

CABINET MEMBER FOR HEALTH AND WELLBEING

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

Date: Monday, 7th November, 2011

Time: 11.30 a.m.

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested, in accordance with the Local Government Act 1972 (as amended March 2006).
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. Minutes of meeting 10th October, 2011 (Pages 1 - 6)
4. Health and Wellbeing Board (Pages 7 - 12)
- minutes of meeting held on 21st September, 2011
5. Home Boarding Licence Conditions (Pages 13 - 22)
6. Joint Strategic Needs Assessment (Pages 23 - 28)
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<http://www.rotherham.nhs.uk/files/Organisational/Comissioning/JSNA%20Report%202011.pdf>
Please note this is a large document and has not been included in the agenda pack
7. October Briefing - Sport, Recreation and Play (Page 29)

CABINET MEMBER FOR HEALTH AND WELLBEING
10th October, 2011

Present:- Councillor Wyatt (in the Chair); Councillors Buckley, Burton, Jack, Pitchley and Steele.

K20. MINUTES OF MEETING

Consideration was given to the minutes of the previous meeting held on 12th September, 2011.

Arising from Minute No. 13 (Conference), it was noted that the Cabinet Member would not be attending the conference due to other commitments.

Arising from Minute No. 14 (Health Summit), it was noted that the event was to take place on 1st December.

Resolved:- That the minutes of the meeting held on 12th September, 2011, be approved as correct record.

K21. TOBACCO CONTROL

Alison Iloff, Public Health Specialist, presented the Tobacco Bulletins for July and September, 2011, which summarised the latest tobacco control activity within Rotherham, national and international news related to tobacco and smoking and outlined any relevant training and development opportunities.

A powerpoint presentation was also given as follows:-

Scale of the Challenge

- Early year smoking caused the greatest number of preventable deaths - 81,400
- The decline in smoking rates had stalled
- National children's rates of smoking (age 11-15)
- Smoking in pregnancy
- Smoking cost the local economy millions every year (£71.9M in Rotherham)
- The annual cost of smoking to smokers (compared to additional costs to our community) - each year, smokers in Rotherham spent approximately £81.5M on tobacco product contributing roughly £62.1M in duty to the Exchequer. This meant that there was an annual funding shortfall of £9.8M in this area

Smoking Attitudes and Behaviours

- Children not adults start smoking - 90% of smokers started before the age of 19
- Children were 3 times as likely to start smoking if their parents smoked
- The majority of children who smoked got their cigarettes from a 'friend'
- The poorer you were the more likely you were to smoke
- Smoking was 1 of the greatest causes of health inequalities
- Poorer smokers were as likely to want to quit and try to quit but half as likely to succeed
- Smokefree environments enjoyed increasing public support.

Tobacco Control and Local Authority Role

- The World Bank has developed a '6 strand' strategy for reducing tobacco use:-
 1. stopping the promotion of tobacco
 2. making tobacco less affordable
 3. effective regulation of tobacco products
 4. helping tobacco users to quit
 5. reducing exposure to secondhand smoke
 6. effective communication for tobacco control

Significant and Growing Role for Local Authorities

- Local Authority responsibilities included enforcement on:
 - Age of Sale
 - 'Smokefree' Places
 - Smuggled and counterfeit tobacco
 - Advertising ban
- From 2013 Local Authorities would take on responsibility to commission services to motivate and support smokers to quit their habit

Working Together for Better Health

- Local Government including Police and Fire
- Local Health Services
- Organisations that work across neighbouring localities within a region
- Employers
- Voluntary sector organisations
- Smokers particularly groups with high rates of smoking e.g. routine and manual smokers

Benefits of Working across Local Boundaries

- Marketing and mass media - to ensure 'health messages' were supportive, clear and do not conflict
- Tackling smuggling - criminal gangs do not pay heed to local government boundaries
- Surveys, research and data collection - cost savings can be had from collectively commissioning research and surveys and sharing the results

Challenges for Rotherham

- Smoking prevalence not declining (although data may not be reliable)
- Smoking in pregnancy was declining, but was still much higher than the national and regional average
- Understanding the apparent increase in young smokers and implementing further programmes to tackle youth smoking
- Cheap and illicit tobacco - continuing availability undermined other tobacco control activity

Key Messages

- Local authorities had a key and important role to play - the NHS alone could not reduce smoking rates

- Smoking was the single biggest preventable cause of health inequalities – reducing rates would bring general improvements in health and cost savings in other areas
- To reduce smoking there was a need to increase the number of quit attempts and the success of each attempt – the poorest smokers should be targeted to narrow the gap in life expectancy between the richest and poorest and improve the health of the poorest fastest

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

- The latest Lifestyle Survey statistics showed an increase in the number of children smoking
Following the meeting it was established that it was a 10% increase on last year and against national trends
- In the last 6 months, Rotherham Trading Standards had:-
 - Undertaken 20 individual test purchases with regard to the sale of tobacco to children from retail premises which had resulted in no failures. However, the Lifestyle Survey stated that 55% of young people got their cigarettes from shops
 - Seized a total 44,160 illegal cigarettes (counterfeit or smuggled) from retail outlets and private addresses – this was over 2,200 packs
 - Seized 10.4 kgs of illegal handrolling tobacco (counterfeit or smuggled) from retail outlets and private addresses – over 800 packs
 - Seized 0.5 kg of illegal handrolling tobacco from an individual selling the product in the town centre – 40 packs
- The Trading Standards Team was now temporarily reduced in size due to some recent voluntary early release applications. However, there were plans to strengthen the Team shortly by way of a restructure.
- Tackling the illegal supply and sale of tobacco would remain a key priority for Rotherham
- The resources used to stop adults from smoking was not cost effective and should be concentrated on young people and pregnant women
- At the moment the national guidance was the 4 week “Quit” programme. However, the Tobacco Control Paper spoke about different routes
- There was little evidence to support the Quit programme for young people being successful. The primary focus of Tobacco Control was prevention rather than helping a young person quit
- There were a whole range of issues beyond what could be done locally such as images in the media and the desire of young people to copy celebrities
- Unclear message about tobacco unlike those of alcohol and drugs
- The Rotherham Titans had done a lot of work around the issue
- There was close work with the Healthy Schools Team who liaised with schools directly. All schools had a Smoke Free Policy but the big problem was when children left school premises to walk home and no longer the school’s responsibility

The draft lifestyle survey had an error stating there were 15% not 10% current smokers. They also included young people who smoked monthly in this figure. The comparative figure is regular smokers (weekly and daily smokers), which was actually 8%, the same as 2010. However, this is still 3 percentage points higher than the England average in 2010.

The Rotherham Tobacco Control Alliance had a meeting on 20th October. The action plan would be considered with a further report submitted to the Cabinet Member.

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

(2) That the attention of the Children's Board be drawn to the increase in the number of children smoking.

(3) That it be noted that the Cabinet Member was to Chair the Rotherham Tobacco Control Alliance.

K22. SUICIDE PREVENTION GROUP/PLAN

Ruth Fletcher-Brown, Public Health Specialist (Mental Health all Ages and Domestic Abuse) and Kate Tufnell, Head of Contracts and Service Improvement, Mental Health, Learning Disabilities and Specialised Services, presented an update on the national and local suicide prevention plans together with proposals as to how to drive the work forward. Suicide was 1 of the proposed Indicators in the Public Health Indicators Framework which was out for consultation.

Suicide was a major issue for the whole of society, affecting not only immediate family and friends but the wider society. Nationally the figure for suicide in 2009, including undetermined intent, was 4,399.

The report drew attention to the following:-

- Most of the people who died by suicide in Rotherham were men which was a similar trend to that found nationally
- The most common age group in England was 20-64 (peaking at ages 35-49). This was similar for Rotherham
- The reduction in numbers since 2008 may be explained by the multi-partnership Public Health work. Suicide prevention was most effective when it was combined as wider work addressing the social and other determinants of poor health and wellbeing
- GP Practices were informed by NHR of suicide and conducted their own internal review to look at lessons that could be learnt. Similarly, RDaSH conducted internal reviews if the person had been in contact with their service
- Hanging accounted for 9 (89%) of Rotherham suicides in the period from July, 2008-2009 and 1 (11%) via suffocation. 50% took place in the deceased's own home, the others were predominantly in homes known to the individual or wooded areas. The majority that took their own life were not in contact with Mental Health Services

In light of the consultation, it was proposed that a Suicide Prevention Group be established. The Group would use local data from the Suicide Audit and the Office of National Statistics to develop an action plan.

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

(2) That it be acknowledged that suicide prevention required a multi-agency approach and, in line with the Government's statement that the planning and preventative work would be carried out locally, a Suicide Prevention Group be established.

(3) That assessment against and implementation of the National Institute of Health and Clinical Excellence clinical guidelines on the long term management of self-harm in the NHS due November, 2011, be noted.

K23. YORKSHIRE AMBULANCE SERVICE 'LOOKING TO THE FUTURE' PUBLIC CONSULTATION

It was noted that the Yorkshire Ambulance Service was looking to apply for Foundation Trust status in 2012 and plans had been developed as to how they would like to take the new organisation forward in the future.

Between now and 4th December, 2011, everyone across Yorkshire was invited to share their views about the plans and help shape the way that Ambulance Services were provided in the future.

They also wished to recruit 'members' to the new organisation who would help influence the decisions made and ensure that they benefitted local communities.

It was noted that the issue was to be considered by the Health and Wellbeing Board at its meeting on 26th October.

K24. GENERAL DENTAL COMMITTEE - PROFESSIONAL CONDUCT COMMITTEE

Dr. Ken Wragg, Consultant in Dental Public Health, submitted a report of the General Dental Council's Professional Conduct Committee held in June, 2011, into Mohammed Shahid Siddiqui.

Mr. Siddiqui was a dentist based in Rotherham until May, 2009 until an unannounced infection control inspection of his practice took place by representatives from NHS Rotherham and the Health and Safety Executive. Areas of poor infection control practice had been found including re-use of items of equipment intended for single use.

Mr. Siddiqui had been immediately suspended from the NHS Rotherham Dental Performer's list meaning he was not allowed to practice NHS dentistry in Rotherham. He was also reported to the General Dental Council (GDC) in accordance with normal practice. The GDC Interim Orders Committee suspended Mr. Siddiqui from June, 2009. When reviewed in June, 2010, the suspension was lifted but imposed 17 conditions of practice until a further hearing could be convened early in 2011. Mr. Siddiqui had been referred by the GDC to its Professional Conduct Committee for full consideration of the case.

In the meantime, Mr. Siddiqui appealed against his removal from the NHS Rotherham Performer's list.

On 13th June, 2011, Mr. Siddiqui had appeared before the GDC Professional Conduct Committee. Of the 23 charges, 20 had been admitted and found proved. It had imposed 21 conditions which would apply for 3 years and would appear in the Dentists Register.

Resolved:- That the report be noted.

K25. HEALTH AND WELLBEING BOARD

The Chairman reported that the draft agenda for the next meeting of the Board included:-

Yorkshire Ambulance Service Consultation
Armed Forces Covenant

The December Board agenda would include:-
Mexborough Montague Hospital including the Emergency Dental Service

HEALTH AND WELLBEING BOARD
Wednesday, 21st September, 2011

Present:-

Councillor Wyatt	Cabinet Member, Health and Wellbeing (In the Chair)
Rebecca Atchinson	NHS Rotherham
Karl Battersby	Strategic Director, Environment and Development Services, RMBC
Michael Clark	Rotherham Partnership
Tracey Clarke	RDaSH
Tom Cray	Strategic Director, Neighbourhoods and Adult Services, RMBC
Councillor Doyle	Cabinet Member, Adult Social Care
Chris Edwards	NHS Rotherham/Rotherham CCG
Matt Gladstone	Director, Commissioning Policy and Partnerships, RMBC
Tracy Holmes	Corporate Communications, RMBC
Brian James	Rotherham NHS Foundation Trust
Shona McFarlane	Director, Health and Wellbeing, RMBC
Martin Kimber	Chief Executive, RMBC
Joyce Thacker	Strategic Director, Children and Young People's Services, RMBC
John Radford	Director of Public Health, NHS Rotherham
Kate Taylor	Scrutiny and Policy Officer, RMBC
Alan Tolhurst	PCT Cluster Board
David Tooth	Chair, Rotherham CCG
Fiona Topliss	Communications, NHS Rotherham
Dawn Mitchell	Democratic Services, RMBC

Apologies for absence were received from Councillor Lakin and Christine Boswell, RDaSH.

D1. WELCOME, INTRODUCTIONS AND APOLOGIES

The Chairman welcomed everyone to the first meeting of the Board.

D2. TERMS OF REFERENCE

Before consideration was given to the proposed interim Terms of Reference, the Chairman invited Alan Tolhurst, PCT Cluster Board representative, to give an update on the current situation regarding the governance of NHS Rotherham:-

- On the 1st October the 4 PCTs in South Yorkshire and Bassetlaw would come together as PCT Clusters. Whilst there would be 5 organisations/statutory bodies, there would be 1 Board that would sit on all 5 bodies.
- Representatives from each of the 5 constituent parts would become members of the Cluster, 2 from each organisation.
- The Chair of the Cluster was Tony Pedder, current Chairman of NHS Sheffield. There would be a number of Executive and Non-Executives sitting

on the Board.

- Locally, the work would be undertaken by the CCGs. The Chair of Rotherham CCG was Dr. David Tooth who would be responsible for most of the budget that up until the present time had been the responsibility of NHS Rotherham, approximately £380M.
- The purpose behind the change was to involve clinicians more in the commissioning of health services.
- The Cluster would remain in being for the next 18 months. One of its primary functions would be to develop the CCG such that on 1st April, 2013, it would take the lead and be responsible for all the commissioning of health services in its respective localities.
- Between now and April, 2013, the CCG would go through a phase of development, the first of which would be delegated responsibility. For Rotherham it would be the delegated responsibility for that part of the budget which in the future would be their responsibility under the CCG.
- The CCG was supported by staff whom up until now had been employed by the PCT.

The Chairman reported that he had been invited to be involved in the CCG.

Consideration was then given to the Terms of Reference which had been the subject of many versions. The following comments were made:-

- The consultation and involvement role was missing.
The Board would be judged on its success by its interactions with communities
- Extension of membership – South Yorkshire Fire Service and VAR?
Further Government guidance had been issued and appropriate to reconsider the membership. Need to be clear who attended with voting rights and who attended for information/involvement
- How would the Board relate to the other Panels that existed within the Authority? Would there be liaison with Licensing and/or Planning Boards both of which impinged on health?
- Where would the minutes of the Board go?
The Board was a Sub-Committee of the Council. The minutes would be submitted to full Council for approval and the LSP Board for information
- Further Government guidance had been issued

Agreed:- (1) That further work take place on the Terms of Reference for submission to the next meeting.

(2) That any comments/suggestions for inclusion in the document be forwarded to Kate Taylor.

D3. PUBLIC HEALTH ANNUAL REPORT 2011

John Radford, Director of Public Health, presented the Public Health annual report which outlined the health needs of the local population. The 2011 report was based on the Marmot Report (2010) which had been produced as part of the Labour Government's examination of progress in addressing health inequalities.

The report had been approved by the Council's Cabinet. It would be the contextual document for the work of the Board in developing the Joint Strategic Needs Assessment and Health and Wellbeing Strategy.

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

(2) That the Marmot principles be supported as a policy framework for developing the Health and Wellbeing Strategy for Rotherham and Rotherham's approach to addressing health inequalities.

D4. ROTHERHAM HEALTH SUMMIT

Rebecca Atchison reported on the Health Inequalities Summit which was to be held on 1st December, 2011. The objectives of the Summit were:-

- To re-energise the approach to address health inequalities in Rotherham
- To develop and deliver a framework that would make a difference to the people in Rotherham by:
 - Updating the progress against the original Health Inequalities action plan (2007/09)
 - Setting out a local vision for addressing health inequalities in Rotherham
 - Reviewing the current offer of services and agreeing areas for improvement
 - Providing additional focus on the needs of the communities who were classified within the 10% most deprived areas in England
- To assist the Council to develop and deliver a Rotherham Health Inequalities Action Plan

The 2 month evidence gathering exercise had commenced at the recent Rotherham Show with approximately 420 people asked about health issues. Consultation would also take place with Area Assemblies and focus groups.

Discussion ensued on the format of the Summit and the desired outcomes.

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

(2) That information packs be sent out to participants prior to the Summit.

D5. CHILDHOOD OBESITY SUMMIT

Joyce Thacker, Strategic Director, Children and Young People's Services, reported that a Childhood Obesity Summit was to be held on 23rd September,

2011.

The objectives of the Summit were:-

- To agree a vision for addressing childhood obesity in Rotherham
- To review the current offer of services and agree areas for improvement
- To agree a Rotherham Childhood Obesity Action Plan

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

(2) That RDaSH send a representative to the Summit if possible.

D6. COMMUNITY INVOLVEMENT AND HEALTHWATCH

Matt Gladstone, Director Commissioning Policy and Partnerships, introduced a report setting out the current position and plans around the development of a local HealthWatch as required by the Health and Social Care Bill.

The Department of Health Guidance highlighted the importance of continuity in service provision; a smooth transition between the current LINKrotherham contract and new Local HealthWatch arrangements would be required. Local HealthWatch organisations would also be required to fulfil additional functions, roles and responsibilities currently not provided by Local Involvement Networks (LINKs). A different model may be necessary to deliver successful local HealthWatch functions.

The report set out the current position and plans for LINKrotherham together with the commissioning plan and timescales for HealthWatch. It also suggested possible models for HealthWatch.

Discussion ensued on the report and possible models with the following comments made:-

- Inclusion of RFT and RDaSH?
- Innovative methods of consultation required
- There should be option appraisals for consideration

Agreed:- That the report be noted.

D7. CENTRE FOR PUBLIC SCRUTINY HEALTH REFORMS PROJECT

Kate Taylor, Scrutiny and Policy Officer, gave a verbal report on the above pilot project which had been completed at the end of August.

There had been a workshop for Board members together with a separate workshop for members of the Health Select Commission. The aim of the project was to have an early insight into the development and accountability arrangements within the Health Reform structures and look at the structure of Scrutiny, Board and CCG.

The workshops had produced a list of questions which the Board may wish to reflect in its Terms of Reference. Consideration needed to be given as to how the Board and Select Commission would work together and support each

other.

The CfPS's report was due next month.

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

(2) That the CfPS report be submitted to the next meeting of this Board.

D8. PUBLIC HEALTH TRANSITION TO LOCAL AUTHORITY

John Radford, Director of Public Health, and Martin Kimber, Chief Executive, gave verbal reports on the above illustrating the following issues:-

- The financial return had been submitted to the Department of Health indicating that currently approximately 5% of NHS Rotherham spend was on Public Health.
- The Secretary of State would then decide the amount of non-regulation funding he gave to local authorities for the transfer of Public Health.
- National determination in relation to the funding was awaited. Eventually funding would move to a formula basis but initially likely to be based around historical spend.
- Nationally, in October, there would be a number of operational documents issued
- The local transition target date was April, 2013
- Partnership work had been undertaken to gain an understanding of the breadth of activity involved in Public Health and discussions held to clarify the interpretation of the Guidance
- Consideration was required as to the best way of preparing for the transition

Agreed:- That the report be noted.

D9. FUTURE WORK PROGRAMME

Agreed:- That the forward plan include the following:-

New Community Stadium
 Children's Centre Review
 Public Health Funding
 Public Health Transition
 Health Inequalities Summit
 Childhood Obesity Summit
 "Wellbeing"
 JSNA

D10. COMMUNICATIONS

The 3 following key campaigns were noted:-

Flu jabs
Choose Well
New NHS Number 111

It was noted that a press release was to be issued on 1st October, 2011, regarding the formation of CCG.

Agreed:- That a press release be issued regarding the 1st meeting of the Board.

D11. DATES OF FUTURE MEETINGS

Agreed:- (1) That the next meeting of the Board be held on Wednesday, 26th October, 2011, commencing at 1.00 p.m. at Oak House, Bramley.

(2) That further meetings be held on:-

7th December, 2011
18th January, 2012
29th February
11th April.

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS
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1.0	Meeting:	Cabinet Member for Health and Well Being
2.0	Date:	7 November 2011
3.0	Title:	Home Boarding Licence Conditions
4.0	Directorate:	Neighbourhoods and Adult Services

5.0 Summary

The Animal Boarding Establishments Act 1963 requires any person who keeps a boarding establishment for dogs to be licensed by the local authority – this includes people who look after other people’s dogs on a commercial basis within their own home.

This report proposes a set of licence conditions to be attached to all licences for the home boarding of dogs.

6. Recommendations

- **That Cabinet Member adopts the Licence Conditions for the Home Boarding Establishment for Dogs set out in Annex I which will be applied to all licences granted.**

7.0 Proposals and Details

The Animal Boarding Establishments Act 1963 requires any person who keeps a boarding establishment for dogs and / or cats to be licensed by the local authority. This law also applies to people who look after other people's dogs within their own home. Home boarding for dogs is the alternative to boarding dogs in kennels and is becoming more popular in recent years.

Licences that are issued for the boarding of dogs have a series of conditions attached to them. These conditions are based a model set published by the Local Authority Coordinators of Regulatory Services (LACORS) in 1996. The aim of the licence conditions is to ensure high standards of animal care, health and safety and precautions against disease, and promote a consistent approach with regard to their licensing function.

The current licence conditions were adopted in Rotherham by the Environmental Health Committee on 28th March 1996 (minute number 3648).

Condition 3.2 of the licence conditions for home boarding states that: "Only dogs from the same household may be boarded at any one time. Dogs must not be boarded with any cat, unless they normally live together in the same household."

The condition is intended to protect the safety of the dogs and to protect the licensee from any claim from a dog attack, injury, etc. As dogs in home boarding situations have the freedom to move around, there are risks that are not present in boarding kennels. If dogs that are strangers to each other are left unattended, there is the potential for one dog to turn on another.

As home boarding has become more and more popular, an increasing number of Councils have chosen to relax condition 3.2 - provided the licensee is able to meet a number of additional requirements / licence conditions. This would allow dogs from more than one household to be boarded at the same time. Additional requirements include:

- Specific written consent of each household showing confirmation that they are content for their dogs to be boarded with others.
- A mandatory, trial (documented) familiarisation session for all dogs prior to stay.
- Separation of dogs from different households in secure areas when left unattended.
- Separate feeding of dogs to minimise the likelihood of dispute and aggression.

The overall number of dogs to be boarded and the number of dogs from different households to be boarded will be dependent on the size of the premises and outside areas. When determining the number of dogs allowed to be boarded consideration is also given to whether the premises are constructed to allow:

- Adequate space for dogs.

- Sufficient space available to be able to keep dogs separately if required.
- The separation of dogs showing signs of disease.

Several other parameters are considered such as disease control and spread of infection etc.

With this in mind, LACORS have published a further set of model conditions. These allow the mixing of dogs but require the consent of the owners and ensure trial sessions are undertaken prior to accepting the dogs. They also put in place other measures to protect the dogs.

This report proposes that these conditions (detailed in full in Annex I) be adopted in Rotherham. The conditions, if adopted, would be applied to every licence to keep Home Boarding Establishments for dogs.

8.0 Finance

This is contained within the existing budget. The licence fee for 2011/12 for Home Boarders was set at £155 and £222 for kennels and catteries per application. It is envisaged there will only be a one or two new applications each year.

9.0 Risks and Uncertainties

A set of model conditions enables officers to ensure each establishment is treated fairly and consistently. The conditions have been written to protect the welfare and conditions of premises in which the dogs are kept. If an applicant considers they have not been treated fairly they can appeal to the courts and the Authority could be involved in unnecessary appeals. If adequate conditions are not applied to the licence a dog boarder could try and claim compensation for not affording their dog suitable protection.

10.0 Policy and Performance Agenda Implications

Strategic Objective 5 states that 'We will ensure that Citizens are satisfied with their community as a place to live. The proposal of setting conditions to be applied to Home Boarding Establishments for dogs contributes to part of the review of the functions undertaken by Regulatory Services.

11.0 Background Papers and Consultation

[Animal Boarding Establishments Act 1963](#)
[CIEH Model Licence Conditions for Dogs](#)
[Annex I](#)

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ANNEX I

**ANIMAL BOARDING ESTABLISHMENTS ACT 1963
LICENCE CONDITIONS TO KEEP A HOME BOARDING
ESTABLISHMENT FOR DOGS (SEPTEMBER 2011)**

1. INTRODUCTION

- 1.1 Unless otherwise stated, these conditions shall apply to all premises/buildings and areas to which dogs have access and/or which are used in association with the home boarding of dogs.
- 1.2 The Licensee must ensure that the establishment is covered by adequate and suitable public liability insurance which will cover dogs boarded from different households and, where necessary, adequate and suitable employers liability insurance. A copy of the current insurance policies must be sent to the Local Authority.
- 1.3 No dog registered under the Dangerous Dogs Act 1991 must be accepted for home boarding.
- 1.4 Dog hybrids registered under the Dangerous Wild Animal Act 1976 (e.g. wolf hybrids) are not to be accepted for home boarding.
- 1.6 Entire males and bitches in season or bitches due to be in season during the boarding, must not be boarded together or boarded with resident dogs.
- 1.7 Puppies must not be boarded with other dogs until completion of their initial inoculations.

2. LICENCE DISPLAY

- 2.1 A copy of the licence and its associated conditions must be suitably displayed to the public in a prominent position in, on or about the premises or made available to each person boarding the dogs.

3. NUMBERS OF ANIMALS

- 3.1 The maximum number of dogs to be kept at any one time is determined by the Authorised Officer and stated on the licence.
- 3.2 Where dogs from more than one household are boarded and mixed together, specific written consent is required from each owner of each dog. This consent must show confirmation that they are content for their dogs to be boarded with others and copies of the consent forms must be available for inspection to the Authorised Officer of the Local Authority.

- 3.3 Dogs from different households must only be mixed following a mandatory, trial familiarisation session. These should be for all dogs prior to their stay and with the specific written consent of the owner of each dog.
- 3.4 Dogs from different households must be separated in secure areas when left unattended.
- 3.5 Dogs from different households must be separated at feeding times in order to minimise the likelihood of dispute and aggression.
- 3.6 The Licensee will be required to make an assessment of the risks of home boarding to include the risk to or caused by children who are likely to be at the property.

4. CONSTRUCTION

- 4.1 Dogs must live in the home as family pets. There must be no external construction of buildings, cages or runs.
- 4.2 The premises shall have its own entrance and must not have shared access e.g. communal stairs.
- 4.3 There must be adequate space, light, heat and ventilation for the dogs.
- 4.4 As far as reasonably practicable all areas/rooms within the home to which boarded dogs have access, must have no physical or chemical hazards that may cause injury to the dogs.
- 4.5 There must be sufficient space available to be able to keep the dogs separately if required.
- 4.6 If a collection and delivery service is provided, a suitable vehicle with a dog guard or cages in the rear must be provided.

5. TRAINING

- 5.1. A written training policy for staff must be provided. Systematic training of staff must be demonstrated to have been carried out.

6 CLEANLINESS

- 6.1 All areas where the dogs have access to, including the kitchen, must be kept clean and free from accumulations of dirt and dust and must be kept in such a manner as to be conducive to maintenance of disease control and dog comfort. All materials used for cleaning and disinfection should be stored safely.

- 6.2 All excreta and soiled material must be removed from all areas used by dogs at least daily and more often if necessary. Disposal facilities for animal waste must be agreed with the Local Authority.
- 6.3 All bedding areas must be kept clean and dry.
- 6.4 Facilities must be provided for the proper reception, storage and disposal of all waste. Particular care should be taken to segregate clinical waste arising from the treatment and handling of dogs with infectious diseases. The final route for all such waste shall comply with current Waste Regulations.
- 6.5 Measures must be taken to minimise the risks from rodents, insects and other pests within the premises.

7 FOOD AND WATER SUPPLIES

- 7.1 All dogs shall have an adequate supply of suitable food as directed by the client.
- 7.2 Fresh drinking water must be available at all times (unless advised otherwise by a Veterinary Surgeon) and the drinking vessel cleaned daily. The drinking water must be changed at least twice a day.
- 7.3 Clients must be encouraged to provide each dog with its own bedding, bowls, grooming materials, etc. These items must be cleaned regularly to prevent cross-infection. The Licensee, however, should also be able to provide extra bedding materials.
- 7.4 Eating and drinking vessels provided must be capable of being easily cleansed and disinfected to prevent cross-contamination. They must also be maintained in a clean condition. Feeding bowls must be cleaned or disposed of after each meal and each dog must be provided with its own bowl.

8 KITCHEN FACILITIES

- 8.1 Airtight containers must be provided for the storage of dry foods. Uncooked food and the remains of opened cans must be stored in covered, non-metal, leak-proof containers in the refrigerator.
- 8.2 All bulk supplies of food shall be kept in vermin-proof containers.

9 DISEASE CONTROL AND VACCINATION

- 9.1 Adequate precautions must be taken to prevent and control the spread of infectious and contagious disease and parasites amongst the dogs, staff and visitors.

- 9.2 Proof must be provided that boarded and resident dogs have current vaccinations against Canine Distemper, Infectious Canine Hepatitis (Canine adenovirus), Leptospirosis (*L. canicola* and *L. icterohaemorrhagiae*) and Canine Parvovirus and other relevant diseases. The course of vaccination must have been completed at least four weeks before the first date of boarding or in accordance with manufacturer instructions. A record that this proof has been supplied must be kept on-site throughout the period that the dog is boarded.
- 9.3 Advice from a veterinary surgeon must be sought in case of signs of disease, injury or illness. Where any dog is sick or injured, any instructions for its treatment, which have been given by a Veterinary Surgeon, must be strictly followed.
- 9.4 A well-stocked first-aid kit suitable for use on dogs must be available and accessible on site.
- 9.5 The Licensee must be registered with a veterinary practice that can provide 24-hour help and advice. The clients own veterinary practice must be known and consulted if necessary.
- 9.6 Precautions must be taken to prevent the spread of fleas, ticks, intestinal parasites and other parasites in both boarded and resident dogs. Proof must be maintained of all routine and emergency treatment for parasites.
- 9.7 The premises shall be regularly treated for fleas and parasites with a veterinary recommended product.
- 9.8 Veterinary advice must be sought in relation to cleaning substances so that they or their fumes cannot be harmful to an animal.

10 ISOLATION AND CONTAGIOUS DISEASE OUTBREAK

- 10.1 Dogs showing signs of any disease or illness shall be isolated from any other dogs until veterinary advice is obtained. There must be sufficient facilities within the licensed premises to ensure effective separation of any sick animal.
- 10.2 The Licensee must inform the Authorised Officer of the Local Authority on the next working day if a dog develops an infectious disease.
- 10.3 Following an episode of infectious disease during any stay, the premises must undergo a reasonable quarantine period before new home boarders are admitted. This period will be specified by the Authorised Officer of the Local Authority as agreed with their Veterinary Surgeon.

- 10.4 The Authorised Officer of the Local Authority must be informed of any animal death on the premises. The Licensee must make arrangements for the body to be stored at a veterinary surgeon's premises until the owners return.

11 REGISTER

- 11.1 A register must be kept of all the dogs boarded. The information kept must include the following:

- Date of arrival
- Name of dog, any identification system such as microchip number, tattoo
- Description, breed, age and gender of dog
- Name, address and telephone number of owner or keeper
- Name, address and telephone number of contact person whilst boarded
- Name, address and telephone number of dog's Veterinary Surgeon
- Anticipated and actual date of departure
- Proof of current vaccinations, medical history and requirements
- Health, welfare nutrition and exercise requirements
- Written consent from the owner of each dog that they are content for their dog to be boarded with other dogs

- 11.2 This register must be available for inspection at all times by an Authorised Officer / Veterinary Surgeon of the Local Authority.

- 11.3 The register must be kept readily available for a minimum of 2 years and kept in such a manner as to allow an Authorised Officer of the Local Authority easy access to such information.

- 11.4 If medication is to be administered, this must be recorded.

- 11.5 Where records are computerised, a back-up copy must be kept. The register must also be available to key members of staff of the establishment at all times and to the Authorised Officer.

12 SUPERVISION

- 12.1 A fit and proper person with relevant experience must always be present to exercise supervision and deal with emergencies whenever dogs are boarded at the premises. This person must not have any conviction or Official Cautions for any animal welfare related offence.

- 12.2 Dogs must be visited at regular intervals, as necessary for their health, safety and welfare, and must not be left unattended for longer than 3 hours at a time and then not on a regular basis.

- 12.3 No home where there are children under 5 years of age will be licensed.

- 12.4 Only people over 16 years of age are allowed to walk the dogs in public places.

13 EXERCISE

- 13.1 Dogs must be exercised in accordance with their owner's wishes. If dogs are taken off the premises, they must be kept on leads unless with the owners written permission.
- 13.2 There must be direct access to a suitable outside area. The area/garden must only be for use by the homeowner (not shared with other residents). The area must be kept clean.
- 13.3 The exercise/garden area of the premises and any other areas to which the boarded dogs may have access, must be totally secure and safe. Fencing must be adequate to offer security to prevent escape and be safe, with no dangerous sharp objects or protrusions. Gates must be able to be locked.
- 13.4 If there is a pond, it must be covered to avoid drowning.
- 13.5 Dogs must wear a collar and identity tag during their time in boarding. The tag must display the name, address and telephone number of the boarding premises.
- 13.6 If a dog which is home boarding is lost the owner of the dog must be informed. The Authorised Officer of the Local Authority must be informed of all lost dogs on that day or by the next working day if out of working hours.

14 FIRE / EMERGENCY PRECAUTIONS

- 14.1 Appropriate steps must be taken for the protection of the dogs in case of fire or other emergencies.
- 14.2 The occupier of the property must be aware of the location of the dogs in the property at all times.
- 14.3 Careful consideration needs to be given to the sleeping areas for dogs to ensure that they can be easily evacuated in the event of a fire, without putting the occupiers of the property at risk.
- 14.4 A fire warning procedure and emergency evacuation plan – including details of where dogs are to be evacuated to in the event of a fire or other emergency, must be drawn up, brought to the attention of those involved in the home boarding arrangements, and/or displayed in a prominent place on the premises. The Licensee must have suitable arrangements for the temporary boarding of dogs in the event that the licensed premises are rendered uninhabitable.

- 14.5 Fire detection equipment must be provided in accordance with general advice given by the Fire Safety Officer. The home must have at least 2 working smoke detectors located at the top and bottom of the staircase, or other appropriate location.
- 14.6 All doors to rooms must be kept shut at night.
- 14.7 All electrical installations and appliances must be maintained in a safe condition. No dog must be left in a room with loose or trailing cables or wires.
- 14.8 All heating appliances must be free of risk of fire as is reasonably practicable. There must be no use of freestanding gas or oil appliances.
- 14.9 A relative, friend or neighbour within 5 minutes travelling time must have a spare set of keys and access to the premises in case of an emergency. These details must be made available to the Authorised Officer.

ROTHERHAM BOROUGH COUNCIL – REPORT TO Health and Well Being Cabinet Member

1.	Meeting:	Cabinet Member for Health and Well Being
2.	Date:	7th November 2011
3.	Title:	Joint Strategic Needs Assessment
4.	Directorate:	Neighbourhoods and Adult Services

5. Summary

Since April 2008, Local Authorities and Primary Care Trusts are under a statutory duty, under the Local Government and Public Involvement in Health Act to produce a Joint Strategic Needs Assessment (JSNA) which establishes the current and future health and social care needs of the Rotherham population. It informs the strategic priorities and targets which in turn informs commissioning priorities with a view to help improve outcomes and reduce health inequalities.

The refreshed, Rotherham's Joint Strategic Needs Assessment will be made accessible through the Rotherham MBC and NHS Rotherham internet and intranet sites from October 2011. This was produced by the Joint Commissioning Team working in collaboration with various key partners in Local Authority, Health and the Voluntary and Community sector.

6. Recommendations

It is recommended that Cabinet Member;

- Note the completion of the Joint Strategic Needs Assessment refresh programme of work.
- Note the key conclusions that are emerging from the assessment of needs.
- Endorse the Refresh Rotherham JSNA 2011.

7. Proposals and Details

7.1 Why we need a JSNA

The Operating Framework for the NHS in England 2008/2009 refers to the importance of the JSNA in informing PCT Operational Plans. The JSNA underpins a number of the World Class Commissioning competencies and forms the basis of the new duty to co-operate. This partnership duty involves a range of statutory and non-statutory partners, informing commissioning and the development of appropriate, sustainable and effective services.

7.2 The Refresh Programme

The first Rotherham JSNA was produced in 2008. Good practice suggests that a refresh of the JSNA is important to ensure that the accuracy and validity of Rotherham's population needs assessment information is maintained. It is recommended that a refresh is undertaken within the first 3 years of producing a JSNA. Adults Board agreed for the refresh programme of work to be led and co-ordinated by the joint Commissioning team on its behalf.

This work began in autumn of 2010. The completion date was extended to 2011 due to changes within both NHSR and the Council therefore creating an opportunity for a much more comprehensive update to be undertaken. To progress the refresh programme a task and finish group was set comprising of key officers pertinent to the sections within the Rotherham JSNA. This ensured that the most appropriate service areas were fully engaged in leading the refresh of their respective data and information. Key representation included Alex Henderson (NHS Intelligence), Ruth Fletcher-Brown (Public Health), Miles Crompton (Policy), Shafiq Hussain (Voluntary Action Rotherham), Mel Daniels (Commissioning), and Deborah Johnson (CYP), each taking a lead role in revising and updating information within their area.

A brief consultation exercise carried out with key officers most likely to use the JSNA across the Health, Council and the voluntary sector suggests that the main areas of concerns as regards to the current JSNA are:

- Access to the document
- Navigating through the document
- Reliable & up to date information

To address these concerns the refresh JSNA , which now extends to approximately 350 pages has been updated and redesigned to take the form of an interactive online resource available via four websites - RMBC, NHSR, VAR and LASOS (South Yorkshire). A printable version will also be made available upon requests from October 2011.

The design and format of the refresh JSNA will act as an up to date platform to support the development the borough wide strategic needs assessment. It is also sufficiently versatile to support ongoing updates and addition of new areas of assessments.

7.3 Emerging Needs

- The key demographic issue facing Rotherham is the ageing population. With healthy life expectancy rising slower than life expectancy, the increased number of people aged 85+ puts growing pressure on health, social care, informal care and supported housing. Growing numbers of older people are living alone which increases the likelihood of need. There will not be enough informal carers to meet the needs of the growing older population, the average age of carers is rising and some are disabled themselves. Demand for services used by older and disabled people is rising so it is vital that the Council, NHS and partners respond to this.
- Another demographic issue is the growing ethnic diversity of Rotherham which has changed the community and customer profile, particularly for children and young people's services, and in the inner areas. Agencies need to be sensitive to different cultural needs and address barriers which make it difficult for some people to access services. New migrant communities in particular need help in understanding what services are available and in overcoming language barriers.
- The gap between the most deprived areas of Rotherham and the rest of the Borough is growing and mainstream funding needs to be targeted to address health, education and employment deprivation in particular.
- For housing, key issues are maintenance of existing stock and major structural repairs needed. The poorest housing condition tends to be in the private sector so working with home owners and landlords is vital. Energy efficiency in housing is crucial to meeting climate change targets, both in providing zero carbon new homes and more crucially improving the efficiency of the existing housing stock.
- High levels of unemployment and long term sickness are a major factor in Rotherham with rates now back where they were 10 years ago. Support for people to find work is needed, especially for the long term workless.
- The scale of lifestyle risk factors in Rotherham means that health and social care agencies need to work effectively with people to promote healthier lifestyles e.g. changing their patterns of exercise, diet, smoking and alcohol consumption. From a service provision perspective, programmes that increase people's healthy life expectancy have the potential to substantially improve the increased demand for services that would otherwise come from an aging population.
- Rotherham has the second highest rate of Accident & Emergency admissions in the region. Continued partnership between health and social care services is also essential to reduce this number. There are increasing numbers of people in Rotherham living with long term conditions and there is work to be done to promote healthier lifestyles with regard to preventing type 2 diabetes.
- Cancer deaths are above the regional and national averages and demand for radiotherapy services is expected to increase over the next 10 years.

- There is a need for mental health services to work in partnership, firstly to raise the awareness of mental health services available and secondly, to ensure that fewer people experience stigma and discrimination when accessing services.
- A significant number of improvements have already been achieved to realign and extend Older Peoples Mental Health Service in order to meet the changing needs of Rotherham's population. The main challenge is the development of an effective community service which promotes independence, maintains cognitive function, and prevents secondary conditions whilst supporting carers.
- There is a need to reduce health inequalities in terms of mental health related hospital admissions where deprivation and unemployment may be a factor.
- A key challenge for health and social care services is to respond to the increasing demand proposed by people living with learning disabilities for longer. As the needs of people living with learning disabilities are greater than those of the general population, services should be prepared for providing quality care by avoiding diagnostic overshadowing. Furthermore, a growing number of BME service users will require services which meet their cultural and spiritual needs.
- The seasonal flu immunization is of great importance to those who may be considered most vulnerable especially during the winter months.
- The uptake of Long Acting Reversible Contraceptives (LARC) is essential for reducing the teenage pregnancy rate in Rotherham due to their high rates of effectiveness and convenience.
- Various consultation highlighted high levels of satisfaction with many of the services delivered by both NHS Rotherham and Rotherham MBC. The challenge is to develop public and patient engagement so that both organisations can maintain a regular dialogue with service users and carers while implementing significant changes to the way we deliver services.
- Education and skills, health and disability and employment all impact on child poverty in Rotherham. Parents of disabled children should be supported in making the best possible choices for their child's health and social care needs. There is a need for more promotional literature about what services are currently available in order to make this happen.
- Deprivation and education & skills are highly correlated and there is need to increase the skill base of Rotherham's school leavers. A further need for children is to detect more cases of diagnosable mental health disorders due to the large disparity in diagnosis by ward.

7.4 Summary

These are the key issues for Rotherham MBC and NHS Rotherham which will need to be considered over the next 5 years.

- The impact of an ageing population.

- The most effective way to promote healthy living initiatives such as increasing physical activity and exercise, nutritional diet and raising awareness of risks of smoking and alcohol consumption
- The most effective way to reduce the gap between healthy and actual life expectancy
- The most effective way of increasing the independence of people with life limiting long-term conditions
- The most effective way of increasing independence, choice and control for people suffering with dementia and the development of new service models to address this effectively in the future
- The effectiveness of using preventative strategies to save future care costs
- Services created to refelcet the changes in the demographic profile of the learning disability population

7.5 Service User Engagement

The Joint Commissioning team carried out a programme of service user / carers and stakeholder engagement as part of the refresh programme. The following key meetings were held as part of this action:

- Carer's Forum - May 2011
- ROPES(Rotherham Older People Experiencing service) - May 2011
- Voluntary Action Rotherham - May 2011
- Magna Event - Oct 2010
- 'Adding Quality , Adding Value', event - Autumn 2010

It is accepted that this area of the JSNA as whole could be strengthened further and therefore feature as a priority within the action plan following the refresh programme.

7.6 Next Steps

As the refreshed JSNA is indented to be a live, continually evolving document it is recommended that the following key steps could be taken to further enhance assessment & analysis information:

- Service user engagement – User perspective
- Deep and narrow analysis of key areas of suspected inequalities locally
- Migrant population
- Assessment and analysis of Assets.

8. Finance

The JSNA is produced internally by RMBC and NHS Rotherham using mainstream resources. The JSNA will have financial consequences in that some of the needs identified have cost implications for services, such as rising demand from vulnerable older and disabled people for social and health care.

The PCT and Local Authority face very challenging years ahead in achieving financial balance. This is before the impact of an ageing more demanding population takes effect. Before any consideration is given to further investment in any of the key

areas highlighted above thought should be directed to the programme of disinvestment that will need to be achieved simply to keep the PCT and Local Authority in financial balance.

9. Risks and Uncertainties

The key risks associated with the JSNA refresh programme of work are;

- Some inconsistency in engagement from service areas following publication of the document
- A change to the current national core data set as recommended by DoH guidance is limited
- Limited user and stakeholder consultation feedback

These risks elements have been reduced by project managing the various activities within the refresh programme and delegating responsibilities to key officers across the Council, Health and Voluntary sector. Key officers could be supported by respective service areas to maintain link with the new team responsible for maintenance of the JSNA. Whilst such risk can be minimised, current changes within service structures impacting on staffing resources and skills will remains a key risk.

The JSNA does not cover every aspect of need and data is always subject to change over time. The JSNA is an evolving document and should be used in conjunction with other data to gain the most accurate picture of need. Other needs assessments such as the JSIA, LEA and CYPS Audit of Need cover areas of need outside the remit of the JSNA and reference to these may provide a fuller picture of local trends.

10. Background Papers and Consultation

- JSNA Main Report: Rotherham MBC and NHS Rotherham Intranet and Internet sites.

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**ROTHERHAM METROPOLITAN BOROUGH COUNCIL
ENVIRONMENT AND DEVELOPMENT SERVICES**

Cabinet member update for Health and Wellbeing: Sport, Recreation and Play.

October 2011

Leisure and Green Spaces

Diversionsary Sport Activities

After a recent restructure in Leisure and Green Spaces, all Sports Development "Play Safe" diversionsary sport projects ceased due to uncertainty over development officers and coaches contracts. Over the past month Chris Johnson has been working closely with Youth Services and Area Assembly staff to target communities to re-start the Play Safe programme. To date a total of 14 sessions spanning each evening during the week in all parts of the borough have been organised to start early in November. Sessions are delivered in parks, community halls and multi-use games areas between 5.30pm and 9pm and will be free of charge for young people. The aim of the session is to provide meaningful activity (such as football and basketball) for young people as a means to reducing the risk of becoming involved in anti-social behaviour.