You are hereby summoned to a meeting of the Health and Wellbeing Board to be held on:-

Venue:	**Town Hall, Moorgate Street, Rotherham S60 2TH**	**Date:**	**Wednesday, 8th July, 2015**
		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 - 16)

5. Communications

6. Care Act Progress Review (Pages 17 - 18)
   Professor Graeme Betts, Interim Director of Adult Social Care

7. RMBC Integrated Services - Adult Mental Health Review (Pages 19 - 20)
   Professor Graeme Betts, Interim Director of Adult Social Care, to present

8. Health and Wellbeing Board Governance and Forward Plan (Pages 21 - 36)
   Councillor Roche/Julie Kitlowski to report

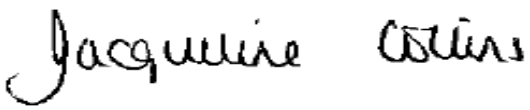
9. Health and Wellbeing Strategy
   Joanna Saunders, Head of Health Improvement, to report

10. Better Care Fund (Pages 37 - 48)
    Lynda Bowen, RMBC, to report

11. Health Select Commission Update
    Councillor Roche to report

12. Local Government Association - Offer of Support on Health and Social Care (Pages 49 - 55)
Commissioner Manzie to report

13. Date of Next Meeting
Wednesday, 26th August, 2015, at 9.00 a.m.



Jacqueline Collins,
Director of Legal and Democratic Services.

HEALTH AND WELLBEING BOARD
18th May, 2015

Present:-

RMBC	
Councillor David Roche	Advisory Cabinet Member (Adult Social Care and Health) **(Chair)**
Councillor Gordon Watson	Advisory Cabinet Member (Deputy Leader)
Stella Manzie	Commissioner and Managing Director
Ian Thomas	Strategic Director, Children and Young People's Services
Jo Abbott	Acting Director of Public Health
Ruth Fletcher-Brown	Public Health Specialist
Professor Graeme Betts	Interim Director of Adult Social Services
Michael Holmes	Policy Officer
Mandy Atkinson	Corporate Communications
Julie Kitlowski	Chair, Rotherham Clinical Commissioning Group
Chris Edwards	Chief Operating Officer, Rotherham CCG
Sue Cassin	Chief Nurse, Rotherham CCG
Tracey McErlain-Burns	Chief Nurse, Rotherham Foundation Trust
Dr. Deborah Wildgoose	Chief Nurse, RDaSH
Chief Superintendent J. Harwin	Rotherham District Commander, South Yorkshire Police
Tony Clabby	Chief Executive, Healthwatch Rotherham
Shafiq Hussain	Voluntary Action Rotherham
Carole Lavelle	NHS England

Also in attendance were Councillor Sue Ellis (Ward Councillor) and five parents (including Frances McCormack, Jimmy Allen, Brian Kiernan and Adrian King), Deborah Cunningham (student of Sheffield Hallam University) as well as a reporter and a photographer from the Rotherham Advertiser newspaper.

Apologies for Absence:-

Steve Ashley	Chair, Rotherham Local Safeguarding Children Board
Janet Wheatley	Voluntary Action Rotherham
Chrissy Wright	Policy and Performance, RMBC

81. SUICIDE - INDEPENDENT REVIEW OF ACTIONS AND FUTURE STRATEGY

1. Introduction

The Chair welcomed everyone to the meeting and introductions were made.

2. Purpose of the Meeting

Councillor Roche, in his opening statement :-

i) explained that there was only one item on this agenda, which was the specific purpose of considering the independent review of actions taken following a group of suicide events in Rotherham and the future strategy in tackling the risk of suicides.

ii) stated that the thoughts of everyone at the meeting went out to all parents affected by these tragedies and that those present shared the deep sorrow. The key was to take action and do as much as possible to make sure that such incidents did not happen again. The purpose of the meeting was to look at the work done and determine how it could be performed better by a number of different agencies.

iii) expressed thanks to the Councillors of the Wickersley electoral Ward, who had originally brought the issues formally to the attention of the agencies and had worked hard on ways of moving the issues forward.

iv) stated that the agencies must look back, learn the lessons and acknowledge that things must be better. Actions, strategies and processes had to be put in place to make improvements, intervene at an earlier stage and prevent suicide happening. Support needed to be provided for the bereaved families and friends, which would be straightforward to access. The aim was to take forward an effective suicide prevention strategy, with the co-operation of all agencies and schools.

3. Suicide in Rotherham - Independent Review of Actions and Future Strategy

Introducing both the covering report, the report of the Independent Review (NB: executive summary) and the supporting documents submitted to the meeting, Jo Abbott offered condolences to the families, stating that she had met family members previously. She was aware that the pain and grief were tremendous. People in the agencies wanted to do what they could to prevent suicide and incidents of self-harm from happening again.

The purpose of the submitted report was :-

(1) to report formally the key findings of the independent report commissioned by the Council to examine circumstances surrounding the four deaths by suicide of boys and young men in Rotherham, aged between 15 and 19 years of age, since 5th November 2011 and two identified self-harm incidents as late as March 2014. Two of those who died by suicide and one of the self-harm incidents were students attending School A; and

(2) to present Rotherham's Suicide Prevention Action Plan and its model Rotherham Suicide and Serious Self-Harm Community Response Plan for consideration and approval by the Health and Wellbeing Board.

Attached to the report were three appendices:-

a) Executive Summary of An Independent Review of Actions Taken Following a Group of Suicide events in Rotherham; (nb: the full document is available on the Council's website);

b) Draft Rotherham Suicide Prevention and Self-Harm Action Plan;

c) Rotherham Suicide and Serious Self-Harm Community Response Plan.

There were five key aims to the independent review:-

1) To provide a supportive critique to the work undertaken to date in relation to prevention measures and response plans in the event of future suicides/unexpected deaths.

2) To determine whether there was an appropriate response to assessing and meeting the needs of the specified cohort of young people who have been identified as being closely affected by the events.

3) To identify areas of work that has been undertaken to date, which requires redesign or additional specific interventions.

4) To develop a plan for a whole system approach to prevention of young people suicides and self-harm in Rotherham and ways in which any barriers could be overcome.

5) To recommend governance and reporting arrangements for the performance management of the Suicide Prevention and Self-Harm Strategy and the Community Plan

The Health and Wellbeing Board noted that the updated Rotherham Suicide and Serious Self-Harm Community Response Plan was developed during the response to the incidents referred to above. This Plan had subsequently been used in schools across Rotherham who have had incidents of serious self-harm amongst their pupils. The schools involved had provided positive feedback about using the plan which addresses a wider community response through 'circles of vulnerability'.

This aspect did not replace the support that the NHS, Social Care and the South Yorkshire Police may be providing for individuals and their families.

The submitted Rotherham Suicide Prevention and Self-Harm Action Plan incorporated the recommendations from the independent review, as well as the six areas for action as outlined in the Department of Health Suicide Prevention Strategy 2012.

The Board noted that the Child Death Overview Panel had discussed the common issues affecting the incidents. After discussions with Public Health England, it was confirmed that there were no United Kingdom national guidelines for dealing with teenage suicides, although The Samaritans have produced comprehensive guidance for use in schools. Instead, use was being made of the 'Melbourne guidelines' from Australia.

In order to increase the national knowledge about teenage suicides, Public Health England recommended independent authors who could write a review of lessons learned. Rotherham Borough Council subsequently commissioned the independent review, the report of which was being submitted that day.

The draft Rotherham Suicide Prevention and Self-Harm Action Plan included the lessons learned from the independent review, plus the six areas for action, identified in the Department of Health Suicide Prevention Strategy 2012 and built on best practice. There was also the Mental Health Crisis Care Concordat, which partners of the Health and Wellbeing Board has signed up to. The Concordat included identifying people in crisis and signposting them to Services.

Since the series of incidents of suicide and self-harm, various initiatives had been implemented, including:-

- a bereavement pathway for children bereaved by suicide;
- a suicide prevention conference aimed at front line workers;
- suicide prevention training such as Applied Suicide Intervention Skills Training (ASIST) and Mental Health First Aid (for front line staff);
- CARE about suicide cards for front line staff (Concern, Ask, Respond, Explain);
- work with the Rotherham Youth Cabinet on self-harm (focus on mental health issues);
- GPs 'top tips' in suicide prevention had been developed;
- Rotherham guidance on self-harm (recognition that there was more work to do).

Alongside the development of these initiatives, the All Party Parliamentary Group on Suicide and Self-Harm published an "Inquiry into Local Suicide Prevention Plans in England" during January 2015. Bench-marking showed that Rotherham performed well against other local authorities in Yorkshire and the Humber. Examples of Rotherham's work were included as good practice, eg: CARE cards and the Suicide Conference.

Ruth Fletcher-Brown referred to the 'Melbourne guidelines', which led to the development of the Rotherham Suicide and Serious Self-Harm Community Response Plan. The latter was a partnership response plan, including representation from all of the various agencies.

The response to the 'circles of vulnerability' was a model used in the Rotherham Suicide and Serious Self-Harm Community Response Plan to identify all groups which may be at risk. Good practice suggested flooding the school community with advice and support, etc., as well as information about the ways of noticing the signs that someone was in distress. The situation in schools would be monitored to ascertain whether any specific staff training should be provided. Schools which had actively engaged in the community response work had been pleased with the support being provided. It was the responsibility of all agencies to be involved in the prevention work. The Community Response Plan was an evolving document. Any recommendations formulated nationally would be incorporated into the Community Response Plan.

The intention was to report on progress to future meetings of the Health and Wellbeing Board, as well as the provision of workforce development and support for staff in the various agencies. The Suicide Prevention and Self-Harm Group was accountable to the Health and Wellbeing Board.

Ruth Fletcher-Brown informed the Board that Rotherham was part of the South Yorkshire Real Time Suicide Surveillance pilot scheme. In the event of a suicide happening, agencies should be informed within 24 to 48 hours. This allowed for a fast response both to support families in their bereavement and also to prevent the contagion (spread) of suicides. Traditionally, agencies had to wait for the Coroner's verdict which may take up to 18 months after a death. This delay was too late for work to be carried out in supporting families and communities and to offer "post-vention" to prevent further suicides.

Questions by members of the Health and Wellbeing Board

(a) Councillor Roche referred to the use of the word 'clusters' (for several incidents of suicide) and asked whether the definition or use of the word was accurate in this context?

Response – Public Health England had advised that agencies should exercise a great deal of caution in the use of this term. There had been several suicides in Bridgend (Wales) but, after lengthy analysis using a specialist IT system, they had not been deemed to be a 'cluster'. The 'Melbourne guidelines' included a definition of "having more than you would expect." There could be an increasing incidence of 'copycat' suicides. Again, it was vital that agencies responded quickly and prevented any more incidents. Rather than talking about 'clusters', the preference was to refer to 'multiple suicides'. Rotherham instead addressed unusual and complex multiple suicides.

(b) Councillor Roche asked whether all schools and academies were engaging with agencies and with the implementation of the Community Response Plan?

Response – There had been a good response from most schools. School A (referred to in the report) had not responded initially and used a targeted approach. The Community Response Plan followed best practice and advocated a whole community response.

(c) Councillor Roche – did the draft Rotherham Suicide Prevention and Self-Harm Action Plan include all the points contained within the Independent Review report (eg: on the provision of counselling)?

Response - Yes, all of the recommendations were dealt within the Action Plan (and officers would check that this was the case).

With regard to the specific issue of the Rotherham Borough Council Chief Executive writing to the Secretary of State for Education and to the Secretary of State for Health, concerning the engagement of School A in the multi-agency response, together with this Council's Strategic Director of Children and Young People's Services, Commissioner Manzie stated that there would be further dialogue with the Head Teacher and the Governing Body of School A on this matter. The reference to Government Ministers would be a last resort, to be used only if the dialogue with School A did not result in satisfactory progress being made.

Chief Superintendent Jason Harwin extended the sympathies of the South Yorkshire Police to the families present. He explained that the South Yorkshire Police were learning the necessary lessons, especially in respect of faster communications and the timeliness of investigations. The safeguarding of people was the first priority, including the need to keep vulnerable people safe. The South Yorkshire Police service structures had changed as a consequence of the lessons learned.

The Members of the Health and Wellbeing Board referred to the recommendation concerning the reporting of progress on the implementation of the Rotherham Suicide Prevention and Self-Harm Action Plan and agreed that the first progress report must be submitted to a meeting of the Board within three months.

The Council's Strategic Director of Children and Young People's Services, Ian Thomas, also expressed sympathy for the families present. He said that whether a school was an academy or a local authority-maintained school, the engagement in the process was necessary and the Authority would intervene with both types of school. All schools had the responsibility of responding effectively. The Regional Schools Commissioner for East Midlands Yorkshire and Humber, Jenny Bexon-Smith, was also available to hold schools to account in this important matter.

The Board noted that most schools welcomed the provision of guidance. Schools also now had representation on the Rotherham Local Safeguarding Children Board and it was intended that schools would be represented on the new Children's Trust arrangements.

The Board noted that discussions at the Council's Health Select Commission (Autumn 2014) had highlighted the lack of Mental Health Services for children and also the lack of Early Help Services. Workforce development would ensure that staff would develop the skills to identify, at an early stage, any signs of suicide tendencies; and also understand the need to put in place help for parents at an earlier stage.

(d) Councillor Roche asked about the availability of Mental Health Nurses in schools.

Response – Chris Edwards extended the sympathies of NHS Rotherham to the families present. He confirmed that the School Nurses should be able to refer pupils immediately to the Mental Health Services available within NHS Rotherham.

Mr. Tony Clabby (Chief Executive, Healthwatch Rotherham) referred to recent experiences and staff undertaking the Applied Suicide Intervention Skills Training (ASIST). Training was being provided within the community as well, it was not only a matter of workforce development.

The Board acknowledged that Rotherham has a good track record of providing Adult and Youth Mental Health First Aid, with service delivery reaching a high standard. Ruth Fletcher-Brown reported that the National Youth Mental Health First Aid course had not yet been developed as a peer-to-peer course. The Rotherham Youth Cabinet appeared to be keen to keep its focus on mental health as one of its main issues. All agencies should be prepared to be involved in this work. This approach should include an investigation of the scope of peer group support and how to train young people to deliver this sort of first aid. The Kirklees Council area (Huddersfield) and areas of London had also developed this approach.

The Health and Wellbeing Board agreed that peer-to-peer approaches should be included in the Rotherham Suicide Prevention and Self-Harm Action Plan.

Mr. Tony Clabby stated that all agencies ought to be smarter and more flexible in what they did. 80 young people had signed up to participate in peer group activity at Wales High School. They would require training because young people preferred speaking to their age group peers.

Julie Kitlowski agreed that the Rotherham Youth Cabinet was already undertaking some very good work. The NHS commissioning process ensured that there was investment in some Mental Health and Support

Services, yet there were sometimes too many services, causing confusion for parents and children. More work should be done to simplify this matter.

(e) Councillor Roche asked about the bi-monthly meetings of the Rotherham Suicide Prevention and Self-Harm Group and whether the meetings occurred frequently enough.

Response – Ruth Fletcher-Brown replied that Rotherham was a real-time suicide prevention pilot area. Information gathered by the South Yorkshire Police and from the Rotherham Clinical Commissioning Group (CCG) was shared with the Suicide Audit Group. This Group, which included Public Health, CCG, RDaSH and the South Yorkshire Police, met bi-monthly. There might at times be a need to have more frequent meetings, although the bi-monthly pattern was considered to be sufficient at the present time. The information provided by the Police and by the CCG was carefully assessed by the Public Health service, upon receipt.

(f) Councillor Roche pointed out that the flowchart of contacts, within the Community Response Plan, ought to include Public Health alerting the Leader of the Borough Council, as well as the Advisory Cabinet Members for Public Health and for Children's Services, in the 'Partners Activated' section.

(g) Councillor Roche stated that any reporting to the Regional Schools Commissioner for East Midlands, Yorkshire and the Humber should refer not only to schools, but also to the academies as well.

Response – it was agreed that the reporting to the Regional Schools Commissioner would include issues concerning schools, academies and colleges.

It was noted that future meetings of the Health and Wellbeing Board would take place on Wednesday, 8th July, 2015 (morning), Wednesday, 26th August 2015 and on Wednesday, 30th September 2015. The initial progress report on the implementation of the Rotherham Suicide Prevention and Self Harm Action Plan should be submitted to a Board meeting no later than Wednesday, 30th September, 2015.

Councillor Roche commented that the Health and Wellbeing Board must keep this issue to the forefront of its agenda and maintain a system of monitoring the progress and work of the Rotherham Suicide Prevention and Self-Harm Group.

Chief Superintendent Harwin commented that, whilst the focus of this discussion was correctly on children and young people, there must also be consideration of the incidence of suicide amongst adults.

Mr. Tony Clabby commented that the speed of information being made available by agencies was good, enabling the prevention work to begin at an earlier stage. Often, it was necessary to have to wait for the result of an inquest, which did not always deliver a verdict of suicide.

Comments and Questions by parents present at the meeting

Q1) Almost without exception, all individuals I met after Oliver's death were well-intentioned and helpful. But it was apparent that the systems and policies served to form barriers between the different organisations. The initial Police response and investigation was very good and the Police officers on the ground were supportive. Even though it was a known fact that it was an apparent suicide, assumptions were made. The Police ought to be better and faster at what they have to do. It seemed that the Police were subservient to the Coroner's Office in the remit of their investigations. That remit looked at four points, but they did not include investigating any connection between the various deaths. Therefore the investigation could not have been sufficiently thorough. Did the Coroner set the terms of the Police investigation? This aspect ought to be checked.

Response - Commissioner Manzie confirmed that the parent's comments would be passed on to the Coroner (it was also noted that the parent had sent an e mail message to the Coroner, in similar vein, in 2013).

Chief Superintendent Harwin commented on the point about the assumption of the death being suicide. The CID would undertake an investigation because suicide was treated as a suspicious death. However, Police Officers had received training so as not to make that type of assumption in the future. The Police were obliged to report any death to the Coroner. The terms of an investigation, as decreed by the Coroner, ought to be told to parents. As responsible agencies, we have to ensure we prevent other deaths happening.

Q2) The situation in Bridgend, Wales, was a cluster of deaths by suicide. What was the downside of not using the term 'cluster'. Should the term 'cluster' be used to ensure that families had better and faster access to services?

Response - The Samaritans provided good guidance to the media about reports of suicide. There were fears that the use of the term 'cluster' in a widespread way could be inflammatory and might encourage more suicides.

Q3) Was the issue treated differently when it was known as a cluster ?

Response - Jo Abbott replied that no, agencies would not do that. The starting point had to be from the position of preventing suicide and preventing others from copying a suicide. It could be difficult to ascertain whether there were connections between cases. It was always hard to

find out exactly what the reasons were for any one case of suicide, as it was often the end point of a complex history of risk factors. Further national guidance was being published by Public Health England, during 2015, to help agencies respond to suicide. Whether the term 'cluster' was used, or whether it was called a series of multiple suicides, the imperative was to support family and friends and prevent further incidents by protecting vulnerable people.

Q4) The Director of Public Health did not identify a connection between the two suicide cases initially. The Director, at the time, did raise the matter with the Child Death Overview Panel (of which he was the Chair). There was initial contact between the two mothers, using social media. I was later contacted myself, from my former wife. I had also known Joyce Thacker because I had been a school governor. The matter had been raised in March of that year (2013) and Joyce Thacker had said that she would contact the Director of Public Health.

Response – The Child Death Overview Panel (CDOP) procedure did note the circumstances of the suicides, occurring 18 months apart and the two deaths being connected to School A.

Commissioner Manzie explained that the new appointee to the post of Director of Public Health would begin work on Monday, 29th June, 2015. An important initial task would be to focus on work with schools. The intention was to ensure the rapid identification of commonalities between cases, such as geography, institution attended, whatever the detail may be. The events over the period in question were horrible and much work had since taken place to ensure that, in future, there would be a much higher chance of making connections. The South Yorkshire pilot scheme concerning 'real-time' suicide surveillance was one such improvement. The Community Response Plan would contain everything together and, within a short space of time, all factors would be in place.

A parent also commented that agencies need to be quicker with their actions, even with 'real time' surveillance.

Q5) The concentric circles model ought to be included in the 'real-time' surveillance model and firmly embedded in it.

Q6) The assumption in the prevention plan and elsewhere was that the circumstances of a suicide case were unique. How did the agencies know that?

Response - The national advice available informed agencies that each suicide was driven by a unique set of circumstances, due to the age range, proximity, link to a school etc.

A parent commented that enough monitoring had taken place for the agencies to be able to say the case was unique. Perhaps there was a national vacuum (of information provision) on this. Agencies must not be complacent when they made their assumptions.

Another parent referred to the Police response and the involvement of a paediatric doctor. Advice had been given to contact School A. On telephoning the school the next day, we had asked the Police why it had been necessary to contact the school. The Police had referred to a 'spate' of suicides at School A.

Q7) Father of Jack - Young people preferred talking to young people of the same age. Jack used Facebook a lot, sometimes early in the morning. There were conversations about X-box and Playstation games. Jack's brothers and friends had not yet come to terms with his loss. It was important not to expect every young person always to communicate about every issue, even with their closest friends.

Response – Communication (and the lack of it) was the key point to make here.

A parent commented that, as parents, we would not always look for preventative support until something awful happens.

Another parent (mum) commented that there was not always accountability in schools.

Q8) The incidence of online bullying was not properly monitored. Jack was linked to different groups via X-box games, Facebook, etc.

Response – Jo Abbott replied that the recommendations contained within the independent review report asked the Health and Wellbeing Board to make public mental health and resilience for young people priorities in the re-fresh of the Strategy. Youngsters needed to be both happy and resilient.

Q9) One father thanked the Authority and other agencies for making parents feel welcome at today's meeting. He said that it was good that preventative work will be undertaken. Agencies must engage with the young people and get them on board with the work on prevention of suicide. As a parent, it had been a nightmare to go through this. We must make improvements in the future. Funding for Mental Health Services would be vital. Suicide was the biggest killer of young people, so it was important to get the issue sorted out. Parents would not always know how to cope. You go through counselling and find a way of dealing with it. You have to do so, to be able to move forward. There was another tragedy because his best friend was involved. Perhaps that may have been a factor. The other tragedies had not just been suicide. It was good for agencies to involve parents. We appreciate the invitation to come and

speak to officials. Some of us had not seen a copy of the report and the other documents.

Response – A full set of reports and supporting documents, considered by the Health and Wellbeing Board, would be provided for all parents. Details of appropriate agencies and officials had been given to all parents identified within the report.

Jo Abbott confirmed that the agencies now had a pathway of support for children and young people, up to the age of 18 years, if people in that age group were bereaved as a result of suicide, or some other traumatic event. Schools would know the individual circumstances and generally have faster access to the Mental Health Services (CAMHS). There would be help for siblings. The feedback from families using this support pathway had been positive, with families agreeing that the service was a good one. It was helpful for everyone to know that the support was there. The Rotherham Suicide Prevention and Self-Harm Group was investigating the possible establishment of a similar pathway of support for adults. It was very helpful for agencies to receive the parents' feedback and their views on the support available at the time of the incidents.

The advice provided by the South Yorkshire Police was specific to the investigation of incidents. But, there also needed to be a balanced approach taken to the range of support services known to be helpful to parents. The provision of emotional support was especially important.

Tony Clabby commented that the information available from the CAMHS Mental Health Services had improved. However, the timely access to Mental Health Services had not. The transition from the CAMHS Service to the Adult Mental Health Services was a very vulnerable time for any person.

Q10) A parent stated that it was helpful to have a single point of contact for families across the whole period of time until the inquest was closed. This was an intense need. Families would not be bothered where that contact person was based.

Q11) A parent referred to the report's references to School A and the interventions made in that School. Did the report address those children and young people who were not pupils of School A, but may still have suffered some level of impact (eg: young people from primary schools or youth clubs)?

Response – Ruth Fletcher-Brown replied that the Community Response Plan would include circles of vulnerability, for example: faith schools, children and young people in other establishments and elsewhere. Agencies must look beyond an immediate area for any contacts there may be with other children and young people. A comprehensive improvement

plan was being put into place. The timeliness of access to appropriate support services was also improving.

Q12) A parent commented that it was good that lessons were being learned and agencies were moving forward on this difficult matter. Prevention and post-incident intervention were important. If these response and improvement plans were all put in place, would this all achieve the outcomes we want? We have to look back at the tragic incidents with that objective in mind. We must ask – has the appropriate action been taken.

A parent thanked the agencies for the invitation to this meeting.

General discussion

Councillor Ellis commented that the language of suicide and self-harm was very difficult to cope with. The careful monitoring of the improvement action plans must be thorough. When the boxes were ticked for the 'red-amber-green' ratings, was there sufficient notice taken of timescales? Was there the correct investigation of the individual circumstances of any incident? The necessary budget details were not included in the improvement and action plans. The budget situation was known to be difficult, yet it was important that all of the different agencies want to be a part of this. There would probably be an impact because of reductions in the budgets for some Health Services and for some schools.

A 'whole community approach' was essential in dealing with loss. Councillor Ellis had become aware because her own children were of similar age to the individuals and they had found out by using social media. It would not be easy to take a 'whole school approach' when dealing with the various academies and types of school. There was now not such strong contact between the academies and the Local Authority, so a heavy-handed approach may sometimes have to be used. The risk or even fear of reputational damage should not prevent people (and agencies) getting involved to do good work.

Councillor Roche stated that the Community Response Plan had to be a 'living' plan and the Health and Wellbeing Board must keep it under continual review. Actions were more important than plans on paper. It was difficult to comment on the budget issues.

There followed a discussion involving Councillor Ellis and Chris Edwards (CCG) about NHS Rotherham's budget of £200,000 for Children's Mental Health Services in the 2015/16 financial year. The plan was for the Services to be a big area of investment, not a budget cut. Councillor Ellis asked about the measurement of success and how much money would be invested in prevention?

There was a discussion about schools and academies, with an emphasis on the importance of the whole community approach. This included a statement from a parent who was critical of an apparent lack of co-operation from academies and schools. They should all be co-operating when it was the lives of young people which were at stake. It should not be a difficult issue (to co-operate) because the safety of children and young people was so important

It was emphasised that most schools had regular Safeguarding meetings held at the Rockingham Professional Development Centre, Kimberworth Park. Schools were making good progress with this issue and appreciated the help they would receive from the range of agencies. The Strategic Director, Ian Thomas, stated that the Borough Council was working hard to strengthen the partnerships with schools, via the arrangements of the Children's Trust Board. There was a process of escalation to the Regional Schools Commissioner if the academies did not want to join in. The Borough Council had that commitment.

Tony Clabby referred to the cases of young people's engagement with the Mental Health Services. What happened in situations where they were sectioned or admitted to a hospital away from the Rotherham Borough area? The Board was informed that there would have to be an investigation of any serious incident which had taken place. All health providers were accountable to the Clinical Commissioning Group, which would ultimately give its independent view on an individual case.

Another parent commented that it was hard to understand why it (suicide) had happened. As parents, they had not seen it coming. Other parents would go through this in the future and you did not get any warning. Self-harm was different, because you could see some of the signs. But it could still be very hard for parents to pick up on it.

Decisions of the Health and Wellbeing Board

Resolved:- (1) To approve the recommendations contained within the submitted report and as set out at (a) to (c) below and with the amendment to recommendation (c) from "at least annually" (suggested in the independent report) to the timescales below :-

(a) That the Health and Wellbeing Board notes the Executive Summary of the Independent Review.

(b) That the Health and Wellbeing Board accepts and endorses the Rotherham Suicide Prevention and Self-Harm Action Plan and tasks the Rotherham Suicide Prevention and Self-Harm Group to implement it.

(c) That the Rotherham Suicide Prevention and Self-Harm Group is tasked to provide a minimum of a quarterly update to the Health and Wellbeing Board about progress made in implementing the plan (frequency increased from the suggested annual update).

(d) That the Health and Wellbeing Board accepts and endorses the Rotherham Suicide and Serious Self-Harm Community Response Plan, the use of which will be promoted by the Director of Public Health in the case of any future incidents.

(2) To support the seven recommendations listed in the report of the Independent Review:-

i) Local stakeholders, led by an agreed lead agency, should agree procedures for the ongoing development of the Community Response Plan and the associated Action Plan (with clear timescales and identified leads) ensuring the Action Plan remains an ongoing and up to date plan.

ii) The Rotherham School Incident Plan should be updated alongside the community response plan to include available support services for suicide/self-harm within Rotherham.

iii) The current Rotherham Suicide Prevention Strategy Action Plan should be updated and thereafter re-updated annually and include the use of suicide audit to inform its redrafting.

iv) The Rotherham Health and Wellbeing Board should develop a Public Health Mental Health and Wellbeing Strategy within which the emotional needs of young people are clearly addressed and are prioritised at Cabinet level in the Council.

v) A clear communications strategy should be developed between Rotherham MBC and its strategic partners. This should proactively promote suicide prevention approaches.

vi) The Rotherham Police and Coroner's Office should consider some of their specific roles and responses to deaths by suicide in light of this report.

vii) Primary Care and Mental Health Service commissioners should review their relevant commissioning strategies in light of this report.

(3) To approve the additional items, as discussed at the meeting and listed below:

a) All agencies must learn the appropriate lessons from these incidents and ensure the long-term focus on appropriate preventative measures being in place.

b) To investigate thoroughly the possibility of establishing one single point of contact for parents' wishing to seek help and access support services.

c) The reports and documents, including appropriate contact details, to be provided for parents attending this meeting.

d) The implementation of a whole school approach to preventative work and ensuring the participation of all academies and schools.

e) To ensure the engagement of all academies and schools in the implementation of the Action Plan and the Community Response Plan and, if necessary, to refer those unwilling to participate to the Regional Schools Commissioner for East Midlands, Yorkshire and the Humber.

f) To ensure that pupils have fast access to the School Nursing Services.

g) The investigations of suicide incidents must include the examination of any links to other, earlier suicides, because an individual's difficulties may develop over a long period of time.

h) To provide the impetus which will ensure the improvement of the focus of a range of partner agencies involved with CAMHS (Child and Adolescent Mental Health Services), noting that the transition from CAMHS to Adult Support Services is a particular issue.

i) To ensure that agencies do not make too narrow an assessment of the needs of young people or parents who were seeking help and support; there may be a diverse range of options for the provision of the necessary support, available from a wide variety of organisations.

j) To investigate, with the Rotherham Youth Cabinet, the possibility of a system of peer group support being available for young people.

k) To have further dialogue with the Governing Body and the Head Teacher of School A on the issue of suicide and self-harm, with reference to Government Ministers only as a last resort, if satisfactory progress was not made.

(l) The Director of Public Health to consider sharing the learning with a wider audience, including Public Health England, NHS England and other local authorities.

The Chair, Councillor Roche, thanked everyone for their participation in and contributions to this meeting.

82. DATES OF FUTURE MEETINGS

Resolved:- That future meetings of the Health and Wellbeing Board take place on:-
Wednesday, 8th July, 2015
Wednesday 26th August 2015
Wednesday 30th September 2015

ROTHERHAM BOROUGH COUNCIL – REPORT TO HWB

1	**Meeting:**	**Health and Wellbeing Board**
2	**Date:**	**8 July 2015**
3	**Title:**	**Care Act Progress Review**
4	**Directorate:**	**Neighbourhoods and Adult Services**

5 **Summary**

RMBC carry out regular stocktakes on behalf of the Association of Directors of Adult Social Services and the Local Government Association. The most recent stocktake took place in June 2015. The stocktakes are a useful measure of regional progress for Care Act implementation. The information below was produced from the recent stocktake.

Under the Care Act, national eligibility criteria were established for the first time to determine when someone should be entitled to help. To date, RMBC has developed Care Act compliant assessment forms and undertaken 215 social care assessments during April and May under Care Act eligibility.

A new duty for councils requires them to offer schemes through which those who need to pay for residential care can get a loan from their local council, which is then paid back from their estate after death. RMBC introduced the deferred payments scheme in June 2015.

For the first time, carers have the same right to assessment and support as the people they care for; previously, they had to provide "substantial care on a regular basis" to receive an assessment. RMBC undertook 145 carers' assessments under Care Act eligibility during April and May 2015.

Those who pay for care themselves will be entitled to go to councils to get advice and information about the care system. Fifty customers requested an assessment as self- funders during April and May 2015.

To help protect people's assets, a **cap on care costs** they have to pay for, set at £72,000 for over-65s, will kick in from April next year. How the cap works for younger people is still to be finalised.

The Care Act's emphasis on prevention and wellbeing is driving forward changes to how services are accessed and delivered. These include improvements in the following areas:

Connect to Support - now being developed to ensure that customers can access Care Act compliant information and advice. This includes a wider breadth of community based assets. There have been approximately 1,988 hits in April and May 2015 on Connect to Support, compared to 666 hits for the same period in 2014. It is clear that further development is required to enable customers to receive more services via Connect to Support.

Commissioning of advocacy support via RMBC is underway. This will ensure that customers can access independent advocacy, which has been identified as an area of urgent need. A review has been completed and a paper is being presented to senior management.

Introduction of the Liquid Logic IT system - This will become the main operating system for RMBC services from April 2016. It will enable the accurate collation of data to ensure that resources are targeted appropriately.

Contact: Nigel Parr
Professional Standards and Development Manager
Email: nigel.parr@rotherham.gov.uk

ROTHERHAM BOROUGH COUNCIL – REPORT TO HWB

1	**Meeting:**	**Health and Wellbeing Board**
2	**Date:**	**8 July 2015**
3	**Title:**	**RMBC Integrated Services – Adult Mental Health Review**
4	**Directorate:**	**Neighbourhoods and Adult Services**

5 **Summary**

In line with the Health and Social Care Act (2001) and NHS Act (2006), Rotherham adult mental health services are integrated under a partnership agreement between Rotherham Council (RMBC) and Rotherham, Doncaster and South Humberside NHS Foundation Trust (RDaSH) which has been in place since 2008. During this time, there has been a gradual loss of social care focus with priority given to complex mental health issues. To ensure a greater focus on prevention as promoted by the Care Act 2014, it is essential that the partnership agreement be re-negotiated.

A strengthened social care model is an essential element within an integrated approach to mental health. The current model of integration has failed to fully utilise the benefits of working together. Effective co-operation between health and social care can be achieved for the benefit of customers and should be mutually inclusive rather than the existing RMBC/RDaSH/local authority integration model. It is therefore timely to review the current RMBC partnership agreement with RDASH (either solely or with the other local authorities of North Lincolnshire and Doncaster) to explore alternative integrated working with health partners.

- RMBC is working with commissioning colleagues in North Lincolnshire and Doncaster to develop a core service level agreement. This will ensure that local authorities have a unified approach to commissioning services from RDaSH. RMBC and the other local authorities will be able to ensure that a clear social care voice exists within the integrated mental health service and have control over the council elements of staff and management.

- The effective utilisation of staff and resources to focus on RMBC priorities is highlighted by the development of the Vulnerable Persons Team (VPT). This responds to citizen feedback following the publication of last year's Jay Report and is in line with Care Act priorities. The work of VPT has been recognised nationally as an initiative for dealing with the adult survivors of child sexual exploitation. RMBC management and police colleagues were invited to present a paper on the work of VPT at the Social Work Live event in Birmingham in May 2015.

- Within an integrated mental health service it is essential that there is a robust supervision or personal development review (PDR) policy and process.

- As the responsible authority for safeguarding, RMBC must take the lead in ensuring Rotherham has an integrated safeguarding policy and related procedures.

Contact: Nigel Parr
Professional Standards and Development Manager
Email: nigel.parr@rotherham.gov.uk

Health and Wellbeing Board

1.	**Date:**	**8th July 2015**
2.	**Title:**	**Health and Wellbeing Board Governance and Forward Plan**

3. Summary

Following on from discussions at the 19th March Board workshop and subsequent recommendations on operation and governance agreed at the 22nd April Board meeting, this report presents updated Board terms of reference and a forward plan of agenda items for discussion and agreement.

4. Recommendations

That the Health and Wellbeing Board:

- **Discuss and agree the draft terms of reference (appendix A), including the Chair/Vice-Chair role description (appendix B)**
- **Discuss and agree the forward plan of agenda items (appendix C), recognising that specific meeting agendas will be agreed prior to each meeting.**

5. Proposals and details

Background

Following the board meeting on 19th March, health and wellbeing board partners participated in an "away session" facilitated by John Deffenbaugh. This session considered priorities for the new health and wellbeing strategy (update provided separately) and issues relating to the operation of the board.

At the subsequent board meeting on 22nd April, members agreed a number of specific recommendations relating to operation and governance, which have now been captured in updated terms of reference.

Terms of reference

The more substantive changes to the terms of reference include:

a. *Non-council vice-chair role (see appendix B)* – the Vice-Chair, initially the Chair of Rotherham CCG, will work closely with the Chair in ensuring the Board's effective operation. The Chair and Vice-Chair will be meeting all Board partners over the next couple of months to discuss their priorities for the year ahead and will then meet partners on an annual basis to assess progress.

b. *Membership* – as the Council's Deputy Leader currently has the Children and Young People portfolio, an additional Councillor Member will be appointed for one year. The Council's Strategic Director of Community Wellbeing and Housing, when appointed, will fulfil the Director of Adult Social Services role. All members will have equal status, including for voting purposes.

c. *Meetings* - the Board will meet every two months, with additional special meetings arranged as required to discuss specific or urgent issues. The meeting venue will rotate between Rotherham Town Hall (RMBC), Oak House (the CCG) and The Spectrum (Voluntary Action Rotherham). The Chairs of Rotherham Local Safeguarding Children Board and Rotherham Safeguarding Adults Board will have standing invites to Board meetings.

d. *Better Care Fund (BCF)* – the terms of reference now have specific reference to the Board's role in ensuring effective delivery of Rotherham's BCF plan.

Forward plan of agenda items

The forward plan is attached at appendix C. The aim is to provide a provisional schedule that captures all regularly recurring items, including core areas of business such as the health and wellbeing strategy and BCF.

Though the terms of reference call for meetings to be held every two months, the board is also required to sign off quarterly BCF monitoring returns to NHS England. This had led to some irregular intervals between meetings, but there is scope for additional special meetings to be arranged as required.

6. Financial implications

There are no direct financial implications.

7. Equalities implications

We will need to confirm that the proposed meeting venues have appropriate facilities to enable equality of access e.g. a hearing loop, disabled access.

8. Report authors

Michael Holmes, Policy and Partnership Officer, Rotherham MBC

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Appendix A

Rotherham Health and Wellbeing Board

(Draft) Terms of Reference
June 2015

1. Context

The Health and Social Care Act 2012 establishes health and wellbeing boards as a forum where key leaders across the health and social care system work together to:

a) Improve the health and wellbeing of the people in their area
b) Reduce health inequalities
c) Promote the integration of services.

These terms of reference set out how the Rotherham Health and Wellbeing Board ("the Board") will operate; building on collaborative working between Rotherham Council, NHS Rotherham Clinical Commissioning Group (CCG) and other key partners, such as NHS England and Healthwatch Rotherham.

Importantly, the focus of the Board will be wide ranging, looking at the health, social, environmental and economic issues which all impact on the health and wellbeing of people in Rotherham.

2. Functions of the Board

The Board is a statutory sub-committee of the council, but will operate as a multi-agency board of equal partners. It will be the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health and other services related to health and wellbeing. The aim is to secure better health and wellbeing outcomes for the whole Rotherham population from pre-birth to end of life, better quality of care for all patients and care users, and better value for the taxpayer.

The Board brings together key decision makers to address issues of local significance and to seek solutions through integrated and collaborative working, whilst being an advocate and ambassador for Rotherham collectively on regional, national and international forums. It has the power to request information from any of its members or organisations represented on the Board for the purpose of assisting it with its functions.

Functions of the Board include:

a) Enabling, advising and supporting organisations that arrange for the provision of health or social care services to work in an integrated way**,** for the purpose of advancing the health and wellbeing of people in Rotherham
b) Ensuring that public health functions are discharged in a way that helps partner agencies to fully contribute to reducing health inequalities
c) Overseeing the development of local commissioning plans, ensuring that they take account of the health and wellbeing strategy and are aligned to other policies and plans that have an impact on health and wellbeing. Where necessary, to initiate discussions with NHS England if an agreed concern exists regarding a failure to take account of the strategy.

Appendix A

d) Holding relevant partners to account for the quality and effectiveness of their commissioning plans
e) Ensuring that there are arrangements in place to provide assurance that local services are safe and accessible and that they meet national standards and local expectations of quality
f) Delegating any of the functions to a sub-group of the Board as the Board feels appropriate
g) Exercising any other functions of the council which the council has determined should be exercised by the Board on its behalf.

3. Remit

a) Developing a joint health and wellbeing strategy to provide the overarching framework for commissioning plans for the NHS, social care and public health, and other services that the Board agrees to consider - such as education, housing and planning - and to subject this strategy to regular review and evaluation
b) Developing a shared understanding of the needs of the local community, including through a statutory joint strategic needs assessment (JSNA), and facilitating public engagement and involvement in the development of the JSNA so that the experiences of local people influence policy development and service provision
c) Reducing health inequalities and closing the gap in life expectancy by ensuring that partners are targeting services to those who need them the most
d) Promoting the development and delivery of services which support and empower the citizen taking control of their own health, whilst ensuring the safeguarding of vulnerable children and adults
e) Assessing whether the commissioning arrangements for children and adult social care, public health and the NHS are sufficiently aligned to the health and wellbeing strategy and promoting joined up commissioning plans and pooled budget arrangements where all parties agree this makes sense
f) Ensuring effective delivery of Rotherham's Better Care Fund (BCF) plan, including monitoring performance against BCF metrics and making decisions on the commissioning or decommissioning of associated services
g) Prioritising services (through the development of the health and wellbeing strategy) that are focused on prevention and early intervention to reduce demand for health and social care services
h) Publishing and maintaining a statement of needs for pharmaceutical services across the Rotherham area
i) Overseeing at strategic level the relevant joint communications, marketing/social marketing and public relations programmes and campaigns required to support the delivery of health and wellbeing objectives in the borough and ensuring that local people have a voice in shaping and designing programmes for change
j) Ensuring that the people of Rotherham are aware of the Board, have access to relevant information and resources about its work and can contribute where appropriate.

4. Operating principles

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

a) Working in collaboration with partners to ensure people get the support and services they need as early as possible
b) Working in the best interests of Rotherham's citizens and communities

Appendix A

c) Involving the right people early on to make sure we get it right first time, reducing bureaucracy and getting better value for money
d) Supporting and enabling our communities to help themselves whilst safeguarding the most vulnerable
e) Prioritising prevention and early intervention
f) Considering the views and needs of all Rotherham people and treating everyone fairly and with respect
g) Working to a set of agreed communications standards, including openness and transparency; clarity and use of plain English; consistency and timeliness
h) Setting clear strategic objectives and priorities
i) Seeking opportunities to increase efficiency across service providers
j) Holding partners to account.

5. Membership, representation and conduct

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

The Board will be chaired by the council's cabinet member for adult social care and health, with the vice-chair from a non-council health partner (e.g. Rotherham Clinical Commissioning Group). Further details of the role of the chair and vice-chair are set out in appendix A.

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

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

Membership of Rotherham Health and Wellbeing Board

Cabinet Member for Adult Social Care and Health (Chair)
Chair of NHS Rotherham Clinical Commissioning Group (Vice-chair)
Cabinet Member with responsibility for Children's Services
Deputy Leader, RMBC*[1]
Director of Public Health
Chief Executive / Managing Director Commissioner, RMBC
Strategic Director of Community Wellbeing and Housing*[2]
Strategic Director of Children and Young People's Services
Chief Officer, NHS Rotherham Clinical Commissioning Group (CCG)
GP Executive Member of NHS Rotherham CCG
Senior representative, NHS England South Yorkshire and Bassetlaw

[1] As the deputy leader has responsibility for children's services in 2015/16, an additional councillor will be appointed to the Board for 2015/16
[2] This post is the director of adult social services; filled on an interim basis by the director of adult social care

Appendix A

Chair, HealthWatch Rotherham
Rotherham District Commander, South Yorkshire Police
Chief Executive, Voluntary Action Rotherham
Chief Executive, Rotherham NHS Foundation Trust
Chief Executive, Rotherham Doncaster and South Humber NHS Foundation Trust

Standing invite as observers:
Chair, Rotherham Local Safeguarding Children Board
Chair, Rotherham Safeguarding Adults Board

5.1 Responsibilities of a Health and Wellbeing Board member

All members of the Board, as a statutory sub-committee of the council, must observe the council's code of conduct for members and co-opted members. Other responsibilities include:

a) Attending Board meetings whenever possible – otherwise ensuring an appropriate deputy attends - and fully and positively contributing to discussions
b) Acting in the interests of the Rotherham population, leaving aside organisational, personal, or sectoral interests
c) Fully and effectively communicating outcomes and key decisions of the Board to their own organisations
d) Contributing to the development of the JSNA
e) Ensure that commissioning is in line with the requirements of the health and wellbeing strategy
f) Delivering improvements in performance against measures within the public health, NHS and adult social care outcomes frameworks
g) Declaring any conflict of interest, particularly in the event of a vote being required and in relation to the providing of services
h) Acting in a respectful, inclusive and open manner with all colleagues to encourage debate and challenge
i) Reading and digesting any documents and information provided prior to meetings to ensure the Board is not a forum for receipt of information
j) Acting as ambassadors for the work of the Board
k) Participating where appropriate in communications/marketing and stakeholder engagement activity to support the objectives of the Board, including working with the media.

6. Meeting Arrangements

The Board will meet every two months, with additional special meetings arranged as required to discuss specific or urgent issues. The schedule of meetings will be reviewed and agreed annually by the Board. The meeting venue will rotate between Rotherham Town Hall (RMBC), Oak House (the CCG) and The Spectrum (Voluntary Action Rotherham).

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

Papers for the Board will be distributed at least one week in advance of the meeting. Additional items may be tabled at the meeting in exceptional circumstances at the

discretion of the chair. Minutes of the Board will be circulated in advance of the next meeting and approved at the meeting.

All agenda items brought to the Board need to clearly demonstrate their contribution to delivering the board's priorities.

6.1 Quorum

A quorum of the Board will be at least one third of members (i.e. six), including at least one representative from RMBC and the CCG.

6.2 Decision Making

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

The following should be taken into account by Board members when taking decisions:

a) The priorities and objectives contained within the health and wellbeing strategy
b) Any recommendations made by other boards/groups
c) The business case.

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

6.2 Support to the Board

Administrative and organisational support for the Board will be provided by officers of the council.

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

7. Governance and Reporting Structures

As a council sub-committee the Board will be accountable to full council, but critically it will also be an integral part of Rotherham Partnership's (local strategic partnership) structures, reporting in to the partnership of which the Board chair will be a member.

Minutes of Board meetings will be forwarded where appropriate to full council meetings, Health Select Commission (RMBC Scrutiny), Rotherham CCG Governing Body and NHS England (South Yorkshire and Bassetlaw).

A BCF executive group is accountable to the Board for delivery of BCF schemes.

An officer/managerial support group will be accountable to the Board for overseeing delivery of the health and wellbeing strategy.

The Board will work closely with Rotherham Local Safeguarding Children Board (LSCB) and the strategic partnership body for children, young people and families, to ensure that the JSNA and health and wellbeing strategy reflect the specific needs of Rotherham children, young people and their families.

Appendix A

Appendix B

Rotherham Health and Wellbeing Board – Terms of Reference

Annex A – Chair and Vice-Chair Roles

As set out in section 5 of the terms of reference, the Rotherham Health and Wellbeing Board will be chaired by the Council's Cabinet Member for Adult Social Care and Health, with the Vice-Chair from a non-Council health partner (e.g. Rotherham Clinical Commissioning Group).

The Chair and Vice-chair will work closely together to ensure that the Board operates effectively and transparently in discharging the functions set out in its terms of reference.

Specifically, the Chair's responsibilities – supported by the Vice-Chair - are to:

1. Build support and engage partners in the work of the Board.

2. Agree an agenda for each Board meeting and review progress against actions agreed at previous meetings.

3. Manage Board meetings in a way that enables all partners to contribute.

4. Hold partners to account for their commitment to and attendance and participation in the Board.

5. Ensure that new representatives or members of the Board understand their role and responsibilities, in line with the terms of reference.

6. Meet once a year with each Board partner to support an annual appraisal of the Board's progress and operation.

7. Sign documentation and release funding on behalf of the Board.

8. Represent the Board at local, regional or national events and actively champion the work of the Board to improve health and wellbeing outcomes for the people of Rotherham.

Chairing meetings:

9. Where appropriate, it may be agreed in advance of the meeting for the Vice-Chair to take the chair for specific items.

10. In the absence of both the Chair and the Vice-Chair, the Board should appoint a temporary Chair for the meeting in question.

June 2015

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Appendix C - Rotherham Health and Wellbeing Board (HWbB) draft forward plan 2015/16

Date	Item	Lead	Comments
18th May (special meeting)	**Special meeting** to discuss suicide prevention and independent review	Public health (PH)	
8th July	HWbB forward plan / governance	RMBC / Clinical Commissioning Group (CCG)	Chair / vice-chair role, terms of ref, fwd plan of agenda items
	Better Care Fund (BCF)	RMBC / CCG	First performance report / NHS England submission
	HWb strategy (HWbS) update	PH	
26th August	BCF	RMBC / CCG	Performance update / NHSE submission sign off
	HWbS oral update	PH	
	Board protocols	RMBC / CCG	i.e. with health scrutiny/Healthwatch; safeguarding children board/children and young people strategic p'ship; adult safeguarding board; and the information sharing protocol
	Suicide prevention and self-harm action plan update	PH	
	CSE Strategy	RMBC	
30th September (special meeting)	**Special meeting** to consider and approve HWb strategy and discuss commissioning arrangements	PH	Including consideration of ongoing performance management and challenge arrangements via the board
25th November	BCF	RMBC / CCG	Performance update / NHSE submission sign off
	Special Educational Needs and Disability (SEND) update	RMBC	Annual update requested at Oct 14 board meeting
	Suicide prevention and self-harm action plan update	PH	
	Draft community strategy and implications for HWbB	Rotherham Partnership	First meeting of new partnership (Rotherham Together) due in September
24th February	BCF	RMBC / CCG	Performance update / NHSE submission sign off
	HWbS update	PH	

	Pharmaceutical needs analysis	PH	Annual review
	Suicide prevention and self-harm action plan update	PH	
20th April	Board annual review	RMBC / CCG	Including consideration of peer review
	BCF annual report	RMBC / CCG	
	JSNA annual review	RMBC	
	Healthwatch annual report	Healthwatch	Overview of work carried out + forward plan for 16/17

Standing item
Items from Health Select Commission - including input to scrutiny reviews at scoping stage and consideration of final reports where there are implications for the board

Regular items
HWbS development / monitoring – bi-monthly (programme of theme/priority updates plus exception reporting and annual review)
BCF – quarterly to fit BCF submissions; plus annual report
Suicide prevention and self-harm action plan

Annual items
Commissioning plans
JSNA review
Pharmaceutical needs analysis review
Healthwatch - overview of work carried out; key messages for board/partners
Public health annual report
Special educational needs and disability (SEND) – i.e. joint planning/commissioning for education, health and care
Relevant strategy updates - e.g. emotional wellbeing and mental health strategy, CSE strategy, growth plan

Other items/issues
CSE – e.g. joint commissioning of support for victims
Links with other bodies via protocols - protocols may call for periodic updates
Customer promises / community engagement / communications
Care Act - implementation updates
Council budget / medium term financial strategy – implications for HWb Board/Strategy

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REPORT TO THE HEALTH AND WELLBEING BOARD - 8th July 2015

Better Care Fund Partnership Framework Agreement Update

Report Sponsors: Rotherham Clinical Commissioning Group (CCG) and Rotherham MBC

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide Board Members with an update on the performance of the Section 75 agreement and Better Care Fund Plan for Rotherham

2. RECOMMENDATIONS

It is recommended that:

2.1 Members note the progress that has been made in projects, plans and the section 75 agreement for the Rotherham BCF, including closer and more integrated joint working between health and social care, and revised and strengthened governance for the BCF.

2.2 Members note the quarterly report submitted to NHS England relating to the performance of the Better Care Fund plan for Rotherham during the last quarter of 2014/15, as set out in Appendix 1. This return was authorised by the BCF executive, as agreed by the Health and Wellbeing Board on 22nd April 2015.

2.3 Members note and agree the reporting timeline for future submissions of returns to NHS England, as set out in Appendix 2.

3. INTRODUCTION / BACKGROUND

3.1 On 22nd April 2015 Rotherham's section 75 agreement, setting out the plans for integration and operation of the BCF plan, was approved by the Health and Wellbeing Board, subject to minor amendments. These minor amendments were promptly completed, and both the CCG and Rotherham Council each have a signed copy of the final agreement.

3.2 The section 75 agreement contained revised governance arrangements for the BCF plan, constituting a new operational group and a new strategic executive group. A reporting and monitoring timetable has been developed, which includes reporting to the Health and Wellbeing Board to ensure the BCF national conditions for BCF accountability are fully met, and ensures the authority meets the NHS England requirements and timescales for submitting quarterly returns.

3.3 The Section 75 agreement set out two pooled funds, comprising a total of 72 separate schemes. Some but not all of the schemes are fully operational, with the BCF Operational Group ensuring progress is being made to implement the few remaining schemes still in the planning stage.

3.4 A joint review is underway on BCF scheme 13. This is the largest of the 16 schemes, and contains some projects which may need to be refocused to more closely relate to BCF strategic priorities. Currently some major projects receive just a small portion of BCF funding; yet such projects have a major impact on the delivery of the BCF targets. It may be that reprioritising existing projects could see a simplified, streamlined and more effective way of reporting and monitoring how Rotherham is focusing on BCF metrics, and especially on reducing non-elective admissions, and increasing patient and customer satisfaction.

3.5 The review of services focuses on: the appropriateness for BCF funding, patient and customer satisfaction, monitoring and metrics, accountability and reporting, value for money, and on service delivery.

3.6 The service review should be completed by early autumn, and a report will be prepared for the Health and Wellbeing Board.

3.7 Quarter 4 (2014/15) monitoring report for the BCF was submitted to NHS England, according to the timetable discussed and agreed in April 2015 by the Health and Wellbeing Board. This report is attached at Appendix 1. It shows performance was in line with expectations. Although the target for reducing non-elective admissions was not reached, this was anticipated as the BCF plan was not fully implemented in this quarter.

4. CONCLUSION / NEXT STEPS

4.1 The Health and Wellbeing Board is asked to note the format, and the timetable, for submitting the quarterly returns to both the board and then to NHS England.

Further reports will be brought to the board on the detail of the schemes funded within the BCF plan, according to the timetable in Appendix 2,

5. FINANCIAL IMPLICATIONS

Schemes within the BCF were delivered within allocated BCF budgets. Some small underspends as a result of late starts to new projects allowed some additional spending on disabled facilities grants. A small underspend on Care Act implementation monies has been carried forward to 2015/16.

The Section 75 agreement set out a risk sharing agreement which withheld BCF funding due to non-achievement of the target for non-elective admissions reductions. This withheld funding was taken from a jointly established risk fund - a pool of unallocated funding which was reserved for this purpose.

There were therefore no issues of any BCF schemes having to take reduced or curtailed funding for 2014/5 as a result of the non-elective admissions target having been missed.

6. CONSULTATION WITH STAKEHOLDERS

The BCF operations group and BCF Executive Group are aware of Appendix 1 and 2 and have discussed and agreed these documents.

7. Appendices

7.1 Appendix 1- Rotherham Better Care Fund Quarter 4 report 2014/5

7.2 Appendix 2 – Better Care Fund Governance and Reporting Timeline

8. Background Papers

Section 75 Agreement Rotherham Better Care Fund

Officer Contacts: Keely Firth CFO, RCCG **Telephone No:** 302025
Officer Contacts: Lynda Bowen, RMBC **Telephone No** 07977 127771

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Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics from the Health &

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by

This initial Q4 Excel data collection template focuses on the allocation, budget arrangments and national conditions. Details on future data collection requirements and mechanisms (including possible use of Unify 2) will be announced ahead of the Q1

To accompany the quarterly data collection we will require the Health & Wellbeing Board to submit a written narrative that contains any additional information you feel is appropriate including explanation of any material variances against the plan and

Content

The data collection template consists of 4 sheets:

1) Cover Sheet - this includes basic details and question completion
2) A&B - this tracks through the funding and spend for the Health & Wellbeing Board and the expected level of benefits
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Narrative - please provide a written narrative
To note - Yellow cells require input, blue cells do not.

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

template have been completed the cell will turn green. Only when all 4 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) A&B

This requires 4 questions to be answered. Please answer as at the time of completion.
Has the Local Authority recived their share of the Disabled Facilites Grant (DFG)?
If the answer to the above is 'No' please indicate when this will happen.
Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

Fund Planning Guidance are still on track for delivery (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/). Please answer as at the time of completion.

are on track. If 'No' or 'No - In Progress' is selected please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.
Full details of the conditions are detailed at the bottom of the page.

Cover and Basic Details

Q4 2014/15

Health and Well Being Board	Rotherham

completed by:	Karen Smith
e-mail:	karen-nas.smith@rotherham.gov.uk
contact number:	01709 254870
Who has signed off the report on behalf of the Health and Well Being Board:	Commissioner Stella Manzie/Chris Edwards

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB.xls' for example 'County Durham HWB.xls'

	No. of questions answered
1. Cover	5
2. A&B	4
3. National Conditions	16
4. Narrative	1

Selected Health and Well Being Board:

Rotherham

Data Submission Period:

Q4 2014/15

Allocation and budget arrangements

Has the housing authority received its DFG allocation?	Yes
If the answer to the above is 'No' please indicate when this will happen	dd/mm/yy
Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?	Yes
If the answer to the above is 'No' please indicate when this will happen	dd/mm/yy

Selected Health and Well Being Board:

Rotherham

Data Submission Period:

Q4 2014/15

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a comment in the box to the right

Condition	Please Select (Yes, No or No - In Progress)	Comment
1) Are the plans still jointly agreed?	Yes	Rotherham HWB agreed a S75 partnership framework at its meeting in April 2015, which established 2 pooled budgets and a revised governance framework.
2) Are Social Care Services (not spending) being protected?	Yes	
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	No - In Progress	BCF plan outlines the need for social care staff to provide 7 day service within A&E. Recruitment to new posts have proved difficult, but arrangements are now in place to develop a sharper focus & new approach to accelerate & implement the revised BCF plans. Our enabling service is successfully operating as 7 day service.
4) In respect of data sharing - confirm that:		
i) Is the NHS Number being used as the primary identifier for health and care services?	No - In Progress	We plan to use NHS no. as primary identifier by the end of Q1 of 2015/16. An additional software requirement has slightly delayed implementation. The plan is to review & develop the LA's existing software, and replacing the existing case management system by April 2016.
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	We use secure e-mail.
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	We recently completed the Information Governance toolkit, and noted there was considerable evidence to support effective IG controls within our organisations.
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes	There is always an accountable professional/practitioner once it has been identified that a person with eligible needs will be in receipt of a care package.
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	When completing the BCF plan, the CCG and the Local Authority engaged with Healthwatch to discuss the planned change in service provision. Further discussion is ongoing to ensure Healthwatch continue to be active within the governance and implementation of the Rotherham BCF plan.

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Selected Health and Well Being Board:

Rotherham

Data Submission Period:

Q4 2014/15

Narrative	remaining characters	32,321

Please provide any additional information you feel is appropriate to support the return including explanation of any material variances against the plan and associated performance trajectory that was approved by NHS England.
As part of our preparation for 2015-16, a financial monitoring and reporting process was introduced and has been evidenced. Both organisations have had an independent audit review and assurance has been given which will be reported to our respective audit committees. Our new governance structure allows our metrics to be monitored closely to align financial activity and performance within each of our schemes and across the BCF as a whole.

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Appendix 2 - Dates of HWB and BCF Groups

BCF Submission Date	Health and Wellbeing Board	BCF Executive Group	BCF Operational Group	Work Plan for Forward Plan
Friday, 29th May, 2015	Monday, 18th May, 2015 (special meeting to discuss suicide prevention)	Tuesday, 19th May, 2015	Friday, 15th May, 2015	Review of S75 Quarterly performance report 1
	Monday, 8th July, 2015	Tuesday, 7th July, 2015	Tuesday, 9th June, 2015	Agree remit for the review of BCF schemes for CH and LB
Friday, 28th August, 2015	Wednesday, 26th August, 2015	Wednesday, 19th August, 2015 KF – apologies MS – apologies	Monday, 17th August, 2015 KF – apologies MS - apologies	Review of S75 Quarterly performance report 2
	Wednesday, 30h September, 2015		Monday, 5th October, 2015	Review of work done by CH and LB on BCF- draft revised set of schemes
Friday, 27th November, 2015	Wednesday, 25th November, 2015	Tuesday, 24th November, 2015	Thursday, 12th November, 2015	Review of S75 Quarterly performance report 3
			Tuesday, 8th December, 2015	Review of funding arrangements for schemes April 2016 onwards
Friday, 26th February, 2016	Wednesday, 24th February, 2016	Wednesday, 18th February, 2016	Tuesday, 16th February, 2016	Review of S75 Quarterly performance report4
			Thursday, 24th March, 2016	
	Wednesday, 20th April, 2016			
Friday, 27th May, 2016		Tuesday, 19th May, 2016	Thursday, 12th May, 2016	Revised S75 Annual report on BCF, as well as quarterly report? Revised S75

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To: Chief Executive
Director of Adult Social Care

9 June 2015

Dear Colleague,

Care and Health Improvement Programme

As you will be aware we have been working with the Department of Health since 2012 on a range of social care improvement and health integration programmes. This work includes programmes centred on Health and Wellbeing Boards, the response to Winterbourne View, the implementation of the Care Act and, more recently, care and health integration and the Better Care Fund.

I want to update you on our Care and Health Improvement Programme for 2015/16 and let you know how you can access the support we are making available.

Care and Health Improvement Programme in 2015/16

In recent months we have been consulting with colleagues from across the sector, within the Department of Health and NHS England, to refresh our programme. In developing the Programme, we have listened very carefully to what authorities, regional leaders and professional associations have told us. The consensus is for a continuation of a sector-led improvement approach that recognises the significant change that is happening within the care and health sector.

Our Programme will therefore seek to ***improve outcomes for local people by helping local authorities and Health and Wellbeing Boards*** to

- deliver better quality care and health;
- embed Health and Wellbeing Boards as place-based health and care leaders;
- make care and health sustainable locally; and
- use sector-led improvement to enable local authorities to increase public, regulator and government confidence in local care and health services.

To achieve this, the programme will provide support you in the following areas:

- *Social Care Improvement:* addressing risk management, resilience, workforce, safeguarding, learning disabilities, mental health and social care improvement;
- *Health and Wellbeing Boards*: supporting systems leaders to be effective in their role and to plan ahead;
- *Care Act:* helping authorities to embed the Act's social care changes and plan for funding reforms;

- *Integration:* supporting authorities to deliver their approved Better Care Fund plans, prepare for the second year of the fund, and support the Pioneers, Vanguards and Five Year Forward View trials; and
- *Informatics:* helping authorities and clinical commissioning groups share data to improve the delivery of care services.

As the new government's plans become clearer we will undertake a mini review of the objectives in July, to ensure our Programme continues to support you. You can find more details of the programme at http://www.local.gov.uk/health/-/journal_content/56/10180/7315475/ARTICLE.

Our offer to you

The Programme provides for a broad range of support to authorities and Health & Wellbeing Boards, some of it universally available and some according to need, including:

Leadership support

- Leadership Essentials for Health & Wellbeing Board Chairs and Vice Chairs;
- Induction sessions for new Health & Wellbeing Board Chairs and Vice Chairs;
- Mentoring for chairs, leaders and directors;
- Leadership training for senior managers in Social Care.

Peer challenge, support and diagnosis

- Health & Wellbeing Peer Challenges and follow-up support;
- Adult Social Care Peer Challenge;
- Social Care Commissioning Peer Challenges and follow-up support;
- Social care practice deep dives to support implementation and improvement;
- Integrated care operational peer support, offered jointly with the NHS;
- Health & Wellbeing bespoke support; and
- Risk assessment, identification and management.

Integration, implementation and improvement support

- Products and tools to support implementation of the Better Care Fund and Care Act focused on the biggest risks areas to implementation;
- Products and tools to support implementation of Adult Safeguarding Boards, Safeguarding and Commissioning for Better Outcomes;
- Support authorities and their CCG partners to redefine the way people with mental health and challenging behaviour are cared for locally;
- Products and tools to support the delivery of the Better Care Fund;
- Bespoke practical support to those places and areas that request it.

Public reporting and analysis

- Social Care Annual Report;
- Health and Wellbeing state of the nation;
- Use of Resources;
- Care Act Stocktakes;
- Area profiles for adult social care, public health and Health & Wellbeing areas.

Regional networks

- Supporting networks of regional Health & Wellbeing Chairs, Chief Executives, Directors of Social Care and operational managers;
- Supporting regional implementation networks for the Care Act and adult social care improvement;
- Providing expert senior Care and Health Improvement Advisers, working with LGA Principal Advisers, to support improvement and change (see below).

In addition to our support for your adult social care, health and health and wellbeing board support member councils also have access to our full corporate support offer. You can find out more about this from your Principal Adviser or at http://www.local.gov.uk/support1.

Our support to you

Nationally, Andrew Webster will continue to lead and direct this programme for the LGA. Andrew is supported by Caroline Tapster, working on health and wellbeing issues, Sarah Mitchell on adult social care and Andrew Hughes on Care Act implementation. Sally Burlington leads our policy and lobbying work across all care and health issues.

You will be familiar with the support provided by our Principal Advisers, but the scale and pace of the agenda in this area means that we need to increase our senior capacity support available to you. We have therefore developed the Care and Health Improvement Advisers (formerly Adults Improvement Advisers) role we created last year. They will work with your Principal Adviser to provide senior professional support, advice and capacity in social care and health to the regional lead Members, Chief Executive and Director of Adult Social Services

We will also provide a limited amount of additional funding to each region to enable co-operative working to support the delivery of the Programme. The Department of Health will also provide additional funds to specifically support the implementation of the Care Act and the NHS will allocate funding to NHS regions to support the implementation of the Better Care Fund in partnership with local government. See Annex 1. We continue to work with the Department to ensure that you have the maximum flexibility to use these funds in a way that meets regional needs and recognises the interrelationship between their policy objectives.

How to access the Offer

To access this offer please contact your regional Principal Adviser or Care and Health Improvement Adviser or see our website www.local.gov.uk. See Annex 2 for more details. They will be able to discuss your particular needs and advise you on what is available to address them.

Finally, we are continually looking to improve our advice and support that we offer to you. If you have any specific comments about the programme, or the way we are working with you to deliver it please contact Jackie Rowe (email: jackie.rowe@local.gov.uk) to discuss this.

Carolyn Downs
Chief Executive, Local Government Association

CC: Principal Adviser
Care and Health Improvement Adviser

Annex 1 LGA Regional Funding and Expectations

Funding from the MoU will be allocated using an existing allocation formula to ADASS regional lead councils, and will entail the expectation that the region will:

- work co-operatively to support the delivery of the Care and Health Improvement Programme objectives under the direction of the regional Lead Member, Chief Executive and Director of Adult Social Care and in discussion with the LGA's Principal Adviser and Care and Health Improvement Adviser;
- adopt, promote and develop a sector-led approach to improvement in social care and the integration with health services that is locally led and accountable, person centred and integrated with health services;
- develop approaches based on an understanding and sharing of local issues, support requirements and approaches that are best suited to deliver the Care and Health Improvement Programme at a regional level; and
- ensure that innovative practice, areas of concern and progress are available and accessible to the national Care and Health Improvement Programme.

Regional Allocations

Region	Regional Lead Chief Executive	Regional Lead Director	Budget Holding Authority	Allocated Funding
East Midlands	John Sinnott Leicestershire CC	Glen Garrod Lincolnshire CC	Nottinghamshire CC	£54,800
East of England	Rob Tinlin Southend Council	Julie Ogley Central Bedfordshire	Suffolk CC	£57,325
London	Martin Smith LB Ealing	Cathy Kerr LB Richmond	LB Hammersmith & Fulham	£72,975
North East	Dave Smith Sunderland City Council	Rachael Shimmin Durham CC	Gateshead MC	£52,250
North West	Margaret Carney Sefton MBC	Sue Lightup Salford MBC	Tameside MBC	£67,675

Region	Regional Lead Chief Executive	Regional Lead Director	Budget Holding Authority	Allocated Funding
South East	Penny Thomson Brighton & Hove City Council Chris Williams Buckinghamshire CC	Denise D'Souza Brighton & Hove City Council Keith Hinkley East Sussex CC	East Sussex CC	£66,450
South West	Phil Norrey Devon CC	Margaret Wilcox Gloucestershire CC	Gloucestershire CC	£60,450
West Midlands	Alistair Neill Herefordshire CC	Ian James Solihull MBC Peter Hay Birmingham City Council	Worcestershire CC	£59,200
Yorkshire & Humberside	Merran McRae Calderdale MBC	Bev Maybury Calderdale MBC	Rotherham MBC	£58,875

Basis of allocation: Minimum of £20,000 per region; plus 50% of the national balance allocated according to the proportion of councils per region and 50% according to the proportion of the local authority social care workforce per region.

Regions should also use any reported underspends from previous LGA grants paid to support these expectations.

Better Care Fund

The Better Care Fund has also allocated £140,000 to each of the four NHS Regions to support implementation of BCF. In addition, at least £1m is being made available to the NHS Regions to commission and provide direct support at a regional level to respond to the key issues raised in the BCF readiness survey. Authorities have access to this funding through their regional lead Chief Executives.

Annex 2 Regional Contacts

Region	Principal Adviser	Care & Health Improvement Adviser
East Midlands	Mark Edgell mark.edgell@local.gov.uk 07747 639 910	Rachel Holynska *(from 1 July)* *07585 328 458*
East of England	Gary Hughes gary.hughes@local.gov.uk 07771 941 337	Rachel Holynska *(from 1 July)* *07585 328 458*
London	Heather Wills heather.wills@local.gov.uk 07770 701 188	Adi Cooper 07468 511 404
North East	Mark Edgell mark.edgell@local.gov.uk 07747 639 910	Sandie Keene 07824 512 908
North West	Gill Taylor gill.taylor@local.gov.uk 07789 512 173	Terry Rich 07956 536 908
South East	Heather Wills heather.wills@local.gov.uk 07770 701 188 Mona Segal mona.segal@local.gov.uk 07795 291 006	Oliver Mills 07881 820 895
South West	Andy Bates andy.bates@local.gov.uk 07919 562 849	Oliver Mills 07881 820 895
West Midlands	Helen Murray helen.murray@local.gov.uk 07884 312235	Mimi Konigsberg 07414 795 670
Yorkshire & Humberside	Mark Edgell mark.edgell@local.gov.uk 07747 639 910	Sandie Keene 07824 512 908

For further contact information please click on the following link for more details of your local and regional contacts
http://www.local.gov.uk/documents/10180/11823/Regional+Allocations_FOR+EXTERNAL+USE+ONLY_Version+1+0_171013/921fea4a-d879-4305-a3b0-a3a4f37f8b89