Herefordshire Council

AGENDA

Health and Wellbeing Board

Date: **Tuesday 19 June 2012**

Time: **3.00 pm**

Place: **Council Chamber - Brockington**

Notes: Please note the **time, date** and **venue** of the meeting.

For any further information please contact:

Tim Brown, Governance Services
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If you would like help to understand this document, or would like it in another format or language, please call Tim Brown, Governance Services on 01432 260239 or e-mail tbrown@herefordshire.gov.uk in advance of the meeting.

Agenda for the Meeting of the Health and Wellbeing Board

Membership

Chairman	**Councillor PM Morgan**	
Non Voting	**Dr Sarah Aitken**	Interim Director of Public Health
	Jacqui Bremner	Local Involvement Network
	Peter Brown	Herefordshire Business Board
	Chris Bull	Chief Executive Herefordshire Public Services
	Jo Davidson	Director for People's Services
	Claire Keetch	Third Sector Board
	Jo Newton	Chairman NHS Herefordshire (PCT) Board
	Dr Andy Watts	Chair - Clinical Commissioning Group
	Mr Martin Woodford	Chief Executive - Wye Valley NHS Trust

GUIDANCE ON DECLARING PERSONAL AND PREJUDICIAL INTERESTS AT MEETINGS

What is a personal interest?

You have a personal interest in a matter if that matter affects the well-being or financial position of you, your relatives or people with whom you have a close personal association more than it would affect the majority of other people in the ward(s) to which the matter relates.

A personal interest can affect you, your relatives or people with whom you have a close personal association positively or negatively. If you or they would stand to lose by the decision, you should also declare it.

You also have a personal interest in a matter if it relates to any interests, which you must register.

What do I need to do if I have a personal interest?

You must declare it when you get to the item on the agenda headed “Declarations of Interest” or as soon as it becomes apparent to you. You may still speak and vote unless it is a prejudicial interest.

If a matter affects a body to which you have been appointed by the authority, or a body exercising functions of a public nature, you only need declare the interest if you are going to speak on the matter.

What is a prejudicial interest?

You have a prejudicial interest in a matter if;

a) a member of the public, who knows the relevant facts, would reasonably think your personal interest is so significant that it is likely to prejudice your judgment of the public interest; and

b) the matter affects your financial interests or relates to a licensing or regulatory matter; and

c) the interest does not fall within one of the exempt categories at paragraph 10(2)(c) of the Code of Conduct.

What do I need to do if I have a prejudicial interest?

If you have a prejudicial interest you must withdraw from the meeting. However, under paragraph 12(2) of the Code of Conduct, if members of the public are allowed to make representations, give evidence or answer questions about that matter, you may also make representations as if you were a member of the public. However, you must withdraw from the meeting once you have made your representations and before any debate starts.

AGENDA

		Pages
1.	**APOLOGIES FOR ABSENCE** To receive apologies for absence.	
2.	**NAMED SUBSTITUTES (IF ANY)** To receive any details of Members nominated to attend the meeting in place of a Member of the Committee.	
3.	**DECLARATIONS OF INTEREST** To receive any declarations of interests of interest by Members in respect of items on the Agenda.	
4.	**MINUTES** To approve and sign the Minutes of the meeting held on 20 March 2012.	1 - 4
5.	**UNDERSTANDING HEREFORDSHIRE - THE 2012 INTEGRATED NEEDS ASSESSMENT** To receive the 2012 summary Integrated Needs Assessment document "Understanding Herefordshire", and note the programme of work towards a "Gold Standard" Integrated Needs Assessment.	5 - 34
6.	**HEALTH WATCH HEREFORDSHIRE** To update the Herefordshire Health and Wellbeing Board on the progress made to date regarding Healthwatch Herefordshire and to seek the Board's views on the issues outlined in the attached discussion paper.	35 - 66
7.	**HEALTH AND WELLBEING COMMUNICATIONS AND ENGAGEMENT STRATEGY AND PARTNERSHIP WORKING** To update the Health and Wellbeing Board on the different strands of work currently underway intended to address key strategic and operation communications issues.	67 - 96
8.	**HEALTH AND WELLBEING BOARD WORK PLAN** To consider the current Work Plan.	97 - 102
9.	**WORKSHOP UPDATE** To receive an update at the meeting on work undertaken since the last workshop.	
10.	**FUTURE MEETINGS** The following meetings have been scheduled (meetings are at 2.00pm unless otherwise stated): Tuesday 10 July 2012 (workshop) Tuesday 18 September 2012 (workshop) Tuesday 16 October 2012 Tuesday 13 November 2012 (workshop) Tuesday 11 December 2012 (workshop) Tuesday 22 January 2013 Tuesday 19 February 2013 Tuesday 19 March 2013	

Tuesday 16 April 2013
Tuesday 14 May 2013

The Public's Rights to Information and Attendance at Meetings

YOU HAVE A RIGHT TO: -

- Attend all Council, Cabinet, Committee and Sub-Committee meetings unless the business to be transacted would disclose 'confidential' or 'exempt' information.
- Inspect agenda and public reports at least five clear days before the date of the meeting.
- Inspect minutes of the Council and all Committees and Sub-Committees and written statements of decisions taken by the Cabinet or individual Cabinet Members for up to six years following a meeting.
- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting. (A list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.
- Access to a public Register stating the names, addresses and wards of all Councillors with details of the membership of Cabinet and of all Committees and Sub-Committees.
- Have a reasonable number of copies of agenda and reports (relating to items to be considered in public) made available to the public attending meetings of the Council, Cabinet, Committees and Sub-Committees.
- Have access to a list specifying those powers on which the Council have delegated decision making to their officers identifying the officers concerned by title.
- Copy any of the documents mentioned above to which you have a right of access, subject to a reasonable charge (20p per sheet subject to a maximum of £5.00 per agenda plus a nominal fee of £1.50 for postage).
- Access to this summary of your rights as members of the public to attend meetings of the Council, Cabinet, Committees and Sub-Committees and to inspect and copy documents.

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- Public transport access can be gained to Brockington via the service runs approximately every 20 minutes from the City bus station at the Tesco store in Bewell Street (next to the roundabout junction of Blueschool Street / Victoria Street / Edgar Street).
- The nearest bus stop to Brockington is located in Vineyard Road near to its junction with Old Eign Hill. The return journey can be made from the same bus stop.

HEREFORDSHIRE COUNCIL

BROCKINGTON, 35 HAFOD ROAD, HEREFORD.

FIRE AND EMERGENCY EVACUATION PROCEDURE

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You should vacate the building in an orderly manner through the nearest available fire exit.

You should then proceed to Assembly Point **A** which is located in the circular car park at the front of the building. A check will be undertaken to ensure that those recorded as present have vacated the building following which further instructions will be given.

Please do not allow any items of clothing, etc. to obstruct any of the exits.

Do not delay your vacation of the building by stopping or returning to collect coats or other personal belongings.

HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Health and Wellbeing Board held at Council Chamber - Brockington on Tuesday 20 March 2012 at 3.00 pm

Present: **Councillor PM Morgan (Chairman)**

Dr S Aitken, Ms J Bremner, Mr P Brown, Mr CJ Bull, Mrs J Davidson, Mrs C Keetch, Mrs J Newton, Mr T Tomlinson and Dr A Watts

In attendance: **Councillors JG Jarvis and JLV Kenyon**

Officers: **D Taylor (Deputy Chief Executive and Director of Corporate Services), M Emery (Head of Business Suppport) Dr A Merry (Consultant Public Health and Dental Public Health), C Wichbold MBE (Grants and Partnership Officer), and T Brown (Governance Services).**

32. APOLOGIES FOR ABSENCE

Apologies were received from Supt C Hill and Mr M Woodford.

33. NAMED SUBSTITUTES

Mr T Tomlinson substituted for Mr M Woodford.

34. DECLARATIONS OF INTEREST

There were none.

35. MINUTES

RESOLVED: That the Minutes of the meeting held 17 January 2012 be confirmed as a correct record and signed by the Chairman.

36. HEALTH AND WELLBEING STRATEGY 2012/13

The Board was invited to agree the Health and Wellbeing Strategy 2012/13 and supporting recommendations.

The Interim Director of Public Health presented the Strategy.

The Board discussed various aspects of the Strategy, in particular the extent to which it would drive transformation of services and how the Board would be able to satisfy itself that this was being achieved. The Board supported the vision and guiding principles for the Strategy but considered that further work needed to be undertaken on the detail of the Strategy itself.

RESOLVED:

That (a) the vision and guiding principles for the Health and Wellbeing Strategy for 2012/13 be agreed together with the focus on the three priority areas: children under five years of age, alcohol harm reduction and older people;

(b) facilitated engagement be arranged with partners to explore how the Board could make the most effective contribution to the priority areas, and the draft Health and Wellbeing Strategy for 2012/13 be revised and submitted to the Board for approval at a future meeting;

(c) the Health and Wellbeing Board work programme for 2012/13 should be informed by the Health and Wellbeing Strategy 2012/13 and have regard to priorities, commissioning cycles and development of the new NHS architecture;

(d) an adult services sub-group of the Health and Wellbeing Board be set up; and

(e) a Population Health Improvement Strategy 2013-16 be developed.

37. PUBLIC HEALTH TRANSITION PLAN

The Board received the Public Health Transition Plan.

The Interim Director of Public Health presented the report.

The Board noted the significance and complexity of the changes. It was highlighted that that not all public health functions would transfer to the Council. The Board emphasised the importance of ensuring that there was an overview of the transition and that appropriate monitoring arrangements for the transition were in place.

RESOLVED: That the Public Health Transition Plan be noted.

38. LOCAL NHS PLANNING

The Board received an update on the Herefordshire Healthcare Commissioning Consortia Operational Plan (HHCC) and the PCT Cluster Integrated System Plan.

The Head of Business Support and Dr Watts, the Chairman of the HHCC, presented the report.

The Board supported the Operational Plan and requested that risks and challenges be included in the next version of the Operational Plan to assist the Board.

RESOLVED:

That (a) the Clinical Commissioning Group Operational Plan be endorsed;

(b) an update on progress against the plan and associated authorisation timelines be made to the Board in September 2012;

(c) the PCT Cluster Systems Plan planning submission and its submission be noted; and

(d) risks and challenges be included in the next version of the Operational Plan to assist the Board.

39. UPDATE ON PROGRESS OF NATIONAL LEARNING SET ON GOVERNANCE

The Board deferred consideration of this item.

40. HEREFORDSHIRE PUBLIC SERVICES UPDATE

The Board noted an update on Herefordshire Public Services.

41. HEALTH AND WELLBEING BOARD WORK PLAN

The Board noted the work plan.

42. FUTURE MEETINGS

The Board noted the list of scheduled meetings.

The meeting ended at 5.00 pm **CHAIRMAN**

Herefordshire Council

MEETING:	**HEALTH AND WELLBEING BOARD**
DATE:	**19 JUNE 2012**
TITLE OF REPORT:	**UNDERSTANDING HEREFORDSHIRE – THE 2012 INTEGRATED NEEDS ASSESSMENT**

CLASSIFICATION: Open

Wards Affected

County-wide

Purpose

For the Health and Wellbeing Board to receive:

- the 2012 summary Integrated Needs Assessment document "Understanding Herefordshire", provided in Appendix 1;

- the programme of work towards a "Gold Standard" Integrated Needs Assessment detailed in Appendix 2.

Recommendation(s)

THAT THE HEALTH AND WELLBEING BOARD:

(a) approve the document "Understanding Herefordshire" as the summary of the 2012 Integrated Needs Assessment; and

(b) approve "Understanding Herefordshire" and the 2012 Integrated Needs Assessment as the evidence base against which strategic priorities and commissioning decisions will be made; and

(c) identify areas where they would like more in depth analysis over the coming year; and

(d) approve the programme of work towards a "Gold Standard" Integrated Needs Assessment.

Key Points Summary

- Understanding Herefordshire provides a single integrated assessment of the needs of the people of Herefordshire, bringing together the Joint Strategic Needs Assessment (JSNA) and the State of Herefordshire Report.

- It is integral to the commissioning cycle, providing an explicit evidence base that will enable strategic priorities, commissioning decisions and partnership working to be based upon a clear

and comprehensive understanding of need.

- It also provides a mechanism to evaluate the effectiveness of commissioning decisions and of interventions, with the ability to monitor or "track" progress over time.

- The assessment will meet the statutory requirement to produce a JSNA, but as we work to develop a "Gold Standard" Integrated Needs Assessment we are aiming to encompass all the needs of local residents, not just those that directly contribute to health and well being.

- As such Understanding Herefordshire is a critical document for everyone engaged in delivering better outcomes for the County. In particular it will be used by the Herefordshire Partnership, the Clinical Commissioning Group in setting strategic priorities and commissioning strategies, and the Council in reviewing the corporate plan.

How will your report meet the vision and guiding principles of the HWBB?

Understanding Herefordshire explicitly identifies the underlying factors that enable people to be resilient; lead fulfilling lives; be emotionally and physically healthy and feel safe and secure.

Reasons for Recommendations

1 When embedded into the commissioning cycle the Integrated Needs Assessment will enable strategic priorities, commissioning decisions and partnership working to be based upon explicit evidence of need.

2 This will enable the Health and WellBeing Board, its members, and their partners, to maximise the return on investment from the use of resources and maximise the health and well-being of Herefordshire.

3 The Integrated Needs Assessment incorporates the Joint Strategic Needs Assessment – so feedback is sought from the Health and WellBeing Board on priority areas for more in depth analysis in 2012, and on the programme of work towards a "Gold Standard".

Introduction and Background

4 The previous Joint Strategic Needs Assessment (JSNA) and State of Herefordshire report have been brought together to provide a single integrated assessment of the health and well-being needs of the people of Herefordshire.

5 Understanding Herefordshire provides the high level summary of this within a single document. It is underpinned by a dynamic web based resource called the Integrated Evidence Base, that is updated in-year with analysis and intelligence as they become available (www.herefordshire.gov.uk/factsandfigures).

Key Considerations

6 The essential point of the Integrated Needs Assessment is that it be used to influence and inform future decision-making.

7 Recommendations from Understanding Herefordshire are that we:

- Be proactive about our changing demographics, identifying the predicted rise in need for services and ways to address it.

- Develop the infrastructure, services and support networks needed to enable people to live independently. As well as direct service provision this will include housing and accommodation that facilitates independence, the economy, spatial planning, transport, engagement with the third sector and communities, and support for carers.

- Continue to build on a community based approach, developing our assets of volunteers, carers, third sector organisations, active communities and statutory services.

- Adopt this community based approach to provide comprehensive and integrated services and support for people living with Dementia.

- Ensure that the environment and infra-structure enables people to make healthy choices such as cycling and walking, as well as supporting economic growth and improved connectivity.

- Target preventative activities at the major causes of morbidity and premature mortality, in particular smoking, alcohol and falls.

- Make childhood obesity a priority for all stakeholders, tackling the underlying causes as part of a joined up strategy.

- Ensure continued improvement for Early Years and Foundation Programme, primary and secondary school children to achieve top quartile performance.

- Ensure the various strategies targeting families living in poverty are joined up to provide an integrated response.

- Address social inequalities through a comprehensive approach, encompassing opportunities such as employment as well as lifestyle behaviours, access to services and community engagement.

- Undertake more in depth analysis in the following areas:

    - Domestic violence

    - The care needs of people with learning disabilities

    - Impact of changes to the welfare system, particularly on families

8 Understanding Herefordshire forms the first year of a three year development programme, to produce a “gold standard” integrated needs assessment in 2014. We’ve begun by:

- Improving our qualitative information, engaging with the third sector to gain a better understanding of the needs of people living with dementia and their carers.

- Adopting an asset based approach to identify the strengths and opportunities within our communities, localities and services.

- Including a place based approach, presenting information by localities and communities as well as by theme.

- Engaging stakeholders across HPS and its partners, and embedding the breadth of analyses undertaken across Herefordshire within the INA.

9 Further developmental work is planned, as detailed in Appendix 2.

Community Impact

10 Working with and supporting the development of stronger communities is a key finding of Understanding Herefordshire.

11 Key findings within the summary document and within the underpinning evidence base (www.herefordshire.gov.uk/factsandfigures) will also maximise our ability to support and develop stronger communities.

Equality and Human Rights

12 The Integrated Needs Assessment explicitly considers inequalities in opportunities and outcomes, paying full regard the public sector equality duty.

Financial Implications

13 Understanding Herefordshire and the web-based Integrated Evidence Base are integral to the commissioning cycle. They provide the explicit evidence base to ensure priorities and commissioning decisions are based upon assessment of need.

14 As such they enable organisations to ensure that resources are directed at local priorities and to maximise the return on investment from the use of resources.

Legal Implications

15 Producing the Integrated Needs Assessment fulfils the statutory requirement (now in the Health and Social Care Act 2012) to produce a Joint Strategic Needs Assessment. From April 2013 the duty will fall on the Council and the Clinical Commissioning Group, working in partnership through the Health and Wellbeing Board.

Risk Management

16 Failure to embed the INA into the commissioning cycle of organisations and of the Health and WellBeing Board represents a risk.

17 The risk is of failure to identify strategic priorities, and to target resources in relation to need, reducing the return on investment from the use of resources and making it harder to improve health and wellbeing.

Consultees

18 Understanding Herefordshire and the Integrated Evidence Base have been developed with input from stakeholders across HPS and it's partners, including third sector organisations.

19 Membership of the reference group who produced the summary document is detailed below:

- Research team
- People's Commissioning Quality & Improvement Team
- Public health

- Transport
- Forward planning
- Housing
- Sustainable communities
- Community Safety
- Herefordshire Clinical Commissioning Group
- Herefordshire Voluntary Organisations Support

The INA has already been to Herefordshire Council Leaders Briefing and Cabinet.

It is scheduled to go also to the Clinical Commissioning Group, Herefordshire Partnership Executive Group, and the Council's Corporate and Commissioning Board.

Appendices

Appendix 1. Understanding Herefordshire. Summary of the 2012 Integrated Needs Assessment

Appendix 2. Programme of work towards a "gold standard" Integrated Needs Assessment.

*

Understanding Herefordshire 2012

An Integrated Needs Assessment

V.2.4

See www.herefordshire.gov.uk/understandhere

May 2012

If you need help to understand this document, or would like it in another format or language, please call the Research Team on 01432 383634 or e-mail researchteam@herefordshire.gov.uk

Herefordshire Council

NHS Herefordshire

Working in partnership for the people of Herefordshire

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About Understanding Herefordshire 2012

Understanding Herefordshire provides a single integrated assessment of the health and well-being needs of the people of Herefordshire, bringing together the Joint Strategic Needs Assessment and the State of Herefordshire Report. It provides an explicit evidence base to inform commissioning decisions, particularly those relating to priority setting and resource allocation. It also demonstrates the interdependencies of many health and wellbeing outcomes, and the opportunities for joint working across organisations and initiatives.

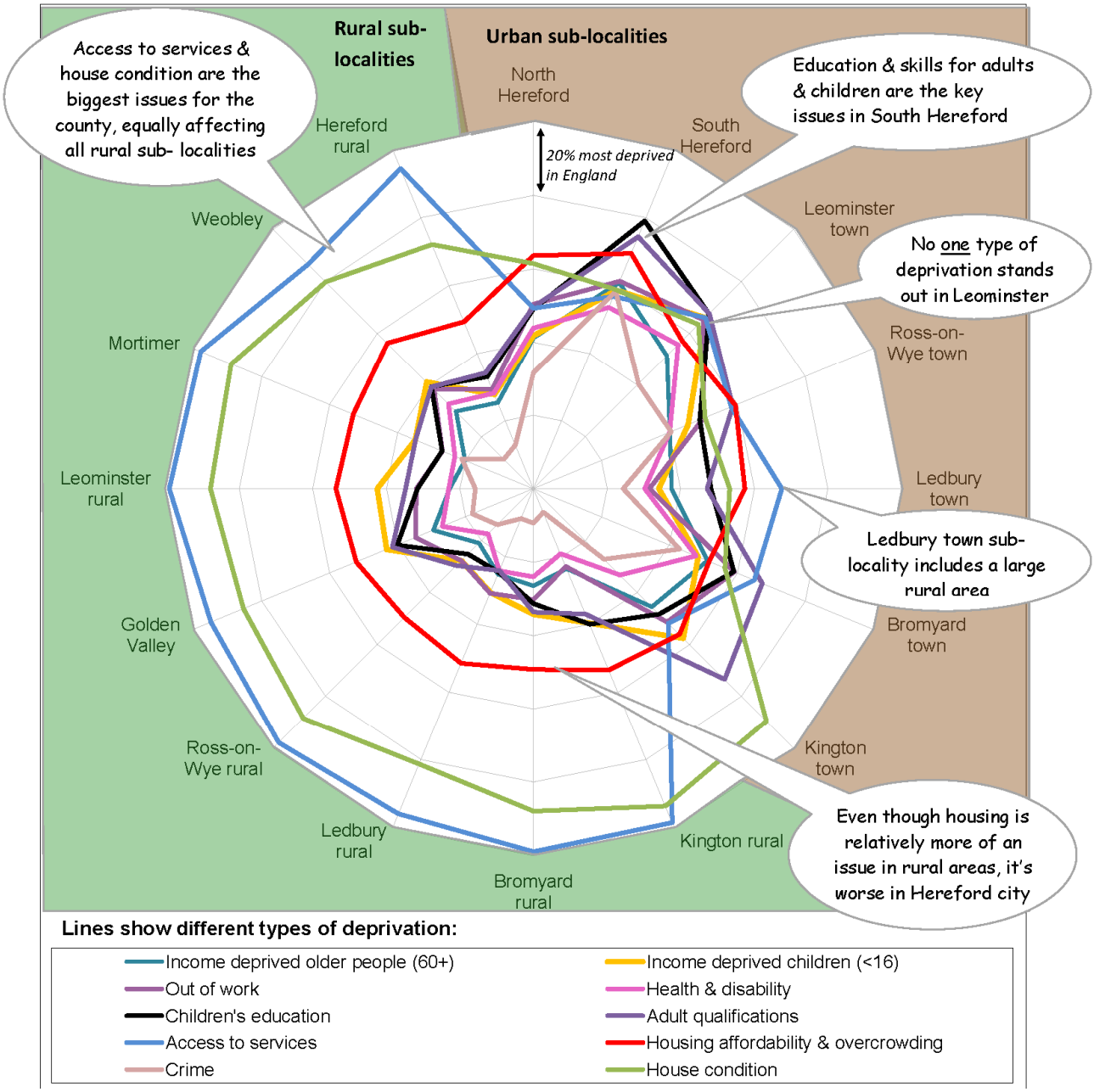
Understanding Herefordshire forms the first of a three year development programme, to produce a "gold standard" integrated needs assessment in 2014. We've begun by improving our qualitative information by engaging with the third sector for a better understanding of the needs of people living with dementia and their carers. We have also adopted an asset based approach to identify the strengths and opportunities within our communities, localities and services.

This document provides only a high level summary. Electronic links to the underlying evidence are provided throughout the document, where more detail and supporting strategies can be found. The integrated evidence base is available at www.herefordshire.gov.uk/factsandfigures. This is updated regularly and will be developed further to make it easier to find information.

Understanding localities

This document is a summary of the needs of Herefordshire as a whole, but wherever possible the underlying analysis has been carried out for smaller areas – and is available by following the **electronic links** to the evidence base. Major geographical differences have been mentioned here where appropriate, but for a fuller understanding of a particular locality *Understanding Herefordshire* should be used alongside the *Key Findings About Herefordshire Localities* available at www.herefordshire.gov.uk/aboutlocalities. These will be developed during the coming year to draw out the specific needs of each locality, but the diagram below gives an overview of how different areas are affected by different types of deprivation and how they compare with the national picture.

Figure 1. Deprivation in Herefordshire localities relative to all of England (a point nearer the outside of the chart indicates greater relative average deprivation)



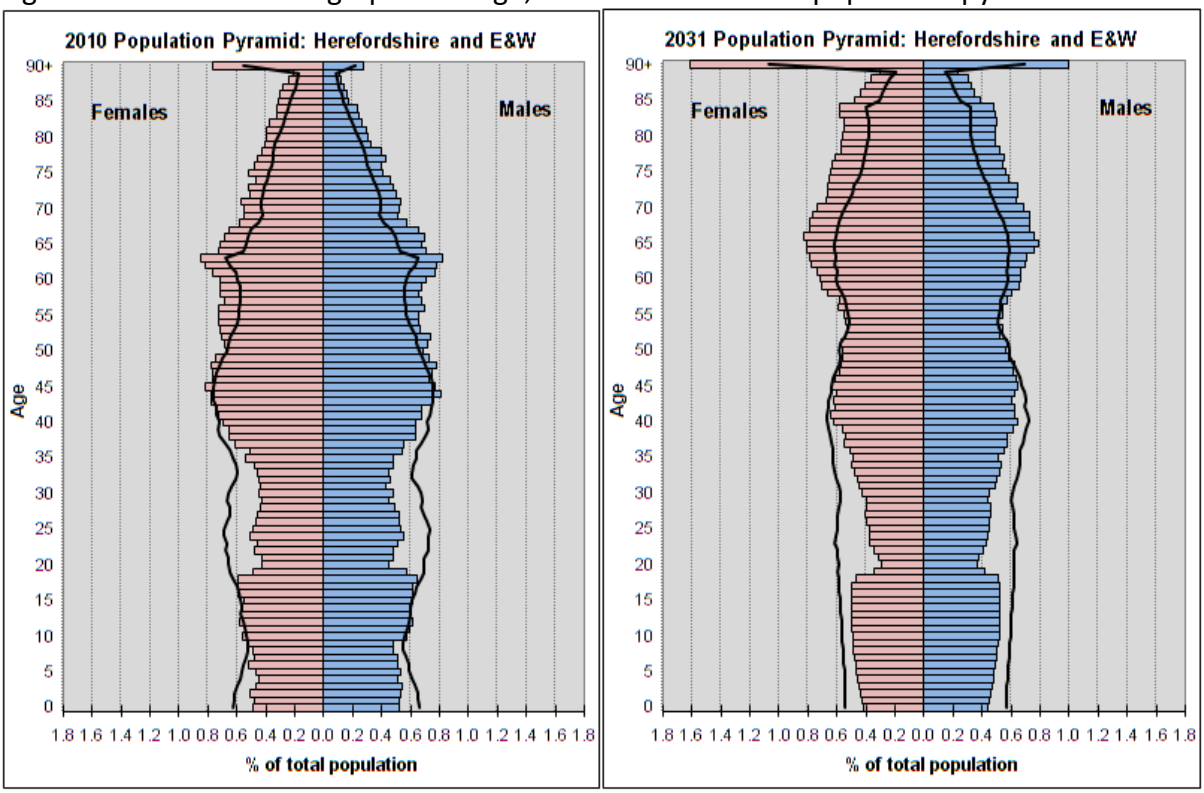
Also available online are statistical profiles of particular areas, including localities:

- Wards, market towns and smaller areas within them
- GP practices

Population and Changing Demographics

Provisional figures estimate the county's **population** is 182,800 (2010 figure). This represents growth of 4% (7,900 people) since 2001 which is almost double the increase expected from official estimates. The difference is due to an underestimation of immigration, particularly in younger adults. This has not significantly changed the overall shape of the population pyramid, either now or in the future.

Figure 2. Predicted demographic change; current and forecast population pyramids.



Sources: *Hfds (pink & blue bars) – ONS mid-2010 indicative population estimates; Hfds 2010-based population forecasts; E&W (black lines) – ONS mid-2010 population estimates & 2010-based national population projections. ONS data is Crown Copyright.*

The population growth is still less than the 6% growth in the population of England and Wales overall, and the county's annual growth has slowed since 2008-09. Herefordshire still remains one of the least densely populated areas of the country, with residents scattered across its 842 square miles.

Forecasts predict the population to grow to 205,700 by 2031, 13% higher than in 2010; an annual average increase of 0.5%. Herefordshire's population already has a relatively old age structure and numbers of older people are expected to increase disproportionately to the total population. In particular, the number of people aged 85+ will more than double to 12,700 by 2031.

THREAT & CHALLENGE

There have been higher **numbers of births** than expected over the last few years (1,800-1,900 rather than 1,600-1,700) due to high fertility rates nationally and locally and an underestimation of the number of women of child-bearing age in the county. Latest forecasts suggest this will lead to a slight increase in the number of children between 2016 and 2025, before levelling off at 31,800 - 3% higher than currently (31,000) but still lower than in any year prior to 2007.

Herefordshire has a relatively small, but growing, **Black, Asian & Minority Ethnic (BAME)** population (at least 10,600 people in 2009 - 6% of total population compared to 3% in 2001). The largest single group is 'White: other than British or Irish' (at least 4,300 people), and it is likely that many are Polish. Language and cultural differences of recent migrants are beginning to pose challenges for public services.

Health and Wellbeing

Life expectancy at birth remains significantly higher in Herefordshire than regionally and nationally, for both males and females. On average male life expectancy is 79.3 years (compared to 78.6 years nationally), and female life expectancy is 83.6 years (compared to 82.6 years nationally). However the gap between Herefordshire and other areas has narrowed.

Herefordshire's mortality rates are consistently lower than nationally and in comparator PCTs. The directly standardised all age, all cause mortality rate is approximately 500 deaths per 100,000 population, which equates to approximately 1,900 deaths per year. The three disease groups of circulatory diseases, neoplasms (cancers) and respiratory diseases account for almost 80% of all mortality in the county.

Herefordshire's premature mortality rate (mortality aged under 75 years) is consistently lower (246 deaths per 100,000 population in 2010) than the average rate for England and Wales and generally lower than comparator PCTs. Circulatory diseases, cancers and external causes such as suicide and accidents account for almost 80% of all premature mortality. Across the county almost 7,500 years of life were lost between 2008 and 2010 due to people dying before the age of 75. Almost 40% of these lost years were due to people dying of cancer and a further 20% due to people dying of circulatory diseases. Premature mortality is far more prevalent among males.

Hospital admissions amongst Herefordshire residents are significantly lower than PCT comparators for both elective and emergency admissions, but continue to rise in line with national trends. Elective admissions have risen by 12.4% from 2006-7 to the latest figure of approximately 24,700 admissions or 'spells' in 2010-11. Cataracts are the most frequent cause of elective admissions – they also have the highest growth rate, along with cancer of the breast and colo-rectal cancer. Emergency admissions have risen by 11.6% since 2006-7 with approx 14,850 admissions in 2010-11 and a further 4,400 spells related to maternity and birth. The commonest causes are complications in pregnancy, bronchitis/COPD and pneumonia. Rates in accident and emergency attendance fluctuate (14,010 attendances in quarter 2 of 2011-12) but fewer attendances than expected result in a hospital admission.

For vulnerable adults such as those with mental health, physical or learning disabilities, the emphasis on supporting people in their own homes is reflected in the decline of both residential and nursing care since 2007-8 (from 1,200 service users to about 1,000 in 2010-11). Around 48% of people receiving care report that they are "moderately" anxious or depressed, highlighting the interdependencies between physical and mental well-being.

Older people make up the majority of the physical disability social care client group and this group are also the main users of homecare services. The number of people aged over 65 with learning disabilities is also projected to increase by one third between 2011 and 2015.

Engagement with parents and carers of **children with learning disabilities** suggest a lack of communication around the "new world" picture of service provision. Parents need information in order to understand available services and to remove barriers to access.

Dementia presents a significant and urgent challenge to Herefordshire. The number of people living with dementia is estimated to be 3,000 but approximately two-thirds of these are undiagnosed. The prevalence is predicted to increase to nearly 3,900 by 2015 and 5,500 by 2030.

THREAT & CHALLENGE

The engagement programme with third sector organisations highlights the social isolation and lack of service coordination experienced by people with dementia and their carers. We need to develop a community based approach that builds on our assets of carers, third sector organisations and statutory services. Although many individuals are receiving support through agencies, day care, respite and residential placements, approximately half receive additional support and care from unpaid carers for example family or friends.

OPPORTUNITY

Adult social care provision will be affected by predicted demographic change. Herefordshire has a slightly lower level of average provision of social care for older people (1,095 per 10,000 people aged 65+) and a higher rate of provision for younger adults (195 per 10,000 people aged 18-64) than other comparable local authority areas, although the speed of assessment and user satisfaction are both above the national average. Overall, while the number of people helped with either residential, nursing or homecare during the course of each year has decreased (from 3,000 in 2007-8 to 2,600 people in 2010-11, more intense support is provided to individuals and total provision of support is rising (e.g. 43% rise in homecare hours delivered in 2010-11 compared to the previous year).

STRENGTH

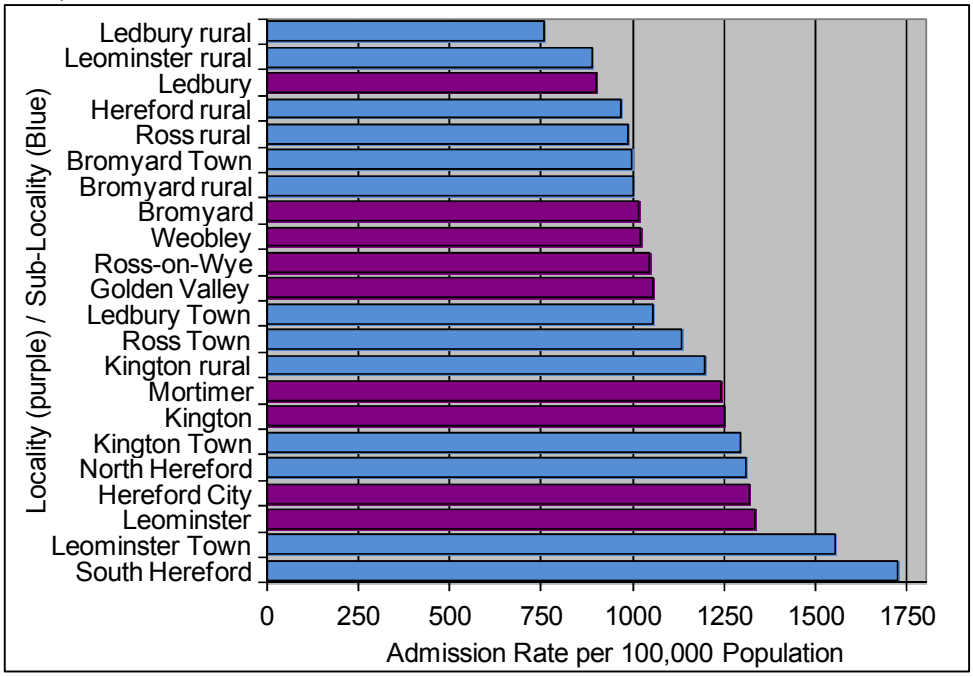
In line with national trends only those assessed as having 'substantial' and 'critical' needs receive social care and a community response is needed to support those with lower levels of need. We have good examples of this in Herefordshire which we need to build on to ensure consistency of support across the county.

There are approximately 31,200 adult smokers in Herefordshire, the prevalence rate of 21% being similar to the national rate. However 61% of current smokers (19,000 people) would like to stop. Despite the ban on smoking in public places almost a quarter of adult non-smokers reported being regularly exposed to other people's tobacco smoke, indoors or outdoors.

OPPORTUNITY

Smoking remains the major cause of preventable death within Herefordshire, with approximately 315 smoking related deaths per year in those aged 35+ years. In addition there are approximately 1,700 hospital admissions per year related to smoking, the major causes being lung cancer, ischemic heart disease and chronic airway obstruction. In 2010-11 this was estimated to cost NHS Herefordshire £3.15 million. Figure 3 shows smoking-related admission rates are highest in Leominster town and South Hereford.

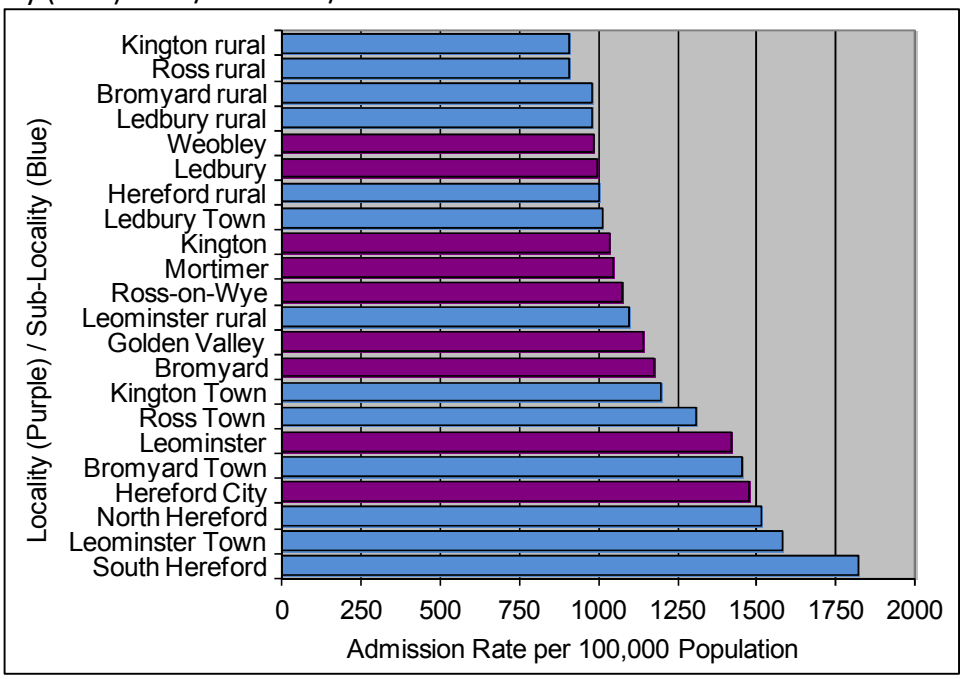
Figure 3. Directly Standardised Smoking-Related Admission Rates by Locality (Purple) & Sub-Locality (Blue) 2007/08 - 2009/10 Pooled.



Around two in five adults report drinking alcohol above the recommended guidelines on at least one day in the previous week, including a fifth who report binge drinking. Twice as many men binge drink than women, and the highest prevalence is found in residents of Hereford City.

Alcohol related hospital admissions increased to 3,500 in 2010-11, a 30% rise since 2007-8 and the second highest rate in the West Midlands. The majority are emergency admissions. By the end of quarter 3 of 2011-12, alcohol related admissions had cost NHS Herefordshire £4.6 million that year. Figure 4 shows alcohol-attributable hospital admission rates are highest in South Hereford with 1,820 admissions per 100,000 population.

Figure 4. Directly Standardised Alcohol-Attributable Admission Rates by Locality (Purple) & Sub-Locality (Blue) 2007/08 - 2009/10 Pooled.



Around 55% of adults are classified as overweight or obese; with 23% of women and 18% of men classified as obese. 36% of adults reported eating the recommended five or more portions of fruit and vegetables on the previous day and around one in three adults reported meeting the guidelines for physical activity in the past week.

23% of children aged 4-5 were either **obese or overweight** in 2010-11 (9% were obese). 33% of children aged 10-11 were either obese or overweight (18% were obese). Although the prevalence figures fluctuate year on year they appear to be increasing overall - this differs from England data which has a decreasing prevalence of obesity in children aged 4-5.

In 2009, 24% of children ate the recommended 5 or more portions of fruit and vegetables a day (higher than other areas), 8% had none. 68% of pupils said they had done at least one hour of physical activity in the previous day – the "Destination Hereford" programme will enable us to examine the relationship between behaviour change, travel choices and obesity levels.

Rates of problematic **drug users** (8 per 1,000 population) are slightly below the national average (8 per 1,000) but rates of injecting drug users (4 per 1,000 population) are higher than nationally (3 per 1,000). Herefordshire has a comprehensive harm reduction service that provides structured treatment, but we need to move towards a full recovery model – currently only 11% achieve successful treatment within 2 years and over 55% have been on treatment for more than 2 years. The systems to achieve the national strategy of a full recovery model (drug free and integrated into society) need to be developed.

In terms of sexual health, there are gradual reductions in rates of teenage pregnancy (19% reduction over ten years to 30 conceptions per 1,000 girls aged 15-17 in 2008-10). In 2010, rates of STIs remain stable at 726 per 100,000 population in line with the West Midlands and lower than rates in England overall. An increase in reported chlamydia rates has been identified and is being investigated further.

Immunisation rates have not improved in Herefordshire in the way that they have elsewhere and we have slipped from above average to poor. Rates for children under 5 were lower than both the England and West Midlands' averages in 2010/11, with differences apparent between Herefordshire's 24 GP practices. This follows a steady increase since the last dip in 2007-08 for the full courses of diptheria, tetanus, pertussis, polio, measles, mumps and rubella. Herefordshire figures appear to follow the national trend in that uptake rate for the vaccines at age 1 are higher than those at age 5, e.g. for Diptheria, tetanus, pertussis, polio and haemophilus influenzae type b (Hib) at 1st birthday the rate in 2010-11 was 92% whereas the booster for Diptheria, tetanus and polio at 5th birthday in 2010-11 was 85%.

The dental health of children in Herefordshire continues to be poor – two in every five children have some experience of tooth decay by the age of 5 years and more than two in every five have experienced decay in at least one of their permanent teeth by the age of 12.

Places and Communities

Herefordshire's economic output is low compared to regionally and nationally; in 2009 GVA[1] per head in Herefordshire was £15,296 compared to £16,602 in the West Midlands and £20,498 across England. This is partly a result of persistently lower wages in the county, with median weekly earnings of £385.10 in 2011. Increased housing provision and population growth is predicted to mean increased demand for **jobs** in 2031 – uncertainty over economic conditions makes it difficult to predict how many jobs there will be to meet this demand. Herefordshire has a lower rate of new business start-ups (41 per 10,000 population aged 16 and over) than England as a whole (49), and in 2010 the rate of new business formation was still lower than prior to the recession. However start-ups are surviving longer than regionally and nationally.

Unemployment is low (2.8%) compared with the West Midlands (5.0%) and England (4.0%), but still as high as during the recession. Female, young people and long term claimants are higher than previously. More people claim an out-of-work benefit because they are unable to work for health reasons than because they are unemployed and actively seeking work.

Herefordshire's working age population is now less well qualified (14% had no qualifications in 2010) than across England (11%). In 2009 a quarter of Herefordshire employers reported having hard-to-fill vacancies, largely because of a lack of skills from applicants, particularly skilled trade occupations. A considerable proportion also reported that young people leaving education were poorly prepared for work. There is still demand for migrant labour in Herefordshire that employers report would be difficult to fill from other sources. This includes several thousand temporary seasonal farm workers every spring or summer.

Volatility in energy prices poses a challenge for **businesses.** Although the cost of renting commercial premises is comparatively low, it is perceived to be a barrier to commercial growth. For businesses looking to establish rurally-based premises poor infrastructure (water, drainage, electricity, broadband, and mobile phone coverage) prevented them from growing and diversifying.

Herefordshire has the worst **housing affordability ratio** (8.6 house prices to earnings) within the West Midlands region. There is high demand for affordable properties in Herefordshire, in particular Hereford City (with an average of 64 bids per property), and the waiting list for social housing is approximately 5,000 households.

There has been a shift in **housing tenure** away from owner occupation towards the private rented sector over the last six years (2005-2011). Across all housing types 27% of houses are in sub-standard condition - an improvement since 2005 (40%) and a similar level to the national rate. Energy efficiency in all residential dwellings has improved to above the national average, but although the standard of insulation has improved this is counterbalanced by increases in fuel prices. This is reflected in the steep increase in the percentage of households experiencing **fuel poverty** in the county (from 7% in 2005 to 17% in 2011).

1 Gross Value Added (GVA) measures the contribution to the economy of each individual producer, industry or sector in the United Kingdom and is a headline measure used to monitor economic performance.

A recent **local housing market assessment** has recommended a long-term target to help balance the rented housing market as 45% social rented and 55% intermediate tenure. This reflects the volume of existing and emerging households who can afford more than social rents, but cannot afford to rent privately or to purchase a home. The proportion of intermediate tenure on the affordable housing stock list is currently very low.

There has been a rise in the number of people applying as **homeless** in Herefordshire (112 applications in Quarter 3 of 2011-12 compared to 92 in the same quarter the year before), resulting in an increase in the number in temporary accommodation (80 households in quarter 3 of 2011-12). There has also been a noticeable increase in the numbers of homeless applications from teenagers as a result of parents no longer willing or able to accommodate them.

The number of new houses proposed to be built in the county by 2031 has been revised from 18,000 to 16,500. Coordinated delivery of housing, employment and infrastructure is likely to be particularly important in Leominster and Hereford reflecting the levels of new development proposed. In particular transport infrastructure including sustainable transport, parking and the Hereford relief road.

There is a need to build more **accommodation suitable for older people**. Location is paramount when choosing future accommodation, including access to transport and the ability to stay in the local area. Changing demographics and increasing prevalence of long term conditions means the numbers needing specialist accommodation of some sort will increase. Development of "homes for life" that facilitate and enable continued independent living when people develop care needs should be a priority.

The natural and built environments are important assets for both residents and businesses (particularly tourism); and access to green space is generally good for residents. The proportion of wildlife sites with active management has seen considerable improvement in recent years (58% compared to 43% in 2009-10). Less of Herefordshire's designated built and historic environment is at high risk (51 scheduled monuments in 2011 compared to 35 in 2010), although this measure only covers a small proportion of heritage assets.

Recent initiatives have been effective in increasing **household recycling of waste** (40% in 2010-11) and reducing the amount going to landfill. We also have relatively low levels of **air pollution** but there are still air quality management areas in Hereford, Leominster and Pencraig and emissions of carbon dioxide per head of population remain much higher in Herefordshire (8.6 tonnes per capita) compared to the UK (7.4). Water quality in parts of the rivers Lugg and Wye is such that further development in the surrounding area will risk breaching water quality standards.

There are a lack of transport options for many rural communities and therefore **high car ownership and dependency**. Population growth is likely to increase the requirement for public and community transport services, and there are potential economies of scale through the integration of transport for health, social services and education, particularly for dispersed populations. Road traffic is expected to increase in the future, although more efficient vehicles are expected to reduce average driving costs and emissions.

Hereford City and the market towns have significant proportions of residents who **travel to work by car** despite living less than 5km from work. There is also significant use of the car for school journeys particularly at primary level. Both these factors contribute to high vehicle demand in the city causing congestion, journey time delays and air pollution. Local research is needed to determine whether these are linked to poor health outcomes.

Stronger Communities

Herefordshire residents have mapped out a wide range of community assets in localities such as **Bromyard**, and also identified opportunities for using assets more effectively, especially to reach socially isolated older people.

Herefordshire also has a **strong community and voluntary sector** with an estimated 1,500 so-called 'third sector' organisations. Most of these do not have a national or regional parent body and are most likely to describe themselves as a charity (54%), voluntary organisation (36%) or community organisation (33%).

We have begun a programme of **engagement with the third sector** as part of the 2012 integrated needs assessment, to gain their intelligence relating to unmet need and quality of services. This commenced with the topic of people with living with dementia, and we need to identify a programme of topics to take this engagement work forward.

We have high levels of **volunteering** with 29% of people reporting that they had volunteered at least once a month in 2008, compared to 23% in England overall. It is estimated that we have 53,000 adults who volunteer in the county, providing the equivalent of just over 3,000 full-time employees and contributing £60 million to the local economy. In addition 21% of the adult population provide **unpaid care**, suggesting that Herefordshire has and is relying on approximately 30,000 **carers**. However only 3,500 carers are currently registered with Herefordshire Carers Support.

The main issues identified by unpaid carers are the need for additional support hours and the length of time taken by services to make decisions or follow through on any actions identified. Practitioners generally echoed these views with more specific points about the funding panels and lack of resources to offer services.

Safer Communities

Crime remains low in the county with a 13% reduction in total crimes over the three years to March 2011. **Anti-social behaviour** and **criminal damage** offences have also reduced, although rural crime, in particular theft of metal and fuel, has become an issue. **Alcohol** is a contributing factor in a number of crimes and there has been a small but steady increase in alcohol-related violent offences since 2008. Alcohol-related assaults generally occur near to licensed premises.

The rate of repeat incidences of **domestic violence** is high (45% of cases heard at MARAC[2] in the six months April to September 2011), even after accounting for national rising trends and the move to a multi-agency approach of assessing and managing risk. Alcohol use and misuse is a recognised contributory factor, and 39% of domestic abuse offences were alcohol related in 2010.

There is an on-going need to address re-offending; although the proportion of offenders in Herefordshire that go on to commit another crime is slightly lower than across England (Herefordshire 23% compared to England 25%), the average number of times that they re-offend is greater (3 offences per offender in Herefordshire compared to 2.8 offences across England).

Despite low crime levels in the county there is still a need to **focus on particular areas** such as Hereford, Ross-on-Wye, Leominster and Ledbury where crime is higher. There is also a need to continue to improve engagement with those areas that experience higher than average **fear of crime**, such as Belmont, St Martin's and Hinton, Three Elms wards and Ross town centre.

The number of people **killed or seriously injured** on Herefordshire's roads has generally been decreasing although there has been a slight increase in 2011 to 75 adults and 3 children (76% lower than our 1994-98 baseline). Hereford & Worcester Fire and Rescue Service still attend the equivalent of four road traffic collisions each week in the county.

Road safety is a key concern for Herefordshire residents, particularly speeding traffic which is seen as anti-social behaviour by local communities. The number of fatal incidents involving young road users is a concern, along with the increase in "drink drive" related accidents.

Inequalities and Deprivation

Overall Herefordshire has relatively low levels of multiple deprivation. However the gap between the most and least deprived areas is widening and several areas of South Hereford and Leominster have been amongst the most deprived in England for over 10 years.

Around a fifth of households in Herefordshire live in poverty[3] (14,500 households), a similar proportion to nationally and regionally. Income deprivation mostly occurs in the urban areas of Herefordshire, including Hereford City, Leominster and Ross-on-Wye, but also to a lesser extent the market towns of Kington and Bromyard. Smaller pockets also occur in more rural areas. Rural households are also likely to face additional costs associated with transport and heating the home, which have increased at a higher rate than inflation.

The link between poverty and households being out-of-work is reflected in the areas with the highest rates of poverty having the highest rates of claiming for out-of-work benefits.

[2] The Multi-Agency Risk Assessment Conference (MARAC) is part of a coordinated community response to domestic abuse.
3 A household is considered to be in poverty if its net income (after housing costs and taxes) is less than 60% of the national average (median).

However people on low wages are also at risk of being in poverty, and wages in the county are significantly lower than nationally and have seen much lower growth than nationally over recent years. The recession has had less of an effect on employment levels than might have been expected given its length and depth. Whilst this is clearly positive, the way in which redundancies have been reduced i.e. through more part-time working and pay freezes, may have exacerbated the problem of "in work poverty" during the recession.

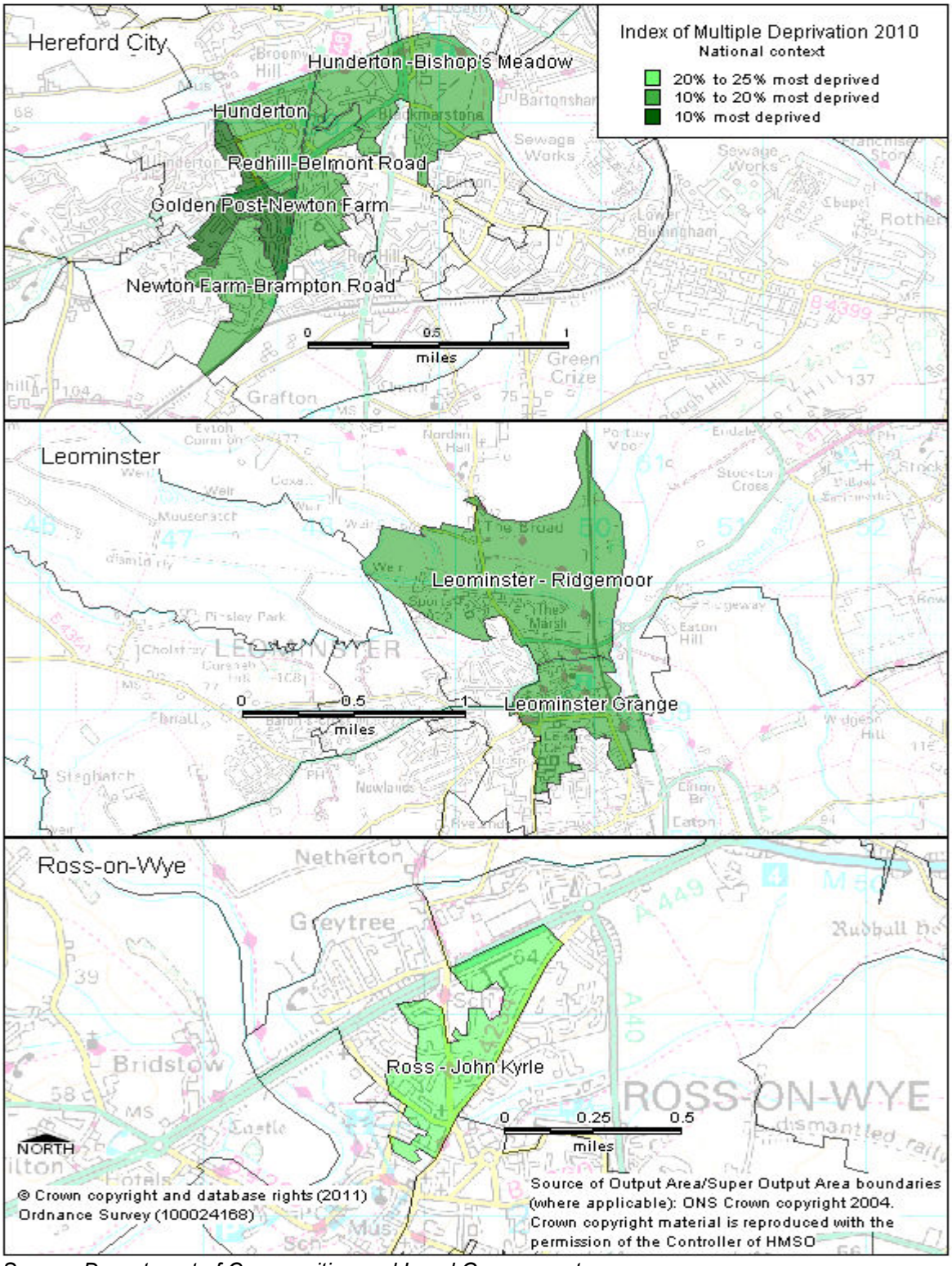
In Herefordshire two and a half times as many people claim an out-of-work benefit due to poor health than because they are unemployed and actively seeking work. In addition proportionally more children are affected by poverty (15% of under 16 year olds) compared to working age adults (8% of 16-59 year olds), and lone parent households are much more likely to live in poverty than cohabiting or married families. Although still below the national average (22%) the percentage of children in poverty rose from 14% to 15% between 2008 and 2009 (315 more children). The areas with children in poverty remain largely unchanged; with Leominster Ridgemoor still the area with the highest percentage (39%).

The proportion of older people (60 and over) living in income deprivation (14%) is considerably higher than the proportion of working age people (8%). However nationally 16% of pensioners live in poverty compared to 22% of working age people. Whilst older people are likely to see a reduction of income in retirement they are also more likely to have reduced housing costs compared to younger age groups, which may explain the difference in the two measures.

54% of Herefordshire's population live in rural areas, and 43% live in the most rural locations. Providing services to a scattered population across a large geographic area is a challenge and additional resources will be required for professionals that need to visit clients across the county. Some health services - such as dentist, GP and hospital - were felt to be **difficult to access** by Herefordshire residents, along with other services such as post office and public transport. Further work is underway to understand access to health services as to whether it is access to appointments, transport, parking or a combination.

Ethnic minority groups and migrant workers highlighted **language as a barrier** for accessing some services.

Figure 5. Areas falling within most deprived areas of England (2010 IMD classification).



Source: Department of Communities and Local Government

Health Inequalities

There is a gap in life expectancy at birth between the most and least deprived areas of the county. This gap has fallen a little for men since 2002, but widened for women; it is now 6.2 years for men and 5.9 for females. As well as having a lower life expectancy those in deprived areas also spend more of their lives with a disability; spending on average 12.9 more years with a disability compared to those from the least deprived areas.

There are higher mortality rates for conditions such as coronary heart disease and cancers in those from deprived areas, however this is not reflected in their hospital admission rates - suggesting there may be an issue with access to services from people living in those areas. The association between alcohol and deprivation is easier to see, with hospital admissions for alcohol specific conditions in the under 18s being 12 times higher in people from deprived areas of the county compared with the less deprived areas.

Further analysis of the health and well-being survey is planned to investigate the association between obesity and adults living in the most deprived areas.

Children and Young People

There has been an increase in the number of children receiving **child protection** plans, to 61 per 10,000 population by the end March 2011. This is significantly above both national rates (38) and comparative authorities (30). This mirrored the national rising trend, with local impacts of the recession, high levels of substance misuse and domestic violence. The last "Serious Case Review" also led to greater awareness and more cases being referred to children's social care. Since the start of 2012 targeted action across agencies has resulted in a significant reduction of plans, to 46 per 10,000 population by end of March 2012 which is similar to comparative authorities and England averages. However the number of children in the cohort who are aged less than 5 years remains disproportionately high.

Educational attainment across the key stages, including the Early Years Foundation Stage Profile, has improved. However the overall rate of improvement is slower than that of comparable authorities and attainment levels remain lower than national figures. Further work is needed to achieve top quartile performance across all the stages:

- Focused improvement within primary schools and early years settings in 2011 led to a rise in performance in the Early Years Foundation Stage Profile**.** This has risen to 56% compared to 59% nationally. In primary schools the proportion of children reaching expected levels of attainment (level 2c+) in reading, writing and mathematics by the age of 7 has improved and Herefordshire is now above the national average for reading and writing.
- Although still below the national average, achievements at the age of 11 indicate an upward trend which, if continued, will move Herefordshire primary schools into the upper quartile of performance nationally within the medium term.
- The performance of young people by the age of 16 and those in full time education up to 19 has been strong in Herefordshire's schools and colleges, with performance consistently in or close to the upper quartile nationally for A levels. The proportion of pupils

achieving 5 A*-C GCSEs including English and Maths was 57.5% in 2011 which is below the national average of 58.4%.

- Although the performance gap between boys and girls achievement has narrowed, there remains the need to raise boys' performance in some schools where the difference is too great.
- Similarly the **inequality gap** in educational attainment between those children receiving free school meals and their peers has narrowed at all key stages, including the Early Years Foundation Stage Profile, Key Stage 2 and Key Stage 4.

The percentage of young people who are not in education, employment and training fell slightly in 2011 (from 7.8% to 7.7%). However, it still exceeds the figures for the West Midlands (6.2%) and England (6.1%).

Older People

Approximately 6,500 households are likely to consist of an **elderly, socially isolated person**, with critical factors being a change in circumstance such as becoming a widow, retirement, developing a limiting long term illness, as well as the support network in place. Being physically isolated in a rural area can add additional challenges in terms of accessing services, and in terms of interacting socially.

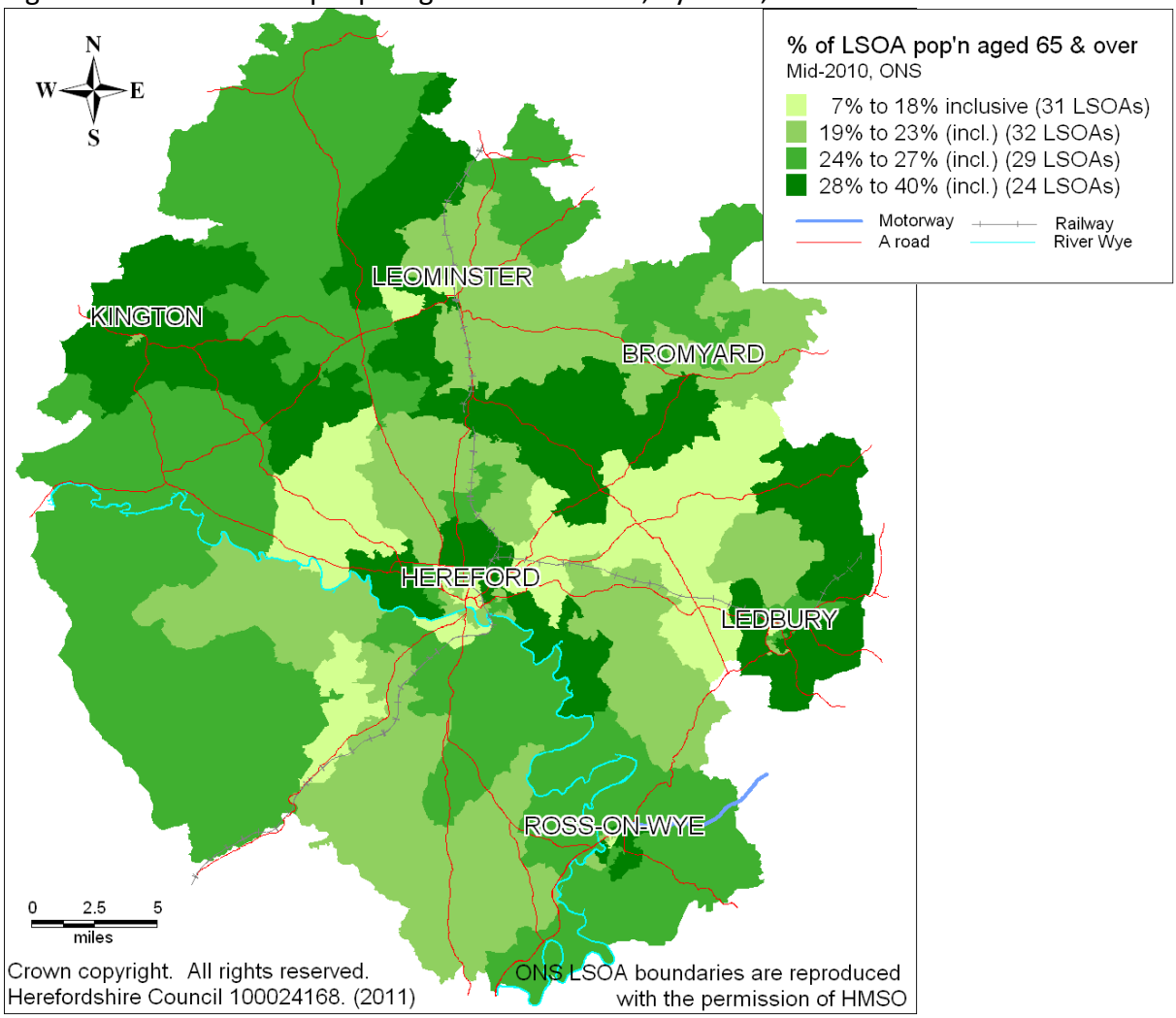
Older people are the main users of health and social services. At national level people aged 65 and over make up 16% of the population but account for 43% (£16.47bn) of total NHS spend and 58% of the total social services budget (£6.38bn).

Falls remain an important cause of avoidable ill-health and death. They are the commonest cause of accident-related hospital admission and the third most common cause of accidental death in Herefordshire. Over 60% of the falls that lead to hospital admission in Herefordshire occur in people over the age of 65 and over half of all serious falls occur at home.

However older people also represent an important asset. They provide large amounts of formal and informal care and community support, and are more likely to volunteer than other age groups. Older residents have themselves identified that they are not necessarily using the knowledge, experience and wisdom they have acquired throughout their life.

There are differences in age structure around the county; most notably Hereford city has relatively high proportions of young adults (aged 20-34), whilst rural Herefordshire has relatively high proportions of older adults (aged 45-75). The market towns have the highest proportions of people aged 80+. Despite these overall patterns, all localities have pockets where there are relatively high proportions of either younger or older people (see Figure 6).

Figure 6. Distribution of people aged 65 and above, by LSOA, 2010.



Source: ONS LSOA Boundaries & Small Area Population Estimates, mid-2010.
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Recommendations

- Be proactive about our changing demographics, identifying the predicted rise in need for services and ways to address it.
- Develop the services and support networks needed to promote self-help and a sense of personal responsibility and to enable people to live independently. This will include direct service provision as well as housing and accommodation that facilitates independence, the economy, spatial planning, transport, engagement with the third sector and communities, and support for carers.
- Continue to build on a community based approach, developing our assets of volunteers, carers, third sector organisations, active communities and statutory services.
- Adopt this community based approach to provide comprehensive and integrated services and support for people living with dementia.
- Ensure that the environment and infra-structure enables people to make healthy choices such as cycling and walking, as well as supporting economic growth and improved connectivity.
- Target preventative activities at the major causes of morbidity and premature mortality, in particular smoking, alcohol and falls.
- Make childhood obesity a priority for all stakeholders, tackling the underlying causes as part of a joined up strategy.
- Ensure continued improvement for Early Years and Foundation Programme, primary and secondary school children to achieve top quartile performance.
- Ensure the various strategies targeting families living in poverty are joined up to provide an integrated response.
- Address social inequalities through a comprehensive approach, encompassing opportunities such as employment as well as lifestyle behaviours, access to services and community engagement.
- Undertake more in depth analysis in the following areas:
    - Domestic violence
    - The care needs of people with learning disabilities
    - Impact of changes to the welfare system, particularly on families

For further information, please contact the Research Team on 01432 383634 or e-mail researchteam@herefordshire.gov.uk

APPENDIX 2. PROGRAMME OF WORK TOWARDS A GOLD STANDARD INTEGRATED NEEDS ASSESSMENT.

HEREFORDSHIRE PUBLIC SERVICES LEADERSHIP TEAM 15TH MAY 2012

Introduction

National Policy has increasingly recognised the importance of "needs assessments" as the evidence base to underpin strategy development and commissioning decisions. This has been translated into the importance of Joint Strategic Needs Assessments (JSNA) within strategic commissioning and the work of Health and Wellbeing Boards.

To become an exemplar commissioning organisation that improves the health and wellbeing of its residents, Herefordshire Public Services requires high quality needs assessments embedded within the commissioning, performance and planning cycles.

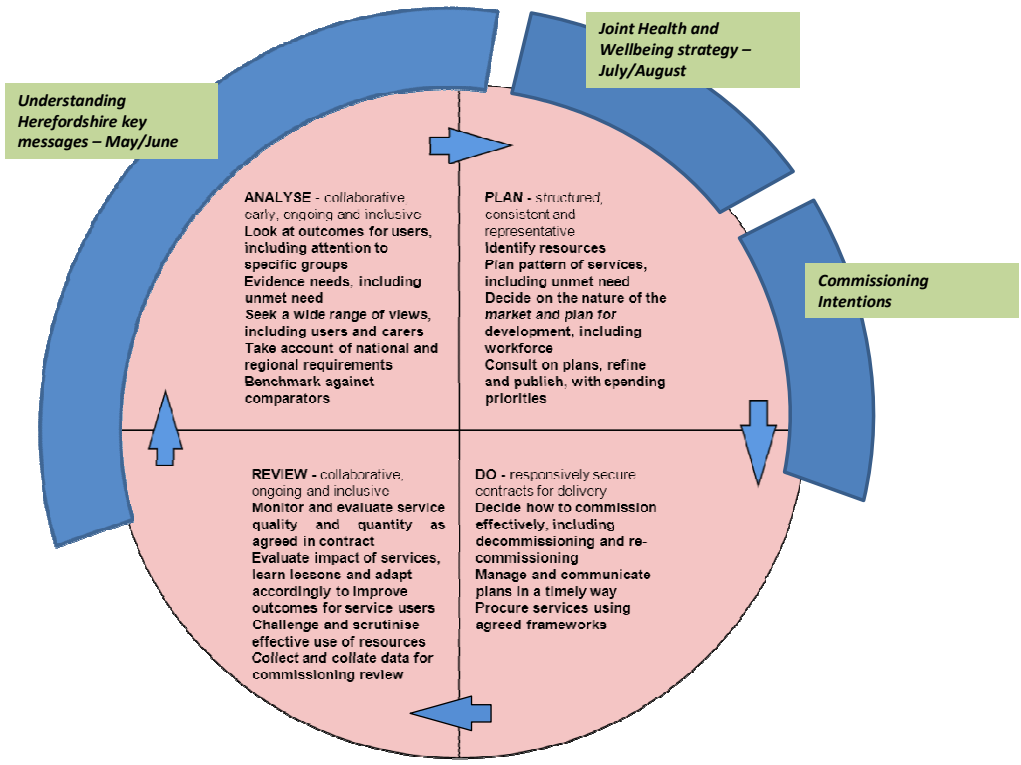


Figure 1. The INA and the commissioning cycle.

The Integrated Needs Assessment Project

The development of an improved JSNA into a "gold standard" integrated assessment of need (INA) began across HPS in June 2011. It was subsequently supported by draft guidance from the Department of Health laying out a framework for the development of JSNAs.

The aim is to provide robust and timely intelligence that:

- Enables evidence-based decision making and strategy development
- Focuses on the need to identify priorities for service improvement and design
- Identifies vulnerable groups that may require targeted services
- Enables the outcomes of commissioning decisions and service developments to be evaluated

The programme of work is being undertaken by the INA steering group, supported by a wider reference group, both of which are drawn from across HPS. Initially implemented under Rising to the Challenge, subsequent governance arrangements are outlined in Figure 2.

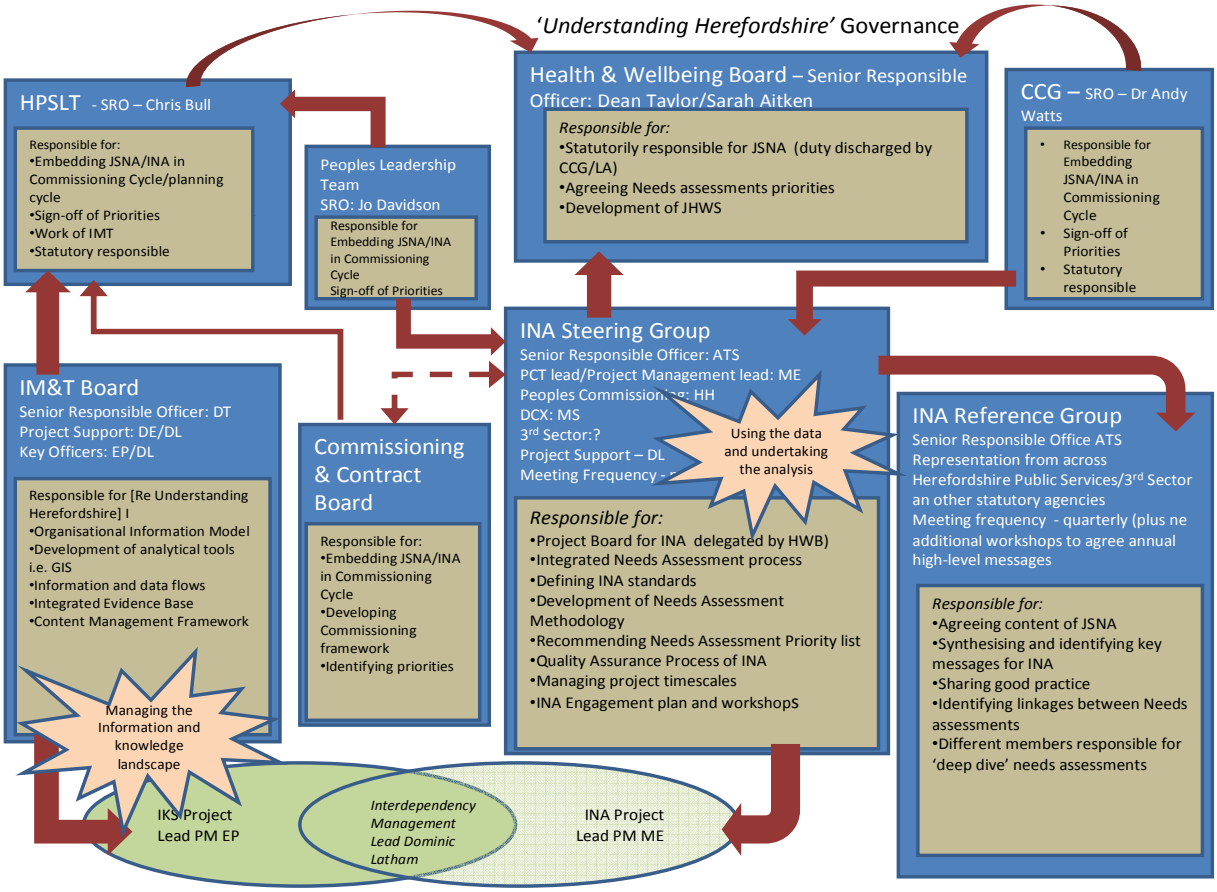


Figure 2. The INA Development Project – Governance Arrangements

Work to Date

As of May 2012 the following milestones have been achieved:

1. Agreement of the overall structure of the INA, as an overarching summary assessment of health and wellbeing needs supported by more in-depth analysis and “deep dive” needs assessments for particular areas.

2. An agreed “standard methodology” for undertaking these in depth analysis/needs assessments across HPS.

3. Engagement of a wider INA reference group from across HPS and their ownership of:

    - The content and structure of the underpinning web-based resource known as the Integrated Evidence Base

    - The content of the Understanding Herefordshire summary document.

4. A planned programme of analysis for bronze (2012), silver (2013) and gold (2014) INAs.

Planned Programme of Analysis

A planned programme of analysis has been identified by the INA steering group – this is kept under regular review with regard to both progress and the need to develop new areas or respond to national or local issues. Key areas are identified within Tables 1, 2 and 3.

Table 1. Bronze INA (2012)

Objective	**Deliverable**	**Progress**
Embedding within commissioning cycle	Time of publication brought forward to May/June	Completed
Robust structure	Overarching summary document bringing together JSNA and State of Herefordshire Report. Underpinned by dynamic web-based integrated evidence base	Completed
Asset based approach	Identification of assets across both communities and services, and of opportunities to build upon them	Completed
Incorporate analysis from HPS and partners across breadth of determinants of health and wellbeing	Include analyses on infrastructure, economics, housing etc as well as demographics, lifestyle factors and health and wellbeing outcomes	Completed
Ability to undertake analysis by place/locality	Sub-county analysis by various measures of geography e.g. locality assessments, GP practice profiles	Completed
Greater use of qualitative information to understand access issues, user experiences and needs of marginalised groups	Engagement of the third sector	Commenced with Dementia, ongoing programme of engagement,
Prioritised programme of in-depth analysis/needs assessments	In-depth needs assessments for falls, dementia, alcohol harm reduction, substance misuse services and childhood obesity	Completed
Understanding effects of economic downturn on need for services	Embedded within existing analysis	Commenced – for development as part of silver
Understand effects of demographic change on predicted need for Health and Social care	Modelling effects of demographic change	Commenced – for development as part of silver
Clear recommendations identifying priority areas for action across HPS and its partners	Clear recommendations within summary document	Completed

Table 2. Silver INA (2013)

Objective	**Deliverable**	**Progress**
Outcome focused summary document	Structure summary document around “Marmot” indicators framework	July 2012 inwards
Improved access and ease of navigation for web-based Integrated Evidence Base resource	New web-site as part of transfer to new platform, “road tested” on commissioners and partners	July 2012 onwards, scoping user requirements commenced
Ongoing development of use of qualitative information	Programme of engagement with third sector	Focus on families in September 2012
Develop economic aspects	Engage stakeholders relating to development of economy and skills	July 2012 onwards
Understanding effects of economic downturn on need for services	Analysis on poverty (include fuel poverty) in Herefordshire; investigate impact of welfare reforms and gather evidence on financial exclusion	Commenced (analysis on poverty done) for development as part of silver
Understand effects of demographic change on predicted need for Health and Social care	Modelling effects of demographic change	Commenced – for development as part of silver
Evaluate performance against NHS, Local Authority and Public Health Outcomes Frameworks	Understand synergies and opportunities for partnership working	Commenced – for development as part of silver
Develop content in Cancer and Cancer related information in line with NCAT guidance	Dedicated web-page containing or linking to relevant resources to provide comprehensive assessment of need	Commenced – for development as part of silver
Make more extensive use of existing intelligence resources	Thematic reports from the health & well-being survey (‘deep dives’). Publication of the healthy housing survey report & further analysis by locality	Further analytical support may need to be commissioned.
Identification of priority areas for in depth analysis	Planned programme of in-depth analysis and needs assessment	To be identified on the basis of evidence up to May 2012

Table 3. Gold INA (2014)

Objective	**Deliverable**	**Progress**
Full interactive web-based resource accessible to analysts and public alike	Ability to "dice and slice" content by both person, theme and place	
A comprehensive INA that meets the requirements of HPS and all it's partners	Further areas of analysis to complete the INA identified by "sense-checking" silver INA with HPS and its partners	
Positive reputation with stakeholders	Further engagement/promotion of INA process and findings	
INA embedded with annual commissioning cycle	Integrated within work of HPS and its partners	
Herefordshire held as an exemplar across the country	Presentations locally/regionally and publication of work around best practice	

Herefordshire Council

MEETING:	**HEALTH AND WELLBEING BOARD**
DATE:	**19 JUNE 2012**
TITLE OF REPORT:	**HEALTHWATCH HEREFORDSHIRE**

CLASSIFICATION: Open

Wards Affected

County-wide

Purpose

To update the Herefordshire Health and Wellbeing Board on the progress made to date regarding Healthwatch Herefordshire and to seek the Board's views on the issues outlined in the attached discussion paper.

Recommendations

THAT:

(a) The Board note the content of the attached discussion paper

(b) The Board specifically endorse the recommendation to pursue option 2 - Herefordshire Healthwatch being provided through an arrangement with the local voluntary sector

Key Points Summary

- The Health and Social Care Act 2012 has established Healthwatch, as the 'consumer champion' for NHS, public health and adult social care services. A major role for the new organisation will be to ensure that public, patients, service users and carers can influence planning and delivery of local services.

- The creation of Healthwatch amalgamates the existing statutory roles and responsibilities undertaken by Local Involvement Networks (LINks), Independent Complaint Advocacy Services (ICAS) as well as incorporating the provision of consumer advice and support for people to make informed health and social care choices.

- A key objective of the local vision is for Healthwatch Herefordshire will be operate as part of the wider network of community based organisations that champion the interests of local residents and consumers.

- There will be a remuneration structure for key board members of the new service.

Further information on the subject of this report is available from
Richard Beavan-Pearson, Assistant Director Customer Services and Communications on (01432) 26721/ 07792880246

Reasons for Recommendations

1 Healthwatch is a requirement of the 2012 act and whilst there are a number of different possible models and approaches, the recommendation to seek the Healthwatch service from local voluntary sector partners will provide a value for money approach through the utilisation of existing partnership arrangements.

Introduction and Background

2 The creation of Healthwatch requires some key decisions to be made regarding the implementation and operational arrangements for the new service. As a significant change to the local Health and Wellbeing system, this requires the views and support of key stakeholders, including the Health and Wellbeing Board.

Key Considerations

3. Are included in the attached document

Community Impact

4 The changes that the new system will bring are intended to provide a strengthened and more visible 'consumer champion' for Health and Wellbeing services within Herefordshire. This will therefore have an impact on all communities and locality areas across the county.

Financial Implications

5. The current budget for LINk is £95,000. Additional monies are expected to be provided by the Department for Health/ Department for Communities and Local Government to support the additional role requirements for the new organisation. Any further funding gap identified through the procurement process is currently expected to be met from within existing Directorate funds.

Legal Implications

6. The local Healthwatch service must be in place by April 2013

   Any further legal issues will be determined through the procurement process

Risk Management

7. Any delays to the implementation of the local Healthwatch service will be contrary to legislative requirements and will delay the procurement process.

8. There is a risk that local voluntary organisations are not willing or capable of taking on the Healthwatch service. If this is the case, then the alternative options outlined in the paper will need to be considered.

9. There is also a risk that the potential funding gap will be too large to be met by directorate funds. If this is the case, further consideration of this issue will be needed.

Consultees

10. The consultation process is not yet completed. Some key stakeholders who have already

been consulted are:

- Chair of the Health and Wellbeing Board
- Cabinet member for corporate services
- Equality and diversity team
- Chair of HCCG
- Chief operating officer for HCCG
- PCT locality NED's
- LINk Herefordshire management board

Appendices

11 Appendix 1: Healthwatch Herefordshire discussion paper

Background Papers

None identified.

Healthwatch Herefordshire

Stakeholder Discussion Paper

Contents

Foreword:

This paper sets out the local vision for Healthwatch Herefordshire and its functions, responsibilities, roles and relationships in the post-NHS reform landscape. It is aimed at all those with an interest in the new local Healthwatch organisation across the NHS and social care, from local authorities to LINks and from emerging health and wellbeing boards and the voluntary and community sectors. The document sets out the main differences from the current system of patient and public involvement in health and social care, including the role of the local authority, and explores some of the issues that will need to be addressed in establishing Healthwatch Herefordshire.

Healthwatch Herefordshire will strengthen the collective voice of local people across both health and social care, influencing the Joint Strategic Needs Assessment and the local joint health and wellbeing strategy – on which local commissioning decisions will be based.

Establishing a successful, local Healthwatch organisation, which is rooted in the community and responsive to local needs, will mean working differently. It will also mean working much more collaboratively so that Healthwatch Herefordshire can operate as part of existing local community networks ensuring they can have maximum reach across the diversity of our local community - drawing on information, advice and local knowledge that already exists.

We would welcome your views thoughts and observations on this important issue of Healthwatch. It would be particularly helpful to us if you could specifically comment on the proposed Options that are enclosed in the document – the details of how to do this are at the end of this document.

Councillor Patricia Morgan, Chair of Herefordshire Health and Wellbeing Board

Councillor Phillip Price, Cabinet member for Corporate Services and Deputy Leader of Herefordshire Council

1.0 Introduction

1.1 The Health and Social Care Act 2012 has established Healthwatch, as the 'consumer champion' for NHS, public health and adult social care services at national and local level. The legislation requires the Healthwatch function to play a key role in ensuring that the public, patients, service users and carers can effectively influence planning and delivery of local health and social care services.

1.2 The creation of Healthwatch amalgamates the statutory roles and responsibilities undertaken by Local Involvement Networks (LINks), Independent Complaint Advocacy Services (ICAS) and also incorporates the provision of consumer advice and support for people to make informed health and social care choices. It is important to note that Healthwatch will be a different organisation, with a wider remit, but we will seek to build on the strong foundation laid by Herefordshire LINk

1.3 The vision for Healthwatch set out in the transition plan published on March 29th 2011 by the Department of Health was that:

> *'Healthwatch will be the independent consumer champion for the public - locally and nationally – to promote better outcomes in health for all and in social care for adults.*
>
> *Healthwatch will be representative of diverse communities. It will provide intelligence – including evidence from people's views and experiences - to influence the policy, planning, commissioning and delivery of health and social care. Locally, it will also provide information and advice to help people access and make choices about services as well as access independent complaints advocacy to support people if they need help to complain about NHS services.*
>
> *Healthwatch will have credibility and public trust through being responsive and acting on concerns when things go wrong and operating effectively and efficiently.'*

1.4 In 2011, Herefordshire Council, NHS Herefordshire and Herefordshire LINk submitted a bid for Healthwatch pathfinder status. The bid set out the proposed functional relationships between Healthwatch Herefordshire and the other health and social care governance structures within the county. It also set out how Healthwatch Herefordshire could work through existing services to provide a single point contact for local people wanting to access support and advice, or to comment on local health and social care services.

1.5 This discussion paper is intended to provide an update on the

preparations currently underway for the transition from LINKs to Healthwatch and it also sets out, for views, options for funding and procurement of the new service

2.0 Healthwatch England and Local Healthwatch services

Healthwatch England

2.1 Healthwatch England will be a national organisation that enables the collective views of the people who use NHS and social care services to influence national policy.

2.2 It will be a statutory committee of the Care Quality Commission (CQC), with a Chair who will be a non-executive director of CQC. Healthwatch England will have its own identity within CQC, but it will be supported by CQC's infrastructure and it will have access to CQC's expertise.

2.3 Healthwatch England's functions will include:

a) *It will provide leadership, guidance and support to local Healthwatch organisations.*

b) *It will be able to escalate concerns about health and social care services raised by local Healthwatch to CQC. CQC will be required to respond to advice from its HealthWatch England subcommittee.*

c) *It will provide advice to the Secretary of State, NHS Commissioning Board, Monitor and the English local authorities, and they are required to respond to that advice. The Secretary of State for Health will be required to consult Healthwatch England on the mandate for the NHS Commissioning Board.*

2.4 A core element of Healthwatch England's work is its relationship with local Healthwatch organisations. This includes two-way communications. CQC will develop web-based tools to enable Healthwatch England to gather and analyse information from local Healthwatch.

2.5 Some of CQC's existing relationships with local involvement networks (LINks) will be mirrored in our relationships with local Healthwatch. CQC's local staff will keep in touch with local Healthwatch and will gather information on the quality of local services directly from them. Local Healthwatch will be able to raise concerns about the quality of services with local CQC staff. Healthwatch England will be able to monitor the concerns raised and to escalate these within CQC if

necessary. During 2012, CQC staff will be briefed about the development of Healthwatch, so that they know how the system is evolving.

2.6 Using information from local Healthwatch and from elsewhere, Healthwatch England will provide advice to other bodies (specified in the Bill) and to the Secretary of State about the provision of care services. It will have a specific remit to comment on how health and social care services are involving people and promoting choice for people. To do this effectively it will need to use CQC's expertise in quality analysis and its understanding of the issues affecting health and social care.

2.7 A crucial function for Healthwatch England is providing leadership and support for local Healthwatch. As part of developing Healthwatch overall, CQC will work with the Department of Health, and with stakeholders and advisers, to draft the essential information that local Healthwatch organisations will need as they get going. This work will draw on lessons from the Pathfinder areas for local Healthwatch. The Department of Health will continue to support LINks as they move towards local Healthwatch.

Local Healthwatch services

2.8 Local Healthwatch services will be a way for local people to get information and advice about local healthcare services and will also give them the opportunity to comment on and get involved in the development and planning of healthcare services.

2.9 The functions of local Healthwatch services extend beyond those currently required of LINks and can be summarised as:

a) *Gathering views and understanding the experiences of patients and the public.*

b) *Making people's views known to commissioners and service providers.*

c) *Promoting and supporting the involvement of people in the commissioning and provision of local care services and how they are scrutinised.*

d) *Recommending investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC).*

e) *Providing advice and information (signposting) about access to services and support to members of the public*

to make informed choices about healthcare services.

f) *Making the views and experiences of people known to Healthwatch England (and to other local Healthwatch organisations) and providing a steer to help it carry out its role as national champion.*

3.0 The vision for Herefordshire

3.1 The Healthwatch Herefordshire pathfinder application clearly laid down the proposed model of working for the local service. It identified some of the challenges faced in Herefordshire as a result of having a small rurally dispersed population and some of the significant developments that have been led by Herefordshire Council to militate against those challenges.

3.2 The proposal was that Healthwatch should provide its key functions through the Council's existing telephone contact centre and 'One Stop' shops, which would enable the most cost-effective, far reaching coverage of the county for the new service.

3.4 The vision set out in the proposal for Healthwatch Herefordshire was that:

a) *Healthwatch Herefordshire will empower the public to make choices and shape health and adult social care services to local needs and improve customer experience.*

b) *Using the 9 localities identified within the county already as a framework for engagement and intelligence gathering, Healthwatch Herefordshire will be integral to the developing locality service arrangements, working alongside other public services, and close to local communities.*

c) *Healthwatch Herefordshire will have an important role supporting everyone in the community, but particularly those who are vulnerable or often unheard.*

3.5 Delays and changes to the new legislation have impacted on the full implementation of the pathfinder proposal. However, the principle of sharing resources and eliminating duplication wherever possible is well founded within local public services – not least through the developing approach of the Health and Wellbeing Board.

3.6 A key objective of the local vision is for Healthwatch Herefordshire to be seen and to operate as part of the wider network of community based organisations that champion the interests of local residents and consumers.

4.0 Proposed governance and board arrangements

Chairman

4.1 The Chairman's role will be to lead and work with the Board in setting the strategic plan and direction of Healthwatch Herefordshire, in line with the Department of Health and Healthwatch England requirements, as well as implementing agreed objectives, through good governance and effective strategic planning.

4.2 The Chairman will hold office for a maximum of 3 years (with an option to extend for a maximum of 3 further years with the support of the management board) and will be remunerated in line with the responsibility and accountability of the role. The broad responsibilities of this role will be to:

4.3 Oversee governance of the organisation, working with the Board to ensure:

a) *Compliance with the financial regulations, standing orders, delegated authorities and agreed codes of governance;*

b) *The Board consists of suitably skilled, experienced and diverse members who understand their roles and responsibilities with appropriate arrangements for appraisal, training and development; and*

c) *Key issues are discussed by the Board in a timely manner with appropriate information and that the Board receives professional advice when needed.*

4.4 Oversee the performance of the Board, ensuring:

a) *The Board's business is conducted efficiently and effectively through a framework of delegation and systems of internal control that also enable the work of Healthwatch Herefordshire to be carried on effectively in-between meetings of the Board*

b) *Implementation of frameworks for effective financial control & management of risk.*

c) *Chair Board meetings and participating in other committees/ groups, as required.*

d) *That all members are given the opportunity to express their views and that appropriate standards of behaviour are maintained in line with an agreed code of conduct; and:*

e) *Decisions are taken as delegated through the appropriate procedures.*

f) *Focusing on performance and working with the Board to oversee performance and continuous improvement to drive excellence.*

g) *Overseeing patient, service user, carer and wider community satisfaction with reference to the performance of comparable organisations.*

h) *Oversee the publishing of an Annual Report and Accounts each year, highlighting priorities, progress and key issues.*

4.5 Ensure employee performance is of a high standard, through*:*

a) *Maintaining good relationships with staff*

b) *Build and maintain effective working relationships with the Senior Officer, the staff team and senior staff within other organisations and ensure that the Board as a whole acts in partnership.*

c) *Provide appropriate management, advice, support and challenge to the Senior Officer.*

d) *Ensure that the Board annually appraises the performance of the Senior Officer and his/ her remuneration*

4.6 Representing Healthwatch Herefordshire, by:

a) *Build and maintain good relationships with key stakeholders, including members of the public, patients, service users, carers, Healthwatch England, the Department of Health, Care Quality Commission, Herefordshire Council, Monitor (Regulator of NHS Foundation Trusts), NHS funded providers, Clinical Commissioning Groups, District Councils & funders.*

b) *Act as an ambassador and representative for the organisation, upholding the reputation of Healthwatch Herefordshire and its values.*

c) *Network and promote the achievements, purposes and benefits of Healthwatch Herefordshire.*

d) *Ensure that Healthwatch Herefordshire is represented on the Herefordshire Health and Wellbeing Board and plays a proactive role in influencing the policy, planning, commissioning and delivery of health and social care.*

Members

4.7 Chairman and Management Board recruited using Nolan Principles of Public Life.

4.8 Members will serve a 2 year term with the option to be re-elected for a maximum of 2 further years.

4.9 Associate Members will be recruited to specific pieces of work or projects, by Management Board members with the appropriate authority. These posts will be voluntary and will not receive remuneration.

Remuneration of Chairman and Management Board Members

4.10 To ensure that Healthwatch Herefordshire attracts the right calibre of candidate to the local Healthwatch management board and Chairman role, the posts will be remunerated in line with the responsibility and accountability required. The case for remuneration is based on experience that this is more likely to result in a higher performing body which delivers better outcomes for local people.

Remuneration for the Chairman

4.11 The proposed scale of remuneration for posts has taken account of practice elsewhere in the country. For example, Worcestershire County Council have suggested remuneration of the Healthwatch Worcestershire Chairman at a level equivalent to £250/day, which at 45 days a year is £11,250 per annum

4.12 Healthwatch Herefordshire will not cover as large a population as Worcestershire and a reduced range of services. Consequently, it is suggested that the Chairman is nominally paid for 3 days per months, or 36 days per year. This would equate to £9,000 per annum.

4.13 It is also suggested that the Vice Chairman be remunerated at £200 per day for management Board meetings (£1200 per annum) and £200 per day where additional work is undertaken on behalf of the Chairman and agreed in advance.

4.14 Expenses will be paid in addition.

Remuneration for management Board members

4.15 It is expected that Healthwatch Herefordshire management board will meet at least bi-monthly and that the members of the board would be require reading and preparation time in advance of the meetings.

4.16 A suggested allowance equivalent to £150 per meeting is therefore proposed. This would equate to £900 per annum.

4.17 Expenses will be paid in addition.

4.18 Management Board Members would also be remunerated for leading specific working groups or task and finish groups. Further, detailed consideration of this proposition would be required before it is confirmed.

4.19 The Management Board will comprise:

a) *A Chairman*

b) *A Vice Chairman*

c) *6 members*

Based upon the proposals outline above, the minimum cost per annum would be£15,600, to be met from the Healthwatch budget

4.20 The Chairman and management board members will be required to sign up to a set code of practice and will be monitored against the code by Herefordshire Council (in the case of the Chairman) or by the Chairman (in the case of Management Board Members).

Staffing

4.20 All staff will have clearly defined Job Descriptions.

4.21 A Senior Officer/Chief Officer post will provide leadership and management for the staff, as well as being the single contact point for

the commissioning organisation.

4.22 The senior officer will be held to account by the Chairman and the management board.

4.23 Additional staff roles will support Healthwatch members to undertake engagement and enter and view functions, along with administration functions.

5.0 Measuring success

5.1 A series of performance criteria, which will be monitored as part of the contractual arrangements with the Council will be established through the contractual arrangements for the new service - these will include:

a) *How fast requests for information and support relating to health and social care are responded to.*

b) *How many contacts about health care services are resolved at the first point of contact.*

c) *How many cases logged with the Patient Advice and Liaison Service (PALS) are resolved; how long they have taken to resolve and the numbers referred to complaints.*

d) *Independent Complaints Advocacy Service – satisfaction rating of service users.*

e) *Influencing service provision/commissioning – evidence of action taken as a result of Healthwatch input and reports.*

5.2 Other success factors and performance measures will be agreed to reflect the challenges that Healthwatch will face and local expectations about what it needs to achieve. Views will be welcome on this.

6.0 Options for the new organisation

6.1 The Health and Social Care Act stipulates that the local Healthwatch organisations must be 'body corporate', which means that they will carry out statutory functions, but are themselves non-statutory (i.e. not created by the Act) corporate bodies. This allows them to employ staff in addition to involving volunteers in their work. They will be able to contract out functions while remaining accountable for the public

funding they receive. There are a number of options regarding how this corporate structure can be created upon which views are sought:

6.2 Option 1 – New Independent Organisation

6.2.1 Set up a new independent organisation with the sole remit of providing the employment and governance arrangements for Healthwatch Herefordshire.

6.2.2 This option could give a great deal of independence to Healthwatch, but would involve the additional expense of setting up a new organisation. However, it would provide clear accountability and performance management arrangements if the local authority retained the rights to remove the senior management and/or chairman if the organisation did not meet the required performance targets.

6.2.3 As a very small organisation it could struggle to provide cost effective and robust human resource, financial and IT systems.

6.2.4 Healthwatch Herefordshire is expected to be in place in shadow form in October 2012, to allow for the Chairman and staff to undertake the member recruitments and other activity required to have a fully operational Healthwatch in April 2013. Setting up a new organisation would take more time than the other options and would be very challenging within the time available.

Pros	Cons
Independence	Cost
Accountability	Potential duplication of functions
Meets legislative requirements	Not in line with strategic direction of HPS
A clear demarcation between the old system and the new	Timescale would be very difficult to achieve
	Requires new networks to be created

6.3 Option 2 - Part of an existing not for profit organisation

6.3.1 Contract with an existing organisation to set up Healthwatch Herefordshire function and employ staff as an independent arm of their existing structure.

6.3.2 The local authority could work with independent not for profit organisations, social enterprises or charities to provide Healthwatch Herefordshire organisational support, through grant in aid funding.

6.3.3 This could be with any suitable local organisation as the legislation

allows for the local authority to fund the local Healthwatch organisation through grant and aid which means there would no requirement to go out to formal tender. This would reduce the cost and time involved with making the appropriate contractual arrangements.

6.3.4 Along with the public sector, the third sector is undergoing substantial changes and restructure in Herefordshire. Therefore taking on the role of Healthwatch may not be seen as a significant priority for some organisations and this would need to be identified prior to undertaking any work with an interested party.

Pros	Cons
Independence i.e.: rooted in the not for profit sector	Perceived lack of Independence (if local organisation involved in Compact or commissioning)
Accountability	May not be organisational priority
Shared overheads	Current changes within not for profit sector within Herefordshire may impact upon resource availability or organisational capacity
In line with strategic direction of local partnership working	
Meets legislative requirements	
Could be developed within timescale	
A clear demarcation between the old system and the new	
Existing networks are retained	

6.4 Option 3 – Rebrand LINk as Healthwatch

6.4.1 Rebrand the existing LINk arrangements as Healthwatch Herefordshire and extend the current brief to include the additional functions that Healthwatch are required to provide.

6.4.2 The current arrangements for the LINk in Herefordshire would not meet the legislative requirements for Healthwatch Herefordshire without significant change. There may also be a perceived lack of independence as the staff are currently employed directly by the local authority.

6.4.3 A local concordat has been developed to clarify roles and responsibilities; however public accountability remains unclear in the current structure.

6.4.4 The Department of Health has confirmed that it will not produce specific guidance documents concerning local Healthwatch procurement.

However, the Healthwatch advisory group has clarified that the grant in aid option or a single tender option is potentially available to a high performing LINk which is distinguished as having a 'unique capacity' to do the job of being a local HealthWatch organisation.

6.4.5 This option would require the local LINk membership to establish a 'body-corporate'.

6.4.6 This is probably not a viable option in Herefordshire, as the current LINk and is almost certainly not high-performing enough and does not provide the unique capacity required to fulfil Healthwatch functions.

Pros	Cons
Cost efficient	Does not meet legislative requirements in current form
Control of priority given to development	Lack of accountability in current structures
Existing membership	Lack of Independence
	Would need to become separate independent organisation in its own right
	Is not a clear demarcation between the old system and the new i.e.: does not meet the local vision for Healthwatch
Existing networks are retained	

6.5 Option 4 – Procure Healthwatch by open tender

6.5.1 Run an open tender exercise to identify and procure a not for profit organisation, social enterprise or charity to set up and run Herefordshire Local Healthwatch

6.5.2 This would involve running a procurement exercise in line with European Guidance.

6.5.3 A full procurement exercise would realistically take a minimum of four months and although we could stipulate the need for local knowledge and partnership working, there would be no guarantee that a local organisation would be successful.

6.5.4 A procurement exercise would enable organisations from across the country (and potentially Europe) to bid to provide the service, this would mean that the potential for recruiting an organisation with

experience in either providing host arrangements for LINks, or having set up other Local Healthwatch pathfinders is greatly increased.

6.5.5 We would not be able to complete a full tender exercise in time for the Healthwatch Herefordshire to take on shadow form in October; however we could potentially still recruit and independent chair and executive board in advance of the procurement exercise being completed.

Pros	Cons
Ability to identify organisations with previous experience	Long time scale required
Meets legislative requirements	Expense involved with procurement
Independence	Not ensured of local solution
	May have provider with a number of other Healthwatch developments and resources shared across areas
A clear demarcation between the old and the new	Risk of new organisation/ individuals
	Requires new networks to be created.

Preferred option:

6.6 Our initial assessment is that Option 2 is likely to provide the best opportunity for a high quality and cost effective local Healthwatch service, by enabling the provision of Healthwatch functions through existing services and networks, as well as ensuring members and staff have the independence they require to scrutinise those functions, along with the commissioning and provision of local healthcare services.

Your views:

We would welcome your views thoughts and observations on this important issue of Healthwatch. It would be particularly helpful to us if you could specifically comment on the proposed Options that are enclosed in the document. We would welcome these comments by the 30 June 2012

We take this opportunity of thanking you in advance for your assistance.

Please forward your responses to:

npriestley@herefordshire.gov.uk

or:

Healthwatch Herefordshire Consultation
C/o N Priestley
Franklin House
Hereford
HR1 2BB

Service Specification **Appendix 1**

1	**Healthwatch Herefordshire Service Specification**
1.1	Title of Service Healthwatch Herefordshire
1.2	Vision
	Healthwatch Herefordshire will be the independent consumer champion for health and social care. Healthwatch Herefordshire will be representative of the diverse communities served by local government. It will provide intelligence - including evidence from people's views and experiences - to influence the policy, planning, commissioning and delivery of publicly-funded health and social care. It will also provide information and advice to help people access and make choices about services as well as provide – directly or through an agreed third party arrangement – independent complaints advocacy to support people if they need help to complain about NHS services. Healthwatch Herefordshire will be a robust and credible player in the local health and social care economy by demonstrating that it has the appropriate level of skills and competencies required to deliver its statutory functions to the highest possible level. It will gain the trust of the general public as well as other health and social care stakeholder groups by being responsive and acting on concerns when things go wrong. It will operate effectively and efficiently so that the local authority can demonstrate value for money against an agreed set of outcomes Healthwatch Herefordshire will empower the public to make choices and shape health and adult social care services to local needs and improve customer experience. Using the 9 localities identified within the county already as a framework for engagement and intelligence gathering, Healthwatch in Herefordshire will be integral to the developing locality service arrangements, working alongside other public services, and close to local communities. Healthwatch will have an important role supporting everyone in the community, but particularly those who are vulnerable or often unheard.

1.3	Key Attributes Healthwatch Herefordshire will be: • Independent - a free-standing body which is respected for its independence and trusted by residents and stakeholders. • Clearly recognised – a body with a clear identity which is strong and distinctive from existing local organisations. It will embrace and utilise the local Healthwatch brand developed at national level. • User-focused – relentlessly championing the voice of the user in the health and social care system • Inclusive – an organisation which finds ways to work with the many different patient and service user representative groups across the local authority area • Well-connected – able to signpost people to good quality information to help them make choices about health and social care; with access to established networks to gather comprehensive patient views. • Evidence based – a body which uses evidence to underpin its priorities and target its efforts • Technically competent – an organisation that can demonstrate the relevant skills and competencies required to deliver its functions • Influential – able to make an impact on the local commissioning of health and social care; complement other inspection regimes; and support patients and residents with signposting to information about the quality of local health services • Flexible – an organisation which can work in partnership with key decision-makers (including the local authority, Clinical Commissioning Groups and other bodies at strategic level) while still being able to listen to individual patient concerns, represent

	them effectively, and challenge those same decision-making bodies when necessary. • Self-aware – an organisation which actively seeks feedback on its own performance and critically assesses its strengths and weaknesses. • Accountable – working to a clear set of standards against which the local authority and the residents it serves can appreciate its success. • Good value for money – an organisation that makes the best use of its resources by seeking to avoid duplication with other bodies in the local authority area, and where possible, working creatively with them to deliver the most cost effective solutions to achieve its chosen priorities.
1.4	Who is Healthwatch Herefordshire for?
	Healthwatch Herefordshire is for anyone who is legally entitled to access health or adult social care services in Herefordshire or anyone who cares for or represents anyone who has access to health or social care services in Herefordshire. Healthwatch has a duty to assist local health and social care commissioners and providers, and other community stakeholders, by providing feedback, research, and information on local people's views and experiences of health and social care, to improve services.
1.5	Access to the Service
	Healthwatch Herefordshire will be accessible to all, across Herefordshire and will actively seek the views and experiences of local people, including 'seldom heard' groups, using a variety of media: • Website and other Digital/ Online Services (including access to surveys) • Telephone (including beyond normal office hours) • Via One Stop Shops in Hereford City and the market towns • Community Outreach Services • Mail Address (including a freepost facility where necessary)

	Healthwatch Herefordshire will make full use of existing and well-established information and support systems and networks.
2	Service Delivery
2.1	Functions Function One: Gathering views and understanding the experiences of patients and the public Healthwatch Herefordshire will: • Ensure systematic and on-going engagement with all sections of the local population, via their members and staff, so that a wide cross-section of views is represented in respect of local health and social care. • Seek the community's views about the current provision of health and social care (including use of high quality research) and use this to identify the need for changes or additions to services. • Have the facility to analyse and channel high quality user feedback and public views on services to relevant commissioners so that they can inform the whole commissioning cycle Function Two: Making people's views known Healthwatch Herefordshire will: • Communicate the local community's views, to health and social care commissioners and providers, in a credible and accessible fashion. Function Three: Promoting and supporting the involvement of people in the commissioning and provision of local care services and how they are scrutinized Local Healthwatch will: • Give input to new or proposed services. • Promote opportunities for comments and engagement provided by commissioners and service providers. • Use the broad range of stakeholder engagement techniques to maximise opportunities for local people to have their say. • Liaise and, where appropriate, work with commissioners and providers on engagement and consultation activity. • Exercise their enter and view powers judiciously by working collaboratively with other inspection regimes.

Function Four: Recommending investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC)

Healthwatch Herefordshire will:

- Have clear, agreed policies and procedures covering the referral of local issues to Healthwatch England and the Care Quality Commission. This will include how Healthwatch Herefordshire will inform local commissioners and providers about concerns arising from local intelligence.
- Continuously evaluate existing health and social care services, making recommendations for special reviews or investigations to the Care Quality Commission, through Healthwatch England, based on robust local intelligence.

Function Five: Providing advice and information (signposting) about access to services and support to members of the public to make informed choices about healthcare services.

Healthwatch Herefordshire will:

- Influence or provide advice and information to ensure that all sections of the local population have access to good quality impartial advice and advocacy relating to the health and social care services available to them.
- Establish and maintain a database of existing local networks and support systems.

Function Six: Making the views and experiences of people known to Healthwatch England (and to other local Healthwatch organisations) and providing a steer to help it carry out its role as national champion

Healthwatch Herefordshire will:

- Ensure local intelligence gathering systems complement those established by Healthwatch England.
- Have clear policies for reporting to Healthwatch England and other Local Healthwatch organisations.

Function Seven: NHS Complaints Advocacy

Local Healthwatch will:

- Make arrangements for supporting local people with any complaints

	they may wish to progress in relation to NHS service provision either through: ▪ A directly provided complaints advocacy service; or ▪ Referral to a third party contracted by the local authority expressly for these purposes • Accountabilities Local Healthwatch will be accountable to: 1. Local service users and resident taxpayers in the local authority area via: a. an annual meeting, open and accessible to local stakeholders/ members b. an annual report c. audited accounts available for public inspection 2. The commissioning local authority in terms of value for money, through regular contract meetings. 3. Healthwatch England in terms of quality standards, through agreed reporting arrangements.
2.2	Partnerships Healthwatch Herefordshire will: • Work closely with Herefordshire local authority, as the commissioning body, to develop and maintain a high quality and cost effective Local Healthwatch in Herefordshire. • Represent local people through its role on the local Health and Wellbeing Board (e.g. to assist in developing the joint health and well being strategy). • Work closely with the national body, Healthwatch England, to deliver a strong public voice. • Foster a broad range of relationships with local health and social care commissioners and with provider agencies across the public, voluntary and private sectors. • Nurture partnerships with local service-user groups, not for profit and other Local Healthwatch organisations to ensure high quality feedback and research • Collaborate and liaise with Local Authority Overview and Scrutiny

	committees to ensure service user and public feedback is a key part of the scrutiny of health and social care.
2.3	Outcomes
	Local Healthwatch will make a positive contribution to the successful local achievement of outcomes set out in national frameworks for the NHS, primary care, adult social care and public health. Particular attention will be paid to: • Improved patient and user experience. • Improved communication between commissioners, service providers and the public • Improved satisfaction of the planning and provision of healthcare in Herefordshire. • Greater patient and public involvement in health and social care. • Strong relationship with commissioners and H&WBs. • Improved access to services. • Improving the publics understanding of their rights. • High level of public awareness about Healthwatch and its functions. • Public have high level of trust in Healthwatch Herefordshire. These outcomes will be measured through a number of tools, including: • Nationally and locally mandated service user and public surveys, • Feedback from service providers and commissioners, • Healthwatch reports and associated action plans, • Complaints and commendations received, • Service users satisfaction ratings collected following contact with Healthwatch, • Healthwatch England performance measures and reports.
2.4	Resources
	Herefordshire local authority will ensure that adequate resources are provided to Local Healthwatch in line with guidelines from the Department of Health and other key local decision makers (e.g. Health & WBs). Current LINk Funding to be transferred in April 2013 = £95,000 Additional resource identified by DoH = £ TBC Independent Complaints Advocacy (ICAS) Funding = £ TBC

	Total = £ TBC We would anticipate the Patient Advice and Liaison Service (PALS) from Herefordshire NHS staying as part of the CIU and providing services on behalf of Local Healthwatch as part of the exiting model. No funds would therefore transfer to the Local Healthwatch Pathfinder start-up allocation = £ 5,000
3	Governance
3.1	Powers & Limitations
	What powers will the group have to achieve its aims? Decision Making Participation Resource Management
3.2	What is the legal status of the group? Non statutory body with statutory powers. The membership and structure are not laid down in law, but the organisation will have certain functions that it must undertake (see 2.1 above). The Local Authority can choose to: • Set up a new independent organisation with the values of a social enterprise, or • Contract with and existing Not For Profit Organisation, Social Enterprise or Charity to set up Local Healthwatch.
3.3	How is the membership of the group defined? Chairman and Management Board recruited using Nolan Principals of Public Life. These posts will receive remuneration in line with the role undertaken. Annual elections for key posts and Management Board Membership. Associate Members will be recruited to specific pieces of work or projects, by Management Board members with the appropriate authority. These posts will be voluntary and will not receive remuneration.
3.4	How will the group be run? And what structures will exist? Annual elections will be held for the key posts and Management Board

	Membership. Associate volunteer members will be recruited to specific pieces of work or projects, which will be managed through sub-committees or task and finish groups.
3.5	Arrangements for sub-contracting work Healthwatch Herefordshire may choose to sub-contract some, or all, of its functions. Any arrangements for sub-contracting of Healthwatch functions must be agreed with the Local Authority and be supported by a clear business case.
3.6	What specific duties and responsibilities will exist? Clearly defined role profiles will exist for the following: • Chair of the Executive • Vice Chair • Executive Members • Associate Members All staff will be recruited to clearly defined job descriptions outlining their functions and their line management arrangements; including their responsibilities to Executive and Associate Members.
3.7	What procedures will exist for managing group meetings? Executive Meetings Agenda will be set by the Chairman in consultation with the Senior Healthwatch Officer Will be chaired by the Chairman or Vice Chairman Members may be co-opted for specific areas of work if required Only full executive members will be able to vote. General Meetings Agenda will normally be set by the Senior Healthwatch Officer in consultation with the Chairman Will normally be chaired by the Chairman, or Vice Chairman Administration to meetings to be supplied by Healthwatch staff Sub Committees, Community Forums or task and finish groups

	Agenda will normally be set by the relevant Management Board Member in consultation with the Chairman or Senior Healthwatch Officer. Will normally be chaired by the relevant Management Board Member Administration to meetings to be supplied by Healthwatch staff
3.8	What is the approach to dispute resolution? Healthwatch Herefordshire will have in place a formal process and associated policy relating to dispute resolution. The policy will cover all potential areas for dispute resolution and clearly identify the actions that will be undertaken and the roles and responsibilities of all parties involved.
3.9	What is the code of conduct for the group? Nolan Principles of Public Life
3.10	How will the group manage its money and assets? (financial and non-financial) The Chairman and Management Board will be responsible for finance and asset management. The Chairman will have overall responsibility and will be accountable to the Local Authority via regular contract review meetings. Operational responsibility will sit with the Senior Healthwatch Officer, who will be accountable to the Management Board.
3.11	What is the groups approach to reporting, Communications and information sharing? Healthwatch Herefordshire will champion openness and transparency; within the confines of the Data Protection Act and all other relevant legislation, Healthwatch Herefordshire will make all of its work, reports, recommendations and communications available to the public.
3.12	Amendments to the Constitution Any amendments to the constitution of Healthwatch Herefordshire will need to be agreed by an appropriate officer within the Local Authority.
3.13	Dissolution of the group At the point of dissolution, any information or records held by Healthwatch Herefordshire will be made available to the Local Authority, or nominated successor organisation, in a suitable format which ensures it can be accessed and used.

Herefordshire Council

MEETING:	**HEALTH AND WELLBEING BOARD**
DATE:	**19 JUNE 2012**
TITLE OF REPORT:	**HEALTH AND WELLBEING COMMUNICATIONS AND ENGAGEMENT STRATEGY AND PARTNERSHIP WORKING**

CLASSIFICATION: Open

Wards Affected

County-wide

Purpose

To update the Health and Wellbeing Board on the different strands of work currently underway intended to address key strategic and operation communications issues and to seek agreement for the recommendations, below.

Recommendations

THAT:

(a) The Board note this report and to continue to support the implementation and development of the joint communications and engagement strategy, attached; and

(b) Specifically support the further local integration of communications and engagement working.

Key Points Summary

- In November 2011, the Health and Wellbeing board, the CCG and NHS Herefordshire board agreed and endorsed the creation and implementation of a joint communications strategy which was designed to support the anticipated changes across the local the Health and Wellbeing economy which were the result of the NHS and Social Care act 2012.
- A number of key actions from the original action plan have been implemented. However, the strategy has been updated and to embed implementation further, there is a requirement to integrate communications and engagement working further.

Further information on the subject of this report is available from
Richard Beavan-Pearson, Assistant Director Customer Services and Communications (01432) 261721/ 07792880246

- The Health and Wellbeing board is key in ensuring that many of those changes are implemented, as well as having oversight of health and social care within Herefordshire. It is therefore important that the communication and engagement priorities of the board are developed and implemented in close coordination to those of other public sector organisations.

Alternative Options

There are no alternative options, given that the Board has identified communications and engagement as a one of its key issues in the Development Framework.

How will your report meet the vision and guiding principles of the HWBB?

1. The creation of joint teams/ partnership groups will support in particular:

   a. **Principle 3:** *Herefordshire Health and Wellbeing Board and its partners will work together to provide a unified service for everyone, through consistently good quality shared care and managed networks. Services will be financially viable, safe and sustainable and affordable for everyone, making use of both public funds when required, and people's own funds if they are able to pay*.

   By working together, joining up communication and engagement strategies and plans, there will be much greater scope to work together, providing value for money services as the recommended way forward will enable duplication to be minimised.

   b. **Principle 6:** *The ladder of intervention framework provides a means of integrating lifestyle and enforcement action into a single strategy for improving health and wellbeing for the people of Herefordshire. This framework will be used by Herefordshire Health and Wellbeing Board and its partners to address health and wellbeing issues across all sectors.*

With a single strategy for improving health and wellbeing in the county, there will be a subsequent need for a single supporting strategy regarding communications and engagement for both signposting and intervention purposes.

Reasons for Recommendations

2. The recommendations have been made to support the principles above.

Introduction and Background

3. The attached strategy is being presented as an update to the Board and to seek the approval for further development of the principle of the joint engagement and communication activities.

Key Considerations

4. A joint communications and engagement strategy was initially developed in 2011 to help support the partners who form the new health and social care landscape.

5. The scope of the strategy aimed to support a seamless public-sector wide health and social care transition commissioning to the identification of key stakeholders who have a role or interest in the changes.

6. The strategy was designed to ensure that, regardless of who is commissioning or providing health and social care, messages are consistent and timely. This is particularly important in times of change which can be unsettling for both patients, the wider public, our partners and stakeholders.

7. The Health and Wellbeing Board were previously informed of key deliverables of the plan. Overall, work on the implementation of the plan continues to be on track.

8. However, the on-going development of the plan has been affected by the diverging organisational priorities and the lack of a locally shared focal point. This, combined with the added and developing requirements from the NHS reorganisation, has meant a dip in the momentum required to implement the action plan. However, the original plan was focused on establishing a baseline position and this has largely been achieved.

9. In order to push the development of a joint plan forward, and within the specific context of Herefordshire, an initial summary proposal was put to and accepted by the Herefordshire Health and Wellbeing board in May 2012.

This proposal (summarised on page 16 of the attached document) *is to*

Consolidate a shared strategy(ies) with the intention of facilitating closely coordinated communications and engagement activities within the local health and wellbeing economy – specifically to.

a. *The Citizen Engagement forum (already established) which will provide coordination and oversight of consultation and engagement activities within partner organisations. The forums will also produce an annual plan of engagement activities which support the Health and Wellbeing strategy priorities.*

b. *A communications (forum?). This is intended to be a more tactical function, which provides coordination of communication and marketing activities within partner organisations. This forum will also produce an annual plan designed to support Health and Wellbeing strategy priorities.*

Due to the extent of overlapping agenda's, activities and priorities the strategy will also propose the creation of permanent engagement and communications partnership

teams, to support the whole Health and Wellbeing economy within the county. This will fit in with the planned, on-going joint HPS communications and engagement service.

10. The broad justification for this approach is:

    a. *The co-terminosity of County Council, strategic providers and Clinical Commissioning Group boundaries.*
    b. *The small population within the county and the associated, emerging risk of engagement/ consultation fatigue amongst local communities.*
    c. *The existing integrated communications and engagement teams within HPS, who already use common systems and processes.*
    d. *Very small resources in other individual organisations to support communications and engagement.*
    e. *The need to demonstrate value for money, cut costs and improve efficiency for each organisation.*

11. Discussions are almost complete to extend the joint communication service provision and support other partner organisations, including key strategic partners. Once agreed, this will provide further economy of scale to communications and engagement activities and provide a more sustainable arrangement for each organisation.

Community Impact

12. Set out any considerations relating to community impact including relationship with community strategy, partnership considerations, community/user engagement, equalities considerations etc.

Financial Implications

13. None at present. However a further iteration of the plan is planned for autumn 2012 which will likely have a financial assessment within.

Legal Implications

14. None identified at present.

Risk Management

15. A lack of integration between communication and engagement activities which support the health and social care changes which are underway within Herefordshire may lead to unnecessary duplication of those activities and associated messages.

Consultees

16. Consultation is on-going, but key consultees to date include:

HPS steering group

Health and wellbeing board

HPSLT

Appendices

18. Appendix 1: Updated Herefordshire joint communications and engagement strategy.

Background Papers

None identified.

The new health and social care landscape – A communications and engagement strategy for the public sector changes in Herefordshire for 2012-2013.

Updated May 2012.

1.0 Introduction

1.1 This strategy is intended to ensure a smooth transition through the period of change to the health and social care system initiated by the Health and Social Care Act 2012. By providing clear and consistent communication to all identified stakeholders during this time and through the instigation of communications and engagement activities required to support the initial Herefordshire Health and Wellbeing strategy this plan will support the principle of continuity during a period of significant change within the public sector.

1.2 In order to ensure that this strategy can work to best effect, it is recommended that it is owned equally by Herefordshire Council Herefordshire Clinical Commissioning Group, Herefordshire Health and Wellbeing board and key partner organisations. It has been informed through the strategic objectives previously set out by the Herefordshire Public Services transition board, Herefordshire Clinical Commissioning Group and the Herefordshire Public Services Leadership Team.

1.3 As it is anticipated that the Health and Wellbeing Board will be the primary vehicle through which local health and wellbeing outcomes will be addressed, the local Health and Wellbeing strategy will increasingly become a focal point for communications and engagement activity within the county.

1.4 Therefore, the work emerging from the Health and Wellbeing Board will provide significant opportunities to impress upon service users, carers and all local communities the need for people to take personal responsibility for lifestyles (of which health is one aspect) and also to improve the way we use feedback from stakeholders and the public. There are also opportunities to develop an on-going dialogue between health and social care commissioners and their stakeholders through innovative engagement work, which can inform future social marketing campaigns, as well as the development of services.

1.5 As the local health and social care landscape is developing rapidly, this strategy is designed to run in 90 day cycles so that it can provide flexibility and evolve to meet changing requirements and milestones during the transition.

1.6 Key documents informing the strategy going forward should include the HPS Joint Corporate Plan, the Herefordshire Health and Wellbeing Strategy, the HPS Transition Plan, the Joint Strategic Needs Assessment, the PCT Annual Plan, the QIPP;

West Mercia, Wales and Gloucestershire Cluster transition plans, NHS listening exercise results and the HPS Public Engagement Strategy and Plan.

1.7 There are three main strands to the strategy: stakeholder communication, internal communication and public and staff engagement.

2.0 Objectives

2.1 This strategy has a number of key objectives, which are intended to inform stakeholders from the partner organisations, the community, regionally and nationally about the changes happening to public services within Herefordshire and which are nationally recognised as innovative. These are:

- To support, inform and supplement 'business as usual' communications for Herefordshire Council, NHS Herefordshire and Herefordshire Clinical Commissioning Group.

- To reaffirm the message that communications and responsibility of ensuring a smooth transition to the new NHS commissioning arrangements is a responsibility shared across the public sector. Everyone within Herefordshire Public Services and beyond has a personal responsibility to advocate for and participate constructively in the changes.

- To support a seamless transition from NHS Herefordshire to Herefordshire Clinical Commissioning Group.

- To support a seamless transition of local public health services to Herefordshire Council.

- To ensure that consistent messages are produced on behalf of all organisations throughout the transition period indicating clearly that good services, based on local need and quality patient care are at the heart of what we do.

- To raise the profile of health and wellbeing with Herefordshire residents, community groups, parish councils, local businesses and increase engagement in, and ownership of, this agenda.

- With colleagues across the wider Herefordshire public sector partnership, to embed a broader culture of personal responsibility, which is wider than the health and social care agenda.

- To create a culture where people take responsibility for their own health and care as much as possible.

- To establish the Health and Wellbeing Board as the central mechanism locally for delivering health and wellbeing outcomes by partners from across the public sector.

- To establish an effective stakeholder engagement programme to inform the work streams identified by the Health and Wellbeing Board and maximise opportunities for local people, staff and targeted stakeholders to get involved.

Specifically:

a) ***children under 5 years old****: For every child in Herefordshire to have an equal chance of a healthy childhood and developing a healthy lifestyle for adulthood.*
b) ***alcohol harm reduction:*** *A reduction in alcohol related harm in Herefordshire.*
c) ***older people:*** *Working with people in Herefordshire to live independently and to be safe and well. We will do this by encouraging people and their communities to help themselves and where necessary, ensuring access to advice, care and support which is financially sustainable; of high quality; timely; accessible and*

innovative.

- To develop a programme of internal communication to keep staff appraised of developments and changes during the transition period and to support the HR processes.

- To support the development of Healthwatch Herefordshire and enable it to promote its work as a local 'health and social care consumer champion'.

- To respond to requirements arising through the wider NHS and social care changes in West Mercia, Wales and Gloucestershire.

3.0 Risks and Issues

3.1 There are a variety of risks and issues which can impact both the direction and speed of travel of the changes and these are set out below.

RISK	IMPACT	LIKELIHOOD	RATING	MANAGEMENT
Continued uncertainty about the future for staff	• Uncertainty can lead to disengagement and low productivity • NHSH and HCCG lose out because staff move on to other jobs, taking their knowledge with them • May impact JCP objective to retain	4	3	Development of internal communications plan to keep staff informed of what is happening. Utilise internal briefing systems

	high quality workforce			
Less third sector funding and this impacts provision of services and support, and their ability to support service redesign	• Impact on local services • Inability to deliver against some health targets • Disengagement of third sector at a time we want to deliver a message of 'everyone having healthcare responsibility'	3	4	Risk analysis required to inform future planning and development
Savings required through QIPP impact frontline services	• £11m savings required – could impact services. Risk not being able to win and retain public/customer support for new health and social care landscape	3	4	Foster a culture of proper use of services Communications plans should be in place to support process
Lack of customer/ stakeholder understanding about who is responsible for services	• Not knowing who to call or contact for help or advice – impact on reputation of ALL organisations	3	4	Single point of contact, branding exercise and direct communication with residents so that they know who to contact
Perceived lack of accountability in how	• As highlighted through the previous NHS Listening Exercise	4	4	Apply any mitigation as directed by government and communicate

services are commissioned				wish to be open and accountable locally
Challenge to make everyone take responsibility for their own health and wellbeing	• Unless communicated positively and effectively, could be seen as council/GPs taking money out of local services in climate where people expect everything to be available to them “we pay for it and expect you to do it for us”	3	3	Stakeholder and public engagement projects to help understand barriers to good health and create sense of responsibility Communicating the choice and control/personalisation agenda to help people stay independent and living in their own homes
Projected health and social care funding gap of £29m by 2014	• Greater demand upon services, unable to meet local need	2	5	Need for current services to be streamlined so that money can be reinvested to meet the growth in demand
That NHS reforms continue to be politically charged and become so at a local level	• Negative messages about health and social care services being shared through media, locally	2	3	Need to create climate of ownership – elected members can play a vital role in delivering and receiving information that can be used to develop effective services

4.0 Opportunities

a) Establishment of new Health and Wellbeing Board Herefordshire early implementer: Opportunity to work with stakeholders to inform Health and Wellbeing Board themes and to begin move to increase people's responsibilities for their own health and overall lifestyles.

b) New role for public health within local authority rather than NHS Herefordshire, role for Herefordshire Council to be championing health and personal responsibility for lifestyles.

c) Establishment of Healthwatch Herefordshire.

d) Herefordshire has existing, close working relationships on integrated NHS, public health and social care services which mean the changes are an evolution in some key areas.

e) The establishment of 9 locality areas allow the develop of precise messages, tailored to the individual needs of each area and delivered through local GPs, elected members, local delivery teams, parish councils and voluntary sector groups.

f) The Herefordshire bespoke segmentation model provides a detailed view of Herefordshire citizens, their propensity to need certain services and to use certain communication channels.

g) A new approach to health and wellbeing, encouraging residents to change their behaviour and take personal responsibility for their own and their family's health. This could be supported through a social marketing campaign, backed by the wider Herefordshire partnership, rather than one organisation.

h) Ability to demonstrate Herefordshire's determination to be locally accountable and transparent from the outset of this new way of working.

i) The Root and Branch review process currently underway within Herefordshire Council will provide an opportunity to review services, re-design and improve in twelve key areas:

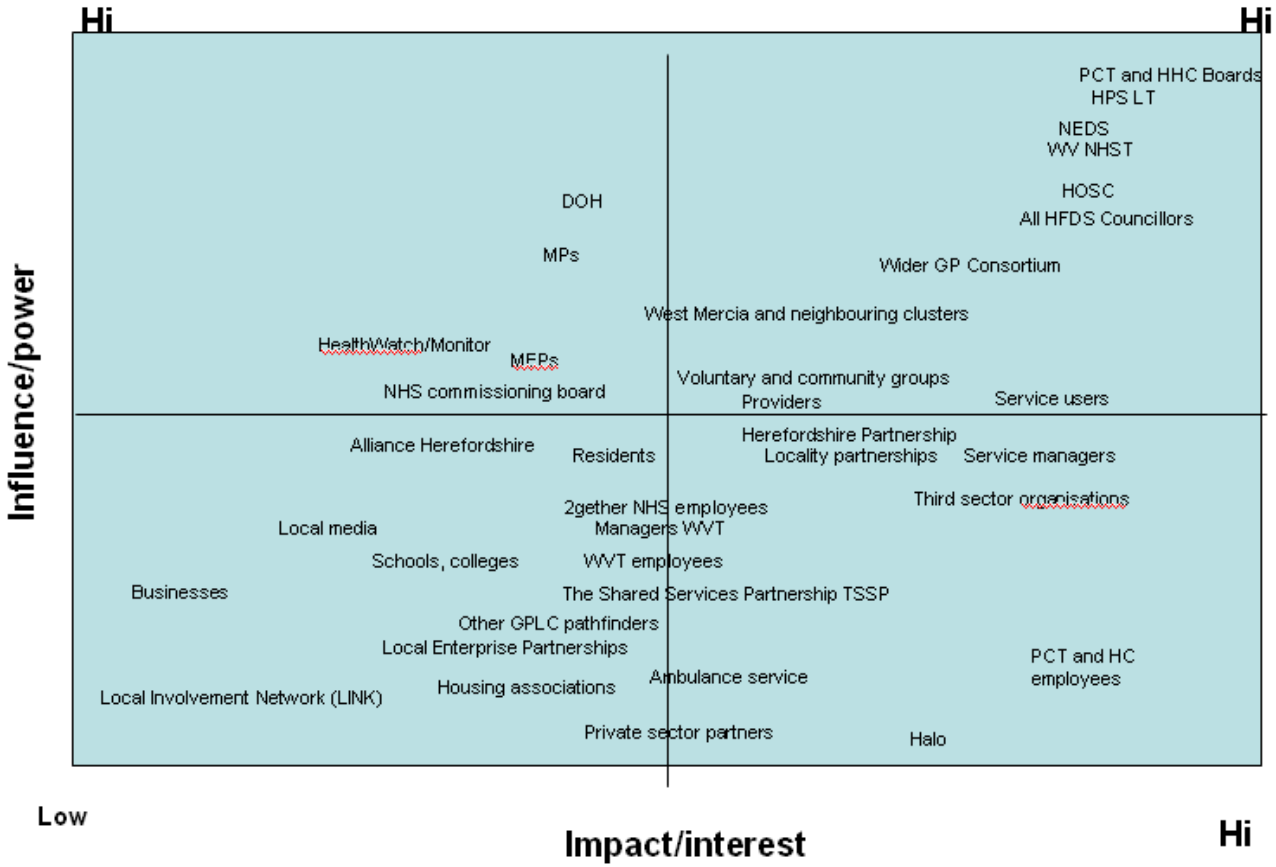
1. Housing, Economy and Regulation
2. Older People in Herefordshire
3. Customer Services
4. Herefordshire Streetscene
5. Supporting Vulnerable People in Herefordshire
6. Transport and Travel in Herefordshire
7. Children & Young People in Herefordshire
8. Safer and Stronger Herefordshire
9. Herefordshire's Environment
10. Learning and Skills in Herefordshire
11. Living & Wellbeing in Herefordshire
12. Herefordshire 2020

j) The reviews will also address 6 underpinning themes: *Localities – Sustainability – Inequalities – Partnerships - Prevention - Support Services.*

5.0 Stakeholders

The matrix below identifies the stakeholders impacted by these changes

Stakeholder map



6.0 Target Audiences

6.1 A number of audiences have been identified as the initial communications and engagement targets of this strategy and have been grouped together to allow development of appropriate messages and communications.

6.2 As we move through the life of the strategy, these can be updated and refocused as required.

- Residents, customers, patients and service users in Herefordshire – specifically described through the Herefordshire segmentation model:

- *Plus the additionally, more recently developed 'vulnerable person' segment*
- Our employees and colleagues across NHS Herefordshire, Wye Valley NHS Trust, 2Gether and the council
- Employees within our numerous contractor and provider organisations, and trade union representatives
- Elected county, town and parish councillors, scrutiny members and appointed non-executive directors, and MPs and MEPs
- Young people – through schools and colleges, after school and special interest clubs and groups
- Third sector providers and partners
- Businesses, trade associations and the private sector

7.0 Key messages

7.1 Key messages will be used in all our communication to ensure consistency and support the transition, clearly demonstrating commitment to continuity within those services during and after the transition, backed by the council, primary care trust and HCCG. General messages should join up across the HCCG strategy, Joint Corporate Plan and the PCT Annual Plan (see 7.2 below). More work should be done to develop these messages, with input and agreement from the Boards to ensure that communications work is owned and steered by their vision alongside tangible targets.

7.2 Added to this, in some cases, key messages will need to be developed to target specific audiences, depending on what it is we wish to ask them, or tell them about the transition period. In some instances, stakeholder and public engagement will also inform key messages to be used in social marketing campaigns around health and social care.

General messages

- That we are committed to continuing to create sustainable health and social care services of the highest quality in Herefordshire and that the partnership of public services within the county will continue to work together to achieve this aim.

- We want to create effective health care services for Herefordshire, influenced and designed by local people and healthcare experts, which meet the needs of our patients.

- Everybody has/we all have a responsibility for their/our own health and wellbeing.

- Herefordshire is leading the national health and social care agenda, thanks to its robust approach to providing health and social care, closer to where people live.

- Patients, service users and carers are at the heart of what we do and they will have a greater voice and more choice in how services are managed and delivered for them by local organisations in their local area

7.2 Key message to staff and colleagues

- ***That we are committed to continuing to create sustainable health and social care services of the highest quality in Herefordshire and that the partnership of public services (which includes HC, NHSH, WVNHST and HCCG) within the county will continue to work together to achieve this aim.***

And more specifically:

- Herefordshire is at the forefront of NHS/ public sector reforms and pathfinders for clinical commissioning consortium and HWBB
- Ensuring a smooth and sustainable transition from PCT to GP-led commissioning is our most important commitment to our customers and patients
- Your experience and knowledge is invaluable during this time of transition
- These new ways of working are an opportunity to make our health and social care services leaders in the field
- We all have a responsibility for our own health and wellbeing and should be advocates for this in the wider community

7.3 Key messages to other stakeholder groups

7.3.1 As the strategy develops, key messages may be developed and tailored to the needs of stakeholder groups identified as key communications targets, depending upon the behaviour you wish to change or influence or whether messages are to inform people about the transition, with no action needed.

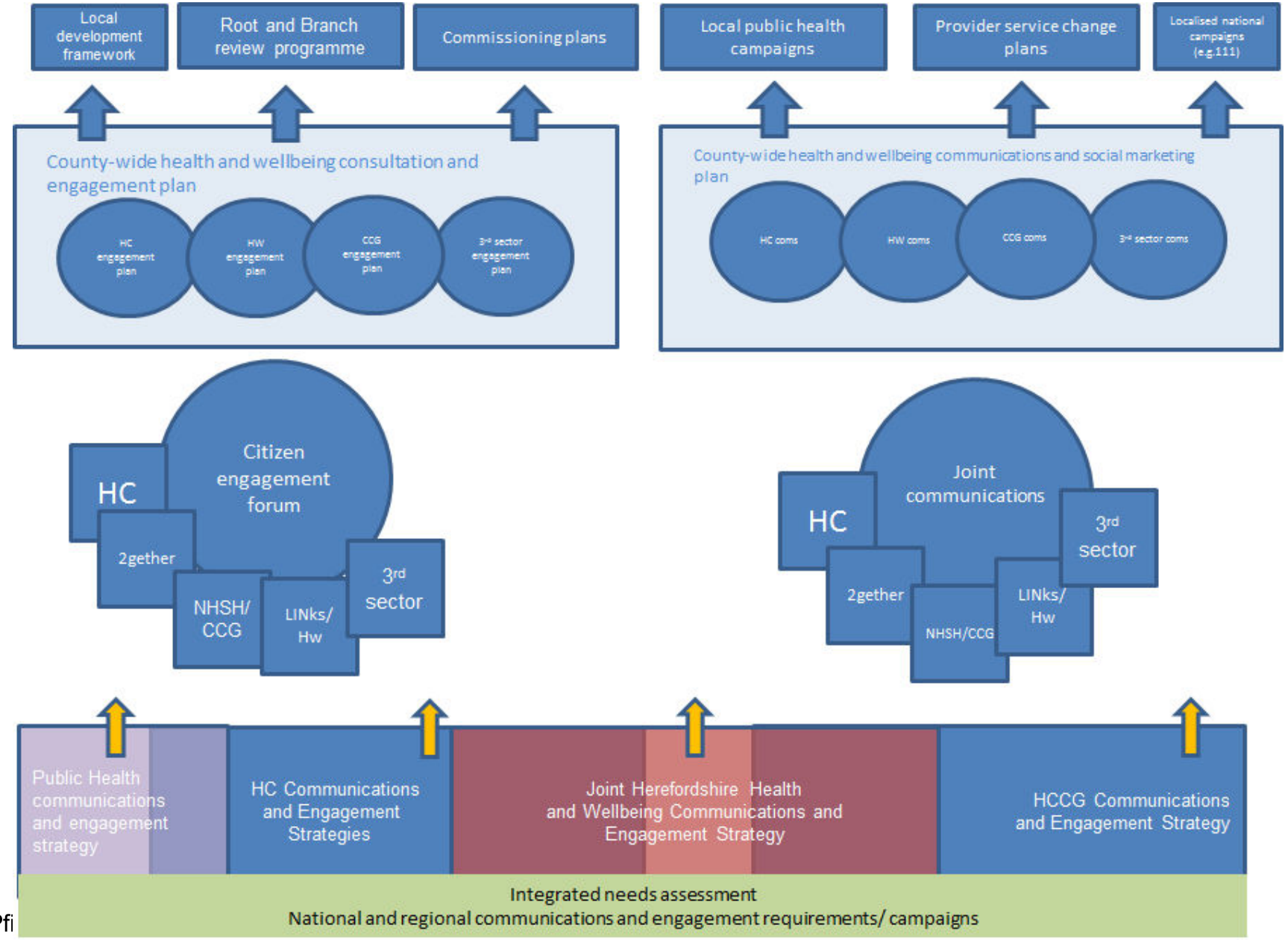
8.0 Key corporate strategic communications activities

8.1 This strategy should be led by milestones emerging from the Joint Corporate Plan, the establishment of the HWBB, the HHCC work plan so that all communications work can be aligned to what is actually happening at key stages.

Board members will be responsible for highlighting these key milestones to the communications team.

8.2 There should be a monthly health story, highlighting a success in healthcare, in order for a repeated drip feed of success, demonstration of continuity of services and on-going commitment to creating high quality and sustainable health and care services.

8.3 The management of these key transitional engagement and communication activities should be coordinated through more integrated teams and through partnership working arrangements, summarised by the diagram below:


Local development framework
Root and Branch review programme
Commissioning plans
Local public health campaigns
Provider service change plans
Localised national campaigns (e.g.111)
County-wide health and wellbeing consultation and engagement plan
HC engagement plan
HW engagement plan
CCG engagement plan
3rd sector engagement plan
County-wide health and wellbeing communications and social marketing plan
HC coms
HW coms
CCG coms
3rd sector coms
HC
Citizen engagement forum
2gether
NHSH/ CCG
LINks/ Hw
3rd sector
HC
Joint communications
2gether
NHSH/CCG
LINks/ Hw
3rd sector
Public Health communications and engagement strategy
HC Communications and Engagement Strategies
Joint Herefordshire Health and Wellbeing Communications and Engagement Strategy
HCCG Communications and Engagement Strategy
Integrated needs assessment
National and regional communications and engagement requirements/ campaigns

8.4 The citizen engagement forum currently exists and it brings together key stakeholders and organisational representatives in order to better coordinate and prioritise engagement activities within the county. This is in order to minimise duplication and maximise the limited resources which are available to undertake engagement locally.

8.5 A similar requirement is therefore necessary for communications and social marketing campaigning reasons.

9.0 Strategic Communications action plan (updated May 2012)

Denotes completed

What	Audience	Action	Additional notes	Timelines	Responsible
PCT/WVT APM	Public and identified stakeholders	Opportunity to communicate key themes and priorities across all organisations		July 2011	PCT board to deliver messages Complete
Stakeholder workshops	As identified through stakeholder map		Beginning of the conversation with key stakeholders	July 2011	Dean Taylor
Develop timed action plan to support public health staff during transfer to council	• Is national guidance available? • Timeframes for transfer • Develop robust communication s to support HR	Communications channels could include face-to-face, Team Talk, manager briefings, CEO road shows, First Press, intranet, change champions		On-going	Communications team with HR
Agree target engagement groups for	Relevant engagement groups as identified		To be signed up to by HWBB,	Autumn 2011	Public engagement team

health change	through work themes		HHCC, HPSLT		
A/E campaign	Herefordshire Citizens	Use range of communications channels to reduce A/E attendances/ admissions	Example of joined up working	Autumn-Winter 2011	HCCG
A/E campaign	Herefordshire Citizens	Use range of communications channels to reduce A/E attendances/ admissions	Example of joined up working	Autumn-Winter 2011	HCCG
Agree a shared health vision	All local people	HHCC, PCT and HC to agree a shared vision and it to be communicated as part of the strategy	Could this be informed by the workshops?	August Complete (see HWBB Development Framework)	HPS LT/ GPCC/HWBB
Healthwatch early implementer	Wider community and stakeholders	Need to communicate the establishment of the HW, its intentions and role in the health and social care landscape going forward	Dependent upon receiving implementer status	August - complete	RBP/communications team
Develop more detailed key messages for each key strategic theme/ outcome	Each stakeholder group	Identify primary and secondary messages from each strategy	To be signed up to by HWBB, HHCC, HPSLT	Autumn 2012	Developed by boards supported by communications team
Series of strong health story for media/	All Herefordshire residents and businesses	Identify forthcoming good health stories which identify commitment to		Once work plans agreed – September 2012	Project/care leaders to highlight to communications

Digital channels		continuity and best practice			team
Develop stakeholder engagement programme	Businesses Third sector Parish councils Older people	Develop an engagement programme based on HWBB work streams, JPC work streams and HHCC work streams	This work has started but is dependent upon the relevant forums providing clear areas of work and priorities	Autumn 2012	Public experience team
Root and Branch review engagement process	• Quality of life survey • Your community, your say engagement events • Specific review are consultation events	To support the root and branch review process – covering the 12 service areas being reviewed. Aligned to health and wellbeing agenda, wherever appropriate	Work to continue through the summer and autumn of 2012 and will fulfil key strategic engagement requirements	Summer-Autumn 2012	RBP/public experience team/ external support team
Develop specific key engagement	• To fit in with the root and branch review process,	As above	As above	As above	RBP/ task and finish group/ public experience team.

and communication plans to support the 3 key strategic aims of the current Health and Wellbeing strategy	where necessary and feasible.				
Drip feed messages and change to all staff	• Agree key priority messages • Put together action plan • Communicate through channels as outlined above	Should be a more general campaign based around changes in organisation and messages arising through HWBB		August/September2011	Led by boards with communications support
Healthwatch early implementer	Local community public sector leaders	On-going communication regarding the development and implementation of the Healthwatch early implementer		October 2011-June 2012	Communications team/ RBP
Healthwatch implementation	Local community Key partner organisations Local communities Partner	• Engagement to support the development of options for the new service		April 2012-July 2012 September 2012-April	Public experience team/ communications team

	organisations	• Communications to support the implementation of Healthwatch and to signpost local people to the new service		2013	
Key public health stakeholder workshops	As identified through stakeholder map	Establish workshop programme	Beginning of the conversation with key stakeholders	July 2012	PH transition board
Develop timed action plan to support and public health staff during transfer to council	• Employees • Timeframes for transfer • Develop robust communication s to support HR	Communications channels could include face-to-face, , core brief, enCore, manager briefings, CEO road shows, , intranet, change champions		April 2012-October 2012	Communications team/ HR
Strong public health stories for media	All Herefordshire residents and businesses	Identify forthcoming good public health stories which identify commitment to continuity and best practice and raise consciousness of public health function within local government		September 2012	HPS communications team
Stakeholder workshops -	Local communities in 9locality areas	• Clarify purpose and scope of these events	Facilitated by public	September 2012– March 2013	SMT/ councillors

localities		• Build upon Reaching the Hearts • Separate stakeholder maps to be drawn up	experience team		
Specific communications and engagement to those directly affected by the changes	• Agree key messages • HR –specific messages • Targeted communications	To support the HR elements of the transfer		April 2012-March 2013	PH transition board/ HCCG/ West Mercia Cluster/ HPS communications team/ HR
Local councillor workshops	• To explain what their role in the new system will specifically be	To widen knowledge and engagement with a key stakeholder group		September 2012	PH transition board/ HPS communications team/ member services

Herefordshire Council

MEETING:	**HEALTH AND WELLBEING BOARD**
DATE:	**19 JUNE 2012**
TITLE OF REPORT:	**HEALTH AND WELLBEING BOARD WORK PLAN**
REPORT BY:	**HEALTH AND WELLBEING GRANTS AND PARTNERSHIP OFFICER**

CLASSIFICATION: Open

Wards Affected

County-wide

Purpose

To consider the current Work Plan.

Recommendation(s)

THAT the Board review the Work Plan and amend it as necessary

Introduction and Background

1 The current Work Plan is appended.

Background Papers

- None identified.

Further information on the subject of this report is available from Clare Wichbold, Health and Wellbeing Grants and Partnership Officer, on 01432 347661

HEALTH AND WELLBEING BOARD
WORK PLAN 1 APRIL 2012 TO 31 MARCH 2013
TIMELINE OF ACTIVITIES AND DECISIONS

BOARD DEVELOPMENT	DATES	DECISION MAKING PUBLIC BOARD MEETINGS
Workshop: • 2012 - progress to date • Governance, membership and working practices • Self assessment and action planning *Pre and post meeting demonstration of the new Service Portal (Service Delivery)*	17 April 2012	
Workshop: • Finalising actions from April Workshop • Discuss the membership of the Board for 2012/13 and any sub-groups for recommendation to the Council • Agreeing the governance relationship with the Safeguarding Children's Board and performance enquiry. • Developing the communication plan	15 May 2012	
	19 June 2012	• The development of Healthwatch – ensuring it will be fit for purpose. • Approving the Integrated Needs Assessment (JSNA) • Approve Communications Plan 2012/13

		• Workshop update
Workshop: • Consider progress of QIPP programmes • Cluster legacy report. • Consider the CCG authorisation proposal. • Public Health Transition Plan and performance / spend on Public Health activities • Review mind map (CH) • Draft HWB strategy considered including priority four financial stability of whole system	10 July 2012	
• **Workshop** • Workshop element withHPEG around INA	18 Sept 2012	• Approve Health and Wellbeing Strategy • Approve CCG commissioning intentions • Learning set update.
	16 Oct 2012	• Healthwatch approval update • Approve adult transformation plan • Communication plan proposals update • Learning set update • Children under five – challenge progress for the Health and Wellbeing Strategy • *Consider the DPH Annual Report and consider implications*
Workshop • • Follow up to report on PH Transition plans • Challenge process for alcohol harm reduction	13 Nov 2012	

• Priority four review		
Workshop • Membership and governance • Council commissioning • Safeguarding update • Self-assessment	11 Dec 2012	
		•
	22 Jan 2013	• CCG Commisioning plans approval • Healthwatch approval • PH transfer to Council approval
	19 Feb 2013	• Formalise governance and membership
	19 Mar 2013	• Healthwatch live • Sign off commissioning contracts
	16 April 2013	**Board becomes fully functioning Health and Well Being Board**

***Notes**:*

1. *(W) Denotes Workshop*
2. *Scheduling is indicative in some cases and will be firmed up as part of the joint agenda planning work*
3. *Work Plan will be updated each month*

Decision Making:	**Quality Assurance**
Public Health Transition CCG Authorisation Process Healthwatch JSNA Health and Well Being Strategy	Is the "system" working effectively together? Is the needs analysis robust? Is the strategy achieving improvements in health and well being outcomes and addressing inequalities. Is everybody doing their bit?