HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 19th February, 2014**

Time: **1.00 p.m.**

A G E N D A

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

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

3. Minutes of Previous Meetings (Pages 1 - 14)

4. Review of Governance Arrangements (Pages 15 - 19)

5. Lifestyle Survey
   - Bev Pepperdine, Performance and Quality, to present

6. Active People Survey (Pages 20 - 26)
   - Rebecca Atchinson to present

7. Recovery from Opiate Dependance (Pages 27 - 29)
   - Anne Charlesworth, Head of Alcohol and Drug Strategy, to present

8. Joint Strategic Needs Assessment Consultation (Pages 30 - 33)
   - Chrissy Wright, Strategic Commissioning Manager, to present

9. Date of Next Meeting
   - Wednesday, 19th February, 2014, commencing at 1.00 p.m.

HEALTH AND WELLBEING BOARD
22nd January, 2014

Present:-

Councillor Ken Wyatt	Cabinet Member, Health and Wellbeing **(in the Chair)**
Chris Bain	RDaSH
Louise Barnett	Rotherham Foundation Trust
Karl Battersby	Strategic Director, Environment and Development Services
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Councillor John Doyle	Cabinet Member, Adult Social Care
Chris Edwards	Chief Commissioning Officer, Rotherham CCG
Jason Harwin	South Yorkshire Police
Julie Kitlowski	Rotherham CCG
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families Services
Dr. David Polkinghorn	Rotherham CCG
Joyce Thacker	Strategic Director, Children, Young People and Families
Janet Wheatley	Voluntary Action Rotherham

Also in attendance:-

Robin Carlisle	Rotherham CCG
Kate Green	Policy Officer, RMBC
Melanie Hall	Healthwatch Rotherham (rep. Naveen Judah)
Pete Hudson	Chief Finance Manager, RMBC
Shona McFarlane	Director of Health and Wellbeing, RMBC
Phil Morris	Rotherham Local Safeguarding board
Joanna Saunders	Department of Public Health (rep. Dr. Radford)
Chrissy Wright	Strategic Commissioning Manager, RMBC

Apologies for absence were submitted by Brian Hughes, Naveen Judah, Martin Kimber and Tracy Holmes.

S64. MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

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

Arising from Minute No. S59 (Flu Vaccination Programme), Joanna Saunders reported that there was no further national information. There was a national meeting convened for the following week from which feedback would be received.

Arising from Minute No. 61 (Joint Strategic Needs Assessment), Chrissy Wright gave clarification of the website address. A report would be submitted in due course on uptake.

Janet Wheatley reported that a consultation event was to take place on 27th January at the Unity Centre for the voluntary and community sector.

S65. COMMUNICATIONS

The following were reported:-

(1) Attendance at a meeting of specialist commissioners by Councillor Dalton.

(2) NHS England's Commissioning intentions had been received and would be circulated.

(3) Rotherham was 1 of 6 areas in the country that had successfully secured funding from the local area CCG and the Police and Crime Commissioner for a pilot initiative for mental health patients in custody. There would be mental health practitioners working alongside the Police and Council employees to identify those with possible mental health issues. An update would be submitted in due course.

(4) "Ramp up the Red" – a national Heart Town initiative – would run though the month of February.

S66. RMBC BUDGET - MEETING THE CHALLENGE

Pete Hudson, Chief Finance Manager, gave the following powerpoint presentation:-

The Financial Challenge
- The scale of financial challenges/risks facing local government was set to continue at least until 2017 (possibly a decade)
- From 2013/14 there had been increased financial risk transferred to local councils through the Local Government Finance and Welfare Reform challenges and restrictions on finances e.g. Council Tax Referenda
- Sustainable medium/long term financial planning was now even more critical

What this meant for Rotherham
- 2010/11 £5M (emergency budget)
- 2011/12 £30M
- 2012/13 £20M
- 2013/14 £20M
- 2014/15 £23M
- 2015/16 £23M (estimate)

Old Budget Principles
- Previous budget principles served the Council well in the past, however, in the context of the Government's Finance and Welfare Reform changes, a new approach was essential to meet future financial challenges:-
  Support Services pared to a minimum

Staff headcount reduced by over 1,000 and management posts reduced by 19%
Lean Council
No longer 'salami slice' services

New Budget Principles
The Council's budget had been developed to:-
- Focus on the things most important to local people
- Help people to help themselves wherever possible
- Provide early support to prevent needs becoming more serious
- Shift scarce resources to areas of greatest need including targeting services and rationing services to a greater extent than at present

What this meant for Rotherham
- Need to create an Investment Fund to focus on delivering Business Growth
- Not doing everything, providing fewer services directly and supporting more people needing help through forging partnerships with other public sector stakeholders, communities, businesses and citizens to help them to do more for themselves
- Using the limited and shrinking resources to tackle the biggest problems for the most needy, focussing on the 11 most deprived areas, accepting some would need to get less or less frequently
- Achieving the best quality, safest, most reliable outcome via the most affordable service delivery method
- Direct provision of service only where the Council was the cheapest/best quality solution to meet the critical needs of its citizens

Rotherham's 2014/15 Budget Challenge
Initial Funding Gap in Medium Term Financial Strategy
£19.1M
- June Spending Round adjustments
  +1.0M
- July Technical Consultation adjustments
  £0.4M

Additional Pressures
- New Government announcements
  +0.7M
  (reduced Housing Benefit grant/reduced Education Support Grant)
- Pensions Triennial Revaluation
  +1.5M
- Undelivered savings target 2013/14
  +0.3M

Revised Funding Gap
£23.0M

Meeting the Challenge: Savings Proposals 2014/15

- Directorate Savings Proposals
  £15.6M
- Central Savings Proposals
  £5.3M
- Revisions to Planning Assumptions
  £2.1M
- Total
  £23.0M

It was noted that the budget proposals were to be considered by Cabinet 5th March, 2014.

Discussion ensued on the presentation with the following comments made:-

- Important for all parties to share their budget proposals to enable collaborative working and achieve maximum impact for the funding available – also to ensure partners did not make budget cuts in the same areas
- Once the full list of all the saving proposals had been compiled Impact Assessments would be worked up to accompany the report to Cabinet to enable Members to be aware of the effect of the savings

Pete was thanked for his presentation.

S67. RMBC COMMISSIONING INTENTIONS FOR ADULTS AND CHILDREN'S SERVICES

Chrissy Wright, Strategic Commissioning Manager, gave the following powerpoint presentation:-

The Big Things – Adult Social Care and CYPS
- Early Intervention and Prevention
- Dependence to Independence
- Joint Commissioning and Integration
- Achieving Financial Efficiencies

Alignment with Health and Wellbeing Strategic Priorities
- Priority 1 – Prevention and Early Intervention
- Priority 2 – Expectations and Aspirations
- Priority 3 – Dependence to Independence
- Priority 4 – Healthy Lifestyles
- Priority 5 – Long Term Conditions
- Priority 6 – Poverty

Adult Social Care – Priority Activities
- Early Intervention and Prevention
  Growth of Connect to Support
- Dependence to Independence

Disinvest in residential care placements and invest in community-based services
- Joint Commissioning and Integration
  Better Care Fund identify current joint work and opportunities for a pooled budget with alignment with RCCG
- Achieving Financial Efficiencies
  Delivering the identified savings in the budget matrix

CYPS Social Care – Priority Activities
- Early Intervention and Prevention
  Partnership with Public Health on breast feeding and smoking cessation in pregnancy
- Dependence to Independence
  Deliver Support and Aspiration SEND reforms
- Joint Commissioning and Integration
  Building transition into the Better Care Fund programme
- Achieving Financial Efficiencies
  Deliver the strategic transformation intentions e.g. reconfiguration of Children's Centres

Discussion ensued on the presentation with the following comments made:-

- Children's Centres had been a flagship for the previous Government, however, the current Government had not provided funding for them. Due to the critical financial challenges faced by the Council, there was only funding for 1 more year
- Given the support for the 11 most deprived areas, many of which had Children's Centres and were a model of good practice, it was felt that closing them would be disastrous
- Just working in the 11 most deprived areas would not achieve the aims/aspirations across the board

Chrissy was thanked for her presentation.

S68. ROTHERHAM CCG PLAN 2014/2015

Robin Carlisle, Deputy Chief Officer, Rotherham CCG, presented the CCG's 5 year commissioning plan for endorsement prior to submission to NHS England on 14th February, 2014.

The plan had been developed in discussion with member GP practices, other Rotherham commissioners (RMBC and NHS England) and providers of health services in Rotherham (including TRFT and RDASH) and circulated to stakeholders. Comments received and the requirements of the planning guidance "Everyone Counts" had been incorporated into the draft.

Comments by Board members would be welcomed particularly on the following:-

- 5 year vision
- Plan on a page
- QIPP (Quality, Innovation, Productivity and Prevention) both Provider and System Wide

There was still work required by the February deadline with regard to financial implications, levels of ambition for outcome measures and Rotherham's approach to the Better Care Fund.

Discussion ensued on the document with the following comments made:-

- Important for all Service providers to understand/know the detail of what the implications were for their particular services and the chance to be involved
- Need to ensure all the plans being submitted to the various bodies all aligned and did not forget the transformational time required to make the plans happen

Resolved:- (1) That any comments on the plan be submitted to the CCG as a matter of urgency to enable the plan to be submitted to NHS England by the 14th February, 2014, deadline.

(2) That the Council and NHS England, as co-commissioners, confirm that the plan was complementary with their own commissioning plans.

(3) That TRFT and RDASH, as substantial providers of health services within Rotherham, confirm that the financial, activity and strategic vision in the plan triangulated with their 5 year organisational plans.

S69. BETTER CARE FUND

Tom Cray, Strategic Director Neighbourhoods and Adult Services, gave the following powerpoint presentation;-

Task Group Terms of Reference
- To work with members of the Health and Wellbeing Board to understand and interpret the requirements of the Better Care Fund
- To develop a local jointly agreed vision for integration
- To develop a plan to be signed off by the Health and Wellbeing Board and submitted to NHS England by 14th February
- To do any necessary further work to ensure the plan was adopted and being monitored by April, 2014

We Are Here:-
- The Health and Wellbeing Board has developed good relationships across the new health and care landscape
- Already agreed the joint priorities through the Health and Wellbeing Strategy informed by the JSNA

- The Health and Wellbeing Board have made a commitment to integration through the local Strategy
- Clear links to what needs to be delivered as part of the Better Care Fund
- Better Care Fund Plan would help deliver the Health and Wellbeing Strategy

Definition of Integration

- Adopt the nationally recognised definition of Integration:
  "I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me" ('National Voices')

Vision

- Overarching vision of Health and Wellbeing Board: To improve health and reduce health inequalities across the whole of Rotherham
- The Better Care Fund would contribute to 4 of the strategic outcomes of the Health and Wellbeing Strategy:
  - Prevention and Early Intervention – Rotherham people will get help early to stay health and increase their independence
  - Expectations and Aspirations – all Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community
  - Dependence to Independence – Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances
  - Long-term Conditions – Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life

Measuring Success

- Develop 'I statements' as a common narrative to help us
  - Keep the voice of Rotherham people at the heart
  - Understand what integration feels like for service users/patients/carers
- Based on what people tell us – way of 'making it real'
- Influencing change through people's experiences
- Adopt this as a principle with aim to implement at a later date (drawing on lessons learned from national consultation)

Criteria for Selection of One Local Measure
Must have:-

- A clear, demonstrable link with the Joint Health and Wellbeing Strategy
- Data which was robust and reliable with no major data quality issues (e.g. not subject to small numbers – see "statistical significance" in next section)
- An established, reliable (ideally published) source
- Timely data available, in line with requirements for pay for

performance – this meant that baseline data must be available in 2013-14 and that the data must be collected more frequently than annually
- A numerator and a meaningful denominator available to allow the metric to be produced as a meaningful proportion or a rate
- A challenging locally set plan for achievement
- A metric which created the right incentives

Local Measure (choose 1 from 9 or select own)
- NHS Outcome Framework
  - Proportion of people feeling supported to manage their (long term) condition
  - Diagnosis rate for people with Dementia
  - Proportion of patients with fragility fractures recovering to their previous levels of mobility/walking ability at 120 days
- Adult Social Care Outcomes Framework
  - Social care related quality of life
  - Carer reported quality of life
  - Proportion of adults in contact with secondary, mental health services living independently, with or without support
- Public Health Outcomes Framework
  - Proportion of adult social care users who have as much social contacts as they would like
  - Proportion of adults classified as inactive
  - Injuries due to falls in people aged 65 or over (Persons)

Does the Local Measure meet the Better Care Fund Criteria?

Local Measure – suggested option
- NHS Outcome Framework
  - Possible new local measure
    Health Related Quality of Life for people with long term conditions, Indicator E.A.2 from the "Everyone Counts"
  - Proportion of people feeling supported to manage their (long term) condition

Next Steps
- To have a clear commitment from all partners to provide data and information as and when required
- To agree the local measure for pay-for-performance element
- Joint offer working group (LA/CCG/NHSE) to ensure we are meeting all national conditions
- Consultation with user/patients/providers
- Next Task Group meeting 31st January to look at:-
  - What is currently commissioned that does not improve Better Care Fund measures
  - What needs to be commissioned to meet the Better Care Fund measures and estimated costs
  - First draft of Better Care Fund Plan

Discussion ensued with the following points raised/clarified:-

- The task group comprised of Martin Kimber, Chris Edwards, Julie Kitlowski, Councillor John Doyle, John Radford and Tom Cray
- It was not new money but the funding currently allocated to the Local Authority and the CCG for Services provided to patients and the citizens of Rotherham
- A regional event had shown that Rotherham had made similar levels of progress as others with regard to the submission
- Challenge was to ascertain which Services met the outcomes and then how to prioritise to meet the Services currently commissioned

Tom was thanked for his presentation.

S70. JOINT PROTOCOL BETWEEN HEALTH AND WELLBEING BOARD AND CHILDREN'S SAFEGUARDING BOARD

Phil Morris, Rotherham Local Safeguarding Children Board (RLSB), submitted a proposed Protocol which outlined and confirmed the functions and responsibilities of Rotherham's key strategic partnerships i.e. the RLSB, the Children, Young People and Families Partnership (CYPFSP) and the Health and Wellbeing Board. It also set out the relationship between them, providing clarity and ensuring that the needs of children and young people in the Borough were identified and addressed at a strategic level:-

- The CYPFSP will formally report to the HWBB on the progress update against the relevant priorities (in line with the Health and Wellbeing Strategy) of both the CYPFSP and the key milestones and targets within the Children and Young People's Commissioning Plan

- The RLSCB will submit its Annual Report of the Health and Wellbeing Board

- The Health and Wellbeing Board will ensure that:
  The Joint Strategic Needs Assessment takes account of key areas for vulnerable children identified via the RLSCB Annual Report and the CYPFSP key priorities. The Director of Public Health had specific responsibility for this

- The Health and Wellbeing Board may also request that the CYPFSP and/or the RLSCB to consider issues for development, action or scrutiny

Resolved:- That the Protocol be approved and be put into operation with immediate effect.

S71. DATE OF NEXT MEETING

Resolved:- That a Special meeting of the Health and Wellbeing Board be held on Tuesday, 11th February, 2014, commencing at 9.30 a.m. in the Rotherham Town Hall.

HEALTH AND WELLBEING BOARD
11th February, 2014

Present:-

Councillor Ken Wyatt	Cabinet Member, Health and Wellbeing **(in the Chair)**
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Councillor John Doyle	Cabinet Member, Adult Social Care
Chris Edwards	Chief Commissioning Officer, Rotherham CCG
Jason Harwin	South Yorkshire Police
Brian Hughes	NHS England
Naveen Judah	Healthwatch Rotherham
Martin Kimber	Chief Executive, RMBC
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families Services
Dr. John Radford	Director of Public Health
Janet Wheatley	Voluntary Action Rotherham

Also in attendance:-

Helen Dabbs	RDaSH
Kate Green	Policy Officer, RMBC
Shona McFarlane	Director of Health and Wellbeing
Clair Pyper	Director of Safeguarding
Chrissy Wright	Strategic Commissioning Manager, RMBC
Keely Firth	CCG

Apologies for absence were received from Chris Bain, Louise Barnett, Karl Battersby, Tracy Holmes, Julie Kitlowski, Dr. David Polkinghorn and Joyce Thacker.

S72. BETTER CARE FUND

Kate Green, Policy Officer, presented Rotherham's Better Care Fund plan for approval by the Board, prior to submission to NHS England by 14th February. The documents to be submitted included:-

Planning Template Part 1 –
Planning Template Part 2
Appendix 1 - Summary of consultation
Appendix 2 - Rotherham Better Care fund Action Plan
Appendix 3 – Health and Wellbeing Strategy
Appendix 4 – Joint Strategic Needs Assessment
Appendix 5 – Overarching Information Sharing Protocol

Kate drew attention to the following:-

- A huge amount of work had been put in by officers from all agencies

- The work had been developed by a multi-agency officer group overseen by the Task Group which provided the strategic overview of the work

- Negotiations had taken place by both the Local Authority and CCG in order to produce a plan and action plan that both partners were fully signed up and committed to

- A range of consultation activity and engagement had taken place as well as collating information from previous consultation. This had included:-
  - Commissioning of Healthwatch Rotherham to conduct consultation with the local community on the envisaged transformation of services. The survey had been completed by 42 people between 31st December, 2014 and 14th January, 2014
  - 12 Council Customer Inspectors were asked a series of questions focussed around the proposed vision including the 4 Health and Wellbeing priorities
  - Emails sent to 305 social care providers in Rotherham inviting them to take part in a survey
  - The results from the Health and Wellbeing Strategy consultation that took place between July-August, 2012 to help shape the priorities
  - Patient Participation Network
  - Mystery shopper volunteers looking at the prevision vision, priorities and seeking their advice on Health and Wellbeing activities
  - Discussions at the Adult Partnership Board

- The findings from the consultation activity were used to develop a set of "I" statements , which demonstrate outcomes that local people want from integrated working:
  - I am in control of my care
  - I only have to tell my story once
  - I feel part of my community which helps me to stay healthy and independent
  - I am listened to and supported at an early stage to avoid a crisis
  - I am able to access information, advice and support early that helps me to make choices about my health and wellbeing
  - I feel safe and am able to live independently where I choose

- The vision for the plan had been based on the local Health and Wellbeing Strategy, A lot of work had gone into developing the local strategy which was being used to influence the plans of a range of partner organisations. The Better Care Fund, if used effectively, should contribute significantly to delivering against the Strategy's outcomes:
  - Prevention and Early Intervention
  - Expectations and Aspirations
  - Dependence to Independence
  - Long term Conditions

- The 12 schemes in the action plan (appendix 2) had been divided under the above 4 themes and the plan demonstrated which BCF outcome measures the schemes would help achieve

- Much more work was now required to add detail to the plan before final submission on 4th April, but the first draft provided the foundation to work from

Finance and Measures (Template 2)

- The funding information mapped directly to the action plan

- For each Metric other than patient experience, it detailed the expected outcomes and benefits of the scheme and how they would be measured

- There were 5 nationally prescribed metrics and one locally agreed measure:-
  - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population
  - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
  - Delayed transfer of care from hospital per 100,000 population (average per month)
  - Avoidable emergency admissions
  - Patient/service user experience
  - Emergency re-admissions (local measure)

- Targets had been set based on the national guidance provided. Further work would be required on them before the final submission in April

Next Steps

- The documents would be submitted to NHS England in accordance with the 14th February deadline with feedback expected by the end of February

- The officer group would continue to meet on a regular basis to further develop the plan and look specifically at the schemes, developing an action and delivery plan for each, identification of leads and timescales.

- The Task Group would also meet to give a strategic overview of the work and the financial plan which had to be submitted by 4th April

Brian Hughes, NHS England, stated that the process followed by Rotherham was what would have been expected. The assessment process was currently in the process of being finalised and once complete, he would ensure that Rotherham received it.

Every bid would have an initial assessment and then subject to a thorough assessment. Brian stated that he would give feedback by 28th February on Rotherham's submission. The bid may not have gone through the national or regional peer process by that date but it would have been subject to the joint assessment by ADAS and NHS England.

Discussion ensued on the presentation with the following issues highlighted:-

- Careful consideration should be given to the emergency readmission measure. It was noted that nationally a lot of Services were taken out of the metric. This has been highlighted on the Risk Register
- Monitoring of the action plan

The Chairman emphasised that it was not new money but money that was already in the system.

He thanked Healthwatch Rotherham, the mystery shoppers and the Patient Participation Group for their assistance in the consultation.

Resolved:- (1) That the Better Care Fund application and supporting documentation be approved for submission to NHS England in accordance with their 14th February deadline.

(2) That Councillor Wyatt, Martin Kimber and Chris Edwards sign off the submission.

(3) That an All Members Seminar be convened to ensure Members were fully informed with regard to the Better Care Fund.

(4) That consideration be given to monitoring of the action plan be given at the next Health and Wellbeing Board.

(5) That a press release be issued on Rotherham's submission.

S73. DATE OF NEXT MEETING

Resolved:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 19th February, 2014, commencing at 1.00 p.m. in the Rotherham Town Hall.

ROTHERHAM BOROUGH COUNCIL - REPORT TO HEALTH AND WELLBING BOARD

1	**Meeting:**	**Health and Wellbeing Board**
2	**Date:**	**19 February 2014**
3	**Title:**	**Governance Arrangements**
4	**Directorate:**	**Resources**

5. Summary

The Health and Wellbeing Board has been in operation as a statutory board since April 2013 and in that time has matured well, developing strong working relationships between partners. There has been real enthusiasm and a commitment to improving the health of the Rotherham community and improving integrated working across the health and social care sectors to support this.

The health and wellbeing landscape has changed considerably and local boards are increasingly being directed by government to provide leadership and direction on a number of key policy agendas. To ensure the Rotherham board remains fit for purpose and able to deliver what is required; it is felt timely for the board to review its governance arrangements.

6. Recommendations

That the Health and Wellbeing Board:

- **Notes the previous agreement to establish an Executive Group and agrees the membership**

- **Considers the recommendations set out in 7.3 and agrees appropriate changes to the terms of reference**

7. Proposals and details

The Health and Wellbeing Board has matured well since taking on statutory responsibilities in April 2013. Strong working relationships have been built and there is a joint commitment across all health and wellbeing partners to improve health and reduce health inequalities, working towards better outcomes for all local people.

It is important that this collaborative approach continues and the board remains focused on the joint priorities as set out in the Health and Wellbeing Strategy. However, in future there is a need for a more business focused approach as the board is increasingly being directed by government to provide leadership and direction on a number of policy agendas, for example the Better Care Fund.

With this in mind, it is felt timely for the board to review its governance arrangements to ensure it remains fit for purpose.

7.1 Health and wellbeing executive

At the meeting of the Health and Wellbeing Board on 11 February 2014, the first draft of the local Better Care Fund (BCF) plan was approved.

As part of this there was agreement that in order to deliver against the requirements of the BCF, clear governance arrangements need to be in place, which does not add to the burden of any agencies or partnership mechanisms.

The local vision for the BCF is fully aligned with the delivery of the Health and Wellbeing Strategy, as a result of this it is agreed that existing mechanisms should be fit for purpose, with some adaptation to support delivery of the BCF actions.

It was therefore agreed by the board to establish an executive group. This group will report directly to and provide a support mechanism for the Health and Wellbeing Board, as well as holding the strategic overview of the health and wellbeing agenda, including delivery of the Health and Well Being Strategy workstreams and the Better Care Fund plan.

The board is asked to consider and agree the appropriate membership of the executive group.

7.2 Feedback from Board members

During September 2013, board members undertook a self assessment, looking at a number of key themes in relation to governance and operation of the board. In reviewing the governance arrangements, it is important to draw on the outcomes from this and the specific issues that were raised.

Members generally felt positive about the board's role, relationships and effective collaborative working that had taken place since being established. There was a clear understanding that the board's unique contribution was to provide a whole system view on issues and promote integration between health and social care. However, a number of key areas are worth considering:

- Board members felt that although the governance arrangements were clear to them personally, outside of the board this was not always the case, and there was often misinterpretation about whether certain items should be brought to the board or not.

- The Health and Wellbeing Strategy was seen as positive, and the sharing of the priority area plans had been useful in embedding the principles. However, members were less aware of significant commissioning decisions having been made on this basis, and felt agendas needed to be much more focused on these priority areas.

- There was concern about the agenda items being presented to the board, some members felt the right issues were being taken but there was a disappointing response to them, or there was insufficient time given to consideration of issues across too wide an agenda, others felt that too many items were being included for information and single issue reports that were not strategic enough or did not fit with the board's priorities.

- There was a view that the frequency and format of meetings needed to be reviewed, to enable a more focused agenda and opportunities for discussion and challenge.

- The majority of board members agreed that providers should be a part of the board. It was felt that providers were able to make significant contributions to the work of the board and were often key to the delivery of the board's Health and Wellbeing Strategy. However, some felt providers were not always active participants and there was a missed opportunity to shape agendas. There was also a general view that providers should remain non-voting members.

7.3 Recommendations

Taking into consideration the new governance arrangements in relation to the executive group and delivering the Better Care Fund Plan, and the responses from the self-assessment, a number of recommendations are being proposed in relation to the operation of the board.

Format of meetings

To enable the board to develop in line with the emerging national policy agendas, allowing for real discussion and challenge between commissioners, and giving providers a forum to influence and contribute to key agendas, it is recommended that the format of board meetings is reviewed.

Although the feedback from members suggested a reduction in meeting frequency, it is proposed that meetings remain monthly for the time being, due to the current volume of work. However, it is recommended that the format changes so that every other meeting is for core members only (commissioners), to cover key business items such as commissioning plans, financial information and any major service reconfigurations, the Better Care Fund plan and performance management. The remaining meetings will be more reflective and in two parts, the first for any necessary core business and the second with provider and VCS involvement, giving an opportunity to contribute to and help shape agendas, specifically around the local strategy priorities. This new format will allow for more focused agendas, which

address the strategic priorities of the board, whilst allowing for real discussion and challenge on specific issues.

Example schedule is shown below:

- March meeting – business meeting (core members only)
- April meeting – reflective meeting in 2 part (providers/VCS invited to second part)
- May meeting - business meeting (core members only)

The Executive Group will hold the strategic overview for the health and wellbeing strategy and Better Care Fund, reporting directly to the board. The health and wellbeing steering group and other relevant groups (delivering BCF actions) will feed into the executive in relation to delivery and performance management.

Board membership

It is recommended that to allow for quality of debate, the Board membership is slimmed down, to only those core members that provide value to the board's key business through decision making and influence. Currently there is some duplication in those who attend the board as participating observers, and there may be more value in some members attending only as and when required, due to the nature of the business.

It is proposed that the membership of the board is reviewed as suggested below:

Core members:
Cabinet Member for Health and Wellbeing (Chair)
Cabinet Member with responsibility for Adult Services
Cabinet Member with responsibility for Children's Services
Director of Public Health
Chief Executive RMBC
Strategic Director of Neighbourhoods and Adult Services
Strategic Director of Children and Young People's Services
Chief Operating Officer CCG
Chair of Clinical Commissioning Group (CCG)
NHS England representative
Chair of Rotherham HealthWatch
Chief Superintendant, South Yorkshire Police

Provider/VCS involvement (for reflective meetings):
Chief Executive RDaSH
Chief Executive Rotherham Foundation Trust
Chief Executive Voluntary Action Rotherham

There are many other professionals who contribute to the health and wellbeing agenda and priorities of the board, many of whom will be part of the delivery structure for the health and wellbeing strategy and better care fund plan, who will report to the executive. Board members are invited to comment if they feel there is any significant value in extending the core list of members.

There is also a need for stronger engagement with the public and the board are asked to consider how they wish to develop this; either through encouraging public attendance at meetings, or through more focused forums on specific topics.

8. Finance

There are no financial implications associated with this report.

9. Risks and Uncertainties

The board continues in its current format and is unable to move to a more business focused approach, which allows for discussion and challenge by commissioners and the opportunity for providers to influence key policy agendas.

Membership of the board is not reviewed to create a more focused board, which allows for proper debate and challenge of the core business priorities.

10. Contacts

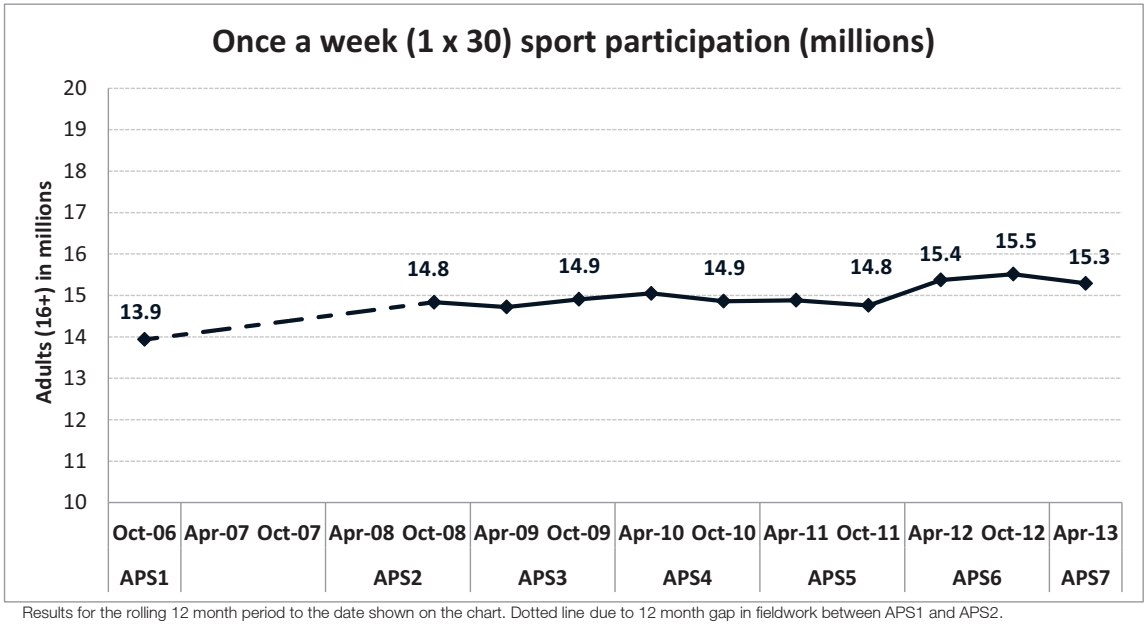
Kate Green
Policy Officer
Kate.green@rotherham.gov.uk

Once a week participation in sport (1 x 30 minutes moderate intensity)

Once a week sport participation

Sport England's main measure of sport is based on the percentage of adults (aged 16+) playing for at least 30 minutes of sport at moderate intensity at least once a week, measured by the Active People Survey (APS). The latest APS results cover the 12 month period from April 2012 to April 2013 (APS7 Q2).

- There has been steady acceleration in people playing sport during 2012 (an increase of 750,000 from October 2011 to October 2012) and the bulk of this growth has been retained (although 220,000 below October 2012, the latest result remains 530,000 above October 2011).
- During the period April 2012 to April 2013, 15.3 million people (35.2%) played sport at least once a week. The latest result represents a 1.4 million increase on 2005/06 (APS1)[i].
- Compared with October 2011 (APS5), the period just before the Olympic year and the start of the new strategy for sport, there are now over 530,000 more people playing sport regularly.



Results for the rolling 12 month period to the date shown on the chart. Dotted line due to 12 month gap in fieldwork between APS1 and APS2.

Seasonality of sports participation

Overall sports participation has a natural seasonal pattern with more people playing during the summer and fewer playing during the winter. Monthly analysis of APS 1x30 sports reveals[ii]:

- Higher than average levels of participation in the late summer period of 2012, immediately after the Olympic Games.
- Resilience in participation despite poor weather conditions, with people continuing to play sport throughout a particularly cold and wet year. Only faced with the exceptionally wet spring of 2012 and cold March of 2013, did participation fall below average, but retaining most of the increase achieved.

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i Difference is statistically significant (i.e. we can say with 95% confidence that there has been a real change)
ii Survey interviews take place throughout the year and respondents are asked about their sports participation in the previous 28 days. As such, there is a slight 'lag' between the sports participation and the interview date.

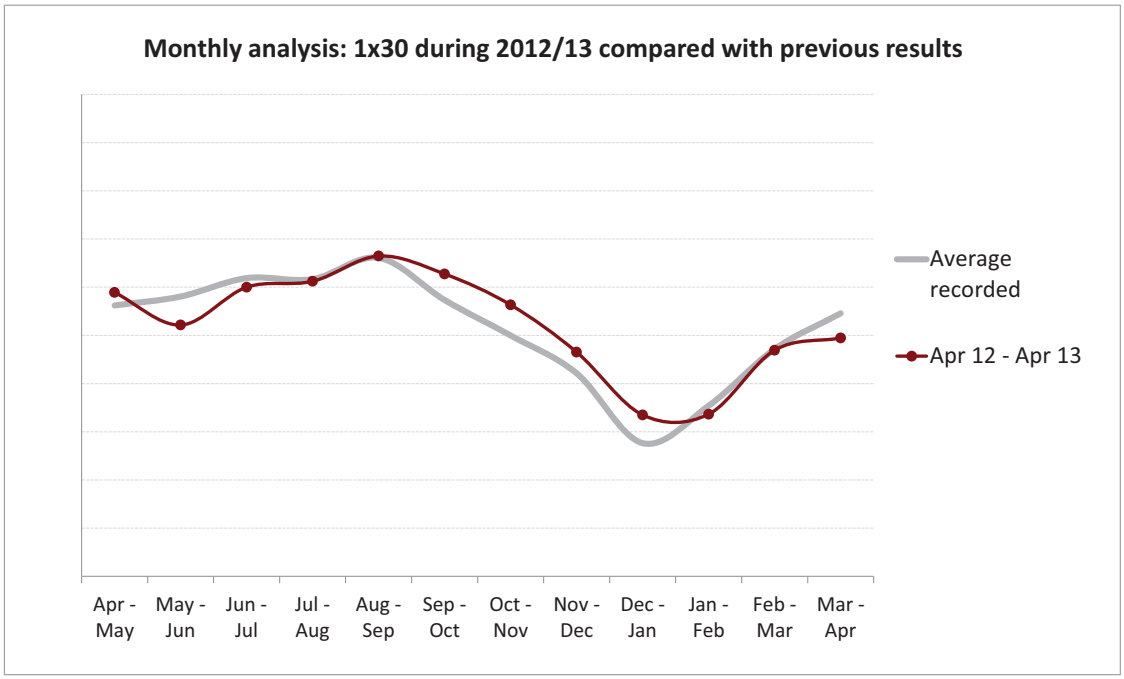
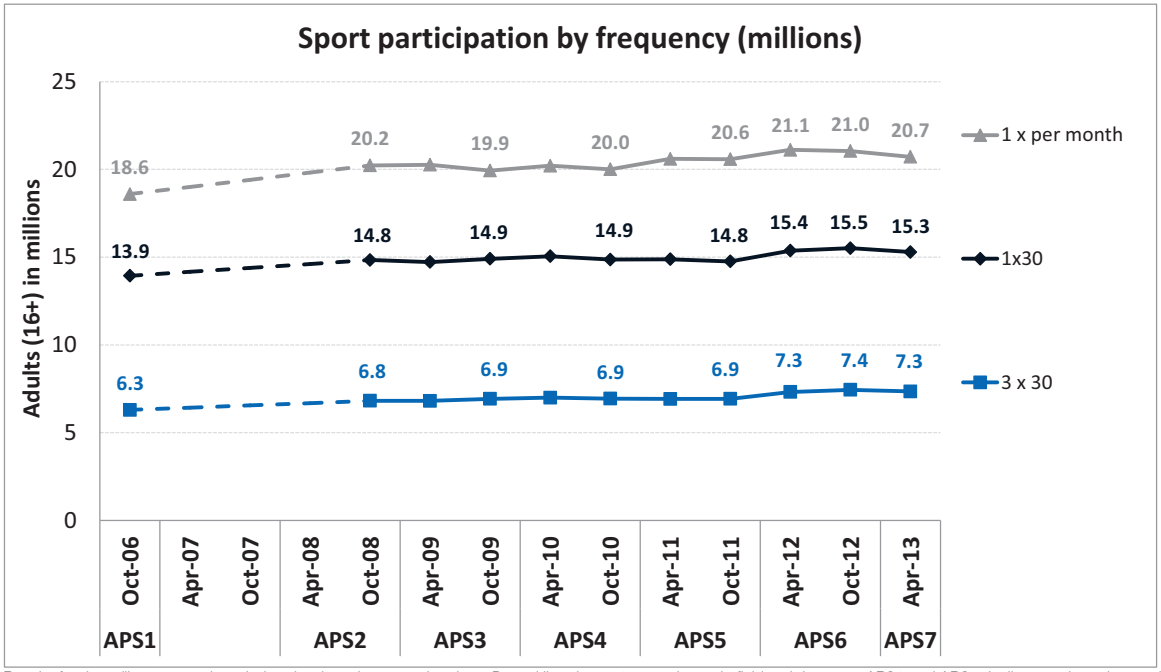


Chart shows monthly participation rates for April 2012-April 2013 (red line) compared with the average recorded by month between April 2005 and April 2012 (grey line)

Other frequencies of participation

During the period from April 2012 – April 2013:

- 20.7 million adults played sport at least once a month. This result is a 2,123,600 increase on APS1[i].
- 7.3 million played sport at least three times a week. This result is a 1,055,000 increase on APS1[i].



Results for the rolling 12 month period to the date shown on the chart. Dotted line due to 12 month gap in fieldwork between APS1 and APS2. Indicators show the number of adults playing sport at least this frequently. 1 x 30 and 3 x 30 measures are for at least 30 minutes of sport at moderate intensity. Once a month indicator is any duration and any intensity.

Once a week sport: key demographics

The following shows the APS7Q2 (April 2012 to April 2013) results for key demographic groups, highlighting changes from APS1 (April 2005 – April 2006).

Gender

One session a week (at least 4 sessions of at least moderate intensity for at least 30 minutes in the previous 28 days)	APS1 (Oct 2005-Oct 2006)		APS5 (Oct 2010 –Oct 2011)		APS7Q2 (Apr 2012-Apr 2013)		
	%	Number	%	Number	%	Number	Statistically significant change from APS 1
Male	38.9%	7,691,400	40.8%	8,463,400	40.1%	8,507,400	Increase
Female	29.8%	6,248,000	29.0%	6,295,500	30.5%	6,784,600	Increase

Source: Sport England's Active People Survey

During the period April 2012 – April 2013:

- 8.507 million men (40.1%) played sport once a week. This result is a 816,000 increase on APS1[i].
- 6.785 million women (30.5%) played sport once a week. This result is a 536,600 increase on APS1[i].

Age Groups

During the period April 2012 – April 2013:

- 3.856 million 16-25 year olds (54.7%) played sport once a week. This age group had been flat lining (with rates of 54% in 2011 and 2012), but is now showing signs of growth.
- 11.436 million adults aged 26 years or older (31.4%) played sport once a week. This result is a 1,147,500 increase on APS1[i]. However this age group recorded a decline of over 280,000 compared with the October 2012 result and accounts for the reduction recorded this period.

Ethnicity

During the period April 2012 – April 2013:

- 12.634 million people describing themselves as White – British (34.9%) played sport once a week. This result is a 812,300 increase on APS1[i].
- 2.658 million people from black and minority ethnic groups (36.7%) played sport once a week. This result is a 531,300 increase on APS1[i].

Disability

During the period April 2012 – April 2013, 1.670 million people with a long term limiting illness or disability (18.2%) played sport once a week. This result is a 353,100 increase on APS1[i].

Socio-economic groups

- The table below shows that participation among adults from socio-economic groups NS-SEC 1-2 and NS-SEC 3 has increased from APS1 to APS7Q2[i]. During the period April 2012-April 2013 there were also more people from NS-SEC 4 and NS-SEC 5-8 playing sport once a week but these changes were not statistically significant.

One session a week (at least 4 sessions of at least moderate intensity for at least 30 minutes in the previous 28 days)	APS1 (Oct 2005-Oct 2006)		APS5 (Oct 2010 –Oct 2011		APS7Q2 (Apr 2012-Apr 2013)		
	%	Number	%	Number	%	Number	Statistically significant change from APS 1
NS SEC1-2 (managerial/professional)	40.1%	4,462,100	41.4%	4,812,000	41.3%	4,903,800	Increase
NS SEC3 (intermediate)	32.3%	1,244,000	32.4%	1,303,700	34.4%	1,415,900	Increase
NS SEC4 (small employers/own account workers)	32.4%	920,200	32.3%	958,400	32.7%	992,400	No change
NS SEC5-8 (lower supervisory/technical /routine/semi-routine/never worked/long term unemployed)	26.9%	3,450,200	26.6%	3,564,800	26.6%	3,639,900	No change

Source: Sport England's Active People Survey

Once a week sports participation: by region

One session a week (at least 4 sessions of at least moderate intensity for at least 30 minutes in the previous 28 days)	APS1 (Oct 2005-Oct 2006)		APS5 (Oct 2010 –Oct 2011		APS7Q2 (Apr 2012-Apr 2013)		
	%	Number	%	Number	%	Number	Statistically significant change from APS 1
NORTH EAST	32.7%	682,200	33.3%	700,300	35.5%	761,900	Increase
NORTH WEST	33.7%	1,859,100	35.2%	1,975,200	35.5%	2,044,000	Increase
YORKSHIRE	33.1%	1,350,200	34.6%	1,498,000	35.2%	1,521,700	Increase
EAST MIDLANDS	33.6%	1,173,400	33.5%	1,232,200	34.4%	1,283,400	No change
WEST MIDLANDS	31.9%	1,373,600	32.7%	1,436,700	32.1%	1,458,900	No change
EAST	34.8%	1,556,100	34.7%	1,647,800	35.4%	1,698,900	No change
LONDON	35.0%	2,126,000	35.4%	2,232,500	36.0%	2,403,500	Increase
SOUTH EAST	36.7%	2,416,500	35.7%	2,474,300	36.2%	2,558,200	No change
SOUTH WEST	33.8%	1,402,300	35.7%	1,561,900	35.4%	1,561,600	Increase

Source: Sport England's Active People Survey

Between APS1 (October 2005 – October 2006) and APS7Q2 (April 2012 – April 2013) there has been a statistically significant increase in once a week sports participation in five of the nine regions (North East, North West, Yorkshire, London, South West). In the remaining four regions (East Midlands, West Midlands, East, South East) there were more people playing in sport once a week than in 2005/06[iii].

iii These differences were not statistically significant and for one region (South East) the increased number of people participating in sport is due to population growth.

Notes

To find out more about the sports participation measure, see the briefing note on Sport England's website.

The latest APS results are based on the 12 month period April 2012 to April 2013 (APS7Q2). 161,000 adults in England (age 16 and over) were interviewed by telephone.

Please note that this report highlights whether changes from APS1 (October 2005-October 2006) to APS7Q2 (April 2012-April 2013) are statistically significant. A statistically significant increase is indicated by 'increase', and a statistically significant decrease is indicated by 'decrease'. This means that we are 95% certain that there has been a real change (increase or decrease) in the participation rate. Where there has been no statistically significant change, this is indicated by 'no change'.

For more information on measuring statistically significant change, see the briefing note on Sport England's website:

http://www.sportengland.org/research/active_people_survey/active_people_survey_2/idoc.ashx?docid=c2da16fe-f44b-4715-a798-5cd4f62fc422&version=2

ONS (Office for National Statistics) 2005 (APS1), 2010 (APS5) and 2012 (APS7Q2) population data has been used in this report.

NS-SEC is the National Statistics Socio-economic Classification. It is derived by combining information on occupation and employment status. NS-SEC:

1. Higher managerial and professional occupations;
2. Lower managerial and professional occupations;
3. Intermediate occupations;
4. Small employers and own account workers;
5. Lower supervisory and technical occupations;
6. Semi-routine occupations;
7. Routine occupations;
8. Never worked and long-term unemployed;
9. Full time students and Occupations not stated or inadequately described.

Sport and active recreation 3x30 was NI8

Local Authority	APS 1 Oct 05-Oct 06 % Base	Survey number	APS 2/3 Oct 07-Oct 09 %	APS 4/5 Oct 09-Oct 10 %	APS 5/6 Oct 10-Oct 12 %	APS6/7 (Oct 11 - Oct 13) %	Survey number	% change	Rank of 325 LAs	Range +/-	Significant change
Barnsley	**19.1%**	997	**20.7%**	**22.4%**	**20.3%**	**22.6%**	992	**3.5%**	252	3.6	No change
Bradford	**21.4%**	1,000	**20.6%**	**22.7%**	**20.6%**	**22.8%**	993	**1.4%**	245	3.6	No change
Calderdale	**22.1%**	1,006	**23.7%**	**24.0%**	**22.1%**	**23.1%**	988	**1.0%**	239	3.7	No change
Doncaster	**17.1%**	1,011	**18.7%**	**20.0%**	**20.1%**	**24.2%**	991	**7.1%**	191	3.5	**Increase**
East Riding of Yorkshir	**23.4%**	1,003	**21.3%**	**23.5%**	**27.1%**	**28.9%**	994	**5.5%**	30	3.9	**Increase**
Hull	**18.1%**	999	**19.5%**	**17.6%**	**19.8%**	**24.0%**	975	**5.9%**	195	3.6	**Increase**
Kirklees	**19.0%**	1,013	**25.1%**	**23.9%**	**23.8%**	**23.5%**	993	**4.5%**	216	3.6	**Increase**
Leeds	**20.6%**	1,019	**26.5%**	**24.6%**	**29.3%**	**31.2%**	999	**10.6%**	7	3.8	**Increase**
North East Lincolnshir	**18.9%**	994	**19.9%**	**21.3%**	**21.7%**	**24.3%**	981	**5.4%**	181	3.6	**Increase**
North Lincolnshire UA	**19.4%**	995	**21.4%**	**20.2%**	**20.3%**	**23.4%**	977	**4.0%**	221	3.6	**Increase**
Rotherham	**18.9%**	1,051	**19.4%**	**21.1%**	**20.0%**	**23.3%**	964	**4.4%**	224	3.6	**Increase**
Sheffield	**18.8%**	1,013	**20.1%**	**22.8%**	**21.5%**	**24.3%**	1,011	**5.5%**	187	3.6	**Increase**
Wakefield	**18.0%**	1,027	**23.2%**	**20.8%**	**21.0%**	**22.3%**	999	**4.3%**	259	3.5	**Increase**
York UA	**24.9%**	994	**22.9%**	**24.7%**	**27.5%**	**27.1%**	1,019	**2.2%**	73	3.8	No change
Craven	**26.0%**	996	**23.8%**	**26.0%**	**28.0%**	**31.1%**	991	**5.1%**	8	4.0	**Increase**
Hambleton	**25.9%**	996	**25.4%**	**27.7%**	**25.8%**	**25.7%**	994	**-0.2%**	126	3.8	No change
Harrogate	**24.2%**	1,009	**27.1%**	**26.5%**	**24.6%**	**29.4%**	994	**5.2%**	22	3.9	**Increase**
Richmondshire	**24.7%**	1,011	**27.0%**	**26.7%**	**27.7%**	**31.8%**	986	**7.1%**	6	3.9	**Increase**
Ryedale	**23.2%**	1,010	**20.0%**	**22.6%**	**22.3%**	**23.6%**	984	**0.4%**	208	3.7	No change
Scarborough	**19.3%**	1,017	**20.8%**	**20.2%**	**16.4%**	**20.6%**	977	**1.3%**	302	3.5	No change
Selby	**20.0%**	1,013	**25.7%**	**21.4%**	**23.2%**	**28.6%**	984	**8.6%**	38	3.7	**Increase**

	APS1		APS2	APS3	APS4	APS5	APS6	APS7 (Oct 12 - Oct 13)			
	%	base	%	%	%	%	%	%	Rank of 49 CSPs	change APS1	Significance
North Yks CC	**23.1%**	7,052	23.7%	25.3%	25.3%	23.6%	23.3%	**30.3%**		**7.2%**	**Increase**
Yorkshire	**20.4%**	21,174	22.7%	22.2%	22.5%	22.9%	23.6%	**27.0%**		**6.6%**	**Increase**
National	**21.3%**	361,075	21.6%	21.6%	21.9%	22.1%	22.9%	**26.0%**		**4.7%**	**Increase**

Sport - 1 x 30

Local Authority	APS 1 Oct 07-Oct 08 %	Base	Survey number	APS 2 Oct 07-Oct 08 %	Base	APS 3 Oct 08- Oct 09 %	APS4 Oct 09-Oct 10 %	APS 5 Oct 10-Oct 11 %	APS 6 Oct 11-Oct 12 %	APS 7 (Oct 12 - Oct 13 %	Base	% change APS2	Rank of 326 LAs	Significant change
Barnsley	31.2%	1,003		31.5%		32.4%	35.0%	28.9%	33.8%	29.9%	500	-1.3%	303	No change
Bradford	33.5%	1,007		34.4%		31.2%	35.3%	35.2%	35.3%	33.2%	512	-0.3%	227	No change
Calderdale	34.5%	1,014		36.8%		36.9%	36.2%	33.2%	37.3%	37.8%	502	3.3%	97	No change
Doncaster	28.3%	1,016		29.1%		30.7%	28.4%	28.1%	32.9%	38.8%	500	10.5%	77	Increase
East Riding of Yorkshir	35.2%	1,009		35.1%		31.5%	34.0%	31.4%	38.3%	37.6%	509	2.4%	103	No change
Kingston upon Hull, Cit	31.3%	1,007		32.5%		32.0%	31.1%	33.3%	34.1%	34.2%	503	2.9%	200	No change
Kirklees	32.4%	1,016		31.8%		33.5%	37.0%	35.2%	40.2%	31.8%	500	-0.6%	269	No change
Leeds	36.4%	1,029		43.7%		38.0%	38.9%	38.6%	37.3%	39.9%	501	3.5%	58	No change
North East Lincolnshire	29.9%	1,003		33.2%		32.4%	31.9%	36.0%	31.8%	33.8%	502	3.9%	218	No change
North Lincolnshire UA	33.0%	1,006		34.7%		34.1%	29.2%	32.3%	30.0%	30.6%	499	-2.4%	292	No change
Rotherham	28.6%	1,058		30.1%		28.7%	34.0%	34.8%	33.6%	36.6%	496	8.0%	126	Increase
Sheffield	33.0%	1,020		34.3%		35.0%	37.9%	35.5%	39.6%	42.9%	500	9.9%	16	Increase
Wakefield	28.8%	1,030		36.9%		31.1%	33.8%	31.4%	33.2%	29.9%	500	1.1%	302	No change
York UA	36.3%	1,002		40.5%		38.9%	38.3%	40.6%	39.6%	37.8%	507	1.5%	96	No change
Craven	33.2%	1,006		32.9%		36.4%	33.7%	38.3%	40.5%	37.9%	500	4.7%	93	No change
Hambleton	36.6%	1,001		35.7%		35.4%	39.5%	40.0%	36.5%	35.0%	499	-1.6%	173	No change
Harrogate	38.3%	1,013		40.9%		38.9%	37.4%	38.4%	42.5%	41.0%	503	2.7%	40	No change
Richmondshire	38.5%	1,018		31.4%		40.1%	38.9%	32.7%	39.5%	39.1%	501	0.6%	69	No change
Ryedale	30.4%	1,018		27.1%		32.6%	31.9%	36.0%	29.1%	33.7%	498	3.3%	221	No change
Scarborough	30.7%	1,029		29.3%		31.6%	29.5%	28.9%	26.7%	32.1%	501	1.4%	263	No change
Selby	35.8%	1,025		41.0%		36.8%	34.1%	31.6%	37.7%	37.9%	501	2.1%	94	No change

	APS1 %	base	APS2 %	APS3 %	APS4 %	APS5 %	APS6 %	APS7 %	Base	% change	Rank of 49 CSPs	Significant change
North Yks CC	35.1%	7,110	35.2%	36.1%	35.1%	35.2%	36.4%	36.9%	3,503	1.8%		No change
Humber	32.8%	4,025	34.0%	32.3%	32.0%	32.9%	34.6%	34.7%	2,013	1.9%	29	No change
North Yorkshire	35.4%	8,112	36.5%	36.8%	35.9%	36.6%	37.2%	37.2%	4,010	1.8%	12	No change
South Yorkshire	30.8%	4,097	31.9%	32.4%	34.5%	32.6%	36.0%	38.5%	1,996	7.7%	5	Increase
West Yorkshire	33.7%	5,096	37.8%	34.6%	36.8%	35.7%	36.8%	35.2%	2,515	1.5%	26	No change
Yorkshire	33.1%	21,330	35.5%	34.0%	35.2%	34.6%	36.3%	36.2%	10,534	3.1%		Increase
National	34.2%	363,724	35.8%	35.7%	35.3%	34.8%	36.0%	35.7%	163,009	1.5%		Increase

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**19th Feb 2014**
3.	**Report Title:**	**Recovery from Opiate Dependence**
4.	**Lead Organisation:**	**Public Health RMBC**

5. Summary:

This paper went to the SRP/DAAT board on 8th Jan, where the action was agreed by the chair that the issues should be also escalated to the HWBB to engage wider support for the improvement of this outcome .

Evidence suggests that people generally are not able to sustain positive outcomes from addiction without having gained or maintained recovery capital in other domains i.e. positive relationships, a sense of wellbeing, meaningful activity, education, training, employment, adequate housing etc. The ACMD (November 2013) also state that "ambition for recovery should be tempered with realism".

There is a need to acknowledge that drug treatment providers cannot deliver the 'recovery' agenda alone but need involvement from Partner agencies to support progress in a number of domains for individuals. Research shows that where an individual has limited capital in a number of domains, overcoming severe drug or alcohol dependence or abstinence without progress in other recovery domains is rarely sustained.

This paper describes the performance assurance processes/data and some of the actions that have been in place to address the shortfall in performance paying particular emphasis to opiate exits.

It goes on to seek support for the application from Rotherham , via Lifeline to apply for PHE capital funds to develop more visible recovery, via a' recovery hub' in Rotherham town centre.

6. Recommendations:

a) Seek support from across the HWB Partnership to build support for recovery initiatives which are seeking to improve this outcome.

b) For the partnership to recognise that this outcome cannot be delivered by the existing system alone , as opiate users in treatment are part of the wider picture of social disadvantage in the borough, and the current opportunities for employment and housing are having some impact on the ability of the services to promote recovery as a positive option.

c) To promote a recognition that any perceived 'quick fix' type solutions to this indicator are likely to have significant negative risks on both the individuals and the crime rate.

7. Proposals and Details:
A number of key issues have had a significant impact on Rotherham's delivery of the Public Health outcome framework indicator '*increasing the number of service users exiting the treatment system in a planned way*'. These include:

a. Audit and improvement of data quality processes performance – the data is now accurate and the treatment provider RDASH, and the GPs now have to acknowledge the poor performance as real, not a data issue.
b. An Opiate Exit plan was produced and monitored by Public Health which included an abstinence pilot programme and treatment outcome profile monitoring. This has been ongoing for 18 months and included input from PHE to try all the 'quick wins'. This has not made any real improvement in the figures, although quality has benefitted. There has been huge levels of resistance from patients to reduce their prescribing.
c. Public Health have continued to work with PHE to benchmark against and learn from other high performing areas based on more recent data and look at barriers with providers/partners in Rotherham.
d. Public Health have devised a programme of quality checking and audit of service delivery against the drug treatment contract requirements in relation to successful treatment exits paying particular attention to opiate exits.
e. There are ongoing negotiations with the Local medical Committee to introduce a new system of payment for the service delivered by GPs to incentivise work on recovery and review long term maintainence prescribing , although the evidence base for this, for many patients remains strong.
f. RMBC are working with lifeline, a national independent sector provider to try to secure Department of Health capital funding for a new 'visible recovery hub ' for the town , which would support this agenda.

Rotherham is not unlike the national picture in that it has an ageing drug treatment population (over 40s) and many of these individuals have been in treatment for some considerable time which makes them harder to help and 'recover' leaving a significant challenge for local areas.

The Yorkshire and Humber region has been an underperformer nationally in terms of performance against successful exits. The NTA (now PHE) created clusters based on a range of social and demographic factors with Rotherham sitting in a cluster with a range of other areas (includes Calderdale, Kirklees and North East Lincolnshire from the Y&H Region). Latest performance figures (Nov – rolling 12 months) show that Rotherham's performance has been fairly static over recent months with a reported figure now of 6.4% against a national average of 8%. The other partnership areas from the Y&H region in the same cluster all sit outside the top quartile range for the cluster which is currently 9% - 13%.

It is recognised that drug users relapse and treatment systems need to be designed to deal with this outcome. Re-presentations to treatment are significant in terms of successful exits and Rotherham performs very well in this area with current performance at 13.3%. This equates to just 6 users whom have previously exited successfully and then returned back to drug treatment within 6 months. This would indicate that despite

successful exits being low locally individuals are better prepared and stay drug free for longer. Performance falls within the top quartile for the cluster.

8. Finance:
Successful completions remain a priority area for the national agenda and discussions are continuing at a national level with regards to incentivising the PH budget via the Health Premium.

2013-14 saw the budget for drug services with RDaSH reducing due to no inflation and a reduction in the investment by the PCC in DIP.

Public Health are currently negotiating with the Local Medical Committee on a new structure for payment for GPs as providers of drug treatment , as they manage over 50% of Rotherham's opiate users, and the majority of exits would be likely to come from primary care. The proposed changes would be aiming to support GPs to review patients more frequently and to support them to help patients to reduce medication safely.

9. Risks and Uncertainties:
Performance figures now reported from ndtms centrally are accepted by both providers and commissioners as being the state of play. Unfortunately this means that Rotherham's performance needs significant improvement in relation to successful exits for opiate users.

Rotherham has a significant challenge ahead in being able to move those entrenched opiate users on methadone programmes out of the treatment system, from a challenging performance position.

10. Policy and Performance Agenda Implications:
Although there are no national targets for successful exits from drug treatment, it is one outcome measure within the Public Health Framework, locally the measure has been included in the SRP suite of indicators. This measure has now been split between Opiates and Non Opiates.

11. Background Papers and Consultation:

https://www.gov.uk/government/news/drug-treatment-performing-well-but-faces-big-challenges

https://www.gov.uk/government/publications/acmd-second-report-of-the-recovery-committee-november-2013

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ROTHERHAM BOROUGH COUNCIL – REPORT TO
Health and Wellbeing Board

1.	**Meeting**	**Health and Wellbeing Board**
2.	**Date:**	**19th February 2014**
3.	**Title**	**JSNA Consultation**
4.	**Programme Area:**	**NAS**

5. Summary

The JSNA is a statutory duty of the Health and Wellbeing Board (HWBB) to evidence the needs of the citizens of the borough. It is critical for health and social care commissioning, service development and it underpins the Health and Wellbeing Strategy.

On 18th December 2013, the Health and Wellbeing Board endorsed a draft JSNA for consultation with stakeholders which took place between 30th December and 9th February. The new JSNA format was well received and a number of constructive comments and suggestions were made. A revised version of the JSNA will be presented to the HWBB, taking account of the representations received.

The web based approach will allow regular updates of the data in the JSNA. Significant changes will be reported to the HWBB each quarter or by exception.

6. Recommendations

6.1 Approve the current version of the Rotherham JSNA, updated following consultation

6.2 Receive quarterly reports of any significant changes included in the JSNA or otherwise by exception

7. Introduction

7.1 Background

The Joint Strategic Needs Analysis (JSNA) is a statutory duty of the Health and Wellbeing Board (HWBB) under the Health and Social Care Act (2012). The JSNA is developed by the Council in partnership with the Rotherham Clinical Commissioning Group (RCCG), the Voluntary and Community Sector (VCS) and Healthwatch Rotherham (HWR).

The Rotherham JSNA provides a comprehensive needs assessment for the borough and is critical to our understanding of the demographics and needs of citizens. The JSNA is used by commissioners in the development of service specifications and by providers in developing their service offers to commissioners and the citizens of Rotherham. The JSNA also serves as an evidence base for the Health and Wellbeing Strategy.

A refresh of the JSNA was agreed by the HWBB in March 2013 and progress was reported in October and December 2013. A draft JSNA was endorsed for consultation on 18th December and this report sets out the stakeholder response received which will contribute to the final refreshed JSNA.

7.2 JSNA Consultation

A 6 week consultation with stakeholders took place between 30th December 2013 and 9th February 2014. Contributions, comments, suggestions and amendments have contributed to a revised version of the JSNA.

Details of the draft JSNA website were circulated to a range of stakeholders, both statutory and VCS agencies. The JSNA website invited users to complete an online survey about the resource. A well attended VCS consultation session was organised by VAR and REMA at the Unity Centre on 27th January.

7.2.1 JSNA Survey Response

Only 2 survey forms were completed although these did offer some useful feedback. Both stakeholders agreed that the JSNA was more accessible than the previous version although there were differing views about the presentation style.

Additional content was suggested on crime, victims of crime, mental health, loneliness and transport. An additional feature requested was a mechanism for service users to share their experience.

7.2.2 VCS Consultation Session

Around 25 representatives of VCS organisations attended the session held on on 27th January. Cllr Wyatt gave an overview of the JSNA and why it is important. After an explanation of how the new JSNA had been developed and

some of the key messages, people were taken through the website content. Comments were made and questions asked as follows:

- Include positive news about what has worked/changed for the better
- Clarify method of submitting data/feedback/information
- Link to emerging issues needs adding
- Communities of Interest: Veterans – were Christine Majer, British Legion, SAFA and MCVC involved in research, add domestic violence
- Communities of Interest: add domestic violence and LAC and family/adult learning even if links to where information already is
- Need section on transitions (perhaps would fit best on services):
    - Children to adults services
    - Education to work/worklessness/training
    - Working to jobless
    - Home to homelessness
- New data flag or quarterly summary so that people know what has changed, been added or updated
- Ensure links to education and schools, and reference to pupil premium
- Engagement in education and meeting the needs of the less able
- How services are making an impact – what works?
- Review how disability is covered, with links between sections
- Not everyone can move away from dependence
- Long term conditions – were GPs involved?
- Social prescribing – SHU / VAR research to add
- Disabled children's aspirations could be added
- Prevention and Early Intervention needs more emphasis
- Engaging families, family learning and adult learning need covering
- Poverty: add transport poverty

7.2.3 Response to Consultation

The consultation was generally positive and stakeholders appreciated the value of being able to contribute to a live process rather than be limited by a fixed document which soon becomes dated. Comments and suggestions made were constructive and will help to develop the JSNA into a more relevant resource. None of the comments have changed the key messages from the JSNA although some of the underlying detail has been enhanced.

Suggested additional content such as the Social Prescribing research will be included in the JSNA provided it is reliable and well evidenced. Additional content on crime, victims of abuse, mental health, loneliness, learning and transport poverty will be added.

Some comments reflected a lack of clarity about which section covered various issues or how cross cutting themes such as disability are dealt with. This can often be resolved by links between different sections and these will be reviewed and added where required. The search function can always be used to find references to any subject.

Further consideration is required under the Services section, notably on child to adult transitions between services. Caution is needed when providing more detail and emphasis on services as the JSNA is primarily an evidence base of needs rather than how organisations respond. The outcome will be reported back to the HWBB at the first quarterly update.

7.3 Directory of Assets

A new requirement for the JSNA is to include a register of community assets which can include individual people, community resources, groups and physical buildings. An asset register as described in previous reports to HWBB will be developed in 2014 with progress reported in JSNA updates.

8. Finance

There are no financial implications arising from this report

9. Risks and Uncertainties

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

That should partners not fully participate or provide capacity of service experts to update the JSNA, it would not be of the required standard.

10. Policy and Performance Agenda Implications

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

11. Background Papers and Consultation

Local Government and Public Involvement with Health Act 2007
Health and Social Care Act 2012
Health and Wellbeing Strategy 2012
JSNA 2011
Health and Wellbeing Board reports on JSNA Refresh in March, October and December 2013

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