CABINET MEMBER FOR HEALTH AND WELLBEING

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

Date: **Monday, 14th April, 2014**

Time: **11.30 a.m.**

A G E N D A

1. To determine if the matters are to be considered under the categories suggested in accordance with Part 1 (as amended March 2006) of Schedule 12A to the Local Government Act 1972.

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

3. Apologies for Absence

4. Declarations of Interest

5. Minutes of previous meeting (Pages 1 - 5)

6. Health and Wellbeing Board (Pages 6 - 26)
   - Minutes of meeting held on 19th February and 26th March, 2014

7. Yorkshire and the Humber Mental Health Commissioning Network
   - Half day conference held on 11th June, 2014, in Wentbridge, Pontefract

8. Rotherham Heart Town (Pages 27 - 30)
   - Notes of meeting held on 11th March,2 014

9. Child Health Profile March 2014 (Pages 31 - 34)

10. Breast Cancer Campaign (Pages 35 - 36)

11. Bereavement Services Forum
    - Feedback from meeting held on 27th March, 2014

12. Motor Neurone Disease Association - MND Charter (Pages 37 - 43)

13. Date of Next Meeting
    - Monday, 9th June, 2014, commencing at 11.30 a.m.

CABINET MEMBER FOR HEALTH AND WELLBEING
10th March, 2014

Present:- Councillor Wyatt (in the Chair).

Councillors Dalton and Steele were also in attendance.

Apologies for absence were received from Councillors Buckley and Tweed.

K66. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

K67. MINUTES OF PREVIOUS MEETING

Consideration was given to the minutes of the meeting held on 27th January, 2014.

Resolved:- That the minutes of the meeting held on 27th January, 2014, be approved as a correct record.

K68. HEALTH AND WELLBEING BOARD

The minutes of meetings of the Health and Wellbeing Board held on 22nd January and 11th February, 2014 were noted.

K69. SUICIDE PREVENTION AND SELF HARM WORKING GROUP

The notes of a meeting of the above Working Group held on 5th December, 2013, were submitted for information.

It was noted that the conference to be held on 3rd April, 2014, was now fully subscribed.

There was to be a meeting of the Bereavement Forum on 27th March, 2014.

K70. OBESITY STRATEGY GROUP

The notes of a meeting of the above Strategy Group held on 5th February, 2014, were submitted for information.

K71. ROTHERHAM TOBACCO CONTROL ALLIANCE

The notes of a meeting of the above Working Group held on 16th January, 2014, were submitted for information.

It was noted that the Council had agreed to sign the Local Government Tobacco Control Declaration.

K72. HEALTHWATCH ROTHERHAM - UPDATE

Melanie Hall, Manager, and Naveen Judah, Chair, attended the meeting to give an update on the work of Healthwatch Rotherham highlighting the following:-

Looked After Children – Barriers to Health Care

- A Sheffield University student was conducting a specific research project on behalf of Healthwatch and holding interviews with care leavers on when they had accessed health care, why they had not etc. to gain an understanding of the issues. The work would be completed by 17th September
- The analysis would inform the CCG and their commissioning
- It would be disseminated to the Health and Wellbeing Board and the CCG

Special Education Needs and Disability

- Working with the Council on the review that was being undertaken - requested to undertake a 6 months project on the engagement with the local population
- Awaiting confirmation as to what consultation was required

CAHMS

- Recent meeting with 6 members of the public who had contact with the Service
- Agreed that the 6 Service users would facilitate a meeting with other users to capture their views and experiences

Trend Analysis

- 6 monthly analysis of the data collected from the public
- 10 organisations had been sent questions to answer with a 30 day deadline

Continuing Health Care

- Remains on the escalation policy
- Information awaited on how information was provided to the public on CHC
- Presentation to the Health Select Commission on 13th March
- South and West Yorkshire were gathering views regarding the Commissioning Support Unit

Learning Disability and Mental Health Discharge Route

- Ascertained that there were instances of delayed discharges due to funding arrangements not being agreed
- Mental Health Act – specific duty

- Local Authority and the CCG to report to the Quality Surveillance Group

Transgender
- Issues with regard to "old" case notes not being transferred to "new" case notes following transgender surgery – implications for allergies etc.
- Reported to the Quality Surveillance Group and was now with NHS England

It was noted that representatives had been invited to present to a meeting of the LGA on 18th March on the impact of Healthwatch.

Resolved:- (1) That the update be noted.

(2) That an update be submitted every 3 months.

(3) That the update be submitted to the Health and Wellbeing Board on 26th March, 2014.

K73. HEART TOWN ANNUAL REPORT 2013

Alison Iliff, Public Health Specialist, presented the Rotherham Heart Town Annual Report 2013 which highlighted the work that had taken place during the year including:-

Cardiovascular Health in Rotherham
Defibrillator Campaign
BHF Heartstart
BHF Health Care and Innovations
BHF Health at Work
BHF Olympic Legacy Project
National No Smoking Day
Health Bus
BHF Publications and Exhibits
Fundraising and Volunteering

Resolved:- That the report be referred to the Health and Wellbeing Board.

K74. 'WORKING TOGETHER FOR A HEALTHIER ROTHERHAM' CONFERENCE

The Chairman outlined the draft format for the above conference which was to be held at the New York Stadium on 16th July, 2014.

K75. "MEETING THE DEMENTIA CHALLENGE" - 13TH MARCH, 2014.

Resolved:- That attendance at the conference entitled "Meeting the Dementia Challenge: Delivering Improvement in Dementia Care and Research" on 13th March, 2014, be not attended.

K76. LONELINESS SUMMIT - 8TH APRIL, 2014

Resolved:- That the Chairman be authorised to attend the Loneliness Summit to be held in Leeds on 8th April, 2014.

K77. EXCLUSION OF THE PRESS AND PUBLIC.

Resolved: - That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972 (information relating to the financial/business affairs of any person (including the Council)).

K78. BETTER CARE FUND FEEDBACK

The Chairman reported receipt on the draft feedback from NHS England (South Yorkshire and Bassetlaw) on Rotherham's submission to the Better Care Fund.

The bid had been subject to an initial peer review and would now be submitted for national consideration. Formal feedback would be expected later in March.

Resolved:- That the report be noted.

K79. HEALTHWATCH ROTHERHAM CONTRACT NOVATION

Clare Burton, Commissioning Officer, presented a report outlining a proposal to commence the novation process for Rotherham's local Healthwatch Service to be provided by Healthwatch Rotherham directly enabling them to operate as a social enterprise.

The contract had been awarded to Parkwood Healthcare Ltd. on 1st April, 2013, with the intention that it would be novated to Healthwatch Rotherham at the earliest opportunity as set out in the original Department of Health Guidance for Healthwatch nationally to become social enterprises.

Discussion ensued with regard to the contract and possible financial implications for the Authority.

Resolved:- That the intention to novate the contract commence to enable Healthwatch Rotherham to operate as a social enterprise as a totally independent organisation by September, 2014.

K80. DATE AND TIME OF THE NEXT MEETING

Resolved:- That the next meeting of the Cabinet Member take place on Monday, 14th April, 2014 at 11.30 a.m. at the Town Hall.

HEALTH AND WELLBEING BOARD
19th February, 2014

Present:-

Councillor Ken Wyatt	Cabinet Member, Health and Wellbeing **(in the Chair)**
Robin Carlisle	Rotherham CCG (representing Chris Edwards)
Bob Chapman	South Yorkshire Police (representing Jason Harwin)
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Councillor John Doyle	Cabinet Member, Adult Social Care
Naveen Judah	Healthwatch Rotherham
Dr. Julie Kitlowski	Chair, Rotherham CCG
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families
Dr. David Polkinghorn	GP Executive Member, Rotherham CCG
Dr. John Radford	Director of Public Health

Also in Attendance:-

Kate Green	Policy Officer, RMBC
David Hicks	Rotherham Foundation Trust (representing Louise Barnett)
Brian Hughes	NHS England
Ian Jerrams	RDaSH (representing Chris Bain)
Dr. Jason Page	GP Executive Member, CCG
Clair Pyper	Director of Safeguarding (representing Joyce Thacker)
Chrissy Wright	Strategic Commissioning Manager, RMBC

Presentation by:-

Rebecca Atchinson	Public Health, RMBC
Anne Charlesworth	Public Health, RMBC
Chris Siddall	Sports Development, RMBC
Sue Wilson	Children, Young People and Families, RMBC

Apologies for absence were received from Chris Bain, Louise Barnett, Karl Battersby, Chris Edwards, Jason Harwin, Tracy Holmes, Martin Kimber and Joyce Thacker.

S74. DR. DAVID POLKINGHORN

The Chairman reported that this would be David's last meeting.

The Board's appreciation was placed on record for his contributions to the work of the Board and wished him well for the future.

S75. MINUTES OF PREVIOUS MEETINGS

Resolved:- That the minutes of the meetings held on 22nd January and 11th February, 2014, be approved as a correct record.

Arising from Minute No. S64 (Flu Vaccination Programme), Dr. John Radford reported that NHS England were pushing back from the national rollout of a flu vaccination programme for delivery to 6-19 year olds; it was for local determination as to whether it was taken forward.

It was felt that the way forward should be discussed at a South Yorkshire level.

Arising from Minute No. 68 (Rotherham CCG Plan 2014/15), Robin Carlisle reported that it had been submitted to NHS England and would be included on the CCG website. It would also be circulated to all stakeholders shortly. Brian Hughes reported that a meeting had taken place with the CCG as part of NHS England's assurance process and would be communicating initial feedback.

Arising from Minute No. S70 (Joint Protocol between Health and Wellbeing and Children's Safeguarding Boards), it was noted that the Protocol had been signed by all the relevant signatories.

S76. COMMUNICATIONS

(1) Conference
It was noted that a conference, led by the CCG with support from the Council, was to be held on 16th July at the New York Stadium entitled "Working Together for a Healthier Rotherham. A request would be made for speakers from partners.

(2) Better Care Fund
Brian Hughes reported that the final guidance template had been issued which he would circulate after the meeting. He would then give initial feedback followed by NHS England, along with a local authority peer, assessing each bid and giving written feedback by 28th February allowing further work to take place between then and the 4th April.

S77. REVIEW OF GOVERNANCE ARRANGEMENTS

Kate Green, Policy Officer, reported that the Board had been in operation as a statutory board since April, 2013, and had matured well, developing strong working relationships between partners. However, the health and wellbeing landscape had changed considerably and Boards were increasingly being directed by Government to provide leadership and direction on a number of key policy agendas. As a result, to enable Rotherham's Board remain fit for purpose and able to deliver what was required, it was felt that a review of the governance arrangements was required.

Board members had undertaken an anonymous self-assessment looking at governance and operation of the Board in September, 2013. A number of comments had been made which had been incorporated into the following proposals:-

- Better Care Fund
  It had been agreed that an Executive Group be established which would report directly to and provide a support mechanism for the Board. It would hold the strategic overview of the health and wellbeing agenda, delivery of the Health and Wellbeing Strategy workstreams and the Better Care Fund plan.

  Appropriate membership of the Executive Group was to be agreed.

- Format of Meetings
  It was proposed that the meetings remain monthly for the timebeing due to the volume of work. However, it was proposed that the format changed so that every other meeting was for core members only (commissioners) to cover key business items i.e. commissioning plans, financial information and any major Service reconfigurations, the Better Care Fund Plan and performance management.

  The alternate meeting would be reflective and in 2 parts, the first for any necessary core business and the second part with provider and VCS involvement.

  It was felt that this would allow more focussed agendas addressing the strategic priorities of the Board.

- Board Membership
  It was proposed that the membership be as follows:-

  Core Members:
  Cabinet Member for Health and Wellbeing (Chair)
  Cabinet Member for Adult Social Care
  Cabinet Member for Children, Young People and Families Services
  Director of Public Health
  Chief Executive, RMBC
  Strategic Director, Neighbourhoods and Adult Services
  Strategic Director, Children's and Young Peoples Services
  Chief Officer, CCG
  Chair of Clinical Commissioning Group
  NHS England representative
  Chair of Healthwatch Rotherham
  Chief Superintendent, South Yorkshire Police

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

- Stronger engagement with the public

Consideration was given to the above proposals. The following issues were raised:-

- What about providers of Primary Care?
- Insufficient representation of Health providers – 3 GP commissioners on the core membership to correspond with the 3 Councillors
- The position of Vice-Chair should not be from the Local Authority – it was noted that this was not possible as the Board was a formal committee of the Council and would involve amending the Council's Constitution.
- Felt to be a retrograde step to not have a representative from the Foundation Trust on the core membership
- Quality of decision making was very much enhanced if providers were there
- Possible loss of additionality – the split of provider/commissioner was not straight forward. The VCS provided both functions
- A number of partners carried out public engagement activities which needed capturing
- The Executive Group had been established to produce the BCF submission and to support its delivery. However, if its remit was broadened to include the strategic overview of the Health and Wellbeing agenda, what was the purpose of the Board?

Resolved:- (1) That 1 additional CCG representative be included on the core membership of the Board.

(2) That Janet Wheatley lead on a review of the public engagement activities carried out by organisations and report to next meeting.

(3) That future agendas include "questions from members of the public".

(4) That the Terms of Reference, membership and organisational diagram for the Executive Group be submitted to the next meeting.

S78. LIFESTYLE SURVEY 2013 RESULTS

Sue Wilson, Performance and Quality Manager, gave the following powerpoint presentation:-

Lifestyle Survey

- The Lifestyle Survey had been ongoing since 2006 capturing the views of young people in Y7 and Y10 in the following topics:-
  Food and Drink, Health, Activities and Fitness, Being in School, Out of School, Young Carers, Bullying and Safety, Smoking, Drinking and Alcohol, Sexual Health and Local Neighbourhood
- The Survey was a joint initiative between Local Authority and Health to capture the views of young people
- Not compulsory for a school or pupils to participate
- Findings from each year's survey shared with Health, Police, Local Authority Teams, Members and the Public

Increased Participation in 2013

- This year was the first year all 16 schools had participated (50% increase) – 2012 – 8 schools participated
- 3,474 pupils participated in 2013 (142% increase from 2012) – 1,434 pupils participated in 2012. This increase was due to a concentrated effort on returns, communications with schools
- Regular updates to schools highlighting the benefits of the survey and supporting schools with clear information on where support could be obtained to support pupils with specific issues

Positive Improvements since 2012

- More pupils felt they were a healthy weight up to 74% from 70%
- More pupils taking regular exercise up to 81% from 79%
- Increase in the number of pupils having 5 portions of fruit and vegetables up to 43% from 42%
- More pupils regularly drinking water up to 67% from 65%
- More pupils having their breakfast at home up to 79% from 67%
- Fruit most popular choice for a break time snack
- More pupils said their home was smoke-free up to 66% from 64%
- Higher % of pupils said they had never tried a cigarette up to 80% compared to 75%

Improvement Actions

- Obesity Strategy Group – supported in past 4 years – 1,721 children access tiered weight management services
- Joint working DC Leisure and RIO (Rotherham Institute for Obesity) supporting young people. Healthy Schools Service promoting support that was available for young people
- The MoreLife programme was a free 12 weeks weight management course to help children maintain a healthy weight. The Programme took place at Rotherham, Maltby and Aston Leisure Complexes
- 98% of schools accredited in Healthy Schools Programme
- Smoking was a priority measure in the Health and Wellbeing Strategy. Activity to reduce smoking among young people was included in the performance framework including requiring schools to have a smoke-free policy

Areas for Attention

- More Young Carers identified
- Safety issues similar to 2012 – Town Centre and Public Transport where pupils felt least safe
- Bullying rates remained similar to 2012, however, less pupils reporting this
- Local shops were identified as 1 of the places where pupils were purchasing alcohol and parents supplying their children with cigarettes and alcohol
- Pupils felt good about themselves had reduced

Progress and Action

- % of Pupils identifying themselves as young carers
  - Barnardos were working in partnership with statutory parents to promote Working Together to Support Young Carers
  - Rotherham UK Youth Parliament members were developing a Young Carers Card
  - Carers Charter had specific actions for young carers
  - Improve the offer of information and support to young carers
  - Awareness raising in schools and in other young people settings of support for young carers and the Youth Carers Services
- Personal Safety
  - Youth Cabinet led the Overview and Scrutiny Management Board meeting and requested that all key partners meet to address the issues of feeling safe in the Town Centre and feeling safe using public transport
- % number of Pupils reported that they had been bullied
  - School were appointing Anti-Bullying Ambassadors
  - 14 secondary schools had signed up to the National Bullying Charter and all schools had an Anti-Bullying Strategy and toolkit
  - Schools could achieve a grading within the Charter from bronze to gold
- Number of pupils involving Smoking, Drinking and Drugs
  - Know the Score was a commissioned service to support young people with alcohol and drug issues
  - Community Alcohol Partnerships had been developed in 2 project areas – Dinnington and East Herringthorpe/Dalton/Thrybergh
  - Smoke free class resources provided to all primary and secondary schools
  - Work underway to ensure all schools had a Smoke Free Policy
- Where pupils were obtaining Cigarettes from
  - Health partners were promoting to parents the health risks giving their children cigarettes and alcohol when they were under age
  - Trading Standards implementing Responsible Retailer Awards
  - Reward responsible operators and share their good practice with others
  - Support for retails to reach the standard which would permit them to use the responsible retailer log

- Where pupils were obtaining Alcohol from
  - Health partners were promoting to parents the health risks of giving their children cigarettes and alcohol when they were under age
  - Rotherham Responsible Retailer Award aims to provide incentive for the operators of licensed premises to improve their standards of operation to the level of a commonly agreed national benchmark
- Feelings
  - Targeted Mental Health in Schools conference held 15th November, 2013
  - Self-harm pathway being developed for frontline workers who had contact with young people (9-25) who were self-harming
  - Bereavement pathway in development which would ensure support for children and young people who were bereaved/affected by suicide
  - Letter sent out via schools in June, 2013, to all parents highlighting support for young people who may be in emotional distress
  - Support services for young people who may be in emotional distress advertised on Public Health Channel during Summer/Autumn months in 2013
  - Youth Cabinet – Children's Commissioner's Day would take place on 27th February, 2014, sharing their work around self-harm

Areas where Young People were being Supported

- Youth Cabinet was taking forward issues raised in the Lifestyle Survey – would be included on the agenda for the Children's Commissioner's Day
- Youth Cabinet was working on a number of the areas for attention identified in the Survey and were working with the Youth Service to put forward their ideas of how they could be addressed
- Members had supported young people in various projects from their Community Leadership Fund

Next Steps

- 15 out of 16 schools had signed up to participate in the 2014 Survey
- Consultation ongoing reviewing the questions with health partners, Safer Neighbourhood Teams, Schools
- Youth Cabinet reviewing the themes of questions in 2014 and plans in place for it to be more involved in the findings and how to make improvements for the 2015 Survey
- Communication in local media – ongoing campaign to support the positive outcomes from the action plan. Communications Team would work jointly with Service Quality, Police, Health, Voluntary Sector and other key stakeholders to produce information for the press on the activities ongoing which supported the outcomes from the Survey
- Plans in place to monitor activities to support young people specifically around the issues raised in the Survey

The information from the Survey fed into many of the Council's Services and also fit with the Joint Strategic Needs Assessment.

It was noted that the results would be presented to the Improving Lives Select Commission and the Safeguarding Board in March.

Sue was thanked for the presentation.

S79. ROTHERHAM ACTIVE PARTNERSHIP

Rebecca Atchinson, Public Health, and Chris Siddall, Sports Development, gave the following powerpoint presentation:-

Why is physical activity important?

- Being physically active contributed towards
  Positive mental health and wellbeing
  Improved quality of life
  Reduced the risk of arthritis, cancer, diabetes, heart disease, respiratory illnesses and more
  Improved the recovery from strokes, falls, osteoporosis
  Was the 5th leading global burden of disease in western Europe
  Was 1 of the top modifiable risk factors
- It was not just preventing/reducing obesity

What is physical activity?

- Everyday activities
  Active travel, walking and cycling, active at work, housework, gardening and DIY
- Active recreation
  Recreational walking and cycling, swimming, exercise and fitness classes, dancing, active play, outdoor pursuits and adventurous activity
- Sports
  Organised team sports, structured competitive activity, PE and School Sports, individual sports
- Move more, more often

Activity levels in Rotherham

- Improving trend from Active People Survey 6
- Over half Rotherham adults did not do physical activity
- Rotherham was the 127/150 least active local authority
- 33.57% inactive adults

The costs of physical inactivity

- Inactive people compared to active people annually had 38% more days in hospital and 6% more visits to their GP
- Rotherham's inactivity rates had been estimated to cost over £22M per year

- National comparisons of lifestyle issues estimated annual costs

Physical inactivity	£8.2B
Alcohol misuse	£17B
Drugs	£15.4B
Smoking	£13.74B
Obesity	£15.8B
Sexual health	£12.05B

- If every local authority was able to reduce inactivity by 1% a year over 5 years local tax payers would save £44 per household

Rotherham's vision
- "Rotherham will be a place where people feel good, are healthy and active and enjoy life to the full"

Links to the Health and Wellbeing Strategy
- Rotherham Active Partnership's new approach followed the life course targeting those least active
- Strong linkages to themes

Further Developments
- Website
  To promote physical activity opportunities across the Borough
  To provide people with long term conditions advice on safe sessions
- Passport of physical activity
  Given to all patients leaving service with a physical activity element
  Clear advice on what they should consider and avoid
  Linked to the website

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

- Linkages to the Health and Wellbeing Strategy that would support funding bids

- Challenge to put physical activity on a par with other therapeutic interventions offered by the NHS

- Social prescribing was 1 of the most successful interventions coming through. Some elderly people could undertake various chair-based activities

- The review of the Partnership could discuss opportunities for funding and how services could be delivered across Rotherham and whether duplication could be reduced to maximise impact

- A successful funding bid had been submitted around the disadvantaged community of Canklow, Dalton, Thrybergh and East Dene; a bid was still pending for Maltby and Dinnington. There would be close work using the community development approach, working

with partners in the area and the 11 Disadvantaged Team Leaders to gain an understanding why the inactivity levels were as high as they were in those areas and what services and intervention was required to try and encourage those that were not active

- Attempted to identify where all the Partnership's services fitted together in order to recognise and use people's skills effectively

Rachel and Chris were thanked for their presentation.

Resolved:- That the Board receive 6 monthly reports from the Rotherham Active Partnership.

S80. RECOVERY FROM OPIATE DEPENDENCE

Anne Charlesworth, Head of Alcohol and Drug Strategy, presented a report on the performance assurance processes/data and some of the actions that had been put into place to address the shortfall in performance paying particular emphasis to opiate exits.

The report had been considered by the Safer Rotherham Partnership/DAAT Board on 8th January where it was agreed that the report be forwarded to the Health and Wellbeing Board to engage wider support for the improvement of the outcome.

Evidence suggested that people generally were 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. There was a need to acknowledge that drug treatment providers could not deliver the 'recovery' agenda alone but needed involvement from partner agencies to support progress in a number of domains for individuals. Research showed that where an individual had limited capital in a number of domains, overcoming severe drug or alcohol dependence or abstinence without progress in other recovery domains was rarely sustained.

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

It was recognised that drug users relapsed and treatment systems needed to be designed to deal with the outcome. Re-presentations to treatment were significant in terms of successful exits and Rotherham performed very well with current performance at 13.3%. This equated to 6 users whom had previously exited successfully and then returned back to drug treatment within 6 months. This would indicate that, despite successful exits being low, locally individuals were better prepared and stayed drug free for longer.

Discussion ensued on the report with the following issues raised:-

- Rotherham had a large number of young people who experienced neglect, sometimes physical injuries, as a result of their parents' mental health and substance abuse/domestic abuse
- Elsewhere in the country the number of opiate users into treatment had dropped off - until the last 6 months Rotherham had seen a significant drop but still had above the average of new users coming into treatment – 370 within Primary Care, 200 within the criminal justice system and 300+ still long term prescribed for opiate dependency
- The new targets would mean there would be pressure to get the individuals currently stable on methadone off the medication
- There were children in Rotherham from the 11 plus age range who had experienced a range of drugs including opiates
- The Government's change of Policy would only work if sufficient levels of service and support were put into place
- Currently GPs provided drug treatment but if a practice had a small number of patients, the increased frequency of reviewing and support may be hard for a practice to sustain and be at the expense of other patients

Resolved:- (1) That the Board's support to build support for recovery initiatives which were seeking to improve the outcome be noted.

(2) That the Board notes that the outcome could not be delivered by the existing systems alone as opiate users in treatment were part of the wider picture of social disadvantage in the Borough and the current opportunities for employment and housing were having some impact on the ability of the services to promote recovery as a positive option.

(3) That a recognition that any perceived 'quick fix' type solutions to the Indicator were likely to have significant negative risks on both the individuals and the crime rate.

S81. JOINT STRATEGIC NEEDS ASSESSMENT CONSULTATION

Further to Minute No. 61 Chrissy Wright, Strategic Commissioning Manager, presented the revised version of the JSNA taking account of the representations received.

The 6 weeks consultation with stakeholders had run between 30th December, 2013 and 9th February, 2014. Details of the draft JSNA website had been circulated to a range of stakeholders, both statutory and VCS agencies, as well as a well attended VCS consultation session held on 27th January.

The consultation had been generally positive. Comments and suggestions made were constructive and would help to develop the JSNA.

A new requirement was to include a register of community assets which would be developed in 2014 with progress reported in JSNA updates.

It was noted that the document had now been "signed off". However, in future "sign off" would be in line with commissioning priorities and planning.

Resolved:- (1) That the current version of the Rotherham Joint Strategic Needs Assessment, updated following consultation, be approved.

(2) That quarterly reports of any significant changes or otherwise by exception be submitted to the Board.

S82. DATE OF NEXT MEETING

Resolved:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 26th February, 2014, commencing at 9.30 a.m. in the Rotherham Town Hall.

HEALTH AND WELLBEING BOARD
26th March, 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 Officer, Rotherham CCG
Naveen Judah	Healthwatch Rotherham
Dr. Julie Kitlowski	Rotherham CCG
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families
Dr. David Polkinghorn	GP Executive Member, Rotherham CCG
Dr. John Radford	Director of Public Health
Joyce Thacker	Strategic Director,

Also in Attendance:-

Kate McDaid	National Energy Action
Kate Green	Policy Officer, RMBC
David Hicks	Rotherham Foundation Trust (representing Louise Barnett)
Brian Hughes	NHS England
Shafiq Hussain	VAR (representing Janet Wheatley)
Catherine Homer	Public Health
Ian Jerrams	RDaSH (representing Chris Bain)
Chrissy Wright	Strategic Commissioning Officer, RMBC

Apologies for absence were received from Chris Bain, Louise Barnett, Karl Battersby, Tracy Holmes, Martin Kimber, Gordon Laidlaw and Janet Wheatley.

S83. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

A member of the public asked, given the impending launch of consultation on the Care Bill, if there were to be any events for stakeholder consultation?

Tom Cray, Strategic Director, Neighbourhoods and Adult Services, reported that there had been stakeholder meetings during the past 12 months the feedback from which had been that there should be separate events to allow focussed discussions. Accordingly, a series of events would be organised the first of which would be before the Summer.

S84. MINUTES OF PREVIOUS MEETING

Resolved:- That the minutes of the meeting held on 19th February, 2014, be approved as a correct record.

Arising from Minute No. S75 (Flu Vaccination Programme), Brian Hughes reported that it was an issue still be discussed across the region.

S85. COMMUNICATIONS

(a) Rotherham Foundation Trust
The Board's congratulations were recorded to Louise Barnett who had been formally appointed as the Chief Executive.

(b) Peer Review
The Chairman reported that the LGA had an offer for Health and Wellbeing Board's to have a peer challenge, which involved a group of peers from other areas coming into the Council and reviewing the work of the Board over a 4 day period.

It was noted that other Health and Wellbeing Boards in the area had taken up the offer.

It was felt that the detail of the review was required as well as any resource implications.

Resolved:- (1) That contact be made with the Local Government Association with regard to taking up the offer of a Peer Review.

(c) Rotherham Heart Town Annual Report 2013
The Board noted the Rotherham Heart Town Annual Report 2013 which highlighted the work that had taken place during the year.

(d) Motor Neurone Disease
The Chairman reported receipt of correspondence from the Motor Neurone Disease Association requesting sign up to the MND Charter "achieving quality of life, dignity and respect for people with MND and their carers".

Resolved:- (2) That the Charter be circulated to all members of the Board.

S86. NATIONAL ENERGY ACTION FUEL POVERTY

Catherine Homer, Public Health Specialist, and Kath McDaid, National Energy Action, gave the following powerpoint presentation:-

Winter Warmth – Preparation for Winter
Project Aims
- HWB members understand that strategic objectives are being delivered at community level via formal process mechanisms
- Delivering the Fuel Poverty Priority
- Community Involvement Officers and other key front line professionals understanding and knowledge of the causes and solutions to cold, damp homes is improved, resulting in signposting and one-to-one support
- Key strategic players aware of fuel poverty agenda and linkages to the Health and Wellbeing Strategy

What happened?

- Facilitate meeting including HWB Elected Members and Council Officers – focus localities of Brampton Bierlow, Wentworth and Harley
- Fuel Poverty briefing for Councillors and interested parties
- Discrete training
- 2 workshops
- Community events
- Feedback to Health and Wellbeing Board

What people said

- "impression that people buying own homes are wealthy but not the case as people tell me that they are struggling"
- "large areas of the Ward are made up of picturesque countryside however rural fuel poverty is a blight on many resident's lives"
- "we can't stop now – we have to keep it rolling, this project has been worthwhile because Fuel Poverty is a taboo subject, it is not recognised in general and now people are talking about it"
- "recognition needed that these areas are not classed as deprived but have high levels of fuel poverty – different problems associated with both properties and residents"
- "dealing with fuel poverty must rank highly in the prevention and early intervention aspects of our joint activities recognising the effects on all age ranges, young families and the elderly"

Unintended Outcomes

- Many of the services and officers engaged in the project have formed networks aside from their own areas of speciality
- Elected and Parish Councillors have together discussed sustaining the momentum within their local areas
- Stronger effective links with the Fitzwilliam Wentworth estate
- Developed a network who are "Green Deal ready"
- Synergy with existing pots of funding and projects

Recommendations for the Health and Wellbeing Board

- Recognition that fuel poverty is not just linked to general poverty in terms of low income but is more complex and has issuing consequences in terms of ill health and common mental disorders
- To recognise that perceived 'affluence' does not preclude people living in cold homes
- Use Ward Councillors and Parish Councillors to emphasise the very negative effects of fuel poverty and recognise the value of this local intelligence in utilising existing networks
- Continue to recognise and uphold the status of fuel poverty as a priority area for action
- Capitalise on the interest shown by health partners for fuel poverty by utilising intelligence networks
- Energy policy is in a statue of hiatus currently with many low income, fuel poor households having no access to grants or support; Health

and Wellbeing Board to consider future investment to 'plug' such gaps in provision

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

- Rotherham was 1 of the very few Health and Wellbeing Boards to have Fuel Poverty within their Health and Wellbeing Strategy
- Rotherham was a long way ahead of other authorities with their work on Fuel Poverty
- The current 8 projects were writing their reports for submission to the Department of Energy and Climate Change
- The Citizens Advice Bureau was running an energy project through some general practices where the practice managers had expressed an interest. The CCG would be happy to work with the project and attempt to get more practices to participate
- Fuel poverty did not just apply to the elderly
- Fitted in with Making Every Contact Count and ensuring all front line staff/volunteers were aware
- The next performance monitoring report would be an opportunity to reflect on the recommendations and consider how to keep the momentum on the initiative

Catherine and Kath were thanked for their presentation.

Resolved:- (1) That the presentation be noted.

(2) That the Parish Council Liaison Officer be contacted with a view to giving a presentation to the Parish Council Network meeting.

S87. BETTER CARE FUND

Tom Cray, Strategic Director, Neighbourhoods and Adult Services, and Chris Edwards, Chief Officer, Rotherham CCG, gave a verbal update on the position with regard to the above.

- The plan had been submitted in accordance with the 14th February deadline which had met the criteria at that time and would act as a catalyst for change that both the Local Authority and CCG were comfortable with

- Feedback from NHS England and the Peer Review had been received in March in relation to the national conditions, performance measures and ambition. The plan had also been the subject of an all Members Seminar and the Health Select Commission

- The plan had a number of "green" with the majority being "amber" which meant that NHS England felt there was the capacity to develop

the plan further in order to satisfy all the conditions by the 4th April deadline

- The Task Group and Officer Group had continued to ensure that the final submission was solid and robust and an ambitious plan

- As a result of the feedback it was felt that it needed to be more explicit in terms of the whole system change that the plan was seeking to achieve. Accordingly, adjustments had been made so as to emphasise how the change at one end of the system would flow through to the other end concentrating on the citizen experience through an integrated approach

- Work was still continuing on the plan with adjustments made to the funding profile and a risk assessment being carried out to ensure there were no unintended consequences anywhere in the system

- All the projects contained within the plan were in synch and fitted with the commissioning plans of both the Council and CCG

- It has been quite a difficult process because of the timescales involved and the national messages been different from the Department of Health and Department of Communities and Local Government

- The Task Group had committed to continuing to meet to ensure that the plan was delivering and take action should any unanticipated issue emerge

- There would be a chance to review the plan in 12 months

- Given the short timescale the CCG had taken the decision to include the minimum of services to establish the principles of the Fund but were committed to having further discussions as to the appropriateness of including more services

Brian Hughes stated that the feedback from NHS England recognised that the plan was a catalyst for change and there was a level of transformation. The plan now needed to show how it had moved from the February submission to the April submission as to how that transformation and citizen empowerment would happen.

Resolved:- (1) That the Task Group be authorised to submit the Better Care Fund submission to NHS England.

(2) That a copy of the submission be submitted to the April Board meeting.

S88. HEALTHWATCH ROTHERHAM PROGRESS UPDATE

Chrissy Wright, Operational Commissioner, presented a report setting out the development of Healthwatch Rotherham and the progress achieved to date.

The following points were highlighted:-

- Healthwatch Rotherham launched on 2nd October, 2013
- Website, Twitter and Facebook account developed and a newsletter regularly circulated
- All staff, Chair and Board Directors appointed with each Director having responsibility to 1 of the 6 Health and Wellbeing Strategy priorities
- The majority of the first half of the year had been spent establishing the service and awareness raising
- Continued to pass on concerns raised by members of the public to commissioners and, where appropriate, to CQC, Ofsted, South Yorkshire and Bassetlaw Quality Survey Group, Scrutiny, RCCG, NHS England, TRFT and Healthwatch England

The report also set out community engagement and project work planned for the forthcoming 6 months.

Parkwood Healthcare had been awarded the Healthwatch Rotherham contract with the intention that once established, the contract would novate to Healthwatch Rotherham to enable it to operate as an independent social enterprise. The Cabinet Member for Health and Wellbeing had approved the intention to novate the contract at his meeting on 10th March, 2014.

Naveen Judah, Chair of Healthwatch Rotherham, reported that Healthwatch Rotherham was being mentioned by Healthwatch England for its good practice and had people from other areas visiting to learn from them. However, it was becoming a victim of its own success. As the work spread about its Advocacy Service, the number of people wanting to use the Service was increasing. Attempts were made to screen the enquiries as to those that could be pointed in the right direction to help themselves and those that the Service would help but the situation would be monitored.

Resolved:- (1) That the progress achieved by Healthwatch Rotherham be noted.

(2) That the decision to novate the contract to Healthwatch Rotherham by September, 2014, be noted.

S89. PROMOTING HEALTH CHECKS

Dr. John Radford, Director of Public Health, reported that local authorities were now responsible for the commissioning of NHS Health Checks which was a national risk assessment and prevention programme. Everyone attending a NHS Health Check would have their risk of developing heart disease, stroke, diabetes and kidney disease assessed through a combination of their personal details, family history of illness, smoking, alcohol consumption, physical activity, body mass index, blood pressure and cholesterol. They would then be provided with individual tailored advice that would motivate them and support and necessary lifestyle changes to help them manage their risk. Where additional testing and follow-up was needed, they should be referred to Primary Care services.

People aged 65-74 would be informed about the signs and symptoms of Dementia and informed about memory Clinics if so required.

Over the last 10 years, Health Checks had had success in reducing cardiovascular deaths as cardiovascular disease was largely preventable. They were extremely important and needed to be promoted.

The objective was to initially screen 18% of the eligible 20% of the population.

Discussion ensued with the following points raised/clarified:-

- 1 of the interventions was the prescribing of Statins which would have impacts for the population as a whole and as well as the GP practice

- The challenge was to deliver in the most deprived and hardest to reach communities and work with the Mental Health sector

- The new NICE Guidance, currently subject to consultation, proposed significant changes to Health Checks – cardiovascular risk for the over 50s was over 10%; the new Guidelines indicated that anyone who had a cardiovascular risk over 10% should be on Statins - implications for a huge section of the population

- The Guidance also contained advice on diet and exercise

- A number of cardiovascular deaths could have been prevented

- There was an ageing population but was it a healthy population? Was it the prolonging of an unhealthy ageing population

- Statins were not a surrogacy for a lifestyle

Resolved:- That the report be noted and a further report submitted in 6 months.

S90. MENTAL HEALTH AND LEARNING DISABILITY SERVICES - FUNDAMENTAL REVIEW

Chris Edwards, Chief Officer, presented a report for information setting out the purpose, scope and timescale of the Clinical Commissioning Group's fundamental review of commissioned services for Mental Health and Learning Disability.

The review would focus on whether the CCG's overall investments in Mental Health and Learning Disability Services was proportionate to the health needs of Rotherham patients, how to ensure parity of esteem, how to strengthen clinical leadership of the efficiency and quality assurance agencies, how to improve the reporting of outcome and activity measures and the implications of Mental Health payment by results.

It would include a market analysis, whether the CCG should be using a greater plurality of providers (including voluntary sector providers, a greater variety of Mental Health Foundation Trust providers, GP providers) and more facilitation of self-help such as computerise Cognitive Behaviour Therapy.

All reports would be completed by the end of May.

From the perspective of the Police Service, it was an area that was growing. Ian Jerrams stated that the Mental Health Triage initiative in Rotherham of having a Mental Health Nurse working alongside the Police in Rotherham had already shown good results.

Resolved:- (1) That the report be noted.

(2) That the CCG ensure that South Yorkshire Police was involved in the review.

(3) That a report be submitted on the Mental Health Triage pilot being operated by South Yorkshire Police.

(4) That, should the review recommend any major Service change, they be reported to the Health Select Commission.

S91. 2014/15 MEETING DATES AND TIMES

Resolved:- That meetings be held in 2014/15 in the Rotherham Town Hall as follows:-

Wednesday,	4th June, 2014	9.00 a.m.
	2nd July	9.00 a.m.
	27th August	9.00 a.m.

17th September	9.00 a.m.
1st October	9.00 a.m.
12th November	1.00 p.m.
3rd December	9.00 a.m.
21st January, 2015	11.00 a.m.
18th February	11.00 a.m.
11th March	9.00 a.m.
22nd April	9.00 a.m.

S92. DATE OF NEXT MEETING

Resolved:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 23rd April, 2014, commencing at 1.00 p.m. in the Rotherham Town Hall.

Rotherham Heart Town
Love our town • Love your heart

Notes		
	Title of Meeting:	**Heart Town**
	Time:	**09:30am**
	Date:	**11th March 2014**
	Venue:	**Town Hall, Room 3**
	Reference:	**AI /SL**
	Chairman:	**Cllr Ken Wyatt**

In attendance:
Cllr Ken Wyatt – Chair
Alison Iliff – Public Health RMBC
Lauren Mallinson – BHF Fundraising Volunteer Manager
Jo Ward – BHF Volunteer
Leon Wormley – RMBC Sports Development
Ben Atkinson – SHU student on placement with Sports Development
Hayley Mills – DC Leisure
Rochelle Scott – DC Leisure
Trish Lister – Start a Heart 247
Susan Leckey – Public Health RMBC

Apologies: Tracey Holmes, Linda Jarrold, Emma Scott, Steph Dilnot, Phill Spencer, Chris Siddall, Andrew Hartley, Kay Denton-Tarn, Mark Cummins, Emily Newman, Lisa Williams

1.	**Welcome / Introduction and Apologies**	
2.	**Minutes of Last Meeting/Matters Arising** Alison has sent a letter to David and June Thomas to thank them for their contribution to Heart Town and to wish them all the best for the future.	
3.	**Presentation and action planning: Research** **Research:** We will build on our position as a research-driven charity, the UK's leading independent funder of cardiovascular research The BHF was founded in 1961 and research in to preventing, diagnosing and treating heart disease and the medical advancements they have been part of have contributed to major benefits for the nation's hearts. For example, deaths from coronary heart disease have halved since the 1960s, and eight in ten babies born with a heart defect now survive into adulthood. In 1976, BHF Professor Michael Davies demonstrated that blood clots cause heart attacks. This understanding of the role of blood clots led to research into how and why they formed and how narrowed and hardened arteries, caused by deposits of cholesterol, contribute to heart attacks.	

	Professor Paul Evans with BHF-funded research has shown why green vegetables are healthy by finding a chemical in them that has protective effects against heart disease. The understanding of anatomy and improved surgical techniques such as keyhole surgery has seen congenital heart disease fall by more than 80%. Dr Timothy Chico (Sheffield University) is looking at pioneering research on zebra fish – an animal capable of mending its own heart. Professor Humphries is studying an inherited disease called Familial Hypercholesterolaemia (FH) which causes dangerously high levels of cholesterol in the blood from an early age. Early identification of FH means people can make changes to their lifestyle, including their diet, and be given medication such as statins to give them the best chance of preventing heart disease and living a longer, healthier life. Professor Humphries' team has developed genetic screening methods for FH. They have used these techniques to establish a national DNA diagnostic service, which has already found many people with FH patients by tracing the relatives of known FH patients. The BHF have raised over £400 million and have over 100 research project, 6 centres of research, 30 world leading professors and account for over half of all heart research in the UK. **Question for steering group:** How can we demonstrate the impact of BHF research on local people and services? **Actions:** • **Invite Ben Kolb and Tim Chico to speak at stakeholder event in June** • **Invite the Advertiser (and one or two other key influencers/potential funders) to a tour of the research labs in Sheffield** • **Identify case study of person/people in Rotherham who has benefited/could benefit from the BHF research via cardiac nurses** There will be a South Yorkshire research appeal launched in May to coincide with the anniversary of Richard Fieldsend's death. We can tie in promotion of BHF research and local impact with this appeal.	**LM** **LM** **AI/LM**
4.	**Heart Town Award – first presentations** Phill Spencer has been in touch with companies already making the requirements; 5 out of the 6 have responded. The window stickers are being printed and we getting ready to do the presentation. Discussions were held as to whether to have a one off event or a series of smaller ones. It was agreed that a visit should be made to the first 5 and an event should be held for the others at a later date. **Actions:** • **PS to liaise with KW for presentation dates** • **PS to liaise with David Barker on press release**	**PS/KW** **PS/DB**
5.	**Heart Town stakeholder event** It was agreed that the stakeholder event should be held on the 10th June in	

	place of the steering group meeting. The venue will be the John Smiths room at the Town Hall with a 9:30-10:00 start and a 12:00 lunch. Attendees should include people who attended last year's event, people on the newsletter circulation list, all of the companies/venues that have a defibrillator and HT award recipients. **Actions:** • **AI, KW, LM and JW will meet to plan the event** • **KW will book the room**	**AI** **KW**
6.	**Health and Wellbeing event** The second health and wellbeing event, *Working Together for a Healthier Rotherham* is on the 16th July at the New York Stadium. The event is being funded by the CCG and the guest speaker is Roy Lilley. In the morning there will be talks from John Radford, RDASH and Healthwatch along with stalls and in the afternoon there will be a number of workshops available. Heart Town, Sports Development and DC Leisure will share a stall on the day.	
7.	**Heart Failure pilot project** DC Leisure and the heart failure nurses have been looking at where physical activity pathways can be clarified and people can benefit from greater promotion. A 12-week pilot has been funded where 10 patients will have functional assessments before and after a tailored exercise programme to identify the difference it can make to their health and daily activity. A request was made for steering group members to help promoting the scheme.	
8.	**Fundraising/volunteering update** The BHF No Smoking Day event is being held at TRFT on 12 March 2014. **Circle of Hope – Saturday 28 June 2014** This event was held in the town centre last year and AI and LM have talked about moving it back to Clifton Park as the take up for this was higher. • LM will focus on the walk and ask the Sheffield branch if they can also help. • KD will get the schools on board with fundraising in June • AI will contact CS and HM about activities outside Riverside. • Themed food will be available at Riverside Café. *Post meeting note: another event is on in Clifton Park on the Saturday to considering moving it to Sunday. LM to update in April* Discussions were held on the Heart Town heart-shaped mile walk being in Clifton Park. Leon advised that there is already a marked walk in the park. **Action: LM will contact CS to discuss.** The neonatal ward at the hospital has a special room called the purple butterfly room to help give a more positive end of life. At the moment there is no such room on the Cardiac Ward and there is also no information for patients leaving hospital to help them or sign post them to other service	**LM**

	that can benefit them. SD, LM and local teams will meet to discuss how they can help. DC Leisure can also help with patients who have been discharged back in to physical activity. These patients would need to be assessed as individuals would need specialised care with appropriate exercise. **LM to give HM contact details of the hospital fundraiser to get thing moving forward** Continuing promotion of volunteering opportunities underway including RFT volunteer recruitment event with VAR, VAR leading on recruitment at the local colleges, a feature will appear in the Advertiser on the need for a new branch chair.	**LM**
9.	**Prevention and care update** Steph was not at meeting. *Post meeting note: two workshops on heart health and diabetes for the BME community have been offered to Rotherham. Planning of these underway with Nizz Sabir.*	
10.	**Communications update** LM has now obtained the access rights to Facebook and Twitter and information will be circulated with the minutes.	
11.	**Any other business** DC Leisure and Public Health and Sports Development have been discussing long term conditions to ID the gaps in signposting to exercise in relation to strokes, COPD, Cancer and Obesity. A pilot scheme is in place for COPD and Strokes and Active Always leaflets have been circulated.	
12.	**Date and Time of next meeting** – 29th April 2014 9.30	

Agenda Item 9

Public Health England

Child Health Profile

March 2014

Rotherham

This profile provides a snapshot of child health in this area. It is designed to help the local authority and health services improve the health and wellbeing of children and tackle health inequalities.

The child population in this area

	Local	Yorkshire and the Humber	England
Live births in 2012	3,264	67,408	694,241
Children (age 0 to 4 years), 2012	16,000 (6.2%)	333,500 (6.3%)	3,393,400 (6.3%)
Children (age 0 to 19 years), 2012	62,400 (24.1%)	1,279,700 (24.1%)	12,771,100 (23.9%)
Children (age 0 to 19 years) in 2020 (projected)	63,700 (23.8%)	1,329,800 (23.6%)	13,575,900 (23.7%)
School children from minority ethnic groups, 2013	5,295 (14.5%)	141,710 (21.2%)	1,740,820 (26.7%)
Children living in poverty (age under 16 years), 2011	23.2%	21.7%	20.6%
Life expectancy at birth, 2010-2012			
Boys	78.0	78.3	79.2
Girls	81.6	82.2	83.0

Children living in poverty

Map of Yorkshire and the Humber, with Rotherham outlined, showing the relative levels of children living in poverty.

Contains Ordnance Survey data

Data sources: Live births, Office for National Statistics (ONS); population estimates, ONS mid-year estimates; population projections, ONS interim 2011-based subnational population projections; black/ethnic minority maintained school population, Department for Education; children living in poverty, HM Revenue & Customs (HMRC); life expectancy, ONS.

Key findings

Children and young people under the age of 20 years make up 24.1% of the population of Rotherham. 14.5% of school children are from a minority ethnic group.

The health and wellbeing of children in Rotherham is mixed compared with the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is worse than the England average with 23.2% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average.

9.5% of children aged 4-5 years and 21.0% of children aged 10-11 years are classified as obese.

A lower percentage of mothers initiate breastfeeding compared to the England average, with 58.5% breastfeeding. By six to eight weeks after birth, the percentage of mothers who breastfeed their babies is lower than the England average, with 29.7% of mothers continuing to breastfeed.

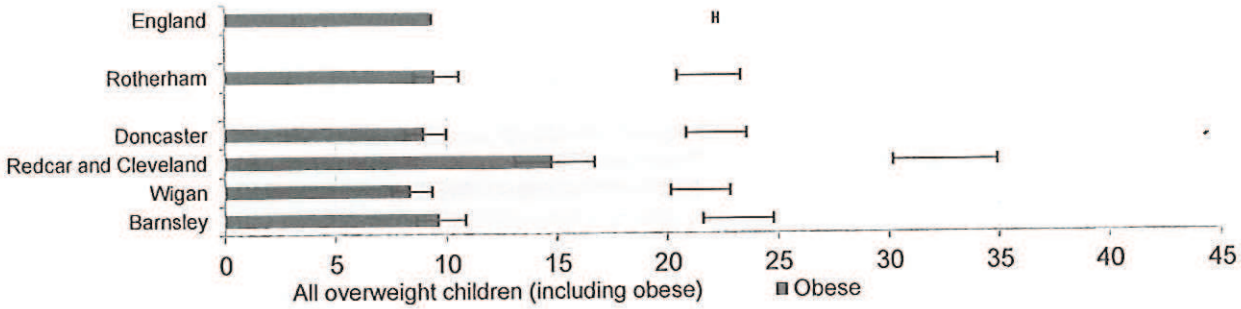
In 2012/13, children were admitted for mental health conditions at a lower rate to that in England as a whole. The rate of inpatient admissions during the same period because of self-harm was lower than the England average.

Any enquiries regarding this publication should be sent to info@chimat.org.uk.

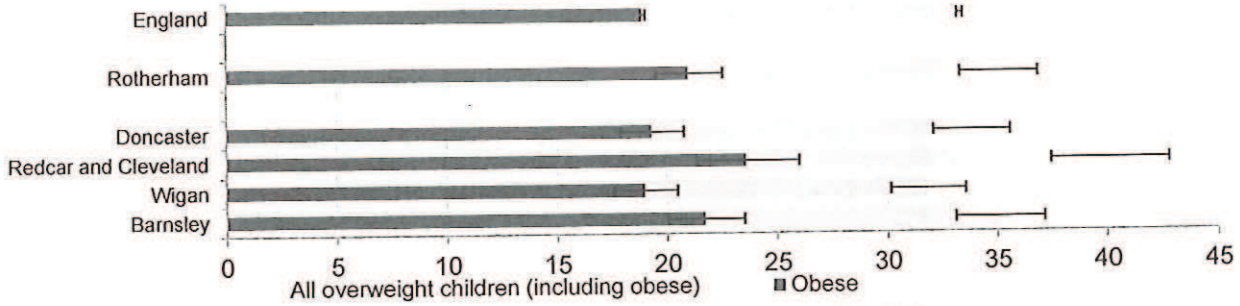
Childhood obesity

These charts show the percentage of children classified as obese or overweight in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) by local authority compared with their statistical neighbours. Compared with the England average, this area has a similar percentage in Reception and a similar percentage in Year 6 classified as obese or overweight.

Children aged 4-5 years classified as obese or overweight, 2012/13 (percentage)



Children aged 10-11 years classified as obese or overweight, 2012/13 (percentage)

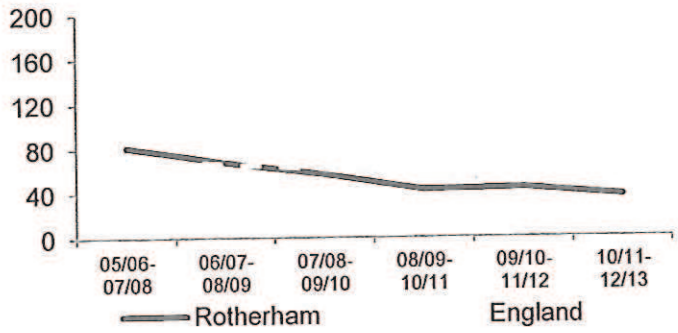


Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese.
I indicates 95% confidence interval. Data source: National Child Measurement Programme (NCMP), Health and Social Care Information Centre

Young people and alcohol

In comparison with the 2005/06-2007/08 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose is lower in the 2010/11-2012/13 period. The admission rate in the 2010/11-2012/13 period is similar to the England average.

Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)

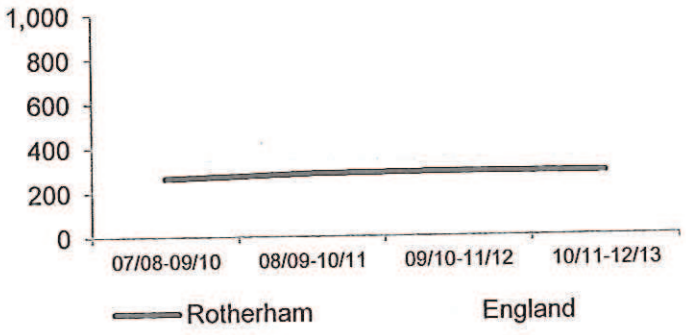


Data source: Public Health England (PHE)

Young people's mental health

In comparison with the 2007/08-2009/10 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm is similar in the 2010/11-2012/13 period. The admission rate in the 2010/11-2012/13 period is lower than the England average*. Nationally, levels of self-harm are higher among young women than young men.

Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10 to 24 years)

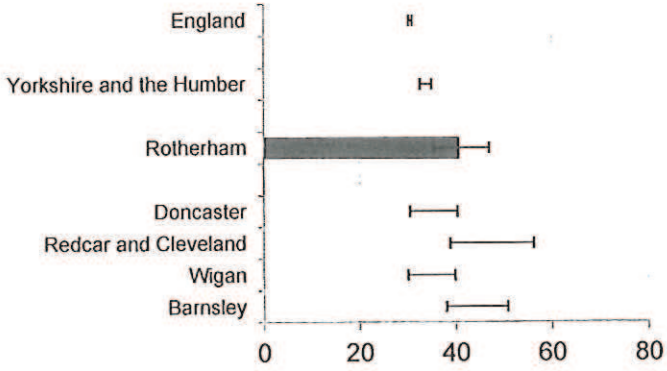


*Information about admissions in the single year 2012/13 can be found on page 4

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

These charts compare Rotherham with its statistical neighbours, the England and regional average and, where available, the European average.

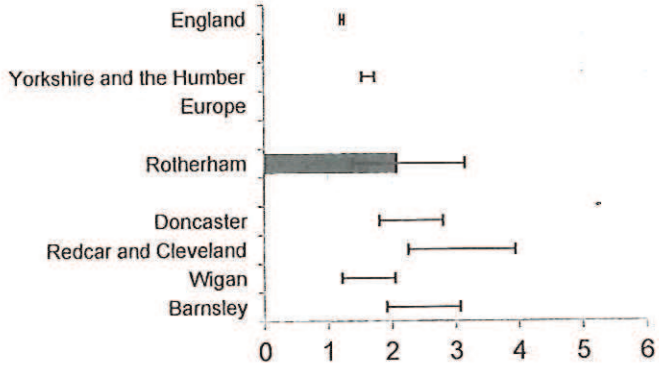
Teenage conceptions in girls aged under 18 years, 2011 (rate per 1,000 female population aged 15-17 years)



In 2011, approximately 41 girls aged under 18 conceived for every 1,000 females aged 15-17 years in this area. This is higher than the regional average. The area has a higher teenage conception rate compared with the England average.

Data source: ONS

Teenage mothers aged under 18 years, 2012/13 (percentage of all deliveries)

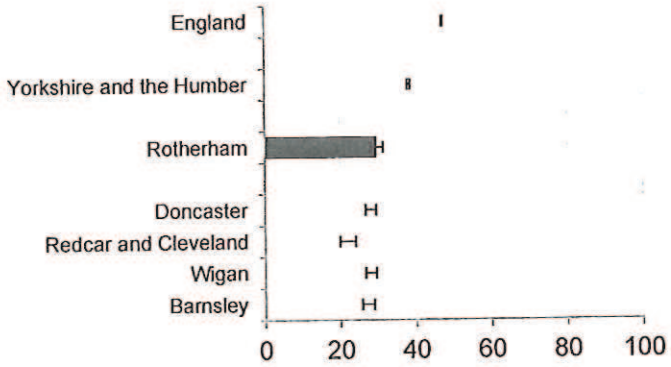


In 2012/13, 2.1% of women giving birth in this area were aged under 18 years. This is similar to the regional average. This area has a higher percentage of births to teenage girls compared with the England average and a higher percentage compared with the European average of 1.2%*.

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

* European Union 27 average, 2009. Source: Eurostat

Breastfeeding at 6 to 8 weeks, 2012/13 (percentage of infants due 6 to 8 week checks)

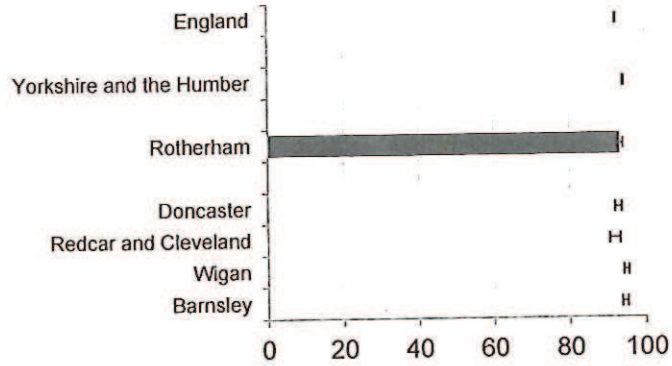


In this area, 29.7% of mothers are still breastfeeding at 6 to 8 weeks. This is lower than the England average. 58.5% of mothers in this area initiate breastfeeding when their baby is born. This area has a lower percentage of babies who have ever been breastfed compared with the European average of 89.1%*.

* European Union 21 average, 2005. Source: Organisation for Economic Co-operation and Development (OECD) Social Policy Division

Data source: PHE

Measles, mumps and rubella (MMR) immunisation by age 2 years, 2012/13 (percentage of children age 2 years)



Compared with the England average, a similar percentage of children (93.2%) have received their first dose of immunisation by the age of two in this area. By the age of five, 91.2% of children have received their second dose of MMR immunisation. This is higher than the England average. In Yorkshire and the Humber, there were 130 laboratory confirmed cases of measles in young people aged 19 and under in the past year.

Data sources: Health and Social Care Information Centre, PHE

Note: Where data is not available or figures have been suppressed, no bar will appear in the chart for that area.

Rotherham Child Health Profile — March 2014

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- Regional average

25th percentile — England average — 75th percentile

	Indicator	Local no.	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	1 Infant mortality	16	5.1	4.3	7.7	1.3
	2 Child mortality rate (1-17 years)	7	12.6	12.5	21.7	4.0
Health protection	3 MMR vaccination for one dose (2 years)	2,928	93.2	92.3	77.4	98.4
	4 Dtap / IPV / Hib vaccination (2 years)	3,048	97.0	96.3	81.9	99.4
	5 Children in care immunisations	280	96.6	83.2	0.0	100.0
	6 Acute sexually transmitted infections (including chlamydia)	1,569	50.0	34.4	89.1	14.1
Wider determinants of ill health	7 Children achieving a good level of development at the end of reception	1,843	55.7	51.7	27.7	69.0
	8 GCSEs achieved (5 A*-C inc. English and maths)	2,224	63.6	60.8	43.7	80.2
	9 GCSEs achieved (5 A*-C inc. English and maths) for children in care	5	22.2	15.3	0.0	41.7
	10 16-18 year olds not in education, employment or training	730	7.4	5.8	10.5	2.0
	11 First time entrants to the youth justice system	111	434.9	537.0	1,426.6	150.7
	12 Children in poverty (under 16 years)	11,525	23.2	20.6	43.6	6.9
	13 Family homelessness	69	0.6	1.7	9.5	0.1
	14 Children in care	390	70	60	166	20
	15 Children killed or seriously injured in road traffic accidents	9	18.9	20.7	45.6	6.3
Health improvement	16 Low birthweight of all babies	250	7.6	7.3	10.2	4.2
	17 Obese children (4-5 years)	299	9.5	9.3	14.8	5.7
	18 Obese children (10-11 years)	582	21.0	18.9	27.5	12.3
	19 Children with one or more decayed, missing or filled teeth	-	40.4	27.9	53.2	12.5
	20 Under 18 conceptions	201	40.9	30.7	58.1	9.4
	21 Teenage mothers	22	2.1	1.2	3.1	0.2
	22 Hospital admissions due to alcohol specific conditions	21	37.4	42.7	113.5	14.6
	23 Hospital admissions due to substance misuse (15-24 years)	29	92.3	75.2	218.4	25.4
Prevention of ill health	24 Smoking status at time of delivery	563	19.2	12.7	30.8	2.3
	25 Breastfeeding initiation	1,713	58.5	73.9	40.8	94.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	914	29.7	47.2	17.5	83.3
	27 A&E attendances (0-4 years)	7,605	481.2	510.8	1,861.3	214.4
	28 Hospital admissions caused by injuries in children (0-14 years)	473	102.3	103.8	191.3	61.7
	29 Hospital admissions caused by injuries in young people (15-24 years)	370	117.9	130.7	277.3	63.8
	30 Hospital admissions for asthma (under 19 years)	119	200.1	221.4	591.9	63.4
	31 Hospital admissions for mental health conditions	29	51.7	87.6	434.8	28.7
	32 Hospital admissions as a result of self-harm (10-24 years)	105	224.6	346.3	1,152.4	82.4

Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2010-2012
2 Directly standardised rate per 100,000 children age 1-17 years, 2010-2012
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2012/13
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2012/13
5 % children in care with up-to-date immunisations, 2013
6 Acute STI diagnoses per 1,000 population aged 15-24 years, 2012
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2012/13
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2012/13
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2013 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2012
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2012
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2011
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2012/13
14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2013
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2010-2012
16 Percentage of live and stillbirths weighing less than 2,500 grams, 2012
17 % school children in Reception year classified as obese, 2012/13
18 % school children in Year 6 classified as obese, 2012/13
19 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
20 Under 18 conception rate per 1,000 females age 15-17 years, 2011
21 % of delivery episodes where the mother is aged less than 18 years, 2012/13
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2010/11-2012/13
23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2010/11-2012/13
24 % of mothers smoking at time of delivery, 2012/13
25 % of mothers initiating breastfeeding, 2012/13
26 % of mothers breastfeeding at 6-8 weeks, 2012/13
27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2011/12
28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2012/13
29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2012/13
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2012/13
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2012/13
32 Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm, 2012/13

breast cancer campaign
Research that saves lives

Clifton Centre, 110 Clifton Street,
London EC2A 4HT
Switchboard 020 7749 3700
Supporter Care Team 020 7749 4114
Fax 020 7749 3701
Web breastcancercampaign.org

Cllr Ken Wyatt
Rotherham Health and Wellbeing Board
Riverside House
Main Street
Rotherham
S60 1AE

13 March 2014

Dear Cllr Wyatt,

I wanted to let you know about a new report published by Breast Cancer Campaign, *Finding the cures, improving the care.* This report explores how more effective monitoring of performance against the NICE *Breast cancer quality standard* (BCQS) could be used to drive improvements in the standard of care for women with breast cancer, and includes recommendations that apply to Health and Wellbeing Boards.

About the report

Around 50,000 women are diagnosed with breast cancer every year, and each of them deserves the best possible care. The NICE *Breast cancer quality standard* sets out markers of high quality, cost-effective patient care in the NHS in England, however this important tool could be used more effectively. There are no formal mechanisms in place to monitor and report on the performance of services against the standard, and no way to comprehensively assess the impact it is having on driving improvements.

To highlight opportunities to address this information gap we considered data from the National Cancer Patient Experience Survey, and found that it can provide useful insights into whether people are being offered a written assessment and care plan; discussions of care by a multidisciplinary team; and meaningful access to a clinical nurse specialist.

The report finds that a lack of comprehensive data collection and reporting could undermine the potential of the BCQS to drive improvements in these key areas, and it makes 16 recommendations to address this problem.

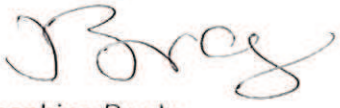
How you can help

As you'll see in the report, there are a number of recommendations that might be of particular interest to you. For example, the report recommends that Health and Wellbeing Boards should take into account the findings from the peer review process during the development of a Joint Strategic Needs Assessment (JSNA), and consider whether there are opportunities to introduce incentives for local trusts to ensure patients with recurrent or secondary breast cancer have their care discussed by a multidisciplinary team.

We would welcome your thoughts on the report and your experience of the *Breast cancer quality standard*, as well as any further ideas you have in relation to implementing the standard. Also, if

your Health and Wellbeing Board is taking action specifically for women with recurrent or secondary breast cancer, for example through your JSNA, we would be keen to hear the details of this, and to discuss actions you can take to ensure compliance with the BCQS in your area. You can contact me on 0207 749 3729, or at jbrady@breastcancercampaign.org.

Best wishes,



Josephine Brady
Public Affairs and Policy Officer

mnda

motor neurone disease association

themndcharter

Achieving quality of life, dignity and respect for people with MND and their carers

themndcharter

Achieving quality of life, dignity and respect for people with MND and their carers

1 People with MND have the right to an early diagnosis and information

THIS MEANS:

- **an early referral to a neurologist**
- **an accurate and early diagnosis, given sensitively**
- **timely and appropriate access to information at all stages of their condition.**

There is no diagnostic test for MND – it can only be diagnosed by ruling out other neurological conditions. People with MND can be halfway through their illness before they receive a firm diagnosis.

GPs need to be able to identify the symptoms and signs of a neurological problem and refer directly to a neurologist in order to speed up diagnosis times for MND.

Appropriate tests must be carried out as soon as possible to confirm MND. The diagnosis should be given sensitively, in private, with the person with MND accompanied by a family member/friend and with time to ask questions. A follow-up appointment with the neurologist should be arranged at diagnosis.

At diagnosis people with MND should be offered access to appropriate information and should be informed about the MND Association. Appropriate information should be available at all stages of the person's condition in a language of their choice.

2 People with MND have the right to access quality care and treatments

THIS MEANS:

- **access to high-quality co-ordinated services managed by a specialist key worker with experience of MND**
- **early access to specialist palliative care in a setting of their choice, including equitable access to hospices**
- **access to appropriate respiratory and nutritional management and support, as close to home as possible**
- **access to the drug riluzole**
- **timely and appropriate access to NHS continuing healthcare when needed.**

People with MND may need as many as 18 health and social care professionals providing care at any one time. This clearly needs co-ordination to work effectively. Co-ordinated care can improve the quality of life of people with MND and provide value for money for the NHS by preventing crises and emergency hospital admissions. The care should be co-ordinated by a specialist key worker with experience of MND who can anticipate needs and ensure they are met on time. On-going education

for health and social care professionals is important to reflect advances in healthcare techniques and changes in best practice.

As MND progresses, the respiratory muscles and muscles of the mouth and throat may be affected. People with MND may therefore need respiratory and nutritional support. It is important that these services are available as close to the person's home as possible so that travelling is minimised and support is available quickly.

In 2001 the National Institute for Health and Clinical Excellence (NICE) recommended riluzole as a cost-effective drug for people with MND. GPs can be reluctant to prescribe riluzole on cost grounds, despite its NICE-approved status, or to monitor for side effects during its use. However, it is vital that people with MND have ongoing access to this important treatment.

As the disease progresses, people with MND may need more intensive health care. It is important that people with MND have timely access to NHS continuing healthcare when they need it.

Half of people with MND die within 14 months of diagnosis. Early access to specialist palliative care[1] from soon after diagnosis is therefore vital and should be available in a setting of the person's choice. Some hospices give preferential access to people with a cancer diagnosis. It is important that access is based on need, not diagnosis, so that people with MND have equitable access to hospice care. Hospices can provide high-quality respite care, which can benefit both the person with MND and their carer.

3 People with MND have the right to be treated as individuals and with dignity and respect

THIS MEANS:

- **being offered a personal care plan to specify what care and support they need**
- **being offered the opportunity to develop an Advance Care Plan to ensure their wishes are met, and appropriate end-of-life care is provided in their chosen setting**
- **getting support to help them make the right choices to meet their needs when using personalised care options**
- **access to appropriate communication support and aids**
- **opportunities to be involved in research if they so wish.**

Everyone with MND should be offered a personal care plan[2] to specify what care and support they need. The plan should be regularly reviewed as the disease progresses and the person's needs change.

As the disease progresses, some people with MND will lose their ability to communicate due to severe speech and physical impairments. It is important that people with MND can access speech and language therapy to help them maintain their voice for as long as possible. However, as the disease progresses, people with MND may need access to communication aids including augmentative and alternative communication (AAC)[3]. The ability to communicate is a basic human right. For people with MND, communication support and equipment are vital in order to remain socially active and to communicate their wishes about their care, especially during hospital stays and other medical environments.

Some people with MND will need support to help them make the right choices to meet their needs when using personalised care options, such as personal budgets.

Many people with MND value the opportunity to be involved in research as it provides hope that one

[1] **Specialist palliative care** – palliative care is the active holistic care of patients with progressive illness, including the provision of psychological, social and spiritual support. The aim is to provide the highest quality of life possible for patients and their families. Specialist palliative care is care provided by a specialist multidisciplinary palliative care team.
[2] **Personal care plan** – a plan which sets out the care and treatment necessary to meet a person's needs, preferences and goals of care.
[3] **Augmentative and Alternative Communication (AAC)** – is used to describe the different methods that can be used to help people with speech difficulties communicate with others. These methods can be used as an alternative to speech or to supplement it. AAC may include unaided systems such as signing and gesture as well as aided systems such as low tech picture or letter charts through to complex computer technology.

day an effective treatment will be developed. Everyone with MND who wishes to should be able to participate in research as far as is practicable.

People with MND should be offered the opportunity to develop an Advance Care Plan[4] to make clear their wishes for future care and support, including any care they do not wish to receive. The plan should be developed with support from a professional with specialist experience and may include preferences for end-of-life care.

4 People with MND have the right to maximise their quality of life

THIS MEANS:

- **timely and appropriate access to equipment, home adaptations, wheelchairs and suitable housing**
- **timely and appropriate access to disability benefits.**

In order to maximise their quality of life, people with MND may need access to equipment, home adaptations, wheelchairs and suitable housing. These needs should be anticipated so that they are met in a timely way. This is particularly true of wheelchairs which are important for maximising independence and quality of life.

People with MND need timely and appropriate access to disability benefits to help meet the extra costs of living with a disability. Information on appropriate benefits needs to be readily accessible in one place and easily understandable.

5 Carers of people with MND have the right to be valued, respected, listened to and well supported

THIS MEANS:

- **timely and appropriate access to respite care, information, counselling and bereavement services**
- **having their needs assessed as carers and individuals, ensuring their health and emotional well being is recognised and appropriate support is provided**
- **timely and appropriate access to benefits and entitlements for carers.**

Caring for someone with MND is physically and emotionally demanding. Carers need to be supported in order to maintain their caring role. Every carer should have their needs assessed and given timely and appropriate access to respite care, information, counselling and bereavement services. It is important to support the emotional and physical needs of the carer in a timely way so that they can continue their caring role.

Carers should also have timely and appropriate access to benefits and entitlements to help manage the financial impact of their caring role.

[4] **Advance care plan** – a plan which anticipates how a person's condition may affect them in the future and, if they wish, set on record choices about their care and treatment and/or an advance decision to refuse a treatment in specific circumstances so that these can be referred to by those responsible for their care or treatment (whether professional staff or family carers) in the event that they lose capacity to decide or communicate their decision when their condition progresses.

themndcharter

Achieving quality of life, dignity and respect for people with MND and their carers

The MND Charter embraces the natural rights of people with MND and their carers and sets out the respect, care and support they deserve and should expect.

We urge all individuals with a connection to MND, either personally or professionally, and organisations working with people with MND to endorse and sign up to the charter.

By signing the charter, you are pledging your understanding and support for the charter statements to help ensure people with MND and their carers have their rights respected and are given the very best opportunity to access the care they need to live the highest quality of life possible and achieve dignity in death.

Motor neurone disease (MND) is a fatal, rapidly progressive disease. It can leave people locked into a failing body, unable to move, walk, talk and eventually breathe. Life expectancy from diagnosis is two to five years, and around half of those die within 14 months. The rapid progression of MND means rapidly changing needs. Therefore, what matters most is that people with MND receive a rapid response to their needs and good quality care and support, ensuring the highest quality of life as possible and the ability to die with dignity – and it will save the Government money in the long run.

The MND Charter sets out the key priorities for local services to help get it right for MND. This disease is particularly difficult to manage. We believe that if we get it right for MND we can get it right for other neurological conditions.

We all have a responsibility to make it work for MND – show your support by signing the five point charter.

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Achieving quality of life, dignity and respect for people with MND and their carers

"Many people with MND die without having the right care, not having a suitable wheelchair, not having the support to communicate.

We have got to set a standard so that people like us are listened to and treated with the respect and dignity we deserve.

We have got to stop the ignorance surrounding this disease and have to make sure that when a patient is first diagnosed with MND, they must have access to good, co-ordinated care and services.

One week waiting for an assessment or a piece of equipment is like a year in most people's lives, because they are an everyday essential to help us live as normal a life as possible and die with dignity"

Liam Dwyer, who is living with MND

The MND Charter aims to gain support from individuals and organisations with a personal or professional connection to MND, in working towards the vision of the right care, in the right place, at the right time for people with MND and their carers.

Anyone can sign up to the MND Charter. By doing so, you are showing that you have listened to the voice of people with MND and their carers, and pledge to understand and support the principles and priorities set out in the charter.

Show your support and sign the MND Charter:

Online: www.mndassociation.org/mndcharter

Email: campaigns@mndassociation.org

Telephone: 01604 611684

MND Association
PO Box 246 Northampton NN1 2PR
www.mndassociation.org

Registered charity no 294354

themndcharter

Achieving quality of life, dignity and respect for people with MND and their carers

1. **People with MND have the right to an early diagnosis and information**
2. **People with MND have the right to access quality care and treatments**
3. **People with MND have the right to be treated as individuals and with dignity and respect**
4. **People with MND have the right to maximise their quality of life**
5. **Carers of people with MND have the right to be valued, respected, listened to and well supported**

sign up now:

Anyone can sign up to demonstrate support for the MND Charter, fill in your details below, or sign online at **www.mndassociation.org/mndcharter**

Please complete and return to:
Campaigns Team, MND Association, David Niven House, 10-15 Notre Dame Mews, Northampton, NN1 2BG

First Name _____ Last name _____

Address _____

_____ Postcode _____

Email Address _____

Send me campaign updates - Yes/No

Public message of support (Optional, may be used to display on website or in print)

_____

_____

_____

I am showing my support as an (e.g. individual, organisation*, politician*, health and social care professional etc)

_____

Organisation (if applicable) _____

*Organisations and politicians who sign up will receive a template press release and a certificate of support to display.

From time to time we would like to send you details of our work and how you can help. If you do not want to receive further information from the MND Association please tick this box ☐

MND Association
PO Box 246 Northampton NN1 2PR
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