and Wellbeing Board have agreed six areas of priority and associated outcomes for the strategy, which represent a desired state for what we want Rotherham to look like in three years:

Priority 1 - Prevention and early intervention

Outcome: Rotherham people will get help early to stay healthy and increase their independence.

Priority 2 - Expectations and aspirations

Outcome: The expectations and aspirations of Rotherham people will be understood and matched by services that are delivered to borough-wide standards, tailored to an individual's personal circumstances.

Priority 3 - Dependence to independence

Outcome: Rotherham people will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances.

Priority 4 - Healthy lifestyles

Outcome: People in Rotherham will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles.

Priority 5 - Long-term conditions

Outcome: Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life.

Priority 6 - Poverty

Outcome: Reduce poverty in disadvantaged areas through policies that enable people to fully participate in everyday social activities and the creation of more opportunities to gain skills and employment.

What we will do - tackle the 'Big Issues'

The Health and Wellbeing Board will prioritise and tackle the 'big issues' highlighted by the JSNA and health inequalities consultation, these are:

Starting Well	• *Low birthweight & high infant mortality* • *High smoking rates in pregnancy* • *Low breastfeeding rates* • *High teenage conceptions* • *High obesity rates*
Developing Well	• *Low attainment, skills and aspirations* • *Low levels of physical activity* • *High levels of lifestyle risks – alcohol, smoking, substance misuse, obesity* • *High rates of teenage pregnancy* • *High rates of emotional, behavioural or attention deficit disorders* • *High emergency admissions* • *Meeting the needs of increasingly diverse minority ethnic and migrant communities*
Living and Working Well	• *High levels of lifestyle risks – smoking, alcohol, diet, obesity* • *High levels of worklessness and benefit culture* • *Low levels of physical activity* • *Low qualification and skill levels* • *High levels of depression and anxiety* • *High deprivation and rising fuel poverty* • *High rates of disability* • *Increasing need for carer support* • *Meeting the needs of increasingly diverse minority ethnic and migrant communities*
Ageing Well	• *Increase in age related conditions such as; dementia, mobility & hearing impairment, diabetes, falls* • *High levels of depression* • *Low levels of physical activity* • *Rising number of older & disabled people living alone & feeling isolated* • *Ageing carers and growing care gap* • *High pensioner poverty and rising fuel poverty* • *High demand for acute care* • *High levels of lifestyle risks – smoking, alcohol, diet, obesity*

How we will do it

To help us achieve an improvement in health and wellbeing we have agreed a set of actions that will bring about step changes to reduce health inequalities in Rotherham.

These are presented in order of priority for what we want to achieve over the next three years, noting that some of the actions will impact on others and therefore need to happen first.

Year one

Strategic Outcome

1 We will coordinate a planned shift of resources from high dependency services to early intervention and prevention.

2 We will provide much clearer information about the standards people should expect and demand.

3 We will change the culture of staff from simply 'doing' things for people to looking for ways of prolonging independence and promoting self care.

4 We will work together to understand our community assets; identifying what and where they are across the borough and how we use them effectively.

5 We will adopt a coordinated approach to managing people with long-term conditions.

6 We will make an overarching commitment to reducing health inequalities, particularly in areas suffering from a concentration of disadvantage.

We will also ask the Rotherham Partnership:

To look at new ways of assisting those disengaged from the labour market to improve their skills and readiness for work.

To ensure that strategies to tackle poverty don't just focus on the most disadvantaged, but there is action across the borough to avoid poverty worsening.

To consider how we can actively work with every household in deprived areas to maximise benefit take-up of every person.

Year two	Strategic Outcome
7 We will focus on motivating people to change behaviours and design our campaigns around prevention and early intervention.	PE
8 We will train all people who work towards reducing health inequalities to respond to the circumstances of individual people and the local community.	EA
9 We will seek out the community champions and support them with appropriate resources, to take action and organise activities.	DI
10 We will identify a common approach to risk profiling for all services and organisations.	HL
11 We will develop a common approach to data sharing so we can provide better support across agencies and put in place a long-term plan for the life of the individual.	LC
Year three	
12 Services will be delivered in the right place at the right time by the right professional.	PE
13 We will ensure all our workforce routinely prompt, help and signpost people to key services and programmes.	EA PE
14 We will develop the concept of “reablement”, stepping up and stepping down, to a much wider range of professionals and services.	DI
15 We will use the health and wellbeing strategy to influence local planning and transport services to help us promote healthy lifestyles.	HL
16 We will ensure all agencies work together to make transitions between services for those with long term conditions seamless and smooth.	LC
Year three onwards	
17 We will develop a joint approach to maximise the use of assistive technology to benefit people.	PE
18 We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions.	EA
19 We will properly enable people to become independent and celebrate independence.	DI
20 We will promote active leisure and ensure those who wish to are able to access affordable, accessible leisure centres and activities.	HL
21 We will work jointly to review our eligibility criteria thresholds and ensure we are able to escalate and de-escalate people through services as their needs change.	LC

Linking the life stages with our strategic outcomes

Bringing about improvement in health and wellbeing is incredibly challenging and we see the need to drive actions forward. We have therefore identified a lead professional who will be accountable for each outcome and life stage. The table shows the lead agency, but also who will need to provide the main supporting and advising role for each area.

	Prevention & Early Intervention	Expectations & Aspirations	Dependence to Independence	Healthy Lifestyles Independence	Long-term Conditions	Poverty
Starting Well	Led by Public Health Supported by CCG, CYPS	Led by CYPS Supported by CCG Advised by PH	Led by CYPS Supported by CCG	Led by PH Supported by CCG & CYPS	Led by CYPS Supported by CCG Advised by PH	Advised by All
Developing Well	Led by CYPS Supported by CCG & PH	Led by CYPS Supported by CCG Advised by PH	Led by CYPS Supported by CCG	Led by PH Supported by CCG & CYPS	Led by CYPS Supported by CCG Advised by PH	Advised by All
Living and Working Well	Led by Public Health Supported by CCG & AS Advised by CYPS	Led by AS Supported by CCG Advised by PH	Led by AS Supported by CCG	Led by PH Supported by CCG & AS	Led by CCG Supported by AS Advised by PH	Advised by All
Ageing Well	Led by AS Supported by CCG & PH	Led by AS Supported by CCG Advised by PH	Lead by AS Supported by CCG	Led by PH Supported by CCG & AS	Led by AS Supported by CCG Advised by PH	Advised by All

AS = Adult Services *CYPH = Children and Young People Services*

PH = Public Health *CCG = Clinical Commissioning Group*

Having agreed leads and support will ensure a coordinated approach across all the life stages. This will help us to work towards breaking the 'cycle' of poor health. We see that we cannot simply shift our resources to 'Starting Well' to prevent poor health, but we need to address the determinants of health at each life stage to ensure young people do not become unhealthy adults and adults do not become unhealthy older people.

What Next?

In order to meet the strategic objectives and outcomes we will require a picture of assets and services that we have available across Rotherham. Continuing to develop this will ensure it provides a clear and comprehensive picture of how services in Rotherham are delivered to meet need, based on the Joint Strategic Needs Assessment.

Commissioning Plans

We will use this strategy to inform commissioning plans for all health and wellbeing partner agencies; including public health, NHS and social care. Commissioning plans will identify who will do the work to help us achieve our goals.

Performance Management Framework

In order to understand whether we have been successful, we will develop a performance management framework using the life stage and strategic outcomes matrix. This will include key indicators from each of the national outcomes frameworks, along with any local measures, which will demonstrate whether we are achieving improvements for each of the big issues, and ultimately our strategic outcomes.

Future Joint Strategic Needs Assessments and the Index of Multiple Deprivation 2016 will also demonstrate whether this strategy has had an impact on deprivation and health inequalities, in line with the national average.

Reviewing the Strategy

The strategy presented here is a three year plan and we will formally review it annually. Over the course of the three years we will continue to build up a much clearer picture of the needs of our population; through our Joint Strategic Needs Assessment, as well as how we commission services. We will also use local people and future developments such as Healthwatch, to help us understand our population needs and how services are actually delivered. This annual review process will help us recognise how well we are doing and show if we are off track and allow us to change direction as needed.

Rotherham people will remain at the centre of the strategy and a continued consultation plan will ensure that the strategy remains focused on listening to the views and improving the health of all Rotherham people.

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LGiU POLICY BRIEFING

Update on Healthwatch

Author: Fiona Campbell, LGiU associate

Date: 14 May 2012

The briefing below can also be downloaded as a PDF Update on Healthwatch

Summary

This briefing provides an update on:

- the final form of the Health and Social Care Act 2012 in respect of Healthwatch
- national policy and practical aspects of Healthwatch not covered in the legislation
- latest information on funding of Healthwatch
- provisions for healthcare complaints and advocacy services

It will be of interest to elected Members and officers with a health and social care brief, particularly those involved in supporting the set-up of Local Healthwatch; members of Health and Wellbeing Boards; members of health scrutiny panels/committees and officers supporting them; and those with an interest in community engagement.

Overview

The legislation provides for the creation of a new national body, Healthwatch England, as a committee of the Care Quality Commission. Local Healthwatch organisations, for which Healthwatch England will set standards, will not be statutory bodies, but will have statutory duties and powers similar to those of Local Involvement Networks (including responsibilities for social care as well as health. They are to be set up by April 2013 (a change from previous requirements). In addition, they will have a duty to provide information about health and social care services and will be able to employ staff. Upper tier and unitary local authorities have significant statutory responsibilities for setting up Local Healthwatch bodies and monitoring their work. They will also be responsible for contracting with organisations to support Local Healthwatch and for setting a local health complaints advocacy service, which need not be their Local Healthwatch.

Briefing in full

Introduction

The Health and Social Care Act 2012 (the Act) establishes Healthwatch England, a national body which will be part of the Care Quality Commission and Local Healthwatch, to replace Local Involvement Networks (LINks) and to be "the local consumer champion for patients, service users and the public". In the paragraphs on the legislation below, the section numbers in brackets refer to the relevant sections of the Act, unless otherwise stated.

Healthwatch England

The legislation

The Health and Social Care Act provides for the creation of a new national body, Healthwatch England (HWE), to be established as a statutory committee within the Care Quality Commission (CQC), representing the view of users of health and social care services, other members of the public and Local Healthwatch organisations (Section 161). HWE is empowered to provide Local Healthwatch organisations with advice and assistance on patient and public involvement and to make recommendations to local authorities on this subject. HWE may also give written notice to a local authority where HWE is of the view that patient and public involvement activities (ie those activities mentioned in section 221(2) of the Public Involvement in Health and Local Government Act 2007) are not being properly carried on in its area. Meetings of HWE must be held in public (Section 181). The duties of the Secretary of State for Health include the duty to ensure that the Care Quality Commission, including the Healthwatch England Committee, is performing its functions effectively (Section 52).

The practicalities

The CQC has indicated that HWE will be set up in October 2012. It is intended that the Chair of HWE will be a member of the CQC Board. The CQC has consulted on the membership of HWE and is currently developing proposals on membership. HWE will be expected to provide local Healthwatch organisations with operating and outcomes standards. It will be required to present an annual report to Parliament on the way it has exercised its functions during the year.

The recent Department of Health policy document on Healthwatch (see links) says that HWE "will be key to enabling the collective views and experiences of people who use services to influence national policy, advice and guidance and as a statutory committee of CQC will help strengthen links between patient/public views and regulation."

Local Healthwatch

The legislation

The Act imposes a duty on upper tier and unitary local authorities to contract with a Local Healthwatch organisation for the involvement of local people in the commissioning, provision and scrutiny of health and social services. These arrangements should include reporting arrangements to HWE (Section 182). Local Healthwatch organisations will not themselves be statutory bodies (ie they are not created by the Act).

The Act also makes provision for contractual arrangements between local authorities and Local Healthwatch, which must be a social enterprise. It also enables local authorities to authorise Local Healthwatch

organisations to contract with other organisations or individuals (known in the Act as Local Healthwatch contractors) to assist them to carry out their activities. Local authorities are given a number of duties in relation to monitoring and reporting on the work of Local Healthwatch (Section 183). The Secretary of State has powers to regulate the contractual relationships between local authorities, Local Healthwatch organisations and Local Healthwatch contractors (Section 184).

Under the Act, the Secretary of State can make regulations to require commissioners and providers of health or social care to respond to requests for information or reports or recommendations of Local Healthwatch organisations and to allow members of Local Healthwatch entry to premises (Section 186). The Secretary of State can also regulate for local authority overview and scrutiny committees to acknowledge referrals to them from Local Healthwatch. It is intended that service-providers, such as local authorities and NHS bodies, will be under a duty to respond to Local Healthwatch recommendations. Commissioners and providers will also have to have regard to the reports and recommendations and will have to be able to justify their decision if they do not intend to follow through on them.

Local Healthwatch organisations must produce an annual report on their activities and finance and have regard to any guidance from the Secretary of State in preparing these reports. Copies of the annual reports must be sent to the NHS Commissioning Board, relevant Clinical Commissioning Groups and HWE among others specified in previous legislation (Section 187).

The legislation permits the Secretary of State to transfer property, rights, liabilities and staff from Local Involvement Networks (LINks) to Local Healthwatch, to assist local authorities to transfer arrangements from LINks to Local Healthwatch, A transfer scheme may require a local authority to pay compensation to a transferring organisation/LINk (Section 188).

Local authorities must have regard and must require Local Healthwatch to have regard to guidance from the Secretary of State on managing potential conflicts of interests between being funded by local authorities and being able to challenge them effectively when required (Sections 183 and 187)

The Health and Wellbeing Boards being set up by each second-tier and unitary local authority are required to have a representative of Local Healthwatch among their members (Section 194).

The practicalities

Following representations from local authorities and LINks, the start date for Local Healthwatch was put back in January 2012 from April 2012 to April 2013. The Department of Health has produced a document,Local Healthwatch: A strong voice for people – the policy explained, which clarifies and restates the Government's vision for Local Healthwatch. This also gives more detail on the relationship between Local Healthwatch and local authorities. It says that local authorities will have "some freedom and flexibility about what organisational form [Local Healthwatch] will take", although there is little explanation of what this will mean in practice.

As non-statutory corporate bodies carrying out statutory functions, Local Healthwatch will be able to employ staff in addition to involving volunteers in their work. Part of their role will be to provide information to service users on local health and care services and to signpost service users to other sources of support.

The DH has indicated that Local Healthwatch will be subject to the public sector equality duty under the Equality Act 2010 and that the Freedom of Information Act will apply to them.

Despite their name, Local Healthwatch cover social care as well as health services. This means that, like

LINks, they will need to have members with an interest in and/or expertise in social care as well as NHS services. Amendments to the legislation at a late stage and policy guidance from the DH (PDF document) have made it clear that Local Healthwatch will be corporate, i.e. non-statutory, bodies carrying out statutory functions. Local Healthwatch will have similar rights and duties in relation to information provision and to visit health and social care premises as the rights currently held by Local Involvement Networks.

The Department of Health's explanatory notes on the Health and Social Care Act 2012 indicate that the kind of issue covered in regulations could include requiring Local Healthwatch to obtain a licence from the CQC or requiring a Healthwatch contractor to be representative of local residents and service users or potential service users.

Funding

The government currently allocates £27 million each year to local authorities for LINks through the local government Formula Grant. In 2012/13 an additional £3.2 million will be made available to support start-up costs for local Healthwatch (through the DH Learning Disability and NHS Reform Grant). In 2013/14, the current £27 million funding for LINks will become funding for local Healthwatch organisations, each year. Additional funding will be made available to local authorities from 2013/14 to support both the information function that local Healthwatch will have and also for commissioning NHS complaints advocacy.

Information about funding allocations will be made available in the routine notifications to local authorities later this year.

The Department of Health provided a small amount of funding for 75 local "Healthwatch pathfinders" in 2011-12 to test how a Local Healthwatch might work in practice. The pathfinders' work concluded in March 2012. No national report of their activities has yet been produced.

Support for Local Healthwatch preparations

Initiatives currently under way to prepare for the transition from LINks to Healthwatch include learning sets for LINks members covering topics such as leadership, representation, equality and diversity and the use of "enter and view" powers; and a learning set on hardwiring public engagement into the work of Health and Wellbeing Boards, as part of the National Learning Network for early implementer Boards.

The DH Healthwatch Programme Advisory Group has produced a checklist of how Local Healthwatch will work on a day to day basis. In brief, this checklist covers:

- Gathering views and understanding the experiences of people who use services, carers and the wider community
- Making people's views known
- Promoting and supporting the involvement of people in the commissioning and provision of local care services and how they are scrutinized
- Recommending investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC)
- Providing advice and information about access to services and support for making informed choices
- Making the views and experiences of people known to Healthwatch England and providing a steer to help it carry out its role as national champion
- NHS Complaints Advocacy – if not provided in-house by a Local Healthwatch, it will maintain a

relationship with the commissioned service, to share information where appropriate.

Complaints and advocacy services

Under the Health and Social Care Act 2012, local authorities have a new duty to commission independent advocacy services for complaints relating to health services. Local authorities may commission Local Healthwatch to provide these services, but they need not do so (Section 185). For example, a local Citizen's Advice Bureau could be asked to provide the service. The Secretary of State may issue directions about how such services are commissioned and run

Local authorities will continue to have responsibility for managing complaints relating to adult social care and to commission advocacy services to support service users including those who may wish to complain.

Comment

The Health and Social Care Act has been the subject of considerable criticism, not only for its content, but also for involving the NHS and local government in major reorganisation at a time of severe financial pressures. It is perhaps even more puzzling that the patient and public involvement system is being reformed just three years after the setting up of LINks, particularly when emerging details about how Healthwatch will operate, suggest it will not be hugely different from LINks. The one potentially significant difference is in the creation of a national body, Healthwatch England. This is to be welcomed, as it has potential to co-ordinate and publicise the findings of Local Healthwatch, using them to influence policy, to discern and draw attention to patterns of problems discovered by Local Healthwatch, and to support the local organisations. Such support is badly needed, as the failure of many LINks to make an impression indicates. However, Healthwatch England's position as both a committee of a regulatory body, the CQC, and also an "independent" body makes it a somewhat strange creature. A national body to bring together, guide and support LINks could easily have been set up without the disruption and expense caused by the creation of Healthwatch.

The DH's recent policy document, Local Healthwatch, a strong voice for people, claims that one reason for the creation of Healthwatch is that "the tripartite structure of local authority, host organisation and LINk has – in some cases – led to lack of visible accountability for LINks and confusion about […] roles, relationships and responsibilities". It is difficult to see how the new structures will help to dispel this confusion, as it appears that there will still be a tripartite relationship between local authorities, Local Healthwatch and Local Healthwatch contractors. Moreover, it is not yet clear how the relationship between any staff employed by Local Healthwatch and any Healthwatch contractor commissioned by a local authority is intended to work. The confusion about roles could be further compounded in areas in which the health complaints advocacy service is commissioned from yet another organisation. And, while a seat on Health and Wellbeing Boards may give a voice to patients and the public, the more powerful these Boards are, the more danger there will be that Healthwatch representatives who are members of them will be unable to retain their independence from executive decisions about health and social care services.

Nor is there any greater clarity than was the case with LINks about the respective roles of local authority health scrutiny and Local Healthwatch. Indeed A strong voice for people says that "The government's aim is for local Healthwatch to hold commissioners and providers of services to account, acting as a critical friend to help bring about improvements". This aim is indistinguishable from most people's understanding of the role of health scrutiny committees. A considerable amount of work will have to be done locally to reach an understanding of respective roles.

A strong voice for people also claims that the creation of Healthwatch is, in part, a response to "the need for a strong visual identity, making Healthwatch at both national and local levels recognisable for users of health and social care services, and members of local communities". It is unfortunate, therefore that the name of Healthwatch does not reflect its responsibilities locally and nationally in relation to social care. It is clear from a number of reports on LINks that these organisations have struggled to maintain an interest among members in social care issues, despite the fact that many such members are among the older section of the population whose social care needs are most in need of an urgent response and who would most benefit from prioritisation, locally and nationally, of social care issues. It is hard to believe that people not already familiar with the system would turn to an organisation called "Healthwatch" for information on social care. Local authorities will have their work cut out to support Local Healthwatch in giving weight to the social care aspects of their work, particularly in light of the potential conflict of interests in this area. It may be that the ongoing cuts to social services will galvanise the newly-formed Local Healthwatch organisations, but it is unfortunately more likely that, like their predecessors, they will focus on more visible NHS services.

A strong voice for people says that the litmus test for Healthwatch, over time, will be whether people "know it is there, understand what it does, know how to use it and know that it makes sure that their voices are heard and represented". This is quite a demanding test which most LINks and their predecessors, Patient and Public Involvement Forums, would certainly fail. To this test should surely be added the requirement that Healthwatch be able to show how it has made a difference to health and social care services, particularly for those in the most deprived communities. If a body that is representative of and represents the interests of service users cannot show this, it is questionable whether it is worth the effort, cost and time that local authorities and community volunteers will undoubtedly be required to put into Healthwatch.

For more information about this, or any other LGiU member briefing, please contact Janet Sillett, Briefings Manager, on janet.sillett@lgiu.org.uk

This briefing can also be viewed on our briefings website and downloaded as a PDF.

- Update on Healthwatch.pdf

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ROTHERHAM BOROUGH COUNCIL – REPORT TO HEALTH AND WELLBEING BOARD

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**6th June, 2012**
3.	**Title:**	**Rotherham Healthwatch**
4.	**Directorate:**	**Resources**

5. Summary:

This paper sets out the requirement for a local Healthwatch to be commissioned by the local authority and to be in place by April 2013. A proposal is made on the preferred option of an organisational model. The specification is discussed and the timeline is set out. Consultation with key stakeholders is integral to the design of the local Healthwatch and the activities to achieve a commissioned local Healthwatch Rotherham is set out in the appended action plan.

The inclusion of the NHS complaints advocacy service is subject to further discussion with NHS colleagues.

6. Recommendations

The Health and Wellbeing Board Members are asked to:-

6.1 Consider and agree the organisational model option at 7.3

6.2 Receive further papers on the outcome of the consultation on the organisational model and the specification

6.3 Note the level of funding available

6.4 Note the activities in the appended action plan

7. Background

The Health and Social Care Act 2012 makes provision for Healthwatch England and a local Healthwatch. The Act states that local Healthwatch should be independent organisations and although accountable to the Local Authority for their effectiveness, should decide their own priorities and programmes of work. At present the Act does not make provision for the local Healthwatch to include children's health or social care but this omission may be corrected in the new guidance due out June 2012. Rotherham Healthwatch will replace the current model of Local Improvement Networks (LiNks) which commenced in 2008.

Healthwatch England will be a new national body and is to be a statutory committee of the Care Quality Commission (CQC). The key function will be to provide leadership and support for local Healthwatch and to ensure that people's views have influence at the national level as well as the local level. The intention is for Healthwatch England to be established in October 2012.

7.1 Local Healthwatch Rotherham

The local Healthwatch Rotherham (HWR) will be a member of the Health and Well Being Board and as such will be integral to the preparation of the JSNA and the Health and Well Being strategy and priority setting on which local commissioning decisions will be based.

Local Authorities will be responsible for commissioning their local Healthwatch and will have some flexibility about what organisational form it will take. The HWR will be commissioned to commence in April 2013 in line with government guidance. Until then Local Involvement Networks (LINks) will continue to operate. Rotherham LINk is currently hosted by Voluntary Action Rotherham (VAR) and it is proposed that this contract will run to end March 2013.

7.2 Commissioning Healthwatch Rotherham

Local Authorities are responsible for commissioning and procuring an efficient and effective local Healthwatch organisation by the 1st April, 2013. It is intended that a formal procurement approach, therefore subject to a competitive tender, is undertaken given the range of functions for Healthwatch.

Once the preferred provider has been appointed the annual programme of work will be developed in partnership with HWR in line with the Health and Well Being Boards priorities. As set out in the Act HWR will also be able to determine its own work programmes and look into issues of concern to members of the community. The Health and Well Being Board, Service providers, the local authority and NHS bodies will be under a duty to respond to HWR reports and recommendations.

7.3.i. Healthwatch Rotherham Project Group

A commissioning project group already exists around contract management of Rotherham LINk and the development of HWR. This includes representatives from Local Authority and NHSR. The work of this group includes:

- To propose the best model for the implementation of Healthwatch Rotherham to the Health and Well Being Board
- To consider the signposting element in the specification
- To develop a communication strategy
- To ensure the results of consultation are fed into the service specification.
- To develop a specification
- To devise a written plan regarding handover arrangements to the new contract.

A key action is to have a consultation plan as it is intended that the commissioning of HWR will be inclusive. The purpose of the communication strategy will be to raise the profile of, and the understanding of, HWR amongst the public, colleagues in health and social care and the VCS and other key stakeholders. Please see the consultation plan appended to this report.

An action plan is in place detailing activities, responsibilities and the timeline. This action plan is appended to this report

7.3.ii Organisational Model of Healthwatch Rotherham

The Health and Social Care Act 2012 makes provision for flexibility in the organisational model of the local Healthwatch. Benchmarking and discussions have taken place regionally and the options for organisational model are:

1. A contract with the one provider to deliver all Healthwatch functions – this could be a social enterprise
2. A contact with the one provider who may sub-contract to other organisations to delivery certain elements of Healthwatch – this could be a social enterprise
3. A contract with a consortium arrangement who have experience of providing specialist functions. (Independence would have to be demonstrated in this instance).
4. A contract with a number of different providers with specialist knowledge but they are required to work in partnership to delivery the local Healthwatch brand.
5. A contract with a specific provider. This could be LINks (grant in aid could be provided) or a group of other people within the community.

It is proposed here that the preferred organisational model option that is commissioned is Options 1 and 2. The tender specification will include that either of these models will be considered. The benefits of

working with one provider are improved partnership working, customers able to access one provider easily and ease of contract monitoring and management. All other options will be complicated and take up substantial resources to support the set up arrangements.

7.3.iii Specification

The specification will be built on the current and imminent government guidance. The HWR specification will reflect that the organisation needs to be truly representative of local communities and should harness the expertise of the public, community and voluntary sectors that already have experience of working with people and groups who have difficulty getting their voice heard. HWR will provide people with a single point of contact and put people in touch with the right advocacy organisations, or help them to find information about their choices.

The specification will include the requirements as set out in government guidance of key roles, responsibilities and functions of local Healthwatch organisations, these include, but are not restricted to :

- Provision of information and advice to the public about accessing health and social care services and choice in relation to aspects of those services eg signposting;
- Gathering people's views on, and experiences of, the health and care system and ensure the insight gathered is fed into Healthwatch England;
- Making recommendations to Healthwatch England to advice CQC to carry out special reviews or investigations into areas of concern;
- Promoting and supporting the involvement of people in the monitoring, commissioning and provision of local care services;
- Obtaining the views of people about their needs for and experience of local care services and make those views known to those involved in commissioning, provision and scrutiny of care services; and
- Making reports and make recommendations about how those services could or should be improved.

The contract would be outcome focused with the expectation that the provider would work in partnership with the existing networks and groups that already exist in Rotherham. Consultation will be undertaken with all key stakeholders on the draft specification including members of the Health and Well Being Board.

It is important to note here that lessons learned from the performance of the Rotherham LINk will be included in the specification including engagement and membership development and areas which were less successful.

7.3.iv Commissioning timeline

The project group action plan appended to this report gives a detailed timeline for the commissioning of HWR. The full timeline is appended to this report and is summarised below:

Initial consultation and awareness raising with stakeholders and scoping the service	May – June 2012
Draft service specification developed	June 2012
Paper to H&WBB for endorsement of model & specification	June 2012
Consultation specially about the Service Specification	July 2012
Develop Procurement Strategy and documents	July 2012
Develop Advert for Council Website	July 2012
Develop Tender Documents	July – August
Tenders Issued (PQQ)	3rd September
Tenders Received (PQQ)	28th September
Evaluation of Pre-Qualification Questionnaires	By 12th October
Inform Successful Providers of their PQQ Submission	By 19th October
Issue Invitation to Tender	By 26th October
Tenders Received	30th November
Tenders Evaluated	14th December
Notification of Results of Evaluation – Preferred Bidder(s)	19thDecember
Standstill Period	Ends 7th January
Contract Award	11th January 2013
Transition Period	Jan – March
Contract Start Date	1st April 2013
Contract Management	Ongoing from 1st April

7.4. NHS Complaints Advocacy

The Health and Social Care Act 2012 includes the provision that the NHS complaints advocacy must be commissioned by the local authority, either as part of the specification of the local Healthwatch contract **or** as a separate contract with another organisation. The proposals for this service are being discussed with NHSR as part of the project group and a preferred option paper will be presented at a later date for consideration by the Health and Well Being Board

7.5 Local Healthwatch Funding

In 2013/14 the current funding for LINks will become funding for local Healthwatch until 2014/15. Additional funding will be made available to local authorities from 2013/14 to support both the information function but also for commissioning NHS complaints advocacy.

Any additional functions given to the local authority for HWR e.g. NHS complaints advocacy, will need to be funded separately but is an option for consideration by the Local Authority as set out in 7.4.

Dependent upon the decision in June/July 2012 of the DH on funding allocation the amounts available will be:

Minimum

Current LINks funding plus signposting services additional funding from PALs	£100,100* £105,446
NHS Complaints Advocacy	£ 66,054**
Total:	**£ 271,600**

Maximum

Current LINks funding plus signposting services additional funding from PALs	£100,100* £140,450
NHS Complaints Advocacy	£ 80,273**
Total:	**£320,823**

*An efficiency of £50K was achieved from the LINks budget in 11/12.

**to be included should the NHS complaints advocacy be part of the HWR specification

Funding of 'Start Up Costs' from DH to pass port to commissioned LHW are yet to be confirmed but are likely to be £20K in 2013/14.

Once funding notification has been made, a further paper will be provided to the Health and Well Being Board to consider that the allocation is ringfenced locally for HWR.

8. Finance

The financial aspect of funding Healthwatch Rotherham have been highlighted in section 7.5

There is a risk that only £80, 450 is available then the specification will need to reflect this.

9. Risks and Uncertainties

There is a risk that should the organisational model, the specification or the contract monitoring and management is not fit for purpose then the lessons of the Rotherham LiNKs will not have been learnt.

10. Policy and Performance Agenda Implications

The performance of and work programme of Healthwatch Rotherham will be clearly linked to the priorities of the Health and Well Being Strategy.

11. Background Papers and Consultation

DH Local Healthwatch: A Strong voice for people – the policy explained (March 2012)
DH, Health and Social Care Act 2012

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Stage 1 - Initial Communication and Consultation

Stakeholder	Key Message	Method	Date	Anticipated Outcome	Results
Health and Wellbeing Board – Officer Group	Report and project documents require consideration. To discuss commencing consultation and communication prior to the meeting on 6th June.	Draft Report which will go on the 6th June.	May ?	Approval of report and contents regarding project management and way forward.	
Health and Wellbeing Board	Approval of Report and proposals for the commissioning of Healthwatch Rotherham.	Draft Report	6th June, 2012	Approval of report and contents regarding vision, development of the service.	
Voluntary Action Rotherham / Rotherham LINk	Notification of the decision to commission the service. Seek the views, experiences and lessons learnt of VAR and LINks. Rotherham LINk to support the project group and facilitate consultation with its members and wider following discussion/agreement.	Through formal meetings with VAR and Rotherham LINk to agree the way forward. LINk to survey / consult members / public as appropriate.	May	Relationship with VAR and LINk maintained and their expertise utilised to facilitate consultation.	
Partner Organisations specifically NHS Rotherham, Clinical Commissioning Group	Notified of the decision to commission the service. Consultation on the development of local healthwatch and their contributions to this.	Through various meetings already organised.	May	NHS organisations and CCGs able to contribute to the development of local healthwatch.	
Voluntary and Community Sector Organisations	Notification of the decision to commission the service. Consultation on the development of local healthwatch and their contributions to this.	Organise a specific event for voluntary and community sector organisations or attend Consortium Meetings / organised meetings.	May	Voluntary and Community sector have a significant input into the development of the service.	

Stakeholder	Key Message	Method	Date	Anticipated Outcome	Results
	Specific discussions around signposting of services /information.				
Members of the public currently using Health and Social Care Services.	Notification of the vision and purpose of healthwatch and seek their views on what they want from the service.	Through the development of an online survey on the website. Specific consultation event in June.	June 2012	People made aware of the development of local healthwatch and been able to influence its design. Online survey completed.	
Staff across NHS and Local Authority.	Notification of the vision and purpose of local healthwatch and how they can contribute to its development	Through already used communication channels.	July 2012	Staff made aware of the development of local healthwatch and been able to influence its design.	

Stage 2 – Detailed Communication and Consultation

Stakeholder	Key Message	Method	Date	Anticipated Outcome	Results
Senior Managers (DLT) and Senior Managers across the Partner Organisations	Informed of progress against the commissioning priorities.	Report on progress on consultation, soft marketing testing, priorities for service.	August 2012	Senior Managers are included in key decisions and kept informed of progress.	
Health and Wellbeing Board	Draft service specification agreed.	Report on service specification and progress to date.	August 2012	Members are able to influence the service specification and kept informed of progress.	
VAR/Rotherham LINk/Consortium Members	To be kept informed of progress and opportunity to influence service design.	Meeting with VAR/LINK / Consortium on progress.	August 2012	Kept informed of progress to inform future arrangements.	
Members of the Public.	Feedback from survey and key message.	Key findings presented on the website or sent to specific	Sept 2012	Members of the public are aware of how they	

Stakeholder	Key Message	Method	Date	Anticipated Outcome	Results
		groups.		have influenced service design and what has changed as a result of their input.	
All Stakeholders	Preferred provider approval. Start date and lead in time.	Various – existing communication channels and meetings with Managers.	Feb 2013 – March 2012	All kept informed (as appropriate) of new provider and handover arrangements.	

Timeline for the Commissioning of Healthwatch Rotherham

		2012																																		2013																			
		May				June				July				August				September				October				November				December				January				February				March				April			
		07/05/12	14/05/12	21/05/12	28/05/12	04/06/12	11/06/12	18/06/12	25/06/12	02/07/12	09/07/12	16/07/12	23/07/12	06/08/12	13/08/12	20/08/12	27/08/12	27/09/12	03/09/12	10/09/12	17/09/12	24/09/12	01/10/12	08/10/12	15/10/12	22/10/12	29/10/12	05/11/12	12/11/12	19/11/12	26/11/12	03/12/12	10/12/12	17/12/12	24/12/12	07/01/13	14/01/13	21/01/13	28/01/13	04/02/13	11/02/13	18/02/13	25/02/13	04/03/13	11/04/13	18/03/20130	23/03/13	01/04/13	08/04/13	15/04/13	22/04/13
	Determine Vision for the Service																																																				
	Develop Consultation and Communication Plan																																																			
	Undertake Consultation with Stakeholders																																																			
	Determine Outcomes for Service																																																			
Procurement	Determine Procurement arrangements																																																			
	Undertake Soft Market Testing																																																			
Specification	Write Specification / Consult on																																																			
Contract	Draft Contract																																																			
	Laise with Legal Services agree requirements																																																			
Tendering	Write Invitation to Tender (ITT)																																																			
	Determine who will be on evaluation panel																																																			
	Develop evaluation criteria & weightings																																																			
	Write / Send OJEU Notice / and advert																																																			
	PQQ packs issued																																																			
	Enquiries from Prospective Providers																																																			
	PQQs returned																																																			
	Evaluation of PQQs																																																			
	Issue Invitation to Tender																																																			
	Enquiries from Prospective Providers																																																			
	Tenders Received																																																			
	Tenders Evaluated																																																			
	Notification of Results to Preferred Bidders(s)																																																			
	Standstill Period																																																			
Award Contract	TUPE Consultation / Negotiations if required																																																			
	Contract Award Notice																																																			
	Issue award notice in OJEU																																																			
	Contract management discussions																																																			
	Give feedback to unsuccessful providers																																																			
	Transition arrangements																																																			
	Evauation of Project																																																			
	Contract Monitoring and Review																																																			
Reports	Progress Updates to Health & Well Being Board														?								?																															

EU Timescales for Tendering
- 40 days from notice to return of their tender (Invite to tender - Return of tender)