HEALTH AND WELLBEING BOARD

Venue: **Town Hall, The Crofts, Moorgate Street, Rotherham S60 2TH**

Date: **Wednesday, 8th May, 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 (Pages 1 - 13)

4. Communications (Pages 14 - 39)
   Disabled Children's Charter

   Conference – Teenage Pregnancy

5. NHS England (Pages 40 - 43)

6. Commissioning Plans (Pages 44 - 72)
   - Rotherham Council Budget 2013/14
   - Public Health Spending Plan and Commissioning Intentions
   - RMBC Commissioning Priorities

7. Workstream progress - Dependence to Independence (Pages 73 - 85)
   - presentation

8. Locally Determined Priority Measure: Smoking (Pages 86 - 92)
   - presentation
   (please see the briefing note attached)

9. Date of Next Meeting
   - Wednesday, 12th June, 2013 commencing at 1.00 p.m.

HEALTH AND WELLBEING BOARD
10th April, 2013

Present:-

Members

Councillor Ken Wyatt	Cabinet Member, Health and Wellbeing **(in the Chair)**
Tracy Clarke	RDaSH
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Councillor John Doyle	Cabinet Member, Adult Social Care
Chris Edwards	Chief Operating Officer, Rotherham Clinical Commissioning Group
Brian Hughes	Director of Performance and Accountability, National Commissioning Board
Martin Kimber	Chief Executive, Rotherham Borough Council
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families
Shona McFarlane	Director of Health and Wellbeing
Dr. David Polkinghorn	Rotherham Clinical Commissioning Group
Clair Pyper	Interim Director of Safeguarding Children and Families
Dr. David Tooth	Rotherham Clinical Commissioning Group
Janet Wheatley	Voluntary Action Rotherham

Also Present:-

Colette Bailey	Integrated Youth Support Services, RMBC
Clare Davis	Parkwood Healthcare
Gavin Drogomirecki	Police and Crime Commissioner's Office
Tony Hewitt	Parkwood Healthcare
Dr. Nagpal Hoysal	Consultant in Public Health Medicine
Sue Wilson	Performance and Quality Manager, RMBC
Shaun Wright	Police and Crime Commissioner

Officers:-

Kate Green	Policy Officer, RMBC
Tracy Holmes	Communications and Marketing, RMBC
Dawn Mitchell	Democratic Services, RMBC

Apologies for absence were submitted from Karl Battersby, Gordon Laidlaw, Michael Morgan, Dr. John Radford and Joyce Thacker.

S74. MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

Resolved:- (1) That the minutes be approved as a true record.

Arising from Minute No. S66 (Robert Francis Inquiry) it was noted that a Council Seminar was to be held on 18th April, 2013.

Arising from Minute No. 69 (Healthy Lifestyles, Prevention and Early Intervention), disappointment was expressed that details of the 2013/14 budget for Public Health and the Council was not included on the agenda.

It was noted that the Council had approved its 2013/14 budget and was a matter of public record.

Resolved:- (2) That the 2013/14 commissioning plans for Public Health and the Council be submitted to the next meeting of this Board.

(3) That the Director of Finance be invited to the meeting to present the information.

Arising from Minute No. S72 (Food for People in Crisis Partnership) it was noted that work was ongoing on this matter.

S75. COMMUNICATIONS

Local Government Association Conference – Teenage Pregnancy
London – 23rd April, 2013

Resolved:- That the conference be referred to the Health Select Commission for attendance.

The Chairman and Dr. Tooth had recently met with representatives from South Yorkshire's branch of the Department for Work and Pensions. A briefing note would be prepared for the Governance Board.

S76. LOCAL HEALTHWATCH

The Chairman welcomed Tony Hewitt, Director of Parkwood Healthcare, and Claire Davis, Operations Manager, to the meeting. Tony and Claire gave the following report:-

- The company's head office was in Lancashire and had been involved in the healthcare market for the last 15 years
- Parkwood had won a number of Healthwatch contracts including Doncaster
- The contract had been signed and a social enterprise established in Rotherham to operate in the Borough
- Interviews had taken place and hoped to appoint a Healthwatch Manager very shortly. A Chairperson and a Board of Directors would be next
- An interviewing panel had been confirmed for the recruitment of the Chairperson. The advert would be explicit that the role was different to that of the Trust and LiNK
- Hoped to be located in the town centre
- Bespoke company database which would be developed and used to collate evidence and undertake research and able to produce a number reports
- In the interim, a Healthwatch service was still provided through the website, e-mail and telephone as well as ongoing work with the PALS Team and Advocacy provider to ensure a seamless transition

It was noted that there had been no TUPE issues as the staff had all secured other employment.

There was a position on the Health and Wellbeing Board for the Chair of Healthwatch once elected. It was suggested that Claire Davies act as representative until such an appointment had been made.

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

(2) That Claire Davies, Operations Manager, represent Rotherham Healthwatch on the Health and Wellbeing Board until a Chairperson had been appointed.

S77. POLICE AND CRIME COMMISSIONER

Shaun Wright, Police and Crime Commissioner for South Yorkshire, attended the meeting and gave a report on his work as Commissioner:-

- Community Safety required a partnership approach – seek to endeavour to align all agencies/services, pooling budgets and jointly commissioning services thereby maximising ever decreasing resources

- The Police and Crime Plan was a key document for the Commissioner and hopefully for partners to ensure alignment to the key areas

- Drug addiction, alcohol and mental health issues were all significant issues impacting on crime and community safety. Whilst substantial funding was being directed to drug interventions, unless the re-offending link to mental health issues and drug/alcohol abuse was addressed, no significant impact would be made

- 90% of prisoners had at least 1 mental health problem. 1/3 of all incidents responded to by the Police were linked to someone suffering with mental health problems. Mental Health Services were very stretched and had been underfunded for a significant time – need to work smarter with the resources available

- Keenness to align the Commissioner Office and South Yorkshire Police with the Board

- The Police were a significant recipient of the Commissioner's funding but he could commission any service he so wished. Keen to tackle reoffending rates

- A certain amount of the budget would be safeguarded for Prevention and Early Intervention as a baseline that could be built upon

- Hallam University had been commissioned to map out current funding and partnerships within South Yorkshire which directly contributed to Community Safety which would feed into the commissioning decisions and the update of the Police and Crime Plan

Discussion ensued with the following points raised:-

- Prevention and Early Intervention was a priority. Work was required to create governance for the budget setting and commissioning strategy for 2014/15

- The need to involve the Commissioner in the consultation on CCG plans

Shaun was thanked for his attendance.

S78. PRIORITY MEASURE - NEETS

Collette Bailey, Integrated Youth support Services, gave the following presentation on the NEET Priority:-

What is the Issue?
- No real improvement in unemployment rate (NEET) for 16-18 year olds
- Vulnerable groups were 3 times more likely to be NEET than the wider cohort
- The NEET group were from poorer soci-economic backgrounds and had worse GCSE attainment

What is the current position?
- 1 in 8 of all 18-24 year olds were unemployed
- 719 young people academic age 16-18 were NEET 7.2%
- Much worse picture for vulnerable 16-19 year olds NEET
  13.% of people with learning difficulties
  29% of care leavers
  74% of teenage mothers
  50% of young offenders in the criminal justice systems

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 meant that young people were not able to compete for available jobs

- Low or no qualifications made work harder to find
- Low income jobs unless upskilled
- Progression into adulthood and becoming parents living in poverty
- Low self-esteem and lack of hope resulted in poor mental health and wider health issues
- Poor/lower outcomes for children in terms of learning and achievement
- Inter-generational unemployment

What helped 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 2 year pathways leading to a relevant qualification for the marketplace
- If you became NEET and had achieved a good range of GCSEs you were 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 was crucial

- Build the key basic numeracy and literacy skills needed to succeed in further education, training or the world of work
- Co-ordinated 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 co-ordination of support to ensure no break in learning
- Co-ordinated approach to young people who disengaged at the age of 17 after completing 1 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 existed in the current setting from schools, colleges and learning providers
- Focusing on complex needs of individuals and families limited time available to spend with NEET churn
- Creating an outcome related intervention with a focus on prevention rather than recovery was essential – service pressures could limit this
- Poverty – lack of financial incentives to engage young people – limited access to work experience or part-time work whilst in learning – limits breadth of skills base and employability

- Alternative options to the basic academic route were fundamental in terms of giving those most at risk a clear pathway with achievable goals
- The recession – young people were unable to compete for fewer opportunities

What can the Health and Wellbeing Board do?

- Training for Integrated Youth Support Services staff on cross cutting themes
- We were all targeting with the same families - partnership could 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

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

- The presentation outlined the importance of getting the early offer right and making contact with families. If families could be identified early and work take place with them, hopefully, in the long term the cycle could be broken
- If funding was removed from Early Intervention it would result in more families coming into the Service
- The Council had done a massive piece of work of opportunities that could link young people into the work taking place around Deprived Communities
- Major employers should be urged to sign up offering work experience opportunities/employment opportunities/apprenticeships for vulnerable young people
- Current Human Resources Policies imposed barriers to those young people with no qualifications or experience. Unless they were changed to facilitate creation of those opportunities nothing would change
- Statistical analysis showed that the longer a person was out of employment there was less likelihood of being able to do so in later life
- There were more opportunities created for young people than for older people
- Had to get it right in schools. Young people had to leave school with some form of qualification
- The Council had committed to helping care leavers get used to the world of work that quite often their parents were not in a position to help them with

Resolved:- (1) That the Health and Wellbeing Board's commitment to the offer of opportunities for work experience for vulnerable young people and the offer of employment opportunities/apprenticeships for vulnerable

groups be noted and that Board members be requested to seek their respective organisations' endorsement.

(2) That consideration be given by partner agencies to the barriers imposed by current Human Resources Policies in relation to young people that had no qualifications or work experience.

S79. HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

Kate Green, Policy Officer, reported that as from 1st April, 2013, the Board had 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 Rotherham's Board was operating in line with the duties, the Terms of Reference which had been previously developed for the Shadow Board, had been updated.

Discussion ensued with the amendments suggested to No. 6 Governance and Reporting Structures.

Resolved:- (1) That the updated Terms of Reference, as amended, be approved.

(2) That the Council's Code of Conduct for Members and Co-opted Members be noted.

(3) That Board Members submit Declarations of Interest for inclusion on the website.

S80. JOINT STRATEGIC NEEDS ASSESSMENT REFRESH

Chrissy Wright, Strategic Commissioning Manager, reported that the Joint Strategic Needs Assessment (JSNA) was last reviewed and revised in 2011 and a further refresh now required. In accordance with Government Guidance, the refreshed document must now include a Directory of Assets which meant community assets, physical infrastructure and individuals.

The report set out the proposed structure of the refreshed document as follows:-

Section 1

- Overarching cross-cutting areas
  Demographics
  Health conditions
  Lifestyle and population behaviours
  Wider determinants of health
  Communities of interest
  National Policy drivers

- Life Stages (as set out in the Health and Wellbeing Strategy)
  0-3 starting well
  4-19 developing well
  20-64 living and working well
  65+ ageing and dying well

- Assets
  Physical infrastructure e.g. buildings, green spaces
  Social and community networks e.g. VCS
  Individuals e.g. Neighbourhood Champions

Section 2

- Directory of Needs Analysis
  Many analyses undertaken by statutory organisations but no repository for all the documents. It would be a resource which all agencies should be mandated to contribute to, a resource that could be accessed by all agencies, enabled an information and data gap analysis and reduced duplication. The Directory would be accessed from the Council home page

Section 3

- Frequency of JSNA
  It would be constantly updated. It was proposed that 2013 would be the last full refresh, subject to future Government guidance, with a 6 monthly update submitted to the Board on any additions/variations to the data

Discussion ensued on the document with the following comments/issues raised:-

- A micro site to be set up where all the information could be collated
- "Final" refresh gave the impression that it was never to be refreshed when this was not the case. It would be continually updated
- A point in time e.g. September for agencies to base their forthcoming commissioning plans
- The voice of the child was fundamental to the document
- Need to get the media involved

Resolved:- (1) That the proposals set out in the report for the refresh of the Joint Strategic Needs Assessment be approved.

(2) That the document be amended to reflect the comments made with regard to the word "final".

(3) That further reports be submitted on a six monthly basis.

S81. MAKING EVERY CONTACT COUNTS

The Board was shown a video of how Making Every Contact Count worked in Salford.

The programme had been developed in 2009 by NHS Yorkshire and the Humber to give staff the skills to talk to individuals about their health and wellbeing. It had been adopted in other NHS regions.

Frontline staff were trained to raise healthy lifestyles issues opportunistically in a conversational manner. It involved giving information about the importance of behaviour change and simple advice and signposting to appropriate lifestyle services for support. It encouraged 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 were core to the MECC approach as the intervention started from where the person was rather than dealing with a condition, illness or label. It could, therefore, also support individuals to access services such as housing or financial support which may be barriers to making a healthy lifestyle choice.

Discussion ensued with the following issues raised/clarified:-

- Where were the boundaries?
- Principle sound but fine tuning required
- Appropriateness/nature of the professional contact
- The initiative had been around for some time and a lot of time spent in Health mapping the principles – what was MECC trying to achieve?
- Should be part of practitioners every day job
- Going the extra mile and listening to what members of the public said in conversation
- Did not want to commit limited staffing resources if it involved mandatory training taking up valuable time

Resolved:- That Tom Cray, John Radford and Nagpal Hoysal discuss further taking on board the points made above and report to a future meeting

S82. PERFORMANCE MANAGEMENT FRAMEWORK

Further to Minute No. S69(4) of the meeting held on 27th February, 2013, Dr. Nagpal Hoysal presented proposed key measures and quarterly proxy measures for each of the Indicators within the 6 Priority areas.

Each Priority had a high level aspiration of what the Board wanted it to achieve. Under each Priority, Key Measures National or Local Indicators were set which were often only measured annually and would enable the Board to monitor progress or consider further action.

There were limitations on the availability of data for several Indicators, including some Key Measures that were also in the Public Health Outcomes Framework. Progress was expected in the next few months on how the information would be collected.

Discussion ensued on each of the Indicators. The following were raised/clarified:-

- There were no new Indicators – they would be picked up as part of Making Every Contact Count

- A number of the Indicators would be delivered by the Tobacco Control Alliance with regard to Priority 1 – Smoking

- Would the effectiveness of Community Alcohol Partnerships be diluted in introducing them throughout the Borough? The 11 Deprived Areas would be the primary focus

- Alcohol consumption profile of parents of looked after children as measured by audit of CAF required further consideration

- Further information had been received since the agenda was compiled for Priority 5 – Fuel Poverty

- Priority 6 – Dementia – it had now been ascertained that information would be available for a number of the Indicators, however, it was felt that the measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life would be a challenge

- Need to ensure the Priority 6 Indicators aligned with the national Dementia Challenge

Resolved:- (1) That the reporting Framework and targets for 2013/14 onwards be supported.

(2) That, with regard to new Indicators, the Board's support and commitment for data collection for key areas such as Every Contact Counts or brief interventions be confirmed due to the real Service change/Service measurement that will be required to deliver the targets.

S83. WORKSTREAM PROGRESS - EXPECTATIONS AND ASPIRATIONS

Sue Wilson, Performance and Quality Officer, gave the following powerpoint presentation on the Expectations and Aspirations workstream:-

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."

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
- 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

Young Person's Pledge
- 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

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
  Do not pass people from pillar to post; try to simplify working practice
- Be respectful
  Be friendly and treat people fairly including colleagues

Action
- Further work around a "single standard" across all the organisations working around Health and Wellbeing
- To include information around what people can expect, demand and that it is okay to feedback or complain about the service

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

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 regarding Employment and Health

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

Challenges
- Continued commitment and engagement from all organisations around the work of the workstream
- Role of Healthwatch alongside the workstream
- Common Set of Standards – was this acceptable and achievable
- Resources
  Budget
  Staff time
  Attendance at training

Discussion ensued with the following issues highlighted/clarified:-

- Members of the public did not know what standard of service/response should be provided by agencies

- A commitment was required from agencies to provide a Common Set of Standards so communities would have the confidence to use the services and confidence to complain and hold agencies to account

- The working group had been established but there had been some issues with regard to attendance

- Plan on a Page developed identifying how the workstream was working with the 6 Strategic Leads of the Priority areas

- The role of Healthwatch aligned closely with the work of the workstream particularly in relation to customer standards and satisfaction levels

- Currently there was no budget associated with the work of the group and the modest costs associated with the work

Resolved:- (1) That the progress being made by the Expectations and Aspirations workstream be noted.

(2) That the issue of commitment to the Expectations and Aspirations workstream, the funding for the modest costs associated with the work and attendance at meetings of the multi-agency group, be raised and discussed at the Chief Executives Group.

S84. DATE OF NEXT MEETING

Resolved:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 8th May, 2013, commencing at 1.00 p.m. in the Rotherham Town Hall.

The Children's Trust Tadworth
For children with multiple disabilities

every disabled child matters

Why sign the Disabled Children's Charter for Health and Wellbeing Boards?

Benefits to Health and Wellbeing Boards of signing the Charter and meeting its commitments:

- Publicly articulate a vision for improving the quality of life and outcomes for disabled children, young people and their families
- Understand the true needs of disabled children, young people and their families in your local area and how to meet them
- Have greater confidence in targeting integrated commissioning on the needs of disabled children, young people and their families
- Support a local focus on cost-effective and child-centred interventions to deliver long-term impacts
- Build on local partnerships to deliver improvements to the quality of life and outcomes for disabled children, young people and their families
- Develop a shared local focus on measuring and improving the outcomes experienced by disabled children, young people and their families
- Demonstrate how your area will deliver the shared ambitions of the health system set out by the Government in 'Better Health Outcomes For Children and Young People: Our Pledge' for a key group of children and young people[1]

Who are we talking about?

The Disabled Children's Charter for Health and Wellbeing Boards and this accompanying document have been developed to support Health and Wellbeing Boards (HWBs) meet the needs of all children and young people who have disabilities, special educational needs (SEN), health conditions, and their families. In this document, when we talk about disabled children and young people we are referring to all the children and young people in this group.

1 Department of Health (2013), Better Health Outcomes for Children and Young People: Our Pledge

Commitment 1: We have detailed and accurate information on the disabled children, young people and their families living in our area, and provide public information on how we plan to meet their needs

Statutory drivers

Health and Social Care Act 2012

Duty to prepare assessment of needs (JSNA) in relation to local authority area and have regard to guidance from Secretary of State

Information

The quality of data and information used to underpin the planning, commissioning and delivery of services for children and young people with very complex needs is often poor. The difficulty of developing accurate, robust data in a standard format about disabled children and young people is an enduring issue for local areas and for national agencies. Reliable performance information about the use and value of services is critical to commissioning decisions. The Children and Young People's Health Outcomes Forum identified the lack of accurate data as the single biggest challenge in relation to the development of outcomes for children with long-term health conditions, disabilities and life limiting conditions[2].

In March 2012, the CQC released a report entitled 'Healthcare for disabled children and young people'[3]. This report gave details of primary care trust (PCT) replies to a self assessment questionnaire on services for disabled children.

PCTs demonstrated an extremely worrying lack of awareness of the needs of local disabled children:

- **Five PCTs** claimed that **no disabled children and young people lived in their area**
- **Fifty five** PCTs **did not monitor whether services allocated as a result of Common Assessment Framework were delivered**
- **Sixty three** PCTs **didn't know how many children were referred for manual wheelchairs** and **nine said children were waiting over 51 weeks for wheelchairs**
- **Fifteen** PCTs said they **didn't provide short breaks services**

Due to the lack of reliable data on disabled children and young people, their strategic involvement and that of their parents is essential to gain a good understanding of the profile of this group

2 Children and Young People's Health Outcomes Forum (2012), Report of the long term conditions, disability and palliative care subgroup p.2

3 Care Quality Commission (2012), Healthcare for Disabled Children and Young People

and the particular challenges and experiences they face. Their views remain underrepresented in surveys and public and patient involvement in the health service.

Meeting Needs

One of the primary tools Health and Wellbeing Boards have to drive strategic commissioning in their areas is the Joint Strategic Needs Assessment (JSNA). The JSNA will assess the current and future health and care needs and assets of a local population and will underpin a Joint Health and Wellbeing Strategy (JHWS). It will interpret available data to develop an understanding of the causes of health inequalities and a narrative of the evidence.

The JSNA can only be an effective tool for evidence-based decision making if it is based on accurate and meaningful data. The bodies Health and Wellbeing Boards delegate collecting data to as part of the JSNA process, must focus on improving the quality and scope of information on disabled children and young people which they use, including: available national data sets; local information sources such as data from Common Assessment Frameworks; qualitative information from direct engagement with service users.

The JSNA process must develop an understanding of the local population which is sufficiently differentiated to understand the needs of all groups of children, particularly those who face the greatest inequalities or experience multiple disadvantages.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- The full range of sources of information collected on disabled children, young people and their families which will be used to inform the JSNA process
- The quality assurance process used to ensure that information and data on disabled children, young people and their families used to inform commissioning is sufficiently detailed and accurate
- The way in which the JSNA will be used to assess the needs of local disabled children, young people and their families
- The way in which information on any hard to reach groups is sourced, and action taken to address any gaps of information with regard to local disabled children, young people and their families
- The way in which disabled children, young people and their families are strategically involved in identifying need, and evidence and feedback on their experiences is used to inform the JSNA process
- Public information on how the HWB will support partners to commission appropriately to meet the needs of local disabled children, young people and their families

Key resources for meeting this Charter commitment

Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

Statutory guidance to support Health and Wellbeing Boards and their partners in understanding the duties and powers in relation to Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

NHS Confederation, Operating principles for Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

Paper designed to support areas to develop successful Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

Child and Maternity Health Observatory: support for commissioners

Help to find the right tools, data and evidence to review, plan and improve services in your local area.

Child and Maternity Health Observatory: tools and data

ChiMat provides easy access to a wealth of data, information and intelligence through a range of online tools designed to support decision-making.

Rightcare (2012), NHS Atlas of Variation in Healthcare for Children and Young Adults

Variations across the breadth of child health services provided by NHS England are presented together to allow clinicians, commissioners and service users to identify priority areas for improving outcome, quality and productivity.

LGA (2011), Joint Strategic Needs Assessment: Data Inventory

Offers practical help to councils, clinical commissioning groups and other members of health and wellbeing boards.

Children and Young People's Health Outcomes Forum (2012), Making data and information work for children and young people

Factsheet on making data and information work for children and young people, including resources.

Contact A Family (2012), Health and Wellbeing Boards: making the case to target disabled children services

Briefing for Parent Carer Forums on the reasons why the Health and Wellbeing board in their area should target disabled children in their Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing strategy (JHWS).

Commitment 2: We engage directly with disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board

Statutory drivers

Health and Social Care Act 2012

Duty to involve third parties in preparation of the JSNA:

- Local Healthwatch
- people living or working in the area
- for County Councils – each relevant DC

Duty to involve third parties in preparation of the JHWS:

- Local Healthwatch
- people living or working in the area

Article 12 of the United Nations Convention on the Rights of the Child (UNCRC)

- The child has the right to express his or her opinion freely and to have that opinion taken into account in any matter or procedure affecting the child.

Article 7 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD)

- Children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realise that right.

Health and Wellbeing Boards should ensure that the voice of disabled children and young people is always heard when decisions are being made that affect them. Health and Wellbeing Board members should use their influence to embed engagement with disabled children and young people throughout the health and care system and in the context of a continuous and current partnership.

The benefits of embedding participation of disabled children and young people are huge: better services will be developed driven by feedback from the people who know and use them; resources are not wasted on services that are not taken up or valued; services will be more child and young person friendly and accessible; disabled children and young people will have insight into the diverse needs and barriers faced by marginalised and vulnerable groups; improved accountability to children and young people as stakeholders; and direct benefits to disabled children and young people themselves such as increased knowledge of services,

confidence, and skills[4].

It should be recognised that many disabled children and young people may face significant barriers to their involvement, particularly in mainstream settings. Recent research from the VIPER project found that young disabled people's participation is still not embedded at a strategic, service level or individual decision-making. It found barriers to participation including a lack of understanding of what participation is and how you make it happen, lack of funding, inclusive practice, resources, time and training, and lack of consistent systems and structures[5].

All disabled children and young people communicate and have a right to have their views heard and this may require targeted approaches and the involvement of Voluntary Sector Organisations (VSOs).

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Evidence of the way in which the HWB or its sub groups have worked with disabled children and young people in the JSNA process, and next steps for JSNA engagement
- Evidence of the way in which the HWB or its sub groups have worked with disabled children and young people in the preparation and delivery of the Joint Health and Wellbeing Strategy (JHWS), and next steps for JHWS engagement
- Evidence of partnership working with any local groups of disabled children and young people

Key resources for meeting this Charter commitment

The NHS Confederation, Royal College of Paediatrics and Child Health and Office for Public Management (2011), Involving children and young people in health services

This report highlights the key findings and recommendations from an event held in September 2011 to discuss the key priorities for child health.

VIPER (Voice.Inclusion.Participation.Empowerment.Research)

VIPER is a three-year project funded by the Big Lottery Fund, to research young disabled people's participation in decisions about services. It began in Summer 2010.

VIPER (2012), The Viper project: what we found

Findings and key messages arising from the research activities of the VIPER project.

VIPER (2012), The Viper project: what we found from the survey

Summary of the findings and key messages from the research activities. The research summarised in this report was carried out between 2010 and 2012.

4 Participation Works (2008), How to involve children and young people in commissioning, p.6.

5 VIPER (Voice, Inclusion, Participation, Empowerment and Research) (2013), Hear Us Out, p.23.

Participation Works

Enables organisations to effectively involve children and young people in the development, delivery and evaluation of services that affect their lives.

Participation Works (2008), How to involve children and young people in commissioning

An introduction to commissioning from a variety of perspectives. It describes the different parts of the process and ways to support children and young people to participate in all aspects of commissioning.

Participation Works (2008), How to build a culture of participation

Information and practical ideas about how to embed participation throughout your organisation in a way that brings about change.

Participation Works (2010), Listen and Change - a guide to children and young people's participation rights

Aims to increase understanding of children and young people's participation rights and how they can be realised in local authority and third sector settings.

Making Ourselves Heard (MOH)

MOH is a national project to ensure disabled children's right to be heard becomes a reality.

Council for Disabled Children (2009), Making Ourselves Heard

Based on a series of eight seminars with local authorities this book sets out the current policy context for disabled children and young people's participation, outlines the barriers and challenges to effective participation and highlights what is working well.

Franklin, A. and Sloper, P. (2009) Supporting the participation of disabled children and young people in decision-making

Presents research exploring factors to support good practice in participation and discusses policy and practice implications.

DfEs (2003), Building a culture of participation: research report

Many of the case studies in this research are attempting to make participation more integral to their organisation.

Commitment 3: We engage directly with parent carers and their participation is embedded in the work of our Health and Wellbeing Board

Statutory drivers

Health and Social Care Act 2012

Duty to involve third parties in preparation of the JSNA:

- Local Healthwatch
- people living or working in the area
- for County Councils – each relevant DC

Duty to involve third parties in preparation of the JHWS:

- Local Healthwatch
- people living or working in the area

The purpose of parent participation is to ensure that parents can influence service planning and decision making so that services meet the needs of families with disabled children. Effective parent participation happens when parents have conversations with and work alongside professionals, in order to design, develop and improve services[6].

The benefits of effective parent participation are well established: resources are not wasted on services that are not taken up or valued; parent carers' insight can help develop cost-effective solutions to local problems; a shared view can be developed between parents and professionals of how to support families within funding limitations; more costly interventions can be avoided in the future; and complaints can be reduced by Parent Carer Forums monitoring services and alerting commissioners and managers if problems occur. The Contact A Family resources below contain a wealth of evidence and case studies into how effective parent participation has benefited the local areas where it has been implemented.

Health and Wellbeing Boards should ensure that parent carers are involved in decisions that affect them at a strategic and service level. Health and Wellbeing Board members should use their influence to embed engagement with parent carers throughout the health and care system and in the context of a continuous and current partnership.

It should be recognised that parent carers may face significant barriers to their participation in mainstream settings but that this should not prevent their involvement in decision-making.

6 Definition from Together for Disabled Children (2010), How to guide to parent carer participation: Section 1 – parent participation as a process, p.2.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Evidence of the way in which the HWB or its sub groups have worked with parent carers of disabled children in the JSNA process, and next steps for JSNA engagement
- Evidence of the way in which the HWB or its sub groups have worked with parent carers of disabled children in the preparation and delivery of the JHWS, and next steps for JHWS engagement
- Evidence of partnership working with local parent groups, including the local Parent Carer Forum(s)

Key resources for meeting this Charter commitment

Together for Disabled Children (v2.0 2010), Parent carer participation: How to guide.

A guide to support parent carer forums, commissioners and managers to develop parent carer participation. It can be downloaded in the following separate sections:

Section 1 - The Process

Section 2 - producing information

Section 3 - consultation

Section 5a - successful meetings Together for Disabled Children

Section 5b - how to reach and engage parents

Section 5c - supporting parent representatives

Section 6b- for strategic leaders

How parent participation and parent carer forums leads to better outcomes for disabled children, young people and their families 2011

Contact A Family (2012), Parent Carer Participation: An overview

This short guide provides examples of successful parent carer participation

Contact A Family, Improving Health Services

Resources to support the commissioning and management of health services.

Contact A Family, Resources

Resources, case studies and information for professionals to help them improve how services are delivered, so they better meet families' needs.

Contact A Family (2013), Parent carer forum involvement in shaping health services - second report

Report into Parent Carer Forum involvement with the health service in the lead up to the new health system coming into effect.

Commitment 4: We set clear strategic outcomes for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account

Statutory drivers

Health and Social Care Act 2012

Duty to prepare a JHWS for meeting needs included in JSNA in relation to LA area and to have regard to guidance from Secretary of State

Power of the HWB to give its opinion to the local authority which established it on whether the authority is discharging its duty to have regard to relevant JSNA and JHWS

CCG is under a duty to involve HWB in preparing or significantly revising the commissioning plan – including consulting it on whether the plan has taken proper account of the relevant JHWS

Duty to provide opinion on whether the CCG commissioning plan has taken proper account of the JHWS. Power to also write to NHS England (formerly the NHS Commissioning Board) with that opinion on the commissioning plan (copy must also be supplied to the relevant CCG). Duty to review how far the CCG has contributed to the delivery of any JHWS to which it was required to have regard and to consult HWB on this

Duty in conducting the performance assessment, to assess how well CCG has discharged duty to have regard to JSNA and JHWS and to consult HWB on its view on CCGs' contribution to delivery of any JHWS to which it was required to have regard (when conducting its annual performance assessment of the CCG)

In response to the report of the Children and Young People's Health Outcomes Forum, the Government set out its ambitions for improving health outcomes for children and young people by launching 'Better Health Outcomes For Children And Young People: Our Pledge'[7]. Health and Wellbeing Boards will play a key role in delivering on these ambitions.

Disabled children and young people will provide a crucial test of the effectiveness of the new health system and improving the outcomes they experience, including those in the NHS and Public Health Outcomes frameworks, will require concerted strategic leadership. However, if a Health and Wellbeing Board can improve integration for local disabled children and young people, who frequently test the interface between multiple services and agencies, it can deliver for all children and young people.

For the JSNA and JHWS process to make a positive impact on the outcomes faced by disabled children, young people and their families, it is essential that the evidence collected through the JSNA process reflects the outcomes that are most meaningful to them. Health and Wellbeing Boards should use the JSNA process to develop a shared understanding of the needs of disabled children, young people and their families, and the causes of the poor outcomes and inequalities

7 Department of Health (2013), Better Health Outcomes for Children and Young People: Our Pledge

they experience. They should set clear strategic outcomes for partners to meet and ensure that mechanisms are in place to measure and monitor progress towards achieving them.

The JHWS should address how the needs of disabled children, young people and their families should be met and make recommendations on cost-effective approaches to reducing the health inequalities they experience. However, if this group is not identified as a priority in the JHWS, the Health and Wellbeing Board should demonstrate how it is providing strategic direction for partners to meet the needs of disabled children and young people.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Public information on the status of outcomes for local disabled children and young people based on indicators such as the NHS Outcomes Framework, the Public Health Outcomes Framework, etc.
- Public information on the strategic direction the HWB has set to support key partners to improve outcomes for disabled children and young people. This may be encompassed by the JHWS, but would need to be sufficiently delineated to demonstrate specific objectives and action for disabled children and young people.

Key resources for meeting this Charter commitment

NHS Confederation (2012), Children and young people's health and wellbeing in changing times

> The purpose of this report is to support implementation of the health reforms to improve children and young people's health and wellbeing.

Report of the Children and Young People's Health Outcomes Forum (2012)

> The Children and Young People's Health Outcomes Forum was established by the Secretary of State for Health and tasked with responding to the challenges set out in Sir Ian Kennedy's report published in 2010 'Getting it right for children and young people'.

Report of the Children and Young People's Health Outcomes Forum - report of the long-term conditions, disability and palliative care sub-group (2012)

> Report discussing the challenges around improving outcomes for this group of children.

Report of the Children and Young People's Health Outcomes Forum - inequalities in health outcomes and how they might be addressed (2012)

> Report commissioned by the co-chairs of the Children and Young People's Health Outcomes Forum from Maggie Atkinson, Children's Commissioner for England.

Children and Young People's Health Outcomes Forum (2012), Health and wellbeing boards and children, young people and families

> Poster produced in June 2012 by the health and wellbeing board learning set for children and young people.

Children and Young People's Health Outcomes Forum (2012), Commissioning in the new NHS for children, young people and their families

Poster setting out the Children and Young People's Health Outcomes Forum's vision for successful commissioning for children, young people and their families in the new NHS.

Department of Health (2013), Improving Children and Young People's Health Outcomes: a system wide response

The Children and Young People's Health Outcomes Forum report made recommendations, aimed at DH, DfE and a wide range of health system organisations, to improve health outcomes for children and young people. This document contains the system-wide response setting out the action already undertaken, in progress and planned in response to the recommendations.

Department of Health (2013), Better health outcomes for children and young people: Our Pledge

Government response to the report of the Children and Young People's Health Outcomes Forum, setting out shared ambitions across the NHS to improve outcomes and services for children and young people.

Contact A family and Strategic Network for Child Health and Wellbeing in the East of England (2012), Principles for commissioning and delivering better health outcomes and experiences for children and young people so that they are comparable with the best in the world

Poster showing 6 principles for commissioning and delivering better health outcomes and experiences for children and young people, developed by the Strategic Network for Child Health and Wellbeing in the East of England.

Department of Health (2010), The NHS Outcomes Framework 2011/12

The outcomes and indicators which make up the first NHS Outcomes Framework, following the consultation Transparency in outcomes – a framework for the NHS.

Commitment 5: We promote early intervention and support smooth transitions between children and adult services for disabled children and young people

The report of the Children and Young People's Health Outcomes Forum emphasised the importance of early intervention and transitions within a life-course approach to reducing health inequalities[8]. This is particularly significant for disabled children and young people and their families, who often struggle to obtain a diagnosis and access appropriate support at an early age and when transitioning to adult services, which affects their outcomes throughout their lives.

It should be emphasised that disabled children and young people may transition to adult services up to the age of 25. Health and Wellbeing Boards should consider the needs of disabled children and young people from 0-25 as well as ensuring smooth transitions to adult services.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- The way in which the activities of the HWB help local partners to understand the value of early intervention
- The way in which the activities of the HWB ensure integration between children and adult services, and prioritise ensuring a positive experience of transition for disabled young people

Key resources for meeting this Charter commitment

Graham Allen MP (2011), Early Intervention: The Next Steps

An independent report to Government, which argues that many of the costly and damaging social problems for individuals can be eliminated or reduced by giving children and parents the right type of evidence based programmes between 0-18 and especially in their earliest years.

Graham Allen MP (2011), Early Intervention: Smart Investment, Massive Savings

Graham Allen MP's second independent report to the Government sets out how early intervention programmes can be paid for within existing resources and by attracting new non-government money.

Child and Maternity Health Observatory, Knowledge Hub: Transitions

The transitions to adulthood hub brings together a range of resources and evidence relating to young people's transition process into the adult world. It is constantly updated with new resources.

8 Report of the Children and Young People's Health Outcomes Forum (2012), p.38

Early Support

A way of working, underpinned by 10 principles that aim to improve the delivery ofservices for disabled children, young people and their families. It enables services to coordinate their activity better and provide families with a single point of contact and continuity through key working.

Early Support (2012), Key working: improving outcomes for all - Evidence, provision, systems and structures

A summary of the key evidence and consistent elements of a key working approach. It presents an analysis of the implications of key working that cuts across health, social care and education.

Ofsted (2013), Good practice resource - Early intervention through a multi-agency approach: Sheffield City Council

Sheffield City Council has developed a creative and innovative approach across the children's workforce by introducing a multi-agency perspective in providing preventative services to children and families.

C4E0, Improving the wellbeing of disabled children through early years interventions (age 0–8)

This section contains the following resources in support of improving the wellbeing of disabled children through early years interventions (age 0–8) priority: links to online tools; key online publications from C4EO partners and other organisations.

Institute of Public Care (2012), Early Intervention and Prevention with Children and Families: Getting the Most from Team around the Family Systems

Briefing paper arguing that effective local systems to identify families who would benefit from additional support and to coordinate support from a range of agencies is as important as delivering effective services.

Transition Information Network (TIN)

An alliance of organisations and individuals who come together to improve the experience of disabled young people's transition to adulthood. TIN is a source of information and good practice standards for disabled young people, families and professionals.

TIN Resource Library

You can use the search form to find a range of resources that can help you to improve your provision for disabled young people in transition to adulthood.

Preparing for Adulthood (PfA)

A 2 year programme funded by the Department for Education as part of the delivery support for 'Support and aspiration: A new approach to special educational needs and disability' green paper. It provides knowledge and support to all local authorities and their partners, including families and young people, so they can ensure young people with SEN and disabilities achieve paid work, independent living, good health and community inclusion as they move into adulthood.

Preparing for Adulthood (2012), PfA resource list

Created for the PfA 'How are you doing?' events which took place in June and July, 2012. Resources are listed under: Paid employment; Independent living; Good health; Community inclusion.

Sloper, P., Beecham, J., Clarke, S., Franklin, A., Moran, N. and Cusworth, L. (2011) Transition to adult services for disabled young people and those with complex health needs, Research Works, 2011-02, Social Policy Research Unit, University of York, York

This research aimed to provide evidence of what works well in developing and implementing multi-agency coordinated transition services for disabled children and those with complex health needs and their families. It also assessed the costs of the services.

Commitment 6: We work with key partners to strengthen integration between health, social care and education services, and with services provided by wider partners

Statutory drivers

Health and Social Care Act 2012

Duty to encourage integrated working:

- between commissioners of health services and commissioners of social care services
- in particular to provide advice, assistance or other support for the purpose of encouraging use of flexibilities under NHS Act 2006

Power to include in the JHWS a statement of views on how the commissioning of health and social care services, and wider health-related services, could be more closely integrated – i.e. the ability for the JHWS to look more broadly than health and social care in relation to closer integration of commissioning

Disabled children and young people access services across multiple agencies, and therefore are disproportionately affected by poor integration between health and social care services and a lack of coordinated commissioning. Health and Wellbeing Boards must work with key partners to meet the needs of disabled children and young people, including: education providers and schools; safeguarding boards, local children's trust arrangements; learning disability partnership boards; and others. Health and Wellbeing Boards should make recommendations to ensure that disabled children and young people experience seamless integration between the services they access.

In particular, Health and Wellbeing Boards should consider how they engage with education services, including schools and colleges, because of the significance of joined up-working between health, education and social care to disabled children and young people's outcomes.

To promote integrated commissioning Health and Wellbeing Boards will also need to consider how specialised health services commissioned by NHS England are joined up with locally commissioned services and ensure they are taken into account by their JSNA and JHWS.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Details of the way in which the HWB is informed by those with expertise in education, and children's health and social care
- Details of the way the HWB engages with wider partners such as housing, transport, safeguarding and the youth justice system
- Details of steps taken to encourage integrated working between health, social care, education and wider partners in order to improve the services accessed by disabled children, young people and their families

Key resources for meeting this Charter commitment

Together for disabled children (2009), Facilitating integrated practice between children's services and health

> This report contains examples of innovative working practice where services are integrated with health.

Council for Disabled Children (2006), Pathways to success: Good practice guide for children's services in the development of services for disabled children - evidence from the pathfinder children's trusts

> This project ran from April 2004 to March 2006 and set out to work alongside the pathfinder children's trusts in developing new ways of working and to capture the learning from their work. The work covered: stratgeic planning; commissioning services, pooling budgets; joint working and co-location; assessment process and information sharing.

East Midlands, Everybody's learning (2012), Assured safeguarding: GP and Health Leader edition

> Resource to help commissioners and health providers reassure themselves they are doing everything possible to ensure that children within the services for which they are responsible are as safe as possible.

Ofsted (2012), Improving outcomes for disabled children by integrating early support and prevention services: Luton Borough Council

> Luton's services for disabled children and their families bring together practice across health, social care and education services, alongside innovative short break and early support provision. The development of an extensive range of integrated early support and prevention services is improving outcomes for disabled children and preventing situations deteriorating so that child protection or looked after services become necessary.

Commitment 7: We provide cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners

Statutory drivers

Health and Social Care Act 2012

Power to encourage close working (in relation to wider determinants of health):

- between itself and commissioners of health-related services
- between commissioners of health services or social care services and commissioners of health-related services

Power to appoint additional members to the board as deemed appropriate

Power for HWB to request information for the purposes of enabling or assisting its performance of functions from:

- the local authority
- certain members or those they represent with a duty to provide

Children Act 2004

Requirement for each local authority to have a children's trust board which must include representatives of the local authority and each of the children's trust 'relevant partners'

Local safeguarding children's boards put on statutory footing

Children and Families Bill 2012-13 (currently in Parliament)

(Clause 25) Local authorities must promote the integration of special education, health and care provision.

(Clause 26) Local authorities and their partner CCGs must make arrangements for the joint commissioning of education, health and care provision for children and young people with SEN.

(Clause 27) Local authorities must keep under review special education provision and social care provision for children and young people with SEN and consider the extent that it is sufficient to meet their needs.

(Clause 30) Local authorities must publish a Local Offer containing information about services available for children and young people with SEN, including education, health and care provision.

The role of the Health and Wellbeing Board must be understood in relation to new and existing partnerships, including: local children's trust arrangements; local safeguarding children's boards; learning disability partnership boards; and others. A clear local framework on how these partnerships interact needs to be established to avoid the duplication of effort or even

competing for resources.

The JSNAs and JHWS need to be aligned with other arrangements, such as: reviewing and commissioning of SEN services via the High Needs Block[9]; safeguarding arrangements; child poverty strategies; and children and young people's plans if they are still used.

Additionally, the Children and Families Bill currently in Parliament contains clauses for promoting integration between special educational provision, health and social care provision (25), making joint-commissioning arrangements (26), keeping education and care provision under review (27), and producing a local offer (30), for children and young people with SEN. These new duties on local authorities all have a clear relevance to the functions of the Health and Wellbeing Board to encourage integrated working, promote close working and undertake a JSNA and JHWS. This is particularly important as CCGs will be under a new duty to secure specific services in education, health and care plans for children and young people with SEN[10]. Indicative regulations also make clear that local authorities must consult Health and Wellbeing Boards when preparing and reviewing its Local Offer[11].

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Information on links to other local integration forums which set strategic direction for disabled children's services, e.g. the local children's trust arrangements, the local safeguarding board, the learning disability partnership board, the school forum, etc.
- Evidence of how the JSNA and JHWS is aligned with other arrangements, such as: reviewing and commissioning of SEN services via the High Needs Block; safeguarding arrangements; child poverty strategies, etc.

Key resources for meeting this Charter commitment

NHS Confederation (2012), Children and young people and health and wellbeing boards: putting policies into practice

Developed by the health and wellbeing board learning set for children and young people, part of the National Learning Network for health and wellbeing boards, to give HWB members some ideas of how other boards are organising themselves to deliver coordinated services for children and young people.

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9 See Department for Education (2012), School funding reform 2013-14, pp. 16-20

10 See Department for Education website (2013), Children and young people with special educational needs to benefit from new legal health duty

11 The Special Educational Needs (Local Offer) (England) Regulations 2014: http://media.education.gov.uk/assets/files/pdf/c/clause%2030%20draft%20regulations%20sen%20local%20offer.pdf

Children and Young People's Health Outcomes Forum (2012), Health and wellbeing boards and children, young people and families

Poster produced in June 2012 by the health and wellbeing board learning set for children and young people.

Easton, C.; Hetherington, M., Smith, R., Wade, P., Aston, H. and Gee, G. (2012). Local Authorities' Approaches to Children's Trust Arrangements (LGA Research Report)

The Local Government Association commissioned the National Foundation for Educational Research (NFER) to investigate local authorities' approaches to their children's trust arrangements and how they are fulfilling their duty to promote cooperation with partners to improve children and young people's health and wellbeing.

General resources

The Marmot Review (February 2010), Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010

Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England.

Kennedy, Prof Sir Ian (September 2010) Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs

An independent review of services provided by the NHS to children and young people, concentrating on understanding the role of culture in the NHS. It focuses on areas where there are cultural barriers to change and improvement and makes recommendations.

NHS Confederation - Resources for Health and Wellbeing Boards

The NHS Confederation has been working with each health and wellbeing board learning set in collaboration with the NHS Institute for Innovation and Improvement, Department of Health and Local Government Association to produce publications which summarise their key points of learning and which will be shared with other shadow health and wellbeing boards.

NHS Confederation (2012), Children and young people's health and wellbeing review of documents

Briefing summarising the key policy documents on children and young people's health and wellbeing that have been published over the last two years."

NHS Confederation (2012), Support and resources for health and wellbeing boards

Summary of the support available to spread networking and learning opportunities for Health and Wellbeing Boards

NHS Confederation (2012), National learning network for health and wellbeing board publications 2012

A list of publications produced by The National Learning Network for health and wellbeing boards to share learning and support the establishment of well functioning boards.

Local Government Associaton - Resources for Health and Wellbeing Boards focusing on children, young people and family issues

The Health and Wellbeing Board learning set for children and young people looked at the issues important to the development of Health and Wellbeing Boards. The learning sets are a part of the Department of Health's development and support programme for Health and Wellbeing Boards which is supported by the LGA, NHS Confederation and NHS Institute. Nine learning sets focused on a number of themes including governance, resources and public engagement.

Getting the Best Out of Your Health and Wellbeing Board Leadership Development Offer - Health and Wellbeing Board Information Resource

This document brings together information about publications and websites which should be of value to Health and Wellbeing Boards.

Child and Maternity Health Observatory

ChiMat was established in 2008 as a national public health observatory to provide wide-ranging, authoritative data, evidence and practice related to children's, young people's and maternal health.

National Voices

The national coalition of health and social care charities in England. They work together to strengthen the voice of patients, service users, carers, their families and the voluntary organisations that work for them.

Regional Voices

Supports the voluntary sector to successfully influence local strategic decision making in health and social care. This group of pages links to a variety of resources to support you develop strategies to influence in your local area.

About Us

Every Disabled Child Matters is the national campaign to get rights and justice for every disabled child. It is run by four leading organisations working with disabled children and their families: Contact a Family, Council for Disabled Children, Mencap and the Special Educational Consortium.

The Children's Trust, Tadworth is the leading UK charity for children with acquired brain injury, multiple disabilities and complex health needs. The Trust's services include the UK's largest rehabilitation centre for children and young people with acquired brain injury, nursing care for technology-dependent children, and education for children and young people with profound and multiple learning difficulties and complex health needs.

Disabled Children's Charter for Health and Wellbeing Boards

The ..... **Health and Wellbeing Board** is committed to improving the quality of life and outcomes experienced by disabled children, young people and their families, including children and young people with special educational needs and health conditions. We will work together in partnership with disabled children and young people, and their families to improve universal and specialised services, and ensure they receive the support they need, when they need it. Disabled children and young people will be supported to fulfil their potential and achieve their aspirations and the needs of the family will be met so that they can lead ordinary lives.

By [date within 1 year of signing the Charter] our Health and Wellbeing Board will provide evidence that:

1. We have **detailed and accurate information** on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs
2. We **engage directly with disabled children and young people** and their participation is embedded in the work of our Health and Wellbeing Board
3. We **engage directly with parent carers** of disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board
4. We set **clear strategic outcomes** for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account
5. We **promote early intervention** and support for smooth transitions between children and adult services for disabled children and young people
6. We work with key partners to **strengthen integration** between health, social care and education services, and with services provided by wider partners
7. We provide **cohesive governance** and leadership across the disabled children and young people's agenda by linking effectively with key partners

Signed by ..... **Date** ..... .
Position: Chair of Health and Wellbeing Board.

For guidance on meeting these commitments, please read the accompanying document: Why sign the Charter?

every disabled child matters

Every Disabled Child Matters (EDCM) is the campaign to get rights and justice for every disabled child. It has been set up by four leading organisations working with disabled children and their families – Contact a Family, the Council for Disabled Children, Mencap and the Special Educational Consortium. EDCM is hosted by the National Children's Bureau, Charity registration number: 258825.

The Children's Trust, Tadworth is a national charity providing specialist services to disabled children and young people across the UK. These services include rehabilitation and support for children with acquired brain injury, expert nursing care for children with complex health needs, and residential education for pupils with profound and multiple learning difficulties at The School for Profound Education. Charity registration number: 288018. Find out more about the work of The Children's Trust, Tadworth at www.thechildrenstrust.org.uk

The Children's Trust Tadworth
For children with multiple disabilities

Teenage pregnancy conference LGA April 2013
Notes

Speaker 1 Dr Ann Hoskins Director of Public health England Nationally TP levels have fallen by 34% still looking for 50% reduction TP Linked to deprivation, look at Tackling inequalities And Educational attainment Looked after children 3x more likely to become teenage parents.
Teenagers with previous pregnancy 20% more likely to have a 2nd child
Drinking. Smoking. Drug use disengagement from school. Crime and antisocial behaviour. All lead to risky sexual behaviour

15%of Neets are teenage mothers or pregnant

She talked about Public health outcomes framework and about only being 3 weeks into Public health England. she talked about Using social media for getting messages out and about Life course perspective, measuring the costs of children born to teenage mums against costs on preventative measures.

New guidance on information sharing coming out shortly Speaker 2 Dr deGruchy DoPH Haringey Their JSNA. Is published in Mini chapters giving bite sized chunks of information.

TP is a signal marker for other issues

Reproductive health is also Part of Sexual health joining up services across health and LA.

Posters promoting Emergency hormonal contraception Also promoting a Young people phone app called young +healthy

Use of school nursing and link to commissioning of Health visitors,gives advice Link to regeneration to support funding

Haringey council. Source for posters.

3. Morag Stewart D o PH Luton
Promotes the use of commissioning cycle. Starts with strategic planning and is not just about procurement.
Young people surveyed. "being young in Luton" giving a comprehensive view of YP needs and wants, included some surveys of parents.

Following survey commissioned a Sexual health service for YP which is YP friendly, Integrated and Accessible

Procured from Brook. Outcomes based block contract, monitored and evaluated against KPIs Achieved reduction in TP rate, increased new diagnosis of HIV and chlamydia. Increase in use of contraception and routine chlamydia screening. There were some Challenges. Eg Local resistance to specific YP services from established services.

4 Anne Colquhoun. YP public health manager. Bristol

When asked YP want to have SRE and so do parents Change round to relationships and sex ed. RSE!!!! Relationships come before sex.
Achieved reduction in TP rates by good Grounding for teachers in PHSE High level commitments rom partner organisations . And from elected members through scrutiny day including YP

Multiagency training essential so all delivering same messages and have understanding of other functions of services.
Dedicated PHSE /RSE posts to deliver training

5 Minister for public health
Anna Soubry

Praises local authorities on reducing TP rates Sexual health framework just published Questions for minister on how schools tackle SRE when it is not mandatory from government.
Q on Science education where reference to sex education is removed a plea to her to lobby education minister School based clinics are brilliant Acknowledged education reforms don't support PHSE in school and is in conversation with Education department.
(**Also praised Rotherhams can do attitude on Obesity services**)

Alison Hadley Director Teenage Pregnancy Knowledge Exchange. University of Bedfordshire Training for all practioners in youth service,teachers etc all who are involved with YP in order to take a pathway approach inc pregnancy testing , children's centres 2nd pregnancy. Not just targeted approach but integrated across all YP Recommends reading Ofsted report on serious case review. Recommends Looking after Young parents supporting them in accord with Marmot principles.

Key themes emerging
It is worth continuing to invest in TP services to continue to achieve downward trend.
Services should be integrated, accessible, young people friendly, with access to good PHSE in all schools, age appropriate. We should adopt a holistic approach to promoting young people sexual health and Wellbeing health and Wellbeing boards are well placed to show leadership.

Elected members could demonstrate commitment and leadership via scrutiny, ?
Health and lives joint review.
Need to adopt a partnership approach especially in the current economic climate.

Judy Dalton
Sent from my iPad

NHS England

NHS England Progress Report – Discussion Document

Rotherham Health and Wellbeing Board

Introduction

In this paper I will summarise the key facts about NHS England (NHS E). I will explain how NHS England will work and I would welcome a discussion with the Health and Wellbeing Board to inform how best to work together. There are no direct financial or legal consequences arising from recommendations made in this report.

NHS England

NHS England (formerly NHS Commissioning Board was created on 1 April 2013. PCTs were abolished. It is an independent body at arm's length to the government. The Secretary of State for Health agrees an annual 'mandate' with NHS England which incorporates the NHS Constitution and NHS Outcomes Framework.

Vision - Everyone has greater control of their health and their wellbeing, supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and constantly-improving.

Purpose - We create the culture and conditions for health and care services and staff to deliver the highest standard of care and ensure that valuable public resources are used effectively to get the best outcomes for individuals, communities and society for now and for future generations.

Values - The values enshrined in the NHS Constitution underpin all that we do:

- Respect and dignity
- Commitment to the quality of care
- Compassion
- Improving lives
- Working together for patients
- Everyone counts

Objectives – NHS England has 11 objectives, including 2 priority objectives

1. **Priority** – Improving patient satisfaction
2. **Priority** – Improving staff satisfaction
3. Preventing people from dying prematurely
4. Enhancing quality of life for people with long term conditions
5. Helping people recover from episodes of ill health or following injury
6. Ensuring people have a positive experience of care
7. Treating and caring for people in a safe environment and protecting them from avoidable harm
8. Promoting equality and reducing inequalities in health outcomes
9. Enabling more people to know their NHS Constitution rights and pledges
10. Becoming an excellent organisation
11. Ensuring quality financial management

Functions – NHS England has four central areas of work that allow it to deliver its objectives. I include my own interpretation of how this fits together:

- **Oversight, facilitation, coordination and leadership** – NHS England is one national organisation and will maintain oversight of the system. To do this it will empower clinical leadership and work in partnership. This includes the development of strategic clinical networks, senates, hosting of the 'safeguarding forum' and hosting the Quality Surveillance Group to have oversight of the safety and quality of NHS care across the area. It also includes membership of local partnerships including Health and Wellbeing Boards. It is the success of these partnerships that will be critical in delivering NHS England objectives
- **Direct commissioning** - of £25bn of health services including primary care, some public health services (e.g. vaccination and immunisation, most screening programmes and under 5 children's public health services), specialised services, all dental services, military health care and offender health care. Summary plans for specialised services, primary care and public health are attached.
- **Supporting the commissioning system** – allocate £60bn to clinical commissioning groups (CCGs) supporting their development and seeking assurance. Also, working with commissioning support units (CSUs), Academic Health Science Networks, Health Education England and others to both coordinate and support an effective commissioning system. NHS England also has regulatory functions including provision of a 'Responsible Officer' to oversee performance of independent contractors (includes GPs, general dental practitioners, community pharmacists and optometrists). Also, provision of an 'Accountable Officer Controlled Drugs' and associated statutory responsibilities.
- **Emergency planning, resilience and response** – ensure that the NHS plans for civil emergencies and is resilient. NHS England is a category one responder.

Organisation – NHS England is one national public body working to one operating model. There is one national support centre, 4 regions and 27 Area Teams. South Yorkshire and Bassetlaw is the NHS England Area Team for this patch. All Area Teams have the four areas of work described above except with regards to certain commissioning responsibilities and strategic clinical networks and senates. Specialised commissioning is carried out by 10 of the 27 area teams (SYB has this responsibility for Yorkshire and the Humber), strategic clinical networks and senates are lead by 12 of the 27 area teams and again SYB leads this for Yorkshire and the Humber. Offender and military health is lead across Yorkshire and the Humber by other area teams.

NHS England South Yorkshire and Bassetlaw

NHS England South Yorkshire and Bassetlaw has a complete senior team and most of the posts in the area team have been filled. NHS E continues to produce policy and further elements of the single operating model. However, NHS E is not yet a mature organisation and does not yet have every policy and operating model it needs. Locally, NHS E is progressing well and is working across as area in which:

- CCGs are developing strongly with effective working arrangements developing between CCGs, with NHS E and with partner organisations (local authorities and provider trusts in particular)
- Public Health transition has been successful, with public health expertise available to the NHS from within local authorities and from Public Health England. Key public health programmes remain in place without which neither local authorities or the NHS can deliver improved health.
- There is relative financial stability
- Generally good performance with regards to NHS Constitution commitments and other 'everyone counts' requirements. However, A&E performance (4 hour wait) is widely inadequate and there are some problems affecting parts of the area such as some waiting times.

Challenges for the future

The main challenges are driven by:

- Financial challenge (lower growth in health spending, negative growth in local authority spending), an ageing population and new technologies
- Long standing inequalities in health and health outcomes.
- A wish for continued improvements in outcomes from health care and the configuration changes needed to deliver these without spending much more money.

Over recent decades health and health care have seen remarkable improvements. These have been driven by factors such as reduced smoking, better health care including the identification and management of long term conditions such as cardiovascular disease, new technologies in health care and the centralisation of specialist services such as those for cancer and major trauma. However, there remains a gaping inequalities gap. Closing this gap is a priority.
This requires action to:

- Tackle the root causes of poor health such as poor educational attainment, worklessness and the cycle of poor outcomes often driven by teenage pregnancy and poorly functioning family and social systems.
- Ameliorate the root causes of ill health by promoting healthier lifestyles. This includes reducing smoking prevalence (the biggest single driver of inequalities in health outcomes), reducing excessive drinking and promoting healthier diets, breast feeding and exercise
- Ensure health care is utilised in proportion to need. Health care interventions such as treatment of cardiovascular risk and cancer screening, taken up by those at highest risk, will reduce health inequalities. Providing the best general practice services to the poorest populations is at the heart of the NHS contribution to reducing avoidable death. Improving self care and coordination of care for older people is also important.

The Health and Wellbeing Board should hold partners to account for delivery within an agreed health and wellbeing strategy informed by the Joint Strategic Needs Assessment. Priorities agreed here clearly also contribute to NHS E objectives.

Conclusion

NHS England South Yorkshire and Bassetlaw is part of a national organisation committed to prioritising patients in everything we do. It empowers clinicians and makes evidence based decision in an open and transparent way. The NHS architecture introduces many changes and a particular risk is the number of interfaces created. However, there are great opportunities to work in partnership and across organisational boundaries, with clinicians and local authorities driving changes that will make a real difference.

Recommendations

1. The health and Wellbeing Board is asked to discuss this report and agree any further actions arising.

Bibliography

Item	Link	Comment
NHS Constitution	http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx	Rights and responsibilities
NHS England home page	http://www.england.nhs.uk/	NHS England home page
NHS England 'Everyone counts'	http://www.england.nhs.uk/everyonecounts/	Describes the new system and its tools and levers
NHS England Business Plan	http://www.england.nhs.uk/pp-1314-1516/	Business plan 2013/14
NHS England resources	http://www.england.nhs.uk/resources/	Link to guidance for CCGs, strategic clinical networks etc
East Midlands Quality Observatory (for all acute trust quality dashboards)	http://www.emqo.eastmidlands.nhs.uk/welcome/quality-indicators/acute-trust-quality-dashboard/published-dashboards/	Acute Trust Quality Dashboards
General practice quality dashboards	Not yet available	Dashboards due to be published for every general practice

Rotherham Metropolitan Borough Council
Where Everyone Matters

Health & Well Being Board

Meeting the Financial Challenge – An overview of the Council's Budget 2013/14 and beyond

Stuart Booth – Director of Financial Services

10th May 2013

The Financial Challenge

- The scale of financial challenges / risks facing local government is **set to continue for at least until 2017 (possibly a decade).**

- Increasing financial risk transferred to local councils through the local government finance and welfare reform changes and restrictions on finances eg CT Referenda.

- Sustainable medium/long term financial planning is now even more critical!!

……. the lack of financial certainty e.g the next Spending Review is only to be announced in late June 2013, and the likelihood of further finance reform / restrictions makes financial planning extremely difficult

What this means for Rotherham?

Rotherham Metropolitan Borough Council
Where Everyone Matters

Never faced such financial challenges before…

- 2010/11 £5m (emergency budget)
- 2011/12 £30m
- 2012/13 £20m
- 2013/14 £20m
- 2014/15 £20m+?
- 2015/16 £??m

Localisation could have significant, adverse impact on future Council resources

Approach Taken

- Established a **clear set** of budget principles
- **Started early** in redesigning services and budget…..reduced head count in last 2 years by over 1,000 and have pushed back the financial 'cliff edge' into later years (2015/16?)
- **Strategic re-positioning** and re-integration of its partnerships eg RBT and 2010 Rotherham allowing further savings to be made
- Focus on reducing the **'back office'** to a minimum level – over 15% reduction in last 2 years
- Concentrated on **reducing management** posts which have reduced by 26% at Director level and 43% from next tier - overall management reduction of 19%; while front line reduction has only been 8%.

Rotherham's 2013/14 Budget Challenge (1)

Rotherham Metropolitan Borough Council
Where Everyone Matters

Initial Funding Gap in MTFS £14.1m

Additional challenges (October):

- Specific grants rolled into Formula Grant at reduced levels (net) +£2.9m
- Freezing Council Tax +£2.2m
- CTRS 8.5% max pass through to working age claimants +£1.0m

Revised Funding Gap £20.2m

Meeting the Challenge (2)

By working together with a clear set of budget principles, we have managed to meet the budget challenge while protecting front line services and those most in need in the borough , and minimising job losses .....

- **over 70% (c£14m) of savings proposals do not affect front line service delivery - key examples being:**
  - Reviewing inflationary assumptions (£4m) and MTFS assumptions (£0.9m)
  - Further back office streamlining (£2.2m)
  - Rationalising customer access (£0.5m)
  - Realising benefits from improved cash flow management (£2.4m)
  - Maximising opportunities through joint working on Public Health/NHS (£0.8m)
  - Working with partner organisations to improve efficiency (£1m)
  - Maximise income from other sources (£0.8m)

Meeting the challenge (3)

- The remaining savings will come from:
  - Front Line Services:
  - Children and Young Peoples £1.776m
  - Neighbourhoods and Adult Social Care £2.974m
  - EDS (excl Customer contact) £1.000m
  - Staff savings to be agreed with TUs £0.300m
  - Critical Friend Reviews of Front line services £0.341m

- Further job losses expected to be contained at 50 to 60 FTEs

- Accepted the CT Freeze Scheme – to protect low income families who are vulnerable in the borough.

Meeting the challenge (3)

- Designed Council Tax Reduction Scheme (CTRS) to protect vulnerable groups by retaining income disregards, allowances and premiums and by taking up the Government's Transitional Grant Support Scheme.

- Used reform of CT discounts and exemptions to minimise cost of CTRS to working age claimants – likely cost £1.56 per week in a Band A property

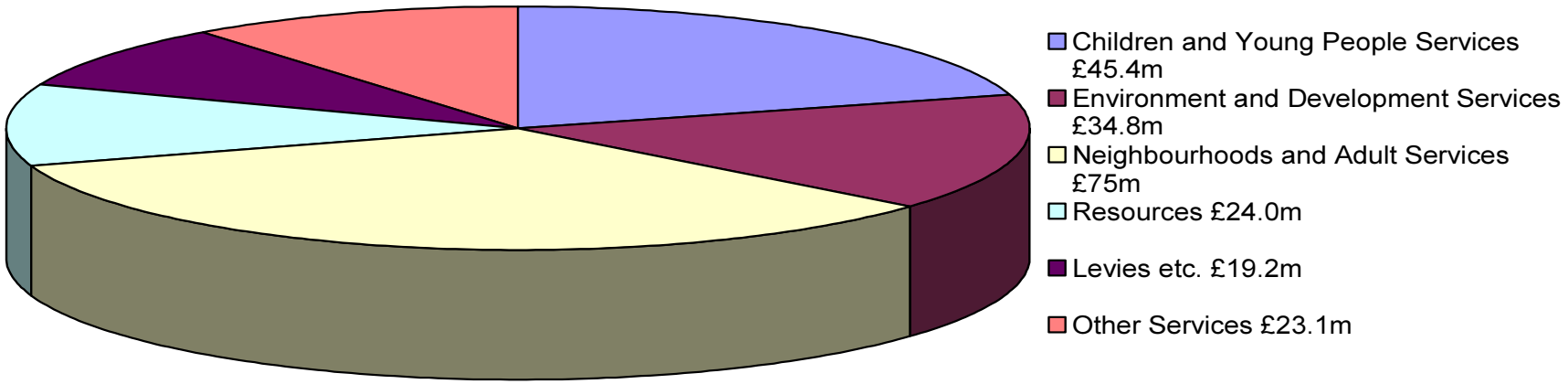
- **Maintaining Financial Resilience** through:
  - sustainable budgeting
  - Effective, medium term management of reserves to meet future significant risks – circa £7m General Reserve

RMBC Revenue Budget 2013/14

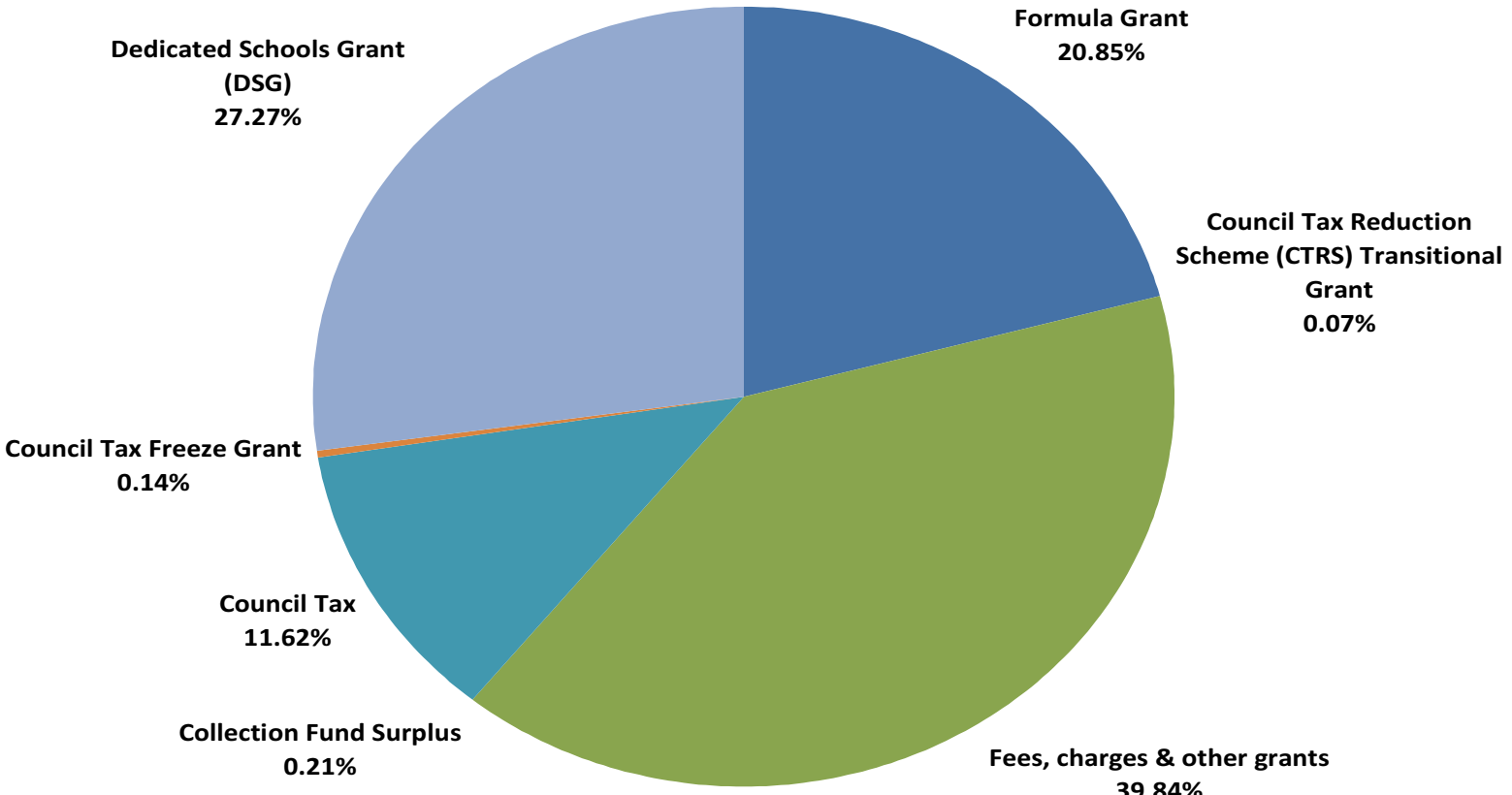
Rotherham Metropolitan Borough Council
Where Everyone Matters

Directorate	Summary		
	Gross Expenditure	Gross Income	Net Expenditure
	£	£	£
CYPS	276,238,494	-230,824,494	45,414,000
EDS	80,133,120	-29,462,201	50,670,920
NAS	125,248,989	-50,291,989	74,957,000
Resources	156,392,212	-129,777,697	26,614,516
Central	35,417,273	-11,599,708	23,817,565
RMBC Total	**673,430,087**	**-451,956,089**	**221,474,000**

RMBC Directorate's Net Revenue Budget 2013/14 £221.474m



RMBC Income 2013/14



Future Years'…..Financial Challenge (1)

Rotherham Metropolitan Borough Council
Where Everyone Matters

What do we know or expect to happen?

- Significant reductions in resources are anticipated for 2014/15 nationally – a reduction of 8.6% is planned! In Rotherham 9.1%!!
- Next Spending Review to be announced …by end June 2013
- Chancellors view…….austerity programme needs to be extended until (at least) 2018 – Autumn Statement
- Further restrictions on finances may come forward – e.g more stringent CT referenda principles for those **not accepting** CT Freeze grant have been muted!
- Further reform of LG Finance bringing about a further transfer of risk to LG Finances???

Future Years'…..Financial Challenge (2)

Rotherham Metropolitan Borough Council
Where Everyone Matters

What do we know or expect to happen?

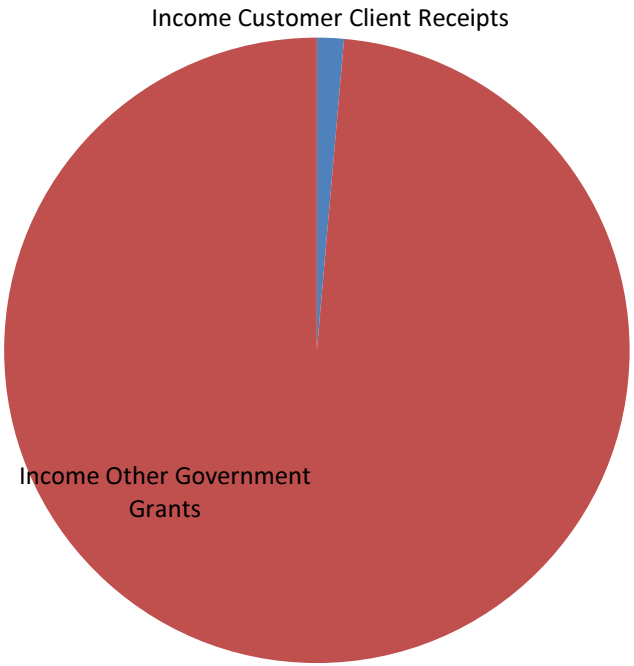
- Impact of localisation of Business Rates – first year?
- Other likely Formula Funding changes eg Education, social care
- Impact on local economy of welfare reform changes eg CTRS, Bedroom Tax etc – including need to annually review CTRS scheme; loss of Transitional Grant (£0.5m); introduction of Universal Credits
- Impact of Triennial Revaluation of LG Pension Fund – April 2014
- **Pressure to prioritise local economic growth initiatives to stimulate the local economy …….**

Public Health

FY 2013/14 Spending Plan
and
Plan for Developing 2014/15 Commissioning Intentions

2013/14 SPENDING PLAN

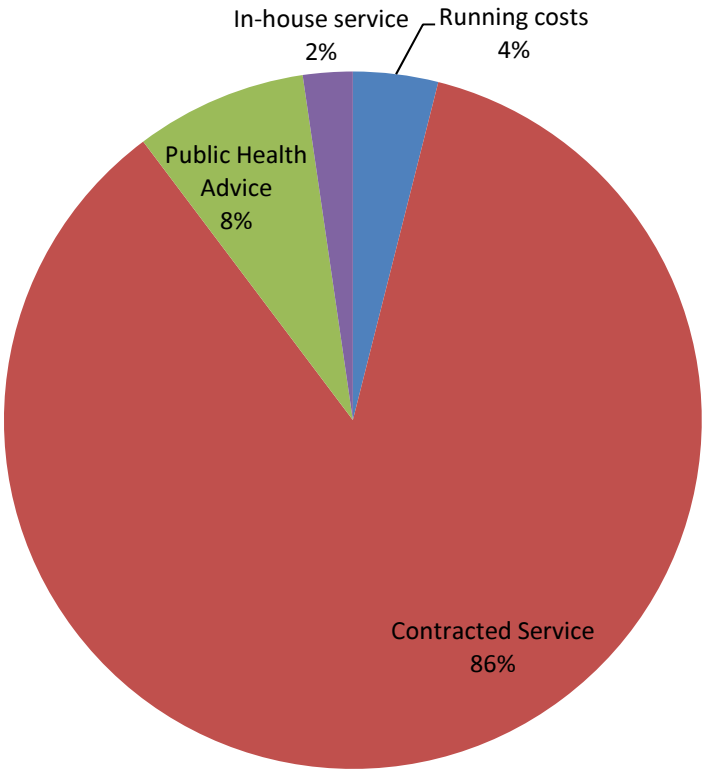
Public Health Income



Total Income £13,983,338

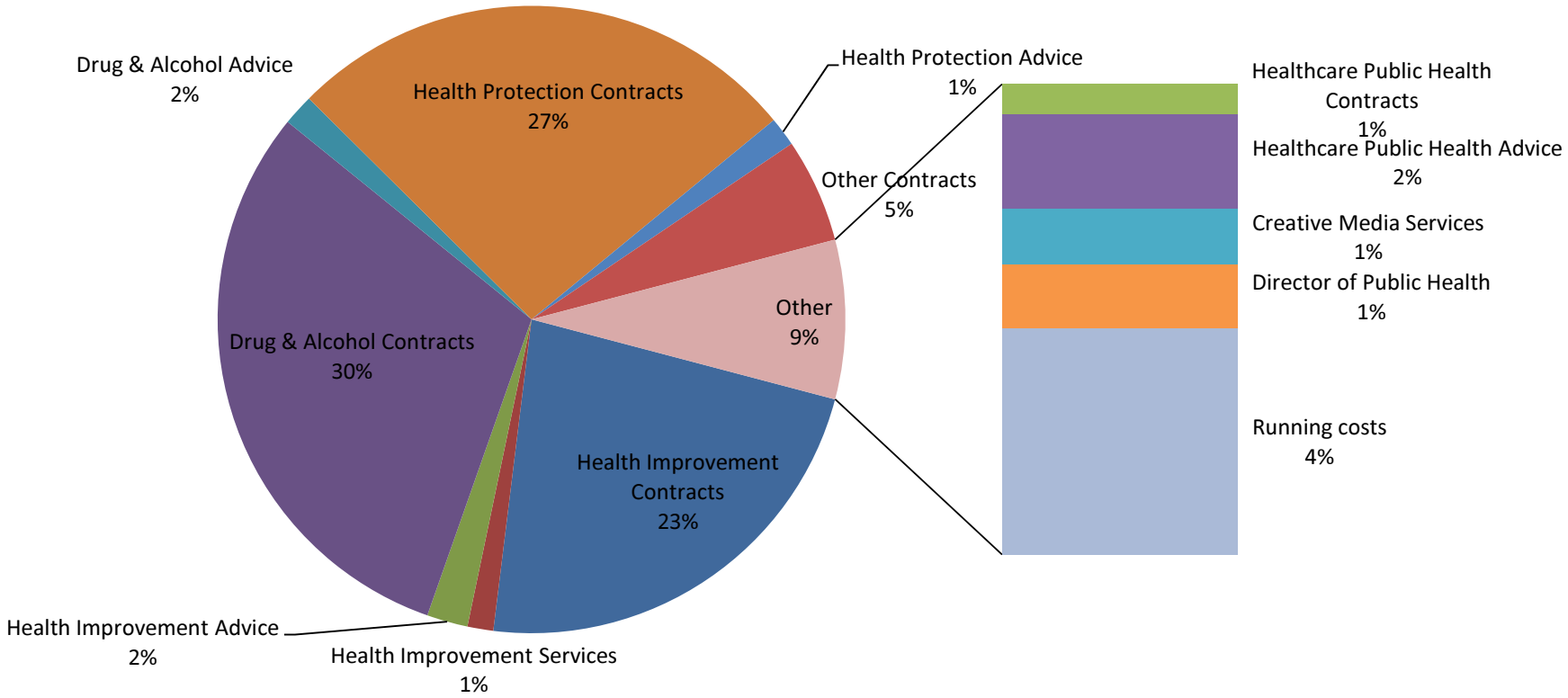
Public Health Grant £13,790,300

Other Income £193,038

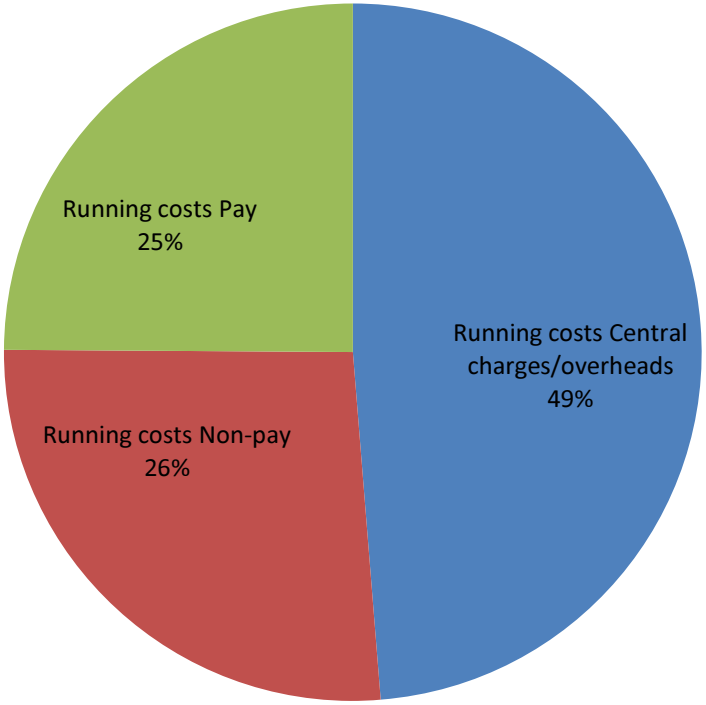


Total Planned Spending £13,983,338

Contracted services	£11,996,638	In-house services	£322,420
Advice Functions	£1,112,706	Running costs	£551,573



Detailed Breakdown of Planned Spending



Detailed breakdown of Running Costs

Total £551,573

PLAN FOR DEVELOPING 2014/15 COMMISSIONING INTENTIONS

Activity	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Strategic Intelligence Review (JSNA, HWB consultation)												
Review current service provision, performance and cost effectiveness												
Produce commissioning intentions (CV, V1, V2)												
Committees												
SLT					X		X		X			
H&WBB								X		X		
HSC								X				
Cabinet										X		
Stakeholders												
RCCG						X		X	X			
NAS						X		X	X			
CYPS						X		X	X			
EDS						X		X	X			
Resources						X		X	X			
VAR						X		X	X			
TRFT						X		X	X			
RDaSH						X		X	X			
SY&B AT						X		X	X			
Area Assemblies						X		X	X			
Public								X				
PHE/DH												
Communications												
Website								X	X			
Rotherham Show						X						
Annual Commissioning Plan								X		X		
Allocations announced									X			
Serve notices/renewals										X		

ROTHERHAM BOROUGH COUNCIL – REPORT TO HEALTH AND WELLBEING BOARD

1.	**Meeting**	**Health and Wellbeing Board**
2.	**Date:**	**8th May 2013**
3.	**Title**	**RMBC Commissioning Priorities**
4.	**Programme Area:**	**Resources Directorate**

5. Summary

This report sets out the work in progress to be carried forward to 2013/14 and sets out proposals for 2013/14 Commissioning Priorities that meet identified priorities for the Directorates, CYP & Families Partnership and Adult Partnership and align to those agreed priorities in the Health and Wellbeing Strategy. Financial information with regard to efficiencies is included in the detail of the report.

These Commissioning Priorities are emerging proposals and are yet to be reported to the Cabinet Member for Children, Young People and Families and Cabinet Member for Adults Social Care.

6. Recommendations

That the Health and Wellbeing Board:

6.1 Approve the proposals set out at 7.2
6.2 Receive future reports on progress through 2013/14.

7. Introduction

Our intention is to work in an open transparent way to support the Health and Wellbeing Board (HWBB), RMBC Directorates and partners achieve the priorities to improve life chances all citizens of Rotherham. The priorities link directly with the government's national agendas, Directorate Service Plans and the HWBB Strategy so that the golden thread links through to commissioning activity for health and social care.

These Commissioning Priorities are emerging proposals and are yet to be reported to the Cabinet Member for Children, Young People and Families and Cabinet Member for Adults Social Care.

These Commissioning Priorities are presented to the Health and Wellbeing Board to align with those already presented by the Rotherham Clinical Commissioning Group (RCCG) and Public Health. This paper reports how the local authorities' commissioning activities contribute to the delivery of the outcomes set out in the HWBB Strategy. The local authority is seeking commitment from partners for the establishment of Memorandum of Understanding with shared principles on how we will work together to deliver against the stated outcomes.

7.1 Proposed Commissioning Priorities

Children and Young People Service Actions

The focus for CYPS commissioning priorities is the Starting Well and Developing Well but in terms of families the work of commissioners impacts across all the four life stages.

a) Special Educational Need and Disabilities
This area refers to the work to meet the requirements of the Support and Aspiration White Paper, contributing to the project steering group and leading the Working Together group. It is important that there is investment in the SEND service and those services are at the optimum level of effectiveness and efficiency so that the outcomes for children, young people and their families are transformed.

This work includes, but is not restricted to:

- Continuing Health Care funding
- Aiming High for Disabled Children
- Higher Needs Funding commissioning: a financial model and criteria for funding
- Speech and Language Therapy
- SEND placements Framework: a coordinated approach to the provider market
- Joint Equipment commissioning: a collaborative approach to access equipment

- Post 16 Educational Placements: maximisation of financial model for High Need
- Working together across statutory agencies
- Personalisation: access to Personal Budgets

Alignment with Health and Wellbeing Strategy:
The SEND service covers the ages of 0-25 and as such covers the first three life stages. The work across the SEND programme and the placements commissioning will deliver against:
Priority 2 - Expectations and aspirations Outcome: The expectations and aspirations of Rotherham people will be understood and matched by services that are delivered to borough-wide standards, tailored to an individual's personal circumstances.
Priority 3 - Dependence to independence Outcome: Rotherham people will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances; this is particularly relevant in the work on implementing personal budgets
Priority 5 – Long Term Conditions Outcome: Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life.
The work on this key priority is shared across the Strategic Commissioning team

Joint work with the Rotherham Clinical Commissioning Group (CCG) on bringing together the commissioning activity around Joint Equipment and Speech and Language therapies is progressing.

b) Leaving Care
The current contract is commissioned from Action for Children and a commissioning plan is being implemented for a new contract to be in place from April 2014. A regional approach is also being investigated with regard to the accommodation element.
The lead commissioning officer is Paul Theaker

Alignment with Health and Wellbeing Strategy:
Priority 3 - Dependence to independence; investment is a priority for a high quality provision so that Looked After Children (LAC) to develop, live, work and age well and achieve independence is a priority.
Priority 1 – Prevention and early intervention, so that the young person leaving care is supported to develop life skills that will sustain them in achieving independence and be prevented from not achieving their potential.
Priority 2 – Expectations and Aspirations, that LAC are encouraged to have aspirations for themselves and to expect to have a quality of life that enables them to live well and achieve economic independence.

c) Contracts for in-house services
This work has commenced with the development of a specification for the Integrated Youth Support Service (IYSS) and will continue to include all in-house services e.g., Early Years, School Effectiveness, Early Integration and Safeguarding etc. The lead commissioning officer is Clare Burton

Alignment with Health and Wellbeing Strategy:
We work across the CYPS service with colleagues to achieve the highest quality of provision and it is important that the services are specified to ensure that performance is high, value for money is achieved and services are organised to meet the needs of children, young people and their families. All services should align with the appropriate life stages and the six priorities of the Health and Wellbeing Strategy and a Performance Management Framework will ensure that this alignment is achieved.

Adult Services Actions

The focus for Adult commissioning priorities is Living and working well and Aging and dying well but the work of adult service commissioners impacts across all the four life stages and all the HWB priorities.

d) Developing Care Market Programme – work with care sector to develop a diverse range of good quality providers and publish a Market Position Statement to assist providers to understand their responsibilities and the business opportunities available to them.

Alignment with Health and Wellbeing Strategy:
We will work with the independent sector and internal Care Market and with our strategic partners to make sure that a good choice of high quality, affordable providers are available to meet needs identified through our JSNA. All services delivered on behalf of the Council to meet the needs of eligible people should align with the appropriate life stages and the six priorities of the Health and Wellbeing Strategy and a Performance Management Framework will ensure that this alignment is achieved.
Lead Officer: Janine Parkin

e) Continue to disinvest in residential care and realign service delivery to assist people to remain at home with personalised support packages – the work includes:

- Review (across all service groups) of Supported Living arrangements, including Extra Care Housing.
- Work with Safeguarding Team/CQC/NHS commissioners to undertake a strategic review of risk/viability of Adult Independent Sector Residential and Nursing Care, identify at-risk homes and implement action plan with homes that do not meet standards.
- With RCCG partners, build on and improve pathways into enabling/ telecare/ intermediate care/ step down services.
- Embed use of Connect to Support Rotherham, and the principles of Think Local Act Personal (TLAP), to improve access to a diverse and good quality care market.
- Develop appropriate quality assurance frameworks to monitor and evaluate the performance of providers and to protect vulnerable people.

Alignment with Health and Wellbeing Strategy:
Priority 1 – Prevention and early intervention Outcome: people are assisted in a timely way using enabling approaches, short term interventions, and technology and equipment to develop self-care skills that avoid or delay the need for health and/or social care.
Priority 2 – Expectations and Aspirations Outcome: people are able to choose care pathways that align with their expressed needs and lifestyle, and maintain their social networks to avoid or delay admission into 24 hour care.
Priority 3 – Dependence to Independence Outcome: people working in the care sector, and their employing organisations embed the principles of recovery and self-help in their work with customers and encourage self-reliance and independence.
Priority 5 – Long Term Conditions Outcome: people with complex needs and limiting illness or disability are supported appropriately by good quality services, which avoid or delay admission into 24 hour care.
Priority 6 – Poverty Outcome: people, including those who fund their own care, are encouraged to access independent financial advice and universal information such as Connect to Support, to maximise their available income and allow them greater choice around how their support is provided into the future.
Lead Officer: Janine Parkin

f) Review Partnership Arrangements for local authority services (Public Health and adult social care) commissioned jointly with RCCG - high profile and high cost contracts with NHS providers require robust programmes of review and recommissioning in 2014/15. These include:

- Community Occupational Therapy Service
- Integrated Community Equipment Service (REWS)
- Learning Disability Service – NHS Contract
- Learning Disability Partnership Agreement
- Intermediate Care Services
- Mental Health Service – Social Care Partnership
- Dementia Services (several contracts)
- Tier 3 Drug and Alcohol Services
- Residential and Funded Nursing Care Services.

Alignment with Health and Wellbeing Strategy:
These initiatives encompass all the priorities in the HWB Strategy.
Lead Officer: Janine Parkin.

Cross Cutting Actions (NAS and CYPS)

g) Budget Action Challenge Plan

It is critical that Strategic Commissioning officers support the ongoing work to achieve the requirement of a balanced budget and there are several current actions within the plan to which a contribution is being made, these are:

- **Review Commissioning activities across CYPS and NAS**
  This work involves mapping all commissioning activity across CYPS and NAS ensuring that these meet financial regulations and standing orders. Also that the statutory requirement for inclusion on the contracts register is met
- **EFQM/Strategic review of statutory services**
  Consideration of statutory minimum and non statutory services and impact on deprived areas
- **Feasibility study of outdoor education**; Habershon and Crowden
  For Crowden this includes review of current partnership arrangements with the YHA and for Habershon developing proposals for future provision
- **Full strategic review of Adult Independent Sector Residential and Nursing Care provision/ Placement Process/ Fee Setting** and an options appraisal on use of residential care going forward.

Alignment with Health and Wellbeing Strategy:
Achievement of Value for Money and effective services aligns with all the priorities for Health and Wellbeing Strategy as is enabling people to have services that are aligned with needs, are high quality and are provided within the financial envelope available.
Lead Officer Chrissy Wright – CYPS/ Janine Parkin - NAS

h) Health and Wellbeing Board outcomes
The role of Strategic Commissioners contributes to achieving the outcomes for the Health and Wellbeing Strategy, including:

- **Joint Strategic Needs Analysis** (JSNA)
  Refresh of current JSNA to increase the data, particularly around CYPS needs, and to develop a needs analysis data base.
  Lead Officer Chrissy Wright

- **Collaboration with Public Health on commissioning activities**
  Develop a coordinated approach to improving health inequalities that particularly impact on vulnerable children, adults and their families and on communities in deprived localities.
  Lead Officers Chrissy Wright and Janine Parkin

7.2. Strategic Commissioning Work Plans

For 2013/14 all commissioning activity and reviews not included in the priorities will be set out in Strategic Commissioning work plans. The plans are dynamic and will, without doubt, grow with new activities and change as work progresses and is completed throughout the year. Areas of work not described under the priorities above will include:

Children and Young People's services

Ongoing
- IYSS – continued support until full implementation of new service

- LAC Transport review – conclusion of policy for in-house provision
- Traded Services – completion of agreed approach
- Youth Restorative Justice – completion of sub regional commissioning
- Adult Safeguarded Learning - commissioning activity and contribution to improvement plan
- Review of in-house residential capacity & provision – void outturn following change in statement of purpose
- Quality Assurance of residential provision – contracting concerns database review of outturn
- Review of quality of provision for children and Young People involved in Domestic Violence – comments and recommendations on current provision
- Local Account – to be presented in June 2013
- Carers Charter – ongoing influence for young carers

New for 2013/14

- Quality Assurance process for independent residential placements
- Speech and Language therapy joint approach with CCG
- Standard contract for CYPS
- Fairer Charging tool for CYPS
- Apprentice for Children's and Adults Strategic Commissioning
- Implementation of LAC placement review actions

Adult Services

Ongoing

Priorities extended into 2013/14 include:

- Development of a joint strategy for dementia.
- Complete the review and recommission the service provided for people with learning disabilities in the RDASH/South Yorkshire Homes.
- Continue shift from block contracting arrangements to realign resources to purchase personalised services.
- Achieve agreement with RCCG on monitoring of Funded Nursing Care and clinical practices in Care Homes.

New for 2013/14

- Feasibility study to align arrangements across RMBC and RCCG for delivery of domiciliary care and achieve agreement on fee-setting.
- Scope and review services for formal adult social care advocacy and develop proposals for future commissioning.
- Recommission arrangements for Direct Payment/ Personal Assistant Support.
- Review and make arrangements to recommission contracted day services for people with physical disabilities.
- Develop new Contracting Concerns Database.

8. Finance

There are no financial implications arising from this report

9. Risks and Uncertainties

That should the commissioning priorities not be agreed there is a risk that the outcomes set out in the Health and Wellbeing strategy will not be achieved.

That should a partnership agreement not be progressed there will be a lack of coordination and collaboration about future financial, commissioning and planning activities across organisations.

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

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Rotherham's Joint Health and Wellbeing Strategy

Dependence to Independence Workstream

Shona McFarlane, Director of Health and Wellbeing

May 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

Dependence - Independence

Rotherham people and families will increasingly identify their own needs and choose solutions which are best suited to their personal circumstances

Dependence - Independence

What needs to change to achieve this?

- A significant shift toward self care and self management and use of Assistive Technology/Telehealth
- Commissioners to review and evaluate plans and approaches to ensure that independence is promoted.
- A defined and agreed approach to risk taking, risk sharing. We need to move away from defensive decisions which historically have focused on avoiding risk and towards defensible decisions. A critical shift in thinking.
- Co-production, customers at the centre

Dependence - Independence

Priority One

We will change the culture of staff from simply ‘doing’ things for people to encouraging and prolonging independence and self care

Actions

- Personal Health budgets workstream is on target
- Assistive Technology Strategy has been drafted
- Self Care work group initiated

Progress

- We will embed a culture through the development of workforce development strategies shared by all relevant agencies that emphasises the promotion of independence and social inclusion - started
- Benchmark workforce development plans
- Identify tools available to support staff to achieve independence and supported risk-taking
- We will empower people to remain in control of their lives by embedding approaches such as self care, self directed support and personal health budgets

Dependence to Independence

Priority Two

We will seek out the community champions and support them with appropriate resources, to take action and organise activities

Progress

- Engage with key community groups to identify current activity
- Ageing Better bid to lottery fund

Dependence to Independence

Priority Three

We will support and enable people to step up and step down through a range of statutory, voluntary and community services, appropriate to their needs

Progress

- We will check and challenge commissioning strategies to ensure they reflect this aspiration – programme in place
- Engagement with voluntary sector taking place

Dependence to Independence

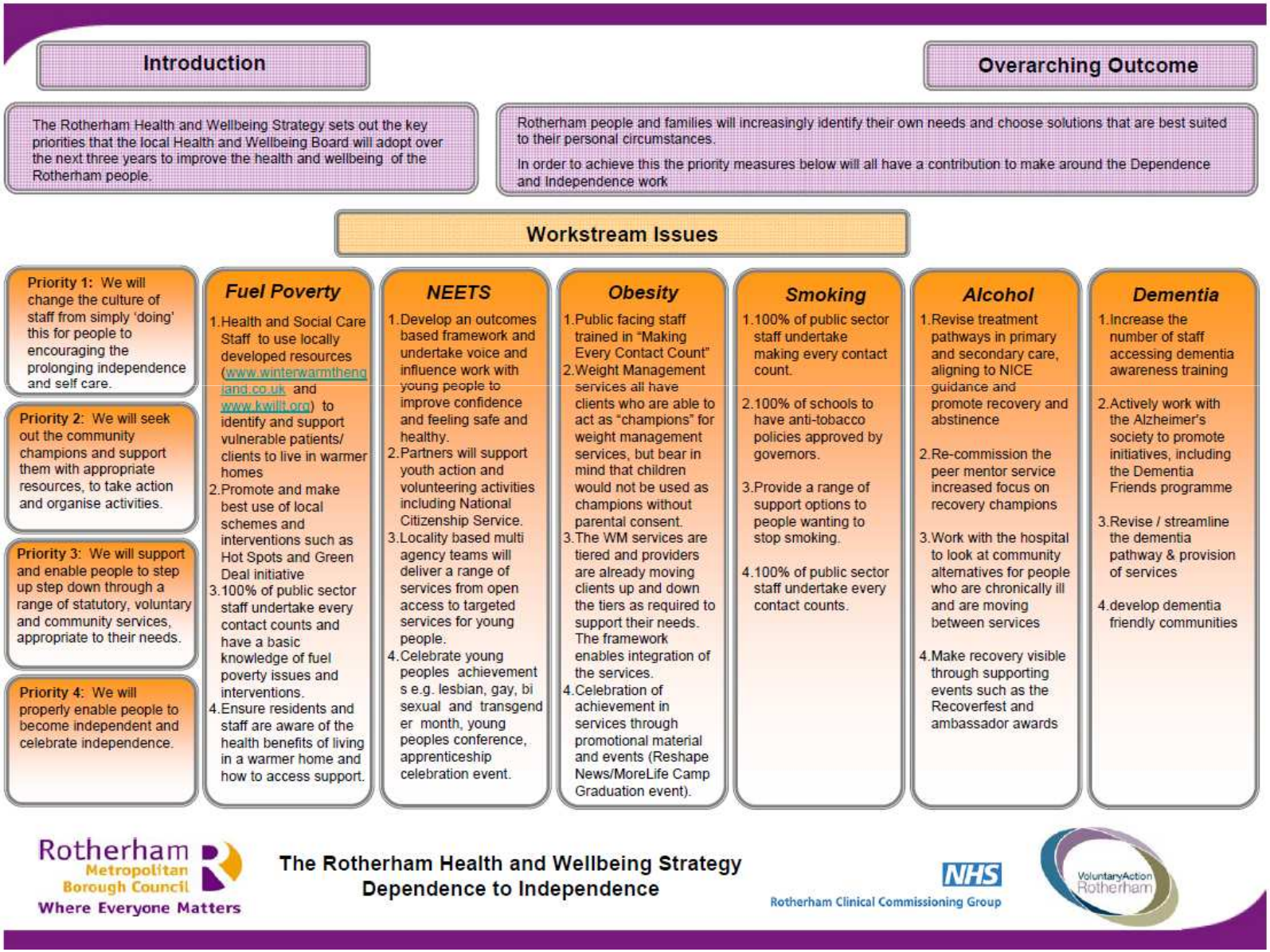
Priority Four

We will properly enable people to become independent and celebrate independence. A longer term goal but some areas have began to work this objective in already

Action

- Young Peoples Achievements, conference, apprenticeship celebration event
- Reshape News
- Making recovery (alcohol) more visible through events such as Recoverfest

Dependence to Independence



Health & Wellbeing Board Actions

- Commissioners need to ensure that all commissioning strategies reflect and enable this outcome consistently
- Commissioners need to find ways to incentivise providers to promote/achieve independence with customers and providers
- Having a shared commitment to the risks and opportunities that this commitment provides – helping people to help themselves can mean saying ‘no’ to some
- Ensuring that this significant culture change is embedded

Challenges

- Achieving significant culture change at a time where welfare reforms may be driving dependence
- Partners having a consistent approach to customers and understanding when one part of the system says no
- Understanding the behaviours that underpin and drive dependence
- Engaging effectively and honestly with citizens

Any Questions?

Health and Wellbeing Board Locally Determined Priority: Smoking

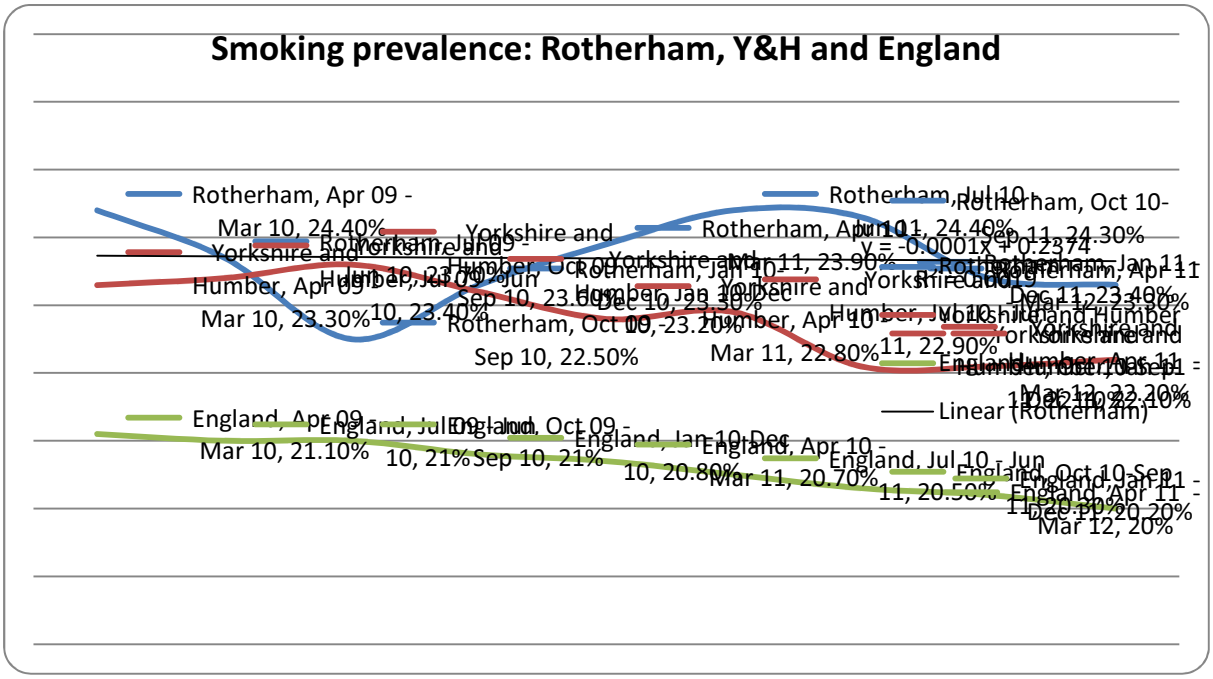
Briefing paper on tobacco control

Providing background information to the presentation

Smoking and tobacco control remains a key national priority as the decline in smoking rates slows and tobacco use continues to be the main cause of preventable death. The public health outcomes framework contains three indicators for smoking prevalence: adult prevalence, prevalence at age 15 and prevalence at time of delivery (smoking in pregnancy rate). Tobacco use in Rotherham is higher than the England average on all indicators. Tobacco is the only product that, when used as directed by the manufacturer, kills 50% of its consumers.

Adult smoking

Rotherham smoking prevalence is currently around 23.5%, compared to an England average of 20%. This masks vast differences between boroughs, with some areas having rates of close to 50%.



Source: Integrated Household Survey, ONS (experimental statistics)

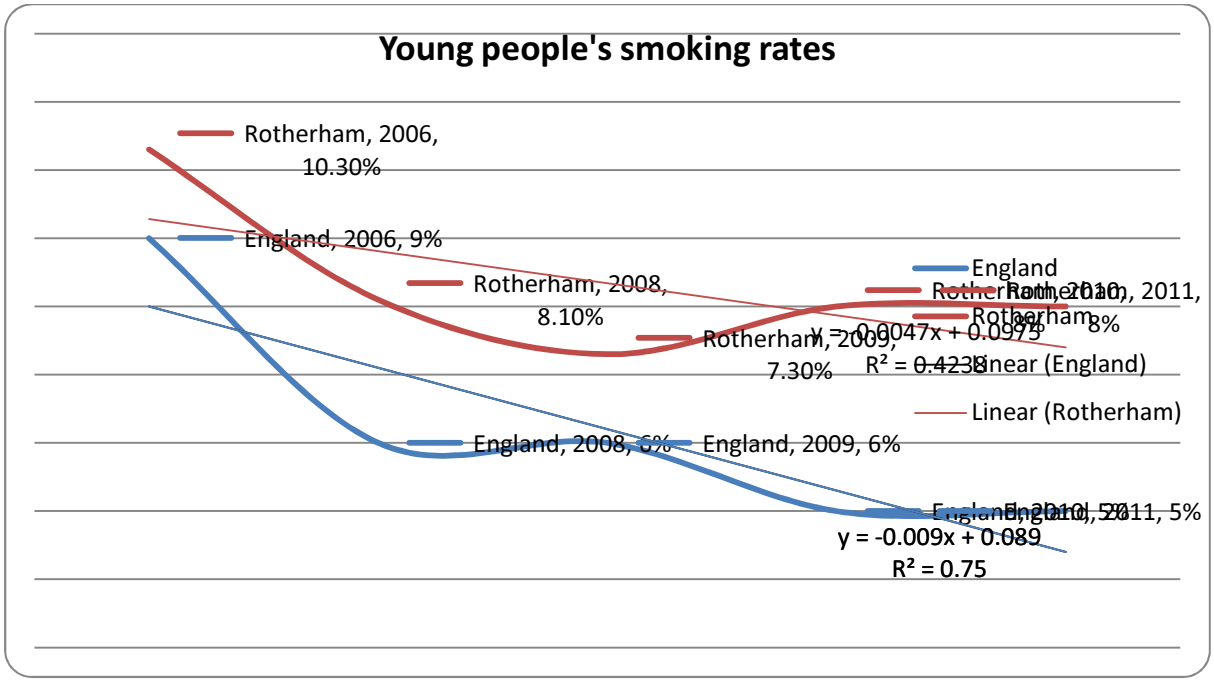
The required measure for adult smoking, up until 31 March 2013, was achieving a set number of 4-week quitters. Our local services have regularly delivered more successful quitters per 100,000 population than the regional and national average. However, the relapse rate for 4-week quitters is high with only around 20% of 4-week quitters still being non-smokers at 12 months. The number of new and relapsed smokers is similar to the number who quit or who die, which means smoking prevalence is remaining fairly static.

National data shows that desire to quit and quit attempts are also reducing. In 2011 two-thirds (67%) of smokers said they wanted to quit smoking, significantly less than the 74% who reported

they wanted to quit in 2007 (Smoking Toolkit Study). The same study also found a year on year decline in people making quit attempts, from 42.5% people making a quit attempt in 2007 to 33.5% in 2011.

Young people's smoking

Children, not adults, start smoking. Over 80% of smokers will start before they are 19, and nearly 40% before they are 16. Exposure to adult smoking increases the likelihood of a child taking up smoking with 99% of all 16 year old smokers living in a household where at least one other smoker (ASH, 2012).



Sources:
1. Smoking, drinking and drug use among young people in England in 2011. National Centre for Social Research, 2010: NHS Information Centre for Health and Social Care.
2. Rotherham Young People's Lifestyle Survey

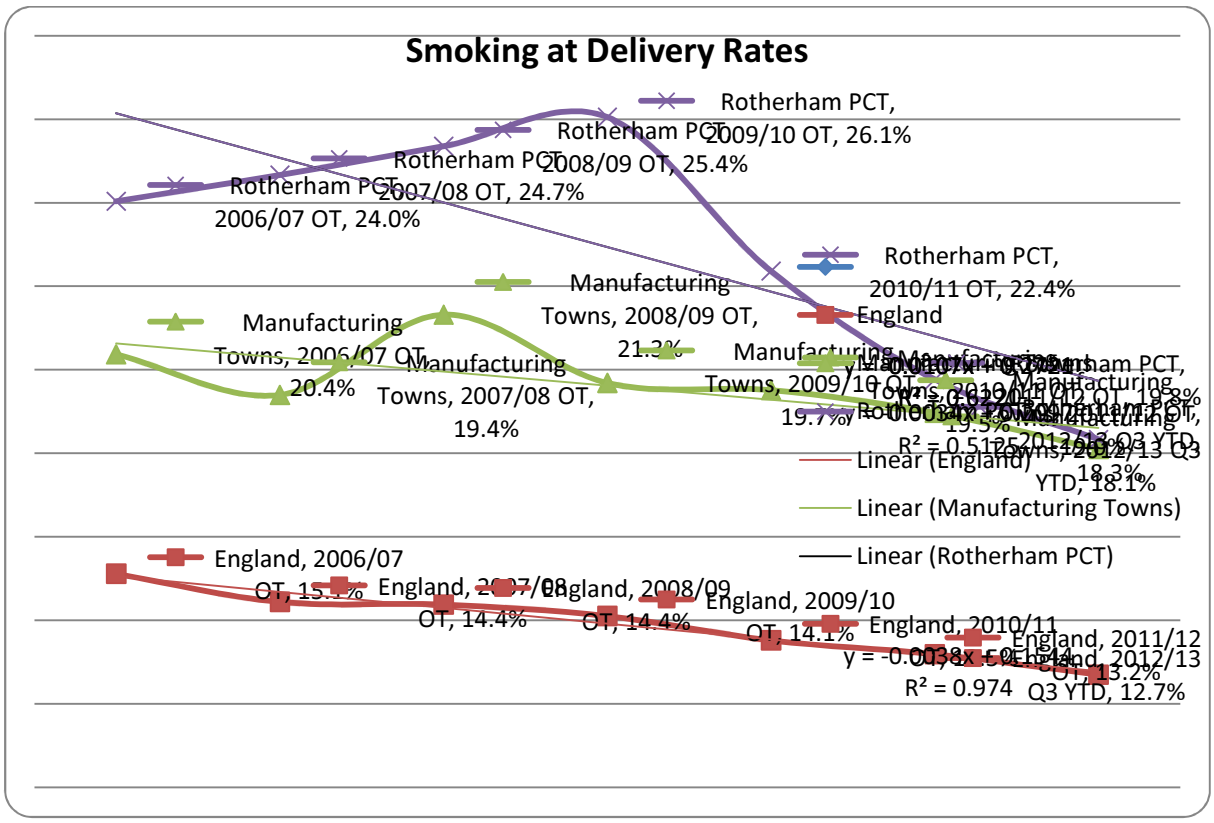
Smoking rates among young people in Rotherham are higher than the England average and the gap is widening, but these figures need to be viewed with caution as they are taken from two different surveys. There is currently no consistent data collection of young people's smoking rates that can be broken down to local areas, although this is in development to fulfil the PH outcomes framework indicator. The local survey asks young people to make a judgement on whether their smoking is social/occasional or regular whereas the Information Centre survey asks whether people smoke every day, more than once a week, once a week etc and then applies the descriptor of 'regular' to those who smoke daily or weekly. The national survey also asks a range of young people between ages 11 and 15, whereas our local survey is conducted at years 7 and year 10 only.

Smoking rates increase as children get older. Both sets of data include younger pupils who will have lower smoking rates. The PH outcomes indicator is for smoking prevalence at 15 years, so we would expect the rates to be higher than those shown here. For information, 11% of 15 year olds nationally smoke regularly; in the local lifestyle survey 14% of Year 10 pupils identified themselves as regular smokers.

There is little evidence for the effectiveness of cessation support for young people; the focus should be on prevention of uptake. We currently provide smokefree class resource packs for secondary and primary schools, each providing a series of 10 in-class activities focusing on promoting the benefits of not smoking and challenging the social norms around young people and smoking. Rotherham also has an active Smokefree Homes programme. Another key issue for tackling young people's smoking rates is to reduce their access to tobacco products. Trading standards obtain intelligence and take action on cheap and illicit tobacco, underage sales and 'fag houses', but the local Lifestyle Survey shows nearly 40% of Year 10 smokers get their cigarettes from local shops.

Smoking in pregnancy

Smoking in pregnancy causes serious complications for mother and baby, including increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy (Royal College of Physicians (RCP), 1992; Salihu and Wilson, 2007). Active maternal smoking causes about 5000 miscarriages, 300 perinatal deaths and 2200 premature births in the UK each year (RCP, 2010).



Source: The Health and Social Care Information Centre, Lifestyle Statistics / Omnibus

Smoking in pregnancy rates are falling at a rate faster than national rates, but the gap between Rotherham and the England picture is still too large. The recent falls are a result of the new pathway embedding smoking cessation advice into routine antenatal care. All pregnant smokers have at least one intervention from the specialist stop smoking midwives as part of their routine antenatal care, whether or not they have expressed an interest in stopping smoking. When a woman attends for her routine scan or any other antenatal appointments, if she is a smoker she will be directed to see the midwife. If she is already receiving support to quit this can provide an additional contact and motivation. If she has not shown any interest before, the midwife delivers a hard-hitting

intervention to describe the harms of smoking to the mother and baby, relating it to local data on still-births, labour complications etc. If the woman still declines help this is recorded in her notes as having refused treatment.

However, the rate of reduction has flattened this year. We still need to continue to encourage women to quit before they get pregnant, to get more women choosing to quit at the earliest point in pregnancy and to support those women who have achieved a 4-week quit to maintain that quit through to delivery and beyond.

Smoking is not just a health issue

Cheap and illicit tobacco

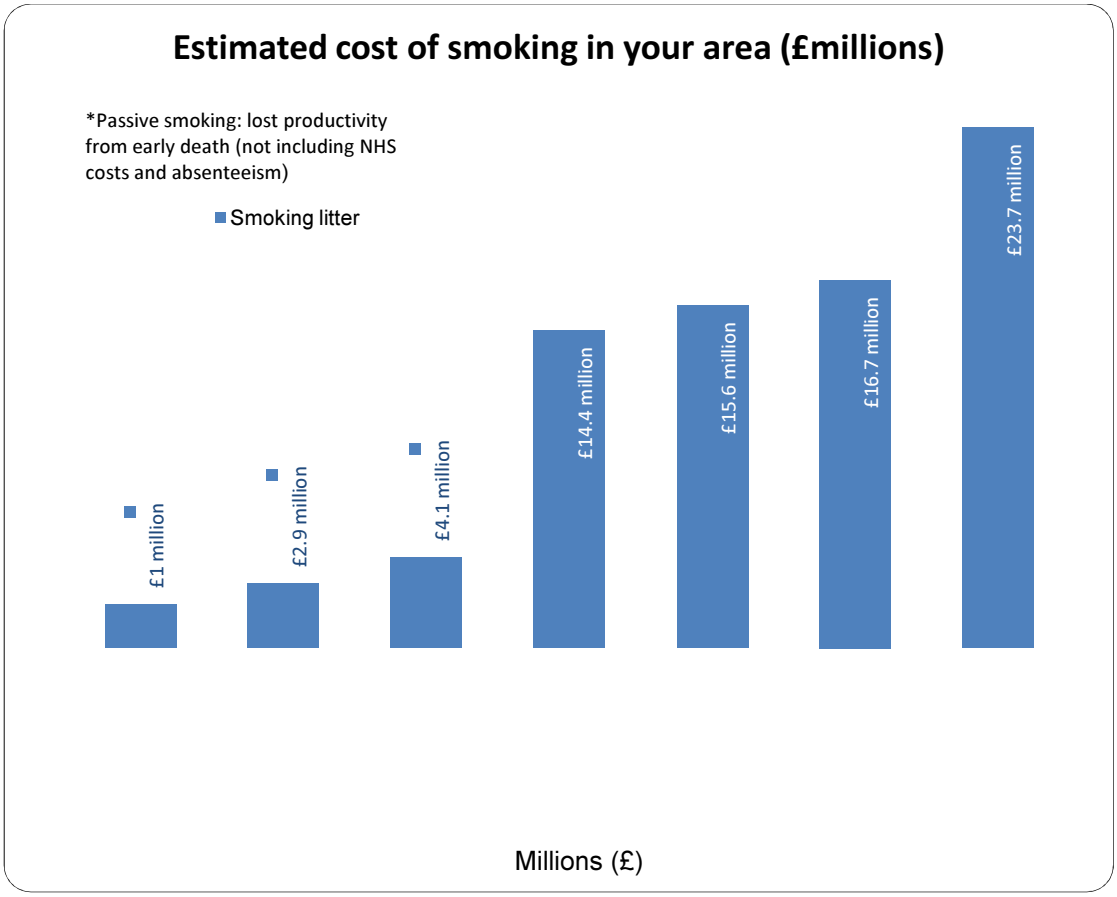
There is a growing supply and use of cheap and illicit tobacco. The term 'cheap and illicit' covers all non UK duty paid products, whether they are genuine products purchased abroad for 'personal use' and sold on by the purchaser, counterfeit versions of regular brands, or brands that have no legal market anywhere (eg Jin Ling). Illicit tobacco is associated with organised crime, with brands such as Jin Ling being produced specifically for smuggling and funding criminal activity. The sale of illicit tobacco takes place in retail premises (under the counter sales), from individuals selling in face to face (car boot sales, markets, white van trade) and 'fag houses', where single cigarettes are often sold to children and young people, which also raises safeguarding concerns.

Cheap and illicit tobacco is not subject to the same quality standards as legal tobacco products. They frequently have higher levels of the toxins that are found in standard cigarettes, as well as factory detritus including floor sweepings, sawdust and rat droppings.

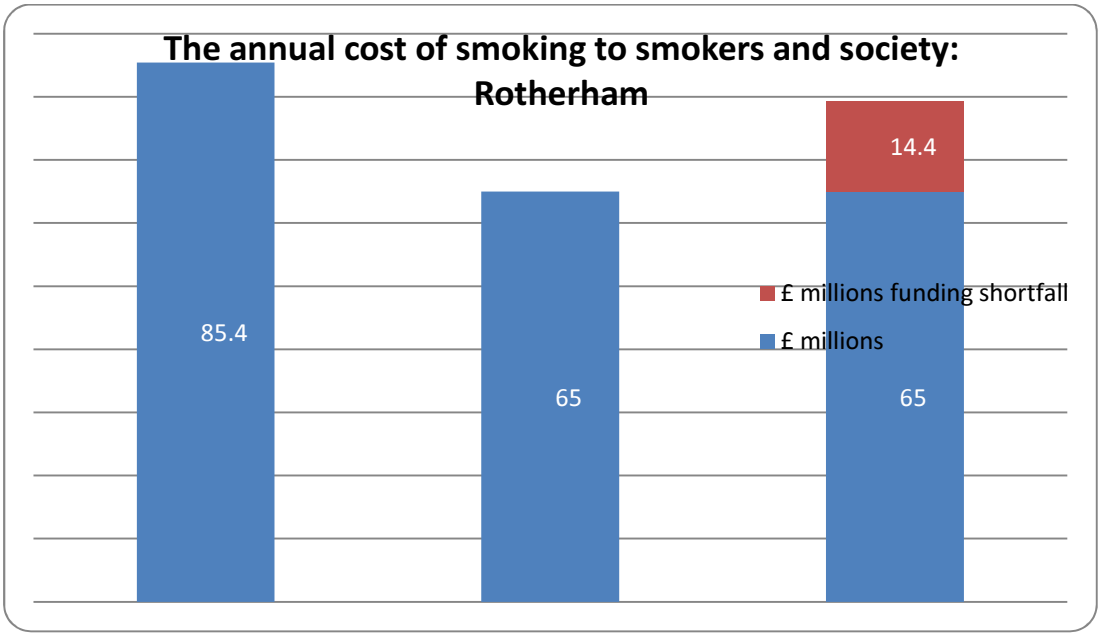
There is a direct relationship between the price of tobacco and smoking prevalence; the World Bank estimates a 10% increase in price leads to a 4% reduction in prevalence. However, the continued availability of cheap and illicit tobacco undermines any impact of price rises.

Economic consequences

The economic consequences of smoking are significant to the local economy, estimated to cost around £79m each year, and are not just additional healthcare costs.



Source: ASH *The case for local action on tobacco*, 2012



Source: ASH *The case for local action on tobacco*, 2012

Smokers in the borough spend more than £85 million on tobacco each year, which contributes £65m to the Exchequer. However, the societal cost is far greater than this, meaning we have a shortfall in funding of £14.4m, or 18%. The figures assume that all tobacco expenditure is on legal, duty-paid products, but we know that national estimates are that 10% of cigarettes and 46% of hand rolling

tobacco is illicit with no contribution to the public purse, and therefore the funding shortfall is likely to be far greater.

A comprehensive programme of tobacco control

Healthy Lives, Healthy People: A Tobacco Control Plan for England (DH, 2011) states that 'Comprehensive tobacco control is more than just providing local stop smoking services or enforcing smokefree legislation.' A comprehensive commissioned tobacco control programme should fulfil the locally deliverable aspects of the World Bank's six strand approach to tobacco control:

- stopping the promotion of tobacco
- making tobacco less affordable
- effective regulation of tobacco products
- helping tobacco users to quit
- reducing exposure to secondhand smoke
- effective communications for tobacco control

Historically almost all funding for tobacco control goes into support to stop smoking and almost nothing into preventing uptake, dedicated activity to reduce the availability of cheap and illicit tobacco and to promoting smokefree as the social norm. This situation isn't unique to Rotherham, and is a result of the 4-week quitter targets – when the target was to achieve larger and larger numbers of 4-week quitters the funding inevitably went into increasing capacity to support quit attempts. We know from the Smoking Toolkit Study that only around 5-6% of quit attempts are made with NHS support despite widespread promotion of services, yet we currently do nothing to provide information and advice to the majority of smokers trying to quit who don't want or use NHS support about what they can do to maximise their chances.

Collaborative work across South Yorkshire and with the School for Health and Related Research (SChARR) at the University of Sheffield has determined a plan for future commissioning of a broader programme of tobacco control, with a shift in the balance of funding away from stop smoking support to free up resources to support the other aspects of a tobacco control programme.

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