HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 3rd December, 2014**

Time: **9.00 a.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. Questions from Members of the Press and Public

4. Minutes of Previous Meeting (Pages 1 - 9)

5. Communications (Pages 10 - 11)
   - NHS England letter on organisational alignment and capability programme (Carol Stubley)
   - Better Care Fund – verbal update (Tom/Chris Edwards)

6. NHS 5 Year Forward View (Pages 12 - 28)
   Carol Stubley, NHS England, to present

7. Care Act
   Presentation by Shona McFarlane, Director of Health and Wellbeing

8. Commissioning Framework (Pages 29 - 49)
   Chrissy Wright to present

9. Health and Wellbeing Strategy Refresh (Pages 50 - 53)
   Michael Holmes to present

10. Date of Next Meeting
    Wednesday, 21st January, 2015 at **11.00 a.m.**

HEALTH AND WELLBEING BOARD
Wednesday, 12th November, 2014

Present:-

Councillor Doyle	Cabinet Member, Adult Social Care and Health **In the Chair**
Councillor Beaumont	Cabinet Member, Children and Education Services
Bob Chapman	South Yorkshire Police
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Chris Edwards	Rotherham CCG
Councillor Hoddinott	Deputy Leader
Julie Kitlowski	Chair of Rotherham CCG
Ian Jennings	
Naveen Judah	Healthwatch Rotherham Ltd.
Jan Ormondroyd	Interim Chief Executive, RMBC
Jason Page	Rotherham CCG
Nigel Parkes	Rotherham C.C.G.
Joanna Saunders	Director of Public Health (representing Dr. J. Radford)
Carol Stubley	NHS England
Janet Wheatley	Voluntary Action Rotherham

Also Present:-

Chris Bain	RDaSH
Michael Holmes	Rotherham Policy and Partnerships
Chris Holt	N.H.S. Foundation Trust
Jane Parfrement	Acting Strategic Director of Children and Young People's Services
Councillor Sansome	Vice-Chairman of the Health Select Commission
Janet Spurling	Scrutiny Services
Jasmine Swallow	Policy and Partnerships
Paul Theaker	Operational Commissioner
Sue Wilson	Performance and Quality Manager

Apologies for absence were received from Louise Barnett and Natalie Yarrow.

S35. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

There were no questions from members of the public or the press.

S36. MINUTES OF PREVIOUS MEETINGS

Resolved:- That the minutes of the two previous meetings of the Health and Wellbeing Board, held on (a) 1st October 2014 and (b) 24th October, 2014, be approved as correct records.

With regards to Minute No. 28 (Vaccinations and Immunisations for Pregnant Women) of the meeting held on 1st October, 2014 it was noted that no specific action had as yet taken place, but an update on progress would be provided at the next meeting.

Reference was also made to Minute No. S33 (Response to the Jay Report) and an update was requested on the priorities and actions assigned to N.H.S. England given that the Health and Wellbeing Board was to monitor progress. The recommendations had also requested that discussions take place between the Chairs of the Health and Wellbeing and Local Safeguarding Children's Boards and for the Needs Assessment and Pathways document be distributed to all partners by email once this had been completed.

The Board heard that no further information was available with regards to the actions assigned to N.H.S. England, but that arrangements were in hand for a meeting between the Chairs of the Health and Wellbeing and Local Safeguarding Children's Boards and the Cabinet Member with regards to a way forward.

An update was also provided on the changes to Public Health leadership, reporting mechanisms and the role of the Child Sexual Exploitation Sub-Group and the remit of the Gold Group. Any issues that needed to be forwarded on should be via the Child Sexual Exploitation Sub-Group, which was a sub-group of the Local Safeguarding Children's Board.

S37. COMMUNICATIONS

(1) Better Care Fund Plan – Assurance Review

Further to Minute No. S24 of the meeting of the Health and Wellbeing Board held on 1st October, 2014, the Board considered correspondence from the National Director (Commissioning Operations), NHS England, stating that the Better Care Fund plan had been assessed as part of the Nationally Consistent Assurance Review (NCAR). The letter stated that the Better Care Fund plan has been placed in the 'approved, subject to conditions' category.

The Strategic Director of Neighbourhoods and Adult Services outlined the content of the letter drawing particular attention to the eight separate actions and the appointment of the Better Care Adviser, Nick Clarke, who would work on developing an action plan to detail how and by when the agreed actions would be addressed to meet the conditions. Many of the conditions would simply be met by the importing the detail onto the new template, which needed to be completed by the 7th December, 2014 deadline.

It was also noted that the Section 256 Transfer Document had not been included as part of the documentation, but that it be noted that

the use of the Better Care Fund was in accordance with the Section 256 Transfer Document.

(2) Health and Wellbeing Website

Michael Holmes and Jasmine Swallow demonstrated the accessibility tabs on the new Health and Wellbeing Website, which would be subject to partnership branding.

This also coincided with the launch of the new online survey on the 29th October, 2014 which had had 102 responses initially. Feedback to date had been positive and had been extended to external and internal organisations and partners.

Discussion ensued on the various links to the partner websites and how the website would be managed through the workstream group.

(3) Health and Wellbeing Board Minutes and Meetings

The Chairman was in receipt of some correspondence from a member of the public who had raised concern about the use of acronyms in some of the reports being presented. To alleviate this problem it was suggested that all reports have the full description with the acronym in brackets.

It was also suggested that some consideration be given to a bullet point list summary of reports for members of the public rather than them having to sieve through the large number of pages on the agenda.

This needed to be explored further on the feasibility of such a suggestion and whether it was something that could be accommodated within the resources available.

In addition, the member of the public referred to an incident involving the Foundation Trust, where an unregistered locum doctor was employed at the hospital via an agency.

The Chief Officer for the C.C.G. Office provided an overview of the incident, the reasons how it came about and the outcome, which had led to an improved agency framework that provided the relevant assurances that such an incident would not occur again in the future. It was stressed, however, that during the course of the two day locum period there were no concerns for members of the public.

(4) Budget Consultation Process

The Deputy Leader provided an overview of the budget consultation process open to members of the public until 31st December, 2014, on three priority areas:-

- Protecting our most vulnerable children and adults.
- Getting back into work and making work pay.
- Making our streets cleaner and better.

The challenge facing the Council was for savings of £23 million next year and £50 million over the next three years.

This was a similar situation being faced across the public sector and formed part of the efficiency programmes around the Health and Wellbeing Board priority outcomes.

S38. JOINT PROTOCOL BETWEEN HWBB /HEALTH SELECT COMMISSION/HEALTHWATCH

Consideration was given to the report detailing the Joint Protocol between Health and Wellbeing Board/Health Select Commission/Healthwatch, which had would ensure that the bodies develop a constructive and productive working relationship with one another. Each body had an independent role and a shared aim to reduce health inequalities and improve health and wellbeing outcomes. The roles were distinctive, but complementary and must add value to each other's work, and avoid duplication. This joint protocol detailed the distinctive roles of each body, and presented examples of working together and reporting arrangements.

The protocol had been considered by each of the respective bodies and was presented to the Health and Wellbeing Board for formal sign up.

It was suggested that slight amendments be made to the document by way of inclusion in the Health and Wellbeing Board box on the diagram, expanding on the role of commissioning and also revisions to the Chairs of the relevant bodies. If the Board were in agreement with these amendments then these would be included and the document signed off.

Resolved:- That the document be revised with the suggestions made above and for this then to be signed appropriately by the Chairmen concerned.

S39. DISABLED CHILDREN'S CHARTER

Consideration was given to the report which presented the Disabled Children's Charter for Health and Wellbeing Boards and requested that partner organisations sign up to this.

The Board considered the merits of signing up to various different charters and their individual stand from their individual organisations.

The Board discussed at length a uniformed approach to accepting Charters in principle, but agreed not to sign up to individual Charters as a

Board. The principles set out in the Charters would be considered and it was this approach that should be taken forward.

Resolved:- That the principles of the Disabled Children's Charter be accepted.

(2) That the Board consider the principles within all Charters submitted to it only and no individual Charter be signed up to going forward.

S40. EMOTIONAL HEALTH AND WELLBEING STRATEGY

Consideration was given to a report presented by Nigel Parkes, Rotherham Clinical Commissioning Group, and Paul Theaker, Operational Commissioner, which detailed the draft Emotional Wellbeing and Mental Health Strategy 2014-19 which had been developed to support Local Authority, Health Commissioners and service providers to improve the emotional health and wellbeing of children and young people in Rotherham.

The final draft of the Strategy and associated action plan had been widely consulted upon. This had been approved through both the Rotherham MBC and Rotherham Clinical Commissioning Group (RCCG) governance processes and was attached to the report and detailed the key recommendations and actions to be taken forward.

The strategy included sections on the scope of the strategy, the needs of children and young people, services in Rotherham, investment, challenges and risks and recommendations.

The strategy was widely consulted on with a wide range of stakeholders in June and July 2014, including RMBC Children and Young People Services, schools, colleges, NHS providers and VCS providers. There have also been specific consultation sessions with parents/carers and with the Youth Cabinet.

The responses from consultation have been evaluated and the draft Emotional Wellbeing and Mental Health Strategy was substantially amended to take into account the comments that have been made. In addition, the Rotherham Health Watch report on Child and Adolescent Mental Health Services (CAMHs) was reviewed to ensure that the key findings were addressed within the strategy.

The Rotherham Clinical Commissioning Group commissioned Attain, an independent sector consultancy organisation, to review CAMHs and their report was considered by the Clinical Commissioning Group. The Attain recommendations that the Clinical Commissioning Group agreed to take forward have been included within the strategy.

The key recommendations outlined within the Strategy were as follows:-

Recommendation 1 - Ensure that services are developed which benefit from input by young people and parents/carers.

Recommendation 2 - Develop multi-agency care pathways which move service users appropriately through services towards recovery

Recommendation 3 - Develop family focussed services which are easily accessible and delivered in appropriate locations.

Recommendation 4 - Ensure that the services being delivered are effective, appropriate and represent the best value for money for the people of Rotherham.

Recommendation 5 - Ensure that the services being provided are delivered at the appropriate time as required and not restricted to normal operating hours.

Recommendation 6 - Ensure that services across all tiers of provision are delivered by appropriately trained staff and that training and support is provided to Universal/Tier 1 services to ensure that patients do not unnecessarily move to higher tiers of provision.

Recommendation 7 - Ensure well planned and supported transition from child and adolescent mental health services to adult services.

Recommendation 8 - Explore the option of a multi-agency single point of access to mental health services for children and young people to ensure that appropriate referral pathways are followed.

Recommendation 9 - Ensure that services are better able to demonstrate improved outcomes for children and young people accessing mental health services.

Recommendation 10 - Promote the prevention of mental ill-health.

Recommendation 11 - Reduce the stigma of mental illness.

Recommendation 12 - Ensure that patients do not face inappropriate delays in accessing services, across all tiers, for assessment and treatment which adversely affect their recovery.

It should be noted that as the governance process progresses for final approval of the Strategy, the key recommendations and actions were already being acted upon. The development of multi-agency care pathways was a priority piece of work and would address a number of issues in relation to thresholds/access to services and pathways such as post diagnosis ASD. A workshop with stakeholders had been held and was informing the work of small time-limited working groups that have been established for each multi-agency pathway.

The Strategy had been approved by the Cabinet Member for Children and Education Services and by the Rotherham Clinical Commissioning Group Operational Executive and is coming to the Health and Wellbeing Board for final joint Council/ Rotherham Clinical Commissioning Group approval.

The Board appreciated the positive approach to the development of this Strategy and its links to the Mental Health Strategy and suggested that it be reviewed in March, 2015.

It was also suggested that as the Strategy began to evolve the baseline information and detailed outcomes be included so the direction of travel could be measured and closely monitored. Waiting times were key and it was uncertain if the Strategy actually addressed this, what action was being taken to reduce waiting times and what were the aspirational targets.

The Board were informed that G.P. surveys had been undertaken which supported the development of the Strategy to assist with measuring waiting time for appointments and G.P. experiences, which had seen a reduction in waiting time down to eight weeks from fourteen/fifteen weeks and significant improvements in referrals for assessment from March, 2015. This would continue to be reviewed on a six month basis. In addition, the Recovery College was an alternative to the Child and Adolescent Mental Health Service.

The Rotherham, Doncaster and South Humber NHS Foundation Trust confirmed that a whole system approach had been adopted to develop capacity and meet demand. A great deal of work had been undertaken with more to do to move forward and consider how best to use resources to meet the needs across all the tiers of support.

The impact measures contained with the report would take time to monitor and were seen as activities. It was unrealistic at this stage to identify outcomes, but this would become more evident moving forward and would then give the assurances that the service was improving.

Resolved:- That the final draft of the Emotional Wellbeing and Mental Health Strategy 2014-19 be approved.

S41. SERVICE CO-PRODUCTION IN ROTHERHAM

Consideration was given to a report presented by Sue Wilson, Performance and Quality Manager, which detailed how the Expectations and Aspirations work stream of the Health and Wellbeing Strategy has a priority in its action plan around co-production of services. This was fully endorsed by the Board's member organisations.

The consultation report, as submitted, provided information around definitions of co-production, examples of where this was already in place in Rotherham and the suggested approach to move this forward across all

organisations.

A key action which underpinned this work was:-

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

Co-production was about delivering public services in different ways and developing relationships with service users that were equal between professionals delivering these services and those customers and carers in receipt of them.

Co-production was not just about consulting with citizens and "user voice" initiatives, it was much more than this. It was a two stage approach that would take time to develop. It was, therefore, suggested that this be considered on an annual basis to see which areas would lend themselves to be co-produced.

The proposal was for organisations to consider and decide which services would be suitable for co-production and begin to move to this as a concept of working. It was clear, however, that that there were some services which would never be suitable to be co-produced.

On this basis it was suggested that organisations cascade the information internally, which could be reported back to the workstream on the 5th December, 2014 with an opportunity for the Health and Wellbeing Board to look at this in more detail in a workshop style setting.

There were already some good examples of where co-production was working in Rotherham such as Lifeline, Speak Up and the Rotherham Charter for Parent and Child Voice.

In considering the principle of co-production, some of the partners expressed some concern with the work that they were undertaking and the lobbying for equal access. It was envisaged that there could be some duplication of work and asked for reassurances around case management and the benefits to the people of Rotherham.

Partners were advised that they were being asked to explore any opportunities that may lend themselves to this method of working and it was only for partners to indicate the areas which they thought were right and could add value and which may fit together for a different way of working and for this to include the voluntary and community sector.

To assist it was suggested that this subject may best be considered in a workshop style setting to consider the shared leadership and delivery outcomes whilst being realistic about budgets and demographic changes.

Resolved:- (1) That the consultation report and associated case studies be received and the contents noted.

(2) That principles be noted and partner organisations cascade the report and information within their organisations.

(3) That a workshop be arranged for the most appropriate people to consider further a two stage approach to move to co-production of services within their organisation and to establish what co-production in Rotherham would look like.

S42. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health and Wellbeing Board be held at the Town Hall, Rotherham on Wednesday, 3rd December, 2014, commencing at 9.00 a.m.

It was suggested that it would be useful to set out a forward work plan for the Board, incorporating reports on the Health and Wellbeing Strategy workstreams. Due to the number of inspections taking place and the urgent timescales associated with the Better Care Fund, there had been less scope recently to focus on the Strategy.

To:
Health and Wellbeing Board Chairs
Local Authority Chief Executives

NHS England
Oak House
Bramley
Moorhead Way
Rotherham
S66 1YY
0113 8253375
e.degilbert@nhs.net

15 October 2014

Dear Colleagues

Re: NHS England Organisational Alignment and Capability Programme (OACP)

Margaret Kitching, Nursing Director, wrote to you on 5 September updating you on work which is taking place within NHS England to get our internal structure working effectively, better focused on our core priorities and at the same time delivering a 15% reduction on our running costs from 15/16.

This work is part of the OACP programme which is now reaching a range of conclusions.

Changes have been made to national structures and work is taking place to streamline operating models to be more efficient.

In the meantime – the field force i.e. the regional and area structures have been redesigned to create a new integrated regional team working in the local areas – focussing on CCG assurance; operational delivery and direct commissioning (primary care; specialised; justice in health; healthcare of the armed forces and elements of public health which NHS England is responsible for – 0-5 yr; screening; vaccinations and immunisation).

These internal changes to our regional and area teams are currently out to collective consultation with staff until 14th November.

As part of the proposed changes there will be one integrated regional team for the north with 4 geographical footprints:-

- North East
- Cheshire, Warrington, Wirral and Merseyside
- Greater Manchester and Lancashire
- Yorkshire and the Humber

South Yorkshire and Bassetlaw will clearly sit as part of Yorkshire and the Humber. The New Yorkshire and the Humber footprint will be led by a single Area Director with a Finance Director, Nursing Director, Medical Director and 3 Locality Directors (North Yorkshire and the Humber, West Yorkshire and South Yorkshire and Bassetlaw). There will still be 3 local hubs in existing area teams offices.

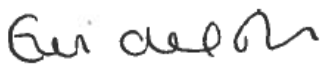
The design of the structure means much fewer senior staff across Yorkshire and the Humber but staff at band 8b and below currently in post have been protected. The operating model is now being designed – recognising the increasing leadership and co-commissioning role of CCGs in local areas.

It is envisaged the new Area Director for Yorkshire and the Humber (subject to consultation on structure) will be appointed w/c 17 November and the new structures and operating model will be fully effective from 1 April 2015.

The NHS England Director representative on your Health and Wellbeing Boards will update the Board around these changes but I am more than happy to provide further clarification if required. I will keep you updated as appointments are made

Best wishes

Yours sincerely



Eleri de Gilbert
Director
NHS England (South Yorkshire and Bassetlaw)


FIVE YEAR
FORWARD VIEW

The NHS have achieved a lot

- Currently ranked #1 healthcare system in the world
- More than 2/3 UK public believe the NHS “works well”
- Cancer survival is at its highest ever
- Operation waiting lists are down - many from 18 months to 18 weeks
- Early deaths from heart disease are down over 40%
- 160,000 more nurses, doctors and other clinicians
- Single Sex Wards implemented

We are delivering more care

Compared with 2009 the NHS is delivering more care:

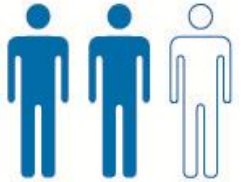
- 4,000 more people are being seen in A&E each day
- 3,000 more people are being admitted to hospital each day
- 22,000 more people have outpatient appointments each day
- 10,000 more tests are performed each day
- 17,000 more people are seeing a dentist each day
- 3,000 more people are having their eyes tested each day

But demand for care is rapidly growing

We are facing a rising burden of avoidable illness across England from unhealthy lifestyles:

- 1 in 5 adults still smoke

- 1/3 of people drink too much alcohol



- More than 6/10 men and 5/10 women are overweight or obese

Furthermore:

- 70% of the NHS budget is now spent on long term conditions
- People's expectations are also changing

There are also new opportunities

New technologies and treatments

- Improving our ability to predict, diagnose and treat disease
- Keeping people alive longer
- But resulting in more people living with long term conditions

New ways to deliver care

- Dissolving traditional boundaries in how care is delivered
- Improving the coordination of care around patients
- Improving outcomes and quality

…but the **financial challenge** remains, with the gap in 2020/21 previously projected at £30bn by NHS England, Monitor and independent think-tanks

The future NHS

The Forward View identifies three ‘gaps’ that must be addressed:

1	**Health & wellbeing gap**	**Radical upgrade in prevention**	• Back national action on major health risks • Targeted prevention initiatives e.g. diabetes • Much greater patient control • Harnessing the ‘renewable energy’ of communities
2	**Care & quality gap**	**New models of care**	• Neither ‘one size fits all’, nor ‘thousand flowers’ • A menu of care models for local areas to consider • Investment and flexibilities to support implementation of new care models
3	**Funding gap**	**Efficiency & investment**	• Implementation of these care models and other actions could deliver significant efficiency gains • However, there remains an additional funding requirement for the next government • And the need for upfront, pump-priming investment

Getting serious about prevention

Focusing on prevention

- Incentivise healthier individual behaviours
- Strengthen powers for Local Authorities
- Targeted prevention programmes – starting with diabetes
- Additional support people to get and stay in employment
- Create healthier workplaces – starting with the NHS

Empowering patients

- Improve information: personal access to integrated records
- Invest in self-management
- Support patient choice
- Increase patient control including through Integrated Personal Commissioning (IPC)

Engaging communities

- Support England's 5.5m carers – particularly the vulnerable
- Supporting the development of new volunteering programmes
- Finding new ways to engage and commission the voluntary sector
- NHS reflecting local diversity as an employer

Developing new care models

- We need to take decisive steps to transition towards better care models
- There is wide consensus that new care models need to:
  - Manage systems (networks of care), not just organisations
  - Deliver more care out of hospital
  - Integrate services around the patient
  - Learn faster, from the best examples around the world
  - Evaluate success of new models to ensure value for money
- There are already examples of where the NHS is doing elements of this
- However, cases are too few and too isolated
- The answer is not ‘one size fits all’, nor is it ‘a thousand flowers bloom’
- We will work with local health economies to consider new options that provide a viable way forward for them and their communities

New deal for primary care

Funding

- Stabilise core funding for two years, and increase investment in the sector over the next Parliament
- New funding for schemes such as the Challenge Fund
- New infrastructure investment

Commissioning

- Increase CCG influence over commission of primary care and specialised services
- New incentives to tackle inequalities

Workforce

- Increase the number of GPs in training
- Train more community nurses and other primary care staff
- Invest in new roles, return and retention

Public engagement

- Building the public's understanding of pharmacies and on-line resources to reduce demand

Multispecialty Community Providers

What they are

- Greater scale and scope of services that dissolve traditional boundaries between primary and secondary care
- Targeted services for registered patients with complex ongoing needs (e.g. the frail elderly or those with chronic conditions)
- Expanded primary care leadership and new ways of offering care
- Making the most of digital technologies, new skills and roles
- Greater convenience for patients

How they could work

- Larger GP practices could bring in a wider range of skills – including hospital consultants, nurses and therapists, employed or as partners
- Shifting outpatient consultations and ambulatory care out of hospital
- Potential to own or run local community hospitals
- Delegated capitated budgets – including for health and social care
- By addressing the barriers to change, enabling access to funding and maximising use of technology

Primary and Acute Care Systems

What they are

- A new way of ‘vertically’ integrating services
- Single organisations providing NHS list-based GP and hospital services, together with mental health and community care services
- In certain circumstances, an opportunity for hospitals to open their own GP surgeries with registered lists
- Could be combined with ‘horizontal’ integration of social and care

How they could work

- Increased flexibility for Foundation Trusts to utilise their surpluses and investment to kick-start the expansion of primary care
- Contractual changes to enable hospitals to provide primary care services in some circumstances
- At their most radical they could take accountability for all health needs for a register list – similar to Accountable Care Organisations

Other new care models (1)

Urgent and emergency care networks

- Simpler and better organised systems, achieved by:
  - Developing networks of linked hospitals to ensure access to specialist care
  - Ensuring seven day access to care where it make a clinical difference to outcomes
  - Proper funding and integration of mental health crisis services
  - Strengthening clinical triage and advice

Specialised care

- Consolidating services where there is good evidence that greater patient volumes lead to greater quality
- Working with a smaller group of lead providers willing to take responsibility for developing geographical networks of specialised and non-specialised care
- Moving towards specialised centres of excellence for rare diseases

Other new care models (2)

Viable smaller hospitals

- Help sustain local hospital services where:
  - They are the best clinical solutions
  - They are affordable
  - They have commissioner support
  - They have local community support
- Consider adjustments to payment mechanisms
- Explore new staffing models
- New organisational models including:
  - Sharing management across sites
  - Satellite provision on smaller sites
  - Primary and acute care systems

Modern maternity services

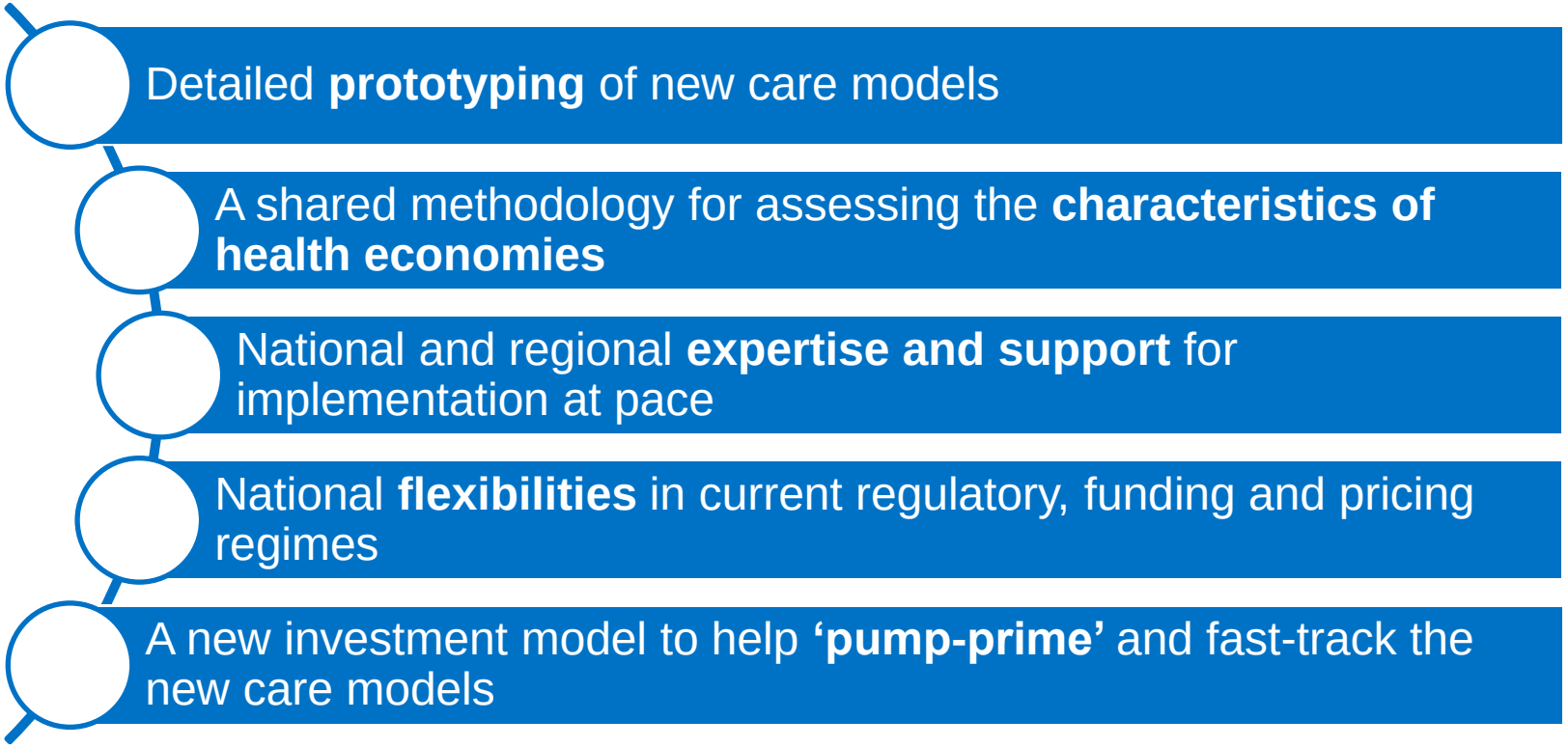
- Explore how to improve our current services and increase choice by:
  - Commissioning a review of future maternity units for Summer 2015
  - Ensure funding supports choice
  - Make it easier for midwives to set up services

Enhanced health in care homes

- Developing new models of in-reach support and services by:
  - Working in partnership with social services and care homes
  - Building on existing success

Implementing new care models

- To deliver new care models we need a new type of partnership between national bodies and local leaders
- Working with local communities and leaders, NHS national bodies will jointly develop:



Delivering innovation and change

To deliver the scale and pace of change required we will also take steps to:

Align NHS leadership	For example, by moving towards a joint way of assessing and intervening in challenged health economies
Develop a modern workforce	Designing and commissioning new and more flexible roles to support the future NHS
Exploit the Information Revolution	To provide transparent data, develop services that care digitally delivered and use data to improve the NHS
Accelerate innovation	Developing new methods for innovating such as ‘test bed’ and ‘new towns’, as well as testing innovations through trials and evaluations

Efficiency and funding

- It has previously been calculated that the NHS faces a gap between expected demand and funding of ~£30bn by 2020/21.
- To address this gap we will need to take action on three fronts: demand, efficiency and funding. Less impact on any one of these will require compensating action on the other two.
- Delivery of the more active ***demand and prevention*** activities outlined in the Forward View would deliver in the short (e.g. prevention of alcohol harm) and medium term (e.g. action on diabetes).
- The long-run **efficiency** performance of the NHS has been ~0.8% annually. We have achieved nearer 2% more recently, although this has been based on some actions that are not indefinitely repeatable, e.g. pay restraint.
- However, with upfront investment and implementation of new care models we believe that we could achieve 2% rising to 3% over the next Parliament.
- Combined with an **increase in funding** equivalent to flat-real *per person* (e.g. adjusted for population growth and age)—about £8bn more—this would close the gap.

Next steps

NHS England is now embarking on work with other NHS national bodies and wider stakeholders to implement the commitments in the Forward View.

Immediate next steps include:

- Engagement with our staff and partners
- Refining outcomes and programmes of work
- Agreeing governance
- Designing a delivery programme

For more information, or questions please email: england.fiveyearview@nhs.net

ROTHERHAM BOROUGH COUNCIL – Report to Health and Wellbeing Board

1	**Meeting:**	**Health and Wellbeing Board**
2	**Date:**	**3rd December 2014**
3	**Title:**	**Commissioning Framework**
4	**Directorate:**	**NAS**

5. Summary

This report presents a Commissioning Framework for consideration by and consultation with the members of the Health and Wellbeing Board.

The council commissions from the independent and voluntary community sector for a significant number of services across a large range of functions including social care, construction, catering services and business services. The council also has in place a number of grant funded arrangements with the voluntary community sector.

The council is seeking to continuously improve its commissioning practice utilising resources in the most economic, efficient and effective approach, supporting local economic growth and meeting the needs of communities and individuals.

6. Recommendations

That the Health and Wellbeing Board:

6.1 Consider the Commissioning Framework

6.2 Offer any comments and amendments

6.3 Receive the final Commissioning Framework at a future meeting

7. Background

7.1 Introduction

In order to continuously improve the quality of commissioning across the council this document has been developed to provide a framework for commissioning to ensure that there is consistent high quality commissioning activity that is in line with national good practice, is outcomes focused and meets the needs of the citizens and the council.

The framework sets out a definition of commissioning, the commissioning principles and the legal requirements. The intention is to have this framework agreed by the appropriate bodies, including Health and Wellbeing, and endorsed by the leader of the council as a public document.

The framework is deliberately concise and clearly sets out the required commissioning approach particularly regarding council Standing Orders, financial regulations, legislation and Equality and Diversity.

The Foreword by the leader will be completed before finalisation of the framework

7.2 Consultation

The consultation of the framework commences at the Health and Wellbeing board where comments and amendments are sought to improve the document. Partners views are extremely important in building a strong commissioning approach across the council.

The framework will be widely distributed for consultation with Elected Members, across the council, health and other partners and the VCS. Comments and amendments will be incorporated where appropriate. Please forward any comments to the author of this report.

8. Finance

There are no financial implications in this report

9 Risks and Uncertainties

1. That should the commissioning framework not be agreed and the strategic commissioning approach of the council will not be appropriately documented.
2. Should the framework not be endorsed there will be a lost opportunity to continuously improve the commissioning activity of the

10. Background papers

- Council Standing Orders and Financial Regulations
- Social Value Act
- Localism Act
- EU procurement rules

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Rotherham Metropolitan Borough Council

Where Everyone Matters

Commissioning Framework

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Foreword

By Councillor Lakin, Leader

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• Introduction

1.1 What do we mean by commissioning?

Commissioning is the whole cycle of assessment of the needs of the local people in the borough and designing services to meet those needs and securing improved outcomes and cost effective services.

Commissioning is flexible to meet the changing needs of a population or group of people. The commissioning process includes reviewing if needs are continuing to be met in the most appropriate way and if the service continues to provide the best outcomes and value for money.

Commissioning is not about the procurement of goods and services or achieving the lowest price, but is about achieving the highest quality of service at the best value.

It is also not micro commissioning where an individual purchases a service to meet their own needs which is then not monitored or managed by the council.

1.2 What is the purpose of this framework?

The intention is to set out a commissioning model that delivers an approach to secure best value for money through positive relationships with partners across the public, voluntary and independent sectors

Enable all to have a shared understanding of the commissioning process and how Rotherham Metropolitan Borough Council (RMBC) will work with colleagues and partners in openness and transparency to achieve best value for money.

1.3 Who does this framework apply to?

This framework applies to all commissioners and commissioning activity in the council, unless for an exceptional reason in that an alternative approach is required because of legislation or to meet specific funding guidelines. Exceptions to this framework will be formally logged and documented.

This framework applies to all commissioning in the council, whether the services commissioned are from the voluntary or independent sector and, in circumstances where the Local Authority or an NHS body has tendered successfully for a service, the public sector.

1.4 How does the framework achieve this?

The commissioning cycle and the supporting processes give clarity for providers and partners and enable consistency, openness and transparency in our commissioning approach.

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The framework includes a set of principles to enable better decision making on achieving the benefits for the whole community. The glossary sets out the terms and links to other useful information.

2. Key Principles of Commissioning

2.1 The focus of high quality commissioning is:

- Achieving good outcomes
- Evidence based
- Utilising local knowledge, skills and resources to best effect
- Delivery of Social Value
- Securing continuous improvement through application of
    - Economy
    - Efficiency
    - Effectiveness

The National Audit Office describes these three elements as:

Economy – spending less - through the minimisation of the cost of resources used or required

Efficiency – spending well – the relationship between the output from goods or services and the resources to produce them

Effectiveness – spending wisely – the relationship between the intended and the actual results of public spending in terms of outcomes

When reviewing services and provision the council will seek to maximise the added value created by commissioning through the combination of economy, efficiency and effectiveness aligned with social value.

2.2 The councils focus will be on achieving the right outcomes for citizens, these outcomes may not always be easily measured through recognised techniques of evaluation. Utilisation of alternative methods such as social return on investment (SROI) and long term economic benefits are acceptable.

2.3 The council is committed to working in partnership with providers and our colleagues in other authorities or in the health architecture to progress innovative or new services and achieve best value. The council has a set of principles and values

for joint working with the Rotherham Clinical Commissioning Group (RCCG), these are transferable to any partnership working relationship. The focus is on establishing long term positive working relationships, building strong communications in an environment of mutual trust and support. It is acknowledged that there are significant benefits for the business economy of Rotherham through partnership working with Small and Medium Enterprises(SMEs), the VCS, social enterprises and consortia.

2.4 We will work with providers to keep them informed of our commissioning intentions via the website and other forums. Market Position Statements (MPS) will be used to set out the current position and the direction of travel for specific areas of service. The intention will be to engage early with providers and to consult with them as appropriate through the commissioning stages. We will involve service users, the VCS and businesses at all stages of the commissioning process.

2.5 When the agreed commissioning priorities identify the need to decommission an existing service to achieve the right outcomes for citizens then we will actively engage service users and providers as early as possible and we will assess the impact of such a decision in order to improve redesigned services.

2.6 It is agreed that the Council supports the benefits of the living wage for employees of commissioned services, or of organisations who are receiptants of grants. The living wage is of particular relevance when the funding supports specific posts.

2.7 The Council will have work in line with the standards as set out in '*Commissioning for Better Outcomes*' (2014) and have regard to the '*Principles of Good Commissioning' (2007):*
Good commissioning is:

- Person Centred
- Focused on outcomes and have these at the heart of strategic planning
- Well led
- Promotes a sustainable and diverse market
- Understanding the needs of users and other communities
- Consultation with potential providers well in advance of commissioning of new services
- Mapping of the breadth of potential providers
- Consideration of investment in capacity of providers particularly those working with hard to reach groups

- Ensuring commissioning and contracting is conducted in an open, transparent and fair way
- Consideration of consortia and sub-contracting where appropriate
- Enable economy, efficiency and effectiveness through longer term sustainable commissioning and risk sharing
- Seeking feedback and utilising reflective learning with service users, providers and partners to review the effectiveness of commissioning to meet needs and improve outcomes

3. Legal Framework

3.1 European Union Procurement Rules

- £5,000 but less than £20,000 - Invite a minimum of two quotations in writing.
- £20,000 but less than £50,000 - Invite a minimum of three quotations in writing.
- £50,000 but under £100,000 - Sealed tender process inviting between three to six tenders.
- £100,000 but under £172,514 - Sealed tender process inviting between three to six tenders. (Opened by a Council Member)
- £172,514 and above - Subject to full OJEU procedures and opened by a Council Member.

3.2 Council Standing Orders and Financial Regulations

The council standing orders Part IV sets out the Contract Standing Orders. These include detailed information on:

- General arrangements - eg contract standing orders and financial regulations
- Authorised Officers and approved list of contracts
- Ascertaining value of contracts – eg open completion for contracts
- The tendering process – eg values for tendering
- Miscellaneous provisions – eg suspension of standing orders

3.3 Localism and Social Value Acts

The Localism Act 2011 includes the Community Right to Challenge which gives the right to a “relevant body” to put forward an “Expression of Interest” (EOI) to provide a “relevant service” on behalf of the Local Authority.

The legislation distinguishes between a function within the Council and a service provided by the Council. If a body is interested in delivering a service on behalf of

the Council then it can submit an EOI. The legislation sets out what information an EOI should contain and what "tests" it must pass for a Council to act upon it.

A successful challenge from an organisation would result in the Council conducting a full commissioning and procurement exercise in which the organisation would be able to take part – as would other interested parties.

All services commissioned must be entered onto the contracts register which is a public document managed by the procurement function.

The Public Services (Social Value) Act 2012 applies to contracts and framework contracts for services that meet the threshold for EU and UK procurement legislation. The Act imposes a duty to consider how what is proposed to be procured might improve the economic, social and environmental well-being of the area. Social value can be defined as "a concept which seeks to maximise the additional benefit that can be created by procuring or commissioning goods and services above and beyond the benefit of merely the goods and services themselves."

The Authority must consider how it might best achieve that improvement through the commissioning and procurement process for example through use of lots, specifications or award criteria.

The Council must also consider whether it should consult on these matters. It is important that these considerations are captured in the paper trail associated with a commissioning or procurement so that the Authority can demonstrate in case of challenge that these considerations have been taken.

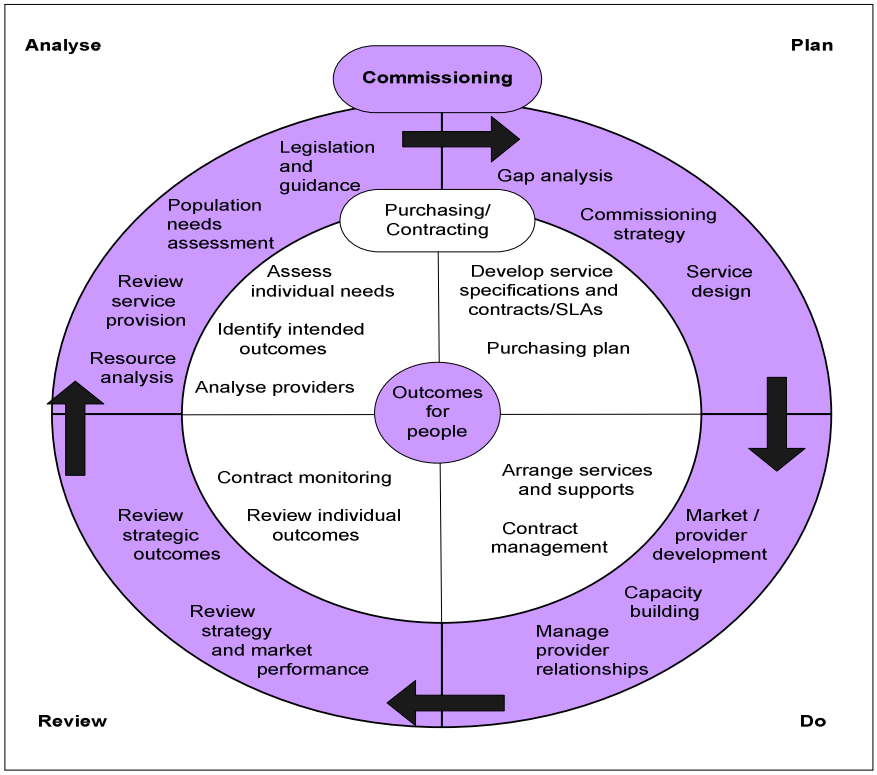
3.4 Public Sector Equality Duty

The Public Sector Equality Duty (PSED) under the Equality Act 2010 applies to all commissioning or procurement, whether for services, supplies or works and regardless of whether the value will exceed procurement thresholds. The Duty requires all local authorities to have due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it, in particular with regards to meeting their needs, removing disadvantages, and ensuring fairness of accessibility.

The relevant protected characteristics are: age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation

4. Commissioning Process

4.1 The commissioning cycle



The commissioning cycle can be broken down into a direction through the following stages:

- Needs Analysis
- Identification of required outcomes
- Specification
- Procuring providers to meet specification
- Contract management and monitoring for improved outcomes
- Learning from delivery to inform future commissioning

4.2 Needs Assessment

In order to achieve good commissioning there is a need to have good information and data. The assessment of need is a critical step in the design of services to meet needs and achieve the outcomes required.

The voice of the service user must be at the heart of good commissioning. Understanding from citizens what works for them and how the services can be

improved. The Council will engage service users and local communities in the planning and commissioning of services to meet needs.

We will work with our colleagues in the VCS where appropriate to link with communities and groups, utilising their advocacy role and their knowledge and experience of how services can be redesigned to meet needs.

The Council will seek information and data to feed into needs analysis through:

- Mapping the current models of delivery
- Understanding the satisfaction of service users
- Benchmarking provision against 'best in class'
- Identification and agreement of local priorities
- Qualitative and quantitative data
- Utilising the

We will utilise the Joint Strategic Needs Analysis (JSNA) as the primary data resource for commissioners. The council meets its statutory duty of the Health and Wellbeing Board (HWBB) under the Health Act (2007) for a JSNA which includes an Asset Register that identifies individual people, community resources, groups and physical buildings across Rotherham.

We will ensure that the JSNA is reviewed and revised annually as a minimum.

4.3 Identification of outcomes and designing services

As a commissioning body the council will identify the priorities to meet the needs of the borough. These priorities will be agreed in the statutory bodies of Cabinet, the Rotherham Local Safeguarding Children's Board (LSCB), the Children, the Adults Safeguarding Board and the Health and Wellbeing Board.

The council will involve service users and potential providers including the VCS, independent businesses and SMEs where appropriate to design and review services. It is acknowledged that these organisations have the skills, experiences and abilities to support and strengthen the commissioning process.

For outcomes focused commissioning the outcomes required need to be in balance and are built from:

- Needs analysis
- National and local political steer
- Information and data from service users, independent and VCS organisations
- Identified 'best practise'

4.4 Procurement, Grants and Grants in Aid

There are several routes to market to achieve the required outcomes against the agreed specification. It is a critical decision to decide the most appropriate procurement route.

The council will no longer hold Service Level Agreements (SLAs) for externally commissioned services. There must be legally binding contracts that set out the terms, conditions and sanctions against the specified service.

All in-house provided services should be held to the same high standards of quality as externally commissioned services. There must be in place for each in-house service a specification and performance management framework against which the service is assessed.

The council will give due consideration to the most appropriate commissioning approach be this commissioning in-house delivery, through a partnership, joint commissioning, co-location, virtual/aligned budgets, regional, sub-regional or external provision. Each time the three principles of Economy, Efficiency and Effectiveness must be applied.

The council will commission through Procurement, Grant or Grant in Aid.

Procurement

All procurement will take place via the YorTender system, the intention is to secure goods and services from external providers to meet the councils identified outcomes. Procurement must be conducted in line with legislation as set out earlier in this framework. Procurement results in a formal legally binding contract. Non-compliance by the provider to this contract will result in default or termination and may include retrospective recovery of costs.

Process

- Needs analysis
- Consultation
- Specification
- Advertise opportunity on YorTender
- Panel evaluation against agreed criteria, which may include face to face interviews
- Awarding of contract including terms and conditions, usual timeline of 3 years plus option for further 2 years
- Contract management and monitoring against specification

Grants

Grants are provided to source specific outcomes, the funding is allocated against the outcome. The grant is for a specified period of time. The council supports the approach of the provider to design the service to deliver the required outcomes.

Process

- Application process advertised on YorTender
- Panel evaluation against agreed criteria, which may include face to face interviews
- Negotiation of grant including a Memorandum of Understanding (MOU) setting out the grant conditions
- Performance management against grant required outcomes
- Consideration of proportionality should be given for the evaluation and monitoring of Grants in relation to the value of the Grant

Grants In Aid

Grants in Aid are to fund resources as a contribution to the work of the organisation's core costs or activities. The funding grant is for a specified period of time. Funding may also be to support agreed specific outcomes. The council will give this type of grant where there is a strong relationship with a high level of trust.

Process

- Applicant process is advertised on YorTender.
- Panel evaluation against agreed criteria, which may include face to face interviews
- A Memorandum of Understanding (MOU) will be negotiated setting out the monitoring and evaluation processes
- Consideration of proportionality should be given for the evaluation and monitoring of Grants in relation to the value of the Grant

The council will seek to be innovative in its approach to strategic commissioning of services. New opportunities will be considered when seeking to commission a service and will include, but not be restricted to:

- Social Impact Bonds
- Mutual Trusts
- Co-operatives
- Community Trusts

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Proposals to Elected Members setting out the commissioning options must refer to the consideration of the above models.

4.4 Tender assessment and evaluation

The specification will set out clearly what organisational requirements are needed. If these criteria are not met then there will be no further consideration of the tender or grant application. The criteria requirements will include:

- Management - strong evidence of governance to include business planning, annual general meeting and regular board or committee meetings
- Financial Systems – there must be inclusion of three years of accounts, compliance with company or charity law, evidence of strong financial controls
- Insurance – adequate insurance cover for company activities including public liability, employers liability, property and equipment cover. The financial amount of cover required is set out in the specification
- Human Resources – strong evidence of open, transparent HR recruitment and management policies including contract terms and conditions. The council encourages organisations to pay the living wage. All staff working with adults, children and young people must have a current Disclosure and Barring Service (DBS) check
- Equal Opportunities – there must be a written equal opportunities/diversity policy and code of practice
- Protection of Vulnerable Adults – those organisations providing services to vulnerable adults must have in place appropriate training for staff and a protection of vulnerable adults/~Safeguarding policy and procedure
- Safeguarding – organisations working with children and young people must have in place a safeguarding policy and procedure and evidence training in safeguarding for all staff

Additionally the council will require further information::

- Sustainability of the organisations
- Resources available to meet specification or plans how recruitment will take place
- Economic and community knowledge of the borough and how they will contribute to improving the local economy

A panel of officers with the appropriate knowledge will assess the tender bids against the specification, criteria questions and against the principles set out in this framework, particularly Economy, Efficiency and Effectiveness. This is to ensure an objective assessment.

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Following evaluation a recommendation will be made to the appropriate delegated powers Cabinet Members meeting to approve the grant funding and the awarding of the contract. In relation to commissioning for services the value of the contract will dictate the decision making level, an officer or Elected Member as set out in the councils standing orders.

4.5 Awarding of contract, grants or grants in aid

The contract or Memorandum of Understanding (MOU) will set out the role and obligations of the provider and the council against the delivery of the specified services, including full terms and conditions.

This will also set out the payment schedule, which may include:

- Payment stages- up front, retrospective, staged or at end of contract
- Payment by results on achievement of against outcomes
- Arrangements for collection of under spent funding
- Fixed regular scheduled payments
- An agreed risk management approach and full cost recovery

Payments will normally be paid in arrears following achievement of agreed terms. Payment can be made in advance to the VCS if there is a clear business case and a risk assessment has been completed.

4.6 Performance Management and Quality Assurance

Performance monitoring and management of a contract or grant or grant in aid is critical to ensure:

- Progress against specification towards achieving outcomes
- Value for Money and utilisation of funding/finances
- Management of risk
- Levels of need against needs analysis
- Early identification of poor performance
- Support of action planning to improve achievement of required outcomes
- Application of sanctions for poor performance including holding payments, default of contract or termination
- Consideration of proportionality should be given for the performance management and quality assurance of Grants and Grants in aid in relation to the value of the Grant

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All organisations who are commissioned by the council will be subject to performance monitoring and management. The performance management framework (PMF) and indicators will be set out in the contract or MOU terms and conditions. The relationship between commissioner and provider will be based on open and transparent dialogue.

The PMF will be proportionate and differ according to the value of the commissioned service and the risk involved. The council will seek to apply proportionality to minimise risk and the burden on providers. It is intended that monitoring will be via online based data returns and/or site visits. Performance management meetings will be regularly scheduled, with timing dictated by the level of funding and risk.

Quality assurance methods focus on building intelligence on the providers of commissioned services, this information should be shared with other authorities and commissioning consortium members. Outcomes of the PMF will be reported by exception through the councils governance structures.

Quality Assurance that will be undertaken includes:

- Regulating authority inspection outcomes
- Complaints and compliments monitoring
- Customer satisfaction
- Contracting concerns raised
- Site visits

4.7 Market Management

Market management and facilitation is becoming increasingly important to ensure that the providers are aware of the requirements of the council as a commissioner. Recent Acts such as the Care Act place a duty on the council to ensure that the market is able to meet the needs of the local population and provide a range of diverse, good quality services. Market management is very important in contributing and building the local economy.
It is important that the Council:

- Gathers market intelligence - so it knows what services are available in the borough, maps current provision, what models of provision exist and what type of services users need.
- Conducts market structuring activities - whereby the Council sets processes in place to better engage and conduct business with providers.
- Engages in market intervention – exploring barriers to entry, provide training, support community led organisations, explore funding streams and investment.
- Completes where appropriate Market Position Statements (MPS) that set out the requirements of the council going forward for a particular market. This

MPS is a resource for potential and actual providers to support them in configuring their services to meet the identified needs of the population and to build their business with the council.

4.8 Decommissioning

Decommissioning is an integral element of the commissioning cycle. Decommissioning or termination can take place at any stage of the commissioning cycle post award of contract or MOU, as a result of:

- a change in priorities
- new evidence of how best to meet needs and improve outcomes
- changes to funding or financial frameworks

When considering decommissioning a review will be undertaken of the current services and an impact assessment will be completed on the service ceasing and legal requirement. The council will have regard to the guidance set out in the Best Value Statutory Guidance (2011).

The review will consider:

- Performance against the specification to meet needs and achieve outcomes
- Value for money
- Delivery against the principles of Economy, Efficiency and Effectiveness
- Findings from the Quality Assurance process

As part of the review and as an integral element to decommissioning the council will undertake an Impact Assessment to ascertain the impact on service users, their families, providers and employees.

The notice period of the contract or MOU will normally be adhered to when a decision to decommissioning has been taken, this is usually three months. A phasing out approach could be supported by the council to support the providers in planning for decommissioning. For time limited grants or grants in aid which are time limited as set out in the MOU no notice period will be provided.

In the position of default and termination of the contract or MOU for poor performance there will be no notice period. On occasions the council will support the providers to continue the service until it is recommissioned, this is in order to ensure service continuity for service users. Support will be appropriate to what is required but will not constitute the taking over of the service and all efforts will focus on recommissioning another provider.

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GLOSSARY

Term used	What this means
Commissioning	**The cycle of assessing the needs of people in a local are, designing services to meet those needs and securing a cost effective service in order to deliver improved outcomes**
Evaluation	**The assessment of the extent to which the commissioned tender meets the specification**
Outcomes	**The real life economic, social and/or environmental improvements that are required results/impact of a commissioned service, planned activity or intervention for a community or an individual**
Social Enterprises	**Businesses trading for social and environmental purposes. The profits made are reinvested towards achieving that purpose**
Tender	**A written request on the YorTender system to provide information about how the provider would contract to supply goods or services as specified. Successful tenders result in the award of a contract to deliver the goods and services specified**
Voluntary and Community Sector (VCS)	**Often referred to as the third sector, refers to a wide range of registered charities and not for profit organisations and community groups**
Performance Management Framework (PMF)	**The process by which the achievement of required outcomes are monitored. This includes measures that are both qualitative on satisfaction and quantitative on metrics**

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Health and Wellbeing Board

1.	**Date:**	**3rd December 2014**
2.	**Title:**	**Health and Wellbeing Strategy: Timetable for Reporting and Refresh**

3. Summary

Rotherham's joint health and wellbeing strategy for 2012-15 is now approaching its final year of implementation and is due to be refreshed by December 2015.

In order to effectively oversee and support the refresh, it will be important for the board to put in place a reporting timetable that enables members to review progress to date against the six strategic outcomes and locally determined priorities, and to discuss priority areas for the updated strategy.

4. Recommendations

That the Health and Wellbeing Board:

- **Discuss and agree the proposed approach and timetable for refreshing the health and wellbeing strategy**

5. Proposals and details

Background
The six 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 or clinical commissioning group. The strategic priorities are:

- **Prevention and early intervention**

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

- **Expectations and aspirations**

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

- **Dependence to independence**

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

- **Healthy lifestyles**

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

- **Long-term conditions**

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

- **Poverty**

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

Each workstream identified a set of actions that would bring about change in the way we do things, ultimately leading to improvements in the health and wellbeing of local people and reduced health inequalities in the borough.

Lead officers have previously attended board meetings to present their action plan, update on progress and pose a set of ‘asks’ for the board to support ongoing delivery.

In addition to the above priorities, the strategy focuses on a number of locally determined priorities – the “big issues” - which are: smoking, alcohol, obesity, dementia, young people who are NEET (not in education, employment or training), and fuel poverty.

These areas also have nominated lead officers and a number of associated performance indicators, with progress reported to the board on a quarterly basis.

Proposals
It is suggested that the board could receive reports on three priority areas at the next four meetings (January to June). The sessions should aim to be constructive but challenging, asking:

- What progress has been made and what factors have prevented further progress?
- Can we identify tangible achievements?
- Is this still a priority and why?

At the end of this process, a workshop either at the June meeting or arranged separately could focus on the refresh, considering outcomes from the board sessions as well as other relevant issues and potential priority areas, for example:

- The relationship between the strategy and the Better Care Fund
- Key messages from the JSNA and other sources of intelligence and research
- The extent to which children's issues should be given greater emphasis within the strategy
- Establishing effective performance management arrangements

Running alongside this, the health and wellbeing steering group will support priority leads, helping to prepare them for the board sessions. From May, it is proposed that a task and finish group be established to work on the refresh.

Timetable
21st January board meeting
- Healthy lifestyles (Joanna Saunders)
- Expectations and aspirations (Sue Wilson)
- Smoking (Alison Iliff)

18th February board meeting
- Dependence to independence (Shona McFarlane)
- Long-term conditions (Dominic Blaydon)
- Dementia (Kate Tufnell)

11th March board meeting
- Prevention and early intervention (John Radford)
- Obesity (Joanna Saunders)
- NEETs (Collette Bailey)

22nd April board meeting
- Poverty (Dave Richmond)
- Alcohol (Anne Charlesworth)
- Fuel poverty (Catherine Homer)

May-August
- Workshop
- Task group to develop draft updated strategy
- Board to agree draft strategy

September/October
- Consultation on strategy

November/December
- Approval of strategy

6. Contacts

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