HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 10th April, 2013**

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 and Matters Arising (Pages 1 - 11)

4. Communications
   LGA Conference – Teenage Pregnancy
   London – 23rd April, 2013

5. Local Healthwatch
   Welcome and Introduction from Parkwood Healthcare

6. Police and Crime Commissioner
   Welcome and verbal update

7. Priority Measure - NEETS (Pages 12 - 21)
   Presentation by Collette Bailey

8. Health and Wellbeing Board Terms of Reference (Pages 22 - 29)
   For approval

9. Joint Strategic Needs Assessment Refresh (Pages 30 - 32)
   Chrissy Wright to present

10. Making Every Contact Counts (Pages 33 - 36)
    Dr. John Radford to present

11. Performance Management Framework (Pages 37 - 45)
    Dr. John Radford to present
    (another report to follow)

12. Workstream Progress - Expectations and Aspirations (Pages 46 - 72)
Update for all workstreams (Pages 46-49)
(Kate Green to report)

Expectations and Aspirations (Pages 50-72)
(Sue Wilson to present)

13. Date of Next Meeting
- Wednesday, 8th May, 2013 at 1.00 p.m.

HEALTH AND WELLBEING BOARD
27th February, 2013

Present:-

Members

Councillor Ken Wyatt	Cabinet Member, Health and Wellbeing **(in the Chair)**
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Helen Dabbs	RDaSH
Councillor John Doyle	Cabinet Member, Adult Social Care
Chris Edwards	Chief Operating Officer, Clinical Commissioning Group/ NHS Rotherham Metropolitan Borough Council
Brian Hughes	Director of Performance and Accountability, NHS Rotherham South Yorkshire and Bassetlaw
Shafiq Hussain	Voluntary Action Rotherham
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families
Shona McFarlane	Director of Health and Wellbeing
Michael Morgan	Interim Chief Executive, Rotherham Foundation Trust
Dr. David Polkinghorn	Rotherham Clinical Commissioning Group
Dr. John Radford	Director of Public Health
Joyce Thacker	Strategic Director, Children, Young People and Families

Officers:-

Kate Green	Policy Officer, RMBC
Tracy Holmes	Communications and Marketing, RMBC
Dr. Nagpal Hoysal	Public Health Consultant
Joanna Saunders	Head of Health Improvement
Dawn Mitchell	Committee services, RMBC

Apologies for absence were received from Christine Bain, Karl Battersby, Martin Kimber, Gordon Laidlaw, Fiona Topliss, Janet Wheatley and Chrissy Wright.

S62. MINUTES OF PREVIOUS MEETING

Resolved:- (1) That the minutes be approved as a true record subject to the following clerical correction:-

S55(e)(Local Medical Committee)
"It was felt that there was GP representation on the Board through the CCG which could reflect the views of GPs as commissioners and not providers."

Arising from Minute No. S54(2) (Information Sharing Protocol), it was noted that RDaSH, NHS Rotherham and the CCG had signed off the Protocol. It was hoped it could be raised as an extra item at the Rotherham Foundation Trust Board meeting the following day.

(2) That the Overarching Information Sharing Protocol be placed on the Council's Risk Register.

Arising from Minute No. S60 (Rotherham HealthWatch), the Chair reported that 7 tenders had been opened and were currently being evaluated. It was hoped that the contract would be awarded to a successful tenderer, however, if that was not the case, there was a fallback position set out in the national guidance.

(Shafiq Hussain disclosed disclosable pecuniary interest in the above item.)

S63. COMMUNICATIONS

(1) Health and Wellbeing Board Work Plan

The Board noted the updated Work Plan illustrating the cycle of reporting up to October, 2013 when an evaluation would then take place.

(2) Health and Wellbeing Strategy Workstream Update

The Board noted a report setting out the progress on each of the workstreams. It was felt that future progress reports would benefit from inclusion of figures so the Board would be able to see what change had been achieved.

(3) Better Health for Women: A Summary Guide

The Board noted the above briefing which should be fed into the Joint Strategic Needs Assessment.

(4) Rotherham Carers' Charter

The Board noted the above which had been considered by the CCG and adopted by the Council.

It was reported that a multi-agency Steering Group had been established, meeting regularly, to progress the accompanying action plan and achieve the plan's objectives.

Discussion ensued on the forthcoming Bedroom Tax and the view that it ought to be included as it would affect carers and foster carers, cross referenced with the work taking place on Welfare Reform.

Resolved:- (a) That Bedroom Tax be included in the Joint Action Plan for Carers cross referenced with the work taking place on Welfare Reform.

(b) That the annual review of the Carers Plan be submitted to the Board.

(5) Conferences

The following conferences were noted:-

2nd Annual Health and Transport Conference: Remaining Healthy Through Sustainable Travel – Transport Planning Society – 10th April, 2013

Rotherham Health and Wellbeing Conference – 17th April, 2013

Health and Social Care Policy Forum and Q&A with Andy Burnham MP, Shadow Secretary for Health – Goole College – 7th March, 2013

S64. HEALTH AND WELLBEING BOARD COMMUNICATIONS PLAN

Tracy Holmes, Head of Corporate Communications and Marketing, submitted a draft Communications Framework.

The primary purpose of the Framework was to ensure effective, consistent and co-ordinated communications, marketing and social marketing activity to support the work of the Board. It set out how strategic and operational communications and marketing activity was undertaken by the range of organisations which contributed to the delivery of the outcomes through Rotherham's Health and Wellbeing Strategy as well as communications activity in support of, and on behalf of the Board itself.

The Framework would be supported by a plan of key actions which summarised the communications and marketing activities/campaigns in support of the work plans for each Priority area. It would be regularly reviewed and monitored by the Board but nominated lead agencies would individually or jointly be responsible for its delivery.

Resolved:- That the draft communications Framework be supported.

S65. ROTHERHAM FOUNDATION TRUST

Michael Morgan, Interim Chief Executive, Rotherham Foundation Trust, gave a verbal update on the Trust as follows:-

- The Trust had received notification from Monitor, the independent regulator of NHS foundation trusts, that it was in significant breach for both finance and Board governance. It had until 18th March, 2013, to provide a plan to Monitor. The proposed plan was to be considered by the Trust's Board on 28th February

- The plan would provide initial short term, 1 year, financial turnaround for the organisation. It would also include a 2 and 3 year financial turnaround

- There would then be a period between 18th March and 15th September, 2013, to provide Monitor with a 3 year strategic plan including the 2 and 3 year financial turnaround in much more detail as would be available for the 18th March deadline

- It was anticipated that the team would be in for 8-12 months. There not only needed to be a financial turnaround but also a cultural change that the team specialised in

- There were 2 ways to turn an organisation around – slash and burn or management style that provided for interaction between the various groups i.e. physicians, consultants, nurses etc. The latter enabled a real perspective of the organisational structure and found to provide a much longer term structure

- Outside independent specialists had been brought in to look at the Patient Record Information System. In the short time they had been there, reassurance had been given that they would probably be able to get the system to a point where there was much more functionality for the specialists and clinics where the majority of the problems were located

- The Ward closures had been put on hold for the present time as it had not been seen as an immediate priority. The new Clinical Director for Medicine had met with approximately 20 of the specialist consultants and unanimously arrived at a new work plan scheme for the organisation. The new scheme would become operational as from 18th March. This was a fundamental building block for the Trust and whereby it may be possible to close a Ward in the future

- If it could be helped areas of staffing that affected patients were never the first starting point. The proposed plan would start in the Executive Suite and Corporate overheads. It did not include Estates and certainly did not include Nursing. The 90 day consultation document issued on 14th December, which finished on 15th March, proposed some rebanding of Nursing and it may be that that would continue.

- The Board had approved the hiring of additional nurses – 50 nurses had signed a commitment to start at the Hospital

- There need to be synergy between the Community aspects of the Trust and the Acute Care side

Michael was thanked for his report.

Resolved:- That the Equality Impact Assessments carried out by the Trust be submitted to future Board meetings.

S66. ROBERT FRANCIS INQUIRY - MID-STAFFORDSHIRE NHS FOUNDATION TRUST

The Board considered a resume of the Francis Report – the independent inquiry into the care provided by Mid-Staffordshire NHS Foundation Trust prompted by unusually high hospital mortality statistics.

Its recommendations and conclusions were many and far reaching with implications for commissioners and providers far beyond those of healthcare. The report found that the failures at the Trust were essentially failures of culture and systems and did not single out any 1 individual for blame.

Discussion ensued on the report with the following points highlighted/raised:-

- "Humanity" was missing from the Trust
- Each organisation of Rotherham's Board should report on what actions they were taking in respect of the Report
- A "mirror" should be held up to commissioners and scrutiny to ascertain that the same failures were not occurring
- The Report referred to some form of Annual Statement but it was not known what it would look like at the present time
- Interaction across organisations was fundamental

It was noted that there was to be a Seminar on the Francis Report on Thursday, 18th April, 2013, commencing at 11.30 a.m.

Resolved:- (1) That the findings of the Francis Report be acknowledged.

(2) That the Board ensures that all commissioning and provision of Healthcare in Rotherham follows the principles and recommendations laid out in the Report.

(3) That, as a minimum, all Rotherham healthcare providers, commissioners and Scrutiny submit evidence that supports their assurances that their organisation and practices were in line with all the Francis recommendations and, in particular, in relation to safe staffing levels and the prioritisation of patient safety ahead of financial pressure.

S67. PUBLIC HEALTH OUTCOMES FRAMEWORK: HIGH LEVEL OUTCOMES

Dr. John Radford, Director of Public Health, presented a report on the Public Health Outcome Framework which was designed to assist the Board in understanding how well it was improving and protecting Public Health.

The high level profile allowed the Board to review performance and consider its priorities for Health Services and to make decisions and plans to improve local people's health and reduce health inequalities. The profile presented a set of important health indicators that showed how Rotherham compared to the national and regional average.

The health profile for Rotherham 2012 illustrated:-

- higher than average under-75 death rate from cancer and coronary heart disease

- injuries and falls in the elderly remained higher than average

- preventable sight loss was higher than average

- access to diabetic retinopathy screening was worse than average

- child poverty, obesity levels in Year 6, pupil absence and 16-18 year old NEETS were of concern as they were all worse than average

- breastfeeding initiation and maintenance rates were worse than average

- emergency re-admissions remained higher than average

Resolved:- (1) That the Board regularly review progress against the Public Health, NHS, Adult Social Care and Children's Outcomes Frameworks.

(2) That the alignment of the current Joint Health and Wellbeing Strategy to address issues highlighted within the report be noted.

S68. PERFORMANCE MANAGEMENT FRAMEWORK

This was taken together with Minute No. 69.

S69. WORKSTREAM PROGRESS: HEALTHY LIFESTYLES, PREVENTION AND EARLY INTERVENTION

Dr. John Radford, Director of Public Health, and Dr. Nagpal Hoysal, Public Health Consultant, gave the following powerpoint presentation:-

Approaches
- Joint Health and Wellbeing Strategy
  Stages of Life Course
  Six Priority Outcomes
- Priority Measures
  Alcohol, Obesity, Tobacco, Dementia, NEETS, Affordable Warmth

Life Course Framework
- The Strategy set out a life course framework which had been adopted from the Marmot life course
- Life course: Early Intervention, Prevention and Behavioural Change

- Integral to the 6 Public Health programmes from Strategy
- System-based responsibility under the Health and Wellbeing Board

Healthy Lifestyles, Prevention and Early Intervention
- Outcome: people in Rotherham would be aware of health risks and be able to take up opportunities to adopt healthy lifestyles
- Outcome: Rotherham people would get help early to stay healthy and increase their independence

Communication
- QTV
- Campaigns – MCAT
- Web-based social media/mobile devices/engagement
- Every contact counts

Starting Well
- Children's Strategy
- Health Visitor 0-5 programme
- UNICEF Baby Friendly Initiative
- Troubled Families
- Family Nurse Partnership
- Imagination Library
- Specialist Midwifery

Developing Well
- Children's Strategy
- Looked after Children
- Healthy Schools
- Communication –website campaigns
- School Nurse Contract Revision
- Healthy Weight Framework
- NEETS system reporting framework

Living and Working Well
- Obesity – system reporting framework
- Alcohol – system reporting framework
- Smoking – system reporting framework
- NHS Healthcheck
- Communication – campaigns website development
- Workplace health

Ageing Well
- Affordable warmth – system reporting framework
- Dementia – system reporting framework
- Healthy Ageing
- NHS Healthchecks
- Flu vaccination

Healthy Lifestyles, Prevention and Early Intervention

- Delivery of a shift towards Prevention and Early Intervention and Healthy Lifestyles required a strong partnership approach
- The system-wide reporting framework proposed would enable the Board to hold the partners to account for their individual responsibilities

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

- Considerable work had taken place in mapping the existing strategies against the Centre for Disease Control Framework for the 3 areas of Obesity, Smoking and Alcohol. Suggested targets would be submitted to the Board

- Linkages with the work of the Children's Board. Starting Well and Developing Well firmly sat within the Children's Board but should there be any issues e.g. partners, governance, they should be reported to the Health and Wellbeing Board

- Key issue of underage drinking – need more rigorous approach to the affordability of alcohol with suppliers, shops etc.

- Low level of referrals for weight issues – no real awareness of Obesity and the associated risks

- Restricting supply – measurable but currently not done. The Council did not have a planning and/or licensing policy restricting the availability of fast food

- Currently if someone was found drunk in Rotherham they were not required to attend a binge drinking course – could be part of an Attendance Order

- Relatively small number of targets across the 3 areas of Obesity, Smoking and Alcohol but all were measurable and quite challenging. If the focus was on a relatively small numbers of measures they would be achievable and make a difference

- How was the Public Health money going to be used to achieve the 6 Priorities?

- Discussion was still ongoing with regard to which Public Health services were contained within the Public Health funding allocation. A budget had not been set within the Council as yet. There would be significant investment in Alcohol, Obesity and Stop Smoking Services but as yet there had been no commitment requested from partners to contribute accordingly

Resolved:- (1) That the presentation be noted.

(2) That the targets and priorities for Public Health be submitted to the next meeting.

(3) That the information contained in the presentation be worked up into measurable proposals.

(4) That the relevant Steering Group consider the NEETS information further.

S70. PRIORITY MEASURE 2: OBESITY

Joanna Saunders, Head of Health Improvements, gave the following powerpoint presentation:-

Why is Obesity a priority?
- Public Health priority nationally and locally
- Can have serious health consequences and impacts on health and social care services
- Can be prevented and treated (NICE)
- Impacts on emotional wellbeing
- Impacts on the economy

What Does a Healthy Weight Framework look like?
- Children
  Tier 1 – Primary activity – School Nurse, GP, Health Visitor
  Tier 2 – MoreLife Clubs
  Tier 3 – Rotherham Institutes for Obesity
  Tier 4 – MoreLife Residential Camps

- Adults
  Tier 1 – Primary activity – GP, Health Visitor, Leisure Services
  Tier 2 – Reshape Rotherham
  Tier 3 – Rotherham Institute for Obesity
  Tier 4 – Specialist Obesity Service

What do we need to do?
- Raise public awareness
- Get more people to engage with services
- Skill people up to live healthier lives
- Make healthy choices the easy choices
- Get everyone to recognise their role and act
- Challenge cultural and “normal for Rotherham” behaviour

What are the current priorities?
- Raise the profile of whole population prevention activity
- Continue to provide a range of services for people who are already overweight or obese

- Maximise the resources already available – training, signposting and referral
- Agree our position on the impact of planning decisions, transport planning

Challenges
- Preventing and treating childhood overweight and obesity in the primary school aged population
- Whole family engagement
- Changing behaviour amongst those that most need to change
- Evidence of what really works
- Funding to support grassroots initiatives

What can the Health and Wellbeing Board do?
- Making Every Contact Count. Power of partners
- Recognition of the importance of health as a driver of deprivation
- Political leadership
- Collaborative commissioning

Health and Wellbeing Board Members commitment
- Commit to all staff doing e-learning on MECC and giving feedback on their performance in signposting and referring to services
- Introduce planning and licensing policy to restrict availability of fast food particularly near schools or in deprived communities and promoting use of green space
- A concentrated effort to address the issue in the primary school population

Discussion ensued on the presentation with the following issues highlighted:-

- Awareness was the big issue
- The message was getting across but people failed to recognise they had a problem
- Many did not have the skills or income to provide healthy food

Joanna was thanked for her presentation.

S71. EXCLUSION OF THE PRESS AND PUBLIC

Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972 (contains information relating to the financial or business affairs of any person (including the Council)).

S72. FOOD FOR PEOPLE IN CRISIS PARTNERSHIP

The Chairman presented a brief report on the 12 VCF organisations in the Food for People in Crisis Partnership providing a range of different services.

The report set out the food parcels and cooked meals provided by each during the months of October and November, 2012.

Discussion was now required on how to progress the work in the future to meet the predicted demand.

Resolved:- That consideration be given to establishing a Steering Group to take this issue forward.

S73. DATE OF NEXT MEETING/FREQUENCY OF MEETINGS

Agreed:- That further meetings of the Health and Wellbeing Board for 2013 be held on Wednesdays, commencing at 1.00 p.m. in the Rotherham Town Hall as follows:-

10th April
8th May
12th June
10th July
25th September
23rd October
27th November
18th December
22nd January, 2014 (9.30 a.m.)
19th February
26th March
30th April

Health & Wellbeing Strategy
NEET Priority

Collette Bailey

Integrated Youth Support Services

Health & Wellbeing Board, March 2013

What is the issue?

- **No real improvement in unemployment rate (NEET) for 16-18 year olds**
- **Vulnerable groups are three times more likely to be NEET than the wider cohort**
- **The NEET group are from poorer socio-economic backgrounds and have worse GCSE attainment**

What is the current position?

- One in eight of all 18-24 year olds are unemployed
- 719 young people academic age 16-18 are NEET 7.2%
- Much worse picture for vulnerable 16-19 year olds NEET
  - 13.2% of people with learning difficulties
  - 29% of Care Leavers-
  - 74% of teenage mothers
  - 50% of young offenders in the Criminal Justice System

What are we trying to achieve ?

- **Improving percentage of young people overall and those on FSM achieving good GCSE including Maths and English**
- **Achieving zero NEET for all 16 year olds by 2013**
- **All young people in learning until their 18th birthday by 2015**
- **Improving percentage of young people achieving level 2 and level 3 qualifications at 19**

Ongoing Impact of being NEET

- **Lack of work experience and employability skills means that young are not able to compete for available jobs**
- **Low or no qualifications make work harder to find**
- **Low income jobs unless up skilled**
- **Progress into adulthood and become parents living in poverty**
- **Low self esteem and lack of hope results in poor mental health and wider health issues**
- **Poor / lower outcomes for children in terms of learning and achievement**
- **Intergenerational unemployment**

What helps young people to stay in learning and work?

- **Making the right realistic choices at 16 – careers guidance**
- **Sufficient suitable education and training provision** for young people at aged 16 with clear two year pathways leading to a relevant qualification for the marketplace
- if you become NEET and have achieved a **good range of GCSEs** you are more likely to secure learning or work
- **Target support towards vulnerable young people to encourage, enable or assist them** to participate and remain in education or training
- Strong supportive families or role models with a good work/ learning ethic

What do we need to do?

Create an outcome related intervention with a focus on prevention of NEET prevention / recovery is crucial

- Build the key basic numeracy and literacy skills needed to succeed in further education, training or the world of work –
- Coordinated transitions at 16 for at risk students identified by the Risk of NEET Indicator (RONI)
- Early identification of post 16 students at risk of becoming NEET (drop out) and the coordination of support to ensure no break in learning
- Coordinated approach to young people who disengage at aged 17 after completing one year learning programmes
- Whole family approach in situations of high presenting needs – Families for Change /Family Common Assessment Framework

Challenges

- Lack of ownership of the NEET agenda that exists in the current setting from schools colleges and learning providers.
- Focusing on complex needs of individuals and families limits time available to spend with NEET churn
- Creating an outcome related intervention with a focus on prevention rather than recovery is essential- service pressures can limit this
- Poverty – lack of financial incentives to engage young people Limited access to work experience or part time work while in learning limits breadth of skills base and employability
- Alternative options to the basic academic route are fundamental in terms of giving those most at risk a clear pathway with achievable goals.
- The recession ……. Young people are unable to compete for fewer opportunities

What can the H&WB do?

- Training for IYSS staff on cross cutting themes
- We are all targeting with the same families partnership can extend both reach and impact
- Support tracking of outcomes for young people
- Offer opportunities for work experience for vulnerable young people
- Offer employment opportunities / apprenticeships for vulnerable groups e.g. Care Leavers

Thankyou!

Further details from Collette Bailey

Collette.Bailey@Rotherham.gov.uk

ROTHERHAM BOROUGH COUNCIL

1	**Meeting:**	**Health and Wellbeing Board**
2	**Date:**	**10 April 2013**
3	**Title:**	**Health and Wellbeing Board Terms of Reference**
4	**Directorate:**	**Resources**

5. Summary

From the 1 April 2013 the Health and Wellbeing Board will become an official sub-committee of the council, taking on full statutory duties as set out in the Health and Social Care Act 2012.

To ensure the Rotherham board is operating in line with these duties, the terms of reference, which were previously developed for the shadow board, have been updated. The Rotherham board is asked to consider and approve these terms of reference.

6. Recommendations

That the Health and Wellbeing Board:

- **Approves the updated terms of reference**
- **Notes the Council's Code of Conduct for Members and Co-opted Members**

7. Proposals and details

The Health and Social Care Act 2012 established local Health and Wellbeing Boards for all upper tier local authorities, including a set of statutory functions which all board's must adhere to.

These terms of reference set out how the Rotherham Health and Wellbeing Board will operate, bringing together the council, the local Clinical Commissioning Group (CCG) and other key partners, such as the National Commissioning Board and Local Healthwatch.

The terms of reference, which have been updated from the previous document produced for the shadow board, include the statutory functions and remit of the board, membership, operating principals and conduct of board members, meeting arrangements and governance. Notably, this includes the requirement for all board members to observe the council's Code of Conduct for Members.

8. Finance

There are no financial implications associated with this report.

9 Risks and Uncertainties

Having an agreed set of terms of reference, which all board members are signed up to, will ensure the board is able to work in line with its statutory functions and meet the requirements expected of it.

10 Background Papers and Consultation

Terms of Reference April 2013 – attached

Council's Code of Conduct for Members and Co-opted Members
http://www.rotherham.gov.uk/downloads/file/8156/rotherham_council_constitution-appendix_7-code_of_conduct

11 Contact

Kate Green
Policy Officer
Kate.green@rotherham.gov.uk

Rotherham Health and Wellbeing Board

Terms of Reference
April 2013

1. Context

The Health and Social Care Act 2012 establishes Health and Wellbeing Boards as a forum where key leaders across the health and social care system will work together to improve health and reduce inequalities within the local population.

These terms of reference set out how the Rotherham Health and Wellbeing Board will operate; building on collaborative working between Rotherham Council, the local Clinical Commissioning Group (CCG) and other key partners, such as the National Commissioning Board and Local Healthwatch. Importantly the focus of the Health and Wellbeing Board will be wide ranging, looking at the health, social, environmental and economic issues which all impact on the health and wellbeing of people in Rotherham.

2. Functions of the Board

The Health and Wellbeing Board is a statutory, sub-committee of the Council. Locally, it will be the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health and other services directly related to health and wellbeing in order to secure better health and wellbeing outcomes for the whole Rotherham population, better quality of care for all patients and care users and better value for the taxpayer.

The Board brings together key decision makers to address issues of local significance and to seek solutions through integrated and collaborative working, whilst being an advocate and ambassador for Rotherham collectively on regional, national and international forums.

Functions of the Board include:

- To enable, advise and support organisations that arrange for the provision of health or social care services to work in an integrated way**,** for the purpose of advancing the health and wellbeing of people in Rotherham
- To ensure that public health functions are discharged in a way that help partner agencies to fully contribute to reducing health inequalities
- To oversee the development of local commissioning plans, to ensure that all commissioning plans take account of the Health and Wellbeing Strategy and are aligned to other policies and plans that have an affect on health and wellbeing, and where necessary initiate discussions with the NHS Commissioning Board if an agreed concern exists regarding a failure to take account of the Strategy
- To hold relevant partners to account for the quality and effectiveness of their commissioning plans
- To ensure that there are arrangements in place to provide assurance that the standards of service provided and quality of service are safe, meet national standards and local expectations
- To discharge any of the functions to a sub-committee of the Board or an officer of the authority as the Board feels appropriate
- To exercise any other functions of the Council which the Council has determined should be exercised by the Board on its behalf

3. Remit

- To reduce health inequalities and close the gap in life expectancy by ensuring that partners are targeting services to those who need it the most

- To develop a shared understanding of the needs of the local community through the statutory joint strategic needs assessment (JSNA), and ensure public engagement and involvement in the development of the JSNA so that the experiences of local people influence policy development and service provision

- To promote the development and delivery of services which support and empower the citizen taking control and ownership for their own health, whilst ensuring the safeguarding of vulnerable adults and children

- To develop a joint Health and Wellbeing Strategy to provide the overarching framework for commissioning plans for the NHS, social care and public health, and other services that the board agrees to consider such as education, housing and planning, and to subject this strategy to regular review and evaluation

- To assess whether the commissioning arrangements for social care, public health and the NHS are sufficiently aligned to the joint Health and Wellbeing Strategy and promote joined up commissioning plans and pooled budget arrangements where all parties agree this makes sense

- To prioritise services (through the development of the Health and Wellbeing Strategy) that are focused on prevention and early intervention to deliver reductions in demand for health and social care services

- To oversee at strategic level the relevant joint communications, marketing/social marketing and public relations programmes and campaigns required to support the delivery of health and wellbeing objectives in the borough and ensure that local people have a voice in shaping and designing programmes for change

- To ensure that the people of Rotherham are aware of the Health and Wellbeing Board, have access to the relevant information and resources around the different work streams and can contribute where appropriate

4. Operating principles

It will be important for the Board to have some agreed business principles to aid decision making and discussion on key issues:

a) Working in collaboration with partners to ensure people get the support and services they need as early as possible
b) To work in the best interests of the Rotherham community
c) Involving the right people early on to make sure we get it right first time, reducing bureaucracy and getting better value for money
d) Having the right people with the right skills in the right place
e) Supporting and enabling our communities to help themselves whilst safeguarding the most vulnerable
f) Prioritising prevention and early intervention
g) Talking and listening to all Rotherham people and treating everyone fairly and with respect
h) Working to a set of agreed communications standards, including openness and transparency; clarity and use of plain English; consistency, co-ordination and timeliness
i) Setting clear strategic objectives and priorities

j) Seeking opportunities to increase efficiency across service providers
k) Holding partners to account

4. Membership, representation and conduct

The membership of the Health and Wellbeing Board is made up of leaders from across the NHS, social care, public health and other services directly related to the health and wellbeing agenda. Membership will be reviewed periodically to ensure that it remains representative of the identified priorities.

The Board will be chaired by the Cabinet Member for Health and Wellbeing and in the absence of the official Chair; meetings will be chaired by either of the two other nominated Cabinet Members.

Members of the Board should be of sufficient seniority to be able to make significant commitments on behalf of their relevant organisations. In the event of the nominated representative being unavailable, a deputy should be provided, who is equally at a suitable leadership/managerial level. All members of the Board will have equal voting status.

The Health and Wellbeing Board is a strategic leadership body and as such takes responsibility for the direction of strategic commissioning. The Health and Wellbeing Board is inclusive of commissioners and providers and it is intended that all members will take part in and support the development of strategic priorities and direction. However, members who have a provider role should be clearly identified as providers and declare any conflict of interest as and when appropriate.

4.1 Code of Conduct

All members of the Board must observe the council's Code of Conduct for Members and Co-opted Members.

Membership of the Health and Wellbeing Board

Cabinet Member for Health and Wellbeing (Chair)
Cabinet Member with responsibility for Adult Services
Cabinet Member with responsibility for Children's Services
Director of Public Health
Chief Executive, RMBC
Strategic Director of Neighbourhoods and Adult Services
Strategic Director of Children and Young People's Services
Strategic Director of Environment and Development Services
Chief Officer, Clinical Commissioning Group
Chair of Clinical Commissioning Group
Representative of the CCG Strategic Clinical Executive
NHS Commissioning Board South Yorkshire and Bassetlaw
HealthWatch representative
Chief Executive, Voluntary Action Rotherham

In attendance (observers)

Chief Executive, Rotherham Foundation Trust
Chief Executive, RDaSH
Director of Health and Wellbeing (Adult Services)
Head of Communications RMBC/NHSR/TRFT or other

4.1 Responsibilities of a Health and Wellbeing Board member:

a) To attend meetings as required and to fully and positively contribute to meetings
b) To act in the interests of the Rotherham population, leaving aside organisational, personal, or sector interests
c) To fully and effectively communicate outcomes and key decisions of the Health and Wellbeing Board to their own organisations
d) To contribute to the development of the Joint Strategic Needs Assessment
e) To ensure that commissioning is in line with the requirements of the joint Health and Wellbeing Strategy
f) To deliver improvements in performance against measures within the public health, NHS and Adult Social Care outcomes frameworks
g) To declare any conflict of interest, particularly in the event of a vote being required and in relation to the providing of services
h) To act in a respectful, inclusive and open manner with all colleagues to encourage debate and challenge
i) To read and digest any documents and information provided prior to meetings to ensure the Board is not a forum for receipt of information
j) To act as ambassadors for the work of the Health and Wellbeing Board
k) To participate where appropriate in communications/marketing and stakeholder engagement activity to support the objectives of the Board, including working with the media.

5. Meeting Arrangements

The Health and Wellbeing Board will meet monthly. The schedule of meetings will be reviewed and agreed annually by the Board.

Health and Wellbeing Board meetings will be conducted in public, however, the Board will retain the ability to exclude representatives of the press and other members of the public from a defined section of the meeting having regard to the confidential nature of the business to be transacted (in accordance with the Public Bodies Act 1960).

Papers for the Health and Wellbeing Board will be distributed one week in advance of the meeting. Additional items may be tabled at the meeting in exceptional circumstances at the discretion of the Chair. Minutes of the Health and Wellbeing Board will be circulated in advance of the next meeting and approved at the meeting.

All agenda items brought to the Health and Wellbeing Board need to clearly demonstrate their contribution to the delivery of the Board's priorities.

Non-members of the Health and Wellbeing Board may attend the meeting with the agreement of the Chair (list of potential organisations which could attend by request of the Chair show in appendix A)

5.1 Decision Making

Decisions are to be taken by consensus. Where it is not possible to reach consensus, a decision will be reached by a simple majority of those present at the meeting, other than those who have declared an interest.

The following should be taken into account by Board members when taking decisions:
(a) The priorities and objectives contained within the Health and Wellbeing Strategy
(b) Any recommendations made by other Boards/groups
(c) The business case

Decisions of the Health and Wellbeing Board will not override organisational decisions, but are intended to influence partners to work for the benefit of the borough as a whole.

5.2 Support to the Board

Administrative and organisational support for the Health and Wellbeing Board will be provided by officers of the Council.

The Council and CCG will be the lead partners for communications, marketing and public engagement, but operational delivery of activity will be shared across Board partners, as appropriate.

6. Governance and Reporting Structures

The Health and Wellbeing Board is a sub-committee of the Council and will therefore be accountable to Full Council, in the first instance through Cabinet.

The Board will also have a link to the Rotherham Local Strategic Partnership Board (LSP), with the Chair being allocated a place on the LSP.

Minutes of Board meetings will be forwarded to the LSP Board, Full Council, the Health Select Commission (Scrutiny), Rotherham CCG Board and NHS Commissioning Board where appropriate.

A Health and Wellbeing Steering Group will be accountable to the Board for delivering the appropriate workstreams in the Health and Wellbeing Strategy.

Appendix A

The following may be required to attend Board by invitation
South Yorkshire Ambulance Service South Yorkshire Fire and Rescue Clinicians South Yorkshire Police Representatives from the Adults and Children's Safeguarding Boards Chair of Rotherham School Improvement Partnership Executive Medical Directors and Chief Nurses Coroner Chief Emergency Planning Officer Environment Agency Voluntary/Community Sector representatives Other provider organisations as required Private sector representation as required i.e. workplace health issues Other organisations as appropriate

ROTHERHAM BOROUGH COUNCIL – REPORT TO
Health and Wellbeing Board

1.	**Meeting**	**Health and Well Being Board**
2.	**Date:**	**10th April 2013**
3.	**Title**	**JSNA Refresh**
4.	**Programme Area:**	**Resources Directorate**

5. Summary

The Joint Strategic Needs Analysis (JSNA) is jointly developed across the council, the CCG and Healthwatch Rotherham, the JSNA is due for a refresh and government guidance requires the addition of a section on 'Assets' including infrastructure, social and community networks and individuals. The Health and Wellbeing Board is the governance body for the JSNA which is a statutory requirement.

Proposals are set out for the structure of the refreshed JSNA, the development of a Directory of Needs Analysis and future reporting of the JSNA to the Health and Wellbeing Board.

6. Recommendations

That Health and Wellbeing Board:

6.1 Approve the proposals in 7.2 for the refresh of the JSNA

6.2 Receive future reports on a six monthly basis as updates to the JSNA

7. Introduction

7.1 Background

The Joint Strategic Needs Analysis (JSNA) is jointly developed across the council, the CCG and Healthwatch Rotherham, the document delivers a comprehensive analysis of the needs across the borough. The JSNA is critical to understanding the demographics and the needs of citizens and is utilised by commissioners in the development of service specifications.

The JSNA was reviewed and revised at the end of 2011. A further refresh is now required. The latest draft government guidance states that the refreshed document must now include a Directory of Assets, which means community assets, physical infrastructure and individuals.

Set out below are proposals for this next phase of the JSNA, with the updated refreshed 2013 JSNA presented at the September Health and Wellbeing Board which is in line with the Boards workplan.

7.2 Proposals

7.2.i. Structure of the JSNA

The current structure is set out against services e.g., Children's Needs. It is proposed here that the refreshed JSNA structure is set out in three sections, commencing with the overarching cross-cutting areas:

- Demographics – e.g., Birth Rates
- Health conditions – e.g., cancer, heart disease
- Lifestyle & population behaviours – e.g., smoking, alcohol
- Wider determinants of Health – e.g., crime, housing, deprivation
- Communities of Interest – e.g., LGBT, Carers, Roma
- National Policy Drivers – e.g., Welfare Reform

Secondly, this section follows the Health and Wellbeing Strategy and is set out in Life Stages:

- 0-3 starting well – e.g. breastfeeding
- 4-19 developing well – e.g., Not in education or training (NEETS)
- 20-64 living and working well – e.g., adults with Learning and physical disabilities
- 65+ ageing and dying well – e.g., dementia

This section will include a focus on vulnerable groups needs

Thirdly, the Assets will be presented across these three areas:

- Physical infrastructure – e.g., buildings, green spaces
- Social and Community networks – e.g., VCS
- Individuals – e.g., neighbourhood champions

7.2.ii Directory of Needs Analysis

It is acknowledged here that there are many needs analyses undertaken by statutory organisations including the council and health and there is no one repository for these important documents. The benefits are that this would be a resource which all agencies should be mandated to contribute to, a resource that can be accessed by all agencies, enables an information and data gap analysis and reduces duplication. The Directory will be accessed from the council home page.

7.2.iii Frequency of JSNA

The JSNA is a live and dynamic resource for all agencies and will be constantly updated. It is proposed here that the refresh of 2013 is the last full refresh, subject to future government guidance, and a six monthly update will be presented to the Health and Wellbeing Board on any additions or variations to the data.

8. Finance

There are no financial implications arising from this report

9. Risks and Uncertainties

That should the JSNA not be refreshed the relevance of the document will reduce and will impact on ensuring that commissioning has the most up to date analysis

That should the JSNA not be refreshed and constantly updated then the Health and Wellbeing Strategy becomes invalid and no longer fit for purpose.

That should agencies not be mandated to contribute to the Directory of Needs Analysis then the JSNA updates will become harder to achieve

10. Policy and Performance Agenda Implications

Link to the Health and Wellbeing Strategy and the JSNA is a statutory responsibility of this Board

12. Background Papers and Consultation

Health and Wellbeing Strategy 2012
JSNA 2011

Contact Name: Chrissy Wright, Strategic Commissioning Manager, 01709 822308, chrissy.wright@rotherham.gov.uk

ROTHERHAM BOROUGH COUNCIL – REPORT TO

HEALTH AND WELLBEING BOARD

1.	**Meeting**	**Health and Wellbeing Board**
2.	**Date**	**10/04/2013**
3.	**Title**	**Making Every Contact Count**
4.	**Directorate**	**Public Health**

5. Summary

Making Every Contact Count (MECC) is a programme that has been developed in the NHS to give staff the skills to talk to individuals about their health and wellbeing. MECC was developed in 2009 by NHS Yorkshire and the Humber and has been adopted in other NHS regions.

Frontline staff are trained to raise healthy lifestyle issues opportunistically in a conversational manner. It involves giving information about the importance of behaviour change and simple advice and sign posting to appropriate lifestyle services for support.

MECC can be supported by advice on healthy lifestyles and how to access services on routine written information.

6. Recommendations

- **That all Health and Wellbeing Board members commit their organisations to adopting the MECC principals and**
- **That all Health and Wellbeing Board members include MECC e-learning in mandatory training for staff**
- **That all Health and Wellbeing Board members commit to including the requirement for MECC in service specifications and contract documentation**

7. Proposals and details

Making Every Contact Count (MECC) is about encouraging and helping people to make healthier choices to achieve positive long-term behaviour change. MECC helps staff take the right approach, at the right time, to the right person to engage in healthy chats. We recognise that many services are already delivering MECC. This paper proposes sustainable 'industrial scale' delivery across all services and workforces.

MECC most commonly raises a lifestyle issue, encouraging individuals to:

- stop smoking
- eat healthily
- maintain a healthy weight
- drink alcohol within the recommended daily limits
- undertake the recommended amount of physical activity
- improve their mental health and wellbeing.

However, the wider social determinants of health are core to the MECC approach as the intervention starts from where the person is rather than dealing with a condition, illness or a label. It can therefore also support individuals to access services such as housing or financial support, which may be barriers to making a healthy lifestyle choice.

MECC is *not* about:

- adding another job to already busy working days
- staff becoming specialists or experts in certain lifestyle areas
- staff becoming counsellors or providing ongoing support to particular individuals
- staff telling somebody what to do and how to live their life.

Training in MECC focuses on the competences required to raise lifestyle issues with individuals in an opportunistic way and can therefore be applied to issues beyond the health sphere, such as to encourage increased recycling. It is based on Skills for Health competences and has been mapped against National Occupational Standards (NOS). It is not health-specific and is transferable across sectors, providing a common language across services, workforces, organisations enabling public health to be everyone's business.

To date training has been delivered face to face using a cascade training model, known locally as healthy chat training. E-learning is in development, providing training at level 1 (brief advice), and is scheduled to go live at the end of March 2013, alongside an electronic self-assessment tool. In addition to this e-learning, staff will need to have details of referral routes to local lifestyle services, in order to signpost appropriately.

MECC has been piloted and subject to informal (case-study based) and formal evaluation. An evaluation of the pilot study was published in February 2012 (http://www.yorksandhumber.nhs.uk/document.php?o=8594) and a final evaluation report of the region's implementation is due to be published shortly. Interim results indicate positive benefits for staff completing the training/e-learning (increased knowledge of lifestyle issues and services, more effective conversations with

patients, families and friends, job enrichment), organisations (better communications between colleagues, increased competence of the workforce as a whole) and patients (improved health and health outcomes). Whilst developed for use in the NHS, it has already been implemented in non-NHS settings, including Leeds City Council where staff were encouraged to have healthy chats with friends and family members.

The face-to-face healthy chats can also be supported with opportunistic written advice, such as the inclusion of health advice or information about lifestyle services on routine communications. For example, fixed penalty notices for littering are frequently given to people discarding cigarette ends and these could include information about stop smoking services on the reverse of the notice. Existing examples of this approach have been seen in the inclusion of lifestyle information services on payslips and promotion of the library service on RMBC headed paper.

The MECC approach has the potential to reach large numbers of individuals and provide new opportunities to change behaviour. If 1,000 public-facing staff delivered MECC only 10 times each year, this would lead to an extra 10,000 opportunities for behaviour change. If we trained 10,000 staff this becomes 100,000 additional opportunities each year.

8. Risks and uncertainties

The success of MECC implementation is linked to organisational and structural support for the approach and to individual competence and training.

Factor	**Individual unlikely to engage**	**Individual likely to listen**	**Individual likely to act**
Time	Staff member feels MECC is a tick-box exercise	MECC is delivered with credibility in a structured way	MECC is delivered in a structured way and backed up with action
Staff training	MECC is delivered by staff who are not trained	MECC is delivered by trained staff	MECC is delivered by somebody who has built up a relationship with the individual
Crisis	MECC is delivered when the individual is in crisis	MECC is delivered when the individual is contemplating change in health behaviours	MECC is delivered when the individual recognises lifestyle change will be beneficial
Environment	MECC is delivered in an unsuitable environment – eg too public	MECC is delivered in an environment that offers opportunities for change	MECC is delivered in an environment that supports change

9. Policy and Performance Agenda Implications

MECC provides a structured framework that supports the Health and Wellbeing Strategy themes of early intervention and prevention, dependence to independence and healthy lifestyles.

10. Background Papers and Consultation

http://www.yorksandhumber.nhs.uk/document.php?o=8594
http://learning.nhslocal.nhs.uk/feature-list/making-every-contact-count

Keywords: **Behavioural change, MECC**
Officer: **Iliff, Alison**
Director: **John Radford**

ROTHERHAM BOROUGH COUNCIL – REPORT

1.	**Meeting**	**Health and Wellbeing Board**
2.	**Date**	**10/04/2013**
3.	**Title**	**Health and Wellbeing Strategy Reporting Framework; Priority Areas**
4.	**Directorate**	**Public Health**

5. Summary

This is an ambitious framework for the Board to monitor progress against the Health and Wellbeing Strategy Priorities. Smoking, alcohol, obesity, NEETS, Fuel Poverty and Dementia.

It allows the Board to oversee the impact of its strategy across the Health System to deliver better Public Health. It tries to set a balance of responsibility for progress across Public Sector Commissioners and Providers of care or services.

Social patterns of behaviour that result in better health outcomes are slow to change across communities and in staff. All partners need to be giving constant consistent messages that influence all areas of delivery and planning, from the built environment to face to face contacts to bring about such change.

Particular emphasis has been placed on the key interaction between the public sector and the public in Every Contact Counts.

For a number of indicators, no 2013-13 target had been set and targets have been proposed for 2013/14 onwards

6. Recommendations

- **The Board is asked to support the proposed reporting framework and targets for 13/14 onward.**
- **For new indicators, we are seeking Board support and commitment from partners to data collection, for key areas such as every contact counts or brief interventions this will require real service change/sevice measurement to deliver the target.**

7. Proposals and details

For each Priority working groups will continue to oversee the detailed strategies to deliver on the aspirational goal.

Each Priority has a high level aspiration of what we want to achieve. Under each priority Key Measures National or Local indicators are set out, these are often only measured annually and will enable the Board to take stock of progress or allow it to consider further action.

Under each Key Measure a series of proxy or process measures are listed. In some cases these are in the form of absolute numbers i.e. for illicit tobacco prosecutions

A number of local measures are also in the National Outcomes Frameworks - achievement of these will be key to getting the Health Premium Incentive and meeting NHS and DH targets

There are limitations on the availability of data for several indicators, including some Key Measures that are also in the Public Health Outcomes Framework progress is expected in the next few months on how this information will be collected.

8. Finance

It is expected that all activity is carried out within existing resources by re-prioritising work.

9. Risks and uncertainties

Workless-ness, the prospect of economic growth and the impact of benefit changes.

10. Policy and Performance Agenda Implications

11. Background Papers and Consultation

Rotherham Health and Wellbeing Strategy 2012

12. John Radford DPH 01709 255844 john.radford@rotherham.gov.uk

Proposed Health and Well-being Strategy Reporting Framework position at Quarter 3 2012-13

General guide to column headings:
Last Quarters Outturn:- Will be Quarter 2 (April-Sep2012)
Current Quarters Outturn:- Will be Quarter 3 (April- December 2012)
Baseline:- 2011-12 Outturn
Quarterly Target :- The target for Current Quarter so for this report will be the target for Quarter 3
Year End Target :- Will be the target for 2012-13
2013-14 Target:- Will be the 2013-14 Target
2014-15 Target:- Will be the 2014-15 Target

For a number of indicators, no 2013-13 target has been set and targets have been proposed for 2013 onwards

For new indicators, we are seeking Board support and commitment to data collection

A number of local measures are also in the National Outcomes Frameworks - achievement of these will be key to getting the Health Premium Incentive and meeting NHS and DH targets

There are limitations on the availability of data for several indicators, including some key local measures that are also in the Public Health Outcomes Framework.

Priority 1 - Smoking

High level aspiration - Reduce smoking in adults to less than national average by 2016

Goal 1 - Preventing initiation of tobacco use amongst children and young people

	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
Key Measure		Percentage smoking at delivery 20.1% (12/13 Qtr 2) to below the national average by 2015	20.1%	17.2%	19.8%	18.5%	18.5%	16.5%	13.0%	TRFT	Alison Iliff
		Percentage of young people (Year 7 & 10) smoking (CYPS lifestyle survey) (regular smokers)	See notes	2%/14%	2%/14%	See notes	See notes	0%/0%	0%/0%	All Partners	Alison Iliff

	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
Quarterly Proxy Measure		All retailers to be part of the responsible retailers scheme – 100%		20		No target set	No target set	100	200	Alan Pogorzelec	Alison Iliff/Mel
		Number of prosecutions for underage tobacco sales		See notes	Nil in last 3 years	No target set	No target set	>4	>4	Alan Pogorzelec	?
		100% of schools to have anti-tobacco policies approved by governers			See notes	No target set	No target set		100%	Schools, Kay Denton	Alison Iliff

Goal 2 - Reducing Harm to Adults from tobacco consumption

	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
Key Measure		Percentage of adults 18 and over smoking (integrated household survey)	23.4%	23.3%	23.3%	See notes	23%	22%	22%	All Partners	Alison Iliff

Quarterly Proxy Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
		100% of key public sector staff undertake every contact counts	This is a proposed indicator					75%	100%	All Partners	Sally Jenks
		100% participation by retailers in Responsible Retailer scheme		20		No target set	No target set	100	200	Alan Pogorzelec	Alison Iliff/Mel
		Number of prosecutions for sales of illicit and counterfeit tobacco		See notes	Nil in last 3 years	No target set	No target set	>4	>4	Alan Pogorzelec	?

Notes:

Goal 1 KM 1 Last Quarter represents Q2 2012/13 (Jul-Sep12); Current Quarter represents Q3 2012/13 (Oct-Dec12); Baseline represents 2011/12 financial year. Baseline data may be affected by high percentage where mother's smoking status not known (for quarter Q1 2011/12)

KM 2 Data shown as Y7/Y10. Baseline represents 2011 Survey data and Current Quarter represents 2012 Survey data. Survey is conducted and reported annually.

QPM 2 No prosecutions in relation to underage sales of tobacco or illicit or counterfeit tobacco in over 3 years.

QPM 3 Information requested by policy lead, awaiting response

Goal 2 KM Last Quarter represents 12 months Jan11-Dec11; Current Quarter and Baseline represents 12 months Apr11-Mar12. Survey is collected and reported annually

QPM 3 No prosecutions in relation to illicit or counterfeit tobacco in over 3 years. May need to reconsider this measure and alternatives include number of seizures.

Priority 2 - Alcohol

High level aspiration - Rotherham is recognised as a place where people drink responsibly

Goal 1 - Preventing harm to children and young people from alcohol consumption

Key Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
		Decreased percentage of Year 10s reporting that they drink alcohol (CYPS Lifestyle Survey) (regular drinkers)		12%	30.0%	See notes	No target set	0%	0%	All Partners	Mel Howard

Quarterly Proxy Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
		100% of key public sector staff undertake every contact counts	This is a proposed indicator					75%	100%	All Partners	Sally Jenks
		Community Alcohol Partnerships across the Borough			2 being developed	No target set	No target set	11		SRP	SRP
		100% particpation by retailers in Responsible Retailer scheme		20		No target set	No target set	100	200	Alan Pogorzelec	Alison Iliff/Mel Howard
		Alcohol consumption profile of parents of looked after children as measured by audit of CAF	This is a proposed indicator								

Goal 2 - Reducing harm to adults from alcohol consumption

Key Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
		Reduce hospital admissions due to alcohol related illness	502	507	2270					GP Contractors, Health Checks, Treatment Services	Mel Howard

Quarterly Proxy Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
		100% of key public sector staff undertake every contact counts	This is a proposed indicator					75%	100%	All Partners	Sally Jenks
		Community Alcohol Partnerships across the Borough			2 being developed	No target set	No target set	11		SRP	SRP
		100% participation by retailers in Responsible Retailer scheme		20		No target set	No target set	100	200	Alan Pogorzelec	Alison Iliff/Mel Howard
		Number of section 27 FPNs and attendance at binge drinking course			0	No target set	No target set	100	100	Police	SRP
		Increased number of brief interventions in general practice	This is a proposed indicator					20000	20000	GP Contractors	NCB
		Increased number of brief interventions in community settings	This is a proposed indicator					20000	20000	TRFT	RCCG
		Increased number of brief interventions in hospital settings	This is a proposed indicator					20000	20000	TRFT	RCCG

Goal 1 KM Represents those reporting drinking regularly. Baseline represents 2011 Survey data and Current Quarter represents 2012 Survey data. Survey is conducted and reported annually.
Goal 2 KM Last Quarter represents Q1 2012/13 (Apr-Jun12); Current Quarter represents Q2 2012/13 (Jul-Sep12); Baseline represents 2011/12 financial year.
Data represents rate per 100,000 standardised population. Annual data represented as the sum of the 4 quarterly rates.
After consideration, it was decided that Best Bar None would not be progressed as responsible retailer should do the same job without the cost that is incurred.

Priority 3 - Obesity

High level aspirations outcome - All people in Rotherham achieve and/or maintain a healthy weight

Goal 1 - Preventing obesity in children and young people

Key Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
		Percentage of overweight and obese children in Reception	19.7%	16.1%	16.1%	See notes		15.0%	12.0%	All Partners	Joanna Saunders
		Percentage of overweight and obese children in Year 6	35.2%	33.0%	33.0%	See notes		30.0%	25.0%	All Partners	Joanna Saunders

Quarterly Proxy Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
		100% of key public sector staff undertake every contact counts	This is a proposed indicator					75%	100%	All Partners	Sally Jenks
		Increase in referrals to and completed Healthy Weight Framework Interventions			See notes	No target set				All Partners	Joanna Saunders
		Percentage of applications for fast food outlets approved that are within close proximity to a school or in a deprived area (in accordance with policy)			See notes	No target set				?	Helen Sleigh

Goal 2 - Reducing harm to adults from obesity

Key Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
		Increased healthy eating prevalence (Integrated Household Survey/ Active People Survey)	Proposed key measure		21.3%	See notes				All Partners	Joanna Saunders
		Increased prevalence of diagnosed diabetes	6.28%	6.33%	6.20%	No target set				GP Contractors, Health Checks, TRFT	Dominic Blaydon

Quarterly Proxy Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
		100% of key public sector staff undertake every contact counts	This is a proposed indicator					75%	100%	All Partners	Sally Jenks
		Increase in referrals to and completed Healthy Weight Framework Interventions			See notes	No target set				All Partners	Joanna Saunders
		Increased greenspace utilisation and access			13.7%	No target set		15.0%	16.0%	All Partners	Chris Siddall

Goal 1 KM1 &2 (Annual data) Last Quarter represents 2010/11 financial year; Current Quarter and Baseline represents 2011/12 financial year.
QPM 2 Activity data has been validated and work is underway to establish baselines and quarterly performance
QPM 3 Planning policy relating to this is currently out for consultation
Goal 2 KM 1 Baseline represents modelled data for 2006-2008 based on Health Survey for England data. Indicator being developed nationally for Public Health Outcomes Framework on which target can be set
KM 2 Last Quarter represents position as at October 2013; Current Quarter represents position as at January 2013; Baseline represents 2011/12 financial year.
QPM 2 Activity data has been validated and work is underway to establish baselines and quarterly performance
QPM 3 Baseline represents survey period March 2009 - February 2012. Indicator is based on annual survey data

Priority 4 - NEET

High level aspirations outcome - Our commitment is that by 2016 all Rotherham's young people will participate in education or training up to the age of 18.

Goal 1 - Reduce percentage of Academic Age 16 - 18 Young People who are Not in Employment, Education or Training (NEET)

Key Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target (3 month ave)	2012-13 Annual target (Nov -Jan Ave)	2012-13 Achieved (Nov -Jan Ave)	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
	N	Percentage of Academic Age 16 - 18 Young People who are NEET	7.1%	7.4%	7.6%	7.1%	7.1%	7.4%	7.1%	7.0%		

Goal 2 – Reduce percentage of Academic Age 16 - 18 Young People whose current situation is Not Known

Key Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target (3 month ave)	2012-13 Annual target (Nov -Jan Ave)	2012-13 Achieved (Nov -Jan Ave)	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
	Y	Percentage of Academic Age 16 - 18 Young People whose current situation is Not Known	5.2%	3.9%	4.8%	5.0%	5.0%	3.9%	5.0%	5.0%		

Goal 3 – Increase percentage of Young People Participating (reporting to commence April 2013)

Key Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	Year End Achieved	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
	TBA	Percentage of Academic Year 12 participating			89.0%				92.0%	95.0%		
	TBA	Percentage of Academic Year 13 participating			80.0%				82.0%	85.0%		

Goal 4 – Reduce percentage of RMBC Corporate Responsibility LAC/CL Young People (Academic Age 12 -14) who are Not in Employment, Education or Training (NEET)

Key Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	Year End Achieved	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
	TBA	Percentage of RMBC Corporate Responsibility LAC/CL Young People (Academic Age 12 -14) who are NEET			28.0%				24.0%	20.0%		

Populated data for current quarter return is based on data as at end of January 2013

Baseline for Outcomes 1 and 2 have been taken from the 2011/12 reported data
Baseline for Outcome 3 taken from the Annual Activity Survey for 2012
NB - DoE are changing the count for NEET as at April 2013 - currency will no longer apply and therefore the adjustment set to NEET % has been amended. This is projected to inflate the NEET % by apProxyamtely 1%
Particicipation is defined as: □□□

- full-time education, such as school, college or home education
- an apprenticeship
- part-time education or training if they are employed, self-employed or volunteering full-time (which is defined as 20 hours or more a week).

Priority 5 - Fuel Poverty

High level aspirations - Everyone in Rotherham can afford to keep warm and keep well

Goal 1 - Reducing the effects of Fuel Poverty

Key Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
		Percentage of residents spending over 10% on fuel to warm their house (Integrated Household Survey)		See notes	18.2%		No target set	18.0%	15.0%	All Partners	?

Quarterly Proxy Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
		Increase the number of properties receiving energy efficiency measures e.g. CESP/CERT, DECC Fuel Poverty, WHHP (Cavity wall insulation)	See notes	732	554		No target set	1000	1300	Energy Companies, Dave Richmond	Dave Richmond
		Increase the number of properties receiving energy efficiency measures e.g. CESP/CERT, DECC Fuel Poverty, WHHP (Loft insulation)	See notes	1005	704		No target set	1300	1600	Energy Companies, Dave Richmond	Dave Richmond

Notes:

Goal 1 KM Baseline represents 2010 calendar year.
QPM1, 2 Baseline represents 2010/11 financial year and Current Quarter represents 2011/12 financial year.
Data represents number of insulations per 10,000 households.

Priority 6 - Dementia

High level aspiration - Enabling people with dementia to live independantly for longer

Goal 1 - Earlier detection of dementia in order to provide effective care

Key Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
		Observed diagnosis rate of people with dementia (QOF)	0.71%	0.71%	0.67%						

Quarterly Proxi Measure	On Target	Indicator	Last Quarters Outturn	Current Quarter Outturn	Baseline	Quarterly Target	Year End Target	2013-14 Target	2014-15 Target	Delivery Lead	Policy Lead
		Number of attendances at memory clinic	Proposed indicator								
		Waiting times for memory clinic	Proposed indicator								
		Number of care packages assessments for people with dementia	Proposed indicator								
	★	**Timeliness of social care assessment within 28 days (all adults)**	**94.58%**	**96.60%**	**83.21%**	**95%**	**95%**	**96%**	**96%**		
		Care package assessments responded within 28 days	Proposed indicator								
	★	**Acceptable waiting times for care packages within 28 days**	**95.52%**	**96.46%**	**97.5%**	**96.0%**	**97.5%**	**97.5%**	**97.5%**		
		Annual reviews of care package assessments for people with dementia	Proposed indicator								
	★	**Percentage of clients receiving a review**	**48.31%**	**66.45%**	**93.00%**	**65%**	**93%**	**93%**	**93%**		
		A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life	Proposed indicator								

Goal 1 KM Last Quarter represents position as at October 2013; Current Quarter represents position as at January 2013; Baseline represents 2011/12 financial year. Data represents prevalence.

QPM 4,6,8 Data via Steve Norcliffe 26/03/13

Last Quarters Outturn:- Will be Quarter 2 (April-Sep2012)
Current Quarters Outturn:- Will be Quarter 3 (April- December 2012)
Baseline:- 2011-12 Outturn
Quarterly Target :- The target for Current Quarter so for this report will be the target for Quarter 3
Year End Target :- Will be the target for 2012-13
2013-14 Target:- Will be the 2013-14 Target
2014-15 Target:- Will be the 2014-15 Target

Health and Wellbeing Board

1.	**Date:**	**10 April 2013**
2.	**Title:**	**Health and Wellbeing Strategy: Workstream Progress**

3. Summary

The Health and Wellbeing Strategy includes 6 strategic outcomes. These outcomes are being delivered through a set of actions to bring about change in the way we do things; to improve the health and wellbeing of all Rotherham people.

Each of the 6 outcomes has been allocated a lead officer from across the council, public health and NHS. It is the responsibility of these lead officers to develop their workstream and deliver the actions.

This report provides the Health and Wellbeing Board with an update on the progress of each of the workstreams, and enables the board to consider any issues or tensions which need to be thought through. This is alongside a more detailed presentation on one of the workstreams at each board meeting.

4. Recommendations

That the Health and Wellbeing Board:

- **Notes progress on each of the workstreams**

5. Proposals and details

A summary of the key actions and progress against these is presented below for each workstream.

Prevention and Early Intervention

The workstream plan is currently being developed with key officers across the local authority and partner agencies.

Key actions to date:

- One of the key actions for the workstream is around 'healthy ageing' and the use of social networks / community groups to improve the health and wellbeing of older people. Discussions have begun with Age UK Rotherham and VAR to link in with the Rotherham Less Lonely campaign
- Development of a public health website is being considered, to enable communication of key health information, although this has been delayed due to technical difficulties with website functionality
- Every Contact Counts is also a key delivery mechanism for this workstream and a paper is being presented to board

Expectations and Aspirations

Full presentation to board

Dependence to Independence

A multi-agency task group has been established and a plan developed to address the four priority areas within the workstream.

Key actions to date:

- A draft action plan has been developed to benchmark existing workforce development plans (across agencies), to establish whether they are designed to achieve the strategic culture change needed and take action to improve plans where there are deficits
- Discussion has taken place with the Self Care task Group to clarify focus on behaviour, attitude and skill of staff in promoting self care and self management
- A Personal Health Budget action plan is now in place to help identify opportunities to personalise services, increase customers' choice and control and choose solutions which are best suited to their personal circumstances (Personal health budgets workstream)
- Consideration has been given to identify opportunities within the CYPS action plan to link across to the Dependence to Independence agenda (such as making links with the Early Help Agenda and SEN Green Paper development activity), although this requires further work

Healthy Lifestyles

The workstream plan is currently being developed. Key actions to date:

- It has been identified that this workstream overlaps with the lifestyle/behaviour

change locally determined priorities (alcohol, smoking and obesity) and discussions have taken place with the leads for each of these to develop and agree where appropriate key actions which are required

- Meetings have been arranged with the lead for transport to consider how we use the health and wellbeing strategy to influence local planning and transport services to help us promote healthy lifestyles
- A meeting has been arranged with the lead for leisure/green spaces to look at how to best promote leisure activities to improve people's lifestyles

Long-term Conditions

This workstream is being delivered mainly through the work of the Rotherham Urgent Care Management Committee, which oversees management of the Long Term Conditions Programme. It actively manages the programme to ensure agreed outcomes are met and that there is appropriate and effective engagement with patients and public.

Partner organisations from Rotherham's health and social care community are currently participating in a national programme aimed at improving services for people with long term conditions.

The programme included 4 workstreams;

1. Risk profiling
2. Integrated neighbourhood teams
3. Self-management
4. Alternative Levels of Care

Poverty

Most areas have completed their area analysis and all bar one have set priorities for intervention. 9 of the areas now have an agreed priority measure regarding health inequalities.

Key actions to date:

- The area plans include actions to consider 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, a mapping exercise is underway, to ascertain the extent of poverty alleviation work currently being undertaken in Rotherham, research is being done to capture national best practice in anti poverty work, which could potentially lead to new anti poverty strategy
- Looking at national best practice will also consider ways to ensure every household in deprived areas is able to maximise their benefit take-up where appropriate

6. Risks and Uncertainties

Not having the appropriate resources to deliver the actions required within the workstreams; including officer time and available budget. This means that leads are having to be innovative and creative in their thinking to ensure delivery effectively and appropriately.

Each lead is currently developing their action plan. Having a plan in place will be crucial in ensuring the right actions are being delivered and enable the board to monitor effective progress.

7. Contacts

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Workstream Leads:

Prevention and Early Intervention
John Radford, DPH

Expectations and Aspirations
Sue Wilson, RMBC

Dependence and Independence
Shona McFarlane, RMBC

Healthy Lifestyles
Joanna Saunders, RMBC Public Health

Long-term Conditions
Dominic Blaydon, NHS Rotherham

Poverty
Dave Richmond, RMBC

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health and Well Being Board**
2.	**Date:**	**10th April 2013**
3.	**Title:**	**Health and Wellbeing Strategy – Expectations and Aspirations**
4.	**Directorate:**	**Commissioning, Policy and Performance, Resources**

5. **Summary**

This report supplemented by a presentation to the Board is intended to provide an up to date position of the work of the Expectations and Aspirations workstream.

6. **Recommendations**

(i) That members of the Health and Wellbeing Board receive this report and recognise the progress being made by the Expectations and Aspirations workstream.

(ii) That partner agencies commit to sharing the small costs required to reinforce key messages through the production of pledge cards and other low cost initiatives

7. Proposals and Details

Raising Expectations and Aspirations is one of the 6 strategic outcomes we aim to deliver through the Health and Wellbeing Strategy:

All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community, tailored to their personal circumstances.

To achieve this culture change on the scale required partners to the Health and Well Being Board have agreed that:

- We will provide much clearer information about the standards people should expect and demand.
- We will train all people who work towards reducing health inequalities to respond to the circumstances of individual people, families and the local community.
- We will ensure all our workforce routinely prompt, help and signpost people to key services and programmes.
- We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions.

A multi-agency group has been established and working together since November 2012.

Attached at appendix A is the action plan of the group

The key element of changing expectations and aspirations of our citizens in Rotherham is underpinned by behaviours and culture change of staff across the agencies and this is currently the key focus of the work of the group in the first year.

Key deliverables and outputs of the group are currently:

- Work around behaviour of staff in relation to customer care inc:
    - Pledge Cards for customers (including one for young people)
    - Prompt Cards for staff
    - Information Sharing event for practitioners in 2 of the deprived neighbourhoods.
    - An analysis of complaints to form a baseline for assessing change in behaviour of staff

Further work of the group will be to look at a rationale for developing generic customer standards for all the partners from the Health and Well Being Board in a single set of standards.

A plan on a page has also been developed which identifies how the Expectations and Aspirations workstream is working with the 6 strategic leads of the priority areas (Fuel Poverty, NEETS, Obesity, Smoking, Alcohol and Dementia) see attached Appendix B

It is recognised that the role of Health Watch aligns closely with the work of the Expectations and Aspirations workstream, particularly in relation to customer standards and satisfaction levels.

8. Finance

There is currently no budget associate with the work of the group and some very modest costs associated with this work eg design and print costs and venue costs for the upcoming information sharing event.

A small budget would be required to ensure that high quality products can be arranged (eg staff prompt cards, customer pledge posters for settings and venues arranged with teas and coffees for practitioners attending).

A commitment from the Health and Well Being Board to all contribute towards these costs, the apportionment of which can be agreed by the officer group, is needed.

9. Risks and Uncertainties

Expectations and Aspirations is about culture change for our citizens and also for our staff working across the organisations. Capacity of staff is a concern and it is important that this is a high priority and that all organisations encourage their staff to attend meetings and are fully engaged with the work of the group. It is also important that all staff required to attend training courses are freed up from their working day to attend such training.

10. Policy and Performance Agenda Implications

The Performance Management Framework underpins the work around the priorities of the strategy and the workstreams.

11. Background Papers and Consultation

Appendix A – Action Plan
Appendix B – Plan on a Page
Health and Wellbeing Strategy

Contact Name: *Sue Wilson, Performance & Quality Manager, sue-cyps.wilson@rotherham.gov.uk 01709 822511*

Rotherham's Joint Health and Wellbeing Strategy Expectations and Aspirations

Sue Wilson – Performance and Quality Manager

10th April 2013

Six locally determined priorities

- Fuel Poverty
- NEETS
- Obesity
- Smoking
- Alcohol
- Dementia

Six Strategic Outcomes

- Prevention and early intervention
- Expectations and aspirations
- Dependence to independence
- Healthy lifestyles
- Long-term conditions
- Poverty

4 Life Stages

- Starting Well
- Developing Well
- Living and Working Well
- Ageing and Dying Well

Expectations and Aspirations

All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community, tailored to their personal circumstances

Expectations and Aspirations

Priority One - We will provide much clearer information about the standards people should expect and demand

Progress

- Complaints baseline
- Service Standards baseline
- Our Pledge
- Young People's Pledge
- Staff Prompt card

Our Pledge

Our Pledge to You

- We will always be helpful and timely; all people are important to us
- We will be patient and listen to you
- We will communicate with you clearly
  - we will be clear about the service that you can expect and you should never feel afraid to share your views and opinions
- We will not pass you from pillar to post; we will try to simplify what we do
- We will treat you fairly and with respect

We will always treat you in this way
and expect you to treat us the same

Young Person's Pledge

Young Person's Pledge

Rotherham Metropolitan Borough Council
Where Everyone Matters

- **We will talk to each other in a way that we both understand**
- **We will be patient, listen to each other and not interrupt**
- **We will respect each others views and feelings**
- **We will be polite about each others opinions - challenge the opinion not the person**
- **We will care about each other and be helpful with each others needs**

We will always treat you in this way
and expect you to treat us the same

VoluntaryAction Rotherham

Staff Prompt Card

Rotherham Health and Wellbeing Strategy
Staff Prompt Card

First Impressions count
Be positive and helpful; people should feel they are important to you

Listen to People
Be polite and patient; and ensure you understand peoples needs

Communicate Clearly
Stick to plain language and check that people understand the service they can expect

Make things Simple
Don't pass people from pillar to post; try to simplify working practice

Be Respectful
Be friendly and treat people fairly - including colleagues

NHS

Rotherham Metropolitan Borough Council
Where Everyone Matters

Voluntary Action Rotherham

Expectations and Aspirations

- **Action**

Further work around a “single standard” across all the organisations working around Health and Well Being

To include information around what people can expect, demand and that it’s ok to feedback or complain about the service

Expectations and Aspirations

Priority Two – We will train all people who work towards reducing health inequalities to respond to the circumstances of individual people. Families and the local community

Action – Customer Care training will be developed including specific training for staff in Deprived Neighbourhoods

Expectations and Aspirations

Priority Three – We will ensure all our workforce routinely prompt, help and signpost people to key services and programmes

Progress

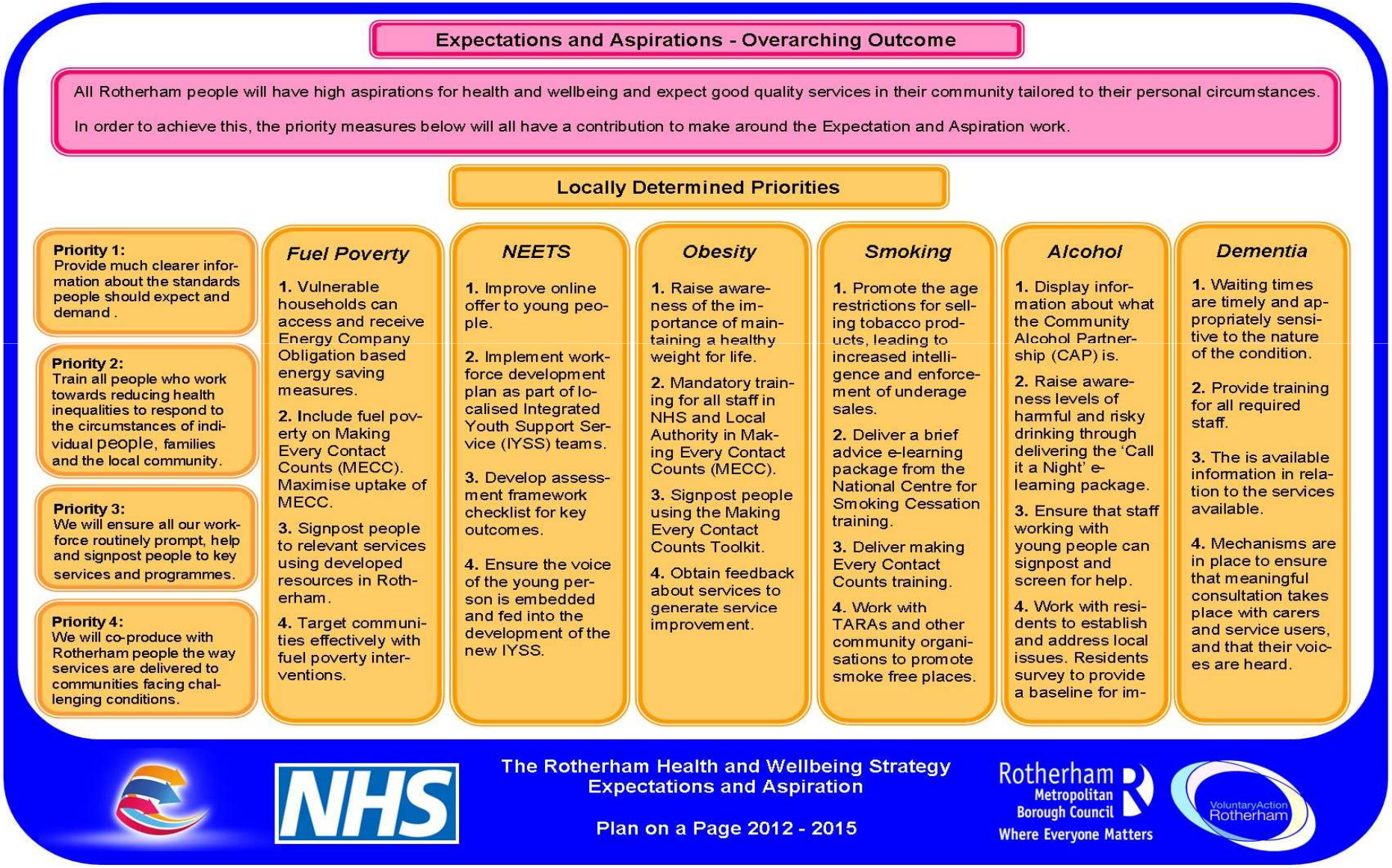
- Audit of online directories and services across partners
- Information Sharing Event planned for 16th May for practitioners working in East Herringthorpe / Dalton and Thrybergh re Employment and Health

Expectations and Aspirations

Priority Four – We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions

Action – Consultative work and co-production of services will be developed across agencies

Expectations and Aspirations



Challenges

- Continued commitment and engagement from all organisations around the work of the workstream
- Role of Health Watch alongside the workstream
- Common Set of standards is this acceptable and achievable?
- Resources
  - Budget
  - Staff time
  - Attendance at training

Thank You

Sue Wilson, Performance and Quality Manager
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Health and Well Being – Expectations and Aspirations

Work Plan

Actions	Responsible Person	Progress	Deadline Date
Overarching Outcome: All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community, tailored to their personal circumstances.			
1. Early base lining across all organisations working around HWB – regarding actions of staff courtesy (complaints).	All members of working group	Request sent out to group asking for details of complaints to be sent to JBA. Complaints submitted from all organisations, requested 2010/11 to carry out analysis and comparison to 2011/12	**Complete**
Analysis to be undertaken to establish a baseline of data	JBA	Baseline commenced for 2010/11 and 2011/13 awaiting further information from CCG	April 2013
Priority One: We will provide much clearer information about the standards people should expect and demand.			
1. Baseline audit across all organisations working around HWB – Council / Hospital / Health Organisations / Voluntary Section	All members of working group	Request sent out to group asking for examples of service standards to be sent to JBA. Service standards received from partners	**Complete**
2. Establish where the gaps are.	JBA / SW and group	Group reviewed submissions and fed into work around customer pledge	**Complete**
3. Develop some generic standards to be used by organisations where there are gaps.	JBA / SW /KG and group	Group to work together to pull together simple statements around customer care	**Complete**

		and developed customer pledge as an example of high level and generic standards around staff behaviours	
4. Develop prompt card for staff	JBA / KG	Group to review sample and agree format, agreed to develop 3 cards, customers, staff and young people. Draft pledges developed. Consultation to take place and final versions to be agreed Budget to be agreed for design and printing costs	May 2013
5. Develop a single set of customer standards agreed by the Health and WellBeing Board	SW	Standards developed, agreed and published	July 2013
Priority Two: We will train all people who work towards reducing health inequalities to respond to the circumstances of individual people, families and the local community.			
1. Develop generic customer care training for across the whole of Rotherham.	SW	Specific work required with workforce leads for organisations and the development of a generic approach.	June 2013
2. Target specific training to meet the needs of residents in all deprived neighbourhoods	SW / JBA	Work with group looking at sharing event for practitioner. Pilot event to be held in May for practitioners	May 2013
Priority Three: We will ensure all our workforce routinely prompt, help and signpost people to key services and programmes.			
1. Develop a better understanding around the services available by promoting the existing online services direction e.g. Family Information Service	Group led by JBA	Audit to be carried out of all available on line systems and raise awareness with practitioners. Initial list compiled of all	May 2013

(early years) and GISMO (voluntary sector).		online directories and internet sites where staff and customers can use for signposting / accessing services Use the DN practitioner events to show case the sites	
2. Develop information sharing sessions where practitioners from across the partnership share information around services they provide. Particularly in deprived neighbourhoods.	SW / JBA	Discussions taken place with Area Coordinators, pilot session to be arranged in East Herringthorpe Pilot practitioner event being planned for MyPlace on 16th May – East Herringthorpe and Dalthon / Thrybergh	16th May pilot event
Priority Four: We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions.			
1. We will ensure that our customers are consulted with as part of the development of services or changes made to a service.	SW/ JS	Work with Community Engagement to ensure services carry out statutory consultation	**Not yet started**
2. We will strive to ensure that all services complete an Equality Assessment where changes are made to services provided	SW / JS	Work with Community Engagement to ensure services carry out EA.	**Not yet started**

Version No.	Date of Change	Description of Change	Changed By
1	11/12/12	Work plan created	J Bratton-Alexander
2	03/01/13	Further actions added	S Wilson
3	21/01/13	Further actions added	S Wilson
4	22/01/13	Version Control added	J Bratton-Alexander
5	23/01/13	Further dates added	S Wilson
6	27/1/13	Further updates added for HWB steering group	S Wilson
7	25/3/13	Further updates in preparation for HWB report	S Wilson

Expectations and Aspirations - Overarching Outcome

All Rotherham people will have high aspirations for health and wellbeing and expect good quality services in their community tailored to their personal circumstances.

In order to achieve this, the priority measures below will all have a contribution to make around the Expectation and Aspiration work.

Locally Determined Priorities

Priority 1:
Provide much clearer information about the standards people should expect and demand .

Priority 2:
Train all people who work towards reducing health inequalities to respond to the circumstances of individual people, families and the local community.

Priority 3:
We will ensure all our workforce routinely prompt, help and signpost people to key services and programmes.

Priority 4:
We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions.

Fuel Poverty

1. Vulnerable households can access and receive Energy Company Obligation based energy saving measures.

2. Include fuel poverty on Making Every Contact Counts (MECC). Maximise uptake of MECC.

3. Signpost people to relevant services using developed resources in Rotherham.

4. Target communities effectively with fuel poverty interventions.

NEETS

1. Improve online offer to young people.

2. Implement workforce development plan as part of localised Integrated Youth Support Service (IYSS) teams.

3. Develop assessment framework checklist for key outcomes.

4. Ensure the voice of the young person is embedded and fed into the development of the new IYSS.

Obesity

1. Raise awareness of the importance of maintaining a healthy weight for life.

2. Mandatory training for all staff in NHS and Local Authority in Making Every Contact Counts (MECC).

3. Signpost people using the Making Every Contact Counts Toolkit.

4. Obtain feedback about services to generate service improvement.

Smoking

1. Promote the age restrictions for selling tobacco products, leading to increased intelligence and enforcement of underage sales.

2. Deliver a brief advice e-learning package from the National Centre for Smoking Cessation training.

3. Deliver making Every Contact Counts training.

4. Work with TARAs and other community organisations to promote smoke free places.

Alcohol

1. Display information about what the Community Alcohol Partnership (CAP) is.

2. Raise awareness levels of harmful and risky drinking through delivering the 'Call it a Night' e-learning package.

3. Ensure that staff working with young people can signpost and screen for help.

4. Work with residents to establish and address local issues. Residents survey to provide a baseline for im-

Dementia

1. Waiting times are timely and appropriately sensitive to the nature of the condition.

2. Provide training for all required staff.

3. The is available information in relation to the services available.

4. Mechanisms are in place to ensure that meaningful consultation takes place with carers and service users, and that their voices are heard.