HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 21st September, 2011**

Time: **1.00 p.m.**

A G E N D A

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

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

3. Welcome, Introductions and Apologies

4. Terms of Reference (Pages 1 - 8)

5. Public Health Annual Report 2011 (Pages 9 - 51)
   - John Radford to report

6. Rotherham Health Summit (Pages 52 - 56)
   - Dr. John Radford, Rebecca Atchison and Carol Weir

7. Childhood Obesity Summit (Pages 57 - 59)
   - Joyce Thacker

8. Community Involvement and HealthWatch (Pages 60 - 64)
   -Zafar Saleem

9. Centre for Public Scrutiny Health Reforms Project
   - verbal updated by the Chairman and Kate Taylor

10. Public Health Transition to Local Authority
    - verbal report by John Radford

11. Future Work Programme

12. Communications

13. Dates of Future Meetings

To be held on Wednesdays commencing at 1.30 p.m. held at the Town Hall unless stated otherwise:-

- 26th October, 2011 (venue to be agreed)
- 7th December
- 18th January, 2012
- 29th February
- 11th April

23 August 2011

Health and Wellbeing Board

Interim Terms of Reference

1. Context

These terms of reference set out how the Health and Wellbeing Board will operate in Rotherham during the transition to formal establishment of the proposed statutory board. These will need to be kept under continual review taking into account any changes made by the government as the new Health and Social Care Bill is debated through Parliament.

The terms of reference aim to build upon the collaborative working between NHS Rotherham, Rotherham MBC and other key partners. Importantly the focus of the Health and Wellbeing Board will be wide ranging looking at the health, social, environmental and economic issues which all impact on the health and wellbeing of people in Rotherham. The scope will also include the new responsibilities for local government in terms of public health.

2. Function

The Health and Wellbeing Board will be the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health and other services directly related to health and wellbeing in order to secure better health and wellbeing outcomes for the whole Rotherham population, better quality of care for all patients and care users and better value for the taxpayer.

The Health and Wellbeing Board is a statutory board (The Health and Social Care Bill 2011) set up by the local authority and brings together key decision makers to address issues of local significance and to seek solutions through integrated and collaborative working.

The Health and Wellbeing Board advocates and acts as ambassador for Rotherham collectively on local, regional, national and international forums.

The Health and Wellbeing Board gives guidance and support, offers challenge, and adds value to both the collective partnership working, and the work of individual partners where appropriate.

2.1 Key responsibilities of the Board

- To reduce health inequalities and close the gap in life expectancy by targeting services to those who need it the most

- To develop a shared understanding of the needs of the local community and approve the statutory joint strategic needs assessment (JSNA).

- To ensure public engagement and involvement in the development of the JSNA so that the experiences of local people influence policy development and service provision.

- To develop a joint Health and Wellbeing Strategy to provide the overarching framework for commissioning plans for the NHS, social care, public health and other services that the Board agrees to consider.

- To assess whether the commissioning arrangements for social care, public health and the NHS are sufficiently in line with the joint Health and Wellbeing Strategy.

- To prioritise services (through the development of the Health and Wellbeing Strategy) that are focused on prevention and early intervention to deliver reductions in demand for health and social care services.

- To promote integration and partnership working across areas, including promoting joined up commissioning plans and pooled budget arrangements across the NHS, social care and public health where all parties agree this makes sense

- To advocate for Rotherham nationally and regionally to maximise resource opportunities.

- To oversee at strategic level the relevant joint communications, marketing/social marketing and public relations programmes and campaigns required to support the delivery of health and wellbeing objectives in the borough and ensure that local people have a voice in shaping and designing programmes for change.

- To ensure that the people of Rotherham are aware of the Health and Wellbeing Board, have access to the relevant information and resources around the different work streams and can contribute where appropriate.

- To ensure that communications across the members' host organisations are consistent and appropriate to the intended audience.

2.2 Operating principles

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

a) Working in collaboration with partners to ensure people get the support and services they need as early as possible
b) Ensuring best interest for the Rotherham community
c) Involving the right people early on to make sure we get it right first time, reducing bureaucracy and getting better value for money
d) Having the right people with the right skills in the right place
e) Supporting and enabling our communities to help themselves whilst meeting the needs of the most vulnerable
f) Focussing on prevention and early intervention where possible
g) Talking and listening to all Rotherham people and treating everyone fairly and with respect

h) Working to a set of agreed communications standards, including openness and transparency; clarity and use of plain English; consistency, co-ordination and timeliness

3. Membership, representation and conduct

The membership of the Health and Wellbeing Board is made up of leaders from across the NHS, social care, public health and other services directly related to the health and wellbeing agenda (as defined in The Health and Social Care Bill 2011).

The membership of the Health and Wellbeing Board may be reviewed periodically to ensure that the membership is representative of the identified priorities. The membership may be subject to change in the early months as a result of structural changes within the NHS.

The membership of the Health and Wellbeing Board is outlined in Appendix A.

The Board will be chaired by the Cabinet Member for Health and Wellbeing. The Board is a statutory sub-committee of the Council; therefore in the absence of the official Chair, meetings will be chaired by either of the two other nominated Cabinet Members.

Members of the Board should be of sufficient seniority to be able to make key decisions in relation to their relevant organisations and budgets. In the event of the nominated representative being unavailable, a deputy should be provided, who is equally at a suitable level for decision making.

The Health and Wellbeing Board is a commissioning body, therefore members will be in attendance first and foremost as 'commissioners', however, members may also have a provider role and should therefore identify themselves as providers and declare any conflict interest as and when appropriate.

3.1 The responsibilities of a Health and Wellbeing Board member include:

a) To attend meetings as required and to fully and positively contribute to meetings
b) To act in the interests of the Rotherham population, leaving aside organisational, personal, or sectoral interests
c) To fully and effectively communicate outcomes and key decisions of the Health and Wellbeing Board to their own organisations
d) To contribute to the development of the Joint Strategic Needs Assessment
e) To ensure that commissioning is in line with the requirements of the joint Health and Wellbeing Strategy
f) To deliver improvements in performance against the indicators within the public health, NHS and Adult Social Care outcomes frameworks
g) To declare any conflict of interest, particularly in the event of a vote being required and in relation to the providing of services
h) To act in a respectful, inclusive and open manor with all colleagues to encourage debate and challenge
i) To read and digest any documents and information provided prior to meetings to ensure the Board is not a forum for receipt of information

j) To act as ambassadors for the work of the Health and Wellbeing Board
k) To participate where appropriate in communications/marketing and stakeholder engagement activity to support the objectives of the Board, including working with the media.

4. Meetings

The Health and Wellbeing Board will meet six-weekly (The 2011/12 schedule of meetings is included as appendix B). The schedule of meetings will be reviewed annually by the Board.

The meetings of the Health and Wellbeing Board are public meetings, however, the Board will retain the ability to exclude representatives of the press and other members of the public from a defined section of the meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public interest (Section 1 (2) Public Bodies (Admission to meetings) Act 1960).

Papers for the Health and Wellbeing Board will be distributed one week in advance of the meeting. Additional items may be tabled at the meeting in exceptional circumstances at the discretion of the Chair.

All agenda items brought to the Health and Wellbeing Board need to clearly demonstrate their contribution to the delivery of the Board's priorities.

Non-members of the Health and Wellbeing Board may attend the meeting with the agreement of the Chair.

Decisions are to be taken by consensus. Where it is not possible to reach consensus, a decision will be reached by a simple majority of those present at the meeting.

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

(a) The priorities and objectives contained within the Health and Wellbeing Strategy.
(b) Any recommendations made by other Boards/groups.
(c) The business case (strong and robust)

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

Minutes of the Health and Wellbeing Board will be circulated in advance of the next meeting and approved at the meeting.

4.1 Support to the Health and Wellbeing Board

Administrative and organisational support for the Health and Wellbeing Board will be provided by Rotherham Metropolitan Borough Council.

Rotherham MBC and NHS Rotherham will be the lead partners for communications, marketing and public engagement, but operational delivery of activity will be shared across Board partners, as appropriate.

5. Governance and Reporting Structures

The Health and Wellbeing Board has a direct reporting link to the over-arching Rotherham Partnership Board. The Chair of the Health and Wellbeing Board is also allocated a place on the Rotherham Partnership Board.

The governance and reporting lines are illustrated at Appendix C.

Appendix A

Core Membership of the Health and Wellbeing Board

Cabinet Member for Health and Wellbeing (Chair)
Cabinet Member with responsibility for Adult Services
Cabinet Member with responsibility for Children's Services
Director of Public Health
Chief Executive, RMBC
Strategic Director of Neighbourhoods and Adult Services
Strategic Director of Children and Young People's Services
Strategic Director of Environment and Development Services
Director of Policy, Performance and Commissioning, RMBC
Chair of Clinical Commissioning Group (CCG)
Clinical Commissioning Group Representative
PCT Cluster Board Representative (until April 2013, when position will be reviewed)
Chief Operating Officer, NHS Rotherham and CCG
Chief Executive Rotherham Foundation Trust
Chief Executive RDaSH
HealthWatch Representative (to be reviewed once body is in place)
Voluntary/Community Sector Representatives (suitable representatives to be considered from user forums)
Head of Communications RMBC/NHSR/TRFT or other

In addition to the core members outlined above, the following may be required by invitation:

NHS Commissioning Board
South Yorkshire Ambulance Service
South Yorkshire Fire and Rescue
Clinicians
South Yorkshire Police Rotherham Force Commander
Representatives from the Adults and Children's Safeguarding Boards
Chair of Rotherham School Improvement Partnership Executive
Medical Directors and Chief Nurses
Coroner
Chief Emergency Planning Officer
Representatives from the Charity Sector
Environment Agency
Other provider organisations as required
Private Sector Representation as required i.e. workplace health issues

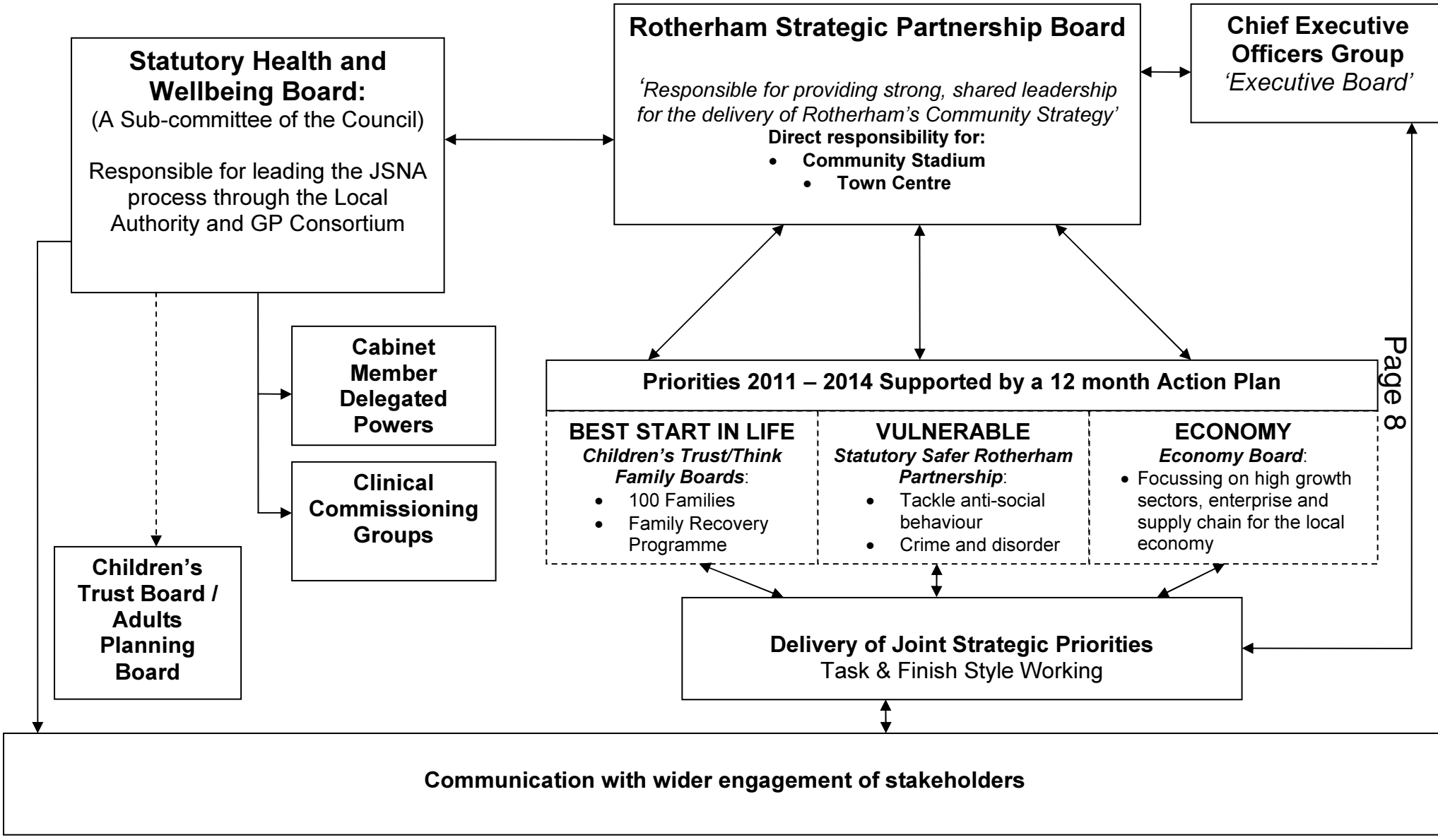
Appendix B

Schedule of Meetings for 2011/12

All meetings will take place in six-weekly in Rotherham Town Hall at 1.00pm, unless stated differently:

- 21 September 2011
- 26 October 2011
- 7 December 2011
- 18 January 2012
- 29 February 2012
- 11 April 2012

APPENDIX C


Rotherham Strategic Partnership Board
'Responsible for providing strong, shared leadership for the delivery of Rotherham's Community Strategy'
Direct responsibility for:
• Community Stadium
• Town Centre
Chief Executive Officers Group
'Executive Board'
Statutory Health and Wellbeing Board:
(A Sub-committee of the Council)
Responsible for leading the JSNA process through the Local Authority and GP Consortium
Cabinet Member Delegated Powers
Clinical Commissioning Groups
Children's Trust Board / Adults Planning Board
Priorities 2011 – 2014 Supported by a 12 month Action Plan
BEST START IN LIFE
Children's Trust/Think Family Boards:
• 100 Families
• Family Recovery Programme
VULNERABLE
Statutory Safer Rotherham Partnership:
• Tackle anti-social behaviour
• Crime and disorder
ECONOMY
Economy Board:
• Focussing on high growth sectors, enterprise and supply chain for the local economy
Delivery of Joint Strategic Priorities
Task & Finish Style Working
Communication with wider engagement of stakeholders

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**21st September, 2011**
3.	**Title:**	**Public Health Annual Report**
4.	**Directorate:**	**Public Health**

5. Summary:

One of the duties of a Director of Public Health is to produce an Annual Report outlining the health needs of the local population. This year's Report is based on the Marmot Report (2010) and produces a review of the position in Rotherham against the Marmot themes. The Marmot report was produced as part of the Labour Government's examination of progress in addressing health inequalities. It set out a new approach to tackling health inequalities based on the "life course"approach.

This year's Public Health Annual Report reflects the Marmot chapter themes with the addition of a chapter which horizon scans future issues:

- Giving every child the best start in life.
- Enable all children, young people and adults to meet their capabilities and have control over their lives.
- Create fair employment and good work for all
- Ensure a healthy standard of living for all.
- Create and develop healthy and sustainable communities.
- Strengthen the role and impact of ill health prevention.
- Identify, monitor and respond to emerging problems.

The Public Health white paper now before Parliament responds to Sir Michael Marmot's *Fair Society, Healthy Lives* report and adopts Marmot's life course framework for tackling the wider determinants of health. It proposes to give Local Authorities responsibility for improving public health and addressing health inequalities.

6. Recommendations

That the Board:

- **Receives the report and supports the Marmot principles as a policy framework for developing the Health and Wellbeing Strategy for Rotherham and Rotherham's approach to addressing health inequalities**

7. Proposals and Details:

The 2011 Health Profile[1] for Rotherham gives average male life expectancy as 76.6 years 1.7 years worse than the England average. Female life expectancy is 80.7 years 1.6 years worse than the England average. Life expectancy is 9.9 years lower for men and 5.9 years lower for women in the most deprived areas of Rotherham than in the least deprived areas.

Smoking rates and levels of adult obesity are above the England average. The percentage of adults eating poorly or exercising regularly (from the Health Survey for England) are far worse than the England average.

The most recent Index of Multiple Deprivation 2008/9 shows that 17% of the Borough is now amongst the 10% most deprived areas in England compared to only 12% in 2007.
Rotherham's position regarding the wider determinants of health is consistently worse than the England average[2].

Health improvement and prevention programmes need to work across life course pathways and work together with citizens, communities and partners to deliver improved health outcomes and reduced inequalities for Rotherham.

The *Strategic Review of Health Inequalities in England Post 2010* by Sir Michael Marmot (2010) was commissioned as a national review of health inequalities across England and the evidence base of interventions to address them. The review has a crucial relevance to the health of Rotherham residents as it sets out a framework for systematically thinking through how to reduce inequalities at a local level.

Marmot's review identifies six high level priorities for action and evidence based objectives within each of these.

Two things stand out: first the importance of tackling all of the social determinants of health taking a 'life course' approach and, second, doing more than just targeting the most disadvantaged, but addressing the whole social gradient.

Rotherham has a strong record of working to tackle health and social inequalities. This has contributed to substantial improvements in health outcomes across the Borough despite the recent deterioration in economic circumstances and Government service cuts.

8. Finance:

For information only

9. Risks and Uncertainties:

The report identifies future health and social care needs of Rotherham. These will allow planners and providers of services to plan accordingly. However there will be financial implications, for example:

- The increasing elderly population with complex health needs,
- People with learning disabilities living longer.

[1] DoH 2011 www.healthprofiles.info
[2] Yorkshire and the Humber Public Health Observatory Wider Determinants of Health Profile, Rotherham. Jan 2011.

10. Policy and Performance Agenda Implications:

The report will be key in setting out the policy areas to be considered as priorities of the Health and Wellbeing Board and will feed into the Health and Wellbeing Strategy.

10. Background Papers and Consultation:

Strategic Review of Health Inequalities in England Post 2010 by Sir Michael Marmot (2010)

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Rotherham Metropolitan Borough Council
Where Everyone Matters

NHS Rotherham

Public Health Annual Report 2011

Contents

Welcome to the 2011 Public Health annual report.

There have been a lot of changes in Public Health over the last year since the election of the new coalition Government. This has led to the publication of a new Public Health White Paper *Healthy Lives Healthy People: Our Strategy for Public Health in England (DH 30 November 2010)*. The paper builds on the work of the Marmot Review and seeks to tackle the major public health challenges facing our community. These include rising levels of obesity, alcohol and substance misuse and a high prevalence of smoking. The paper outlines a commitment to protecting the population from serious health threats.

Fair Society, Healthy Lives (the Marmot Review)

The Strategic Review of Health Inequalities in England Post 2010 by Sir Michael Marmot (2010) was commissioned as a national review of health inequalities across England and the evidence base of interventions to address them. The review has a crucial relevance to the health of Rotherham residents as it sets out a framework for systematically thinking through how to reduce inequalities at a local level.

Marmot's review identifies six high level priorities for action and evidence based objectives within each of these.

Fair Society, Healthy Lives high level priorities are:

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.

Two things stand out: first the importance of tackling all of the social determinants of health taking a 'life course' approach and, second, doing more than just targeting the most disadvantaged, but addressing the whole social gradient.

This report aims to take Rotherham into the next phase of work as Public Health Departments prepare to merge with Local Authorities. This provides a great opportunity for a joint approach to Public Health that addresses the wider factors that shape the health and wellbeing of individuals, families and

local communities – such as education, employment and the environment. The Public Health Initiatives within this report strongly support Rotherham's Children's Plan, the Community Strategy, Rotherham Metropolitian Borough Council Corporate Plan and the NHS Single Integrated Plan.

This years annual report therefore forms the bases for discussion about this new approach to Public Health and the development of a Health and Wellbeing Strategy for the Borough as part of the Governments ambitious plan to improve Public Health.

Each chapter is divided into:

- What the data shows…
- What are we currently doing in Rotherham to address these priorities?
- What more could we be doing and what are the key challenges?

I have attached an appendix showing Rotherham's performance indicators against the Marmot areas for information.

Life expectancy in Rotherham remains significantly worse than the England average. Through closer working of the NHS, Local Authority, Voluntary Agencies and communities we can work together to drive the change we need to create a healthier Rotherham.

Dr John Radford
Director of Public Health

The facts:

- Life expectancy in men is 76.6 years. This is 1.7 years less than the national average.
- Life expectancy in women is 80.7 years. This is 1.6 years lower than the national average.
- Men living in the Neighbourhood Renewal Strategy (NRS) target areas are likely to live around 3 years less than the Rotherham average. Women living in these areas are likely to live 2 years less.
- Rotherham cardiovascular disease rates are dropping faster than the national rates, with deaths halving in the last 10 years. However it still remains one of the largest causes of death across the borough.
- 1 in 3 deaths are due to cancer, especially lung and breast cancer.
- 1 in 7 deaths are due to respiratory diseases such as bronchitis and pneumonia.

1

Chapter 1 -
Give Every Child The Best Start In Life

What the data shows...

- 25% of children in Rotherham live in poverty. In some areas this is as high as 70%.
- 14.2% of all Rotherham children live in areas which are within the 10% most deprived nationally.
- A quarter of all mums in Rotherham smoke during pregnancy. Smoking in pregnancy increases the risk of complications in labour, having a low birth weight baby and/or a baby who suffers from asthma and behavioural problems. It also increases the risk of sudden unexpected death in infancy (known as cot death).
- 9% of all babies born in Rotherham have a low birth weight (much higher than the national average).
- Rotherham has approximately 20-25 infant deaths every year (under 1 year).
- The review of child deaths shows that parental alcohol use and smoking are significant factors implicated in a number of infant deaths (under 1 year).
- Half of all mums in Rotherham breastfeed their babies at delivery and only one in five babies is still breastfed at 6-8 weeks.
- Two out of three babies are born in some of the most deprived areas in Rotherham, lessening their life chances, throughout all stages of their lives.
- There are more teenage pregnancies in Rotherham than the national average.

Pregnancy and the first three years of life are the most important stages in our life cycle; foundations of future health, development and wellbeing are laid down.

1

It is increasingly recognised that giving babies a healthy start is crucial to every aspect of a child's development – physical, intellectual and emotional. What happens in the early years, beginning in pregnancy, has lifelong effects on many aspects of health and wellbeing – from obesity, heart disease and mental health, to educational achievement and economic status.

Rotherham's Children & Young Peoples Plan 2010-13

Marmot's Priority Objectives:

1. Reduce inequalities in the early development of physical, learning and social skills in children under 3 years of age.
2. Provide early intervention into the pre, post natal and early years to ensure family functioning and wellbeing is of an optimum standard.
3. Build the resilience of families to ensure that the health, welfare and social needs of their children are met.

Marmot's Policy Recommendations:

1. To increase the proportion of overall expenditure allocated to the early years.
2. Support families to achieve progressive improvements in early child development, for example through good pre and post natal care, paid paternity leave, offering good routine support.
3. Provide good early years education and childcare.

What are we currently doing in Rotherham to address these priorities?

Maternity Services:

- Direct and quicker access into an effective midwifery service.
- Employing additional maternity support workers, to support a reduction in smoking in pregnancy and an increase in the number of women breastfeeding.
- Ensure that all families and the people working with them are aware of safe sleeping to prevent cot death.
- Employing specialist midwives to address issues detrimental to infant health and wellbeing at point of delivery and in the early years e.g. smoking, alcohol and substance misuse.
- Ensuring that teenage parents and their children are given the additional support and guidance required to meet their long term health and wellbeing needs.
- Implementing breastfeeding peer support across Rotherham through joint working with children's centres.
- Implementing Stage 2 of UNICEF Baby Friendly Initiative

Health Visiting Services for Children from Birth to Age Three:

- Access for all families to a universal health visiting service.
- Strengthen parents' understanding of childhood and the importance of healthy eating, physical activity and keeping children safe.
- Ensure that parents receive timely, up to date information to support them in making informed decisions on their child's health and welfare.
- Provide a specialist health visiting service to support universal provision ensuring that issues detrimental to good outcomes are identified at the earliest opportunity.
- The number of Health Visitors nationally will be increased by 4,200 between 2010-2015. Rotherham's allocation will be an additional 20.00 WTE funded by NHSR and 4.00 WTE funded from existing provider services resources. The main focus of the 'new' Health Visitors Service will be on 0-3 year olds and their families and a return to Public Health Nursing. There will be an expectation to achieve quality outcomes which will be monitored against 4 delivery levels:

1. Community – Health Visitors should know what exists in the community they are assigned to and work to develop these for children and families e.g. Sure Start Services.

2. Universal Services – delivery of the Healthy Child Programme and support for parents to access a range of community services/resources.

3. Universal Plus – rapid response from the Health Visitor when families require specific expert help e.g. postnatal depression; sleepless baby; feeding concerns.

4. Universal Partnership Plus – ongoing support from the Health Visitors Team plus a range of local services to deal with complex issues over a period of time, working with Children's Centres, charities and where appropriate Family Nurse Partnerships.

Prevention and Early intervention Services:

- Schools, children's centres, youth workers, maternity services, GPs, the health visiting and school nursing services and voluntary and community sector organisations work together to ensure that vulnerable children are identified and that action is taken to prevent and tackle problems before situations escalate into crisis , and that these professionals have access to Common Assessment Framework training and development.

What more could we be doing and what are the key challenges?

- The 25% of children living in poverty in Rotherham need extra support to achieve their full potential. This equates to 18,000 families (assuming three children per family).
- Delivering early interventions during pregnancy and ongoing support in the early years are critical to the long term health and development of the child and other long term family outcomes.
- Integrating pre natal, post natal and early years services to ensure that services are seamless is essential to good outcomes.
- Ensure high quality maternity and health visiting services through effective, nationally evaluated parenting programmes, leading to a successful transition into childcare and early years education.
- Professionals working with pregnant women and new mums should identify and offer support and treatment to women with mental health issues.
- Professionals working with pregnant women and new mums should identify and offer support and treatment to women with a history of substance misuse.
- Targeted interventions are necessary for a significant number of children and families, where children will fail to achieve as they grow up and develop.
- Families have exclusive influence on their children in the early years – influencing care at this stage is a challenge.
- Greater embedding of Early Intervention and Family Support processes.

Investment in early years is vital for reducing health inequalities and needs to be sustained otherwise its effect is lessened. Returns on investments in early childhood are higher than in adolescence. Currently spending is higher in later childhood and needs to be rebalanced towards early years. The obstacle is that resources invested in initiatives to tackle health inequalities in the early years don't produce instant returns.

Where children are unable to remain with their birth family services are supported to ensure sustainable and permanent alternative family care.

In September 2011 a Family Nurse Partnership (FNP) will be implemented in Rotherham providing intensive support to pregnant teenagers from the ante-natal period and for 2 years following the birth of the baby. It is expected that the FNP will demonstrate positive health and wellbeing outcomes.

2

Chapter 2 - Enable children, young people and adults to maximise their capabilities and have control over their lives

What the data shows...

- Many health risks affecting young people are more common in deprived areas, for example teenage pregnancy, smoking, obesity, substance misuse (including alcohol) and accidents.
- Attainment in Rotherham's schools is below the regional and national average at all key stages.
- Rotherham has almost 12,000 children living in households where there was no one in employment (2001 census)
- Indicators suggest Rotherham's16-24 year olds are less likely to enter further education than is the case in other areas, preferring to seek employment in jobs that may not be sustainable.
- Rotherham's workforce is gradually transforming. Currently (2008) 22% of the working age population are qualified to at least NVQ level 4, compared to less than 15% in 2001. Despite this improvement we are still behind regional and national averages.
- 6.6% of all 16-17 year olds in Rotherham are not currently in employment, education or training. This has dropped from just under 11% in 2006.
- 1in 6 people (adults aged over 16) will have a mental health problem at any one time and for half of these people the problem will last longer than a year. The number of people on Rotherham GP practice registers with a mental health problem at the end of 2009-10 was 25,807 (QOF data).

Supporting children and young people through childhood and adolescence into adulthood lays important foundations for healthy, fulfilled lives. Early child development and educational attainment are crucial for future health and wellbeing, as well as improving job opportunities and providing a route out of poverty.

2

Marmot's Priority Objectives:

1 Improve educational aspirations and attainment to reduce the inequalities in educational outcomes.

2 Ensure that schools, families and communities work in partnership to improve health, wellbeing and resilience in children and young people.

3 Improve the access and use of quality life long learning.

Marmot's Policy Recommendations:

1 Ensure that reducing social inequalities in pupils' educational outcomes is a sustained priority.

2 Prioritise reducing social inequalities in life skills by:

- a Extending the role of schools in supporting families and communities and taking a 'whole child' approach.
- b Developing the school-based workforce to build their skills in working across school-home boundaries and addressing social and emotional development, physical and mental wellbeing.

3 Increasing access and use of quality lifelong learning opportunities across the social gradient, by:

- a Providing easily accessible support and advice for 16-25 year olds on life skills, training and employment opportunities.
- b Providing work-based learning, including apprenticeships, for young people and those changing jobs/ careers.
- c Increasing the availability of non-vocational lifelong learning for people of any age.

What are we currently doing in Rotherham to address these priorities?

Healthy Schools

- 97% of Rotherham schools have achieved Healthy Schools status.

- Working towards and sustaining Healthy Schools status equips schools to promote universal health by embedding health behaviours and wellbeing outcomes into the everyday business of school life. Tackling emotional health and wellbeing with school-based mental health promotion improves self esteem and reduces risky behaviour.

Support for parents

- Families are supported by multiagency staff, including health visitors and children's centres, to develop an interest in and skills to support their children's education. What parents do to support their children is crucial for children's development and attainment – home learning activities have a greater impact upon children's intellectual and social development than parental occupation, education or income. Furthermore good parent-child relationships help build children's self esteem and confidence and reduce the risk of children adopting unhealthy lifestyles.

School nursing service

- Each school has a designated school nurse who delivers the Healthy Child Programme for all school-aged children including both universal and targeted provision. The school nursing service is fundamental to a healthy school service, managing pupils' wellbeing, medical and long term conditions and developing schools as health promoting environments.

Teenage pregnancy care pathway

- Teen parents are supported to continue or get back into education, employment or training via the teenage pregnancy care pathway. The multiagency pathway has been developed and implemented to address the needs of teen parents and their children and pull together key services at the right time including support from specialist Connexions personal advisors dedicated to teen parents. The Rowan Centre provides an alternative education programme for teen mothers who are of statutory school age where they learn parenting skills as well as continuing formal education. A holistic team centred on the family is adopted to nurture both parent and child whilst learning.

  The Family Nurse Partnership will provide intensive and structured home visiting for first time teenage mothers with the aim of improving pregnancy outcomes, child health and development and parents' economic self-sufficiency. Much of the work will focus on behaviour change.

Mental Health First Aid

Training has been provided for front line staff including health, social care, housing and the voluntary sector. The course helps identify signs and symptoms and refer to appropriate agencies.

Healthy Eating

The content and quality of food eaten is related to developmental, cognitive and behavioural outcomes that are important in childhood for health and well-being. Various initiatives encourage children and young people in Rotherham to make informed choices and develop good eating habits. These include Maltby MasterChef, implementing Healthy Packed lunch polices within schools and taking part in the Small Steps programme in Partnership with the School Food Trust.

Physical Activity

The School Sports Partnerships through enforcing two hours of Physical Education, providing school sport coaching, interschool competition, leadership and volunteering opportunities and formalising links to sports clubs and the community have significantly increased the number of local young people engaging in sport and physical activity.

Rotherham's children and young people's plan 2010-13

This multiagency plan demonstrates how all the partners are working together to provide services that will improves children's lives. Areas included in the plan are:

1. **Keeping children and young people safe**
2. **Tackling inequalities**
3. **Prevention and early intervention**
4. **Transforming Rotherham's learning**

What more could we be doing and what are the key challenges?

The key challenges are:

- Maintaining the initiatives in the face of government cuts.
- Supporting the 18,000 families living in poverty.
- Prioritising health in services for families and in schools in face of competing priorities.
- Delivering the Rotherham children and young people's plan, particularly support or training and employment opportunities for 16-25 year olds.
- Support the implementation of the prevention and early years strategy.

3

Chapter 3
Create fair employment and good work for all

What the data shows...

- Rotherham has 21,600 workless people, who are predominantly concentrated within the more deprived areas.
- There is a generational worklessness damaging aspirations and access to opportunities to develop enterprising behaviour.
- Numbers claiming Job Seeker's Allowance (JSA) have risen sharply during the recession.
- Sharp rise in long-term worklessness, with the numbers claiming JSA for over 12 months increased by over 200% in the last two years, to 1,430.
- Numbers in employment are not predicted to reach pre-recession levels until around 2020.
- Over 14,000 people are on Employment Support Allowance (ESA) or Incapacity Benefit.
- Only 23% of those who are economically inactive state that they want a job.
- Rotherham has 7,000 more people without any qualifications than the national average.
- Average earnings are 10% below the national average.
- 6.5% of the Rotherham working population claimed Incapacity Benefit or ESA in February 2010 (10,540 people).
- The two most common long term conditions leading to Incapacity Benefit/ESA claims are mental illness and musculoskeletal disorders.
- 37% of the borough remains within the top 20% most deprived areas nationally for employment.

3

Unemployment in Rotherham is higher than the national average. Although employment rates have improved dramatically in recent years the recession has hit Rotherham hard and rates have now fallen. Many of those who are unemployed state that they do not want a job (JSNA 2010). Of the people that are in work, a higher than average proportion are in low skilled jobs.

Marmot's Priority Objectives:

1. Improve access to good jobs and reduce long-term unemployment across the social gradient.
2. Make it easier for people who are disadvantaged in the labour market to obtain and keep work.
3. Improve quality of jobs for all.

Marmot's Policy Recommendations:

1. Prioritise active labour market programmes to reduce long term unemployment.
2. Encourage, incentivise and, where appropriate, enforce the implementation of measures to improve the quality of jobs by:
   - a Ensuring public and private sector employers adhere to equality guidance and legislation.
   - b Implementing guidance on stress management and the effective promotion of wellbeing and physical and mental health at work.
3. Develop greater security and flexibility in employment by:
   - a Prioritising greater flexibility of retirement age.
   - b Encouraging and incentivising employers to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems.

What are we currently doing in Rotherham to address these priorities?

Reducing long term unemployment

Rotherham has invested in ***Improving Access to Psychological Therapies*** which provides talking therapies to people experiencing mild to moderate mental health problems. Mental ill health is one of the main causes of sickness absence and unemployment due to ill health. Improving access to a range of treatments will help people to stay in work or return to work more quickly.

Rotherham Occupational Health Advisory Service is an additional service funded by NHS Rotherham that provides support and advice to help people deal with work related health issues. The service enables people to stay in work or return to work successfully following a period of absence and can provide mediation with employers to ensure that the work is not damaging to the person's health.

Rotherham Health Trainer Service provides free and confidential support and advice to people wishing to make a behaviour or lifestyle change. Health trainers work with clients to promote self efficacy, self care, increase health literacy and encourage people to take responsibility for their own health. In doing so they empower individuals to manage their physical health which may lead to improved attendance at work and make it less likely that individuals will become unable to work due to ill health. Where a client is not currently in employment this empowerment approach may increase confidence and motivation to seek employment.

NHS Rotherham hosts the ***Mind Your Own Business*** project funded by the Big Lottery Fund. This project aims to improve the mental well being of those who live and/or work within Rotherham through targeted work with employers. The project has helped almost 100 local employers to improve the mental wellbeing of their workforce and has provided training such as Mental Health First Aid to around 1000 employees.

Community services such as ***Stop Smoking Services, Reshape Rotherham*** and ***Health Trainers*** provide their services within workplaces to help improve the health of staff.

Improving employment opportunities

The Rotherham Economic Plan aims to promote productive and competitive businesses in Rotherham, raise aspirations to increase the number of employable young people and to create conditions for sustainable growth in Rotherham.

Rotherham Metropolitan Borough Council (RMBC) has developed Access All Areas which provides voluntary work placements to people with disabilities who wish to return to or start work. To date over 100 people have benefitted from the experience gained during Access All Areas placements. Of these 32 have now gained paid employment through open recruitment, the Future Jobs Fund or the RMBC Move on to Employment project.

What more could we be doing and what are the key challenges?

- Rotherham continues to be badly hit by the recession and unemployment figures have increased. Spending cuts in the public sector may further increase unemployment rates as a large proportion of people in Rotherham work within the public sector.
- The workplace is potentially a powerful vehicle for improving people's health. Most full time workers spend more than a third of their waking hours at work, so their workplace will have a significant influence on their health and wellbeing. We should be supporting small and medium sized business to promote health.
- Prioritise the under 24's living within deprived communities to reverse the apathetic attitude towards employment by raising personal aspirations.
- We should continue to support the Rotherham Occupational Health Advisory Service and Improving Access to Psychological Therapy services.
- We should consider how NHS Rotherham can support the new Department for Work and Pensions Work Programme which aims to help unemployed people back to work.
- Public sector organisations are some of the largest employers in Rotherham and need to set an example to other employers in creating healthy, supportive workplaces. Particular care needs to be taken in light of the likely job losses that adequate support is put in place for staff at risk of redundancy. The public sector has also been encouraged to take positive action to recruit staff from disadvantaged groups. Recruitment freezes mean that organisations will find it difficult to achieve this.
- Mental health issues need to be addressed in an attempt to reduce sickness/ absence rates.
- Due to short term funding and changes in commissioning arrangements some of the services working with employers and employees to improve health may come to an end within the next few years. This could lead to an increasing number of people becoming or remaining out of work due to ill health.
- Reduce the number of people in Rotherham claiming Employment Support Allowance by ensuring adequate, structured, systematic, evidence-based services are offered, as a minimum, in the areas of mental illness and musculoskeletal problems.

4

Chapter 4
Ensure a healthy standard of living for all

What the data shows...

- Deprivation has reduced over the last ten years but Rotherham is still in the bottom 20% of local authorities when considering overall deprivation.
- The recent recession has also had a major impact on many of the factors which affect families living in poverty.
- 31,000 or 12% of the Rotherham population live in the 10% most deprived areas nationally.
- 36,000 households in the district are managing on less than the minimum income needed to achieve an acceptable standard of living.
- In the winter of 2009/10 Rotherham had 136 excess winter deaths.

The Marmot review recognises that not having enough money to lead a healthy life is a highly significant cause of health inequalities. If there is a gap between the minimum income for healthy living (a figure which takes into account costs for nutrition, physical activity, housing, social interactions, transport, medical care and hygiene) and actual income then standards in health will not be maintained.

The review also acknowledges that people on low incomes spend a larger proportion of their money on commodities that attract indirect taxes than those on higher incomes.

4

Marmot's Priority Objectives:

Marmot's recommendations are about influencing national policy, for example establishing a minimum income. The recommendations below are how we might influence and support these at a local level.

There should be a focus upon:

1. The unemployed having access to good benefits advice to ensure maximum uptake of the benefits they are entitled to.
2. The unemployed having good access to job opportunities including support with applications and interview technique.
3. Providing opportunities for people to gain work experience, for example, through the voluntary sector and back to work/ community schemes.

Marmot's Policy Recommendations:

These are based on ensuring a healthy standard of living for all.

1. Ensuring the availability of healthy, affordable food.
2. Developing a good transportation network.
3. Providing accessible, affordable recreation.
2. Providing life-long learning opportunities.
3. Developing affordable warmth initiatives.

What are we currently doing in Rotherham to address these priorities?

- *Hotspots* is a partnership project to address affordable warmth/energy efficiency, finance, safety and health. The project offers free energy saving and grant advice, home safety checks, benefit entitlement checks (for those over 60) and stop smoking advice and support.

- *Housing market renewal* offers great opportunities for regeneration in many parts of Rotherham. The regeneration team aims to improve the quality and choice of affordable housing in Rotherham.

- *Rotherham Local Ambition Programme* aims to increase volunteering and assist people into work and self-employment in three of our most deprived and vulnerable neighbourhoods. A number of projects/initiatives have been delivered to tackle child poverty.

- *Shop Local* is a partnership between the council and local retailers and enables people who have signed up to the scheme to receive discounts and offers at 60 shops and restaurants in Rotherham town centre. The scheme ran for six months from July 2010 to January 2011.

- *Food Aware* is a not for profit social enterprise which redistributes surplus food. A key objective of the project is to redistribute healthy 5-a-day produce e.g. tomatoes, peppers, cucumbers and fruit.

- *Maltby Masterchef/Market Meals* are campaigns which promote family lifestyle interventions around affordable healthy eating in a community setting.

- *Affordable, accessible recreation* activities are offered across Rotherham by DC Leisure and RMBC.

- *Ministry of Food* has taught over 6,000 people to prepare and cook simple meals using fresh, local ingredients over the last two years. The initiative has also provided training and employment opportunities.

- *A transport strategy* is being developed by the South Yorkshire Passenger Transport Executive to ensure that local public transport is affordable, accessible, reliable, safe, well publicised and easily understood. Rotherham Community Transport has a variety of 'door 2 door' services available to provide transport to people with disabilities.

4

What more could we be doing and what are the key challenges?

- Ensure that people are receiving the benefits they are entitled to and that families receive adequate support to avoid serious debt.
- All agencies must work together to ensure that everybody in Rotherham has access to good quality, affordable food, access to affordable recreation, can travel easily, safely and efficiently across the borough and live in homes which are sufficiently warm and free from damp.
- Aim to achieve the aspiration that 'everyone can expect to live longer and healthier lives regardless of where they live'. This would require further targeting of preventative services to our more disadvantaged populations – challenging the new GP commissioning consortium and adult and children's social care.
- Many of our interventions have used short term funding which is now coming to an end. The challenge is to ensure that good practice is not lost and to prioritise funding appropriately.

5

Chapter 5
Sustainable places and communities

What the data shows...

Green issues:

- Access to green spaces improves people's mental and physical health.
- Areas with more green spaces have lower health inequalities.
- Rotherham has a lot of green space available for use.
- Appropriate planning can encourage people to walk and cycle.
- On average, each person in the UK throws away seven times their body weight in rubbish every year.
- Around 67% of private rented housing stock in Rotherham would fail the Government's Decent Homes standard due to excessive cold.

Community cohesion:

- Being involved in your community is associated with better health outcomes.
- Approximately 1 in 7 local households (14.4%) has a pensioner living alone.
- Rotherham's black and minority ethnic population are fairly evenly divided between those born in the UK and those born abroad, the latter being more likely to have limited English language skills.
- Nearly 8% of pupils have English as a second language.
- 79.4% of Rotherham's population describe themselves as Christians. 2.6% belong to other religions, the largest of which is Islam (2.2%).
- National estimates suggest that 6% of the UK population are lesbian, gay, bisexual or transgendered. This would equate to 15,200 people in Rotherham.

5

Climate change presents a growing threat to health. Many of the activities promoted to prevent climate change – for example walking, cycling and eating less meat – have additional health benefits.

Marmot's Priority Objectives:

1. Develop common policies to reduce the scale and impact of climate change and health inequalities.
2. Improve community capital and reduce social isolation across the social gradient.

Marmot's Policy Recommendations:

1. Prioritise policies and interventions that reduce both health inequalities and mitigate climate change by improving active travel, access to affordable healthy food and improving the energy efficiency of housing.
2. Fully integrate the planning, transport, housing, environmental and health systems to address social determinants of health.
3. Support locally developed and evidence based community regeneration programmes that remove barriers to community participation and action and reduce social isolation.

What are we currently doing in Rotherham to address these priorities?

- Regeneration of Clifton Park has produced an environment where the whole borough can enjoy the green space, improving social integration.
- Rotherham public sector organisations have sustainability plans. These cover waste management, recycling and green/active travel.
- Rotherham Hospital has received an award for their work towards the NHS Carbon Management Plan.
- Rotherham public sector organisations support the Rotherham: One Town, One Community Strategy that promotes and celebrates the values that unite people living in Rotherham, including fairness, understanding, mutual respect, and a desire to achieve the best for Rotherham.

What more could we be doing and what are the key challenges?

- Ensure that people are receiving the benefits they are entitled to and that families receive adequate support to avoid serious debt.
- All agencies must work together to ensure that everybody in Rotherham has access to good quality, affordable food, access to affordable recreation, can travel easily, safely and efficiently across the borough and live in homes which are sufficiently warm and free from damp.
- Support the development and implementation of the green spaces sport and recoration plan.
- Support the development and implementation of the environment and climate change strategy.
- Support the development and implementation of the waste strategy.
- To prioritise policies and interventions that reduce health inequalities and lessen climate change by:
    - Improving active travel for all.
    - Improving the availability of good quality open green spaces.
    - Improving the access to good quality affordable food.
    - Improving energy efficient housing in the private sector.
    - Fully integrate the planning, transport, housing, environmental and health systems to address social determinants of health.
- Support locally developed and evidence based community regeneration programmes that remove barriers to community participation and action and reduce social isolation.

6

Chapter 6
Strengthening the role and impact of ill health prevention

What the data shows...

Unhealthy lifestyles are too common in Rotherham.

Many residents are not fit and do not have healthy diets. Each year, more and more adults and children are becoming obese. Drug and alcohol misuse is more common. Many Rotherham residents also smoke, including pregnant women who put their unborn children at risk. Many residents have developed a long term condition or disability when they reach retirement age and are in poor health with illnesses such as heart disease and diabetes.

- 9 in 10 adults are not physically active.
- 4 in 5 don't eat healthily.
- 28% of adults and 12% of children are obese.
- 1 in 5 adults binge drink.
- 1 in 4 adults smoke.
- 1 in 4 pregnant women smoke.
- 30% of adults over the age of 65 years report not being in good health.

Smoking, poor diet, and a lack of exercise all lead to poor health, especially cancer, heart disease, diabetes and respiratory disease.

6

Marmot's Priority Objectives:

1. Prioritise prevention and early detection of those conditions most strongly related to health inequalities.
2. Increase availability of long term and sustainable funding in ill health prevention.

Marmot's Policy Recommendations:

1. Prioritise investment in ill health prevention and health promotion.
2. Implement an evidence based programme of ill health prevention, including medical intervention as well as smoking cessation and alcohol reduction.
3. Focus core efforts of public health departments on interventions related to the social determinants of health.

What are we currently doing in Rotherham to address these priorities?

- Community alcohol services such as *Lifeline* and *Clearways* provide a wide range of services including counselling, support and help for people to come off and stay off alcohol. Trained doctors, nurses and other staff identify and help people who misuse alcohol. Rotherham has several access points to alcohol related brief advice and information as well as to longer term interventions.

- *Reshape Rotherham* and the *Rotherham Institute for Obesity* have helped people lose weight and to lead healthier lives. Weight management programmes for children and their families are provided by *Carnegie International Camps* and *Carnegie Clubs*. There are also innovative projects such as the *Mini-Masterchef* challenge in Maltby to encourage families to make healthier food choices.

- Rotherham Metropolitan Borough Council promote walking for health programmes such as *Steps to Health* and have helped to train local walk leaders. For older residents, there are physical activity schemes, such as *Active Always Keep Moving* and *Active in Age*, run by exercise instructors and health trainers to promote healthy, active ageing.

- The National Child Measuring Programme delivered in reception and year 6 provides statistical data to support plans to tackle childhood obesity. Early identification of childhood obesity enables targeted work to take place to prevent escalation.

- *Stop Smoking Services* have helped more than 2,700 people quit smoking. The *Smokefree Homes* scheme has got more than 3,000 homes signed up to be smokefree.

Examples of our local partnerships

Fire and Rescue Service - *Smokefree Homes*

Police Service - *Lifewise scheme to encourage safer communities and good citizenship.*

DC Leisure - *Carnegie Club children's weight management programme*

Rotherham Metropolitan Borough Council - *Active Always and Walking for Health programmes*

Rotherham United Football Club - *Extra Time physical activity scheme*

What more could we be doing and what are the key challenges?

- It is important that people realise that ill-health can be prevented. There needs to be new and sustained ways to spread health messages, for example through shopping centres, parks, pubs and other community hubs. Every meeting with residents is an opportunity to encourage them to adopt healthy lives; it is important to make every contact count.

- Young people must be helped to live healthily by taking exercise, having supportive social networks and enjoying a socially responsible time across Rotherham. Getting the message across to our young people and helping them adopt healthy lifestyles is vital.

- We need to cut down the number of smokers and especially mums-to-be who smoke. To do this we need to change attitudes, and help them to not just quit smoking but to stop for good.

- Physical activity helps people get fit and keep fit. We therefore need to get people playing sport, walking and cycling more.

- It is a challenge not only to encourage people to choose healthier lifestyles, but also to help them maintain them. The spending cuts likely in the next few years will put a strain on services. We need to make sure we can keep preventative services going.

- There are also other people in our community who are vulnerable and need more help to adopt a healthy lifestyle, such as pregnant mums, those living in poverty and those with chronic ill-health.

6

Chronic disease

The largest causes of death in Rotherham are cancer, coronary heart disease and respiratory disease making these priority areas. Sadly, many of these deaths are preventable.

What the data shows...

- 1in 3 deaths are due to cardiovascular disease such as heart attacks and strokes.
- 1in 3 deaths are due to cancer, especially lung and breast cancer.
- 1in 7 deaths are due to respiratory diseases such as bronchitis and pneumonia.

What are we currently doing in Rotherham to address these priorities?

- All GPs have chronic disease registers, including diabetes, which has a strong link to heart disease.
- Over the last 18 months GPs have been carrying out NHS Health Checks to detect early signs of heart disease and prevent them developing further.
- Rotherham's Breathing Space facility focuses on lung rehabilitation for people with breathing problems.
- There are successful cancer screening programmes for breast, cervical and bowel cancers.

What more could we be doing and what are the key challenges?

- Maintaining a focus on prevention by ensuring that evidence-based clinical and lifestyle interventions are implemented. GPs should continue to improve the health and wellbeing of their patients, thus ensuring that children's resilience, learning and development opportunities and adults' abilities to make a positive contribution to the workforce are maximised.

This can be done through offering preventative services including:

- NHS Health Checks (measuring cardiovascular disease risk)
- Screening
- Immunisation and vaccination, for example MMR, seasonal flu
- Lifestyle advice including alcohol and drugs , smoking, healthy eating and diet and physical activity
- Mental health services
  Understanding the causes of mental ill health by intervening in the social causes such as debt, and making appropriate referrals.

GPs need to look at new ways of working collaboratively to promote good health including:

- Working more closely with citizens' advice agencies, benefit agencies, debt counselling and housing organisations in an attempt to address the causes of ill health.
- Working with occupational health services and other agencies to maximise the full potential of the Fit Note.
- Working with others to prevent seasonal excess deaths, for example housing, provide advice on keeping warm and refer to the Hot Spots scheme and Warm Front.

Rotherham can address the wider determinants of health through areas such as adequate private sector housing, transport and green spaces.

7

Chapter 7
Identifying, monitoring and responding to emerging problems for the population as identified in the joint strategic needs assessment for Rotherham (2010).

The following highlight some key challenges that Rotherham will have to address over the coming years in terms of health and social care needs.

Aging and dementia

- **Dementia is predicted to increase by 38% in 15 years (from 2,851 diagnoses in 2010 to an expected 3,934 by 2025).**
- **Our population is growing older with the number of people over 85 years of age expected to double in the next 20 years. This means there will be an increasing need for care services for the elderly and for services to treat conditions associated with old age.**
- **19.5% of dementia patients in Rotherham are prescribed an anti psychotic (a powerful behaviour controlling drug).**

Learning disability

- **As people live longer the number of adults with learning disabilities over 65 years is predicted to increase by 52% between 2010 and 2030. This is an increase of 14% from previous predictions.**

The four main reasons for the increase in the number of people with a learning disability are :

- *Increased life expectancy, especially among people with Down's Syndrome.*
- *Growing numbers of children and young people with complex and multiple disabilities who now survive into adulthood.*
- *A sharp rise in the reported numbers of school age children with autistic spectrum disorders, some of whom will have learning disabilities.*
- *Greater prevalence among some minority ethnic populations of South Asian origin*.

Long term conditions/ physical disability

- It is estimated that in 2015 there will be 28,199 people over 65 in Rotherham with a long term clinical or psychological condition which causes a disability.
- The 2001 census shows that 22.4% of the population considered themselves to have such a disability, compared with 17.9% nationally.

What more could we be doing and what are the key challenges?

Health and social care services need to plan and respond to the anticipated increases in these conditions and ensure evidence based services are implemented. This may involve redesigning care pathways towards prevention of disability rather than a response to it.

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Appendix 1:

The following Information has been obtained from the Yorkshire and Humber Public Health Observatory.

The spine charts in table 2 report on the six Marmot chapters.

Table 1

Rotherham	District data		Within district inequality (Slope index of inequality)		
	Rate	Pop base (to nearest 100)	SII (95% CIs)	Relative SII	SII range
AAACM (2005-09)[1] DSR per 100,000 persons	658	770400 (av per year)	-434	0.66	-800 0
Early Years Foundation Status (2008/09) [2] (% of children with 'good development')	51.0%	2900	35.9%	0.70	0 60
Child poverty (2008)[3] (% of children < 16 in families in receipt of CTC (<60% median income) or IS/JSA)	22.7%	49800	-46.9%	2.07	-70 0
Educational attainment (2008/09)[4] (% of pupils achieving 5+ A*-C grades including English & Maths)	46.5%	3400	34.7%	0.75	0 70
Long term unemployed (Oct 2010)[5] (% 12months+ of those aged 16 to 64)	1.0%	162500	-1.3%	1.30	-6 0
Live unfilled vacancies (Oct 2010)[5] (% of those aged 16 to 64)	0.9%	162500	-0.4%	0.45	-5 1
Civic participation (2009)[6] (% of all households)	13.0%	110200	5.4%	0.42	-2 12
Housing in poor condition (from IMD 2007)[7] (% of housing in poor condition)	28.2%	110200	-12.4%	0.44	-40 0

Glossary of terms:

AAACM - All Age All Cause Mortality
CTC - Child Tax Credit
DSR - Directly Standardised Rate
IMD - Index of Multiple Deprivation
IS - Income Support
JSA - Job Seekers Allowance

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Table 2

Spine charts for wider determinants of health

	Rotherham	Year	Current rate	Significantly different from England (95% confidence)	Eng 'Worst'	National Range (Y&H, District, England) Z scores	Eng 'Best'
1: Give every child the best start in life	**NI 72: Early Years Foundation Stage Profile teacher assessments**[1] (% of children with 'good development' - 78 points across all 13 EYFSP scales at the end of the academic year in which they turn 5)	AY 2008/09	51.0		36		67
	Child poverty[2] (% of children under 16 in families in receipt of CTC <60% median income or IS/JSA)	CY 2008	22.7		55.3		4.1
	Under 18 teenage conceptions[3] (rate per 1000 females aged 15-17)	2006-08	53.5		74.8		14.9
	Mothers breastfeeding at 6-8 weeks[4] (% by PCT)	Q1 2010/11	28.7		21.9		83.0
	NI 50: Emotional health of children[1] (% of children who enjoy 'good relationships' with their family and friends)	FY 2009/10	56.4		43.8		62.7
	Households accepted as being unintentionally homeless and in priority need[1] (per 1000 households)	FY 2009/10	0.7		8.3		0.0
2: Enable all children, young people and adults to maximise their capabilities and have control over their lives	**Educational attainment**[5] (% of pupils achieving 5+ A*-C grades including English & Maths)	AY 2008/09	47		38		80
	NI 117: Proportion of 16-18 year olds Not in Education or Training - NEET[1] (%)	CY 2009	7.9		11.9		0.0
	NI 150: Adults receiving secondary mental health services in employment[1] (% at the time of their most recent assessment)	FY 2009/10	1.8		0.8		22.9
	NI 079: Achievement of a Level 2 qualification by the age of 19[1] (%)	AY 2008/09	70.9		62.5		99.1
	NI 051: Effectiveness of child and adolescent mental health (CAMHS) services[1] (%)	FY 2009/10	14		10		16
	NI 118: Take up of formal childcare by low-income working families[1] (% of working families benefiting from the childcare element of Working Tax Credit)	FY 2008/09	13.8		7.6		30.0
	NI 54: Services for disabled children[1] (% Parents general experience of services and delivery)	FY 2009/10	60		57		68
3: Create fair employment and good work for all	**Long term - 12months+ unemployed**[6] (% of those aged 16 to 64)	Oct 2010	1.0		2.2		0.0
	Unemployment rates[6] (% of those aged 16 to 64)	Jan to Mar 2010	10.8		16.3		0.0
	Claimant rates[7] (% of those aged 16 to 64)	Oct 2010	4.5		0.3		7.1
	Live vacancies at Job Centres[6] (% of those aged 16 to 64)	Oct 2010	0.9		0.2		3.8
5: Create and develop healthy and sustainable places and communities	**Housing stocked deemed as decent**[1] (%)	CY 2009	93.6		42.8		100.0
	Neighbourhood perception[1] (% people perceiving neighbourhood as being improved)	CY 2009	13.9		6.9		41.6
	Access to green space - A comparison of accessible land[8] (% of all land)	CY 2009	3.8		0.0		47.3
	Civic participation[8] (% of all households)	CY 2009	13.0		12.8		29.7
	NI 6: Participation in regular volunteering[1] (taking part in formal volunteering at least once a month in the 12 months - %)	CY 2008	20.0		14		36
6: Strengthen the role and impact of ill-health prevention	**Healthy life expectancy at 65** (years) **Males**[1]	CY 2001	5.9		4.2		10.5
	Females[1]		6.7		0.0		11.7
	Cervical Screening Programme - all eligible women seen for screening[10] (% by PCT)	FY 2008/09	79.8		65.8		86.8
	Estimated prevalence of adults who eat healthily[11] (%)	2006-08	19.8		18.3		48.1
	Participation in moderate intensity sport and active recreation on 20 or more days in the previous 4 weeks[11] (%)	FY 2008/09	9.2		5.4		16.6
	Proportion of adults (aged 16+) who binge drink[11] (%)	2007-08	27.8		33.2		4.6
	Proportion of adults (aged 16+) who smoke[11] (%)	2006-08	26.4		35.2		10.2
	Claimants of incapacity benefit/ severe disablement allowance with mental or behavioural disorders[2] (%)	CY 2008	34.9		58.5		9.0

Sources (further details available in the main report's metadata): 1: Dept for Communities and Local Government. 2: Dept of Work and Pensions. 3: Every child matters. 4: Unify2. 5: Dept for Children, Schools and Families. 6: NOMIS. 7: Taylor Associates. 8: Acxiom survey data. 9: Natural England. 10: Information Centre. 11: APHO Health Profiles

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ROTHERHAM BOROUGH COUNCIL - REPORT TO MEMBERS

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**21st September 2011**
3.	**Title:**	**Health Inequalities Summit**
4.	**Directorate:**	**Public Health**

5. Summary

To highlight to the Health and Wellbeing Board the Health Inequalities Summit, to be held 30th November 2011.

As part of the action to investigate and address the health inequalities in Rotherham, a high level summit has been arranged to plan the next steps in addressing health inequalities locally. The objectives of the summit are:

- To re-energise the approach to address health inequalities in Rotherham.
- To develop and deliver a framework that will make a difference to people in Rotherham (based on the model overleaf) 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 are classified within the 10% most deprived areas in England
- To assist RMBC to develop and deliver a Rotherham Health Inequalities Action Plan.

6. Recommendations

That the Health and Wellbeing Board:

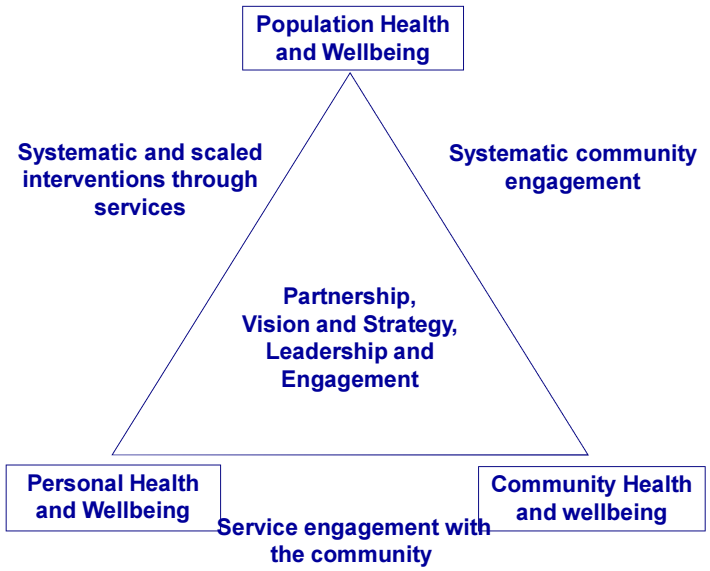
- Recognise health inequalities in Rotherham as a priority area for action.
- Support the community consultation exercise and November summit.
- Mandate partnership action.
- Receive a report on the outcomes of the Summit and the agreed actions.

7. Proposals and details

Rotherham's position regarding the wider determinants of health is consistently worse than the England average[1]. The most recent Index of Multiple Deprivation (IMD) 2008/9 shows that 17% of the Borough is now amongst the 10% most deprived areas in England compared to only 12% in 2007. There has been a downwards shift of the whole population which increases the risks of living in poverty. The Child Wellbeing Index value is worse than the national average at 203, compared to 169, demonstrating the lower levels of child wellbeing across a number of indicators.

Health inequalities arise because of a complex mix of economic, social and cultural factors as well as access to services to support the most vulnerable. People need safe warm housing to support their health across the public and private sector housing markets. This requires a coordinated response from a range of professionals. There has been previous activity to address health inequalities.

Model for developing action on Health Inequalities



Producing Percentage Change at Population Level

Adapted from C. Bentley 2007

Partnership Engagement

NHSR have undertaken a number of meetings to promote the aims and objectives of the summit (as outlined above) to ensure it meets all partners' needs and leads to success in addressing health inequalities in Rotherham. Through this process partners have the opportunity to shape both the consultation and summit event to ensure a successful outcome. A range of engagement activities have been undertaken including: partnership meetings, scrutiny presentation, health and wellbeing cabinet members delegated powers meeting, and, health and wellbeing board paper.

Community Consultation

To inform the summit, community consultation will be undertaken in Autumn 2011. A mixed methods approach will be taken, flexible to respond to new ideas and themes as these are generated by the research. Initial scoping will be undertaken at the Rotherham Show, to gain an understanding of possible reasons for the apparent increase in health inequalities. The scoping exercise will be followed by focus groups held with Rotherham residents in area assemblies and

[1] Yorkshire and the Humber Public Health Observatory Wider Determinants of Health Profile, Rotherham. Jan 2011.

communities of interest to gain a deeper understanding. This information will be collated and presented to the summit in November.
A pragmatic approach will be taken to the community consultation, as outlined in Appendix 1.
Summit Event
A high level summit is planned for 30th November 2011, an outline of the event is provided in Appendix 2.

8. Finance
Community consultation activity is being undertaken by NHSR Public Health staff in partnership with RMBC Community Engagement Team within current resource. Tackling health inequalities is about co-ordinating the efforts, resources and support of the NHS, RMBC and all local partners.

9. Risks and Uncertainties

Risk	Mitigation
1. Lack of partnership engagement	Planned engagement activities as outlined above.
2. Community Consultation • Lack of engagement • Timescales • Not asking appropriate questions	NHSR Public Health using the evidence base and evidence of best practice from working in partnership with Patient and Public Engagement and RMBC Community Engagement Team to develop an effective framework.
3. Summit Event • Lack of engagement • Not achieving the aims and objectives	Planned engagement activities to raise awareness and shape the summit to achieve successful outcomes.
4. Health Inequalities continue to increase	Partnership engagement, community consultation, summit, agreed action plan delivered.

10. Policy and Performance Agenda Implications
Successfully addressing health inequalities in Rotherham will have a positive impact on all performance targets and policy areas, conversely a failure to address this will have a negative impact.

11. Contacts
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Cllr Ken Wyatt, Health and Wellbeing Cabinet Lead. Ken.wyatt@rotherham.gov.uk

APPENDICES

Appendix 1 – Process for Community Consultation

Process	Aim & Objectives	Groups	Method	Proposed Outcome	Deadline
Review of recent community consultation on similar issues	Initial review of recent community consultation to identify areas for investigation, emerging themes etc	Documentary analysis and meetings with stakeholders e.g. JSNA, Health and Wellbeing Board, Health Scrutiny etc	Content analysis	Additional areas of interest to inform Focus Group discussions. Existing areas that have already been identified.	August/ September 2011
Initial Scoping	To gain understanding of possible reasons for the apparent increase in health inequalities	Attendees at Rotherham Show	Closed question questionnaire. Interactive display.	Quantitative approach to enable some descriptive statistical presentation of results. Ideas may be offered that can inform the qualitative elements of the consultation.	September 2011
More in depth discussion with specific targeted groups	To gain deeper understanding of possible reasons for the apparent increase in health inequalities	Area Assemblies (n=7) Communities of Interest (n=7) Special interest groups	Short suitable presentation/ introduction re health and inequalities to stimulate discussion. Facilitated focus groups.	Thematic analysis to identify key themes	October/ November 2011

Appendix 2 – High Level Summit – Outline - 30th November 2011 9-12.

Part One 9:15 - 10.30
09:15 - 9:30 - Introductions, Purpose, Outline
09:30 – 10:30

1. Presentations (based on the model above)
    - Health Inequalities: the nature, the scale, the causes across the whole of Rotherham.
    - The ten target communities (Eastwood, Dalton and East Herringthorpe, Masbrough, Dinnington, East Dene, Maltby, Town Centre, Wath, Rawmarsh, Kimberworth Park).
    - Pockets of deprivation/rural agenda
    - Progress against Inequalities Action Plan 2007-09
    - Community Consultation Feedback
    - Tools, JSNA and Health and Wellbeing Board
    - Evidence of what works elsewhere

Part Two 10.30 – 12.00

2. Facilitated workshops - using Marmot as a framework to guide discussions
    - Vision
    - Current offer of services
    - Areas for improvement
    - How can we make the biggest difference
    - Agree actions for the Health and Wellbeing Action Plan (evidence based, outcomes orientated, systematically applied, scaled up appropriately, appropriately resourced, persistent)
    - How we will do it?
    - Who is accountable?

Summit Invitees

NHSR	**RMBC**	**CEC**	**Wider health leaders**	**Wider audience**
Dr John Radford Chris Edwards Dr Robin Carlisle Sarah Whittle Jo Abbott Dr Nagpal Hoysal Joanna Saunders Anne Charlesworth Rebecca Atchinson Carol Weir Helen Wyatt Alex Henderson	Cllr Ken Wyatt Cllr Paul Lakin Cllr John Doyle Cllr Mahroof Hussain Martin Kimber Matt Gladstone Joyce Thacker Tom Cray Karl Battersby Zafar Saleem Miles Crompton	Dr David Tooth Dr David Polkinghorn Dr Russell Brynes Dr Ian Turner	Brian James Andy Irvine Christine Boswell Andy Buck Mike Wilkinson David Whiting	Janet Wheatley Chris Bentley Cathy Reed Carole Haywood Brian Chapple Paul Douglas Chief Constable Meredydd Hughes Chief Fire Officer Jamie Courtney

ROTHERHAM BOROUGH COUNCIL - REPORT TO MEMBERS

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**21st September 2011**
3.	**Title:**	**Childhood Obesity Summit**
4.	**Directorate:**	**Children & Young People's Services and Public Health**

5.
Summary

To highlight to the Health and Wellbeing Board the Childhood Obesity Summit, to be held 23rd September 2011. The summit aims to plan the next steps in addressing childhood obesity in Rotherham. The objectives of the Summit are:

- 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.

6. Recommendations

That the Health and Wellbeing Board:

- Recognise childhood obesity in Rotherham as a priority area for action.
- Support the summit.
- Mandate partnership action to address childhood obesity in Rotherham.
- Receive a short report on the outcomes of the Summit and the agreed actions.

7. Proposals and details

The purpose of the Summit is to update those attending on the progress and performance of the Rotherham Healthy Weight Commissioning Framework (Appendix 1), to review current activity and develop a plan to continue to address Childhood Obesity in Rotherham based on the Healthy Weight Framework (an outline of the event is detailed in Appendix 2).

To date the children's obesity data has shown a slight levelling off but alongside increasing coverage this seems promising, as anecdotally we know it is the more overweight and obese children who are opted out of the weighing and measuring programme. However, prevalence of obesity remains high (most recent data is for school year 2009/10 Yr 6 20.2% obesity prevalence, coverage 95%) and is higher than both the regional and national averages (18.8% and 18.7% respectively).

8. Finance

Obesity treatment services (Tiers 2-4, Appendix 1) are funded until March 2012, and as such all services were given 12 months notice of this. Obesity continues to require effort to prevent and treat in order to avoid the health and social costs associated with an increasingly obese population. Activity at the summit will also focus on the development of a business case for recommissioning services, subject to resource.

9. Risks and Uncertainties

To date, there is very little published evidence to support the effectiveness of any weight management interventions, although it is widely recognised nationally that Rotherham has led the way. The activity in Rotherham is based on the NICE Guidance CG43 (obesity) (2006) and PH 27 (CHD Prevention) (2010), the Standard Evaluation Framework (NOO, 2009), the recommendations outlined in Healthy Weight, Health Lives (DH, 2008), the Collection of Resources on Evaluation (NOO, 2009), the lessons learned from similar frameworks delivered elsewhere and the Rotherham experience. In 2009 NHS Rotherham won a National Health and Social Care Award for the Healthy Weight Commissioning Framework, the model has been adopted by the National Obesity Forum as their model of best practice, and shared on the NICE website.

10. Policy and Performance Agenda Implications

The prevalence of unhealthy weight remains high with 35% of children in Rotherham classified as overweight and obese (2009/10 National Child Measurement Data for age 10/11). This is higher than regional and national averages (both 33%).

11. Contact

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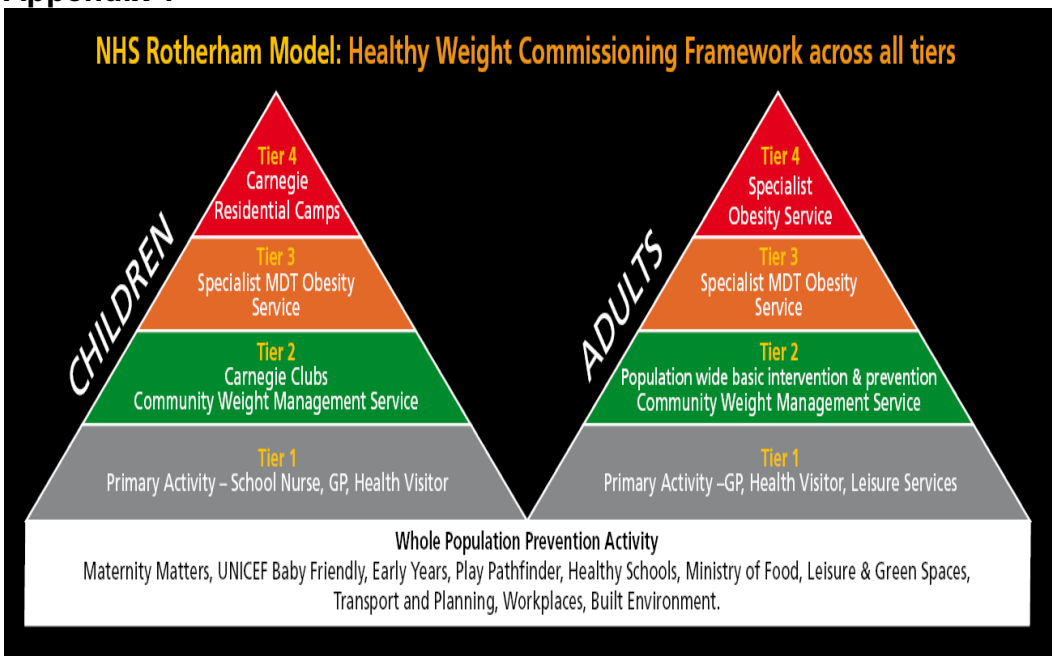
Joanna Saunders, Head of Health Improvement, NHS Rotherham.
Joyce Thacker, Strategic Director of Children and Young People's Services, RMBC

APPENDICES

Appendix 1



Appendix 2 - Summit Outline

Part One 9:15 - 10.00
09:15 - 9:30 - Introductions, Purpose, Outline

09: 30 – 10:00 - Presentation (based on the model in Appendix 1):

- Obesity: causes, consequences, prevalence, relative position in Rotherham.
- Activity since 2008 – description of services and model
- Progress – achievements, outcomes, benchmarking

Questions 10:00- 10:15

BREAK 10:15-10:30

Part Two 10:30 – 12.00 - Presentation and Facilitated discussion
2a. Presentation 10:30 - 11:00

- Areas for on-going/further work
  - Areas and opportunities for improvement
  - Gaps in services e.g. prevention, Tier 1, maternity
- Evidence of how to address areas for on-going/further work focussing on:
  - Prevention – Sheffield Let's Change4Life, other Healthy Towns learning
  - Tier 1

2b. Discussion 11:00 – 11:45

- Vision for post March 2012
- Review current offer of services and areas for improvement
- How can we make the biggest difference?
- Action Plan - Agree actions, roles and responsibilities, timescales, next steps

ROTHERHAM BOROUGH COUNCIL – REPORT TO THE HEALTH AND WELLBEING BOARD

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**21st September 2011**
3.	**Title:**	**Community Involvement and HealthWatch Update**
4.	**Directorate:**	**Chief Executives**

5. Summary

This report sets out the current position and plans around the development of a local HealthWatch as required by the Health and Social Care Bill.

6. Recommendations

That the Health and Wellbeing Board:

- **Approve the current position and plans around the Healthwatch policy**
- **Approve the commissioning process and timescales**
- **Receive a report in January 2012 recommending the most appropriate model and structure for Rotherham HealthWatch.**
- **Approve the methodology for wider voluntary and community sector involvement as outlined in section 7.5 of the report.**

7. Proposals and details

7.1 Background

The Health and Social Care Bill, currently going through Parliament, makes provisions for the establishment of HealthWatch England and subsequent local HealthWatch organisations. Subject to Parliamentary approval, HealthWatch will be introduced from October/November 2012. Local Authorities will be under a duty to ensure there is an effective and efficient local HealthWatch in their area.

Department of Health Guidance highlights the importance of continuity in service provision and thus a smooth transition between the current LINKrotherham contract and new Local HealthWatch arrangements will be required. That said local HealthWatch organisations are required to fulfil additional functions, roles and responsibilities that are not currently provided by Local Involvement Networks (LINks). Therefore, a different model may be necessary to deliver successful local HealthWatch functions.

7.2 LINkrotherham - Current Position and Plans

Due to the uncertainty around the future requirements of HealthWatch and delays in the enactment of the Health and Social Care Bill, a new 6 month contract will be issued to LINKrotherham from 1st October – 31st April 2012. A new service specification has been drawn up by the RMBC & NHS Rotherham Joint Commissioning Team under which Voluntary Action Rotherham in their capacity as "Host" will be commissioned to:

- Support consultation and engagement on Health and Wellbeing agenda including the forthcoming health summits
- Develop the capacity and skills of the Governing Board and members.
- Ensure the all member meetings are called to ensure members are retained and engaged.
- Improve the demographic data collected on the membership to ensure it reflects the make up of the local community.
- Maintain the website, membership database; produce regular newsletters, and arranging consultation meetings between the Governing Board, the LINkrotherham membership, and the statutory partners on health and social care issues. .

7.3 HealthWatch - Commissioning Plan and Timescales

The Joint Commissioning Team is leading on the development of models and options working collaboratively with the Council's Commissioning, Policy and Performance Team and through the HealthWatch Project Group (comprising officers from Rotherham NHS, RMBC, and Rotherham NHS Foundation Trust). The most appropriate model for Rotherham will be established by December 2011 upon receipt of Department of Health Guidance around HealthWatch requirements.

The overall commissioning timetable is as follows:

- Joint Commissioning Team to develop the Contract and Service Specification for local HealthWatch by 31st March 2012.

- Commence the tendering process for the most appropriate model for Rotherham in March 2012, allowing 6 months for completion. However, the tendering process and timescale will be dependent on the agreed HealthWatch model for Rotherham.

- Issue contracts in September/October 2012 and establish Rotherham HealthWatch by October/November 2012.

- The reviewing and monitoring regime of the contract performance will be configured in line with the agreed HealthWatch model for Rotherham.

7.4 HealthWatch Models

It is expected that HealthWatch will deliver on the following key functions:

- An emphasis on influencing the outcome of health and social care services
- Providing information on health services
- Providing influence at a strategic level for users of health and social care services by taking up a place on the Health & Wellbeing Board
- Providing a consumer voice through an advocacy and complaints service
- Acting as conduit to the Care Quality Commission and local practice, and linking into Health Watch England

Not all of these functions are required to be delivered by one single organisation. Therefore, the Health Watch project group are exploring various models in collaboration with neighbouring HealthWatch pathfinder authorities and regional LINk commissioners.

1. NHS Trust Model
    - Wide reference group and a small strategic elected or selected management core, which may or may not receive remuneration.

2. LSP/Paid Chair Model
    - Wide membership group with remunerated position of a Chair who acts as a key figurehead in driving the organisation forward.

3. Social Enterprise Model
    - Social enterprise is formed using existing staff together with the establishment of a board to deliver local HealthWatch priorities.

4. Partnership Model
    - Work across regional boundaries (Doncaster, Barnsley and Sheffield) with the core of the organisation's work in partnership with other experienced agencies to deliver local HealthWatch priorities.

5. Contracted Services Model
    - Work is delivered on a contractual basis e.g. voluntary and community or private sector organisations, requiring strong finance and contracting skills amongst board members.

7.5 Wider patient, service user, and voluntary sector engagement – the duty to involve

One of the success criteria by which local Health & Wellbeing Boards (HWBB) will be measured is the extent to which they engender ownership of healthcare developments by the local community. To support the Rotherham HWBB fulfil its duty to involve and lead on public and patient engagement it is proposed to establish a mechanism to enable service users and voluntary and community sector (vcs) representatives to be consulted on and contribute to the development of the HWBBs strategic plans and priorities. Any network or forum established would complement existing involvement structures with terms of reference that would be different from the responsibilities of other bodies, such as HealthWatch which already has a statutory right to membership of the HWBB.

It is proposed that the HWBB adopts a thematic approach that would enable a wide section of the community to be engaged with and a broad spectrum of issues to be represented. Thus involvement would vary according to the priority the HWBB was focussing on at the time, as would the methodology adopted. For example, dependent on the specific subject matter focus groups, public meetings, or community events could be scheduled with members of the HWBB to explore/discuss issues with information gathered used to inform decision making, commissioning and policy development. Community engagement and/or consultation lead officers from the Council and Rotherham NHS would then support the delivery of the activities in line with section 4.1 of the HWBB draft terms of reference. A community engagement plan would be produced to support delivery of the HWWB work programme.

The above approach would be more inclusive than establishing a standing committee of vcs representatives or seeking the election or nomination of a single person/agency to represent the whole of the vcs via a seat on the HWBB.

8. Finance

Local Authorities will have funding for HealthWatch built into their existing allocations, including funding for current NHS functions (complaints advocacy, and provision of advice and information on health services) which will be transferred to Rotherham MBC.

Nationally, it is anticipated that HealthWatch will receive Department of Health funding of £53.9 million for 2012/13 plus £3.2 million for start-up costs. In 2013/14, when local authorities take on responsibility for commissioning NHS complaints advocacy, the combined funding will rise to £66.1m. The local allocation to Rotherham is yet to be determined.

The Department of Health has advised that the Ongoing Personal Social Services Grant funding (which includes the funding for LINks) will be maintained at current levels, rising in line with inflation, for the Spending Review period. The Spending Review period is until 2014/15. This means funding will be made available to local authorities to support them to fulfil their statutory duties around LINks and, subject to Parliamentary approval, HealthWatch for the next four years.

9. Risks and Uncertainties

- Plans and timescales are subject to the Health and Social Care Bill being passed through parliament which makes provisions for the establishment of HealthWatch.

- Timescales are still unclear due to delays in National Guidance being issued from the Department of Health.

- The number of suitable organisations applying for tender is currently unknown together with stipulations for applying for tender.

- Staff/Financial transfer from PALS including employment rights and TUPE arrangements are still uncertain.

10. Policy and Performance Agenda Implications

As per section 7.1.

11. Background Papers and Consultation

Reports, Project Plan and associated papers for the Review of LINKrotherham and Healthwatch
Department of Health – Healthwatch Transitional Plan
Upcoming Department of Health guidance and reports

12. Contact

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