HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 16th October, 2013**

Time: **1.00 p.m.**

A G E N D A

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

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

3. Minutes of Previous Meeting and Matters Arising (Pages 1 - 14)

4. South Yorkshire Police
   - To consider South Yorkshire Police becoming a formal member of the Board

5. Communications

6. Health and Wellbeing Board Self-Assessment (Pages 15 - 19)

7. Health and Wellbeing Board - Annual Report (Pages 20 - 27)

8. Joint Strategic Needs Assessment Refresh (Pages 28 - 31)

9. Performance Management Framework (Pages 32 - 47)

10. Social Care Support Grant (Pages 48 - 52)

For Information

11. Annual Local Safeguarding Children's Board Report and Business Plan (Pages 53 - 94)

12. Number of GP and Dental Practices in Rotherham (Pages 95 - 97)

13. Healthwatch Rotherham Outcomes Framework and Work Plan (Pages 98 - 111)

14. Date of Next Meeting
- Wednesday, 27th November, 2013 at 1.00 p.m.

HEALTH AND WELLBEING BOARD
11th September, 2013

Present:-

Councillor Ken Wyatt	Cabinet Member, Health and Wellbeing (in the Chair)
Councillor John Doyle	Cabinet Member, Adult Social Care
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families Services
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Joyce Thacker	Strategic Director, Children and Young People's Services
Chris Edwards	Chief Operating Officer, Rotherham Clinical Commissioning Group
Brian Hughes	NHS England
Michael Morgan	Acting Chief Executive, NHS Rotherham Foundation Trust
Dr. John Radford	Director of Public Health
Janet Wheatley	Chief Executive, Voluntary Action Rotherham

Also Present:-

Tracey Clarke	RDaSH
Catherine Homer	Health Improvement
Naveen Judah	Chair of Healthwatch Rotherham
Shona McFarlane	Director of Health and Wellbeing
Dave Richmond	Director of Housing and Neighbourhood Services
Kate Tufnell	NHS Rotherham Clinical Commissioning Group
Chrissy Wright	Strategic Commissioning Manager, RMBC
Kate Green	Commissioning, Policy and Performance, RMBC

Apologies for absence were received from Karl Battersby, Tracy Holmes, Dr. David Polkinghorn and Dr. David Tooth.

S26. MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

Resolved:- (1) That the minutes of the previous meeting of the Health and Wellbeing Board held on 10th July 2013 be approved as a correct record, with a clerical correction of the inclusion of Brian Hughes in the list of persons who had sent their apologies for that meeting.

(2) That, with regard to Minute No. 19 (NHS South Yorkshire and Bassetlaw Primary Care Strategy), a report about the number of GP and dental practices in the Rotherham Borough area shall be submitted to the next meeting of the Health and Wellbeing Board, to be held on Wednesday, 16th October, 2013.

S27. COMMUNICATIONS

The Health and Wellbeing Board discussed the following issues:-

(1) Rotherham Borough Council Cabinet Member responsibilities – Councillor Wyatt referred to recent changes to the Council's Cabinet Member responsibilities, which would be in place temporarily; as a consequence, Councillor John Doyle would act as Chair of the Health and Wellbeing Board during that period of time.

(2) Making Every Contact Count : Applying the Prevention and Lifestyle Behaviour Change Competence Framework – a workshop is taking place at the Town Hall, Rotherham on Monday 16th September, 2013, with contributions from Leeds City Council and from the North Derbyshire Community Council (a report about this workshop will be submitted to the next meeting of the Health and Wellbeing Board).

(3) The first meeting of the South Yorkshire Joint Health and Wellbeing Board will take place on Thursday, 19th September 2013 at the Council's Riverside House building.

(4) 'Think Pharmacy' – this event will take place on Thursday 26th September 2013, at the New York football stadium, Main Street, Rotherham.

(5) The Regional Parliamentary Health and Well Being event – this event will take place on Friday, 25th October at the NHS Rotherham building, Oak House, Moorhead Way, Bramley.

(6) Self-Assessment of the Health and Wellbeing Board – the self-assessment is a part of the work plan for the Health and Wellbeing Board; all Members are encouraged to complete and return the evaluation document. A report containing an evaluation of the self-assessment will be submitted to a future meeting of the Health and Wellbeing Board.

(7) NHS Sustainable Development Unit – assessment of environmental performance – the document would be issued to Members of the Health and Wellbeing Board so that they may submit the appropriate returns giving evidence of their organisations' environmental performance. It was noted that the Borough Council has submitted its Environment and Climate Change Strategy document, as part of this assessment process.

S28. HEALTHWATCH ROTHERHAM

Further to Minute No. 76 of the meeting of the Health and Wellbeing Board held on 10th April, 2013, Mr. Naveen Judah attended the meeting and gave a presentation about the recently established Healthwatch organisation in the Rotherham Borough. The presentation included the following salient issues:-

: Mr. Naveen Judah had been appointed as the Chair of Healthwatch Rotherham with effect from September 2013;

: it was intended that there should be a partnership approach in respect of the role of Healthwatch and the Health and Wellbeing Board;

: Healthwatch, as a successor organisation to the LINk (Local Involvement Network), is to be a consumer champion for health and social care (a role whose importance was reinforced by the Francis Report, the independent inquiry into care provided by the mid-Staffordshire NHS Foundation Trust);

: ensuring the patient's voice is influential in the planning and improvement of health care provision (to be the 'eyes and ears' of the community);

: the implications of the Winterbourne View Joint Improvement Programme and the commitments made nationally that individuals should receive personalised care and support in appropriate community settings;

: the NHS England Call to Action – with neighbourhoods and communities stating the type of services they need from the NHS;

: endeavouring to establish good practice in the provision of health care services;

: the importance of what happens at a local level eg: working in accordance with the priorities of Rotherham's Joint Health and Wellbeing Strategy 2012 – 2015;

: establishing the appropriate structure for Healthwatch Rotherham, because different structures are being put in place for Healthwatch organisations around the country;

: details of the Healthwatch Rotherham business model and staffing structure were displayed (Healthwatch has only a finite resources); the organisation will also utilise a number of volunteers;

: engaging with the community in many forms; benchmarking with similar communities; identifying local issues and priorities; asking for issues to be investigated, for later consideration by the Health and Wellbeing Board;

: Healthwatch Rotherham is now based in premises at High Street, Rotherham, which helps with raising the profile of this new organisation.

The Health and Wellbeing Board discussed the level of assistance which could be provided for Healthwatch Rotherham, especially with regard to specific project work. Information (such as newsletters and posters) about Healthwatch Rotherham could be displayed in GP surgeries and other areas so as to attract the attention of the public. It was noted that effective day-to-day contact had already been established between Healthwatch Rotherham and public health service providers, in order that all

organisations may contribute to and benefit from the Joint Health and Wellbeing Strategy.

The Health and Wellbeing Board thanked Naveen Judah for his informative presentation.

S29. WORKSTREAM PROGRESS PRESENTATION - POVERTY

Consideration was given to a report presented by the Director of Housing and Neighbourhood Services describing progress with the Poverty theme of the Health and Wellbeing strategy. The report included the work plan outlining the activity being undertaken in respect of the strategy's priority to "make an overarching commitment to reducing health inequalities, particularly in areas suffering from a concentration of disadvantage".

The Director of Housing and Neighbourhood Services gave a presentation about the strategy's Poverty theme, which included the following salient issues:-

: the locally determined priorities and strategic outcomes;

: details of the lead Member and lead Officer contacts for each of Rotherham's deprived neighbourhoods;

: indices of multiple deprivation – showing a worsening of deprivation in these eleven areas of the Borough : Canklow; East Herringthorpe; Rotherham town centre; Dinnington; Eastwood; Ferham and Masbrough; Rawmarsh East; Aston North; East Dene; Maltby South East; Dalton and Thrybergh;

: examples of progress being made in each of the deprived areas – priority one (health inequalities) : the establishment of Community Alcohol Partnerships; the Community First Funded Wellgate Wellness Project; events focusing on health and employment;

: priority two : considering new ways of assisting those disengaged from the labour market to improve their skills and readiness for work; eg: job clubs funded by Community First; community development and the Community Organisers Programme; employment opportunities at the Rotherham's new Tesco store;

: priority three : ensure strategies to tackle poverty don't just focus on the most disadvantaged, but there is action across the Borough; the work of the Council's Officer group; mapping exercises being undertaken; research of other local authorities' anti-poverty strategies;

: priority four - consider how we can actively work with every household in deprived areas to maximise benefit take-up of every person; provision of benefits and debt management sessions; establishment of temporary posts of Money Advice Officer;

: other work in the eleven areas of deprivation – crime and anti-social behaviour; environmental issues (examples in Dinnington and in Maltby); community engagement (Canklow Community Connections; Adopt-a-Street campaign);

: challenges - getting all organisations to put a deprived neighbourhoods philosophy at the heart of their service planning and doing so without unduly impacting on appropriate service levels elsewhere;

: request to the Health and Wellbeing Board – to take back into all organisations and consider how this can shape service planning; especially, support for long-term unemployed people.

Discussion took place on the work already taking place to try and reduce the level of poverty in the Rotherham Borough area. A suggestion was made that a draft strategy should be formulated for further consideration by the Health and Wellbeing Board. Reference was made to the public service expenditure reductions, the Governments welfare reforms and the economic recession, all of which are factors having a continuing profound effect upon levels of deprivation and poverty.

Resolved:- (1) That the report be received and its contents noted.

(2) That the work plan for the Poverty theme of the Health and Wellbeing strategy, as now submitted, be endorsed.

(3) That partners take into account the deprived neighbourhoods work when service planning.

(4) That a report be submitted to a future meeting of the Health and Wellbeing Board providing a further update on progress with the Poverty theme work plan.

S30. LOCALLY DETERMINED PRIORITY - PRESENTATIONS

The Health and Wellbeing Board considered the following reports and presentations:-

(A) Fuel Poverty

Further to Minute No. 20 of the meeting of the Health and Wellbeing Board held on 10th July, 2013, the Board noted that Fuel Poverty and Excess Winter Deaths remain key national priorities and are both indicators contained in the Public Health Outcomes Framework. Fuel poverty levels in Rotherham are higher than the national average and occurs throughout the Borough area, not only in areas of high deprivation.

Catherine Homer, Health Improvement Specialist, gave a presentation about fuel poverty:-

Why is Fuel Poverty a priority?

- Current definition – when householders need to spend more than 10% of their income to heat their home adequately
- Causes of fuel poverty: energy efficiency of the property; fuel costs; behaviours and knowledge, characteristics and household income
- Fuel poverty is a serious problem from three main perspectives – poverty, health and wellbeing and carbon reduction
- Heat or Eat
- Cold weather kills – living in a cold home has significant implications on the health and wellbeing of residents across our Borough particularly the most vulnerable
- People with an existing chronic health condition or disability, the very young or older people are more at risk from the negative impacts of living in a cold home
- Children living in cold homes are likely to have poorer attendance and attainment in school

The private and social cost of Premature Death and Illness related to Cold Homes

- Source of evidence
  English Housing Conditions Survey
  Mental Health and Housing Conditions in England, National Centre for Housing Research 2010
  Housing Health and Safety Rating System
- Economic model mapping cold, damp and mould to probability of harm
- Probability of harm further mapped to economic and NHS cost
- Probable this is an underestimate of effect since the model assumes only one person per dwelling

Rotherham

- Fuel poverty levels above national average (16% of households in Rotherham, compared to 14% nationally)
- The rise in fuel prices – energy costs have risen 96% since 2004 or an average of £700 over the same period
- Average of 144 Excess Winter Deaths per year 1990-2010
- 17,800 Council properties have been supported through Carbon Energy Reduction Target (CERT)
- 400 Council properties have received solid wall insulation through CERT
- 1,049 private sector properties have received solid wall simulation through the Community Energy Saving Program (CESP)
- 1,649 non-traditional build properties in the Borough
- Green Deal including Energy Company Obligation

Strategic Objectives

- Reduce levels of fuel poverty across the Borough
- Significantly reduce levels of cold-related illness and excess winter deaths
- All of Rotherham's occupied private rented housing stock has an Energy Performance rating of E and above
- Target all Council stock not improved under Decent Homes because of resident choice
- Raise awareness of fuel poverty and associated interventions amongst Council staff, partner organisations and householders
- Meet vision and ambitions set in the Rotherham Warmer Homes Strategy
- Creation of electoral Ward profiles

What do we need to do?

- Continue to engage new and existing stakeholders through the Rotherham Warmer Homes Strategy
- Set up and deliver the Green Deal/Energy Company Obligation Framework
- Continue to utilise existing intelligence and support development of new research
- Raise awareness of links between health and fuel poverty
- Use 'Make Every Contact Count' (MECC) as a tool to ensure more departments/staff raise issues of fuel poverty
- Maximise personal assets, capability and behaviour
- Adopt a whole system approach to reduce levels of fuel poverty

Challenges

- Causes of fuel poverty
- Structural and organisational change (dealing with competing priorities)
- Reliance of new Policy as main vehicle
- Lack of engagement and understanding
- Most vulnerable and hard to reach populations most likely to be in fuel poverty
- Welfare Reform
- Climate impacts

What can the Health and Wellbeing Board do?

- Professionals consider the effect of cold on patients/clients and use the principles of MECC to signpost and advise eg: Willmott Dixon
- Support the use of the Winter Warmth England toolkit www.winterwarmthengland.co.uk
- Support Green Deal as a Council priority – eg: ensure that householders properly understand how to use the heating controls
- Support and attend the 'Warm Well Families Feedback' event and 'Abacus' workshop

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

: the connection between 'heat or eat' – eg: demands for food;

: voluntary sector work – 'warm homes – healthy people";

: the Warm Well Families feedback event takes place on Wednesday 2nd October, 2013 at the Town Hall, Rotherham.

Catherine was thanked for her informative presentation.

(B) Dementia

Further to Minute No. 17 of the meeting of the Health and Wellbeing Board held on 10th July, 2013, the Health and Wellbeing Board considered a report about the cross-cutting theme of Dementia, which has been identified as a key priority for the future provision of services. The expectation is that there will be an increasing demand, within the next three years, for services both for people suffering dementia and also for their carers. Kate Tufnell, Head of Contracts and Service Improvement, NHS Rotherham Clinical Commissioning Group, gave a presentation about the Dementia priority:-

Overview
- Overseen by Older People's Mental Health Group
- 4 ways you can support the Programme

What is the Problem ?
- Dementia was now the greatest health concern for people over 55 and the economic cost of Dementia was more than Cancer, Heart Disease or Stroke
- Rotherham – 1,688 people on the GP Dementia Register (3,034)
- By 2025 the number of people in Rotherham with Dementia could rise to 4,397 (Joint Strategic Needs Assessment 2011)

The Cost of Dementia
- Dementia was an expensive condition with a considerable cost to both public and private finances
- a large proportion of the cost of caring for a person with Dementia was borne by the carer
- In the UK = £23 billions per year

Symptoms of Dementia (examples)
- Memory loss
- Difficulties of completing familiar tasks
- Confusion of time and/or place
- Trouble with visual images – eg: colours and contrasts
- Language difficulties – unable to follow conversations

- Misplacing items
- Changes of mood and personality – eg: depression; aggressiveness
- Withdrawal from hobbies and leisure activities
- Self-care problems
- Difficulties posed for carers of people with dementia

Dementia Programme
- The Programme incorporates four workstreams:-
  Dementia - Prevention Group
  Dementia – Early Diagnosis Group
  Living Well with Dementia Group
  Dementia and End of Life Care Group (eg: care planning)

Six Priority Outcomes
- Prevention and early intervention (RMBC bronze to platinum programme, for the care of people with dementia)
- Expectations and aspirations
- Dependence to independence
- Healthy lifestyles
- Long term conditions
- Poverty

Four ways in which the Board can support the Programme
- Continue the Dementia Workforce Development Programme
- Strong leadership to break down barriers on joint working
- Continue to support the further development of the Dementia Pathway
- Support the development of a Dementia Friendly Community and Dementia Alliance in Rotherham
- Partnership work with the Yorkshire Dementia Alliance and with the business community

Challenges
- This is everyone's business
- Increase demand on Service to be delivered within same resources
- Complexity of Pathway and independencies
- Variation across the system and potential inequalities

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

: the priority given to the issue of dementia, by the Prime Minister;

: the likelihood of a significant increase in the number of people suffering dementia, with consequential pressure upon resources and services;

: Alzheimer and dementia champions in Rotherham and in Doncaster (National Alzheimer's Programme) – provision of training.

Kate was thanked for her informative presentation.

S31. CCG ANNUAL COMMISSIONING PLAN 'PLAN FOR A PLAN'

Consideration was given to the 'plan for a plan' document, presented by Chris Edwards, Chief Operating Officer, Rotherham Clinical Commissioning Group, outlining the necessary consultation and approvals process and timescale for the Rotherham Clinical Commissioning Group's Annual Commissioning Plan 2014/2015. The Board noted that there would be consultation about the contents of the Annual Commissioning Plan, prior to its approval during March, 2014.

The Health and Wellbeing Board acknowledged the various budget pressures affecting the Council and partner organisations and the Annual Commissioning Plan. Emphasis was placed upon the need for the priorities of the Plan to be aligned with other service plans utilised by the Council and partner organisations.

During discussion, Michael Morgan (Acting Chief Executive, Rotherham Foundation Trust) outlined the progress of the current re-structuring of the NHS Rotherham Foundation Trust.

Members of the Health and Wellbeing Board were requested to provide feedback on the Annual Commissioning Plan, during the consultation process.

It was noted that the Health and Wellbeing Board will be having discussions about finance and budgets at the meeting to be held on Wednesday 27th November 2013. In the interim, an issue concerning the funding for adults and children, young people and families' social care, in accordance with the provisions of Section 256 of the National Health Service Act 2006, would have to be considered at this Board's next meeting.

Resolved:- That the contents of the 'plan for a plan' document and the timescale for preparation and approval of the Annual Commissioning Plan 2014/2015 be noted.

S32. RIGHT CARE, FIRST TIME CONSULTATION UPDATE

Consideration was given to a report presented by Chris Edwards, Chief Operating Officer, Rotherham Clinical Commissioning Group, stating that the formal public consultation on the proposals for Urgent Care had concluded on 26th July, 2013, after 18 months of engagement which had taken the form of a series of discussions, focus groups, market research and briefings. Work with local stakeholders, including patient and community groups, had initially helped the Rotherham Clinical Commissioning Group to understand the use and perceptions of NHS services and how they could be improved and developed to meet patient needs. The formal consultation had sought views on the proposal to bring

together services for patients who required urgent care into one place, at a new Urgent Care Centre.

The consultations results were now being analysed. There had been 98 responses from individuals/groups with an equal division between those who either agreed/strongly agreed with the proposals and those who disagreed/strongly disagreed. 11% of responders were neutral. The main issues raised included:-

- Car parking at the hospital (availability, convenience, cost, proximity to Urgent Care Centre)
- Quality of care (i.e. the desire to see quality at least maintained or improved overall as well as the opportunities closer working with Accident and Emergency would bring)
- Convenience of the Walk-in Centre location (this included both its physical location and the convenience of the services it offered)

Comments had also been received about the physical accessibility of the proposed building and how the design and planning of the new service could improve the patient and carer experience.

The Board noted that the Governing Body of the Rotherham Clinical Commissioning Group would also be considering this issue during November 2013.

Resolved:- That the report be received and its contents noted.

S33. WINTERBOURNE VIEW JOINT IMPROVEMENT PROGRAMME: LOCAL STOCKTAKE

The Director of Health and Wellbeing submitted a reported about the Winterbourne Stocktake of the progress made in Rotherham against the key commitments required by the Winterbourne Joint Improvement Programme established in 2012 following the emergence of the scandal of sustained ill treatment of people with a learning disability at the Winterbourne View Hospital.

Contained within the Stocktake document were specific questions asked in each of the eleven specific areas under consideration and reported upon accordingly. Issues included partnership working, co-ordinated financial management, case management of individuals, reviews, safeguarding, commissioning, local team working, crisis management, understanding future needs, transition planning from Children's Services into Adult Services and understanding future requirements.

The Stocktake document for Rotherham was able to demonstrate excellent partnership working arrangements across Health and Social Care which were meeting the overall requirements in all the areas of the Joint Improvement Programme.

Reference was also made to (i) the Joint Self-Assessment on Learning Disabilities and (ii) the Autism Self Assessment, both of which will be reported to future meetings of this Health and Wellbeing Board.

It was noted that the report would also be submitted to the Rotherham Local Safeguarding Children Board.

Resolved:- That the Winterbourne Stocktake report, as now submitted, be noted and its contents endorsed.

S34. ROTHERHAM SMOKEFREE CHARTER

Further to Minute No. 90 of the meeting of the Health and Wellbeing Board held on 8th May, 2013, the Director of Public Health presented a report stating that consultation on the Rotherham Smokefree Charter had been carried out during a period of six weeks and included a range of individuals and groups including Elected Members, the Rotherham Health and Wellbeing Board, the Council's Health Select Commission and the Rotherham Partnership Board. Feedback from the consultation had been wholly positive, with all responders indicating a willingness to adopt the Charter's principles.

The Charter (a copy of which was included with the submitted report) would be formally launched in October, 2013, as part of the Stoptober campaign which this year included a focus on employers.

Resolved:- (1) That the Rotherham Smokefree Charter be adopted.

(2) That commissioned services be required to adopt the Rotherham Smokefree Charter.

(3) That the Rotherham Smokefree Charter be promoted through professional networks.

S35. CARING FOR OUR FUTURE: IMPLEMENTING SOCIAL CARE FUNDING REFORM

The Chairman referred to the submitted correspondence from the Department of Health (letter dated 18 July 2013) concerning the consultation on the implementation of care and support funding reform. The period of consultation would end on 25th October, 2013. Plans to help people better prepare for the cost of their future care needs had been published alongside details of how the new fairer funding system would protect homes and savings.

From 2016, the Government's reforms would deliver a new cap of £72,000 on eligible care costs, additional financial help for people of modest wealth with less than £118,000 in assets including their home and, from 2015, a scheme to prevent anyone having to sell their home in their lifetime.

Views were being sought on how the changes to the funding system should happen and be organised locally.

Resolved:- That the contents of the letter dated 18 July 2013, from the Department of Health, be noted.

S36. BETTER HEALTH OUTCOMES FOR CHILDREN AND YOUNG PEOPLE PLEDGE

The Chairman reported receipt of a letter dated 20th July, 2013, issued jointly by the Department of Health, the Local Government Association, the Royal College of Paediatrics and Child Health and by Public Health England. Contained within the letter was an invitation for Health and Wellbeing Boards to sign up to the "Better Health Outcomes for Children and Young People Pledge" which was part of the February 2013 system-wide response to the Children and Young People's Health Outcomes Forum Report (2012). A copy of the Pledge was appended to the letter.

It was hoped that signing up to the Pledge would demonstrate a commitment to giving children the best start in life. Local authorities and other organisations were being encouraged to share good practice so that learning could be promoted nationally.

During discussion, the Board requested the submission of a further report about the Disabled Children's Charter (previous Minutes of the Health and Wellbeing Board refer: Minute No. 86(1) of the meeting held on 8th May 2013 and Minute No. 2 of the meeting held on 12th June, 2013).

Resolved:- (1) That the contents of the letter dated 20th July, 2013, be noted.

(2) That the Rotherham Health and Wellbeing Board agrees to sign up to the "Better Health Outcomes for Children and Young People Pledge".

S37. PHARMACEUTICAL NEEDS ASSESSMENT

The Director of Public Health presented a report stating that the Health and Social Care Act 2012 conferred responsibility for developing and updating the Pharmaceutical Needs Assessment to Health and Wellbeing Boards. The report stated that the Pharmaceutical Needs Assessment was designed to inform commissioners about the services which were or could be provided by community pharmacies to meet local need. This assessment would contribute to the overall Joint Strategic Needs Assessment.

NHS England would rely upon the Pharmaceutical Needs Assessment when making decisions on market entry for applications to open new pharmacy and dispensing appliance contractor premises. Such decisions

were appealable and decisions made on appeal could be challenged through the Courts.

The Health and Wellbeing Board was required to issue a Pharmaceutical Needs Assessment for its area by 1st April, 2015 and to publish a revised assessment as soon as was reasonably practicable after identifying significant changes to the availability of pharmaceutical services since the publication, unless it was satisfied that making a revised assessment would be a disproportionate response to the changes. Health and Wellbeing Boards were required to publish a revised assessment within three years of publication of their first assessment. Rotherham would be working with neighbouring Boards to consider cross-border commissioning of Services and impact within the Pharmaceutical Needs Assessment.

Resolved:- (1) That the report be received and its contents noted.

(2) That the requirement for the publication of the Pharmaceutical Needs Assessment by 1st April, 2015 and the proposed timetable for delivery be noted.

S38. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health and Wellbeing Board be held on Wednesday, 16th October, 2013, commencing at 1.00 p.m., at the Town Hall, Rotherham.

ROTHERHAM BOROUGH COUNCIL
REPORT TO HEALTH AND WELLBEING BOARD

1	**Meeting:**	**Health and Wellbeing Board**
2	**Date:**	**16 October 2013**
3	**Title:**	**Health and Wellbeing Board Self-Assessment 2013**
4.	**Programme Area:**	

5. Summary

Health and Wellbeing Board members and official attendees were asked to complete a self-assessment questionnaire during September 2013, to consider the governance and operational arrangements of the Rotherham Board.

13 responses were received in total. This report provides a summary of the responses and outlines the key comments and issues raised. Members of the board are asked to consider and agree appropriate actions which may be required to address any issues and further develop the board's work programme.

6. Recommendations

For the Health and Wellbeing Board to:

- **Consider the responses and comments made by members of the Board**
- **Discuss and agree appropriate actions needed to address any issues raised**

7. Proposals and Details

Summary of responses

Theme 1: Governance

Q 1. Is the local Health and Wellbeing Board governance structure understood?

69% agreed that decision making routes and engagement processes were clear, and as a sub-committee of the council, political decision making was clear.

However, a number of respondents felt that:

- It may be understood by those involved in the main meetings and sub groups, but unsure whether it is understood by a wider audience, including front-line staff and managers
- The governance structure is clear but there have been times in the board when the interpretation of the structure and whether certain items should be brought to the board, has been debated
- The relationship with scrutiny is not clear
- There is a need for a clear governance structure document to be included in the terms of reference

Q 2. Do you understand clearly where the HWB fits in your organisation?

92% either strongly agreed or agreed, but there was a view that outside of the board, other stakeholders did not necessarily understand or appreciate its significance. Information sessions had been used in some areas and were suggested as a good way of raising awareness.

A number of respondents suggested it was unclear what the role of board was in decision making and where the board fit within certain service areas (mainly in relation to RMBC).

Q 3. Is the HWB having an impact and influencing decision-making for the council, CCG and other organisations?

77% either strongly agreed or agreed and felt the board's priorities were now becoming embedded across organisations and starting to influence thinking.

However, those who disagreed or were unsure, felt that it was too early to tell whether the board was having any impact on influencing and challenging decisions as yet. And it was felt that the 'board' itself may not be having impact as it felt too much like its component parts, rather than a single unit.

Operation of the board

Q 4. What do you think is the unique contribution of the HWB in Rotherham?

Comments included:

- A whole system view on issues and aiding integration between health and social care

- Networking & effective communication
- The HWB strategy provides a clear, comprehensive and accessible document that guides organisations
- Meaningful debate and challenge that can result in actual improvements for the residents of Rotherham
- The breadth of its membership and the effective collaborative working are particular strengths of the Rotherham board.
- Education not being included in the Rotherham board was seen as a negative.

Q 5. Is the HWB fulfilling its role in promoting integrated working across the health and wellbeing sector?

77% agreed and felt there had been a positive start, with the board agreeing to proposals that support integration. However, those who agreed also felt much more work was needed, there were good examples of integrated working in Rotherham, but no real drive being led by the board. It was felt that to improve integrated working, partners needed to start sharing commissioning and budget plans to ensure there was alignment on priorities and spending.

Those who disagreed or were unsure felt there was no "appetite" for integrated working from all partners, and that some partners were not actively contributing to the discussions. Some also felt there were no new ideas or innovation coming from the board.

Q 6. Is the HWB effecting change in Rotherham, through the delivery of the strategy?

85% agreed that the development of the strategy had been a good start, and the initial phase of sharing the work of the workstreams had been useful in embedding the principles. However, members were less aware of significant commissioning decisions having been made on this basis.

A number of respondents felt it was too early to tell, and the scale of the task was significant, but that there was real potential to effect change and this was a positive beginning.

Q 7. Is the HWB having an impact on reducing inequalities within Rotherham?

Only 38% agreed, with a number of respondents unsure of the impact, mainly because it was felt to be too early to tell, and there were many factors outside local control that was impacting on health inequalities, although the right local issues were being focused on.

Those who disagreed felt there had been positive work in key areas, but no evidence of significant changes being made as yet.

Q 8. Are the right issues coming to board?

There was roughly a 50/50 split with those who agreed or disagreed with this question (with 1 being unsure).

Those who agreed felt the right issues were going to the board, but there was a disappointing response to them, or there was insufficient time given to consideration of issues across too wide an agenda.

Those who disagreed felt that:

- Too many items included for information and single issue reports which are not strategic enough and do not fit into the board's priorities, some felt the frequency of meetings needed to be reviewed and possibly reduced to enable a more focused approach
- There was often a crowded agenda resulting in disengagement and a lack of opportunity for debate
- The agenda needed to be better focused on key priorities, The board needs to be able to drive forwards strategy, and have the opportunity to debate and challenge commissioning priorities (from all partners), how we do things differently, and how we spend and refocus activity
- Budgetary allocation and budgetary decisions and challenges, and the potential impact on partner agencies needs to be considered much more
- There has been a lack of children's issues at the board

Q 9. Do you feel comfortable that you are able to positively contribute to discussion?

100% either strongly agreed or agreed and felt that everyone had the ability to contribute at the meetings.

Q 10. Are HWB members fulfilling their role as set out in the terms of reference:

a) To attend meetings as required or send deputies where necessary

100% agreed

b) To act in the interests of the Rotherham population, leaving aside organisational, personal, or sector interests

62% strongly agreed or agreed

c) To fully and effectively communicate outcomes and key decisions of the HWB to their own organisations

69% strongly agreed or agreed

d) To contribute to the development of the joint strategic needs assessment and joint health and wellbeing strategy

92% agreed.

e) To deliver improvements in performance against measures within the Public Health, NHS and Adult Social Care outcomes frameworks

69% agreed.

Some felt the board was not there yet and there were still a number of gaps, including children's issues.

f) To act in a respectful, inclusive and open manner with all colleagues to encourage debate and challenge

92% agreed, although a view that some members attend but do not always contribute to discussions.

g) To read and digest any documents and information provided prior to meetings to ensure the board is not a forum for receipt of information

77% agreed, however the lack of debate suggested to some that papers were not always read.

h) To act as champions for the work of the HWB

85% strongly agreed or agreed.

General comments for Q10a – h:

- The strategic role and planning history of Rotherham's HWB has been exemplary
- There is clearly a collective commitment to effective working and to optimise the contribution of the board
- The board has not developed as it should have done over the last 12 months. Partners are too passive, both inside and outside meetings. It's easy to agree on issues, more difficult to implement.
- Change has been slow. Agenda items not coming from members.
- The chair is a champion of the work of the board

Q 11. Providers are not a statutory member of HWBs, and local authorities differ greatly on this subject; should providers be a part of the Rotherham HWB?

77% either strongly agreed or agreed that providers should be a part of the board, with the majority view that they should be non voting members. It was felt that providers are able to make significant contributions to the work of the board and are often key to the delivery of the board's Health and Wellbeing Strategy.

However, it was also felt there has not been active provider participation or challenge at the board, and providers were missing the opportunity to play an active role in shaping messages.

8. Contact

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ROTHERHAM BOROUGH COUNCIL
REPORT TO HEALTH AND WELLBEING BOARD

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**16th October, 2013**
3.	**Title:**	**Health and Wellbeing Strategy: Annual Progress**
4.	**Programme Area:**	

5. Summary

The Rotherham Health and Wellbeing Strategy is 12 months into implementation, therefore it is timely to present to the Health and Wellbeing Board an update on progress.

The 6 strategic outcomes of the strategy are being delivered through a set of workstreams, to date each workstream lead has attended a board meeting and presented their action plan and progress. This report builds on that to provide board members with an overview of where we are, what was agreed at the board in relation to the challenges, what actions have not happened, and what needs further consideration.

6. Recommendations

That the Health and Wellbeing Board:

- **Notes progress on each of the workstreams**
- **Reflects on what was agreed at the previous meetings in relation to each workstream, and**
- **Considers and commits to a set of actions required to enable workstream leads to deliver their outcomes**

7. Proposals and details

The 6 strategic priorities of the Health and Wellbeing Strategy are being delivered through a set of workstreams, each with an identified lead officer from the council, public health and NHS. Each workstream has a set of actions which are being delivered to bring about change in the way we do things; to improve the health and wellbeing of all Rotherham people. Over the previous 12 months, each lead has attended a board meeting to present their action plan, describe progress made against key actions, and pose a set of 'asks' for the Health and Wellbeing Board to support delivery of their workstream.

This report provides the Health and Wellbeing Board with an update on the progress of each of the workstreams, acts as a reminder as to what was agreed at the previous board meetings and outlines what actions have taken place as a result of the presentations. It asks that board members give consideration to any further actions that may be needed to enable the workstream leads to continue to achieve their outcomes.

Workstream 1: Prevention and Early Intervention

The Public Health team have embedded the prevention early intervention and healthy lifestyle theme into their work priorities in all settings. Over the year there has been a significant increase in the range of televisual activity promoting active prevention. Work needs to continue to develop this advice and support into a web based presence.T Significant achievments include obesity levels in children at reception being amongst the lowest in the UK and a significant reduction in obesity levels in year 6. Rotherham is ranked first by Public Health England in preventing premature deaths from coronary heart disease, lung cancer, liver cirrhosis and cancer compared to similar areas.

Further information on Public Health England mortality rankings can be found here:
http://longerlives.phe.org.uk/mortality-rankings#are/E08000018/par/E92000001

The Health and Wellbeing Board were asked:

- To commit to delivering on a shift towards prevention and early intervention in all agencies' plans

Progress on key actions

- Individual commissioning plans for the locally determined priorities (smoking, alcohol and obesity) being developed, ensuring they have a focus on prevention and early intervention
- An increase in the numbers of adults screened and offered brief intervention within primary care in relation to alcohol.
- The CCG's strategy is delivering more alternatives to hospital admission, treating people with the same needs more consistently and dealing with more problems by offering care at home or close to home.
- We remain one of the best performing Health Check programmes with 57% of people in Rotherham having completed a first Health Check since 2006. We will need a step change in performance to achieve the 20% annual target of eligible people screened.
- Every Contact Counts model has been agreed in principal at the previous HWBB

- The Suicide Review Group has been established this now reviews all suicide deaths and looks to support actions to improve mental health and wellbeing including the development of active bereavement support to reduce risk of suicide in family members.

Future Challenges

- Health profiles for the borough show an increase in child poverty and long term unemployment
- Ensuring that the MECC model is fully signed up to and all staff from all agencies understand its principles and deliver it effectively
- Developing Rotherham as a healthy ageing town

Workstream 2: Expectations and Aspirations

The multi-agency workstream group has been pro-active and worked together to achieve some of the early actions and priorities. The group has recently expanded to cover the Starting Well and Developing Well life stages of the HWB strategy and additional officers from CYPS now sit on the group. Work is currently taking place to map activity and projects with the CYPP and other work from across CYPS. This will be the key link into CYPS for the HWB activity.

The Health and Wellbeing Board were asked:

- To consider making a small amount of funding available for the work required of the workstream, this was not agreed by the board, but signposted to the LSP. This was never progressed, it was not a strategic request, appropriate to go to the LSP, funding so far has come from RMBC service budgets
- To sign up to a single pledge and set of standards

Progress on key actions

- A customer pledge has been developed and is currently going through the final agreement stage, which although was agreed by the board, has not progressed as well as hoped
- Complaints baselines have been collated
- Practitioner Information Sharing events are developing well, the second event is taking place on the 23rd October at New York Stadium (7 out of the 11 will have then had an event)
- A single set of customer standards was consulted on at the Rotherham Show in September

Future challenges

- All organisations signing up to a single set of customer standards will be difficult, some organisations have to work to their own “professional practice standards” and these take precedence over any others, it is felt that by having an additional set will be too confusing for staff. Further work is needed with board members for this to be understood and the message spread through their organisations that as a member of the board their organisation will be signing up.
- Developing a customer pledge, although agreed at board, is proving a challenge. A letter has been drafted to be sent to board members asking them to personally agree and gain ownership at their relevant boards and cascade this down to staff within their organisations

- Co-production of services is also a challenge, agreement has been made with Joyce Thacker that a pilot can take place as part of the CYPS Transformation Programme for the budget savings.

Workstream 3: Dependence to Independence

After a slow start, mainly around organisations identifying key participants, the workstream group is now established with good attendance. The group has an agreed work plan. Scope of the group has been key to ensuring focus and connections have been made to a number of other groups/workstreams in order to ensure consistency and avoid duplication. These include:

- Personalisation sub-group of Urgent Care Management Board
- Assistive Technology
- Shared Decision Making

The Health and Wellbeing Board were asked:

- To ensure all commissioners ensure commissioning strategies reflect and enable this outcome.
- That commissioners find ways to incentivise providers.
- To have a shared commitment to the risks and opportunities provided. A task group to develop a Positive Risk Taking Strategy is now in place.
- To ensure the culture change needed is embedded in all organisations.

Progress on key actions

- A formal review process to validate that this element of the Health and Wellbeing strategy is (a) embedded and (b) resulting in effective outcomes is being undertaken
- A workforce strategy group is established and a draft workforce strategy now in place
- Risk Strategy Task and Finish group is in place, terms of reference and action plan in place
- A shared decision making framework has been agreed
- Presentation made to Shaping the Future Provider Forum on 9 July 2013
- Presentation to future Crossroads and Age UK Annual General Meetings
- Voluntary sector representative on workstream group
- Joint Telehealth strategy agreed
- Progress made towards Personal Health Budgets – will be in place by 31 March 2014
- Intermediate Care – Netherfield Court staff were tasked with developing an approach that looked beyond people's physical rehabilitation to a more holistic approach. They have added a range of services and support to customers to sustain their sense of wellbeing.

Future challenges

- The area where less progress has been made is in priority three: *We will support and enable people to step up and set down through a range of statutory voluntary and community services, appropriate to their needs.*
- There is now a real sense of priority from the group in supporting commissioners to review strategies and ensure that independence is embedded at every opportunity. Providers were given an opportunity to examine how they might

meet this challenge at the Shaping the Future event. It was clear that this is an area where providers may need significant support to develop and The Workforce Strategy will support this.

Workstream 4: Healthy Lifestyles

Work progresses across the overarching outcome and three key priorities. Rotherham has seen external professional and media interest in its programmes which support health behaviour change and reduce mortality, and proposed changes to planning guidance which promote public health.

The Health and Wellbeing Board were asked:

- Commit to all staff doing e-learning on MECC and giving feedback on their performance in signposting and referring to services
- Introduce planning and licensing policy to restrict the sale of fast food or illegal tobacco products
- A concerted effort to address health behaviour in early years and schools – increasing health literacy and expectations for the best health

Progress on key actions

- Strong focus on delivery of health behaviour change activity across the Borough, but focussing specifically on deprived neighbourhoods (monitored in service performance and review) and attendance at community events by services to raise awareness and referrals
- Adoption of the Smokefree Charter and endorsement by elected members at the October H&WB followed by roll-out and promotion through voluntary and community organisations, businesses and educational establishments
- Commissioned training for agencies providing support to members of the public affected by Welfare Reform, with particular focus on mental health and support services
- Making Every Contact Count workshop held on 16 September (see Youtube
- http://www.youtube.com/watch?v=FVeUHT1s714) and forward plan in development
- Refresh of Rotherham Active Partnership and engagement of Elected Member as Chair
- Work has continued on the review of a number of behaviour change services and development of new service specifications prior to retendering (see details in Obesity and Smoking updates) or transfer of commissioning responsibility to the Local Authority
- Weight management providers are actively seeking to extend their reach into children's centres, schools and colleges
- Obesity and Tobacco Control programme activity was presented at the inaugural Public Health England Conference in Warwick in September

Future challenges

- Planned re-commissioning of services continues; an opportunity for the board to debate and challenge

Workstream 5: Long-term Conditions

The long-term conditions area of work incorporates 4 key workstreams;

- Risk profiling
- Integrated neighbourhood teams
- Self-Management
- Alternative Levels of Care

In Rotherham the Urgent Care Management Committee (UCMC) is responsible for overseeing implementation of the Long Term Conditions Programme. The Committee actively manages the programme to ensure agreed outcomes are met and that there is appropriate and effective engagement with patients and public.

The Health and Wellbeing Board were asked:

- To support development of personal health and social care budgets
- To support development of workforce development programmes on self-care
- To support the effective use of alternative levels of care
- To identify high-intensity users of health and social care users
- Deliver specialised psychological support services for people with LTCs
- To support development of a person held health and social care record

Progress on key actions

- Plans in place to extend personal health budgets to a wider cohort of patients during pilot period working in partnership with RMBC to 1 April 2014. Subgroup formed with agreed terms of reference
- Self-Management Strategy agreed by the Urgent Care Management Committee
- RCCG has developed a practitioner skills programme on self-management. Currently trying to identify GP Practices that are willing to utilise the programme
- Intermediate care facilities are fully operational and winter-ready. These provide an alternative level of care for people with long term conditions who cannot remain at home.
- The Joint Commissioning Team has identified high intensity users of social care services. Next step is to match these people against high uses of health services to establish whether there is a correlation
- Specialist psychological support is now being provided to all stroke survivors as part of the integrated stroke care pathway. Needs rolling out to other care pathways
- Winter Plan includes process for identifying those people with LTCs who are vulnerable

Future challenges

- Slow progress on the development of a person-held health and social care record
- Engagement of key partners on the development of a self-management workforce development programme

Workstream 6: Poverty

All 11 areas have coordinators in place and management arrangements agreed.

Each area has undertaken a local analysis and developed rich pictures and action plans, between 4 and 7 key priorities have been identified for each area.

Focussed activity is now taking place and coordinators are working corporately to ensure interagency commitment and progress on these priorities.

A Strategic group has been established to drive forward the deprived neighbourhoods agenda across all agencies and ensure appropriate support and resources are available to successfully deliver the programme.

The Health and Wellbeing Board were asked:

- To take back into all organisations and consider how this can shape service planning
- To consider collectively, how we can provide a better coordinated approach for the long-term unemployed
- To consider how to deliver a more coordinated approach to tackling poverty and develop a local multi-agency 'strategy' for Rotherham

Progress on key actions

- 9 of the 11 deprived neighbourhoods have identified health as a key priority area and actions to address this priority are embedded into neighbourhood plans where appropriate.
- Actions around the health priority include learning about healthy lifestyles, improving access to health support services and reducing alcohol consumption on the streets. An example of this work is the launch of Community Alcohol Partnerships in Dinnington, Dalton & Thrybergh and East Herringthorpe.
- Adult Skills has been identified as a key priority in 8 of the 11 deprived neighbourhoods therefore actions have been included in plans to address this priority. Traditional methods such as job clubs have been established in a number of neighbourhoods however innovative approaches are also being used such as a volunteering project aimed at developing volunteering opportunities within the Local Authority.
- A ½ day workshop is also being planned, aimed at service providers the objective of the workshop will be to determine what a strategy would look like to get those away from the labour market 'work ready'.
- Mapping exercises have been completed to ascertain the extent of poverty alleviation work currently being undertaken in Rotherham and also to capture national best practice in anti-poverty work. Discussions are currently underway to map out what a building resilience strategy would look like.
- There is limited capacity to achieve the priority around actively working with every household in deprived areas to maximise benefit take-up. A corporate review is being considered which will examine the appropriateness of welfare advice services. As well as the review, 2 temporary Money Advice Officers are being funded through the HRA and benefit/debt management sessions are being held in some of the deprived neighbourhoods.

Future challenges

- A presentation on 'Deprived Neighbourhoods' was made to the M3 Manager session on 24 September 2013. Managers were reminded that this is a corporate responsibility and all services should be proactive with ideas and plans and that this provides a real opportunity to do something differently.
- Key challenges relate to ensuring that the D.N. approach is embedded in the planning of all major services, and resources are being appropriately targeted.

- Workshops are being planned to ensure that we fully understand the sufficiency of services in relation to benefits advice and support and access to employment and training for those divorced from the labour market.

6. Contacts

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Workstream Leads:

Prevention and Early Intervention
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Expectations and Aspirations
Sue Wilson, RMBC

Dependence and Independence
Shona McFarlane, RMBC

Healthy Lifestyles
Joanna Saunders, RMBC Public Health

Long-term Conditions
Dominic Blaydon, NHS Rotherham

Poverty
Dave Richmond, RMBC

ROTHERHAM BOROUGH COUNCIL – REPORT TO
Health and Wellbeing Board

1.	**Meeting**	**Health and Wellbeing Board**
2.	**Date:**	**16 October 2013**
3.	**Title**	**JSNA Refresh**
4.	**Programme Area:**	**NAS**

5. Summary

The JSNA is a statutory duty of the Health and Wellbeing Board (HWBB) to evidence the needs of the citizens of the borough and is critical for the development of commissioning plans for health and social care services in Rotherham.

The JSNA was reviewed and revised at the end of 2011. A further refresh is now required and was agreed at the March 2013 Health and Wellbeing Board (HWBB).

This report sets out the progress to date to achieve the refresh by early 2014 as agreed. The refreshed JSNA must now include user's perspectives and a Directory of Assets, which includes community assets, physical infrastructure, networks and individuals and as such will meet the latest government guidance on JSNA content.

An online format is proposed for approval by the Health and Wellbeing Board; this is currently at the prototype stage. The website includes a break down of information across separate pages within the website and links to further information. The potential to register on the site to receive updates as new information is uploaded is being explored.

6. Recommendations

That the Health and Wellbeing Board:

6.1 Notes the progress made in achieving a refresh of the JSNA

6.2 Commits to all partners being full participants in the ongoing development of the JSNA

6.3 Approves the proposals set out at 7.2 of this report

6.4 Receives future report in early 2014 on the completion of the refresh

7. Introduction

7.1 Background

The Joint Strategic Needs Analysis (JSNA) is jointly developed across the council, the CCG and Healthwatch Rotherham, the document delivers a comprehensive analysis of health and wellbeing needs across the borough. The JSNA is a statutory duty of the Health and Wellbeing Board (HWBB) under the Health Act (2007). The JSNA is critical to understanding the demographics and the needs of citizens and is utilised by commissioners in the development of service specifications and by providers in developing their service offers to commissioners and the citizens of Rotherham.

The JSNA was reviewed and revised at the end of 2011. A further refresh is now required was agreed at the March 2013 Health and Wellbeing Board (HWBB).

This report sets out the progress to date to achieve the refresh by early 2014 as agreed. The refreshed document is now an online resource and this website will include a Directory of Assets, which takes account of community assets, physical infrastructure and individuals and as such will meet the latest government guidance on JSNA content. This content will include, but not be restricted to:

- Demography of Rotherham's population including details about specific communities of interest
- Wider determinants of health
- Lifestyle behaviours
- Ill health and disease
- Existing services and user satisfaction with them
- Profiles of places within Rotherham such as wards

7.2 Proposals

7.2.i. JSNA as an online resource

A website has been created with the unique address of Rotherham.gov.uk/jsna

This is accessible via the internet and intranet. It is proposed here that this format for the refreshed JSNA is approved by the HWBB. A presentation of a prototype will take place at the HWBB meeting.

The JSNA online is broken down into the following pages:

- Home – the welcome page providing links to a background to the JSNA process, a statement of the current priorities identified within the JHWBS, links to FAQs, downloads (including a content pack containing all the sections of the website for offline use), links to resources, feedback form and news

- People – provides information about the demography of Rotherham's population including numbers, age, gender, ethnicity, vital statistics and detailed information about specific communities of interest
- Quality of life – this section provides details about the wider determinants of health such as housing, poverty, education, and inequalities
- Healthy living – contains epidemiological information about lifestyles and behaviours such as tobacco use, alcohol misuse, substance misuse, teenage pregnancy, obesity (including eating habits and physical activity)
- Ill health - contains epidemiological information about the major causes of disease and infirmity in Rotherham
- Services – describes the performance of and user satisfaction with existing services
- Places – sub-district profiles and asset register

Within each section, there is an introductory page and links to pages covering specific issues

Each of these pages is populated with links to further research and information. The intention is not to have a 'busy' large website but to link off to the relevant information sites to give the best response to the requirements of the user. The JSNA is a live and dynamic resource for all agencies and providers and will be constantly updated.

The refresh has included work to extend the content of the JSNA and examples of new needs analysis are:

- Roma population needs analysis
- Women's health
- LGBT needs analysis
- Eye Health
- Domestic Abuse

In due course, there will be an opportunity for users to register with the site for updates as and when new information is published and content is refreshed. Sign-up for this will also provide a mechanism for monitoring and evaluation of the impact of the JSNA across the borough.

Should the format be approved, the work in progress for the refresh of the JSNA will continue to include the Directory of research/resources as agreed at the March 2013 HWBB. These analyses relate to that undertaken by statutory organisations including the council, health and the VCS or other stakeholders. Currently there is no one repository for these important documents. The benefits are that this would be a resource which all agencies should be mandated to contribute to; a resource that can be accessed by all agencies; enables an information and data gap analysis and reduces duplication.

An editing group will be set up to manage future development of the site and this will include membership from commissioners across health and social care in Rotherham. The purpose of the group is to filter proposed content to ensure it is appropriate for inclusion and fits within the general style of the website.

7.2.ii Asset based approach

This is the key area for new content development within the Rotherham JSNA and is also the part that will take the longest time to develop. The development of an asset register is being piloted in Canklow and in due course this will be extended across the borough. The pace at which this will happen is determined by resources that are available. Assets include individual people, community resources, groups and physical buildings.

7.2.iii Consultation

Should the format for the online JSNA be agreed by HWBB consultation will be commenced with regard to the content with all key stakeholders in particular identified service experts. This work is proposed to take place in November and December with the completion of the refresh and the website in early 2014. A report will be presented to the HWBB at this time demonstrating the finalised site.

8. Finance

There are no financial implications arising from this report

9. Risks and Uncertainties

That should the JSNA not be refreshed the relevance of the document will reduce and will impact on ensuring that commissioning has the most up to date needs analysis, also the requirement of the Health Act (2007) will not be met.

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

That should partners not fully participate or provide capacity of service experts then the JSNA will not be of the required standard.

10. Policy and Performance Agenda Implications

The JSNA is a statutory responsibility of the Health and Wellbeing Board

12. Background Papers and Consultation

Health Act 2007
Health and Wellbeing Strategy 2012
JSNA 2011
JSNA refresh Health and Wellbeing Board report March 2013

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ROTHERHAM BOROUGH COUNCIL –

REPORT HEALTH AND WELLBEING BOARD

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**16th October, 2013**
3.	**Title:**	**Performance Management Framework**
4.	**Programme Area:**	**Public Health**

5. Summary

This paper introduces the second performance report to the Health and Wellbeing Board.

6. Recommendations

Members of the Board are invited to note progress.

7. Proposals and details

This is the second performance report to the Health and Wellbeing Board about each of the six priority measures that the Board determined were key to the delivery of the Joint Health and Wellbeing Strategy. The data presented represents the most recently available and published metrics.

Where a metric has a significant lead-time before its publication and/or effect being observed, intermediate proxy measures are reported if possible every Quarter. In some instances the publication of refreshed metrics is less than Quarterly or will require the development of new data collection. The Board had previously indicated that it wanted to minimise new data collection.

Accountable Officers have been asked to provide metrics where these are available and details for each measure are provided below.

8. Finance

No new data collection has been instituted to complete the report. The report uses existing data collection systems.

9. Risks and uncertainties

Data quality and reporting timelines are an issue for some of the metrics and this will result in some metrics relating to a specific period changing in subsequent reports.

10. Policy and Performance Agenda Implications

Making Every Contact Count (MECC)

The MECC workshop took place in mid-September and was well attended. The event stimulated a lot of debate and partners now have to reflect on how to implement this approach in their services. The Director of Public Health will meet with Public Sector Human Resource Directors to embed MECC in training and development for staff.

Priority 1 Smoking - Goal 1 Preventing Initiative of Tobacco use amongst children and young people

<u>Percentage of smoking at time of delivery</u>

No new data has been published nationally.

<u>Smoking Prevalence</u>

2012-13 outturn is expected later in 2013.

Priority 2 Alcohol - Goal 1 - Preventing harm to children and young people from alcohol consumption

Development of Community Alcohol Partnerships (CAPs) across the borough

Number of CAPs remains at 2. Both have been launched and a detailed update will be presented to HWBB in November.

Goal 2 - Reducing Harm to Adults from alcohol consumption

Alcohol related admissions

The team to deliver this local data has now been selected with work to commence in October/November 2013. Figures will be reported to HWBB in the Quarter 3 report.

FPN Waivers which result in attendance at binge drinking course

Quarter 1 2013-14 figures significantly down on 2012-13 levels.

Brief interventions

Number of brief interventions in general practice – Q1 2013-14 = 6,846. This is a significant increase (over 2012-13 levels), the contract specifications changed from 1/4/2013 to 'any' patient aged 18 or over (from specified diagnosis group).

Brief interventions in hospital settings will start being recorded from September 2013 and the first and that months figure will be reported in December 2013.

Priority 3 Obesity – Goal 1 Preventing obesity in children and young people

National Child Measurement Programme data

Overweight and obesity in Reception/Year 6 data is published annually. The 2012-13 outturn figures are expected in December 2013.

The National Local Authority Health Profile published by NHS England places Rotherham as one of the best performing Local Authority areas for reduction in childhood obesity in reception and year 6.

Weight Management Framework Activity

Activity figures presented are enrolments and completions. The latter is a subset of the former and the duration of the treatment may go beyond the reporting cut-off; therefore, the 2012-13 outturn is liable to change when next reported.

Applications for fast food outlets in proximity to schools or in any of the 11 areas

Work is still required to develop this metric as the definition of deprived area has not been routinely used by the planning department RMBC.

Development of fast food outlets is permitted within existing centres (eg Town, district or local) within 400m of schools and there is no prohibition to development within deprived areas.

RMBC Planning would welcome a view from the Board on their stance towards:

- Developing policy to prohibit approval of new fast food outlets within 400m of a school.
- Developing policy to prohibit approval of new fast food outlets within the defined deprived areas.
- Reporting of the actual numbers of approvals in each of the above (including ones that are within policy) so that the Board can develop full situational awareness.

Goal 2 – Reducing harm to adults from obesity

Healthy eating prevalence is ranked red. There is no new data, this is from the 2006-2008 household survey and refers to Rotherham's ranking in the 2013 Local Authority Health Profiles.

Increased prevalence of diagnosed diabetes for Rotherham is also ranked red in the National Local Authority Health Profile. The Rotherham rate is 6.3% compared to the national rate of 5.8% which ranks Rotherham in the lowest quartile of Local Authorities. This reflects high levels of obesity within the community. This indicator can also be viewed positively indicating general practice is identifying people with diabetes.

Priority 4 NEET

<u>RMBC Corporate Responsibility LAC/CL Young People (Academic Year 12 -14) who are Not in Employment, Education or Training</u>

The make-up of this cohort comprises 35 individual young people, of whom 25 (71%) are aged 18 and 19. This age group are able to claim benefit in their own right and live independently and therefore are an extremely hard group to engage in any form of learning. We, as a service, are endeavouring to work more closely with Job Centre Plus to provide a more coherent approach to this group.

The remaining 10, (29%), young people are all of Y12 academic year, with 2 being resident outside of Rotherham and 1 refusing any offer of learning.

The other 7 young people have all recently left learning and are in the transition period. We are hopeful that they will re-engage in learning in September when the new academic year begins.

<u>The number of properties receiving energy efficiency measures through Community Energy Saving programme (CESP)</u>

The programmed work is now scheduled to be completed in Q1 of 2014-15 and the total number of houses this will assist is set to exceed 1,285.

Priority 5 Fuel Poverty

The number of properties receiving energy efficiency measures through the green deal is not yet available.

Priority 6 Dementia – Earlier Detection of Dementia in order to provide effective care

Dementia

Dementia specific care package assessment metrics (number, timeliness and reviews) are not currently available but are being considered for development in order to report from 2014-15.

Dementia raising has become a mandated part of the NHS Health Checks from April 2013. The read codes were made available over the summer of 2013 and practices are starting to report on these codes. This applies only to 65 year olds and over receiving Health Checks.

11. Background Papers and Consultation

Keywords: Performance Report, Health and Wellbeing Strategy

Officer: Dr Nagpal Hoysal, Consultant in Public Health Medicine

Director: Dr John Radford, Director of Public Health

Health and Wellbeing Strategy Reporting Framework

Priority 1 - Smoking

High level aspiration - Rotherham: a smoke free town

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

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Key Measure	Percentage smoking at delivery 20.1% (12/13 Qtr 2) to below the national average by 2015	20.8%	19.2%	19.1%	A	Update due late 2013		18.8%	A	17.9%	16.7%	Alison Iliff
	Percentage of young people (Year 7 & 10) smoking (CYPS lifestyle survey) (regular smokers)	2%/14%	2%/14%	No target		2012	2%/14%	See notes		1.9%/13.5%	1.8%/13%	Alison Iliff

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Quarterly Proxy Measure	Participation in Responsible Retailer Scheme in CAP areas	New Measure for 2013-14				01-04-13 to 01-07-13	29%	20%	G	50%	75%	Alan Pogorzelec
	Number of enforcement interventions taken in relation to the sale of tobacco to children	New Measure for 2013-14				01-04-13 to 01-07-13	0	0	G	5	5	Alan Pogorzelec
	Schools with anti-tobacco policies approved by Head	New Measure for 2013-14				Q2 13/14	50.80%	40%	G	50%	100%	Alison Iliff

Goal 2 - Reducing Harm to Adults from tobacco consumption

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Key Measure	Percentage of adults 18 and over smoking (integrated household survey)	23.3%	N/A	N/A	N/A	2011-12	23.3%	23%	A	22%	22%	Alison Iliff

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Quarterly Proxy Measure	Percentage of key public sector staff undertaking Making Every Contact Counts									75%	100%	
	Participation in Responsible Retailer Scheme in CAP areas	New Measure for 2013-14				01-04-13 to 01-07-13	29%	20%	G	50%	75%	Alan Pogorzelec
	Number of enforcement interventions taken in relation to illicit and / or counterfeit tobacco	New Measure for 2013-14				01-04-13 to 01-07-13	3	2	G	5	5	Alan Pogorzelec

Priority 1 - Smoking

Goal 1 **KM 1 (smoking at delivery)**

Baseline data may be affected by high percentage where mother's smoking status not known (quarters Q1 and Q2 2011/12)

Targets adjusted to match national ambition decrease of 21.7% between 2009/10 and 2014/15 (to be achieved between Q3 2010/11 and 2014/15) (31/05/13)(AI)

Quarterly position shows high variation, so suggest notice is predominently taken of outturn figure, which will show year to date or, at Q4, the whole year's picture.

Smoking at delivery data for Q1 12/13 not available "due to operational reasons". Data to be included in Q2 report published 27/11/13.

KM 2 (young people smoking)

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

When information issued about data collection mechanism for PHOF indicator "Smoking at age 15", this KM will be amended.

QPM 3 (anti-tobacco policies)

New measure for 2013-14. Whole school review audit used to establish baseline of schools with policies. As at quarter 2 2013-14 this was 51%.

Denominator = 120 schools (24/06/13). Denominator figure = 120 schools (Primary – 95 LA and 3 Academies, Special 6 LA, Secondary 11LA and 5 Academies). (AI)

Goal 2 **KM 1 (adults smoking)**

11-12 and current position represent 12 months April 11-Mar 12. Survey is collected quarterly. Publication is erratic - no data published since August 2012.

QPM 1 (making every contact count)

Under development.

Goal 1 - QPM 3	**13/14**			**14/15**			
Trajectory for schools with no-smoking policies:	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	40%	45%	50%	65%	72%	90%	100%

Priority 2 - Alcohol

High level aspiration - Rotherham: a place where people drink responsibly

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

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Key Measure	Percentage of Year 10s reporting that they drink alcohol (CYPS Lifestyle Survey) (regular drinkers)	30%	12%							0%	0%	Kay Denton

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Quarterly Proxy Measure	Percentage of key public sector staff undertaking Making Every Contact Counts											
	Community Alcohol Partnerships across the Borough	New Measure for 2013-14					2 launched	No target	A	No target	11	Mel Howard
	Participation of retailers in Responsible Retailer scheme in CAP areas	New Measure for 2013-14				01-04-13 to 01-07-13	29%	20%	G	50%	75%	Alan Pogorzelec

Goal 2 - Reducing Harm to Adults from alcohol consumption

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Key Measure	Reduce hospital admissions due to alcohol related illness		1,069	No target		Q1 13/14	252	214	R	20% less	TBC	Anne Charlesworth

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Quarterly Proxy Measure	Percentage of key public sector staff undertaking Making Every Contact Counts											
	Community Alcohol Partnerships across the Borough	New Measure for 2013-14					2	No target	A	No target	11	Mel Howard
	Participation of retailers in Responsible Retailer scheme in CAP areas	New Measure for 2013-14				01-04-13 to 01-07-13	29%	20%	G	50%	75%	Alan Pogorzelec
	Number of FPN waivers which result in attendance at binge drinking course		86	No target		Q1 13/14	9	No target	R			
	Number of brief interventions in general practice		8,749	No target		Q1 13/14	6,846	3,000	G	12,000	16,000	Anne Charlesworth
	Number of brief interventions in community settings (Lifeline plus Health Trainer statistics)	2,673	3,192	No target		Q1 13/14	700	1,000	A	4,000	8,000	Anne Charlesworth
	Number of brief interventions in hospital settings											Anne Charlesworth

Priority 2 - Alcohol

Goal 1 **KM 1 (Year 10s reporting drinking)**

Represents those reporting drinking regularly. Baseline represents 2011 Survey data and 2012-13 represents 2012 Survey data. Survey is conducted and reported annually.

QPM 2 (community alcohol partnerships)

Both launched and update paper going to HWBB subject to agreement by NAS SLT.

Goal 2 **KM 1 (hospital admissions due to drinking)**

Data represents number of admissions to Rotherham Foundation Trust by Rotherham CCG patients.

The team to deliver this piece of work has now been selected, work will begin in October/November. Figures will be reported to HWBB in quarter 3 data.

QPM2 (community alcohol partnerships)

(see Goal 1 QPM2)

QPM 4 (Fixed Penalty Notice waivers)

This is a significant decrease. SYP to be notified and report requested from them

QPM 5 (brief interventions in general practice)

This is a significant increase, the contract specifications changed from 1/4/2013 to 'any' patient aged 18 or over (from specified diagnosis group).

QPM 6 (brief interventions in community settings)

The new service that will deliver increased community interventions does not start their contract until 01/11/13.

Community brief interventions includes Lifeline and Health Trainer provision - in 2012-13 this was 1952 and 1240 respectively, in 2013/14 Q1 this was 406 and 294.

QPM 7 (brief interventions in hospital settings)

The team to deliver this piece of work has now been selected, work will begin in October/November. Figures will be reported to HWBB in quarter 3 data.

After consideration, it was decided that Best Bar None would not be progressed as responsible retailer should do the same job without the cost that is incurred.

Priority 3 - Obesity

High level aspiration - Rotherham: a place where being a healthy weight is the norm

Goal 1 - Preventing obesity in children and young people

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Key Measure	Percentage of overweight and obese children in Reception	16.1%	Update due Dec 2013			2013-14 due Dec 2014			A	15%	12%	Joanna Saunders
Key Measure	Percentage of overweight and obese children in Year 6	33.0%	Update due Dec 2013			2013-14 due Dec 2014			A	30%	25%	Joanna Saunders

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Quarterly Proxy Measure	Percentage of key public sector staff undertaking Making Every Contact Counts											
Quarterly Proxy Measure	Referrals of children to Healthy Weight Framework interventions	313	286	No target		Q4 2012-13	83	No target	A			Joanna Saunders
Quarterly Proxy Measure	Completed Healthy Weight Framework interventions by children	144	119	No target		Q4 2012-13	44	No target	A			Joanna Saunders
Quarterly Proxy Measure	Percentage of applications for fast food outlets approved that are within close proximity to a school or in a deprived area (in accordance with policy)											Helen Sleigh

Goal 2 - Reducing harm to adults from obesity

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Key Measure	Healthy eating prevalence (Integrated Household Survey/ Active People Survey)	21.3%		No target		2011-12	0	28.70%	R			Joanna Saunders
Key Measure	Increased prevalence of diagnosed diabetes	6.2%	Update due end Oct 2013			Jan 2013	6.33%	No target	R			Dominic Blaydon

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Quarterly Proxy Measure	Percentage of key public sector staff undertaking Making Every Contact Counts											
Quarterly Proxy Measure	Referrals of adults to Healthy Weight Framework interventions	2884	2253	No target		Q4 2012-13	624	No target	A			Joanna Saunders
Quarterly Proxy Measure	Completed Healthy Weight Framework interventions by adults	1414	1067	No target		Q4 2012-13	311	No target	A			Joanna Saunders
Quarterly Proxy Measure	Increased greenspace utilisation and access	13.7%	Update due late 2013			Update due late 2014			A	15%	16%	Chris Siddall

Priority 3 - Obesity

Goal 1 **KM1 &2 (overweight and obese children)**

Data published annually in December.

QPM 2/QPM 3 (Healthy Weight Framework interventions)

Activity figures presented are enrolments and completions. The latter is a subset of the former and the duration of the treatment may go beyond the reporting cut-off.

The 2012-13 Outturn and Q4 2013-14 represent revised data since the July Board submission. Provisonal data for Q1 2013-14 is as follows:

Goal 1 (children): Referrals 110, Completed 38. Goal 2 (adults): Referrals 590, Completed 182.

QPM 4 (fast food outlets)

Planning policy relating to this is currently out for consultation

Goal 2 **KM 1 (healthy eating)**

Baseline represents modelled data for 2006-2008 based on Health Survey for England data. Indicator being developed nationally for Public Health Outcomes Framework on which target can be set

KM 2 (diagnosed diabetes)

Prevalence data published annually.

QPM 2/QPM 3 (Healthy Weight Framework interventions)

(See Goal 1 QPM2/QPM 3)

QPM 3 - Current Postion represents Q4 2012-13. This is affected by a high percentage of missing data for completions.

QPM 4 (greenspace utilisation)

Baseline represents survey period March 2009 - February 2012. Indicator is based on annual survey data

Priority 4 - NEET

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

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

Key Measure	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
	Percentage of Academic Age 16 - 18 Young People who are NEET	7.6%	7.4%	7.1%	A	August 2013	7.6%	7.4%	A	7.1%	7.0%	Collette Bailey

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

Key Measure	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
	Percentage of Academic Age 16 - 18 Young People whose current situation is Not Known	4.8%	3.9%	5.0%	G	August 2013	5.5%	5.0%	A	5.0%	5.0%	Collette Bailey

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

Goal 2 - Reducing harm to adults from obesity

Key Measure	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
	Percentage of Academic Year 12 participating	89.0%	N/A	N/A	N/A	August 2013	89.5%	80.0%	G	92.0%	95.0%	Collette Bailey
	Percentage of Academic Year 13 participating	80.0%	N/A	N/A	N/A	August 2013	80.5%	70.0%	G	82.0%	85.0%	Collette Bailey

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

Key Measure	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
	Percentage of RMBC Corporate Responsibility LAC/CL Young People (Academic Year 12 -14) who are NEET	28.0%	25.3%	N/A	N/A	July-August 2013	33.4%	24.0%	R	24.0%	20.0%	Collette Bailey

Priority 4 - NEET

Goal 1/2 KM1 (NEET/ Young people whose situation is not known)

2011-12 Baseline is the 2011/12 reported data and Outturn 2012-13 is the 2012 reported data (Nov-Jan averages)(from DfE)

Goal 3 KM 1&2 (academic year 12/13 participating)

Baseline taken from the Annual Activity Survey for 2012.

August and September are a major transition time (start of new academic year) so targets around learning and participation are made lower for this period.

Goal 4 KM 1 (RMBC corporate responsibility NEET)

The make-up of this cohort comprises 35 individual young people, of whom 25 (71%) are aged 18 and 19. This age group are able to claim benefit in their own right and live independently and therefore are an extremely hard group to engage in any form of learning. We, as a service, are endeavouring to work more closely with Job Centre Plus to provide a more coherent approach to this group.

The remaining 10, (29%), young people are all of Y12 academic year, with 2 being resident outside of Rotherham and 1 refusing any offer of learning.

The other 7 young people have all recently left learning and are in the transition period. We are hopeful that they will re-engage in learning in September when the new academic year begins.

NB - DoE changed the count for NEET as at April 2013 - currency will no longer apply and therefore the adjustment set to NEET % has been amended.

This is projected to inflate the NEET % by approximately 1%.

Participation is defined as

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

Priority 5 - Fuel Poverty

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

Goal 1 - Reducing the effects of Fuel Poverty

	Indicator	2010 Baseline	2011-12			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Key Measure	Percentage of the population needing to spend more than 10% of household income to achieve adequate levels of warmth in the home and meet their other energy needs.	18.2%	Data Released in 2014			01/01/2011-31/12/2011	16.7%	17.2%	G			Catherine Homer

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Quarterly Proxy Measure	The number of properties receiving energy efficiency measures through Community Energy Saving Programme (CESP)		1,049	1,285	R	Q1 13/14	0	0	G	200	CESP superceded by GD/ECO	
	The number of properties receiving energy efficiency measures through Carbon Emissions Reduction Target (CERT)		1%	1%	G	CERT schemes have come to an end (31st March 2013) and have been superseded by Green Deal / ECO						
	The number of properties receiving energy efficiency measures through Dept of Energy & Climate Change (DECC)	To be delivered July 2013 onwards				Q1 13/14	0	0	G	320		
	The number of properties receiving energy efficiency measures through Green Deal / Energy Company Obligation (ECO)	1st year of collection anticipated in 4th quarter 2013-14				Apr-Sep 2013	50*					

Priority 5 - Fuel Poverty

Goal 1 **KM 1 (spending more than 10% of household income to keep home warm)**

Current Position represents 2011 calendar year. Baseline represents 2010 calendar year.

QPM 1 (energy efficient measures through CESP)

Is currently achieving the quarterly target. The pot of money initially secured to complete the DECC works in 2012-13 has now been allowed to roll over into 2013-14.

The programmed work is now scheduled to be completed in Q1 of next year and the total number of houses this will assist is set to exceed 1,285 .

QPM 4 (energy efficient measures through Green Deal/ECO)

Figure of 50 represents council properties. Private figure unknown. However, HHCRO referrals = 20 to private.

*Further update due before submission date.

Priority 6 - Dementia

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

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

	Indicator	2011 Baseline	2012-13 Outturn	2012-13 Target	2012-13 RAG	Current Position Period	Current Position Outturn	Current Position Target	Current Position RAG	2013-14 Target	2014-15 Target	Accountable Lead
Key Measure	QOF identified prevalence as a % of calculated 'true prevalence'	59.50%				Q4 2012-13?	59.50%			64.99%	69.99%	Kate Tufnell

	Indicator	2011-12 Baseline	2012-13 Outturn	2012-13 Target	2012-13 RAG	Current Position Period	Current Position Outturn	Current Position Target	Current Position RAG	2013-14 Target	2014-15 Target	Accountable Lead
Quarterly Proxy Measure	Number of referrals to memory clinic			550		Q4 2012-13?	192	137	G			Kate Tufnell
	Number of assessments undertaken in memory clinic			500		Q4 2012-13?	153	125	G			Kate Tufnell
	Number of new plans of care in place for people with dementia	new - data not available										Kate Tufnell
	% of patients seen within 18 weeks (Referral to Treatment - Memory Clinic Pathway)			95%			67%		A	95%	95%	Kate Tufnell
	Timeliness of social care assessment within 28 days (all adults)	83.2%	93.7%	93%	G	1 Apr 13 to 17 Jun 13	92.6%	92%	G	94%	94%	Michaela Cox
	Care package assessments responded within 28 days for people with dementia											
	Acceptable waiting times for care packages within 28 days	97.5%	97.5%	97.5%	G	1 Apr 13 to 17 Jun 13	93.3%	92.5%	G	97.5%	97.5%	Michaela Cox
	Annual reviews of care package assessments for people with dementia											
	Percentage of clients receiving a review	93.0%	93.1%	93%	G	1 Apr 13 to 17 Jun 13	22.6%	25%	G	93%	93%	Michaela Cox
	A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life	Proposed indicator										Kate Tufnell

General guide to column headings:
2011-12 Baseline:- 2011-12 Outturn
2012-13: Outturn for full year 2012-13 or year end position as applicable.
Current position: Year To Date or latest figure as applicable.
2013-14 Target:- Will be the 2013-14 Target
2014-15 Target:- Will be the 2014-15 Target

For a number of indicators, no 2013-14 target has been set and targets have been proposed for 2013 onwards
For new indicators, we are seeking Board support and commitment to data collection
A number of local measures are also in the National Outcomes Frameworks - achievement of these will be key to getting the Health Premium Incentive and meeting NHS and DH targets
There are limitations on the availability of data for several indicators, including some key local measures that are also in the Public Health Outcomes Framework.

ROTHERHAM BOROUGH COUNCIL - REPORT TO MEMBERS

1	**Meeting:**	**Health and Wellbeing Board**
2	**Date:**	**16th October, 2013**
3	**Title:**	**Social Care Support Grant 2013/14**
4	**Directorate:**	**Neighbourhood and Adult Services**

5. Summary

This report provides information on the transfer to Rotherham MBC of the Social Care Support Grant. It provides details of the local allocation and sets out recommendations on how the allocation will be spent. For the 2013/14 financial year, NHS England will transfer £4.81 million to Rotherham MBC. This includes an increase of £1.3m from 2012/13 levels @ £3.48 million.

Payment of the Social Care Support Grant is to be made via an agreement under Section 256 of the 2006 NHS Act. The agreement will be administered by the NHS England Area Team (not the Rotherham Clinical Commissioning Group). Funding from NHS England will only pass over to local authorities once the Section 256 agreement has been signed by both parties.

Social Care Support Grant must be used to support adult social care services that deliver a health benefit. However, beyond this broad condition, NHS England wants to provide flexibility for local areas to determine how this investment in social care services is best used.

Guidance relating to the Social Care Support Grant requires NHS England to ensure that the local authority agrees with its local health partners on how the funding is best used. Health and Wellbeing Boards will be the forum for discussions between the Area Teams, CCGs and local authorities on how the funding should be spent.
In line with their responsibilities under the Health and Social Care Act, NHS England will make it a condition of the transfer that RMBC and RCCG have regard to the Joint Strategic Needs Assessment for their local population. NHS England will also make it a condition of the transfer that RMBC demonstrate show the funding transfer will make a positive difference to service users.

6. Recommendations

That the Health and Wellbeing Board:

- **Agree to the programme of expenditure set out in Section 8**
- **Agree to the development of a light-touch performance framework for the grant**

7. Proposals and details

It is proposed that the Social care Support Grant be used to support existing services and transformation programmes, where such services or programmes are of benefit to the wider health and care system. The funding will support new services or transformation programmes, again where joint benefit with the health system and positive outcomes for service users have been identified.

NHS England will ensure that the CCGs and local authority take a joint report to the Health and Wellbeing Board to agree what the funding will be used for, any measurable outcomes and the agreed monitoring arrangements in each local authority area.

As part of the S256 agreement, NHS England will ensure that it has access to timely information (via Health & Wellbeing Boards) on how the funding is being used locally against the overall programme of adult social care expenditure, in order to assure itself that the conditions for each funding transfer are being met.

It is proposed that funding focuses on the following key areas.

- Additional short term residential care places, or respite and intermediate care.
- Increased capacity for home care support, investment in equipment, adaptations and telecare.
- Investment in crisis response teams and preventative services to avoid hospital admission.
- Further investment in reablement services, to help people regain their independence

8. Finance

Appendix 1 sets out the proposed spending programme for 2013/14.

9 Risks and Uncertainties

The key risks associated with the Social care Support Grant funding are;

- That the funding is subject to annual review so could reduce in future years
- Difficulties in measuring health outcomes
- Relationship between Social care Support Grant and the new Integration Fund

10 Policy and Performance Agenda Implications

There is no requirement to develop a performance framework for this funding. However national guidance does stipulate that investment should focus on health outcomes. It is proposed that the Health and Well Being Board endorse the development of a light-touch performance management framework for this grant, overseen by the Adult Partnership Board

11 Background Papers and Consultation

Gateway Reference: 00186 - Funding Transfer from NHS England to social care – 2013/14

12 Contacts

Author: Dominic Blaydon
Title: Head of Long Term Conditions and Urgent Care
Tel: 01709 302 131

Appendix 1: Proposed Spending Programme – Social Care Support Grant

Action	Impact	Allocation (£000)
Existing Funding		
Interim Care beds	For patients deemed medically stable and fit for discharge but for whom intermediate care is not appropriate	100
Community based support - home care/re enablement	Same day discharge at weekends. Provide SS support to restart services to enable supported discharge on Saturdays and Sundays	500
Therapy staff x 2	To support increased use of intermediate care beds	100
Social workers in A & E	Provision of social work presence in A & E/hospital to minimise admissions and expedite discharge	180
Expand fast response service	Provision of increased resources to extend the rapid response from 2 to 5 days	220
2 SSO reviewing officers to fast track assessments during re enablement	Provide early reviews of care effectiveness to allow early decision to increase care package	98
Fast response Nursing team	To assess patients who need additional support to remain at or return home. The service co-ordinates are for patients for up to 72 hours and is delivered by trained nurses and support workers	60
Home improvement agency (HIA)	Preventative service related to falls etc to reduce hospital admissions	60
New Investments		
Provision of residential short term or respite care for older people to avoid hospital admission or speed up discharge.	To reduce the need for admission to hospital or long term residential care during winter periods	115

Action	Impact	Allocation (£000)
Learning Disabilities independent sector residential care	Provision of short term or respite care for people with learning disabilities to reduce the need for admission to hospital or long term residential care.	582
EMI Day Care	Day care provision for EMI clients to assist in maintaining independence and reduce the need for long term care	100
Social Workers in GP Practices	Social workers work within GP Practices to identify the needs of clients who are at most risk of hospital admission and co-ordinate social care input with the community health service to ensure more effective and efficient services	100
Mental Health - To promote early discharge from hospital into specialist rehabilitative care to enable access to community based services.	Additional funding to meet the increase in early discharge from hospital and the growth in proportion of service users with more complex needs. There is a statutory duty to provide secure placements, no lower cost options available.	150
PDSI -Community support including Direct Payments/ Personal Budgets -to support enablement for individuals	Target to increase the number of people helped to live at home. Promotes independence and provides more personalised services.	220
To provide additional home care/supported living through Direct payments/Self Directed Support.	Investment into Respite and Community based care (Direct Payments) maintaining independence.	734
Older People - Pressures on Domiciliary Care Budgets	Anticipated increase in population over 85+ over the next three years (source ONS). Statutory requirement to increase intensive home care packages. Better use of resources, underpins the personalisation agenda and supports social inclusion.	380
Learning Disabilities - increase in demand for Direct Payments	To meet year on year increase demand for direct payments. Promotes personalisation agenda and social inclusion by maintaining independence.	314
Mental Health - Increased Drug and Alcohol Community based rehabilitation services	Additional funding to meet the Safer Rotherham Drug Action Plan target to increase the number of assessments and services over the next three	59

Action	Impact	Allocation (£000)
	years.	
Transformational		
Development of specialist supported living scheme for people with a learning disability	Development of new scheme to meet Valuing People Targets and both increased demand and customer expectation. A more cost effective alternative to long term care.	46
Develop community based dementia care service	Provision of community based support to provide carer breaks. Avoids breakdown of carer support and resultant admission to hospital	100
Investment into specialist community based support for people with a learning disability	Alternative investment to enable people with higher dependency needs to be supported in the community. Provides breaks for elderly carers and avoids unnecessary admissions into residential care and hospital	37
Further Investment into Intermediate Care	Prevention and early intervention to avoid unnecessary admissions or readmissions to hospital care. Also avoids need for high levels of home based social care	560
Total		**4,815**

ROTHERHAM BOROUGH COUNCIL – REPORT

1.	**Meeting:**	**Health and Well Being Board**
2.	**Date:**	**16th October 2013**
3.	**Title:**	**Rotherham Local Safeguarding Children Board Annual Report 2012-13**
4.	**Directorate:**	**Rotherham Local Safeguarding Children Board**

5. Summary

Since April 2010, Local Safeguarding Children Boards (LSCBs) have been required to publish an annual report on the effectiveness of safeguarding children in the local area. This report introduces the 2012-13 Rotherham LSCB Annual Report and offers background information to it.

6. Recommendations

- **That the Health and Well Being Board receive this report as an introduction to the 2012-13 Rotherham LSCB Annual Report (separate report).**

7. Proposals and Details

The requirement for LSCBs to produce and publish and annual report on the effectiveness of safeguarding children in the local area is mandated in the Children Act 2004 (S14a) as amended by the Apprenticeships, Skills, Children and Learning Act 2009.

Under the recently revised statutory guidance, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* (HM Government March 2013), the annual report should:

1. provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period

2. be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and wellbeing board.

3. list the contributions made to the LSCB by partner agencies and details of what the LSCB has spent, including on Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training. All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be strong and effective. Members should share the financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on a small number of partner agencies.

Key priorities for Rotherham LSCB - highlighted in the 2012-13 Annual Report, being progressed through 2013-16 RLSCB Business Plan and the work of its Sub Groups

These include:

- A multi-agency local protocol (framework) for the assessment of children
- A performance and quality framework to measure the effectiveness of Early Help Services on outcomes for children and their families
- A Learning and Improvement Framework to enable lessons learned to be translated into improved outcomes for children
- Revised protocols for effective governance and partnership arrangements within the Borough (for example between the LSCB and Health and Wellbeing Board)
- An updated LSCB constitution and revisions to its Sub Groups so that they can deliver the work and priorities of the board

- Ensure that the Child Sexual Exploitation Service, including other partners, are responsive to the need of young people involved in or vulnerable to CSE, through the implementation of the CSE Strategy and delivery of the CSE Action Plan
- Continue to develop the importance of understanding the child's voice and journey through services, in particular the child protection process
- Ensure that children subject to Child Protection Plan receive thorough multiagency assessments of need and risk, effective care plans that address these and review them well.

8. Finance

The LSCB has its own budget financed by member agencies, the key agencies for such financing being Children's Social Care Services, Children's Health Services, and the Police. A budget statement is included in the RLSCB Annual Report.

9. Risks and uncertainties

The revised Ofsted framework for the inspection of services for children in need of help and protection, children looked after and care leavers is due to be implemented nationally from November 2013. Rotherham LSCB is working with partner agencies to assess and prepare the evidence of positive outcomes for children that will be required when the inspection is undertaken in Rotherham.

10. Policy and performance information

The LSCB Annual Report, in terms of the effectiveness of the LSCB, its partners, and outcomes for children, should inform local policy and commissioning priorities relating to safeguarding children and young people, and also informs the regulatory inspection of children's services from Ofsted and other inspectorates.

11. Background Papers and Consultation

The Children's Safeguarding Performance Information Framework 2012
Apprenticeships, Skills, Children and Learning Act 2009
Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children: HM Government 2013
Rotherham LSCB Annual Report 2012 - 13
Rotherham LSCB Business Plan 2013-16
Proposals for the inspection of services for children in need of help and protection, children looked after and care leavers: Ofsted 2013

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Rotherham
Local Safeguarding Children Board

Annual Report 2012 – 2013

1. Introduction from the Independent Chair of Rotherham's Local Safeguarding Children Board (RLSCB)

I'm pleased to introduce the Rotherham Local Safeguarding Children Board's (RLSCB) 2012-13 Annual Report and 2013-16 Business Plan. The report is intended to provide an assessment of how effective local arrangements are to safeguard and promote the welfare of children in Rotherham. It recognises the achievements and progress made in the past year, but also seeks to offer a realistic assessment of the challenges which remain and how the board will respond to these, primarily through its Business Plan.

The Business Plan which accompanies this report is a living document, and hence its content represents a "snapshot" picture of current priorities and areas of work rather than necessarily incorporating all the issues raised in this report.

In addition to its publication on the Board's website, this report and will be submitted to the Chief Executive and the Leader of Rotherham Council, the South Yorkshire Police and Crime Commissioner and the local Health and Well-Being Board.

The past year has been a particularly challenging year not least because of the media attention given to the issue of Child Sexual Exploitation which has seen its profile and public awareness increase nationally; and subsequent evidence provided to the Home Affairs Select Committee, which has now reported it findings. The enquiry into the Jimmy Savile allegations has also reminded organisations that their safeguarding children arrangements should always remain a priority and there is no room for complacency. I am pleased to say that Rotherham LSCB is and will continue to keep Child Sexual Exploitation as a high priority. To support the excellent work already undertaken in this area of protecting children the Board has introduced a revised Child Sexual Exploitation Strategy and Action Plan to support multi-agency working which is founded on the latest research and best practice from across the country.

The inspection of child protection services by Ofsted in July 2012 did raise some concerns that some children in the borough may be being seriously neglected for too long and that the multi-agency response to this was not as effective as we would want. The LSCB in conjunction with its partner agencies undertook some evaluation of this area of safeguarding and reported its findings to the Rotherham Children's Improvement Panel. Ofsted have announced that from October 2013, it will be undertaking inspections of child protection and children in care at the same time.

The new statutory guidance for safeguarding and promoting the welfare of children, Working Together 2013, although shorter and more succinct, does introduce some future areas of development for the Board and its partners, including the development of a new local protocol for assessing children in need or at risk of harm, new approaches to undertaking Serious Case Reviews, and the requirement for LSCBs to monitor and evaluate the effectiveness of Early Help services for children and their families.

A revision of the Board's Constitution in the light of the new statutory guidance must now be undertaken as a matter of some urgency. This will include a review of the remit of the Board's Sub Groups – these are the "engine room" of the LSCB and it has recently become clear that these should be made more fit for purpose for current requirements.

The Board's role continues to be to ensure that, despite the challenges above and those identified within this report, services and communities can continue to work together effectively to protect and safeguard the children and young people of Rotherham. The Board will endeavour to provide regular feedback on whether this is the case and will encourage and coordinate collaborative working to improve outcomes for children and young people who must continually be at the centre of all that we do.

Alan Hazell
Independent Chair
Rotherham Local Safeguarding Children Board

2. Rotherham Children and Young People in Context

2.1 Population

The most recent population estimate (2011) shows that there are approximately 62,400 children and young people, aged 0-19, living in Rotherham - this represents 24.2% of the borough's total population. The gender split for children and young people in Rotherham has remained constant at 51% male, and 49% female (2011).

Local birth statistics show that live births in Rotherham increased from 2,527 in 2000/01 to 3,381 in 2006/07. Births then fell and levelled off at 3,111 in 2009/10, 3,198 in 2010/11 and 3,057 in 2011 (calendar year).

2.2 Ethnicity

In the 2011 Census, 64% of Rotherham's Black and Minority Ethnic (BME) population was concentrated in four central wards: Boston Castle, Rotherham East, Rotherham West and Sitwell – a distribution which has changed little since 2001. In Rotherham South Area Assembly (Boston Castle, Rotherham East and Sitwell), there is a large and growing BME population, based on school pupil data (2005 compared to 2012). The link between family size and BME population is also shown in 2011 Census data, where Rotherham East and Boston Castle wards have the highest percentages of both families with three or more children and BME school pupils. Since 2004 there has been a significant increase in the arrival of EU migrants to the borough although the numbers have reduced in recent years. In the 2008/9 school year, there were 375 new arrivals of school age children from overseas, 56% (209) of whom were from Slovakia or the Czech Republic (mainly of Roma heritage). School registration data shows that 451 children arrived in 2009/10 but the numbers fell to 284 in 2010/11. Czech and Slovak children (mainly Roma) made up 68% (307) of new arrivals in 2009/10, but this fell to 49% (139) in 2010/11.

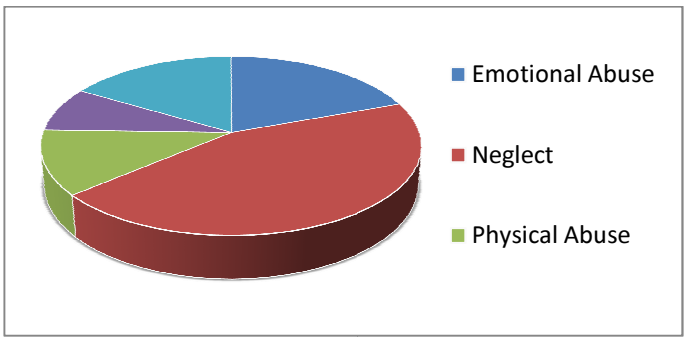
2.3 Areas of Deprivation

Deprivation in Rotherham is increasing according to the Indices of Deprivation produced by *Communities for Local Government.* Rotherham was ranked as the 68th most deprived district in England in the 2007 Index of Multiple Deprivation (IMD), and is now ranked 53rd in the 2010 IMD. Rotherham remains amongst the 20% most deprived districts in England. 21% of Rotherham children aged 0-15 live in areas which are within the 10% most deprived in England, and 43% of Rotherham children who live in low income households live in the 10% most deprived areas nationally (based on the *Income Deprivation Affecting Children Index (IDACI*) 2010).

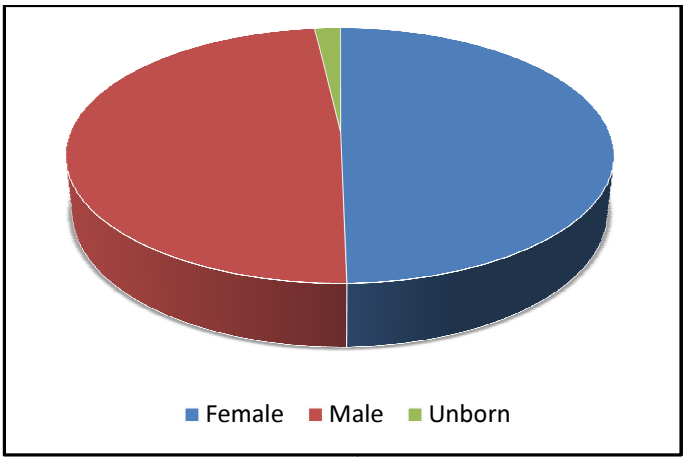
2.4 Children on a Child Protection Plan (as at 31st March 2013)

Number of Children on a Child Protection Plan	334

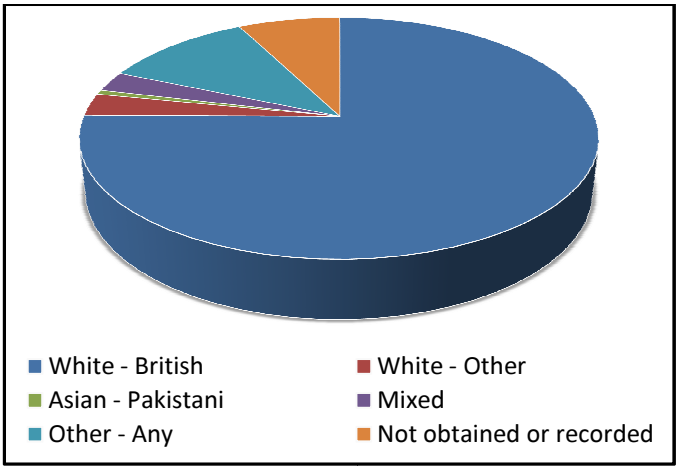
Child Protection Category	Number	%
Emotional Abuse	65	19%
Neglect	148	44%
Physical Abuse	39	12%
Sexual Abuse	27	8%
Multiple Categories	55	16%



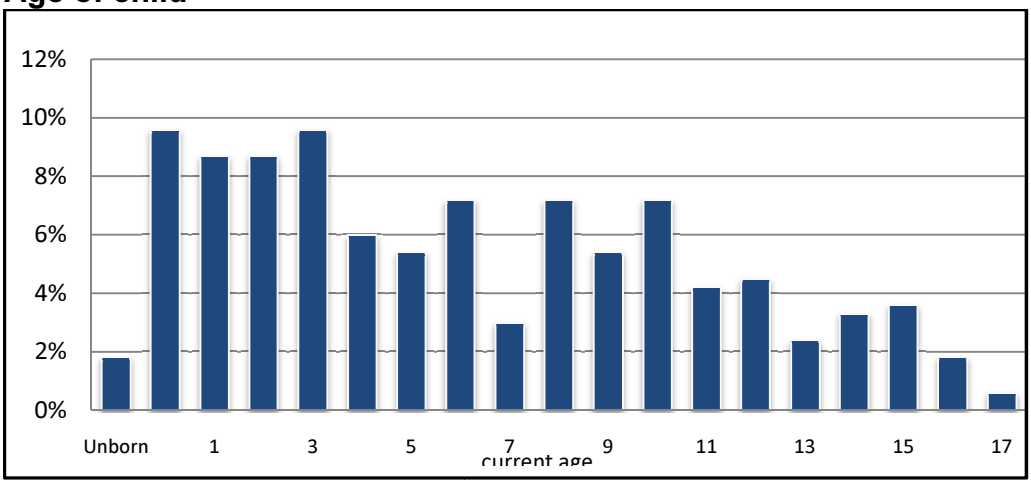
Gender	Number	%
Female	166	50%
Male	162	49%
Unborn	6	2%



Ethnicity	Number	%
White - British	251	75%
White - Other	10	3%
Asian - Pakistani	2	1%
Mixed	9	3%
Other - Any	37	11%
Not obtained or recorded	25	7%



Age of child



3. Governance, Partnerships and Service Arrangements

3.1 Governance and Partnership Arrangements

Working Together (2013) sets out that the LSCB should work with the Local Family Justice Board (in relation to children in care proceedings) and the local Health and Well-Being Board, the latter established in Rotherham in September 2011. The Health and Well-Being Board develops the Joint Strategic Needs Assessment, from which key commissioning activity should be derived, and the LSCB within its remit should both inform and draw from this in relation to vulnerable children. The relationship between these groups requires greater clarification, and a protocol is therefore currently under discussion to formalise the governance and arrangements between the Health and Well-Being Board, the Children, Young People and Families Strategic Partnership and the LSCB.

3.2 Key roles within Rotherham Local Safeguarding Children Board

There are some key roles on RLSCB some of which are set out and described in the *Working Together (2013)* guidance. These are:

3.2.1 Independent Chair

It is expected that all LSCBs appoint an Independent Chair who can bring expertise and focus to ensure that the LSCB fulfils its roles effectively. Crucially, the Independent Chair provides the separation and independence required from all the agencies which provides a balance in influence and decision making. The Chair is subject to an annual appraisal, to ensure the role is undertaken competently and that the post holder retains the confidence of the RLSCB members. The Independent Chair should work closely with all LSCB partners and particularly the Director of Children's Services.

3.2.2 Director of Children's Services

The Director of Children's Services (known in Rotherham as the Strategic Director of Children and Young People's Services) has the responsibility within the local authority, under section 18 of the Children Act 2004, for improving outcomes for children, local authority children's social care functions and local cooperation arrangements for children's services.

3.2.3 Local Authority Chief Executive Officer

Though not a member of the Board, ultimate responsibility for the effectiveness of the RLSCB rests with the Chief Executive of Rotherham Metropolitan Borough Council who also has the responsibility to appoint or remove the LSCB Chair with the agreement of a panel including LSCB partners and Lay Members. The Director of Children's Services reports to the Chief Executive of the Council.

3.2.4 Lead Member

The elected councillor who has responsibility for children and young people in the borough is known as the Lead Member, and sits on RLSCB as a 'participating observer'. This means that the Lead Member is able to observe all that happens and can contribute to discussion, but cannot participate in any voting. This allows the Lead Member to scrutinise RLSCB and challenge it if necessary from a political perspective, as a representative of elected members and Rotherham communities.

3.2.5 Lay Members

Lay members are full members of the Board, participating on the Board itself and relevant Sub Groups. Lay Members should help to make links between the LSCB and community groups, support stronger public engagement in local child safety issues and an improved public understanding of the LSCB's child protection work.

3.2.6 All Board Members

Members of an LSCB should be people with a strategic role in relation to safeguarding and promoting the welfare of children in their organisation and should be able to speak for their organisation with authority; commit their organisation on policy and practice matters; and hold their own organisation to account and hold others to account.

3.3 Financial Arrangements

Rotherham Local Safeguarding Children Board - Budget 2012/13 Outturn

Income: £284,662

Expenditure: £277,722

Overall expenditure for the year 2012/13 was within budget.

A surplus of £6,940 was carried forward £841 of which to be earmarked for learning and development activity and the remaining £6,099 will part fund the 2013/14 budget.

Invoices have been raised for all agency contributions for 2012/13. The contributions from South Yorkshire Probation Trust and CAFCASS have been set in accordance with the respective regional and national arrangements. The difference between the contributions received and the funding formula is reflected in the accounts as an under-recovery of income from CAFCASS and an over recovery from South Yorkshire Probation.

The accounts reflect full income recovery for all other contributions. For further detail, see Appendix 3. Child Death Review administration costs of £14,427 are included in these accounts

The Board has an agreement in place for two thirds of the cost of any Serious Case Review Overview Reports to be funded by RMBC and one third to be funded by the NHS in Rotherham. In 2012/13 no such expenditure has been incurred.

4. Progress on Board priority areas and the 2012-15 Business Plan

Some of the key areas of progress during this past year are that the Board has:

- Submitted partner agencies to a rigorous evaluation of their safeguarding children arrangements under Section 11 of the Children Act 2004

- Supported the Voluntary and Community Organisations Sector to self-assess safeguarding arrangements

- Contributed to commissioning and service specifications for new and future contracts

- Through its Child Death Overview Panel has reviewed all child deaths in the borough. This has resulted in:

- More detailed scans on unborn babies following any scan anomalies

- New care pathways for children and young people with diabetes

- The introduction of a safe sleeping assessment for all new-born babies

- Has introduced a Child Sexual Exploitation (CSE) Strategy and developed a Multi-agency Action Plan, reflecting the learning from local and national cases

- Has developed a Multi – Agency Support Hub with the CSE Team at its heart

- Provided learning for partner agencies from the detailed review of serious neglect cases resulting from the Ofsted Inspection of Child Protection Service.

- Implemented a focussed Quality Assurance programme for children at risk of significant harm, which has resulted in:

    - Improved assessment and care planning tools for professionals to use where children are subject to a Child Protection Plan

    - Improved participation by GPs in the Child Protection process

    - The development of multi-agency threshold descriptors and a practice resolution protocol for resolving differences of professional opinion in children's cases

    - increased scrutiny and challenge to agencies on the quality of practice and outcomes for children and young people

- Supported the development of a local Early Help Strategy, and commissioned learning and development activity to support the implementation of the strategy.

5. Performance and Quality Assurance Sub Group

5.1 Performance against National Safeguarding Indicators

This performance report relates to performance data as at the end of the 2012/13 reporting year. It includes performance against ex-National Indicators and a selection of key local indicators and should be read in conjunction with the data tables provided in Appendix A.

The service uses the national average as the minimum standard whilst striving for continuous improvement and maintaining its high performing areas. Therefore some targets are set in line with the National average and some are significantly higher.

A Red/Amber/Green (RAG) status has been applied as follows;

Green	-	on/above local target and on/above national average
Amber	-	below local target but on/above national average
Red	-	below local target and below national average

Where ever possible analysis is given by local targets, direction of travel and National benchmarking data.

Performance by RAG Status

RAG STATUS: **GREEN**

NI 64 – Percentage of Child protection plans, which have ceased, that lasted 2 years or more

2011/12	2012/13 Performance	Local Target	National Ave (min standard)	Stat Neighbour
2.2%	**3.8%**	4%	5.6%	6.1%

Good performance for this measure is low

Of the 395 child protection plans that have ceased in the current year 15 had lasted for over 2 years. This equates to a performance figure of 3.8% and remains better than national and statistical neighbour averages.

NI 68 – Percentage of referrals to children's social care going on to initial assessment

2011/12	2012/13 Performance	Local Target	National Ave (min standard)	Stat Neighbour
93.9%	**91.9%**	74.6%	74.6%	77%

Good performance for this measure is high

Measured by the number of children referred to children's social services departments during the financial year against the number of initial assessments completed within the financial year.

A total of 3833 referrals were received and 3521 initial assessments completed over the year placing performance at 91.3%. Although dropping by 2% in the last 12 months, performance remains high and well above local targets and benchmarking averages.

NI 67 – Percentage of child protection cases which were reviewed within required timescales

2011/12	2012/13 Performance	Local Target	National Ave (min standard)	Stat Neighbour
100%	**100%**	99%	90.5%	92.0%

Good performance for this measure is low

238 child protection conferences took place in 2012/13. All were within timescales.

RAG STATUS: **AMBER**

NI59 – Percentage of Initial Assessments carried out within 10 working days of referral

2011/12	2012/13 Performance	Local Target	National Ave (min standard)	Stat Neighbour
86.6%	**78.2%**	86%	77.4%	83.1%

Good performance for this measure is high

2901 of the 3521 initial assessments completed in 2012/13 were completed within 10 working days. Performance has therefore dropped since the previous year however remains above the national average. We have now slipped below Statistical Neighbour averages.

NI 62 – Percentage of looked after children which had 3 or more placements within the year (Stability of placement: Moves)

2011/12	2012/13 Performance	Local Target	National Ave (min standard)	Stat Neighbour
10.2%	**9.9%**	9.5%	10.7%	9.8%

Good performance for this measure is low

In 2012/13 39 of our 392 children had three or more placements within the year, equating to a performance of 9.9%. This is off target but shows an improvement on the previous year and compares well with national averages.

NI 66 – Percentage of Looked After Children cases reviewed within timescales

2011/12	2012/13 Performance	Local Target	National Ave (min standard)	Stat Neighbour
98.0%	**96.1%**	97.5%	90%	92%

Good performance for this measure is high

346 of the 360 Looked After Children included within this indicator had their cases reviewed within required timescales resulting in a performance of 96.1%. This is a drop in performance and is below local targets however remains above national and statistical neighbour averages therefore is rated Amber.

RAG STATUS: **RED**

NI 60 – Percentage of Core Assessments completed within 35 working days Status Red

2011/12	2012/13 Performance	Local Target	National Ave (min standard)	Stat Neighbour
69.4%	**71.1%**	75.1%	75.5%	84.8%

Good performance for this measure is high

1148 of the 1614 assessments completed in 2012/13 were finished within 35 working days placing performance at 71.1%. This is an improvement on the previous year however remains below target and benchmarking averages.

NI 61 – Timeliness of placements of looked after children for adoption following an agency decision that the child should be placed for adoption

2011/12	2012/13 Performance	Local Target	National Ave (min standard)	Stat Neighbour

50%	**61.1%**	74%	74%	75.1%

Good performance for this measure is high

36 children were adopted in 2012/13 which is 10 more adoptions than in 2011/12. 22 of these were within 12 months of the decision the child should be placed for adopted resulting in a performance of 61.1%. This remains significantly below target and benchmarking data.

NI 63 – Percentage of long term Looked After Children who have been in the same placement for at least 2 years (Stability of Placement: Length)

2011/12	2012/13 Performance	Local Target	National Ave (min standard)	Stat Neighbour
64.2%	**62.2%**	68.8%	68.6%	65.5%

Good performance for this measure is high

Long term Looked After Children have been looked after for at least two and a half years. Of the 148 children who fell into this category, at the end of 2012/13, 92 had been in the same placement for at least 2 years resulting in a performance of 62.2%.

NI 65 – Children becoming subject to a child protection plan for a second or subsequent time

2011/12	2012/13 Performance	Local Target	National Ave (min standard)	Stat Neighbour
11.8%	**16.3%**	13.3%	13.8%	14.0%

Good performance for this measure is low

319 children became subject to a plan in 2012/13, of these 52 had been subject to a previous plan placing performance for this measure at 16.3%. This is a drop in previous performance and places Rotherham below national and statistical neighbour averages.

5.2 Quality Assurance

The P&QA Sub Group has responsibility for monitoring performance in relation to safeguarding children and young people, and for reviewing and commissioning relevant quality assurance work.

To manage its performance management remit, the Sub Group has routinely reviewed the National Safeguarding Children Performance Indicator Report. However, the Group has now extended this and has requested members to consider which key performance metrics they

believe would be the most appropriate data from their own agency. The expectation is that this approach will be helpful as part of overall assessment of performance across the multi-agency spectrum. Likewise, the Group has extended the remit of reviewing the annual Complaints and Comments report of Children and Young People's Services, and has now begun to receive customer feedback and complaints analysis from other agencies in order to capture specific themes and trends.

Safeguarding Assurance (Health Trusts) resulting from the Jimmy Savile enquiry

Following serious and significant allegations against 3 NHS organisations across the country about whom allegations of abuse have been made, the Department of Health instigated a review into Jimmy Savile's role within the health system, and the Secretary of State has appointed a barrister to provide assurance that the Department of Health and relevant NHS organisations are following a robust process aimed at protecting the interest of patients. Sir David Nicholson requested that NHS provider Chairs, Chief Executives and their Boards, took the opportunity to reflect upon their safeguarding arrangements and practices relating to all vulnerable people. They were asked to focus on access to patients, including that afforded to volunteers and/or celebrities; and to consider how effective they are at listening to and acting on patient concerns. A report was presented to the Performance and Quality Sub Group that synthesised the work of local Health Trusts to provide assurance of policies and practices within their organisations in the light of the Savile media reports and subsequent enquiry.

Audit Work undertaken

This is an area that has improved rapidly during the past year, and which allows the group to be assured of agencies' work, focus and improvement across the arena of safeguarding. The details below outline some of the key audit activity of the past year:

GP participation at Child Protection Conferences

The audit, undertaken twice in 12 months, reflected that GP participation at Initial Child Protection conferences needed to be greatly improved. With the assistance of the named GP for Safeguarding, the findings of the audit were reflected back to the GP community in conjunction with a Conference Report template for their use. The impact of this is that participation rate in Initial Child Protection Conferences has increased from 30% to 64%.

Agency referrals to the Social Care Contact and Referral Team (CART)

This audit area was recently embedded within the CYPS Quality Assurance Framework. Initial findings indicate that there are several areas for improvement, including the need for improvement in referral quality from non-social care professionals/agencies, more robust

screening by social care, and consistent application of thresholds by all agencies. To enable and support improvements in this area of practice, the development of Multi-Agency Threshold Descriptors, a Multi-Agency Referral Form and a Practice Resolution Protocol have all been implemented.

Multi-Agency Audit of Serious Neglect Cases

The requirement to undertake this work arose from the Ofsted unannounced inspection of child protection in July 2012 and the consequent action plan, monitored by the Rotherham Children Improvement Panel. A shortlist of cases was prepared using parameters which included, for example, children being on a Child Protection Plan under the category of Neglect for more than 15mths. Social Workers for these cases were requested to undertake an assessment using the Graded Care Profile – a tool to assist those working with neglect cases to understand the quality of care a child is receiving. From a further shortlist, two cases were identified for an in-depth multi-agency audit. These cases were prepared into case studies for presentation to and discussion at the Improvement Panel and other forums.

Themes arising from the case studies included:

- An over reliance on evidence from parents who self-report on the progress and outcomes for their child. This indicates that some parents present "disguised compliance" with professionals and requires professionals to adopt and approach of "respectful uncertainty"* in their practice (Laming 2003).
- Inconsistency of Child Protection Conference chairs, resulting in poor continuity for families and front line professionals through the Child Protection Planning process. Further analysis (fig 1) of this issues identified that historically this was indeed an issue, but significant progress has since been made, with further plans within the safeguarding unit to improve this area of practice.

Fig 1.

	Chairing Consistency Child Protection Conferences (% of families with same chair person)
2010-11	11.5%
2011-12	21.4%
2012-13	55.5%

- Inconsistent and weak planning/review in relation to Child Protection Plans, resulting in the activity with and on behalf of the family not being translated into positive outcomes for the children.

- Assumptions were made that the parents had the capacity to change without a fuller assessment and understanding of their true capacity to do so.

The above themes resulted in drift and delay for the children in the case studies in terms of their outcomes and long term care, either to remain at home, kinship care in the wider family being an option, or care proceedings being initiated.

Case Review Group

The Case Review Group has received fewer referrals to consider during 2012/13. In part, this was as a result of Child Protection Conference chairs better exercising their judgement and independence when decisions are made about whether children should be subject to a Child Protection Plan; it was also as a result of audits, and an escalation protocol which enables them to raise case work issues with social care services directly. This area is to be evaluated by the P&QA Sub Group later in 2013. This will also provide the capacity for the Case Review Group to focus on other multi-agency areas of practice relating to child protection activity.

Section 11 Assessment and Assurance

Organisations are required to have robust safeguarding arrangements as set out in S11 of the Children Act 2004. As part of the scrutiny of these arrangements, RLSCB held a series of challenge meetings with individual organisations in April 2013 and a report indicating trends and principles was presented to the June 2013 Board Meeting.

Audit Plan 2013-14

One of the main priorities for the Sub Group is to formulate an annual audit plan. Given that audit work can be resource intensive, it is important that each area identified for auditing has a justified rationale and links to key priorities and themes. Some of the areas identified for audit in 2013-14 are:

- Child Sexual Exploitation
- Child Protection Planning – outcomes
- The effectiveness of Early Help to children and families
- Quality of referrals to social care services and the application of thresholds

- Engagement in multi-agency working of substance misuse and mental health services

The Board recognises the importance of quality assurance in relation to services to safeguard and promote the welfare of children and the appointment in 2011 of a dedicated Quality Assurance Officer has provided increased effectiveness of the scrutiny of partnership arrangements, multi-agency working and outcomes for children.

5.3 Management of allegations against Professionals, Foster Carers and Volunteers

RLSCB is pleased that central government decided to maintain the role of the Local Authority Designated Officer (LADO) in the revised Working Together (2013) statutory guidance for this important area of safeguarding children.

In Rotherham, the LADO role is embedded within the Safeguarding Children Unit and its head has responsibility for oversight and coordination of all allegations that fall within the remit. The LADO has responsibility for convening and chairing strategy meetings where necessary and liaising with partner agencies to discuss and agree the most appropriate way forward on specific cases. Planning includes appropriate action in relation to the adult concerned and safeguarding plans for any children involved.

The work requires effective collaboration with all partner agencies, including the voluntary and private sector, human resource departments, the police and professional regulatory organisations.

Referrals to the LADO 2012-13

Alleged person by Employment Type	Number
Child Minder	1
Faith Group	3
Foster Carer	5
Nursery	2
Primary Education	10
Secondary Education	8
Special Education	1
Support Worker	1
Voluntary Youth Organisation	1
Social Care	1
Residential Carer	2
Total	35

Outcomes from the above referrals to date are that 6 referrals were substantiated and 13 were not substantiated. Given that enquiries and investigations involving these cases can be complex and take some time to conclude, including being taken forward to the following year, ie 2013 – 14, it is not possible at the time of publishing this to report on outcomes for all referrals. Progress, however, on every case is closely monitored on a month by month basis. A separate report is submitted to the RLSCB in September annually and this report will be updated accordingly.

6. Serious Case Review (SCR) Sub Group

The Serious Case Review (SCR) Sub Group meets to consider any cases that have been referred to it against the criteria for a Serious Case Review, to make recommendations on any other appropriate lessons learned reviews and to monitor action plans arising from case reviews.

As part of South Yorkshire Probation Trust's procedures, any serious further offence committed by an offender under supervision triggers a Serious Further Offence Review by the Trust. If the case involves a child or young person, the Probation Trust is required to notify the LSCB for it to consider the need for a Serious Case Review. Two such cases were referred to the Serious Case Review Sub Group in 2012-13, neither case meeting criteria for a SCR, and Rotherham Probation undertook the Serious Further Offence Review.

In 2012 a baby died unexpectedly at home, due to Sudden Unexpected Death in Infancy Syndrome (SUDI). The siblings had previously been subject to a Child Protection Plan and there were significant historical concerns relating to parental alcohol use and neglect. The case was referred to the SCR Sub Group by the Child Death Overview Panel and the case was considered against SCR criteria. The case did not meet the criteria for a Serious Case Review. Public Health and the RLSCB are supporting awareness raising and learning fro parents and practitioners in relation to safe sleeping, and an audit has been commissioned for autumn 2013 by the Rotherham Foundation Trust into safe sleeping advice, guidance and assessments.

Child S Serious Case Review.

Following the initial publication of the overview report into this case in May 2012, the Department for Education requested that RLSCB consider publication of a version of the report with less redacted details. RLSCB undertook the revision of the report and published this final version on 19 June 2013.

The new central government's (DfE) statutory guidance, Working Together (2013), was published in April 2013. The LSCB has considered the implications on the new guidance, and is developing a learning and improvement framework that incorporates Serious Case Reviews and other lessons learned reviews.

7. Child Death Overview Panel (CDOP)

The role of Rotherham's Child Death Overview Panel (CDOP) is to review the deaths of all children resident in Rotherham. The purpose of this is to establish patterns, identify modifiable factors, and promote messages to prevent future death. The panel has a multi agency membership, including the introduction in 2011 of a lay member. Rotherham CDOP has referred deaths to the Serious Case Review Sub Group for consideration where appropriate. The panel is also an active member of the South Yorkshire CDOP, which meets regularly to share information and best practice.

Data relating to child deaths in Rotherham 2012-13

Cause of Death	Number of Deaths
Deliberately inflicted injury, abuse or neglect	0
Suicide or deliberate self-inflicted harm	0
Trauma and other external factors	0
Malignancy	5
Acute medical or surgical condition	1
Chronic medical condition	1
Chromosomal, genetic and congenital anomalies	5
Perinatal/neonatal event	5
Infection	2
Sudden unexpected, unexplained death	2
Total	21

Gender of Children

Gender	Male	Female	Total
Number of Children	11	10	21

Age of Children

Age of Child	0-27 days	28 days-364 days	1 year -4 years	5-9 years	10-14 years	15-17 years	Total
Number of Children	9	3	1	2	4	2	21

Time taken from death of child to review	Under 6 months	6 or 7 months	8 or 9 months	10 or 11 months	12 months	Over one year	Total
Number of Deaths	2	2	6	4	2	5	21

Challenges and Lessons Learned

Learning from Case 1

Under section 43 of the coroner's rules, the coroner wrote to the Walk in Clinic to advise that their procedures needed to be reviewed to ensure that patient questionnaire assessments carried out by the nurse were routinely seen by doctors before the patient is reviewed. This followed the death of a child who showed signs of chicken pox but then displayed new symptoms - this procedure had not occurred, and signs of the seriousness of the child's illness were missed. At Rotherham General Hospital a Departmental review regarding the level of seniority of medical involvement after admission to the Children's Assessment Unit was carried out. Where discharge home after observation is undertaken, new arrangement are now in place specifying a minimum of registrar review within 4 hours of admission and/or registrar review before discharge home (in this case, review was by a junior doctor). Had the appropriate treatment been instituted on any of the three occasions he attended the Walk-in clinic or Accident and Emergency, it is possible his death could have been prevented.

Learning from Case 2

A 13 year old child with insulin dependent diabetes died from diabetic ketoacidosis a treatable complication of diabetes (this can cause severe metabolic upset and death). Overall control of his diabetes was poor, he had difficulties in school, his compliance with treatment was far from idea,l and he had repeat episodes of ketoacidosis. Repeated attempts were made to gain greater compliance with his care in a multidisciplinary setting. Discussions with the paediatric endocrinologists responsible for the care of children in Rotherham have increased awareness of the need to intervene more assertively in such cases and have resulted in new care pathways for children and young people with diabetes.

Learning from cases 3 and 4

Two children died from Sudden Infant Death Syndrome (SIDS) aged under 6 months, both sharing beds with their parents, were not breast fed, and where there had been parental alcohol consumption and associated smoking. The review of some of these and other SIDS cases has highlighted the requirement to raise the awareness of safe sleeping for babies. In addition to the

individual health trusts, the RLSCB and Public Health are promoting the importance of safe sleeping advice in all training for professionals and those involved in the care of young children and families, including the training of foster carers in the near future. This includes the use of a safe sleeping assessment by midwives and health visitors, and key messages using TV screens in hospital, GP surgeries and council buildings.

Learning from cases 5, 6 and 7

Three children died from childhood cancers. All were in receipt of care from Bluebell Wood Hospice and all received palliative care of a high standard. The CDOP panel has developed joint review with midwifery and obstetrics of intra-partum and congenital abnormality deaths. One child died in Leeds from complications of transposition of the great vessels. This was detected at antenatal scan by a sonographer but this was "overruled" by an obstetrician. After intervention by CDOP, it has been agreed that all anomalies suspected will result in more detailed scanning.

One of the three children who died from congenital abnormality died from a specific inherited genetic condition. Prenatal diagnosis with first trimester chorionic sampling makes it possible to detect this condition and to offer parents termination (this carries a significant risk of miscarriage to the pregnancy) and is not culturally sensitive to some families.

8. Policy and Procedures Sub Group

The maintenance of Multi-Agency Safeguarding Children procedures is a key function of the LSCB. The Policy and Procedures Sub Group has worked closely with the external provider of the procedures manual to ensure that all the procedures are up to date and fit for purpose and includes any new procedures or protocols required for Rotherham. The following procedures have been reviewed and implemented by the Sub Group since April 2012:

- Surrogacy (new)
- Hidden Harm (revised)
- Fabricated illness (revised)
- Safe Sleeping (new)
- Child Sexual Exploitation Procedures (revised)
- Multi-Agency Threshold Descriptors (new – live from 4th April 2013)
- Practice Resolution Protocol (new – live from 4th April 2013)
- Procedures for allegations against staff, carers and volunteers (amended re Disclosure and barring service)
- Family CAF (new)

- Cross (International) Border cooperation in Chid Protection Cases (new – live from April 2013)

End user statistics.

The data which enables some understanding of the frequency of use of the procedures is generic (in relation to which professional groups or agencies are accessing and using the procedures) and does not allow these groups to be identified as professional groups. However, the data does enable a general overview of the most utilised procedures, the most frequently used ones between July 2012 and January 2013 being:

- Referring Concerns to Children's Social Care or the Police
- Safeguarding Children form Sexual Exploitation
- Managing Adults who pose a risk to Children and Young People
- Domestic Abuse protocol

Working Together (2013) Statutory Guidance.

A priority for the Sub Group in 2013 will be to ensure than any necessary revisions are made to procedures and protocols as a result of the new Working Together (2013) guidance, published recently, and effective from April 15th 2013.

9. Exploitation Sub Group

9.1 Child Sexual Exploitation

Child Sexual Exploitation (CSE) is and will continue be a priority for RLSCB.and its member partners. Earlier in 2013, based on research, national and local learning, RLSCB implemented its CSE Strategy and Action Plan:

Rotherham CSE Strategy 2013-16 PREVENT - PROTECT - PURSUE

PREVENT children becoming victims of CSE through education and awareness raising and assuring local communities that agencies take the issue seriously.

PROTECT children and safeguard them from risk of harm from CSE.

PURSUE the perpetrators of CSE, and ensure appropriate multi-agency plans are in place to support victims and to enable them to disclose the abuse safely and provide the evidence to prosecute offenders.

CSE is recognised nationally as one of the most important challenges facing agencies today. It is therefore one of RLSCB's key priorities. We recognise the serious long term and lasting impact CSE can have on every aspect of a child or young person's life, including their health, physical and emotional wellbeing, educational attainment, personal safety, relationships, and future life opportunities. The impact of CSE on family life can be significant, placing considerable strain on all family member, and can ultimately lead to family breakdown.

Due to the very nature of CSE, and its emotive nature, there has been national media attention. Rotherham has featured in this from both positive and negative perspectives. In 2010, the media praised Rotherham agencies for the way that five men were prosecuted following Operation Central, with reports that "this case shows how seriously South Yorkshire Police and Rotherham Council treat the issue of child sexual exploitation". By contrast, there is also the potential for highly negative press where failings are found. This has been seen in Rotherham in the months following the publication of articles in The Times in September 2012. Since then, Council and South Yorkshire Police senior representatives have been required to attend and answer to the Home Affairs Select Committee and the findings have been published in the national press.

The role of the local community in Rotherham is vital in sharing information, and identifying area of concern. Local residents are very often the eyes and ears of the community, and have a duty to pass on any concerns to any of the partner agencies. Part of the work of the CSE Service is to raise professional and public awareness. This is being undertaken through the delivery of multi-agency training for professionals, briefings to elected members, development of leaflets for children and young people, parents and carers, targeted consultation and community engagement activity, as well as a positive working relationship with the local media.

On 1st October 2012, Children's Social Care and South Yorkshire Police co-located to create a specialist CSE service, including police officers, social workers, youth workers and other council support staff. A health worker is soon to join the team, which is based within the Public Protection Unit at Maltby Police Station.

The remit of the Child Sexual Exploitation Team is to:

- Develop and build on current education programmes and engage with schools to reduce and prevent CSE
- Raise awareness of CSE risk indicators and referral processes within all agencies
- Provide a rapid response to the investigation of CSE

- Reduce and prevent CSE by deterring, disrupting and prosecuting offenders
- Support young people to be able to identify themselves as victims of CSE
- To support parents and carers in understanding the implications of CSE and reducing the risks.

The work of the CSE Service also involves collaborative work with the Taxi Licensing Board, Alcohol Licensing and Housing. These agencies can help not only by providing vital information to help identify hotspots, but also provide a multi-agency approach to securing evidence to suspend or revoke licences.

South Yorkshire Police has confirmed its long term commitment to this area of safeguarding children by including it as a key priority, supported with additional funding for specialist officers and training, in its Police and Crime Plan 2013-17.

Multi Agency action in Rotherham to prevent and protect children and young people from Child Sexual Exploitation (CSE) in 2012/2013

437	Contacts* received relating to 212 children
129	Referrals** relating to 119 children
13	Initial Assessments completed by CSE Team ***
4	Core Assessments completed by CSE Team ****
13	Schools engaged and over 911 pupils involved in preventative work
114	Police referrals into Rotherham Public Protection Unit
28	Abduction notices served
3	Attrition visits conducted by the Police
110	Police Supervising Officers trained
45	Council Ward Members trained
36	Ward Members attended Local Government Yorkshire and the Humber CSE Conference in March
19	Senior Managers trained
171	Staff undertaken multi agency training on CSE
175	Multi agency staff trained on the lessons learned from the Child ‘S’ Serious Case Review

* a contact is the first point of contact with social care services from someone making an enquiry or wanting to report a concern.

** a referral is a contact that requires further investigation and assessment to see whether a child or their family needs help from social services

*** an initial assessment is a brief assessment of each child referred which includes relevant information from a number of agencies

**** a core assessment is an in-depth assessment which looks at the detailed needs of the child, and whether their parents or carers have the capacity to respond to those needs. It involves other agencies who will provide information about the child or parents and contribute specialist knowledge.

9.2 Children Missing Education

The local authority has a duty to identify, track and monitor all children and young people within the borough without a school place. This applies to children who are not on a school roll but does not include those who are on a school roll but are not attending school or those who have been excluded. The Children Missing Education Officer, based in the Education Welfare Service, has specific responsibilities in conjunction with the duties on schools and partner agencies.

Referrals to the Children Missing Education Officer for the period April 2012 – March 2013 totalled 874, which is a 60% increase on the previous 12 months.

The breakdown of these referrals of children by school year group is detailed below.

School Year	0	1	2	3	4	5	6	7	8	9	10	11	12	Total
Total	41	232	76	72	64	40	45	53	50	68	56	73	4	874

The improved systems and processes between the School Admissions department and the Education Welfare Service has identified that the numbers of children of reception age and at KS1 (Years 1&2) who are identified as Children Missing Education (not on a school roll) is significant as a proportion of the total – 31%. Evidence indicates that this is due to under capacity in Rotherham of school places at primary level. The School Organisation and Planning services are reviewing current capacity issues with the intention of increasing primary school places in the borough. In addition an EU Migrant Community Engagement worker has been employed to work with Roma families, supporting them to take up educational opportunities for their children across the borough.

Children from minority ethnic groups are over represented in referrals and this is partially as a result of families moving to and from the United Kingdom and across local authority boundaries. The recruitment of a bilingual engagement officer, speaking Romani and Slovakian, is currently being recruited to work across the School Admissions, Education Welfare Service, Families for Change programme and School Effectiveness Service. The post will be responsible to the Children Missing Education Officer and will supervise two modern apprentices from the Roma community to assist with engagement and access to services.

The Department for Education ended a consultation in February 2013 of a proposed revision of statutory guidance in relation to Children Missing Education, reducing guidance from 44 pages to 3 pages. A robust consultation response was submitted to the DfE, outlining some of the identified deficiencies in the revised guidance, some of which do not support strong and effective partnership working and provide clarity of roles and responsibilities. The publication of the new DfE guidance has now been delayed until later in 2013.

9.3 Children Missing from Home and Running Away

Nationally, children represented approximately two thirds of the estimated 360,000 missing person incidents in 2009–10. Children in care are three times more likely to go missing from their home than children who are not in care. However, due to the unreliability of available data at a national level, it is likely that the true scale of the problem is not fully understood. A number of recent high-profile court cases concerning child sexual exploitation and high-profile inquiries have highlighted the vulnerability of children who go missing, and the associated risks of sexual exploitation.

On a sub-regional basis, agencies across South Yorkshire are party to a Joint Runaways (Children Missing from Home or Care) Protocol. The aim of the protocol is to ensure an effective and accountable partnership response and service provision for these children and young people. This includes ensuring that:

- There is an agreed plan in place whenever children and young people run away/are missing to ensure appropriate actions take place to trace and return the child/young person
- Risk assessments are completed at the time a child/young person goes missing and shared with the appropriate agencies
- Issues of equality and diversity should be considered in the response given to every child or young person who goes missing or runs away.

Local analysis of missing children incidents (Jan – March 2013)

- A slight reduction in the number of young people reported missing month on month in 2013, from a total of 20 in , 19 in February, and 18 in March
- Girls continue to be most reported, being two-thirds of the total children and young people reported missing since January 2013

- The percentage of Looked After Children in Rotherham who are reported missing is higher than that for the rest of the child population in Rotherham, but lower than the national average
- The highest % age group is 14yrs to 15yrs, accounting for 85.5% of all those reported missing. The youngest reported was 13 yrs of age
- Fewer than 7% of children reported missing were of an origin other than white European
- The number of children repeatedly reported missing averages around 6 children each month, with one child reported 8 times in January. The same child was reported missing once in March
- South Yorkshire Police recorded the child's comments on every occasion. In the period January to March, only one child reported an actual concern
- South Yorkshire Police also record whether there are any Child Sexual Exploitation concerns. One was reported in the period January to March.

(The above analysis was provided by the Rotherham Runaways Action Group.)

A new definition for missing persons and protocol was agreed by the Association of Chief Police Officers (ACPO) in January 2013. The definition is described as *'representing a new approach to safeguarding vulnerable people'* and is based on a model developed through pilots in a number of police force areas. ACPO intend to implement the new model across the country commencing 1st April 2013, in South Yorkshire this is likely to be autumn 2013.

Key features of the new model:

- Incidents of missing and absence must be regarded as indicators of harm and investigated properly.
- A revised definition of 'missing' (see below)
- Introduction of a new category of 'absent' (see below)
- Emphasis on effective and dynamic risk assessment.
- More discerning police response and recording protocols.

- The importance of the role of the missing person co-ordinator.
- The requirement for a shared commitment between key statutory agencies.
- The need for thorough investigation of all 'missing' incidents – with particular emphasis on return interviews.

The new definitions are:

Missing:

Anyone whose whereabouts cannot be established and where the circumstances are out of character, or the context suggests the person may be a subject of crime or at risk of harm to themselves or another.

Absent:

A person not at a place where they are expected or required to be.

9.4 Licensing

The Licensing Act 2003 deals with the licensing of premises for various activities, which include the following:

- To sell alcohol by retail
- To supply alcohol to a club member, or to sell alcohol to a guest of a club member in the case of qualifying clubs
- To provide regulated entertainment
- To sell hot food or drink (late night refreshment) between 11.00pm and 5.00am for consumption on or off the premises

The Licensing Act 2003 sets out four licensing objectives:

- Prevention of crime and disorder
- Public safety
- Prevention of public nuisance
- Protection of children from harm

Examples of activities which are a potential cause of harm to children and young people are:

- Selling alcohol to children under age
- Selling alcohol (by proxy) to children under age
- Selling alcohol to parents who are intoxicated and are supervising their children
- Allowing children into premises where there is gambling or adult entertainment

Where there has been evidence of a risk to children and young people, the RLSCB has, in addition to other local Responsible Authorities, made representations to the Licensing Board, and licences have been revoked and premises closed as a result.

Although the Licensing Act 2003 does not cover licences for vehicles for public hire (taxis), the Responsible Authorities forum shares information and discusses issues where there is a taxi company or driver whose conduct is a cause for concern, and instigates appropriate courses of action. Where there are sufficient concerns and evidence, the matter is referred to children's social care services and the police, and the licence for a driver can be suspended or revoked by the Council Licensing Board.

9.5 E-Safeguarding

The e-safety special interest group continues to meet on a termly basis; however, attendance is not always regular with some agencies not sending representatives to meetings. Whilst this could be as a result of structural changes in organisations and or capacity of staff to attend, it is important that e-Safeguarding is kept high on agendas of all agencies, and further work will be done during 2013/14 to re-engage these organisations.

The priorities for the special interest group have continued to be:

- Looked After Children's access to the internet and social networking
- Reporting and monitoring of on-line safety incidents
- Sharing of good practice across partner agencies
- Education and training in relation to e-Safeguarding

A significant amount of support has been received from Yorkshire and Humber Grid for Learning (YHGL) in relation to leading on specific areas of work and being able to share regional good practice.

The group endeavours to include participation of young people in the work to try to ensure engagement but unfortunately, this year attendance by young people at the group has not been as evident as in previous years.
Meetings for 2013/14 are already being planned with young people in attendance, including work with students at Thomas Rotherham College, and some anti-bullying work with students at Dinnington Comprehensive School.

Looked After Children in Residential Care

At the request of Rotherham Borough Council Elected Members all children and young people within Rotherham Residential Care were provided with a laptop for their personal use, to support them in their education, and to access information and services available through the internet and on the World Wide Web. To support this initiative, each residential unit was equipped with a dedicated broadband connection. The connection was configured with additional security software to protect the young people from accessing inappropriate web content. However, it was recognised that the young people would require access to social media sites to support and allow them to engage with their peers and support networks. To help support both the staff and young people in using this new facility, RLSCB commissioned the YHGL to deliver eSafety training specifically tailored to meet the individual needs of those involved in the project. The sessions informed the young people how to protect themselves whilst on-line and how to set up their social media profiles to reduce their vulnerability whilst engaging in on-line communication. It also focused on their "digital footprint" and how any inappropriate use of the internet and social media sites could impact on future job prospects. A support package was produced to help the residential units become self-sufficient in training new staff and young people.

Other specific areas of e-safeguarding work during the year have included:

- E-Safeguarding links made from the RSCB website to resources on the YHGFL website.
- Review undertaken of anti-bullying guidance for schools working with RMBC's anti-bullying officer
- CEOP's "think you know" training delivered by members of the group to staff across all settings in Rotherham
- Reviews of e-Safeguarding resources and recommendations to schools and other settings.

10. Learning and Development Sub Group

The commencement of the 2012/13 business year saw the re-launch of the RLSCB Learning & Development Prospectus. The Prospectus was revised in response to attendance and evaluation analysis from the programmes delivered in 2011/12, and new workshops have been added to the RLSCB offer, including "Safeguarding Children with Disabilities"; "Safeguarding and the Internet"; "Prevent"; and "Working effectively with parents and carers".

In 2012-13 there were 3207 participants, from a wide range of agencies and voluntary sector organisations, who had attended one of the 142 workshops that the RLSCB has commissioned. This shows a significant increase when compared to the 1913 participants in 2011/12. Representation has been high from all partner agencies, with the majority of workshops delivered having been evaluated positively. Engagement from Rotherham's schools in learning and development activity remains strong, and in line with this, the Safeguarding Leads Forum for Schools continues to be well represented. This has included specific focus on the lessons learned from the Child S Serious Case Review. RLSCB also contributed to the GP Protected Learning Time event in November 2012, whose theme was safeguarding.

Following the initial publication of the Child S Serious Case review, the LSCB has also held 8 workshops to share learning with front line staff and managers, with a total of 175 practitioners attending. The RLSCB Independent Chair and the Business Manager have also provided workshops on demand for specific groups of elected members and senior officers.

The RLSCB has sponsored or supported a number of key events in 2012/13:

- Conference developed by the Local Authority's Get Real Team "Improving Life Chances for Children in Our Care" which had 123 practitioners in attendance
- Early Help Conference for frontline practitioners, which was held at Magna and had 283 staff in attendance
- Safeguarding learning event for the Voluntary and Community Sector. Following the OfSTED inspection of Children's Services in July 2012, RLSCB also hosted a regional event in October 2012 to share lessons learned with senior officers from the 14 other local authority areas within the Yorkshire and Humber region.

The Child Sexual Exploitation workshops have been revised and updated to reflect service redesign, and to reflect lessons learned following recent service reviews and learning nationally. In partnership with the Independent Safeguarding Authority, a workshop was delivered in October 2012 for recruitment leads across Adult and Children's Services and partners on their duties to refer those posing a risk to children.

The Independent Chair has continued to lead Group 8 development by facilitating RLSCB Development Days, focussing on national initiatives, and ensuring that the LSCB is fit for purpose moving forward in 2013 and beyond. A schedule of Quality Assurance of LSCB Workshops has been undertaken in 2012/13 in line with the RLSCB QA Framework for Learning & Development, and no concerns relating to content or delivery have been identified.

In preparation for the 2013/14 financial year, an Early Help prospectus has been developed to provide a tiered approach to developing competencies for the effective delivery of preventative/early interventions with the children, young people and families' workforce. This was launched in April 2013 and will run in parallel to the LSCB "Child Protection" focused prospectus. Activity relating to Early Help will largely be funded by Department for Education grants specifically relating to the implementation of the Munro Review (2011).

It has been agreed that the additional contributions made to learning and development by Health and the Local Authority will be maintained in 2013/14.

11. Lay Member's Report

Following the recent departure of one of the Board's two Lay Members, RLSCB has very recently recruited to the vacancy. In the meantime, the current Lay Member has provided the following statement for inclusion in the RLSCB Annual Report:

I feel that the role of Lay Member continues to be received positively by Board Members and Sub Groups, and I wish to offer my thanks to the Sub Group Chairs, and the Independent Chair of the Board in particular, for the way in which the Board is chaired in a challenging yet inclusive manner.

Over the past two years, I have seen the significant commitment and progress made by the Board in the area of safeguarding children from sexual exploitation, and have confidence that Rotherham is in a strong position to tackle this issue.

It is disappointing that the re re-redacted Child S Serious Case Review report has taken so long to be published, though the Board has done everything within its control to resolve this.

In relation to the Child Death Overview Panel (CDOP,) I feel that I have to comment on how professional and thorough but also sensitive the panel members are in evaluating factors that contribute to child deaths in the local area, and initiating changes to services where appropriate.

In terms of developing the role of Lay Members, it is planned that a comprehensive induction programme will be introduced for the new Lay Member, and that opportunities for a Lay Member forum could be developed regionally.

12. Rotherham LSCB Challenges and Priorities for 2013-2016

12.1 Priorities arising from the revised Working Together guidance (2013)

These will include the development and implementation of:

- A multi-agency local protocol (framework) for the assessment of children
- A performance and quality framework to measure the effectiveness of Early Help Services on outcomes for children and their families
- A Learning and Improvement Framework to enable lessons learned to be translated into improved outcomes for children
- Protocols for effective governance and partnership arrangements within the borough
- An updated LSCB constitution and revisions to its Sub Groups so that they can deliver the work and priorities of the board
- A risk register for the LSCB.

12.2 Additional key priorities within the 2013-2016 Business Plan

- Ensure that the Child Sexual Exploitation Service, including other partners, are responsive to the need of young people involved in or vulnerable to CSE, through the implementation of the CSE Strategy and Action Plan
- Continue to develop the importance of understanding the child's voice and journey through services, in particular the child protection process
- Ensure that children subject to Child Protection Plan receive thorough multi-agency assessments of need and risk, effective care plans that address these and review them well.

13. Appendices

Appendix 1

Safeguarding Children and Families - Performance Table 2012/13 (unvalidated)

Ref	Definition	Good Perf is	2011-12 PERFORMANCE	LOCAL TARGET	2012-13 PERFORMANCE *(unvalidated)*	Direction of Travel*	RAG STATUS**	Latest Benchmarking Data: Statistical Neighbour Average	Latest Benchmarking Data: National Average	Service Commentary
NI 59	Percentage of initial assessments for children's social care carried out within 10 working days of referral	HIGH	86.6% (3996/4614)	86.0%	**78.2%** (2901/3521)	Declined	**Amber**	83.1%	77.4%	Drop in performance since previous year. Below statistical neighbour but above national averages.
NI 60	Percentage of core assessments for children's social care that were carried out within 35 working days of their commencement	HIGH	69.4% (1345/1937)	75.1%	**71.1%** (1148/1614)	Improved	**Red**	84.8%	75.5%	Performance has improved on the previous year but remains below target and comparators.
NI 61	Timeliness of placements of looked after children for adoption following an agency decision that the child should be placed for adoption	HIGH	50% (13/26)	74.0%	**61.1%** (22/36)	Improved	**Red**	75.1%	74.0%	More children have been adopted wthin the year (26 in 11/12 compared to 36 in 12/13). Timeliness of these adoptions remains an area for improvement. Those waiting for a placement over 12 months are reducing and it is projected that this performance drag should have less of an impact in future years.
NI 62	Stability of placements of looked after children: number of placements (3 or more)	LOW	10.24% (39/381)	9.5%	**9.9%** (39/392)	Improved	**Amber**	9.8%	10.7%	Performance is worse than target but has improved on the previous year and remains better than national.
NI 63	Stability of placements of looked after children: Length of placement	HIGH	64.19% (95/148)	68.6%	**62.2%** (92/148)	Declined	**Red**	65.5%	68.6%	This measure remains red as performance is below target and below national. Analysis shows a key area for improvement are placements commissioned externally. Commissioning team are

Ref	Definition	Good Perf is	2011-12 PERFORMANCE	LOCAL TARGET	2012-13 PERFORMANCE *(unvalidated)*	Direction of Travel*	RAG STATUS**	Latest Benchmarking Data: Statistical Neighbour Average	Latest Benchmarking Data: National Average	Service Commentary
										working with providers to tackle this issue.
NI 64	Child protection plans lasting 2 years or more	LOW	2.2% (8/362)	4.0%	**3.8%** (15/395)	Declined	**Green**	6.1%	5.6%	Although performance has declined this remains good performance, better than target and comparators.
NI 65	Percentage of children becoming the subject of a Child Protection Plan for a second or subsequent time	LOW	11.8% (52/442)	13.3%	**16.3%** (52/319)	Declined	**Red**	14.0%	13.8%	Performance has declined and below targets and comparators.
NI 66	Looked After Children cases which were reviewed within required timescales	HIGH	98.02% (346/353)	97.5%	**96.1%** (346/360)	Declined	**Amber**	92.0%	90.0%	Performance is below target however compares well against comparator data.
NI 67	Percentage of child protection cases which were reviewed within required timescales	HIGH	100% (335/335)	99.0%	**100%** (211/238)	Same	**Green**	92.0%	90.5%	100% performance
NI 68	Percentage of referrals to children's social care going on to initial assessment	HIGH	93.9% (4614/4913)	87.6%	**91.9%** (3521/3833)	Declined	**Green**	77.0%	74.6%	Although there is a slight drop performance is high and well above comparators.

***Direction of Travel**
Due to the nature of some of the indicators good performance can sometimes be high figures and other times low. This helps understand of whether performance has improved, declined or stayed the same when compared to the previous year.

****RAG Status definition**:
Green – on/above target
Amber – off target but in line with stat neighbours and national average
Red – off target and below stat neighbours and national average

Appendix 2

Board Member Attendance

Attendance of RLSCB Members in 2012 – 2013 (including Development Days and Extraordinary Meetings)			
		Total Attendance (inc deputies)	**Attendance as %**
Name	**Job Title and Agency**		
Alan Hazell	Independent Chair, Rotherham Local Safeguarding Children Board	6 out of 6	100%
Joyce Thacker	Strategic Director of Children and Young People's Services, Rotherham Metropolitan Borough Council	4 out of 6	67%
Howard Woolfenden Clair Pyper – interim from Dec 2012	Director of Safeguarding Children and Families, Rotherham Metropolitan Borough Council	5 out of 6	83%
Paul Grimwood	Youth Offending Services Manager, Rotherham Metropolitan Borough Council	5 out of 6	83%
Dorothy Smith	Senior Director of Schools and Lifelong Learning, Rotherham Metropolitan Borough Council	5 out of 6	83%
Jane Skupien	Head Teacher, Sitwell Infants School	2 out of 6	33%
Nick Whittaker	Head Teacher, Hilltop and Kelford Special Schools	0 out of 2	0%
John Radford	Director of Public Health, NHS Rotherham	3 out of 6	50%
Juliette Greenwood	Chief Nurse, The Rotherham NHS Foundation Trust	5 out of 6	83%
Deborah Wildgoose	Deputy Director of Nursing, Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH)	4 out of 6	67%
Shona McFarlane	Director of Health and Wellbeing, Neighbourhoods and Adult Services, Rotherham Metropolitan Borough Council	4 out of 6	67%
Pete Horner / Dave Stopford	Public Protection Unit Manager, South Yorkshire Police / Detective Chief Inspector, South Yorkshire Police	6 out of 6	100%
Maryke Turvey / Sarah Mainwaring – from Aug 2012	Head of Rotherham Delivery Unit, South Yorkshire Probation Trust	3 out of 6	50%
Pat Armitage / Anne Riley – from Dec 2012	Enhanced Service Manager, CAFCASS	3 out of 6	50%
Maryann Barton	Service Manager, Action for Children	5 out of 6	83%
Richard Burton	Lay Member, Rotherham Local Safeguarding Children Board	4 out of 6	67%
Gary Smith / Diane Smith	Lay Member, Rotherham Local Safeguarding Children Board	2 out of 4	50%
Martin Oldknow / Steve Green – from Dec 2012	Group Manager East Area (Doncaster & Rotherham), South Yorkshire Fire and Rescue Service	2 out of 6	33%
David Polkinghorn	General Practitioner, NHS Rotherham	4 out of 6	67%
Sue Cassins	Executive Lead for Safeguarding at the Clinical Commissioning Group, Rotherham	4 out of 6	67%

Appendix 3

RLSCB Budget Statement 2012/13 Outturn

Budget Statement 2012/13 Outturn	Funding Formula	Budget 2012/13	Outturn 2012/13
	%	£	£
Income 2012/13			
Annual Contributions			
Rotherham Borough Council	55.80%	99,479	99,479
NHS Rotherham	25.90%	45,589	45,589
South Yorkshire Police	15.30%	26,901	26,901
South Yorkshire Probation	Capped	5,300	5,480
CAFCASS	0.30%	590	550
Other Contributions			
Surplus from previous year		42,663	42,663
NHS Rotherham - L&D Contribution		22,000	22,000
Grant Income - Munro Monies		42,000	42,000
Total Income		**284,522**	**284,662**
Expenditure 2012/13			
RLSCB Salaries *		154,889	155,196
Public Liability Insurance		800	694
IT & Communications		3,100	302
Printing		1,200	1,497
Stationery and Equipment		401	152
Learning & Development (RLSCB and Multi-agency) *		97,632	96,791
Independent Chair		20,000	16,940
Software licences & maintenance contracts		6,500	6,150
Total Expenditure		**284,522**	**277,722**
Surplus		**0**	**6,940**

* Child Death Overview Panel administration costs of £14,427 are included in these accounts.

15. Glossary of Terms

Although great effort has been taken to avoid jargon in this report, this Glossary of Terms may be helpful in explaining again the use of any acronyms or abbreviations.

ACPO	Association of Chief Police Officers
CAF / FCAF	Common Assessment Framework
CAFCASS	Children and Family Court Advisory and Support Service
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CPP	Child Protection Plan
CYPS	Children and Young People's Services
CYPTB	Children's Trust Board
DASH	Domestic Abuse, Stalking and Honour Based Violence
DCS	Director of Children's Services
DfE	Department for Education
IMR	Individual Management Reviews
ISA	Independent Safeguarding Authority
LAC	Looked After Children (in care)
LSCB	Local Safeguarding Children Board
NAS	Neighbourhoods and Adult Services
OFSTED	Office for Standards in Education
RDASH	Rotherham Doncaster and South Humber NHS Foundation Trust
RFT	Rotherham Foundation (Hospital) Trust
RLSCB / Board	Rotherham Local Safeguarding Children Board
SCR	Serious Case Review
YOT	Youth Offending Team

GP and Dental Practices: Insight and intelligence for Rotherham Health and Well Being Board

For the purpose of this information comparisons have been made between Rotherham and Barnsley CCG (both ex –mining towns with similar demographics) and the South Yorkshire and Bassetlaw area. According to the CCG classification groups published by Public Health England; Rotherham, Barnsley, Doncaster and Bassetlaw all have an orange classification meaning that they have a population with an average age structure, average deprivation levels and a low population density. Sheffield has a yellow classification meaning that they have a younger population with a higher than average proportion of the population from Black and Asian ethnic groups and moderate levels of deprivation

Demographics

According to the Health profile published 24th September 2013[1] the health of people in Rotherham is generally worse that the England average whereas the health of the people in Barnsley is varied compared to the England average. In both Rotherham and Barnsley deprivation is higher than average and about 11,500 and 10,700 children respectively live in poverty. Life Expectancy is in Rotherham slightly worse than in Barnsley with10.2 years lower for men and 6.4 years lower for women in the most deprived areas than in the least deprived. In both Barnsley and Rotherham over the last 10 years, all-cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen and despite this remains worse than the England average.

GP Practices

In summary and in response to the question; Is the number of GP practices in Rotherham comparable with other areas? The answer based on the information below is yes the number of GP practices is comparable with other areas.

Rotherham has 36 practices; 5 APMS (with 3 working as a social enterprise), 8 GMS and 23 PMS practices with an actual registered population (as at July 2013) of 256,793; showing an increase of 130 patients since April 2013. Out of the 36 practices 6 (17%) of those are single handed GPs. In comparison;

Barnsley has 38 practices; 3 APMS, 18 GMS and 17 PMS practices with an actual registered population (as at July 2013) of 251,486; showing and increase of 562 patients since April 2013. Out of the 38 practices 6 (16%) of those are single handed GPs; proportionately Rotherham has slightly more singlehanded GPs.

[1] Rotherham – Health Profile 2013 Public Health England

The annual national GP survey shows that 46% of patients from Barnsley and Rotherham rated the overall experience of the GP survey as very good and 43% & 42% of patients respectively rated the experience as fairly good.

The Primary Care Web based tool (has 2 modules quality and improvement and quality assurance) provides CCG and practice level information across 5 domains (premature mortality, Long Term Conditions, Recovery from injury/illness, patient experience and patient safety) and 38 indicators mapped across to the domains.

Barnsley has 6 practices having been identified as having 5 or more points across the 38 indicators which are considered as outliers whereas Rotherham has only 3 practices that are considered as outliers. Discussions are on going about the assurance process from a contracting perspective.

Dental Services

In answer to the specific question raised i.e. "Is there sufficient dental provision within Rotherham compared to other areas?"

The figures shown at Appendix One shows that for all our localities, including Rotherham we have better access rates when compared with the England average. However, it is noteworthy that nationally although the numbers of people accessing dental services has gone up, as a percentage of population children visiting a dentist had remained stable in recent years, ie about 7 in 10 children. This apparent lack of change will be of interest to policy makers.

At the other end of the age spectrum we have an increasingly dentate elderly population. Nationally the proportion of adults, including those over 85 years of age, retaining natural teeth is increasing. Although many oral diseases are largely preventable older people are more likely to experience difficulties in managing their oral care. The Local Professional Network (Dental) will be establishing a domiciliary dental care workstream to develop a way forward. There are significant variations in domiciliary care offered within Rotherham and across South Yorkshire and Bassetlaw. An increasing proportion of older people will be susceptible to both tooth decay and gum disease and will require more complex dental treatment to prevent progression.

Unplanned care in Rotherham (and across SYB) is arranged via a Dental Access Service. This provides a means of accessing dental care for those patients who choose not to go to a dentist on a regular basis.

Appendix One

Patients seen in the previous 24 months as a percentage of the population, by patient type and primary care trust from 31 March 2006, 31 March 2013 and 30 June 2013 (including orthodontic patients)

	Adults			Children					
PCT Name	**31 Mar 2006**	**31 Mar 2013**	**30 Jun 2013**	**31 Mar 2006**	**31 Mar 2013**	**30 Jun 2013**	**31 Mar 2006**	**31 Mar 2013**	**30 Jun 2013**
England	**51.6**	**52.5**	**52.5**	**70.7**	**69.1**	**69.1**	**55.8**	**56.1**	**56.0**
BARNSLEY PCT	60.8	64.4	64.4	72.1	77.0	76.9	63.3	67.0	67.0
BASSETLAW PCT	52.8	59.1	59.2	63.4	69.7	69.5	55.1	61.3	61.3
DONCASTER PCT	64.3	70.5	70.1	74.6	78.0	77.8	66.6	72.1	71.8
ROTHERHAM PCT	50.4	60.9	60.9	63.6	74.0	73.9	53.4	63.7	63.7
SHEFFIELD PCT	61.3	60.3	60.4	80.9	75.9	76.1	65.3	63.5	63.6

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**16th October, 2013**
3.	**Title:**	**Healthwatch Rotherham Outcomes Framework and Work Plan**
4.	**Directorate:**	**Neighbourhood and Adults Services**

5. Summary:

Parkwood Healthcare Ltd was awarded the Healthwatch Rotherham contract which commenced on the 1st April, 2013. Contract monitoring arrangements have been established, this includes an outcomes framework. This framework requires performance against the outcomes to be achieved, as detailed within the contract, to be monitored and reported against on a monthly basis.

The work plan for Healthwatch Rotherham details the specific pieces of work that Healthwatch Rotherham will undertake, or contribute to, in line with their role. This work plan is based on the Health and Wellbeing Strategy priorities but also local intelligence gathered about health and social care services in Rotherham. There is capacity within the work plan for Healthwatch Rotherham to respond to the number of ever increasing enquiries/issues from members of public or to undertake specific consultation with members of the pubic as determined appropriate.

6. Recommendations

That the Health and Wellbeing Board:

6.1 Approves the Outcomes Framework for Healthwatch Rotherham

6.2 Approves the Healthwatch Rotherham Work Plan for 1st September, 2013 to 31st March, 2014.

6.3 Receives exception reports on the performance of Healthwatch Rotherham and progress against the outcomes framework and the work plan.

7. Proposal

7.1 Background

RMBC has commissioned Healthwatch Rotherham (HWR) and the contract commenced on the 1st April, 2013. It was the intention that the contract would be between a new social enterprise company named Healthwatch Rotherham and RMBC. However, this was not possible in the timescales due to the re-tendering process and therefore the current contract has been awarded to Parkwood Healthcare Ltd on the basis that they support and provide leadership to Healthwatch Rotherham. It is, however, the intention that once the infrastructure for HWR has been established and all concerned are confident that they can operate independently, there will be a contract novation (obligation transferred) to HWR.

The contract sets out the specific requirements and outcomes to be achieved during the term of the contract. RMBC's usual contract monitoring arrangements have been established and this includes monthly meetings with HWR/Parkwood Healthcare Ltd.

7.2 Appendix 1 - The Outcomes Framework for Healthwatch Rotherham

This outcomes framework sets out how the outcomes to be achieved (as agreed within the contact) will be delivered, measured and within what timescales. This outcomes framework will enable Parkwood Healthcare and HWR to evidence their achievements and the level of performance they are operating within. This framework focuses on the roles and functions that HWR should deliver as a consumer champion and through the performance measures identified be able to demonstrate the impact achieved overall.

Rotherham is part of the Yorkshire and Humber Regional commissioning group for Healthwatch and this group has developed outcomes and measures that can be used by the group Authorities to enable some element of benchmarking to be achieved. These outcomes are highlighted in italics in the document with a reference: (Y&H). The regional group are also currently developing the customer survey which will be used to capture customer satisfaction with Healthwatch and provide some of the evidence that they are operating effectively.

7.3 Appendix 2 – Healthwatch Rotherham Work Plan 1st September, 2013, to 31st March, 2014.

The Healthwatch Rotherham work plan details the specific work that HWR will undertake during the first year until the 31st March, 2014. This work has been identified through the HWB steering group, specific issues raised with HWR from both the public and partners but also recognising specific activity is required eg. Rotherham Show along with attendance at relevant strategic meetings. The work plan will enable Parkwood Healthcare and RMBC to manage the requirements of / expectations of HWR within the capacity available. There is however some flexibility within the work plan to undertake specific engagement activity that relates to the HWBB strategy and

this would be for the HWBB to determine. Some flexibility is also required to meet the future demand for the service and given this is the first year for HWR the volume and variety of everyday activity is yet to be determined. It is also unknown whether there are any further specific requirements of HWR from other partners that were not detailed in the legislation.

It is anticipated that there will be more capacity in the work plan for the second year of the contract given the functions will have been fully established and operational. However, it is recognised that HWR will also be responding to more issues/enquiries from members of the public by then given the ongoing public awareness of the service and the impact it is making, it is likely to attract more service users to take up their issues with HWR.

It is proposed that the Health and Wellbeing Board approve the Outcomes Framework and the Work Plan. Future reports on performance will be presented to the Health and Wellbeing Board.

8. Finance

The value of the Healthwatch Rotherham contract is £220,000 per annum, the contract is for two years 2013-2015. No additional finance will be required to undertake the activity within the work plan attached or respond to the outcomes framework.

9. Risks and Uncertainties

Healthwatch Rotherham is a relatively new service and the more people that become aware of its purpose, the greater the response that will be required from HWR on a daily basis. The uncertainties around managing the potential increase in enquiries from service users or the public along with implementing the prescribed activity within the work plan will remain. It is the intention however that the work plan and any concerns regarding the volume of work will be monitored as part of the contract review meetings.

10. Policy and Performance Agenda Implications

The performance of, and work plan for, HWR is linked to the priorities within the Health and Well Being Strategy.

11. Background Papers and Consultation

None

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Healthwatch Rotherham Outcomes Framework (Version 3 August 2013) APPENDIX 1

The key outcomes to be delivered by Healthwatch Rotherham are detailed in this document. It was always the intention that the timescales, outputs and evidence to demonstrate achievement of these outcomes would be discussed in more detail with Parkwood Healthcare when developing Healthwatch Rotherham (HWR).

This document will enable HWR, with the support from Parkwood Healthcare, to detail their performance against the outcomes agreed with RMBC and demonstrate that HWR has robust mechanisms in place for seeking and recording customer and stakeholder feedback; activity levels and quality service delivery.

This document will be used at each contract performance monitoring meeting and progress should be provided in advance. This outcomes framework includes the Yorkshire and Humber Commissioners Group outcomes which are highlighted in italics for reference.

1. An effectively managed Healthwatch Organisation

	Outcome	Performance Measure(s)	Output	Timescales
1.	The HWR Service is established with the support from Parkwood Healthcare to include:- - establishment of management and governance structures, agreement to HWR constitution and appointment of members.	Full staff compliment recruited along with HWR Board with clear roles and responsibilities. (1 original community engagement post to remain vacant until demand determined)	Full staffing structure in place and providing HWR functions.	31st July 2013
	- recruitment to Executive Officers, Board Members and staff to deliver HWR functions.	Successful appointment to roles.	HWR Team able to respond to every day functions.	5th September, 2013
	- determining representatives on strategic bodies eg scrutiny.	Representatives determined and relevant body informed.		20th September, 2013
	- budget profiling and regular budget management.	Budget profile reconciled against actual spend.	Budget re-profiled for the year following recruitment/set up.	Quarterly and Annually
	- develop and maintain relevant policies and procedures for HWR functions including safeguarding and enter and view and provide training.	Evidence of policies developed and being implemented.		30th August 2013.
	- leadership and operational business systems to enable HWR eventually to operate independently as a social enterprise.	Systems in place and operating eg. making payments.	HWR operating as an independent organisation.	To discuss / date to be confirmed by Parkwood Healthcare
2.	The priorities for HWR are developed in	Minutes of meetings.	Work plan agreed by HWBB	30th September 2013

	Outcome	Performance Measure(s)	Output	Timescales
	partnership with local stakeholders and the wider community and based on evidence and local need.	Record of issues brought to HWR and disaggregated by stakeholders.	Board by September 2013	
3.	*People who engage with HWR (the public, HSC partners and other stakeholders) are satisfied with the service provided. (Y&H outcome)*	*Overall satisfaction of people who engage with HWR. (Numbers/% but needs a sufficiently large sample)* *Evidenced through Customer and Partner Surveys, evaluation sheets.*	Satisfaction survey developed and distributed to those who have engaged with the service within the year (sample of if significant numbers). Number of contacts with HWR are recorded, including some detail of the contact.	Annual Satisfaction Survey conducted and report 31st June 2014.
4.	HWR is visible and has a presence in the town centre and is widely recognised by the community.	*Overall awareness of HWR among local people (reflecting demographic profile of whole area), commissioners and providers.* Measured through Customer and Partner surveys and CRM, database, marketing and comms strategy (Y&H) *Baseline completed around awareness of HWR.*	HWR is recognised by official branding as an independent consumer champion.	Local Shop access point available 31st July, 2013.
5.	*People have easy access to accurate and appropriate information about Health and Social Care Service so they can make better choices or decisions. (Y&H)*	Overall satisfaction with access to services provided by HWR/quality of information provided/outcome of signposting. % people stating information provided by HWR has helped them make decisions/signposted them to appropriate information. Number of people successfully signposted/details of support given. Measures: Customer and Partner Survey, evaluation forms, c*omplaints and compliments received about information provide, hits on website, level of media coverage, case studies..*	Number of enquiries recorded broken down by method of communication. Record of nature of signposting enquiry maintained along with support given. Information published on website, publicity material, newsletters etc. Also made attractive to young people	Ongoing / reported monthly. Year 1 baseline.

	Outcome	Performance Measure(s)	Output	Timescales
6.	An independent complaints advocacy function is established to provide advocacy support to NHS service users and their carers who wish to make a complaint.	Number of people using the service, details of support required and that provided. Record maintained of detail of the complaint, length of time taken to resolve, plus detail around escalation and outcomes. Performance monitoring around numbers, timescales and eligibility for access to be monitored.	Record maintained of number of NHS complaints advocacy cases responded to. An overview of the Health complaints procedures and relationships with complaints staff maintained to facilitate effective resolution to complaints.	Ongoing. Monthly reports.
7.	A performance management framework is in place to enable self evaluation of performance and identification of areas for improvement. This should include the ability to demonstrate how HWR it has made a positive impact on local decision-making and improved services.	Self assessment tool developed by Parkwood Healthcare for use by HWR and examples provided of where and how it has been used. Quality measures are used to monitor performance inducing service user complaints and compliments.	Reports on self evaluation.	Annually.

2. Independent, Influential and Accessible to Everyone

No	Outcome	Performance Measure	Output	Timescales
8.	*Greater patient and public involvement in the commissioning cycle for Health and Social Care (including from minority and seldom heard groups). (YH outcome)*	*Numbers/% of local people who have been involved in HSC planning, commissioning, deliver or review, as a direct result of HWR* *[Evidence of] HSC services having more engagement with communities who are traditionally least engaged, as a result of HWR work programme.* *Measured through customer and partner survey i.e. numbers of HSC partners involving more people in different aspects of their services through LHW.*	Record maintained of the number of community engagement meetings held along with details of the key challenges raised. To include what was the outcome of the challenge.	Ongoing / monthly monitoring meetings Date of survey to be agreed. Year 1 baseline.

No	Outcome	Performance Measure	Output	Timescales
9.	*Local people have a better understanding / greater awareness of Health and Social Care issues so they can gain control over their own lives and act on issues they define as important (Y&H)*	*Increasing numbers of people gaining the skills, information or knowledge that will help them have more confidence or self-sufficiency in accessing HSC services that benefit them or their family.* *Measured through Customer survey, database, volunteers surveys, evaluation forms, annual report* *Measured through work plan around engagement, examples of collaboration with HSC partners, board minutes.*	Record of information given against enquiries.	Ongoing / reported monthly. Year 1 baseline.
10.	*People can connect with HWR in a way that suits them, to give or get information (Y&H)* Innovative methodology and inclusive social activities are used to encourage participation.	*Overall satisfaction with opportunities to be involved with HWR (by protected characteristics) / % people agree HW uses appropriate engagement methods.* *Measured through customer and partner survey, database.* *Increased number of partners and communities (geographic, community of interest, seldom heard) engaged in HWR network and provided with opportunities to contribute and raise issues.* *Measured through annual engagement plan, customer and partner surveys, HWR records on database*	Record of engagement activity, community groups engaged, engagement tools used and whether successful. Record of issues discussed. Explore the development of apps and/or social networking for young people to use.	Year 1 baseline
11.	*Commissioners and providers have a greater understanding of local health and social care needs from people's experience of services, including NHS complaints advocacy. (YH Outcome)*	*Increased numbers of commissioners and providers agreeing that HWR presents accurate information in a credible way, demonstrating high quality robust data gathering and analytical skills.* *Measured through partner survey, reports to HWB.*	Partner survey developed and used to gather evidence around whether HWR has enabled a greater understanding of HSC needs.	Ongoing – Monthly Report around activity. Date of survey to be agreed. Annual for information.

No	Outcome	Performance Measure	Output	Timescales
		HSC provider actions/responses to HRW reports. *Number of reports showing that HWR makes sense of all the information it has available locally (including JHWS, JSNA, MHSCA and HWE 'Hub'), identifies gaps and suggests appropriate action.* *All measured through partnership survey, reports to HWB, HSC provider actions/responses to HWR reports, HWR references in HSC plans/strategies. .*		
12.	*Patient, public and carer voice is driving improved Health and Social Care Services and a better patient experience (YH Outcome)*	*Number of cases where HWR can demonstrate where community involvement, supported by HWR, has resulted in HSC service improvement or evidenced the need for change to services (Y&H measure)* Measured through case studies, annual report, reports to HWB, HSC provider actions/responses to HWR reports and customer and partner survey. Reports to indicate what changes have been made following HWR involvement.	Reports presented to HWBB to influence service improvements. Reports and information for accountable bodies are published in a constructive way using good information governance and professional standards including confidentiality.	Ongoing – monthly report activity.
13.	*Local people and groups feel that HWR is working effectively on their behalf (Y&H)*	Numbers / % people and groups connected with HWR who feel that it is acting as an effective consumer champion in the area, ie. Ensuring that the voice of consumers and those who use HSC services reach decision makers. Increased numbers of requests for support or involvement from CCG's and relevant HSC networks including 3rd sector i.e. HWR adding value and not duplicating existing networks. Measured through customer and partner survey, case studies, annual report.	Number of people who state HWR is an effective consumer champion.	Ongoing – quarterly activity. Year 1 baseline.

No	Outcome	Performance Measure	Output	Timescales
14.	HWR is seen as a credible and influential voice on the HWBB. (Y&H outcome)	*Number of requests from HWBB, commissioners and providers to provide intelligence around HSC services/contribute to JSNA.* *[Evidence of] a clear and transparent process for prioritising work of HWR.* Measured through partnership survey, annual report, case studies, annual work programme.	HWR responded to requests from HWBB around consultation / intelligence to inform service improvements. Made positive contribution to JSNA, local health and social care planning and commissioning. Evidence presented is credible and reflects local communities view/can constructively challenge on behalf of the community/works well with others LHW on cross-boundary issue.	Ongoing – Quarterly report. Year 1 baseline.
15.	A timely two-way information flow will be established between Healthwatch England and HWR. Information is gathered from various sources as evidence to support appropriate recommendations to Healthwatch England and/or the CQC	Evidence of facilitating local resolution to issues identified. Evidence of working in partnership to improve services.	Local resolution of issues is facilitated and encourages a positive 'critical' friend approach. Relevant reports submitted to Healthwatch England and/or CQC.	Ongoing – Quarterly Report.

3. Representative, and Promotes Community Involvement

No	Outcome	Measure	Output	Timescales
16.	Awareness is raised amongst commissioners, providers and other agencies about the importance of engaging with communities, and recognising the expertise and value that individuals and the voluntary and community sector can bring to discussions and decision making on local and national issues.	Reports to CQC, Health and Wellbeing Board, Quality Surveillance Group and statutory partners in this context.	Engagement with service users around service design and service improvements.	Ongoing – Quarterly Report. Year 1 baseline.

No	Outcome	Measure	Output	Timescales
17.	An understanding of the local communities in Rotherham and their health and social care needs is maintained to ensure services reflect need. Regular discussions on issues relevant to young people are included.	Evidence of how the needs of priority groups have been determined and discussed with relevant service providers and influenced wider commissioning activities.	Local input into JSNA.	Ongoing – Quarterly Report. Year 1 baseline.
18.	*HW is an inclusive, people-centred and learning organisation which demonstrates a commitment to continuous improvement by acting on feedback. (Y&H)*	*Number of volunteers / retained volunteers and level of involvement. (Y&H). Measured through customer satisfaction survey as detailed above.* *Evidence that HWR staff and volunteers are highly skilled and informed and appropriate training provided.* *Measured through HWR records and policies (training needs and skills analysis), customer and partner surveys, annual report, 360 degree feedback.*	Feedback following consultation is provided to those originally involved.	Ongoing – Quarterly Report. Year 1 baseline.

Healthwatch Rotherham Work Programme 1st September, 2013 to 31st March, 2014 APPENDIX 2

Action No.	Measure/Milestone	Task Manager	Timeline	Task Status (R, A, G,)	Progress/Outcomes
1. To Deliver the Healthwatch Rotherham Functions in an effective way					
1.1	The Healthwatch Rotherham outcomes framework is agreed and progress against the outcomes is reported monthly (or as detailed in the outcomes framework document).	Melanie Hall	Ongoing and Reported Monthly		Outcomes framework completed.
2. Contribute to the improvement of Health and Social Care Services by sharing concerns raised with relevant providers.					
2.1	Discuss with social care and health providers the issues that are raised about their service through public enquiries to Healthwatch Rotherham and facilitate local resolution.	Melanie Hall	Ongoing		
2.2	Attend and contribute as appropriate to the regional Quality Surveillance Group.	Melanie Hall	Quarterly Meeting		
2.3	Meet with the Care Quality Commission to understand / share wider service development issues as appropriate.	Melanie Hall	Quarterly Meeting		
2.4	Attend the Patient Participation Group to share information on local concerns raised by the health community.	Melanie Hall	As required		
2.5	Make contact with the Youth Cabinet to raise awareness of Healthwatch and determine other opportunities to gather the views of children and young people on current health and social care issues that mater to them.	Melanie Hall	To be determined		
2.6	Attend Area Assemblies / Parish Council Meetings as when required to keep abreast of current issues/concerns from the wider public.	Melanie Hall	Ongoing		
2.7	Continue to attend relevant community events to raise the profile of Healthwatch Rotherham.	Melanie Hall	Ongoing		

3. Gather the views of Health and Social Care Service Users to inform specific changes across Health and Social Care					
3.1	In conjunction with the HWBB, and in line with the HWB strategy, identify specific areas that require consultation with members of the public to inform change management programmes.	Naveen Judah	To be determine as appropriate		
3.2	Determine the scope, outcomes and reporting parameters for such specific consultation (taking into account the capacity of HWR)	Naveen Judah	To be determined		
3.3	Consider where Healthwatch Rotherham can contribute to a specific Scrutiny Review to assist the understanding of the different roles of each function.	Naveen Judah	To be determined		
3.4	Consider how Healthwatch Rotherham can contribute to specific pharmacy change requests from NHS England	Naveen Judah	Monthly		
3.5	Consider how Healthwatch Rotherham can contribute to the NHS acute hospital annual place assessment (6 week programme).	Naveen Judah	Monthly		
4. Contribute to existing quality assurance processes using 'Enter and View' process					
4.1	Determine in consultation with RMBC the residential homes where 'enter and view' would support the ongoing quality assurance process.	Naveen Judah	October 2013		
4.2	Determine in consultation with CCG and NHS England the health settings where 'enter and view' would support the ongoing quality assurance process.	Naveen Judah			
4.3	In conjunction with RMBC, CCG and NHS England, respond to requests for 'enter and view' visits.	Naveen Judah	Ongoing		
4.4	Agree with RMBC, the first 'enter and view' to be undertaken jointly to share the learning and ensure processes are understood.	Naveen Judah	December 2013		
4.5	Agree with CCG and NHS England, the first 'enter and view' to be undertaken jointly to share the learning and ensure processes are understood.	Naveen Judah	December 2013		

5. To contribute to the Safeguarding Board Requirements					
5.1	Attend the RMBC Safeguarding Adults Board and the Children Safeguarding Board to feed in issues and concerns and using Safeguarding alert knowledge into the Healthwatch process. (This is not about undertaking consultation or engagement around safeguarding)	To be confirmed	Quarterly Meetings		
5.2	To consider the strategic safeguarding issues identified by the Safeguarding Boards and ensure these are communicated to Healthwatch Rotherham Members and relevant Stakeholders.	To be confirmed	Ongoing		
6. Contract review meetings with RMBC					
6.1	Healthwatch Rotherham Manager and Parkwood Healthcare representative (when required) to attend monthly performance/contract review meetings and report on progress	Melanie Hall	Monthly		
7. To Recruit and retain Volunteers					
7.1	Healthwatch Rotherham to have specific volunteer roles and volunteer coordinator with a rolling programme of induction and training in relation to the projects to be undertaken by Healthwatch Rotherham	Melanie Hall	On going		
8. Rotherham Show					
8.1	Healthwatch Rotherham to manage a stall and plan for the event to include both awareness raising and responding to issues raised.	Melanie Hall	September		Completed
8.2	Healthwatch to follow up on any issues raised with individuals and services where necessary	Melanie Hall	September		

8.3	Healthwatch to report on issues raised and outcomes of the show to be submitted to RMBC	Melanie Hall	November		
9. Innovative ways to engage the wider public					
9.1	Attend Rotherham College welcome week	Melanie Hall	September		
9.2	Meet with hairdressers across Rotherham to explain benefits of working with Healthwatch	Melanie Hall	Ongoing 2013-14		
9.3	Meet with Rotherham college and hairdressing students	Melanie Hall	December		
10. Connect 2 support					
10.1	Encourage and enable members of the public to use connect to support to purchase and identify services to met their health and social care needs	Melanie Hall	Ongoing		
10.2	Healthwatch Rotherham staff to undertake training using the e-learning package.	Melanie Hall	Ongoing		
11. Launch Healthwatch Rotherham					
11.1	Plan and deliver an official launch event	Melanie Hall	2nd October		
11.2	Evaluate Launch and measure impact.	Melanie Hall	10th October		
11.3	Continued public awareness raising of HW Rotherham	Melanie Hall	August 2014		
11.4	Complete a further impact assessment of public awareness of Healthwatch Rotherham using 2013 baseline.	Melanie Hall	October 2014		