HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 27th February, 2013**

Time: **1.00 p.m.**

A G E N D A

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

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

3. Minutes of Previous Meeting (Pages 1 - 7)

4. Communications (Pages 8 - 32)
   Health and Wellbeing Board Work Plan (pages 1-5)

   Health and Wellbeing Strategy Workstream Update (pages 6-9)

   Better Health for Women: A Summary Guide January, 2013 (page 10)

   Rotherham Carers' Charter (pages 11-25)

   Conferences:-

   - 2nd Annual Health and Transport Conference: Remaining Healthy Through Sustainable Travel - Transport Planning Society - 10th April, 2013

   - Health and Wellbeing Conference – 17th April, 2013

5. Health and Wellbeing Board Communications Plan (Pages 33 - 39)
   - Tracey Holmes to report

6. Rotherham Foundation Trust
   - verbal update

7. Robert Francis Inquiry - Mid-Staffordshire NHS Foundation Trust (Pages 40 - 43)

8. Public Health Outcomes Framework: High Level Outcomes (Pages 44 - 49)
   - John Radford to present

9. Performance Management Framework (Pages 50 - 74)
   - John Radford/Nagpal Hoysal to present

10. Workstream Progress: Healthy Lifestyles, Prevention and Early Intervention (Pages 75 - 84)
   - John Radford to present

11. Priority Measure 2: Obesity (Pages 85 - 95)
   - Joanna Saunders to present

(The Chairman authorised consideration of the following item to enable Board members to be fully informed)

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

13. Food for People in Crisis Partnership (Pages 96 - 97)

14. Date of Next Meeting/Frequency of Meetings
   - Wednesday, 11th April, 2013

HEALTH AND WELLBEING BOARD
Wednesday, 16th January, 2013

Present:-
Members:-

Councillor Ken Wyatt	Cabinet Member, Health and Wellbeing **(in the Chair)**
Karl Battersby	Strategic Director, Environment and Development Services
Tracy Clarke	RDaSH
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Councillor John Doyle	Cabinet Member, Adult Social Care
Chris Edwards	Chief Operating Officer, Clinical Commissioning Group/NHS Rotherham
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families
Shona McFarlane	Director of Health and Wellbeing
Dr. David Polkinghorn	Rotherham Clinical Commissioning Group
Clare Pyper	Children, Young People and Families, RMBC
Dr. John Radford	Director of Public Health
Dr. David Tooth	Rotherham Clinical Commissioning Group
Janet Wheatley	Voluntary Action Rotherham

Officers:-

Kate Green	Policy Officer, RMBC
Tracy Holmes	Communications, RMBC
Fiona Topliss	Communications, NHS Rotherham

Also present:-

Anne Charlesworth	Partnership Lead, Public Health
Gordon Laidlaw	Rotherham NHS

Apologies for absence were received from Chris Boswell, Phil Foster, Martin Kimber, Matthew Lowry and Joyce Thacker.

S54. MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

Resolved:- (1) That the minutes be approved as a true record subject to the following clerical correction:-

S48 (Health and Wellbeing Performance Management Framework) Resolved:- That each meeting of the Health and Wellbeing Board consider two Priority themes (Smoking, Alcohol, Obesity, Dementia, NEETS and Fuel Poverty), with the Priority theme's Lead Officer invited to attend the relevant meeting.

Arising from Minute No. S49 (Overarching Information Sharing Protocol), discussion ensued on how the matter was to be progressed.

Resolved:- (2) That each Board member ensure their organisation had signed off the Protocol and report accordingly to the next Board meeting.

(3) That the Overarching Information Sharing Protocol be submitted to the Cabinet for approval.

Arising from Minute No. 53 (Unscheduled Care Review), it was noted that arrangements had been made for an Elected Member Seminar to be held on

13th February, 2013.

S55. COMMUNICATIONS

(a) Challenge on Dementia/Dementia Strategy
The Board noted a letter that had been sent to Chairs of Health and Wellbeing Boards from the co-Chairs of the Health and Care Sub-Group requesting commitment to the Dementia Challenge and assistance in taking the agenda forward.

Dementia was 1 of the Board's Priorities in its Health and Wellbeing Strategy.

Central Government had announced that Clinical Commissioning Groups had to have a Dementia Strategy and included on its website. Due to the timescale given, there had been insufficient time to co-ordinate across the health and social care community. A draft Strategy had been published on the CCG website by 31st December, 2012, in line with the Yorkshire and Humber Strategic Health Authority requirement.

(b) Friends and Family Test
The Board noted the forthcoming mandatory 'Friends and Family' Test and Rotherham Foundation Trust's implementation plans to achieve full coverage of prescribed areas. From April, 2013, a short survey had to be completed upon a patient's discharge, or within 48 hours of discharge, to ascertain their rating of care about the Ward/Department they had spent the most time in. The Trust would be required to submit data returns which would be published nationally.

The report set out the actions the Trust would undertake to fulfill this requirement.

(c) Conference
'Tackling Health Inequalities in the North' – 8th March, 2013 – Durham
Details of the above conference were submitted for the information of the Board.

(d) ROSPA Big Book of Accident Prevention
Copies of the above were circulated to Board Members.

(e) Local Medical Committee
The Chair reported receipt of a request from Dr. Thorman, Secretary of the Local Medical Committee, seeking representation on the Board.

Discussion ensued on the request. It was felt that there was GP representation on the Board through the CCG which could reflect General Practices' views and beliefs. It was a public meeting that was open to members of the public to attend and observe if they so wished.

Resolved:- (1) That Dr. Thorman be thanked for his interest in the Board but the request for representation be declined at the present time.

(2) That a copy of the Board minutes be supplied for information.

(Dr. Tooth declared an interest in the above and did not take part in the

discussion.)

S56. ROTHERHAM CLINICAL COMMISSIONING GROUP ANNUAL COMMISSIONING PLAN

Dr. Tooth presented the draft CCG Annual Commissioning Plan which it was required to formally submit to the NHS Commissioning Board Area Team by 25th January, 2013. The core aim was to ensure that the needs of the citizens of Rotherham, as set out in the Joint Strategic Needs Assessment and reflected in the Health and Wellbeing Strategy, were captured.

Unfortunately, due to the timescale for submission it had not been possible to include any Public Health, Council etc. commissioning proposals as the timelines had not corresponded.

It was queried whether it would be possible for the Council and Public Health commissioning proposals to be submitted to the Board before the end of March to ensure alignment with the Health and Wellbeing Strategy?

The Council had to formally set its budget first but work was well advanced on its commissioning intentions to which Public Health would now be added. There was a opportunity to identify areas where it was possible to pool budgets for better value for money or more consistent outcomes delivered by commissioning more intelligently.

It was noted that a number of agencies had already submitted their feedback on the document.

Resolved:- That the Rotherham Clinical Commissioning Group Annual Commissioning Plan be endorsed for submission to the NHS Commissioning Board Area Team.

S57. PERFORMANCE MANAGEMENT FRAMEWORK

Further to Minute No. 48 of the previous meeting, John Radford, Director of Public Health, reported that it had been hoped to submit a suite of Indicators for consideration to the meeting, however, it had proved to be more difficult than envisaged. He gave the following presentation:-

System Change

- System accountability
- Local delivery prevention interventions
- NHS, RMBC, Commissioning Board and CCG
- Engagement private and third sector
- Public engagement
- Resources
- Service Activity
- Behaviour Change
- Mortality
- Commissioning for outcomes
- Profile \ media \ social media
- Disease Information

Outcomes Framework Annual Reporting
- Local Priorities agreed by Board.
- Align with Outcome Frameworks
- Need to agree specific outcomes for each priority
- Identify specific outcome measures that will progress over time
- Board to review its progress

Local Priorities
- Need to identify local (outputs) measures that help monitor progress bi-monthly throughout 3 year period of the strategy
- Report back next time with proposed outcome and output measures

The Board then received Anne Charlesworth's presentation (see Minute No. 58 Priority Measure: Alcohol) and discussion on the possible Performance Indicators for that Priority.

Discussion ensued on the way forward for all 6 Priority Themes:-

- The Board had agreed 6 Priorities that would make the biggest difference to the health and wellbeing of Rotherham citizens and reduce health inequalities
- Definition of the desired outcomes for each Priority required
- Need to decide where to focus activity and then outcome measures and outputs would follow
- Better definition of what want to achieve
- Engagement and commitment from all partners to drive the agenda within their Services

Resolved:- That each of the 6 Priority Leads submit a suite of Indictors for their respective Priority Theme to the next Board meeting.

S58. PRIORITY MEASURE: ALCOHOL

Anne Charlesworth, Partnership Lead, Public Health, gave the following presentation on the Alcohol Priority:-

The Vision
- 1 in 4 of Rotherham's adults drink above recommended safe levels
- To challenge the culture of binge drinking
- To deliver the messages about risks to those adults who drink at risky levels

Rotherham Adult Population
- Drinking above low risk levels 26.2% (51,569)
- Drinking at harmful levels 5.3% (10,432)
- Depend upon alcohol 3.6% (7,068)

National Strategy
- Change behaviour so people think it was not acceptable to drink in ways that cause themselves or others harm
- Reduce alcohol-fuelled violent crime

- Reduce the number of adults drinking above NHS guidelines
- Reduce the number of people binge drinking
- Reduce the number of alcohol related deaths
- Sustain reduction in both the numbers of 11-15 year olds drinking and the amounts they consume

Local Strategy

- Programme of alcohol social marketing interventions using the 'single message' including E-learning packages and workplace interventions
- Trialling Community Alcohol Partnerships
- Identification of premises which cause problems and taking effective partnership action
- Identifying individuals who cause repeated issues e.g. using Fixed Penalty Notices to attend alcohol awareness

Treatment System Priorities

- To increase numbers seen in primary and secondary care by:-
  Increased screening in GP practices – now also in Health Check
  Re-commission Tier 2 provision and include more work on population awareness, screening and workplace initiatives
  Gaps in provision against NICE Guidance
  Keeping waiting times low
  Payments by Results – Rotherham was 1 of only 4 pilots

Alcohol-related Hospital Admissions

- 53,689 alcohol-related hospital admissions – significantly higher than the national average. Between 2010-11 and 2011-12 Rotherham's rate had increased
- 28,827A&E – the relative position in terms of all 326 local authorities had remained the same (in the highest 25% of rates)
- 6,587 In-patients – Mortality from chronic liver disease – Rotherham's rate was similar to England (not statistically different)
- 18,257 Out-patients – In 2010-11 Rotherham's rate was lower than England but increase in 2011-12 and was now higher than England (but still similar). Rotherham ranked in the highest 50-70% of all local authorities (Quartile 3)

Hospital

- Hospital-based services – one of the Department of Health 'hi impact changes'
- Already have an A&E pathway targeting young people
- 1 specialist nurse working on admissions
- Work with Ambulance Service and RFT on 'frequent flyers' and high volume users of hospital front line services. Some were already known to services but not all
- Protocol which allowed those detoxing to be discharged early to their GP
- CCG proposing to invest in a new Service.

Opportunities

- Every organisation had to recognise the costs of alcohol and contribute to prevention

- The Public Health budget may offer opportunities to increase prevention – there had been no budget for this in the past
- How was each organisation addressing the issues through the themes:-
  Prevention and Early Intervention
  Expectations and Aspirations
  Dependence to Independence
  Healthy Lifestyles
  Long Term Conditions
  Poverty

Discussion ensued on possible outcomes that could be measured including:-

- Number of parents who children were included on the Child Protection Register/come into care due to alcohol related conditions
- Danger that the specialist treatment services would not be able to cope with the increased referrals
- Indicators important in terms of how Services were delivered
- Measure self-harm, behaviour in Town Centre, effect of families by domestic violence
- Every patient use Audit Check

The Board discussed this item and the previous item together. Please see Minute No. S57).

S59. EXCLUSION OF THE PRESS AND PUBLIC

Resolved: - That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972 (as amended 2006 – information relates to finance and business affairs).

S60. ROTHERHAM HEALTH WATCH

Clare Burton, Operational Commissioner, presented an update on the recent OJEU tender process for Healthwatch Rotherham.

A preferred provider was not appointed as there had been no bids of sufficient quality to move to the awarding of a contract. A proposed way forward was set out in the report submitted to ensure that there was a Healthwatch Rotherham in place by the 1st April, 2013.

Resolved:- (1) That the outcome of the OJEU tender process be noted.

(2) That the proposal to re-tender the Service, as set out in the report submitted, be approved.

(3) That further progress reports be submitted in due course.

(Janet Wheatley and Gordon Laidlaw disclosed disclosable pecuniary interests in the above item and withdrew from the meeting.)

S61. DATE OF NEXT MEETING

Resolved:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 27th February, 2013, commencing at 1.00 p.m. in the Rotherham Town Hall,

Health and Wellbeing Board Work Plan 2012 – 13

HWBB Cycle	Agenda Item/Outcome for the HWBB	Action Required	Lead
31 October 2012	Agree HWBB work plan	Plan developed from outcomes of self-assessment activity and reflection from Board members – including 'excellence plan' for continued annual assessment/review of Board's progress	Kate Green
	Agree and publish Joint Health and Wellbeing Strategy 2012 -15	Final strategy to be presented to Board following consultation activity and amendments	Kate Green / HWB Steering Group
	'End of Life' – Rotherham Hospice	Exploring how the Rotherham Hospice can help the Board achieve its priorities	HWBB / Mike Wilkerson, RH
28 November 2012	Agree Performance Management Framework, including: • Agreed measures for Board to monitor • How performance will be reported • Performance reporting schedule	Develop framework based on national Outcomes Frameworks and Board priorities, and agree a set of 5/6 measures which the Board will monitor at planned meetings. For the Board to also agree the schedule for thematic discussions on each of the priorities – one per meeting.	HWB Steering Group (meeting 14 Nov)
	Clear reporting mechanism for the Board in place *(not agenda item)*	Undertake mapping exercise; looking at partnership governance structures to provide a clear reporting mechanism which reports by exception and for purpose, stopping duplicate reporting and clarifying the decision making process.	HWB Steering Group
	Unscheduled Care Review	For the Board to consider the NHS review	Ian Atkinson / Dr Ian Turner
	Health and wellbeing in BME communities	For the Board to explore needs of BME communities in Rotherham; what services are available and delivery issues	HWBB / Nizz Sabir, Rotherham Council of Mosques

16 January 2013	Rotherham CCG Annual Commissioning Plan	For the Board to be presented with the plan and discuss opportunities and alignment with the HWB Strategy	Chris Edwards
	HealthWatch	Update report on the HealthWatch tendering process	Chrissy Wright / Claire Burton
	Performance Management Framework	To provide a position statement and data on the 6 priority measures, plus joint indicators (from Outcomes Frameworks)	HWB Steering Group / Nagpal Hoysal to present
	Priority Measure 1: Alcohol	To present data and information on Alcohol issues and services	Anne Charlesworth
27 February	Joint Action Plan for Carers	For information	Shona McFarlane/Kate Green
	HWBB Communications Plan	To go to HWB Steering Group for discussion	Tracy Holmes
	Performance Management Framework	To provide the board with the final suite of measures for monitoring performance and position statements for the 6 priorities, plus national outcomes frameworks	John Radford
	Workstream progress report: Prevention & Early Intervention	To provide information on the workstream plan; current actions and progress being made	John Radford
	Priority Measure 2: Obesity	To present data and information on obesity	Joanna Saunders
10 April 2013	Police and Crime Commissioner	Newly appointed Commissioner to attend Board; providing an update and exploring opportunities for health and wellbeing priorities	PCC

	Joint commissioning framework	Develop a joint commissioning framework – to be presented to the Board for discussion/agreement	Chrissy Wright
	Public Health Commissioning Plan (noting PH now fully integrated into local authority)	For the board to be presented with the commissioning plan, to ensure alignment with the HWB strategy and other plans	John Radford
	Frances Review of Mid-Staffs Foundation Trust	For partners (commissioners and providers of healthcare services) to share assurances for how organisations are implementing the recommendations from the Frances review	All relevant partners
	Local HealthWatch in place	Welcome Healthwatch to the Board	Healthwatch representative/ Chrissy Wright
	Scrutiny Review of Continuing Healthcare	For the Board to receive the Cabinet response to the recommendations and agree an action plan for implementation	TBA
	Workstream progress report: Expectations and Aspirations	Progress update - including: what is working / any blockers / tensions	Sue Wilson
	Priority Measure 3: Dementia	To present data and information on dementia, including local dementia strategy and issues	Kate Tufnell
22 May 2013 (date tba)	Workstream progress report: Dependence to Independence	Progress update - including: what is working / any blockers / tensions	Shona McFarlane
	Priority Measure 4: Smoking	To present data and information on smoking prevalence, related risk factors and smoking cessation services	Alison Iliff
3 July 2013 (date tba)	Workstream progress report: Healthy Lifestyles	Progress update - including: what is working / any blockers / tensions	Joanna Saunders
	Priority Measure 5: Fuel Poverty	To present data and information on fuel poverty and associated factors and health impacts	Paul Benson / Jo Abbott

September 2013 (tba)	Workstream progress report: Long-term Conditions	Progress update - including: what is working / any blockers / tensions	Dominic Blaydon
	Workstream progress report: Poverty	Progress update - including: what is working / any blockers / tensions	Dave Richmond
	Priority Measure 6: NEETs	To present data and information on NEETs and related issues	Collette Bailey
October 2013 (evaluation workshop session tba)	HWBB Annual Report	Compile the Board's annual report –including a position statement for all strategic priorities / priority measures - to feed into commissioning/planning and budget setting cycle and inform the Board's agenda going forward	HWB Steering Group - to begin work September – presented to Board Oct to feed into self-assessment & planning
	HWBB Self-Assessment	For the Board to reflect on progress to date; explore any issues, tensions between the agencies and consider the position within each of the workstreams	HWBB
	Financial planning 2014/15	Financial information to be shared by all agencies; for the Board to explore issues and opportunities to inform commissioning and budget setting process	HWBB
	Commissioning Planning	All agencies	HWBB

2013 Self Assessment Tool

Strategy, Purpose and Vision	
1.	The strategy has influenced the strategic direction of the local authority and partner organisations
2.	Individual commissioning plans of the CCG and local authority align with JSNA/JHWS
3.	Partner organisations can describe how the HWBB will make a difference and a shared and effective communications plan exists
Leadership, Values and Relationships	
4.	Local health and social care resources are understood
5.	Relationships between CCG and local authority are positive and there is ongoing dialogue about commissioning and contracting decisions
6.	Relationships enable members to influence beyond their own organisations
7.	The board empowers the local HealthWatch member to act as an independent effective voice for users and the public
8.	The board can demonstrate that it promotes equality in all its actions, including consultation, priority setting and service improvement and undertakes equality assessment on its plans
Governance	
9.	The board has regular updates on the priorities of the wider local authority, NHS Commissioning Board and key local partners
10.	The relationship between the HWBB and the local authority scrutiny function is clear
11.	An agreement regarding pooling of resources is in place and a risk sharing agreement exists between the local authority and CCG
Measures and Accountabilities	
12.	HWBB informed by real-time intelligence, demonstrating improved outcomes, quality and efficiency across health and social care
13.	Priorities balance improvements in service provision with improvements in population health and wellbeing
14.	The HWBB reviews itself regularly against benchmarks and adapts plans as necessary
15.	HWBB Annual Report demonstrates achievement of outcomes

Health and Wellbeing Board

1.	**Date:**	**27 February 2013**
2.	**Title:**	**Health and Wellbeing Strategy: Workstream Progress**

3. Summary

The Health and Wellbeing Strategy includes 6 strategic outcomes. These outcomes are being delivered through a set of actions to bring about change in the way we do things; to improve the health and wellbeing of all Rotherham people.

Each of the 6 outcomes has been allocated a lead officer from across the council, public health and NHS. It is the responsibility of these lead officers to develop their workstream and deliver the actions.

This report provides the Health and Wellbeing Board with an update on the progress of each of the workstreams, and enables the board to consider any issues or tensions which need to be thought through. This is alongside a more detailed presentation on one of the workstreams at each board meeting.

4. Recommendations

That the Health and Wellbeing Board:

- **Notes progress on each of the workstreams**

5. Proposals and details

A summary of the key actions and progress against these is presented below for each workstream.

Prevention and Early Intervention

Full presentation to board

Expectations and Aspirations

A multi agency group has been established to look at the 4 Expectation and Aspiration priorities in the strategy. Initial work has taken place around a customer pledge (including a young person's version) and a credit card sized prompt card for staff reminding them of joint customer care standards. These will be consulted on and then presented to a future Board Meeting before being adopted by all agencies.

Analysis is taking place around customer complaints (those relating to the quality of service and actions of staff) to be used as a baseline.

Planning is underway for a pilot practitioner event for 2 of the Deprived Neighbourhoods (Dalton/Thrybergh and East Herringthorpe) with a focus on Employment and Skills and Health. This will encourage practitioners working in the 2 areas to gain a better understanding of the services in those areas and make linkages to other practitioners. This will then be rolled out across the other Deprived Neighbourhoods.

Meetings are taking place with the 6 priority measure leads to establish at least one thing we can do differently in relation to Expectations and Aspirations and this will form part of the action plans.

The aspiration element of this workstream is not as evident as 'expectations', therefore aspirational raising activities are also being collected as part of meetings with specific priority measure leads.

Dependence to Independence

A multi-agency task group has been established and a plan developed to address the four priority areas within the workstream. Key to the delivery of this work area is culture change, so a review of workforce commissioning priorities will be completed, as will a review of all commissioning strategies to ensure that they reflect the requirement to support people to be as independent as possible. Personalisation of services offers people an opportunity to make choice and have more control over their lives, so a link has been made to a number of other workstreams including: personal health budgets, early help strategy, intermediate care commissioning group and unscheduled care group. An action plan is in place and good progress is being made.

Healthy Lifestyles

Work started on the theme overview and demonstrating links to the priorities identified as part of the strategy. Meeting with lead for Expectations and Aspirations theme to explore links. Attending Deprived Neighbourhoods Coordinators and Steering Group meetings as often as possible to support Coordinators in developing

links with behaviour change services and raising awareness of services in communities. Met with colleagues from Planning and Development to support the public health agenda in the development of the Core Strategy and Guidance Framework (linking planning agenda to increasing physical activity; green transport; healthy eating).

Continue to oversee commissioning of a range of behaviour change services including weight management, stop smoking and Health Trainer service.

Long-term Conditions

Partner organisations from Rotherham's health and social care community are currently participating in a national programme aimed at improving services for people with long term conditions.

The programme included 4 workstreams;

1. Risk profiling
2. Integrated neighbourhood teams
3. Self-management
4. Alternative Levels of Care

The Rotherham the Urgent Care Management Committee oversees management of the Long Term Conditions Programme. It actively manages the programme to ensure agreed outcomes are met and that there is appropriate and effective engagement with patients and public. The UCMC adheres to the following key principles;

- Its work is aligned with the principles of the Health and Wellbeing Strategy
- Change delivered without cost-shunting to partner organisations
- Services that are of limited patient benefit or clinical value will be decommissioned
- Organisational sovereignty will not override the best interests of the local community
- Change will be delivered by improving joint working and collaboration amongst partners
- Effective stakeholder, patient and public engagement informs service

The programme is concerned with changing the system of care locally so that it reduces reliance on acute hospital and residential care. Rotherham CCG is currently preparing a progress report on the work that has been carried out within these 4 workstreams. The report will identify and evaluate existing initiatives aimed at supporting people with long term conditions in the community. It will also set out proposals for a joint action plan, to be overseen by the Health and Well Being Board.

Poverty

All Deprived Neighbourhoods coordinators in place and making progress.

Most areas have completed their area analysis and all bar one have set priorities for intervention.

1. A Mapping exercise is underway, to ascertain the extent of poverty alleviation

work currently being undertaken in Rotherham.
2. Research is underway to capture national best practice in anti poverty work.
3. Potentially leading to new anti poverty strategy. + added to strategic group work plan.

Health inequality activity features in 9 of the 10 Deprived Neighbourhood Action Plan priorities so far determined.

6. Risks and Uncertainties

One of the main concerns of the priority leads is in relation to capacity of the officers involved in the development of the workstream to deliver the priorities. Often, delivering the workstream priorities are as well as their usual working practice and specific priorities associated with that.

There is also a risk that there is no health and wellbeing budget for delivering specific pieces of work to meet the priorities of the strategy. However, this means that workstream officers are having to be innovative and creative in their thinking to ensure delivery effectively and appropriately.

7. Contacts

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

Workstream Leads:

Prevention and Early Intervention
John Radford, DPH

Expectations and Aspirations
Sue Wilson, RMBC

Dependence and Independence
Shona McFarlane, RMBC

Healthy Lifestyles
Joanna Saunders, RMBC Public Health

Long-term Conditions
Dominic Blaydon, NHS Rotherham

Poverty
Dave Richmond, RMBC

BRIEFINGS

January 2013

WHEC Women's Health & Equality Consortium

BETTER HEALTH FOR WOMEN: SUMMARY GUIDE

Introduction

Women form half the community, so Joint Strategic Needs Assessments (JSNAs), and Joint Health and Wellbeing Strategies (JHWSs) must assess and aim to meet their needs at the local level. Women are more likely to live in poverty and to experience health inequalities so health and wellbeing boards need to ensure women have a voice in decision-making processes that affect their health.

More information can be found in our Guide 'Better Health for Women' (on our website, http://www.whec.org.uk). It signposts essential sources of supporting evidence to inform JSNAs and JHWSs, including an example *Women's JSNA* and case studies, plus a simple, five-step process to identify where there are health gaps for women (where special action is needed to close the gap between women and men in health outcomes across the community) and where there are women-specific health issues.

Why focus on Women?

It's evidence-based

The evidence shows women's health needs are different: for example, they suffer more from poverty, gender inequality, gender-based violence and mental problems. Our guidance will help health and wellbeing boards identify where particular groups of women have specific health needs.

It's better service provision

Reducing health inequalities is one of the NHS's top five priorities. Investment decisions based on women's specific health needs are a practical, cost-effective way of delivering the NHS Social Inclusion Agenda. For example, the cost of violence against women and girls to the NHS is around £1.2 billion a year; domestic abuse alone costs an additional £176 million a year in mental health services, while each rape costs in total around £96,000. The return on investment on prevention is therefore significant: for example, low-cost community-based based support services (such as refuges or rape crisis centres) can reduce the demand on GP services, A&E and admissions to hospital. Around 50% of women who use mental health services have experienced violence and abuse.

It's better community engagement

JSNAs need to be rooted in communities, reflecting their priorities. Women are under-represented in high-level decision-making resulting in inadequate knowledge of their specific needs. The valuable intelligence on service users' needs that is collected by the health and social care voluntary and community groups that work with women and girls must feed into JSNAs. This will help health and wellbeing boards understand what assets and resources local communities can offer to help meet local needs and improve health and well-being outcomes.

It's the law

The Health and Social Care Act 2012 includes a duty to reduce health inequality which applies to CCGs, and Local Authorities have a duty to improve the health of their communities. All public bodies must comply with the Equality Act 2010 as well as the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) (Article 12).

How to Do it: in Five Steps

1. Gather gender disaggregated data
2. Analyse data
3. Listen to women
4. Design and implement
5. Evaluate (listen again)

Listening to women – Dos and Don'ts

- ✓ **Do** make a special effort to reach the women who are the most marginalised and invisible (BME women, women living with HIV, women with experience of prison, women and girls living with legacies of child sexual abuse, etc.) Some women will find it easier to attend meetings that are women-only; while some may need separate engagement mechanisms, such as focus groups hosted by representative organisations.
- ✓ **Do** seek effective, long-term engagement, through dialogue, engagement and funding, with local organisations that support women and women's health. Such organisations are crucial intermediaries, directly in contact with women who may find it hard to be heard in formal consultation events.
- ✓ **Do** provide crèche facilities for women with caring responsibilities.
- ✓ **Do** meet travel expenses to avoid excluding women living in poverty.
- × **Don't** just talk to groups that are led by men, excluding women's voices.
- × **Don't** hold meetings late at night - many women don't leave home in the evening for safety and child care reasons.
- × **Don't** hold meetings when public transport is not running: women have less access to private transport.

Rotherham Carers' Charter
2013

1. Introduction

Rotherham Council and Clinical Commissioning Group are committed to supporting carers to reach their full potential and lead the lives they want, recognising that carers make a vital contribution to society. Current changes to the NHS architecture and legal framework means we need to review our current strategy in Rotherham to ensure we are able to meet the requirements expected of us and that we continue to deliver the best possible outcomes for carers. We have jointly agreed a Rotherham Charter which provides a clear commitment to all carers in Rotherham.

Our Commitments

- We will review and develop our overall strategy based on the changes to the NHS and legal framework and carers views
- We will increase the proportion of carers who report that they have been included or consulted in discussion about the person they care for
- We will increase the proportion of people who use services and carers who find it easy to find information about services
- We will improve health-related quality of life for carers

2. Why we need to develop our strategy for carers

In Rotherham, there are 31,000 carers across the borough (2011 Census). A carer is an adult or young person who provides unpaid care for a partner, relative, friend, an older person or someone who has a disability or long term illness, including people with alcohol/substance misuse and mental illness. The Rotherham Joint Strategic Needs Assessment (JSNA) states that around 3% of the Rotherham population provides 50 hours or more of care per week (compared with the England average of 2%). Although the majority of carers are traditionally 45 – 64, there has also been an increase in carers aged 65 plus which reflects the growing numbers of people who are caring for their spouse.

To understand what has been done for carers locally, a review of the last Carers' Strategy (2008 to 2011) was undertaken; involving a wide range of internal and external stakeholders who have contributed information to review the progress made against each of the previous objectives.

This activity identified many positive achievements and outcomes for adult and young carers across Rotherham. However it also highlighted some gaps and areas for continued development which will be addressed through the Action Plan for Carers 2013 -16.

Key achievements from previous Carers Strategy 2008 – 2011

- Opening of the Carers Centre in 2010, supporting thousands of carers to get the help and support they need in Rotherham.
- Refreshed the Carers Handbook
- Rotherham is one of the best performers in the country for undertaking carers needs assessments and providing support, advice and information, carrying out over 2800 assessments in 2011/12 – all within 28 days.
- Customer satisfaction with carers services in Rotherham is 97.5%
- A range of Information events such as National Carers Week, Carer's Rights Day, Fairs Fayre and Lets Talk
- Targeted information for BME Carers, carers in rural areas and outreach work
- Producing an NHS DVD and '7 steps to caring' leaflet
- Carers Assessment form amended and improved to include signposting to a wide range of services
- Support to carers offered through a range of healthcare services such as the Memory Clinic, Breathing Space, Continuing Care Service, Macmillan and Rotherham Hospice
- A range of training offered specific to carers such as first aid and moving and handling
- Jobcentre Plus providing carers advisers in Job Centres
- Barnardos delivering a Young Carers Service and inclusion of questions about being a carer in the schools Lifestyle Survey
- Support to carers offered through a range of voluntary and community sector organisations, including carers breaks

2.1 Local policy context: Rotherham's Joint Health and Wellbeing Strategy

Rotherham, through the local Health and Wellbeing Board, has made a commitment to improve the health of all Rotherham people and reduce health inequalities through the production of the Joint Health and Wellbeing Strategy 2012-15. The Strategy is made up of six areas of priority which the Board and health and wellbeing partner organisations have committed to.

To improve the health and wellbeing of Rotherham people:

1. We will focus on prevention and early intervention to ensure Rotherham people get help early to increase their independence
2. We will understand the expectations and aspirations of Rotherham people and ensure services are delivered to a borough-wide standard
3. We will ensure people increasingly identify their own needs to enable them to move from dependence to independence
4. We will ensure people in Rotherham are aware of their own health risks and are able to take up opportunities to adopt healthy lifestyles
5. We will ensure Rotherham people are able to manage long-term conditions to enjoy the best quality of life
6. We will reduce poverty in disadvantaged areas through policies that enable people to fully participate in every day activities and the creation of more opportunities to gain skills and employment

To enable us to deliver this high-level framework, there will be a range of action plans and commissioning priorities which sit underneath. These plans will demonstrate how specific services and agencies will help us achieve the overall vision for improving health and wellbeing in Rotherham. Our Carers' Charter and Joint Action Plan will form part of this implementation through key actions that relate directly to improving the health and wellbeing of all our carers.

2.2 National policy context: Caring for our future white paper

The Government have published the Care and Support White Paper and draft Care and Support Bill, which sets out new responsibilities and proposed legislations in relation to providing support and meeting the needs of carers. The two key implications are:

1. From April 2013 the NHS Commissioning Board and Clinical Commissioning Group will be responsible for working with local authorities and carers' organisations to agree plans and budgets for identifying and supporting carers
2. The draft Care and Support Bill extends carers' rights to an assessment and for the first time entitles them to have assessed eligible needs met to maintain health and wellbeing

These responsibilities will have implications for the local authority as well as the NHS, and will mean much closer working between the two partners is crucial to ensure better care and support services are available locally for carers. At the root of this partnership working will be the local Health and Wellbeing Board and in ensuring appropriate actions are delivered specific to carers to ensure their voices are heard and they receive what they are entitled to.

3. Our priorities for carers in Rotherham

To develop a set of priorities for our Joint Action Plan, an analysis was done of the outcomes of 30 consultation exercises which have taken place with adult and young carers between 2009 and 2011. The views from carers were clear that improvements were needed in providing better access to information and advice, although a number of improvements had been made in this area, more work was needed locally.

A working group from the Council, Carers Centre and Clinical Commissioning Group used the information gathered, along with a review of the previous strategy (2008-11) and stakeholder engagement to develop four key themes, which represented what carers had told us. These four themes were validated and ranked in order of priority through consultation with the public during carers' week 2012.

Each of the four priority areas has been developed into an outcome; which represents a desired state for what we want services and support to look like for carers in Rotherham in three years and how this will help us achieve our strategic health and wellbeing priorities.

Outcomes for carers and how these relate to health and wellbeing priorities

Priorities and Outcomes for Carers	Link to 'Health and Wellbeing' priority
Priority 1. Health and Wellbeing All carers will be supported to make positive choices about their mental and physical health and wellbeing	• Prevention and early intervention • Promoting healthy lifestyles
Priority 2. Access to information Accessible information about the services and support available will be provided for all carers in Rotherham	• Prevention and early intervention • Expectations and aspirations
Priority 3. Access to services All carers will be offered and supported to access a range of flexible services that are appropriate to their needs	• Prevention and early intervention • Dependence to independence
Priority 4. Employment and Skills All Carers will be able to take part in education, employment and training	• Dependence to independence • Reducing poverty • Expectations and aspirations

4. How we will achieve this

This Charter includes a set of commitments for the council and NHS Rotherham, shown below. To help us achieve these commitments and an improvement in the specific carers outcomes listed above, a set of actions will be required that bring about change for carers in Rotherham over the next three years. These actions are set out in the Joint Action Plan for Carers 2013 – 2016.

Although the action plan is owned by the council and CCG; who will be accountable for its success, a range of key partners, such as voluntary and community sector organisations and Job Centre Plus, will play a key role in helping to deliver the actions.

Charter Commitments

1. To improve health and Wellbeing of carers:

- We will work with GPs to increase support and information available for carers
- We will work with healthcare staff to continue raising the need for people to recognise themselves as carers, and therefore access the help and support they may be entitled to
- We will offer personalised support to carers, enabling them to have a family and community life
- We will actively speak to carers about ensuring where possible that their own health does not suffer as a direct result of caring
- We will work with carers to ensure they are kept safe

2. To improve access to information:

- We will make sure that all carers are able to access information, advocacy, advice and support.
- We will ensure information is provided to prevent carers experiencing financial hardship as a result of their caring role
- We will improve the offer of information and support to young carers
- We will make sure appropriate and up to date training is undertaken by all staff that work with carers to ensure information can be shared

- We will continue to review the Carers' Handbook to ensure the right information is available and it is widely accessible to all carers

3. To improve access to services:

- We will review the Rotherham Carers' Centre to ensure existing services meet the needs of carers
- We will raise awareness of staff to identify and support young carers
- We will explore potential for low level preventative services to support carers, including carers of people with dementia
- We will make sure carers are referred to preventive services at an earlier stage to help prevent them from reaching crisis point

4. To enable carers to take part in employment and training:

- We will support carers to identify their personal goals in work
- We will actively support all carers, including young carers, to remove barriers
- to education, training and employment
- We will actively promote flexible and supportive employment policies that benefit carers

Underpinning actions

We also acknowledge that a number of actions will be needed to underpin all of the four priority areas. These will ensure we are able to meet the requirements of the Care and Support Bill and work with all carers to coproduce services to ensure the best quality of life for them and the people they care for:

- we will improve how we identify and work with carers by increasing the number and quality of carers' assessments in Rotherham
- we will involve carers in individual care packages and make sure they are a valued care partner
- we will involve carers in the design and commissioning of services for both themselves and the people they care for

5. Next Steps

We have used this Charter to help us develop and implement the Joint Action Plan for Carers to improve the health and wellbeing of all carers in Rotherham.

This has ensured that the views of local carers, which have been gathered through the consultation exercises, translate into appropriate, measurable actions.

We will continue to review our overall strategy for carers; ensuring we meet and where possible go beyond, the requirements of us set out in the draft Care and Support Bill.

Rotherham's Joint Action Plan for Carers 2013-2016

Outcome 1 - All carers will be kept safe and supported to make positive choices about their mental and physical health and wellbeing

What we will do (Carers Charter Commitment)	**How we will do it**	**Measure/Outcome**	**Accountable Organisation/ lead officer**	**Completion**
We will work with GPs to increase support and information available for carers	Partner sign up to the Carers Plan through CCG/Health and Wellbeing Board	Approval of action plan by GP Reference Group/Operational Executive/Strategic Commissioning Executives/Rotherham Clinical Commissioning Group/NHS Commissioning Board/ HWBB	**RCCG/ NHSCB / HWBB** **Julie Wisken / Kate Green**	**April 2013**
	Review carers information sent to all GP's and update where appropriate, done via practice manager forums, GP events, newsletters, NHS Rotherham intranet site and postal services	Ensure GP's have up to date information and are promoting the Supporting Carers' document and 7 steps DVD.	**RCCG/NHSCB Julie Wisken**	**May 2013**
	Link with the heart town project to ensure the Heart Health Caring publication from BHF is offered to all carers of people with a heart condition	GP practices have access to BHF patient information brochure (online/print) which can be used as an information prescription	**Public Health Alison Iliff**	**April 2013**
	Continue to maintain and extend GP carers register within GP practices	Increased number of carers registered within each GP practice	**NHSCB/RCCG Julie Wisken Karen Curren**	**Review end 2013**
	Promote benefits of flu jabs to carers through the carers database	Increased number of carers contacted via GP's/public health to offer flu jabs	**NHSCB/Public Health Kathy Wakefield**	**Sept. 2013**

We will work with healthcare staff to continue raising the need for people to recognise themselves as carers, and therefore access the help and support they may be entitled to	Develop a plan to promote awareness to healthcare staff of accessible information at a number of events/forums and through newsletters/intranet.	Attendance at Fayre's Fair, Carers Day, Protected Learning events, practice managers forum, promotion through a number of publications including promotion of carers document.	**RCCG Julie Wisken** **Carers Corner Richard Waring**	**April 2013**
	Develop pack of information which can be electronically sent to all GP practices, which provides information and guidance on setting up 'virtual carers corners' within practices	Number of Patient Participation Groups who have received information Number of GP practices with 'Virtual Carers Corners'	**Carers Corner Richard Waring** **GP Practice Managers**	**April 2013** **Evaluate end 2013**
	GP's and healthcare staff to signpost to voluntary sector for advice	Provide a link on GP systems to the voluntary sector organisations	**RCCG Julie Wisken**	**May 2013**
We will offer personalised support to carers, enabling them to have a family and community life	Monitor outcomes from personalised support and commissioning respite care from voluntary groups	Monitored through commissioning contracts	**RCCG Jacqui Clark**	**End 2013**
	The Rotherham Expert Patient Programme will offer support through the 'looking after me' programme to carers.	Number of carers attending the course will be monitored through the Expert Patient Programme Lead	**RGGG Anne Robinson**	**End 2013**
We will actively speak to carers about ensuring where possible that their own health does not suffer as a direct result of caring	All carers attending RDaSH Memory Services to be offered the opportunity to complete a self assessment of needs	Monitor through contracts the number of carers assessments carried out and their experiences	**RCCG Kate Tufnell**	**Review March 2014**
	All carers will be offered a joint assessment or a carers specific assessment on assessment and review of customers	Performance management of NI 135 (target to be confirmed)	**Assessment & care mgt Service Michaela Cox**	**April 2013**
	Promote a Family CAF to identify health needs and wider Early Help support	Monitor number and quality of Family CAFs	**CYPS Paul Theaker**	**Evaluate end 2013**

We will work with carers to ensure they are kept safe by: • Empowering carers to speak up about abuse • Ensuring carers are clear about rights and standards • Recognising carers as "expert partners" and advocates • Recognising the impact of the caring role • Respecting carers rights	Raising awareness of what abuse is and how to report it through an appropriate communication strategy Timely and careful assessment will be offered to all carers	Safeguarding Adults Board Communication Strategy and Action plan. Performance management NI 135 / Carers Assessments	**RMBC Safeguarding CYP Phil Morris** **Adults Sam Newton**	**Review end 2013**
	Carers concerns will be listened to and responded to quickly and effectively, and when abuse has occurred the safeguarding process will be person centred and carers views will be considered and represented throughout the process	Evidence in safeguarding plans – Quality Audit	**RMBC Safeguarding Sam Newton**	**Annual Performance Outcome 2013/14**

Outcome 2 - Accessible information about the services and support available will be provided for all carers in Rotherham

What we will do (Carers Charter Commitment)	**How we will do it**	**Measure/Outcome**	**Accountable Organisation/ Lead Officer**	**Completion**
We will make sure that all carers are able to access information, advocacy, advice and support.	Review current systems of communications in place and devise a strategy to ensure we are reaching as wide an audience as possible through a range of methods	Better distribution of information to more carers and better use of communication methods such as social media/website/texting services	**Carers Steering Group**	**Review End 2013**
	Ensure that Carers are included within the Communication, Information and Engagement Strategy for Connect to Support Rotherham. This will involve: • Attending existing support groups • The promotion of Connect to Support	Carers aware of the CtS website	**RMBC Tanya Palmowski**	**March 2013** **Review end 2013**

	at Carers events • Displaying information in Carers Corner			
	All carers receiving an assessment to be sign-posted to information, advice and support	Monitored through carers assessments and monitoring NI 135	**RMBC Assessment and care management Service**	**Annual performance outcome 2013/14**
	Establish a voluntary forum group to provide information for carers going through transition between children's and adult services	More support available for parent carers going through transition period – reviewed by Carers Corner	**Carers Corner Richard Waring**	**March 2013**
We will ensure information is provided to prevent carers experiencing financial hardship as a result of their caring role	Carers Corner to provide information and a facility for voluntary sector to provide benefit advice to support carers to maximise their income where possible, through: • Weekly drop-in session • Leaflets available in the centre Delivery of Carers Rights Day and Carers Week activities to provide information and advice to carers in relation to finance, benefits and employment	More carers accessing information through Carers Corner and annual activities	**Carers Corner Richard Waring**	**Review June 2013** **Annual events June / November**
We will improve the offer of information and support to young carers	Raise awareness in schools and in other young peoples settings of support for Young Carers and of the Young Carers Service Support the Rotherham UK Youth Parliament Members in developing a Young Carers Card	More young people accessing information and in receipt of support	**CYPS (lead to be determined)**	**Sept. 2013**
We will make sure appropriate and up to date training is undertaken by all staff that work with carers to ensure information can be shared	Workforce development programme to be put into place, to ensure appropriate awareness training is available to all staff that require it (statutory and voluntary sector)	Increased number of staff taking-up training	**NAS L&D service Claire Tester**	**Sept. 20313**

We will continue to review the Carers' Handbook to ensure the right information is available and it is widely accessible to all carers	Booklet to be reviewed annually to ensure information remains up to date and fit for purpose Booklet to be distributed to all carers through a number of ways and feedback to be sought from carers to establish how well this works: • Hard copy of the booklet to be taken out by all Carer Support Officers when carrying out Carers Assessments • Booklet available for all carers calling into Carers Corner • On-line version available on RMBC/RCCG/RFT websites • booklets to be available in all GP surgeries across Rotherham	Annual review of booklet More carers receiving the booklet either through support officers, GP practice or Carers Corner	**Carers Corner Richard Waring**	**Booklet reviewed end 2013** **June 2013 (as part of carers corner review)**

Outcome 3 - All carers will be offered and supported to access a range of flexible services that are appropriate to their needs

What we will do (Carers Charter Commitment)	**How we will do it**	**Measure/Outcome**	**Accountable Organisation/ Lead Officer**	**Completion**
We will review the Rotherham Carers' Centre to ensure existing services meet the needs of carers	Undertake an evaluation of the centre to include: • review of the numbers of carers who have accessed the centre to from 2010 • review and cleanse of the centre's database • evaluation of the outcomes and targets achieved since 2010 • equality analysis of the centre; reviewing monitoring forms to understand where users of the service are coming from across the borough (whether reaching carers out of the town centre) and whether the centre is reaching carers	Evaluation reporting to Adults Board Review to provide a benchmarking to enable future evaluation of outcomes and equality analysis National Carers Survey	**RMBC NAS David Stevenson**	**June 2013**

	from BME communities • review the current location of the centre (taking into consideration the relocation of other council buildings)			
We will raise awareness of staff to identify and support young carers	Assessment & care management to actively promote services available for Young Carers Review data from Lifestyle survey 2012, which shows an increase in young people identifying themselves as young carers, and put in place appropriate actions to identify and support these young carers	Increased number of young carers identified and accessing information	**Adult services Michaela Cox** **(CYP lead to be determined)**	**Review Nov. 2013**
We will explore potential for low level preventative services to support carers, including carers of people with dementia	Identify best use of investment to increase the availability and choice of carers support services available in Rotherham. Involve carers in the development of Carers Service Specifications, procurement and evaluation of tenders and established carers services. Review in house and contracted carers services Implement a small grants scheme which will increase the capacity in the community to provide low level support for people with dementia, of which carers will be a beneficiary	Monitoring the investment committed to new projects. Surveys, Consultation Sessions Evidence reported to NAS DLT/Health and Wellbeing Board Contract monitoring to evaluate outcomes	**RMBC Commissioning and Contracting Team Jacqui Clark**	**April 2014** **Sept 2013** **Dec 2013** **March 2014**
	Ensure carers are considered and involved in the development of the local Dementia Strategy	Consult with carers and identify services needed via the Dementia summit	**RCCG Kate Tufnell**	**March 2014**
We will make sure carers are referred to preventive services at an earlier	Put in place systems to ensure Assessment Direct signposts carers to appropriate services and activities	More carers identified early and signposted to appropriate services	**RMBC, NAS Darren Rickett**	**April 2014**

stage to help prevent them from reaching crisis point	Case Management Pilot to identify patients and carers and signpost to early support	Monitor the number of carers identified and offered support where possible	**RCCG Dominic Blaydon**	**Monitor end 2013/14**

Outcome 4 – All Carers will be able to take part in education, employment and training where they wish to do so

What we will do (Carers Charter Commitment)	**How we will do it**	**Measure/Outcome**	**Accountable Organisation/ Lead Officer**	**Completion**
We will support carers to identify their personal goals in work	Specialist Carers Advisers (Job Centre Plus) to work with carers to develop personalised plans to support them to achieve their careers / training goals and potential benefit take-up Job Centre Plus to provide replacement care costs and childcare costs to those who are eligible, to help with attending interviews/JCP approved activities.	More carers taking up employment opportunities and receiving advice to prevent financial hardship Numbers of carers referred to JCP	**Job Centre Plus Simon Freeston**	**On-going**
We will actively support all carers, including young carers, to remove barriers to education, training and employment	Consult with carers on their training needs and work jointly with Learning and Development Teams in NAS and CYPS to deliver appropriate training Ensure learning and development is offered flexibly at a time and venue to suit the needs of carers ie mid morning, evenings. Promote training and development opportunities through a range of places and in different formats Ensure Learning and Development information/representation is available at all	Increase in the range of learning and development opportunities available Improved flexibility in training delivery to meet the needs of carers More carers accessing training Increased access to learning and development	**NAS L&D Team Claire Tester**	**L&D plan in place April 2013** **Review end 2013**

	roadshows/events for carers to ensure the take up of training is optimised.			
	Identify what support Integrated Youth Support (IYS) offer young carers	Understanding of support offered and developed if needed	**CYPS Paul Theaker**	**April 2013**
We will actively promote flexible and supportive employment policies that benefit carers	Flexible working arrangements and HR procedures for staff (RMBC/NHS) who are also carers RMBC 'Support for Employees who are Carers' document to be reviewed and promoted on an annual basis	More staff who are carers aware of the support available to them, and feel able to balance their caring role with employment	**CCG Julie Wisken** **RMBC Tracey Priestley**	**On-going**
	Voluntary sector to develop employment policies that support carers and feedback on what is in place	Voluntary sector organisations offering support for carers to enable them to continue working	**VAR**	**Sept. 2013**

Underpinning actions

We acknowledge that a number of actions will be needed to underpin all of the four priority areas. These will ensure we are able to meet the requirements of the Care and Support Bill and work with all carers to coproduce services to ensure the best quality of life for them and the people they care for.

What we will do	**How we will do it**	**Measure/Outcome**	**Accountable Organisation/ Lead Officer**	**Completion**
We will improve how we identify and work with carers by increasing the number and quality of carers' assessments in Rotherham	All carers to continue be offered a joint assessment or a carers specific assessment at the point of assessment and review with customers We will involve carers in individual care packages and make sure they are a valued care partner	More carers identified and receiving an assessment in Rotherham / Performance management NI 135 National Carers Survey	**RMBC Assessment and care management Service Michaela Cox**	**March 2014**

We will involve carers in the design and commissioning of services for both themselves and the people they care for	Additional carer (s) representative to be recruited to the Learning Disability Partnership Board	Carer representative on Partnership Board	**LD Service John Williams**	**June 2013**
	Promote continued Young Carers Voice and Influence within Barnados Young Carers Service and wider Voice and Influence work	Evidence of Young Carers involvement in service design and wider V&I work	**CYPS Paul Theaker** **Barnardos Lindsey Hallatt**	**Review end 2013**
We will take steps to ensure carers from groups with protected characteristics under the Equality Act 2010, who may have different needs to other carers (such as Black and minority ethnic, male and lesbian, gay, bisexual and transgender carers), are increasingly identified, supported to access services and contribute to service design and commissioning	We will develop a clearer understanding of protected characteristics and equality issues in relation to carers, for the development of future plans	Review of Carers Action Plan Equality Analysis	**Carers Steering Group**	**May 2013**
	Work in partnership with Voluntary and Community groups to explore opportunities to set up a BME male carer's group in Rotherham to support their needs	Male carers group established	**RMBC Mohammed Nawaz**	**Dec. 2013**
	Put in place a plan to identify hard-to-reach and disadvantaged carers i.e. Pakistani / Kashmiri, Yemeni, Chinese, African-Caribbean, Refugee and Asylum seeker, Eastern European communities, to provide the right advice and information so they can continue to provide the care to their family	More BME carers accessing information and services, including through Carers Corner	**Carers Corner Richard Waring**	**Sept. 2013**
We will review and evaluate the Care and Support Bill when it becomes an Act and put in place appropriate actions to ensure we can implement the changes required	Establish a task and finish group to review the legislation and government response to the Bill's consultation (expected early 2013)	Revised action plan in place	**RMBC/CCG multi-agency task group**	**Sept. 2013**

Continue to review the action plan to ensure it is on track and refresh as required	On-going monitoring of the action plan will be done through the Carers Strategy Steering Group (on a quarterly basis) An annual review of the plan will be reported to Cabinet Member for Adult Social Care and appropriate CCG boards.	To ensure the continued implementation and success of the plan, and to ensure it remains fit for purpose	**Carers Strategy Steering group**	**July 2013** **End 2013**

Key:

RMBC – Rotherham Metropolitan Borough Council
NHSCB – National NHS Commissioning Board
RCCG – Rotherham Clinical Commissioning Group
NAS – Neighbourhoods and Adult Services
LD Service – Learning Disability Service
L&D – Learning and Development
IYS - Integrated Youth Support

ROTHERHAM HEALTH AND WELLBEING BOARD
COMMUNICATIONS FRAMEWORK AND KEY PRINCIPLES

1. Introduction

The primary purpose of this plan to ensure effective, consistent and co-ordinated communications, marketing and social marketing activity to support the work of Rotherham's Health and Wellbeing Board in achieving its vision to ***"improve health and reduce health inequalities across the whole of Rotherham"*** across six priority outcome areas

Priority 1 - **Prevention and early intervention:** Rotherham people will get help early to stay healthy and increase their independence.

Priority 2 - **Expectations and aspirations:** All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community, tailored to their personal circumstances.

Priority 3 - **Dependence to independence:** Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances

Priority 4 – **Healthy Lifestyles:** People in Rotherham will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles.

Priority 5 – **Long-term conditions**: Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life.

Priority 6 – **Poverty**: Reduce poverty in disadvantaged areas through policies that enable people to fully participate in everyday social activities and the creation of more opportunities to gain skills and employment.

And across a number of life stages:

- **Starting well**
- **Developing well**
- **Living and working well**
- **Ageing and dying well**

Draft 1
February 2013
Health and Wellbeing Board communications framework

This document sets the framework for :

i) how strategic and operational communications and marketing activity is undertaken by the range of organisations which contribute to the delivery of these outcomes through Rotherham's Health and Wellbeing Strategy
ii) communications activity in support of and on behalf of the Health and Wellbeing Board itself, such as responding to media enquiries which are cross-cutting or relate specifically to the Board, rather than to a specific member organisation.

The framework will be supported by a plan of key actions which summarises of communications and marketing activities/campaigns in support of the workplans for each priority area. This will be regularly reviewed and monitored by the Board, but nominated lead agencies will individually or jointly be responsible for its delivery.

2. Principles of Effective Communications

All organisations represented on the Rotherham Health and Wellbeing Board share ownership of this plan and also share responsibility for its delivery, adhering to the following core principles:-

- Consistent – there will be no conflict in the information provided
- Credible and based on sound knowledge – adhering to the above principles should ensure that communication can be trusted.
- Targeted – the right messages and information reach the right audiences at the right time and in the appropriate format

(both particularly important in the context of messages relating to lifestyle, health and wellbeing)

- Open and transparent – demonstrating accountability, and explaining the reasons when information cannot be provided
- Clear and honest – free of jargon and in plain English wherever possible
- Timely – information will be provided when and where it is needed by the people with whom it is shared
- Co-ordinated – a "joined-up" approach will be taken to communicating with all stakeholders and across all channels
- Two-way – processes in place to enable stakeholders to feed back to the Board and/or its constituent organisations
- Efficient – uses existing established communications methods wherever possible and delivering value for money where new channels are established

3. Target Audiences

In the context of delivering the Health and Wellbeing Strategy, market segmentation ie the identification of specific target groups who need to receive key messages and respond to achieve the required outcomes will be particularly important, and this will be reflected in the detailed operational plans and campaigns, based on market research and other relevant evidence.In general terms, however, it is envisaged that the following target audiences will be covered by this framework:

i) Members of the Health and Wellbeing Board
ii) Elected Members, RMBC

iii) Partner organisations (Board members, staff)
iv) People living, learning and working in Rotherham
v) Carers
vi) Print and broadcast media (local, regional, national and specialist)

(others to be inserted)

4. Roles and Responsibilities

All organisations represented on the Board share responsibility for adopting the principles of this framework and the delivery of effective communications and marketing to support joint objectives around improving health and wellbeing. Overall across agencies in Rotherham, the communications/media/marketing resource (both human and financial) is diminishing in the current financial climate and the capacity to take on additional work is limited. Some agencies no longer have their own communications and/or marketing resource. This framework, therefore, needs to be realistic about what can be achieved, and is based upon using the people, channels, mechanisms and campaign opportunities already in place.

Specific roles and responsibilities are summarised as follows:-

i) *Chair of the Health and Wellbeing Board/RMBC Cabinet Member for Health and Wellbeing*
Acts as ambassador for the health and wellbeing agenda; representing the Cabinet portfolio of health and well-being through democratic processes; championing health and wellbeing; primary media spokesperson on issues relating to specific Board activities and generic health and wellbeing issues; participating in positive PR opportunities; leading by example and acting as communications role model; advocate for communications and marketing to support key Board objectives.

ii) *Leader of the Council/Director of Public Health*
Acts as ambassador for the health and wellbeing agenda; primary media spokesperson on issues relating to specific medical public health interventions eg communicable diseases, sexually transmitted diseases; participating in positive PR opportunities; leading by example and acting as communications role model; advocate for communications and marketing to support key Board objectives.

iii) *Communications representatives – Health and Wellbeing Board*
Rotherham Borough Council's Head of Corporate Communications and Marketing (or nominated deputy) and the lead communications officer working on behalf of the Rotherham Clinical Commissioning Group (or nominated deputy) will be the designated communications leads for the Health and Wellbeing Board. They will act as strategic and operational communications advisers to the Board; ensure that the communications/social marketing perspective on all activities, projects etc coming through the Board and Steering Group have been properly considered; ensure expert challenge is provided, and will work with the agencies to map operational activity and to ensure delivery. However, they are not responsible for providing direct communications support to all issues considered by the Board (see below).

iv) *Policy Officer – Health and Wellbeing Board*
Maintaining effective communication with Health and Wellbeing Board members, eg circulation of Key Issues policy briefings; maintenance and development of Health and Wellbeing Board website.

v) *Members – Health and Wellbeing Board*
Working with lead officers in their own organisations, Board members will take responsibility as appropriate for communications activity, including the cascade of key messages coming out of Board meetings into their own organisations; leading by example and acting as communications role models; promoting support for communications and marketing activity within their own organisations, in support of relevant priority outcomes.

vi) *Communications/marketing staff, Board Member organisations*
Acting as strategic and operational communications advisers to their Health and Wellbeing Board representative; ensuring all opportunities to deliver against the communications aims of this framework are identified and maximised; to participate as required in delivery of the action plan.

5. Communications/Marketing Channels

This framework applies to a range of marketing communications channels, to be used as appropriate.
These include:-

- local, regional, national print and broadcast media
- websites
- involvement in events
- screen technology (eg Qmatic at Riverside House, QTV)
- brochures, leaflets
- core presentations (eg to community groups)
- staff communications eg newsletters, e-bulletins
- social media – eg Twitter, Facebook,Youtube
- display/exhibition materials
- posters
- training materials for staff
- advertising – print and broadcast

6. Information Sharing/Media Handling Protocols

i) Individual Board members agree that their organisations will share with others any information which does, or has the potential to, impact on the work or reputation of the Health and Wellbeing Board, or the public perception of the work programme which supports the Board in achieving its objectives. This will be shared, in the first instance, with the Chair of the Board who will determine the need and process for any further cascade to other Board members, with the support of the lead communications representative (RMBC or CCG).

ii) Any media enquiries relating to the work of the Health and Wellbeing Board will be directed to the lead communications representative (RMBC), who will then discuss in the first instance with lead officer(s) and Board Chair, and any other officers as appropriate, and an appropriate response will be drafted. Where time allows, this response will be shared with member organisations through their respective communications/media departments, with an opportunity for comment. However, where this is not possible, authority will rest with the lead officer(s) and Board Chair.

iii) Member organisations will be responsible for their own internal approval/information sharing processes.

7. Review and Evaluation

This communications framework and key principles will be reviewed at six-monthly intervals by the Health and Wellbeing Board.

Communications/Marketing Issues will be a standing item at each Health and Wellbeing Board meeting, including the identification of any key messages arising from the meeting for sharing with internal/external/media audiences. Reporting against the priority outcome action plans will be on an exception basis.

Tracy Holmes
Head of Communications and Marketing
RMBC
February 2013

Health and Wellbeing Board – Communications Action Plan **SAMPLE PAGE**

Communications in support of the Health and Wellbeing Board

Proposed Activity	**Timescale**	**Lead Organisation/ Responsible Officer**	**Outcomes/Additional Comments**
Maintenance and development of Health and Wellbeing Board website	Ongoing	Policy Officer, HWBB	
Publicity to support Rotherham Health and Wellbeing Conference	February/March 2013	HCCM, RMBC/ Comms Lead, Rotherham CCG	

Health and Wellbeing – Communications Action Plan **SAMPLE PAGE**

Priority 1:- Prevention and early intervention: Rotherham people will get help early to stay healthy and increase their independence.

Proposed Activity	Timescale	Lead Organisation/ Responsible Officer	Outcomes/Additional Comments

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**27 February 2013**
3.	**Title:**	**The Francis Report: Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009**
4.	**Directorate:**	**Public Health**

5. Summary:

The Francis Report and accompanying reports (Thomé, Alberti) are the culmination of the Inquiry into complaints of substandard care provided by Mid Staffordshire NHS Foundation Trust prompted by unusually high hospital mortality statistics.

Its recommendations and conclusions are many and far reaching, with implications for commissioners and providers far beyond those of healthcare. The report finds that the failures at the Trust were essentially failures of culture and systems and does not single out any one individual for blame.

Common themes repeated through the reports include:

- Accountability and responsibility for healthcare standards.
- Putting the patient first, ahead of all other considerations.
- Fundamental standards of staff behaviour.
- Consolidation of monitoring and regulation responsibility and compliance
- Transparency, use and sharing of information, including performance management by outcomes, not process.

6. Recommendations:

That the Health and Wellbeing Board:

- **Acknowledges the findings of the Francis Report and ensures all commissioning and provision of Healthcare in Rotherham follows the principles and recommendations laid out in the report**

- **Requests all Rotherham healthcare providers and commissioners to report back to the Board with assurances that their organisation and practices are in-line with all the Francis recommendations, and in particular in relation to safe staffing levels, and the prioritisation of patient safety ahead of financial pressure**

7. Proposals and Details

The Francis Report (the *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust*) is one of three reports into care standards at the Trust between 2005 and 2009 which also includes:

- *A review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission report* by Professor George Alberti.
- *A review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation* by Dr David Colin Thomé.

The Francis Report covers a wide range of healthcare issues and reaches many conclusions including:

- **Long-term failure** and deficiencies in staff and governance existed prior to 2005. However, the **action** taken by management to address many of the issues they identified was **ineffective**, and included long-term habituation, denial, lack of engagement and commitment, and weak leadership
- **Financial issues were prioritised** ahead of safe staffing levels
- **A confused view of responsibilities** by the Trust Board between strategic and operational issues and a disclaimer of responsibility for the latter, and that it was necessary for Directors to "roll up their sleeves and see for themselves what was actually happening"
- **Staff were disengaged** from the process of management, with a lack of support for staff through appraisal, supervision and professional development
- The Board's approach to problems such as lack of effective governance **lacked urgency** and were not comprehensive. The lack of urgency was accompanied by an absence of follow-up, review and modification
- There was a corporate **focus on process at the expense of outcomes**
- A common response to concerns has been to refer to generic data or benchmarks such as star ratings, **rather than the experiences of actual patients** and their families. The story of Stafford shows graphically and sadly that benchmarks, comparative ratings and foundation trust status do not in themselves bring to light serious and systemic failings
- The evidence before the inquiry exposed a number of **weaknesses in the concept of scrutiny and Local Involvement networks**. Local scrutiny committees and public involvement groups detected no systemic failings; neither did they appreciate the significance of any signs suggesting serious deficiencies at the Trust

The conclusions of the inquiry have led to the production of a set of recommendations, based on a number of key themes, including:

- Putting the patient first
- Fundamental standards of behaviour for all professionals
- An integrated hierarchy of standards of service
- Regulating healthcare systems governance
- Enhancement of the role of supportive agencies

- Effective complaints handling
- Commissioning for standards, Performance management and strategic oversight
- Patient, public and local scrutiny
- Medical training and an increased focus in nurse training and professional development
- Openness, transparency, candour and leadership
- Professional regulation of fitness to practise
- Improving communication and responsibility of care for the elderly
- Common information practices, shared data and electronic records

Summary of themes of the two related reports

Thomé Report:

- ***Involving patients and the public:***

- 'Real time' patient feedback.
- Holding commissioners to account for engaging patients.
- A duty to report concerns.
- Review of complaints procedures.

- ***Commissioning for outcomes supported by excellent use of appropriate data and information:***

- All organisations should ensure they are focussing on the broader picture of improving health outcomes, NOT on interim process measures.
- All concerns should be investigated.
- An increased capacity to review, interpret and use data.
- All patient safety and quality data should be publicly available

- ***Ensuring governance and clarity of accountability of all the different organisations in the system***

- Ultimate responsibility for patient safety rests with the commissioner.
- All providers must allow commissioners ready access to review their services.
- Greater co-operation between Health commissioners and Monitor including data sharing

- ***Clinical Leadership***

- Arrangements should be reviewed at Board level with separate responsibility for medical and nursing director input at board level.
- Review the role of PEC in relation to quality assurance.
- An overarching duty for clinicians to speak up for patients when they witness poor quality care.
- A greater awareness and responsibility for awareness of provider staff issues by health commissioners

Alberti Report:

- This reports conclusions relate specifically to progress of Mid Staffordshire since the healthcare commission.

For further details please see each of the background papers

8. Finance

There are no financial implications directly associated with this report.

9. Risks and Uncertainties

Failure to learn from the findings of this report and consider where all local commissioners and providers of healthcare services may need to do things differently in future could have detrimental consequences to our local services.

There is an opportunity presented by this review, to assess current practices and ensure that we are locally fit for purpose, delivering the best possible outcomes for local people and have the appropriate mechanisms in place to deal with performance and leadership issues should they arise.

10. Policy and Performance Agenda Implications

The Health and Wellbeing Board and their locally agreed strategy sets out the priorities for all health and wellbeing partners to be focusing on over the next 3 years. The performance management framework, which includes the monitoring of the national outcomes frameworks (for NHS, public health and adult social care) will form a crucial element of ensuring that we are successful locally in delivering positive outcomes for people.

11. Background Papers and Consultation:

- *The Francis Report: Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009. Stationary Office, London.*

- *A review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission report by Professor George Alberti. Stationary Office, London.*

- *A review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation by Dr David Colin Thomé. Stationary Office, London.*

12. Contacts

Giles Ratcliffe, Specialty Registrar, Rotherham Public Health, giles.ratcliffe@rotherham.gov.uk Tel. 01709 255874

Dr John Radford, Director of Public Health, Rotherham Public Health, john.radford@rotherham.gov.uk Tel. 01709 255845

Kate Green, Policy officer, RMBC
Kate.green@rotherham.gov.uk Tel. 01709 822789

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**27th February 2012**
3.	**Title:**	**Performance Management Framework - High Level Reporting**
4.	**Directorate:**	**Public Health**

5. Summary:

The Public Health Outcome Framework is designed to assist the Board in understanding how well it is improving and protecting Public Health.

The Board needs to be aware of patterns of mortality or illness that affect the people of Rotherham and use this to inform its Strategy.

This high level profile allows the Board to review performance and consider its priorities for health services and to make decisions and plans to improve local people's health and reduce health inequalities; the profile presents a set of important health indicators that show how Rotherham compares to the national and regional average.

6. Recommendations:

The Board regularly reviews progress against the Public Health, NHS and Adult Social Care Outcomes Frameworks.

The Board should note that the current JHWBS is aligned to address the issues highlighted within the report.

7. Proposals and Details:

The Board notes higher than average under-75 death rates from cancer and coronary heart disease.

Injuries and falls in the elderly remain higher than average.

Preventable sight loss is higher than average.

Access to diabetic retinopathy screening is worse than average.

Breastfeeding initiation and maintenance rates are worse than average
Child poverty, obesity levels in Year 6, pupil absence and 16-18 year old NEETS are of concern as they are all worse than average.

Emergency re-admissions remain higher than average.

8. Finance:

The Report is produced and regularly updated by PH England.

9. Risks and Uncertainties:

Match to existing strategies and priorities.

10. Policy and Performance Agenda Implications:

System wide intervention to address outlying outcome indicators.

Contact:
John Radford DPH
Tel. 01709 255844
Email. john.radford@rotherham.gov.uk

Rotherham

This profile gives a picture of health in this area. It is designed to help local government and health services understand their community's needs, so that they can work to improve people's health and reduce health inequalities.

Visit the Health Profiles website for:

- Profiles of all local authorities in England
- Interactive maps – see how health varies between areas
- More health indicator information
- Links to more community health profiles and tools

Health Profiles are produced by the English Public Health Observatories working in partnership.

www.healthprofiles.info

Population 255,000

Mid-2010 population estimate

Source: National Statistics website: www.statistics.gov.uk

DH Department of Health

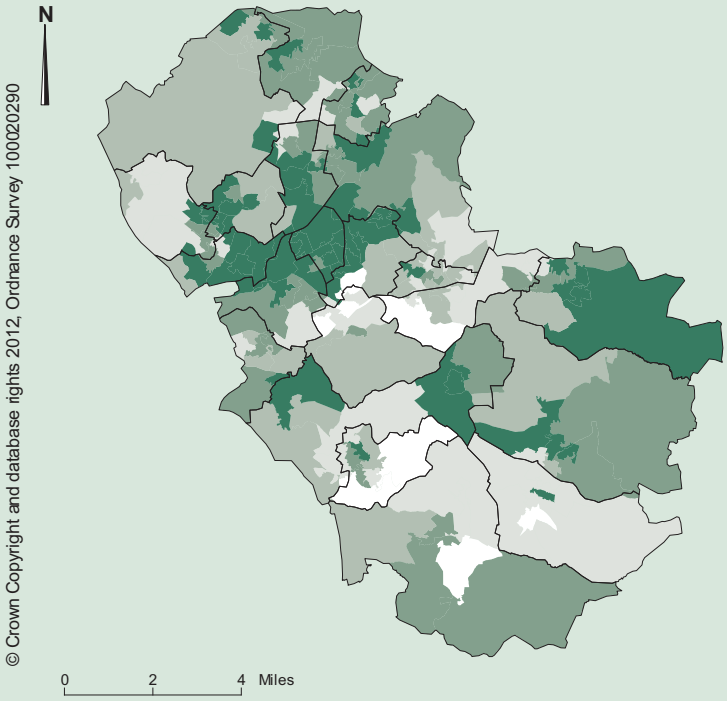
Rotherham at a glance

- The health of people in Rotherham is generally worse than the England average. Deprivation is higher than average and about 12,000 children live in poverty. Life expectancy for both men and women is lower than the England average.
- Life expectancy is 10.2 years lower for men and 6.4 years lower for women in the most deprived areas of Rotherham than in the least deprived areas.
- Over the last ten years, all cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen but is worse than the England average.
- About 21.6% of Year 6 children are classified as obese, higher than the average for England. Levels of teenage pregnancy, GCSE attainment, breast feeding initiation and smoking in pregnancy are worse than the England average.
- Estimated levels of adult 'healthy eating', smoking and obesity are worse than the England average. Rates of sexually transmitted infections, smoking related deaths and hospital stays for alcohol related harm are worse than the England average. The rate of road injuries and deaths is better than the England average. The rates of statutory homelessness and violent crime are lower than average.
- Priorities in Rotherham include improving life expectancy, reducing smoking and alcohol use. For more information see www.rotherham.nhs.uk or www.rotherham.gov.uk

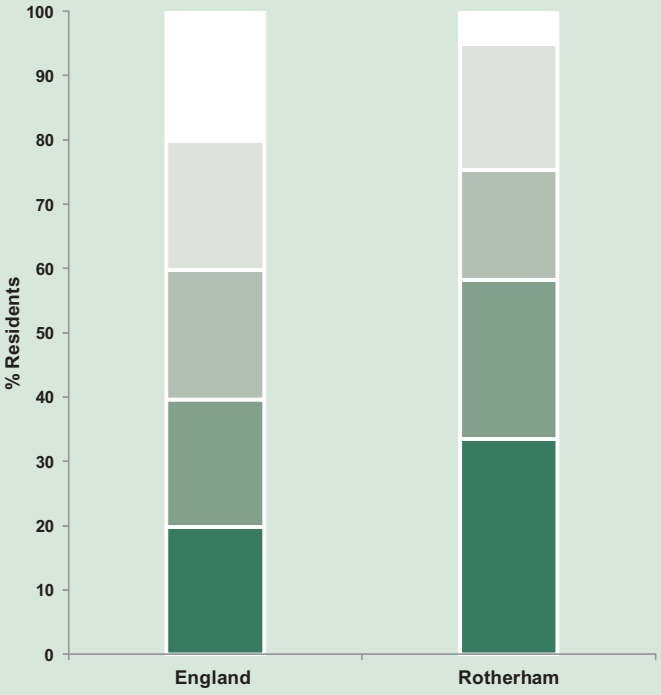
NHS

Deprivation: **a national view**

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.



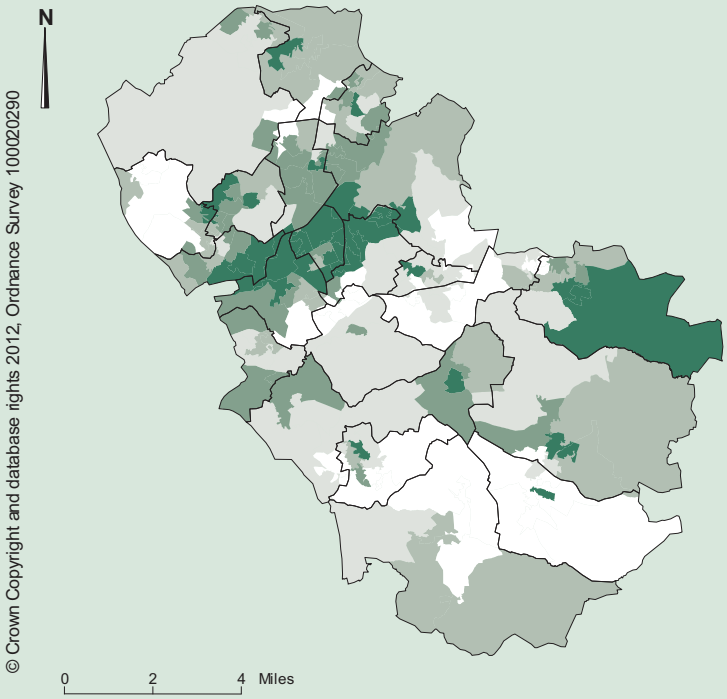
This chart shows the percentage of the population in England and this area who live in each of these quintiles.



1 - most deprived quintile | 2 | 3 | 4 | 5 - least deprived quintile

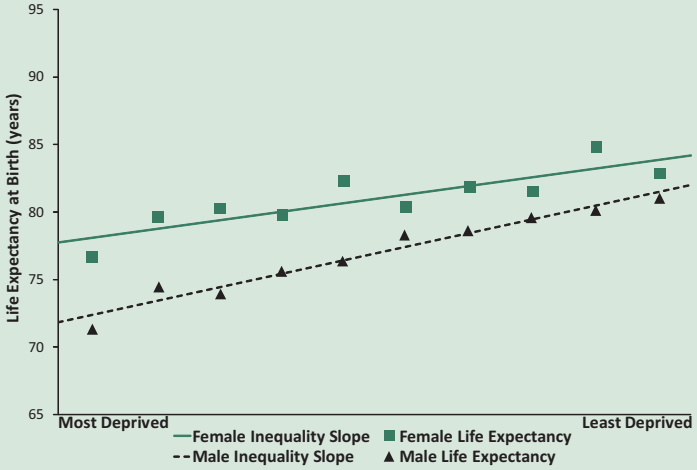
Health inequalities: **a local view**

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.



Legend as above

The lines on this chart represent the Slope Index of Inequality, which is a modelled estimate of the range in life-expectancy at birth across the whole population of this area from most to least deprived. Based on death rates in 2006-2010, this range is 10.2 years for males and 6.4 years for females. The points on this chart show the average life expectancy in each tenth of the population of this area.



Health inequalities: **changes over time**

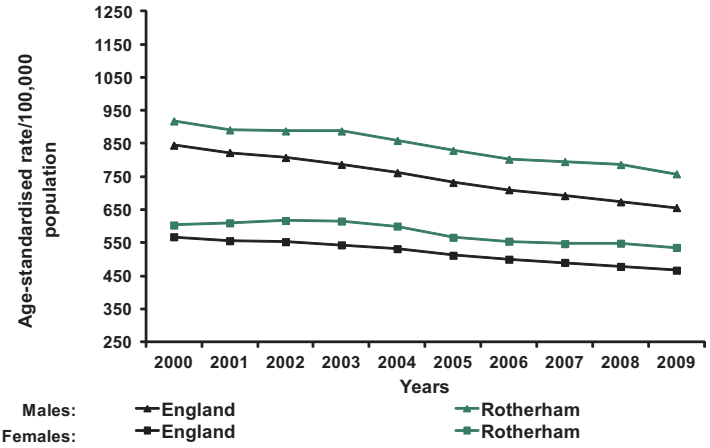
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

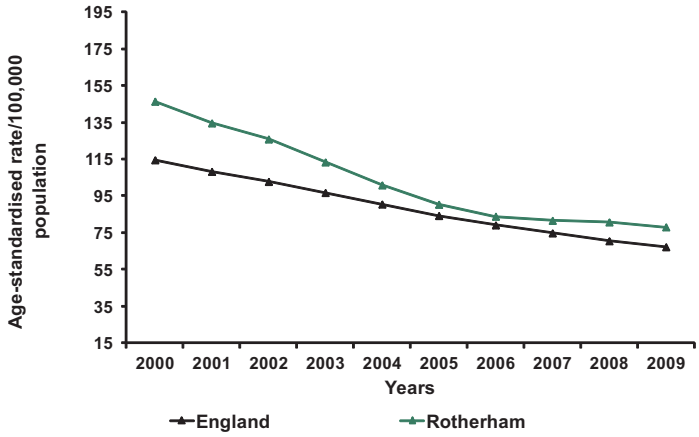
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

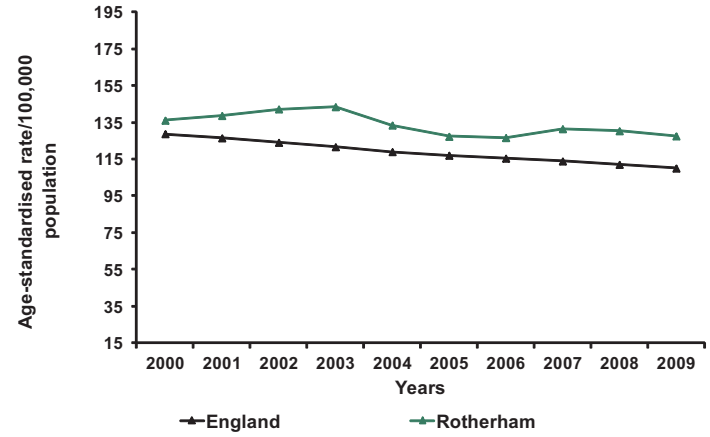
Trend 1:
All age, all cause mortality



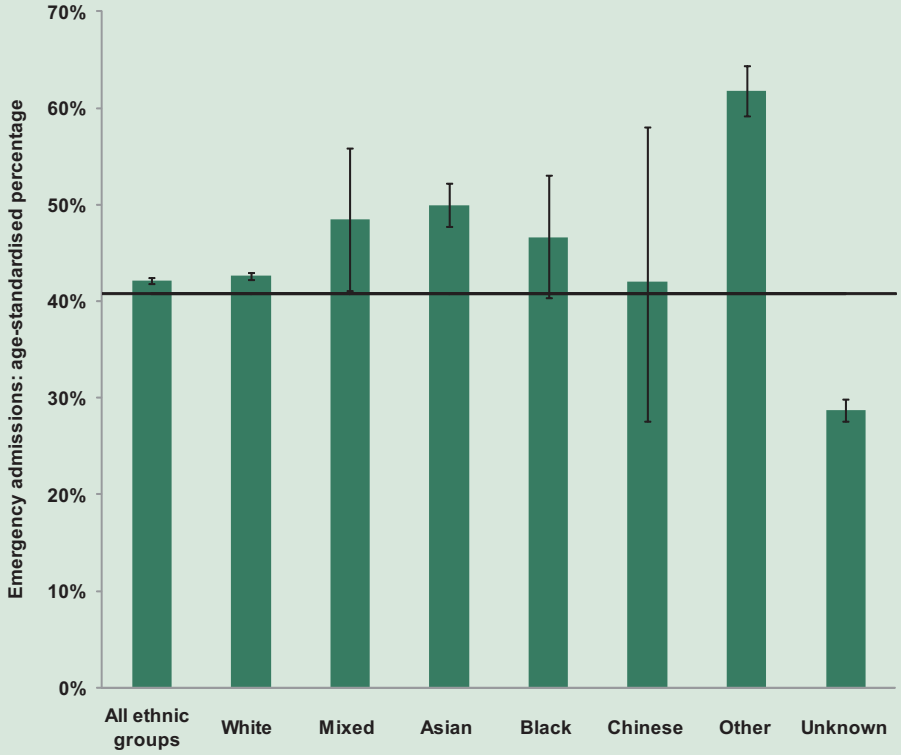
Trend 2:
Early death rates from heart disease and stroke



Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**



This chart shows the percentage of hospital admissions in 2010/11 that were emergencies for each ethnic group in this area. A high percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions. By comparing the percentage in each ethnic group in this area with that of the whole population of England (represented by the horizontal line) possible inequalities can be identified.

Rotherham

England average (all ethnic groups)

95% confidence intervals

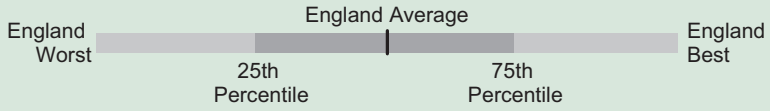
Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
32935	29132	98	1023	112	16	914	1640	**Local number of emergency admissions**
42.1%	42.6%	48.5%	49.9%	46.6%	42.1%	61.8%	28.7%	**Local value**
40.8%	41.3%	39.7%	45.3%	44.2%	37.4%	46.6%	31.1%	**England value**

Health summary for Rotherham

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

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



Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	84567	33.4	19.8	83.0		0.0
	2	Proportion of children in poverty ‡	12010	24.0	21.9	50.9		6.4
	3	Statutory homelessness ‡	97	0.9	2.0	10.4		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	1979	56.7	58.4	40.1		79.9
	5	Violent crime	2520	9.9	14.8	35.1		4.5
	6	Long term unemployment	1332	8.2	5.7	18.8		0.9
Children's and young people's health	7	Smoking in pregnancy ‡	659	23.0	13.7	32.7		3.1
	8	Breast feeding initiation ‡	1770	60.2	74.5	39.0		94.7
	9	Obese Children (Year 6) ‡	637	21.6	19.0	26.5		9.8
	10	Alcohol-specific hospital stays (under 18)	32	56.8	61.8	154.9		12.5
	11	Teenage pregnancy (under 18) ‡	245	49.4	38.1	64.9		11.1
Adults' health and lifestyle	12	Adults smoking ‡	n/a	23.9	20.7	33.5		8.9
	13	Increasing and higher risk drinking	n/a	21.6	22.3	25.1		15.7
	14	Healthy eating adults	n/a	21.3	28.7	19.3		47.8
	15	Physically active adults ‡	n/a	10.4	11.2	5.7		18.2
	16	Obese adults ‡	n/a	27.6	24.2	30.7		13.9
Disease and poor health	17	Incidence of malignant melanoma	35	13.7	13.6	26.8		2.7
	18	Hospital stays for self-harm ‡	498	206.8	212.0	509.8		49.6
	19	Hospital stays for alcohol related harm ‡	6686	2209	1895	3276		910
	20	Drug misuse	2047	12.3	8.9	30.2		1.3
	21	People diagnosed with diabetes ‡	12262	6.0	5.5	8.1		3.3
	22	New cases of tuberculosis	20	7.9	15.3	124.4		0.0
	23	Acute sexually transmitted infections	2215	870	775	2276		152
	24	Hip fracture in 65s and over ‡	260	456	452	655		324
Life expectancy and causes of death	25	Excess winter deaths ‡	166	20.7	18.7	35.0		4.4
	26	Life expectancy – male	n/a	77.1	78.6	73.6		85.1
	27	Life expectancy – female	n/a	81.0	82.6	79.1		89.8
	28	Infant deaths ‡	19	5.8	4.6	9.3		1.2
	29	Smoking related deaths	497	257	211	372		125
	30	Early deaths: heart disease and stroke ‡	232	78.1	67.3	123.2		35.5
	31	Early deaths: cancer ‡	378	127.6	110.1	159.1		77.9
	32	Road injuries and deaths ‡	83	32.7	44.3	128.8		14.1

‡ Substantially similar to indicator proposed in the Public Health Outcomes Framework published January 2012

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2009 3 Crude rate per 1,000 households, 2010/11 4 % at Key Stage 4, 2010/11 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2010/11 6 Crude rate per 1,000 population aged16-64, 2011 7 % mothers smoking in pregnancy where status is known, 2010/11 8 % mothers initiating breast feeding where status is known, 2010/11 9 % school children in Year 6 (age 10-11), 2010/11 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2007/08 to 2009/10 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2008-2010 12 % adults aged 18 and over, 2010/11 13 % aged 16+ in the resident population, 2008/2009 14 % adults, modelled estimate using Health Survey for England 2006-2008 15 % aged 16 and over, Oct 2009-Oct 2011 16 % adults, modelled estimate using Health Survey for England 2006-2008 17 Directly age standardised rate per 100,000 population, aged under 75, 2006-2008 18 Directly age sex standardised rate per 100,000 population, 2010/11 19 Directly age sex standardised rate per 100,000 population, 2010/11 20 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2009/10 21 % people on GP registers with a recorded diagnosis of diabetes 2010/11 22 Crude rate per 100,000 population, 2008-2010 23 Crude rate per 100,000 population, 2010 (chlamydia screening coverage may influence rate) 24 Directly age and sex standardised rate for emergency admissions, per 100,000 population aged 65 and over, 2010/11 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.07-31.07.10 26 At birth, 2008-2010 27 At birth, 2008-2010 28 Rate per 1,000 live births, 2008-2010 29 Directly age standardised rate per 100,000 population aged 35 and over, 2008-2010 30 Directly age standardised rate per 100,000 population aged under 75, 2008-2010 31 Directly age standardised rate per 100,000 population aged under 75, 2008-2010 32 Rate per 100,000 population, 2008-2010

More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@sepho.nhs.uk

ROTHERHAM BOROUGH COUNCIL – REPORT TO CABINET MEMBER

1.	**Meeting**	**Health and Well-being Board**
2.	**Date**	**07/02/2013**
3.	**Title**	**Reporting Performance and Progress for System-wide change**
4.	**Directorate**	**Public Health**

5. Summary

There are a number of problems affecting health and well-being in Rotherham that have been identified by the JSNA and health inequalities consultation. In response, JHWBS has identified priority outcomes to be focussed at each stage of the life course.

A strong partnership approach is required to tackle these problems and involves coordination of the efforts of statutory, voluntary and commercial sectors so that they deliver those improvements.

6. Recommendations

To support the approach to reporting the performance of programs that require system-wide change.

7. Proposals and details

The Rotherham JSNA and Health Inequalities Consultation identified significant problems affecting the health and well-being of people in Rotherham and stark inequalities. Much of the premature mortality in Rotherham is largely preventable and related to lifestyles.

In response, the Joint Health and Well-being strategy has identify six priority outcomes around which action is to be focussed at each stage of the life course:

- Prevention and Early Intervention
- Dependence to Independence
- Aspiration and Expectation
- Healthy Lifestyles
- Long term conditions
- Poverty
-

In addition, a number of priority measures have been identified as requiring urgent attention. These are Alcohol misuse, Tobacco consumption, Obesity, Affordable warmth, NEETS and Dementia.

Finally, in response to the overarching goal to improve health and well-being for all and ensuring the most deprived communities improve fastest, 11 deprived areas in Rotherham have been identified as requiring priority action.

The key to improving health and well-being is a strong partnership based approach. There are a number of short and intermediate term outcomes that will need to be achieved in order for the improvements in long term outcomes to happen.

There are a number of ways of measuring what we are doing (the short and intermediate outcomes) and whether our strategy is on track:

- Outcomes that already have an associated indicator that is being collected
- Outcomes that require new data collection and an indicator developed
- Outcomes that can be measured using retrospective audit or survey
- Outcomes that rely on a narrative description of progress

Indicators are rarely perfect at measuring the outcomes that we are interested in and triangulation of information from a number of sources will be required. There is also a trade-off in spending resources on collecting new data for indicators as this may have to be diverted from front-line services.

We will know that what we are doing now is affecting the problems affecting the health and well-being of people in Rotherham by monitoring the long-term outcomes.

It is likely to take a long time to see changes in these outcomes as a result of what we are doing now. The timescales are of the order of 10 to 20 years.

8. Risks and uncertainties

Timescales for most public sector change management programmes tend to have a time-window of no more than 1 to 5 years. This presents a problem for public health programmes that have much longer timescales and require mass changes in behaviour. Action taken now may not be noticeable in the short term. Timescales for impact on long-term public health outcomes are usually of the order of 10 to 20 years or more.

The risk from these long timescales is that the perceived lack of progress against long-term outcomes can cause concern and lead to abandonment of programmes. The end result is the risk of failure of programmes to improve health and well-being. This is why it will be important to consider a wide range of information in order to triangulate whether the strategy is on track to improve long-term outcomes

9. Policy and Performance Agenda Implications

Public Health programmes need a holistic approach to assessing performance. The delivery of the long term goals are dependent on the coordination of the efforts of individual organisations represented at the Health and Wellbeing Board. Therefore, it is recommended that Appreciative Inquiry guided by the CDC inspired evaluation frameworks is used to monitor and drive performance.

10. Background Papers and Consultation

..\..\..\Individual Lifestyles\ALCOHOL\Health and Wellbeing Board Alcohol\RotherhamAlcoholStrategyEvaluationFrameworkV04.docx

..\..\..\Individual Lifestyles\ALCOHOL\Health and Wellbeing Board Alcohol\AlcoholStrategyPerformanceReport.docx

http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/key_outcome/index.htm

Keywords: **Performance, Management, Public Health**

Officer: **Dr Nagpal Hoysal, Consultant in Public Health Medicine**

Director: **Dr John Radford, Director of Public Health**

Goal - Alcohol 1: Preventing harm to children and young people from alcohol consumption

Timescale	Outcome	Performance Indicator	Narrative
Short-term (1 year)	Increased proportion of workforces trained in making every contact counts	See narrative – audit required	Will be delivered as part of commissioning process for tier 2 alcohol service due to commence September 2013. All agencies also have a responsibility to ensure staff have completed alcohol e learning package and utilise the 'single message' pack. A brief interventions e learning package is also available on www.alcohollearingcentre.co.uk
	Increased enforcement of restrictions of sales of alcohol for consumption by under 18s	See Narrative	This is the responsibility of the trading standards departments who work with the SY Police in delivering this, it is done on an ad hoc basis or as a result of intelligence. It also forms part of the Responsible Retailers scheme.
	Increased alcohol policies and programs in schools including awareness raising via school parents evenings	See Narrative	Healthy schools consultant ensures good practice and best practice examples are disseminated to PSHE leads, there remains a gap in delivery for colleges. This will be delivered in all CAP areas (see below) as part of the programme and on a more ad hoc basis in other areas dependant on schools engagement.
	Increased number of established Community Alcohol Partnerships	See Narrative	2 initial areas are to be launched Feb/March, action plans are developed and partnership groups established. Retailer meetings are planned. Updates on progress will be provided for the board request for recommendations for next stage areas.
	Complete borough-wide participation in "Responsible Retailer schemes	See Narrative	The scheme is to be rolled out as each CAP is developed, a lead officer has now been identified and a 'toolkit' for partners is in development, this will ensure that the partnership and communities have responsibility for ensuring the retailers continue to act within the remit of the scheme.
Intermediate (1-10 years)	Reduced susceptibility to harmful experimentation with alcohol	Figures not yet available	National research would suggest that less young people are drinking yet those that are drink significantly more. The Local Alcohol Profile for England (www.LAPE.org.uk) shows that Rotherham is currently better than average for alcohol specific A+E admission in under 18's. Note; Rotherham has a system in place where those who access A+E under the influence of alcohol aged 16 and under receive a follow up intervention from the school nursing service. This enables a treatable moment and aims to stop repeat attendances as well as alcohol education The LAPE data shows hospital admissions but not A+E attendances.
	Reduction in the alcohol consumption profile of parents of children receiving any social care intervention	See narrative	Screening tool (AUDIT) should be used in this setting and a pathway into treatment established (this could be measurable if systems allow).
	Increased numbers of problem drinkers entering and successfully completing treatment	Treatment Entry Q2 2012-13 = 646 Successful Treatment Completion Q2 2012-13 = 51%	Reported to Alcohol Treatment Group, numbers need to increase.
	Decreased anti-social behaviour associated with alcohol consumption	See narrative	Again this is measured as part of the CAP process, work is on-going on with SYP call handlers in ensuring that offences are correctly flagged with the alcohol marker therefore the figures may well increase as this happens and

Timescale	Outcome	Performance Indicator	Narrative
			tolerances decreases in CAP communities.
	Decreased access to underage sales	See narrative	Responsible Retailing, CAP's including improved communication on the responsibility of the public to report will impact on this.
	Ease of access for frontline workers to specialist advice about problem drinking in children and young people	See narrative	Current service contract covers this aspect of delivery, performance managed by Public Health.
Long-term (10-20 years)	Young people lead healthier lifestyles	Indicator needs development: Trend in response to alcohol questions in CYPS lifestyle survey	The reduced alcohol admissions, and school surveys can possibly measure this, as perhaps can increased school attendance and attainment? The last survey had smaller response than previous yeard.
	Positive perception of night economy	Indicator needs development: Potential use of 'your voice counts survey'	Part of communication plan from SYP and alcohol strategy action plan is to report the improvements in the town centre.
	Reduced drink driving	Data requested	Currently measured by SYP. Drink Impaired Drivers programme delivered by Probation Trust. Prevention of this by increased education will be key.
	Increased perception of safe community	Indicator needs development: Potential use of 'your voice counts survey'	SYP communications plan and via the CAP communication plan may impact
	Reduction in domestic violence	Data requested	
	Reduced alcohol related mortality – liver and heart disease, accidental death	Provisional premature mortality considered preventable from liver disease 2009-11 = 12.7	Trajectory appears to currently be increasing, if all plans are delivered over the long term it may improve the outcomes for next generation.

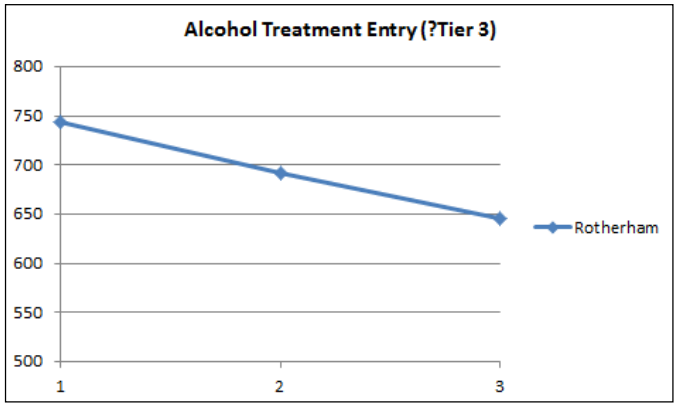
ID	Indicator	Period	Value	Period	Value	Period	Value	Latest England Period	Latest England Value	Latest Y&H Period	Latest Y&H Value
Alc_1L1	Percentage of young people who drink alcohol (regularly or when socialising/Infrequently)			2010-11	38.0%	2011-12	42.0%				
Alc_1M1	Number of young people attending A+E due to intoxication			Figs available 8/2/13							

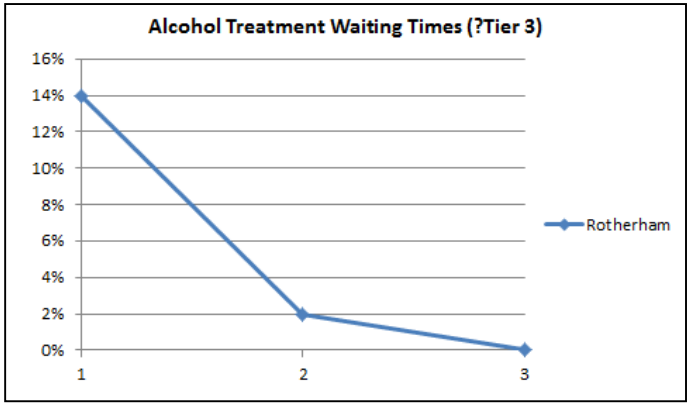
Alc_1L2	Reduced drink driving	Request for figs from SYP	
Alc_1L3	Reduction in Domestic violence	Request for figs from SYP	
	Referrals to Know The Score young peoples service ? *To be confirmed*		

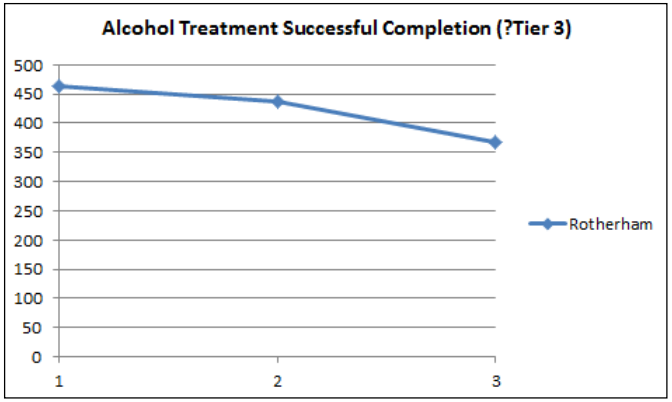
Goal - Alcohol 2: Reducing harm to adults from alcohol consumption

Timescale	Outcome	Performance Indicator	Narrative
Short-term (1 year)	Increased proportion of workforces- trained in every contact counts.	See narrative – audit required	Will be delivered as part of commissioning process for tier 2 alcohol service due to commence September 2013. All agencies also have a responsibility to ensure staff have completed alcohol e learning package and utilise the 'single message' pack. A brief interventions e learning package is also available on www.alcohollearingcentre.co.uk
	Complete borough-wide participation in "Responsible Retailer" and "Best Bar None" schemes	See narrative	The scheme is to be rolled out as each CAP is developed, a lead officer has now been identified and a 'toolkit' for partners is in development, this will ensure that the partnership and communities have responsibility for ensuring the retailers continue to act within the remit of the scheme.
	Communication plan developed and implemented	See narrative	The Alcohol strategy has action points regarding communication which are currently in development. All agencies are requested to ensure that outlets for messages are utilised for example sharing the single message.
	Increased numbers of brief interventions in primary care and other settings	See narrative – audit required	The GP led alcohol primary care service contract (Locally Enhanced Service) is to be amended from April 2013 to ensure all adults are screened using AUDIT. A+E are also currently delivering screening where possible on those who access. The 'health checks' for those aged 40+ will also now include alcohol. Dentistry are using AUDIT to ask re alcohol. The tier 2 alcohol service are also to be commissioned to ensure these opportunities a re maximised. By agencies taking on the single message, improved awareness and the work place training we can improve this significantly.
	Increased number of established CAPs	See narrative	2 initial areas are to be launched Feb/March, action plans are developed and partnership groups established. Retailer meetings are planned. Updates on progress will be provided for the board request for recommendations for next stage areas
Intermediate (1-10 years)	Reduced admissions to hospital related to alcohol	Alcohol related admissions 2011-12 2322	We currently receive data based on the NI39 attributable fractions of admissions and can plot trajectories based on this.
	Increased numbers of problem drinkers entering and successfully completing treatment	Treatment Entry Q2 2012-13 = 646 Successful Treatment Completion Q2 2012-13 = 51%	Reported to Alcohol Treatment Group, numbers need to increase.
	Reduced alcohol consumption profile of patient entering specialist treatment services	NATMS (national data system) entry and completion rates/numbers	The profile of drinkers that are currently accessing alcohol treatment shows that they are consuming greater amounts of alcohol prior to treatment (than the national average profile), early identification and interventions by other agencies that come into contact with these individuals may also impact on this.
	Reduced numbers of people carried drunk by Ambulances	See narrative	YAS are currently working to establish numbers of this, they have already implemented a referral process for those who are carried under the influence of alcohol. Other actions will have an impact on this for example responsible

Timescale	Outcome	Performance Indicator	Narrative
			retailing, improved education etc.
	Increased compliance with section 27 FPNs and attendance at binge drinking course	Data requested	SYP have increased numbers and continue to promote the course as part of FPN waiver Restorative Justice and staff education
	Increased unit price of alcohol	See narrative	Current proposals are 45p per unit, it currently stands at 50p in Scotland. Consultation is on-going. http://www.homeoffice.gov.uk/publications/about-us/consultations/alcohol-consultation/
	Reduced hospitalisation and complications of people with LTCs related to alcohol	See narrative	CCG and public health working on a plan for possible increased investment, measurable via national indicator on admissions. Any local investment would include additional outcome measures.
Long-term (10-20 years)	Positive perception of night economy	Indicator needs development: Potential use of 'your voice counts survey'	Part of communication plan from SYP and alcohol strategy action plan is to report the improvements in the town centre.
	Reduced drink driving	Data requested	Drink Impaired Drivers programme delivered by Probation Trust. Prevention of this by increased education will be key.
	Increased perception of safe community	Indicator needs development: Potential use of 'your voice counts survey'	Features as part of SYP communications plan and via the CAP communication plan will impact
	Reduction in domestic violence	Data requested	This is only reported DV, un reported DV remains uncaptured, Probation trust and support services may also be key in the reducing repeat offending.
	Reduced alcohol related mortality – liver and heart disease, accidental death	Provisional premature mortality considered preventable from liver disease 2009-11 = 12.7	Trajectory appears to currently be increasing, if all plans are delivered over the long term it may improve the outcomes for next generation.







ID	Indicator	Year	Value	Year	Value	Year	Value	Latest England Year	Latest England Value	Latest Y&H Year	Latest Y&H Value
Alc_2M1	Alcohol related admissions to hospital	2009-10	1887	2010-11	2209	2011-12	2322	2011-12	1974	2011-12	2047
Alc_2L1	Directly age-standardised rate of mortality from chronic liver disease per 100,000 (aged under 75)	2009	18.3	2010	14.42	2011	15.12	2011	14.9	2011	16.21
Alc_2L2	Age-standardised rate of mortality that is considered preventable from liver disease in persons less than 75 years of age per 100,000 population	Not yet published				2009-11 (provisional)	13.7	2009-11 (p)	12.7		

ID	Indicator	Quarter	Value	Quarter	Value	Quarter	Value	Quarter	Value	Latest Y&H Value
Alc_2M2	Alcohol Treatment Entry (?Tier 3) *Number* (rolling 12 months)			2011-12 Q4	743	2012-13 Q1	692	2012-13 Q2	646	
Alc_2M3	Alcohol Treatment Entry (?Tier 3) *Proportion* (a)			2011-12 Q4	58%	2012-13 Q1	67%	2012-13 Q2	57%	
Alc_2M4	Alcohol Treatment Waiting Times (?Tier 3)			2011-12 Q4	14%	2012-13 Q1	2%	2012-13 Q2	0%	
Alc_2M5	Alcohol Treatment Successful Completion (?Tier 3)			2011-12 Q4	66%	2012-13 Q1	45%	2012-13 Q2	51%	
Alc_2M6	Drinking profile of those entering treatment.									

Preventing harm to children and young people from alcohol consumption

Inputs

Stakeholders:
- Alcohol outlets
- Ambulance Service
- Fire Service
- GPs
- Hospital
- NAS
- Neighbourhood teams
- Police
- Public Health
- Schools
- Trading standards
- Youth Service
- Etc…

Activities

Community mobilisation:
- Community Alcohol Partnerships
- Making every contact count
- Think Family
- Call it a night

Counter marketing:
- Staff having contact with children trained in alcohol education
- Single message
- Call it a night
- National alcohol awareness week

School based prevention:
- Reduce pupil absence
- PSHE
- Teachers trained in alcohol education (including young person's screening tool)

Policy and regulatory action:
- Responsible retailer scheme
- Section 106 agreements
- Test purchasing
- LicenseWatch
- Treatment Services
- Op Conquer
- Use of AUDIT-C in Family CAF

Targeted first at the 11 deprived areas

Outputs

Completed activities to reduce and counteract harmful drinking messages

Completed activities to delay onset of alcohol use and disseminate sensible drinking messages

Completed activities to restrict sales of alcohol to under-18s, including proxy sales and supply of alcohol by parents.

Completed activities to increase education in schools about the single message – to include screening tool

Completed activities to influence policy and regulatory landscape

Outcomes

Short-term

Increased knowledge of, sensible drinking message and improved attitude towards alcohol use. Increased support for policies to prevent harm to children and young people from alcohol consumption

Increased proportion of workforces- trained in every contact counts.

Increased enforcement of restrictions of sales of alcohol for consumption by under 18s

Increased alcohol policies and programs in schools including awareness raising via school parents evenings

Reduced alcohol industry influences

Complete borough-wide participation in "Responsible Retailer schemes

Increased number of established Community Alcohol Partnerships

Intermediate

Reduced susceptibility to harmful experimentation with alcohol – reduction in child A&E attendances due to intoxication

Reduction in the alcohol consumption profile of parents of children receiving any social care intervention

Increased numbers of problem drinkers entering and successfully completing treatment

Decreased anti-social behaviour associated with alcohol consumption

Decreased access to underage sales

Ease of access for frontline workers to specialist advice about problem drinking in children and young people

Shift of focus towards prevention and early intervention

Long-term

Young people lead healthier lifestyles

Positive perception of night economy

Reduced drink driving

Increased perception of safe community

Reduction in domestic violence

Reduced alcohol related mortality – liver and heart disease, accidental death

Not measurable | Narrative | Measurable

Reducing harm to adults from alcohol consumption

Inputs

Stakeholders:
- Alcohol outlets
- Ambulance Service
- Fire Service
- GPs
- Hospital
- Neighbourhoods and Adult Services
- Police
- Public Health
- Trading standards
-

Activities

Community mobilisation:
- Community Alcohol Partnerships
- Making every contact count

Counter marketing:
- Call it a night
- Single message pack

Workplace and community based prevention:
- Making every contact count

Policy and regulatory action:
- Responsible retailer scheme
- Section 106 agreements
- Test purchasing
- LicenseWatch
- Best Bar None
- Treatment Services
- Minimum alcohol pricing
- Op Conquer
- Use of AUDIT-C in Family CAF
- Making every contact count

Targeted first at the 11 deprived areas

Outputs

Completed activities to reduce and counteract harmful drinking messages

Completed activities to disseminate sensible drinking and pro-health messages

Completed activities to train workforce in making every contact count

Completed activities to lobby for minimum alcohol pricing and loss-leading promotions

Outcomes

Short-term

Increased knowledge of, sensible drinking message and improved attitude towards alcohol use. Increased support for policies to reduce harm to adults from alcohol consumption

Increased proportion of workforces- trained in every contact counts.

Complete borough-wide participation in "Responsible Retailer" and "Best Bar None" schemes

Communication plan developed and implemented

Increased numbers of brief interventions in primary care and other settings

Increased number of established CAPs

Intermediate

Reduced admissions to hospital related to alcohol

Prevention and Early intervention of problem drinking

Increased numbers of problem drinkers entering and successfully completing treatment

Reduced alcohol consumption profile of patient entering specialist treatment services

Reduced numbers of people carried drunk by Ambulances

Increased unit price of alcohol

Reduced hospitalisation and complications of people with LTCs related to alcohol

Increased compliance with section 27 FPNs and attendance at binge drinking course

Long-term

Adults lead healthier lifestyles as a result of a change in behaviour to think that it is not acceptable to drink in ways that could cause harm to themselves or others

Positive perception of night economy

Reduced drink driving

Increased perception of safe community

Reduction in domestic violence

Reduced alcohol related mortality – liver and heart disease, accidental death

Not measurable

Narrative

Measurable

Goal – Tobacco 1: Preventing initiation of tobacco use amongst children and young people

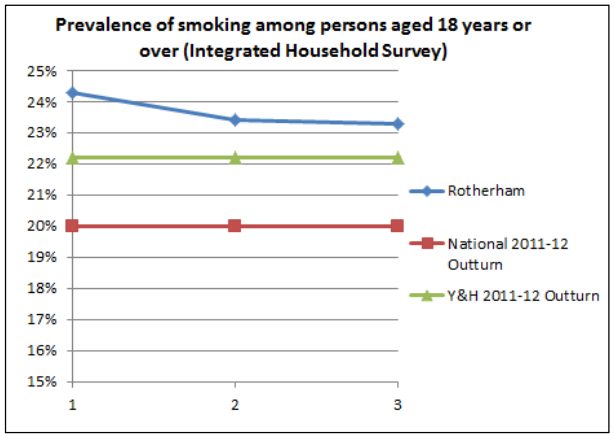
Timescale	Outcome	Performance Indicator	Narrative
Short-term	Increased anti-tobacco policies and programs in schools	See narrative – audit required	Currently offer the smokefree class activity pack to all secondary schools in Rotherham. This has been running for 4 years and is aimed at year 7 pupils, although some schools have extended to a larger age group. A new pack aimed at primary schools was introduced in December 2012 – no feedback as yet on implementation. All schools seeking to be healthy schools must have smokefree policies, a sample policy is provided. An enhanced schools pack is in development, including advice on policy implementation, education about smoking and a warning scheme with template letters for pupils that persist with smoking.
	Increased restriction and enforcement of restrictions on underage tobacco sales	See narrative	Trading standards carry out set programme of test purchases at retailers. Information from lifestyle survey and source of cigarettes, as well as intelligence reports, can help to target these at suspect premises *(check with AP)*.
	Increased restriction and enforcement of restriction of sales of illicit and counterfeit tobacco	See narrative	Trading standards carry out investigation and enforcement action based on intelligence around sources of illicit and counterfeit tobacco.
Intermediate	Increased number of smokefree homes	Proportion of young people reporting living in a smoke-free home 2011-12 = 64%	Currently c.4500 Rotherham households signed up to voluntary smokefree homes scheme. This will not capture the full picture of smokefree behaviour. Other sources of information include the Young People's lifestyle survey (64% of children said they lived in a smokefree home, up from 61% in 2011) and a recent social norms campaign in Treeton (82% did not allow smoking in their home).
	Decreased access to tobacco products		
	Reduced susceptibility to experimentation with tobacco products		
Long-term	Reduced initiation of tobacco use by young people		
	Reduced prevalence of tobacco-use among 15 year olds	Future indicator	Indicator being developed nationally. Lifestyle survey data can be used to track against smoking, drinking and drug use survey among 11-15 year olds until indicator has been developed. 2012 lifestyle survey has 8% of respondents smoking 'regularly' (England data is 5% of 11-15 year olds smoking regularly). In the national survey regular smoking is classified as pupils who smoked at least one cigarette per week, but in the local lifestyle survey 'Regularly' is not defined. Recommend that the local survey questions about smoking are revised to mirror the national survey to allow robust comparison.

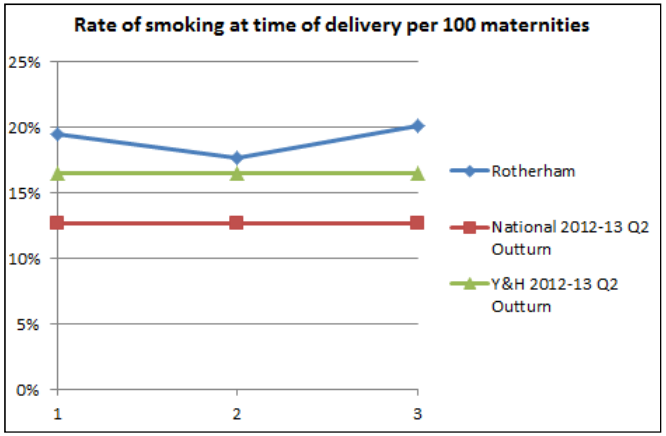
Timescale	Outcome	Performance Indicator	Narrative
	Reduced tobacco–related morbidity and mortality	Provisional preventable premature mortality from cardiovascular disease 2009-11 = 40.6	
	Decreased tobacco related health inequalities		
	Shift of focus towards prevention and early intervention		Work is underway across South Yorkshire to change the profile of investment in tobacco control for greater focus on prevention and early intervention rather than solely on treatment of current smokers.
	Reduced smoking prevalence in adults	23.3% overall (integrated Household Survey April 2011-March 2012. LHO http://www.lho.org.uk/viewResource.aspx?id=16678) 28.9% routine and manual working group prevalence.	
	Reduced smoking at time of delivery rate	20.1% at Q2 2012/13 (year to date 18.9%) (NHS Information Centre. Statistics on Women's Smoking Status at Time of Delivery: England www.ic.nhs.uk)	

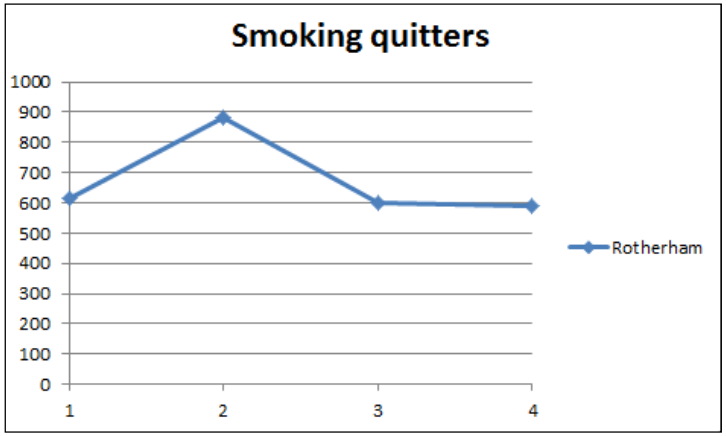
Goal – Tobacco 2: Reducing harm to adults from tobacco consumption

Timescale	Outcome	Measure	Current position
Short-term	All RMBC public facing staff completed very brief advice e-learning		No progress to date. National e-learning programme available but focused on general practice staff. Brief intervention face-to-face training is offered by the Rotherham NHS Stop Smoking Service.
	All health public facing staff completed very brief advice e-learning		No progress to date. National e-learning programme available but focused on general practice staff. Brief intervention face-to-face training is offered by the Rotherham NHS Stop Smoking Service.
	Individuals in target groups supported to stop smoking		
	Increased restriction and enforcement of restriction of sales of illicit and counterfeit tobacco		Trading standards carry out investigation and enforcement action based on intelligence around sources of illicit and counterfeit tobacco.
Intermediate	Reduced smoking at time of delivery rates	20.1% at Q2 2012/13 (year to date 18.9%) (NHS Information Centre. Statistics on Women's Smoking Status at Time of Delivery: England www.ic.nhs.uk)	
	Reduced smoking prevalence among adults	23.3% overall (integrated Household Survey April 2011-March 2012. LHO http://www.lho.org.uk/viewResource.aspx?id=16678) 28.9% routine and manual working group prevalence.	
	Increased price of tobacco products		
	Reduced access to counterfeit and illicit tobacco		Trading standards carry out investigation and enforcement action based on intelligence around sources of illicit and counterfeit tobacco.
	Increased number of smokefree homes	See narrative	Currently c.4500 Rotherham households signed up to voluntary smokefree homes scheme. This will not capture the full picture of smokefree behaviour. Other sources of information include the Young People's lifestyle survey (64% of children said they lived in a smokefree home, up from 61% in 2011) and a recent social norms campaign in Treeton (82% did not allow smoking in their home).
Long-term	Reduced number of stillbirths and neonatal deaths	Infant mortality rate 2011 = 4.3	

Timescale	Outcome	Measure	Current position
	Reduced number of low birth-weight babies	Low-birth weight 2010 = 3.3	
	Shift of focus towards prevention and early intervention		Work is underway across South Yorkshire to change the profile of investment in tobacco control for greater focus on prevention and early intervention rather than solely on treatment of current smokers.
	Reduced tobacco–related morbidity and mortality	Provisional preventable premature mortality from cardiovascular disease 2009-11 = 40.6 Provisional preventable premature mortality from all cancers 2009-11 = 61.9	
	Decreased tobacco related health inequalities		
	Reduced prevalence of tobacco use among 15 year olds		Indicator being developed nationally. Lifestyle survey data can be used to track against smoking, drinking and drug use survey among 11-15 year olds until indicator has been developed. 2012 lifestyle survey has 8% of respondents smoking 'regularly' (England data is 5% of 11-15 year olds smoking regularly). In the national survey regular smoking is classified as pupils who smoked at least one cigarette per week, but in the local lifestyle survey 'Regularly' is not defined. Recommend that the local survey questions about smoking are revised to mirror the national survey to allow robust comparison.







ID	Indicator	Year	Value	Year	Value	Year	Value	Latest England Period	Latest England Value	Latest Y&H Period	Latest Y&H Value
Obesity & Smoking	Age-standardised rate of mortality from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years of age per 100,000 population	2009	79.2	2010	71.33	2011	73.77	2011	57.97	2011	66.46
Obesity & Smoking	Age-standardised rate of mortality that is considered preventable from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years of age per 100,000 population	Not yet published				2009-11 (provisional)	51.2	2009-11 (p)	40.6		
Obesity & Smoking	Age-standardised rate of mortality from all cancers in persons less than 75 years of age per 100,000 population	2009	124.5	2010	128.6	2011	122.4	2011	107.0	2011	115.9
Obesity & Smoking	Age-standardised rate of mortality that is considered preventable from all cancers in persons less than 75 years of age per 100,000 population	Not yet published				2009-11 (provisional)	71.2	2009-11 (p)	61.9		
Smoking	Percentage of young people who report living in a smoke free home			2010-11	61.0%	2011-12	64.0%				
Smoking	Prevalence of smoking among 15 year olds	Not yet published						2010	17%		

Smoking	Age-standardised rate of mortality that is considered preventable from all cancers in persons less than 75 years of age per 100,000 population	Not yet published				2009-11 (provisional)	71.2	2009-11 (p)	61.9		
Smoking	Age-standardised rate of mortality from respiratory diseases in persons less than 75 years of age per 100,000 population	2009	31.6	2010	27.57	2011	33.94	2011	23.51	2011	28.28
Smoking	Age-standardised rate of mortality that is considered preventable from respiratory diseases in persons less than 75 years of age per 100,000 population	Not yet published				2009-11 (provisional)	12.4	2009-11 (p)	11.6		

Theme	Indicator	Quarter	Value	Quarter	Value	Quarter	Value	Quarter	Value	Last full year period	Last full year value	Latest England Period	Latest England Value	Latest Y&H Period	Latest Y&H Value
Smoking	Prevalence of smoking among persons aged 18 years or over (Integrated Household Survey)			Oct10-Sep11	24.3%	Jan11-Dec11	23.4%	Apr11-Mar12	23.3%	Apr11-Mar12	23.3%	Apr11-Mar12	20.0%	Apr11-Mar12	22.2%
Smoking	Rate of smoking at time of delivery per 100 maternities			2011-12 Q4	19.5%	2012-13 Q1	17.7%	2012-13 Q2	20.1%	2011-12	19.8%	2012-13 Q2	12.7%	2012-13 Q2	16.5%

Smoking	Smoking quitters	2011-12 Q3	616	2011-12 Q4	884	2012-13 Q1	601	2012-13 Q2 (RSSS)	590		2012-13 Q1	86341

Preventing initiation of tobacco use amongst children and young people

Inputs

Stakeholders:
- Schools
- Colleges
- Youth service
- School nurses
- Public Health
- Trading standards team
- Healthy Schools team
- Communications
- Stop Smoking Service
- General Practice
- Pharmacies
- Dentists
- Fire Service
- CAMHS
- Retailers
- All health service and local authority staff
-

Activities

Community mobilisation:
- Smoke free homes/cars
- Smoke free environments
- Making every contact count
- Social norms-based community campaigns
- Youth advocacy

Counter marketing:
- Targeting national media campaigns
- Internet presence
- Stoptober, New Year, New You
- Social norms-based community campaigns
- Promoting dangers of cheap and illicit tobacco

School based prevention:
- Making every contact count
- Smoke free policies
- Smokefree Class activities
- Smokefree Schools pack

Policy and regulatory action:
- Specialist stop smoking services
- Plain packaging
- Pricing
- Counterfeit/illicit sales
- Underage sales
- Point of sale display ban
- Section 106 agreements
- Brief interventions and very brief advice in health and social care

Targeted first at the 11 deprived areas

Outputs

Completed activities to reduce and counteract pro-smoking messages

Completed activities to disseminate anti-smoking and pro-health messages

Completed activities to restrict sales of tobacco to under-18s, including proxy sales

Completed activities to increase education in schools about harms of smoking

Completed activities to influence policy and regulatory landscape

Outcomes

Short-term

Increased knowledge of, improved anti-tobacco attitudes toward, and increased support for policies to reduce youth initiation

Increased anti-tobacco policies and programs in schools

Increased restriction and enforcement of restrictions on underage tobacco sales

Increased restriction and enforcement of restriction of sales of illicit and counterfeit tobacco

Reduced tobacco industry influences

Intermediate

Reduced susceptibility to experimentation with tobacco products

Decreased access to tobacco products

Increased price of tobacco products

Increased number of smokefree homes

Long-term

Reduced initiation of tobacco use by young people

Reduced prevalence of tobacco-use among 15 year olds

Reduced tobacco–related morbidity and mortality

Decreased tobacco related health inequalities

Shift of focus towards prevention and early intervention

Reduced smoking prevalence in adults

Reduced smoking at time of delivery rate

Reducing harm to adults from tobacco consumption

Inputs

Stakeholders:
- Colleges
- Public Health
- Trading standards team
- Communications
- Stop Smoking Service
- General Practice
- Pharmacies
- Dentists
- Fire service
- Retailers
- All health service and local authority staff

Activities

Community mobilisation:
- Smoke free homes/cars
- Smoke free environments
- Making every contact count

Counter marketing:
- Targeting national media campaigns
- Internet presence
- Stoptober, New Year, New You
- Making every contact count
- Promote dangers of cheap and illicit tobacco

Workplace and community based prevention:
- Smoking in workplace policies
- Making every contact count

Policy and regulatory action:
- Stop smoking support
- Plain packaging
- Pricing
- Counterfeit/illicit sales
- Section 106 agreements
- Brief interventions and very brief advice in health and social care
- Point of sale display ban

Targeted first at the 11 deprived areas

Outputs

Completed activities to reduce and counteract pro-smoking messages

Completed activities to disseminate anti-smoking and pro-health messages

Completed activities to train workforce in making every contact count

Completed activities to influence policy and regulatory landscape

Outcomes

Short-term

Increased knowledge of, improved anti-tobacco attitudes toward, and increased support for policies to reduce smoking

All RMBC public facing staff to complete very brief advice e-learning

All health public facing staff to complete very brief advice e-learning

Individuals in target groups supported to stop smoking

Increased restriction and enforcement of restriction of sales of illicit and counterfeit tobacco

Intermediate

Reduced smoking at time of delivery rates

Reduced acceptability of tobacco use

Reduced smoking prevalence among adults

Increased price of tobacco products

Reduced access to counterfeit and illicit tobacco

Increased number of smokefree homes

Long-term

Reduced number of stillbirths and neonatal deaths

Reduced number of low birthweight babies

Shift of focus towards prevention and early intervention

Reduced tobacco–related morbidity and mortality

Decreased tobacco related health inequalities

Reduced prevalence of tobacco use among 15 year olds

Rotherham Warmer Homes Strategy:

Aim: To reduce the effects of fuel poverty

Inputs

Stakeholders
:Residents
RMBC
NAS
EDS
CYPS
CEX
NHS
Community Health Services
CCG
RFT (discharge planning)
Voluntary sector:
Rotherham CAB
Age UK
Rotherham Stay Put
VAR
National Energy Action
Private Sector:
Utility Companies
Construction Partners
Other statutory organisations:
Dept of work and pensions
South Yorkshire Fire and Rescue

Activities

Community mobilisation:
- Making Every Contact Count
- Implement KWILLT findings and resources
- Hot Spots scheme
- Warmer Homes Healthy People project

Counter marketing:
- Winter Warmth England LINK
- Energy Efficiency Schemes

Intelligence through:
- Green Deal Research with private landlords
- KWILLT R&D LINK
- Warm Well Families

Workplace/ community based prevention:
- Energy Efficiency Programmes e.g. CERT/CESP, Warm Front, Green Deal, DECC Fuel Poverty, Warm Homes Healthy
- People Behaviour change training and awareness

Policy and regulatory action:
Energy Conservation Act 2000
UK Fuel Poverty Strategy/ Hills Review
NICE Excess Winter Deaths (in development)
DH Cold Weather Plan for England 2012
Marmott Review 2011
National Housing Strategy
Welfare Reform Act

Targeted first at the 11 deprived areas

Outputs

Completed activities to raise awareness of the negative effects of living in cold homes

Completed activities that improve Rotherham Housing standards

Complete data gathering and evidence to inform targeted activity.

Contribute to development of National and local policy

Complete implementation of national and local strategy

Outcomes

Short-term

Increase the number of properties receiving energy efficiency measures e.g. CESP/CERT, DECC Fuel Poverty, WHHP

Identify targeted areas and households to receive energy efficiency measures.

Complete research and data intelligence gathering

Local Cold Weather Plan implemented

Increased numbers of workforces trained in MECC/ Hot Spots

Intermediate

Increase the number of properties receiving energy efficiency measures e.g. Green Deal

Reduce the number of household in fuel poverty across the Borough.

Meet the HECA target

Change behaviours linked to heating homes and energy efficiency of residents and work force

Long-term

Reduce seasonal excess winter deaths

Reduced excess winter admissions to hospital

Increased community resilience

Reduced number of people with Long term Conditions

Reduce levels of fuel poverty and numbers of residents living in cold homes

Inputs

Stakeholders:
•

Activities

Community mobilisation:

Counter marketing:

Workplace and community based prevention:

Policy and regulatory action:

Outputs

Completed activities to disseminate pro-health messages

Completed activities to train workforce in making every contact count

Completed activities to lobby

Outcomes

Short-term

Intermediate

Long-term

Increased knowledge and awareness of health impacts of living in a cold home and energy efficiency measures

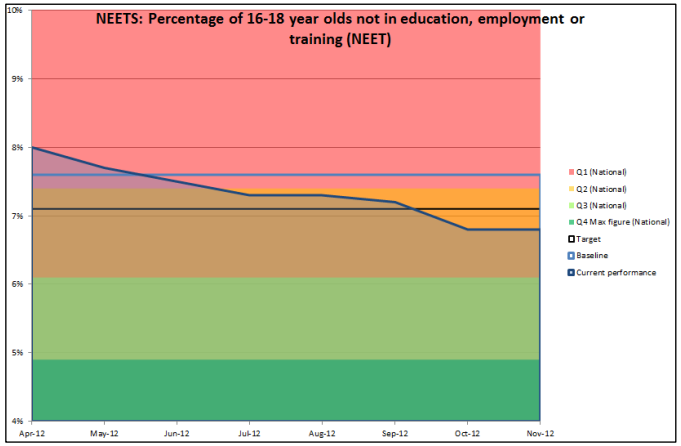
I

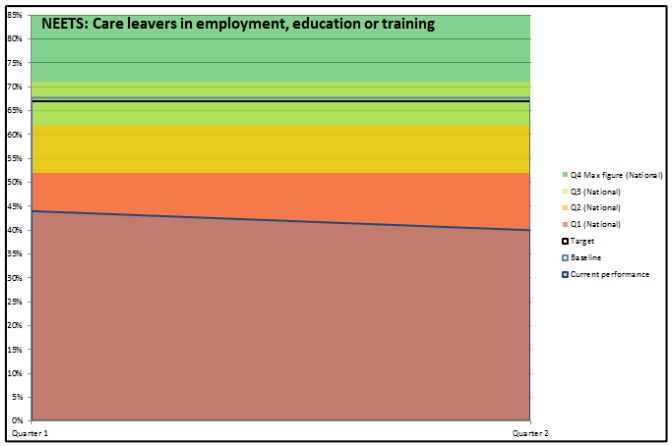
Targeted first at the 11 deprived areas

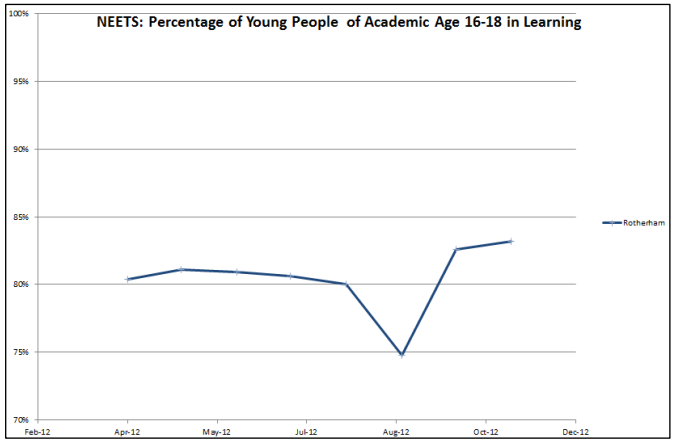
Priority Measure 4 – NEETS (Accountable Lead – Collette Bailey (RMBC)

Monthly / Quarterly Measures

Indicator	Framework	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Control Target for the last Figure Recorded	Year End Target	2010-11 Outurn	2011-12 Outurn	Latest Benchmarking Position	Available updates	Responsible Officer
NEETS: Percentage of 16-18 year olds not in education, employment or training (NEET)	PHOF	8.00%	7.70%	7.50%	7.30%	7.30%	7.20%	6.80%	6.80%						7.10%		7.60%	Bottom Quartile	Monthly	Collette Bailey
NEETS: Care leavers in employment, education or training		44.00%			40.00%										44.00%		67.70%	Local Indicator not bench markable	Quarterly	Collette Bailey
NEETS: Percentage of Young People of Academic Age 16-18 in Learning		80.4%	81.1%	80.3%	80.6%	80.0%	74.8%	82.6%	83.2%											







Narrative

NEETS: Percentage of 16-18 year olds not in education, employment or training (NEET)

- Progress has been made since April 2011 with performance against the local measures improving from the same period last year.
- The 3 month average position of 7.2% for Q2 (July to September) has improved from 8.9%for the same period in 2011/12.
- The average number of academic age 16 -18 NEET for this year is 591 (compared to 749 for the same period last year which is a reduction of 158 young people).
- The latest statistical neighbours information available at this point relates to August 2012 and shows Rotherham NEET figure of 7.4% being well below the average of 9.1%.

NEETS: Care leavers in employment, education or training

- Care leavers are exponentially more likely to be NEET in comparison to the whole cohort.
- Most of the care leavers who are NEET are at sub level 2, are not able to access apprenticeships and are competing in a highly competitive labour market for diminishing lower level employment opportunities.
- In year 14 half of the care leavers NEET are unavailable to the labour market due to illness or teenage parenthood. This compares to 20% of the wider cohort of 16-19 year olds.
- From September 2013, all young people in England will be required to stay in learning until the end of the academic year in which they turn 17 and from September 2015 until their 18th birthday.
- A significant proportion of Rotherhams young people aged 16-19 enter lower level labour market opportunities without recognised training and would be unwilling to stay in learning

NEETS: Percentage of Young People of Academic Age 16-18 in Learning

- From September 2012 the statutory responsibility for the provision of careers guidance passed from the Local Authority to schools who are free to dispense this duty as they see fit. This has resulted in a mixed economy of provision with no consistent standards of delivery and may present a risk to increasing participation in the future.
- Vulnerable groups including those with emotional and behavioural needs , learning difficulties or disabilities , teenage parents and looked after children and care leavers are less likely to continue to participate in learning until 18

Rotherham Metropolitan Borough Council
Where Everyone Matters

Healthy lifestyles Prevention and Early Intervention

Approaches

- JHWBS:
  - Stages of Life Course
  - Six Priority Outcomes

- Priority Measures:
  - Alcohol, Obesity, Tobacco, Dementia, NEETS, Affordable Warmth

Life Course Framework

- The Strategy sets out a life course framework, which has been adapted from the Marmot life course.
- Life Course; Early Intervention, Prevention and Behavioral Change
- Integral to 6 PH programmes from strategy

obesity,alcohol,smoking,fuel poverty,dementia,NEETS

- System based responsibility under H+W Board

Healthy lifestyles
Prevention and Early Intervention

Outcome: People in Rotherham will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles.

Outcome: Rotherham people will get help early to stay healthy and increase their independence

Communication

- QTV
- Campaigns – MCAT
- Web – based social media/mobile devices/engagement
- Every contact counts

Starting well

- Children's Strategy
- Health visitor 0-5 programme
- UNICEF Baby Friendly Initiative
- Troubled families
- Family Nurse Partnership
- Imagination Library
- Specialist midwifery

Developing Well

- Children's Strategy
- Looked after children
- Healthy Schools
- Communication- website campaigns
- School Nurse Contract Revision
- Healthy weight framework
- NEETS System reporting framework

Living and working well

- Obesity - System reporting framework
- Alcohol - System reporting framework
- Smoking - System reporting framework
- NHS Healthcheck
- Communication – campaigns web site development
- Workplace health

Ageing well

- Affordable warmth - System reporting framework
- Dementia - System reporting framework
- Healthy Ageing
- NHS Healthchecks
- Flu vaccination

Healthy lifestyles
Prevention and Early Intervention

- Delivery of a shift towards Prevention and Early Intervention and Healthy Lifestyles requires a strong partnership approach
- The system-wide reporting framework proposed will enable the Board to hold the partners to account for their individual responsibilities

Health & Wellbeing Strategy
Obesity priority

Joanna Saunders

Head of Health Improvement

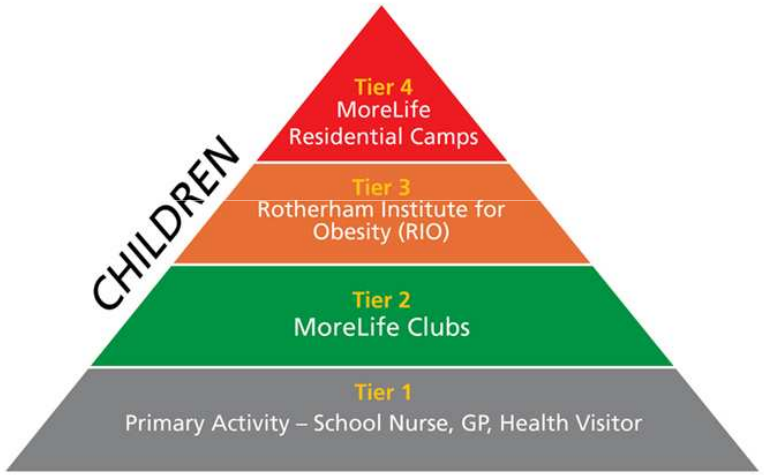
Rotherham Public Health

Health & Wellbeing Board, February 2013

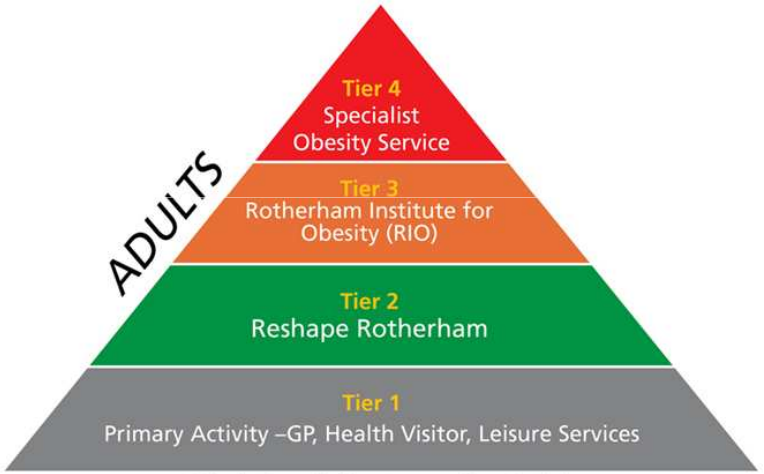
Why is obesity a priority?

- PH priority nationally and locally
- Can have serious health consequences and impacts on health and social care services
- Can be prevented and treated (NICE)
- Impacts on emotional wellbeing
- Impacts on the economy

What does a Healthy Weight Framework look like?



Whole Population Prevention Activity
Maternity, UNICEF Baby Friendly, Early Years, Play Initiative, Healthy Schools, Ministry of Food, Leisure & Green Spaces, Transport and Planning, Workplaces, Built Environment.



Whole Population Prevention Activity
Maternity, UNICEF Baby Friendly, Early Years, Ministry of Food, Leisure & Green Spaces, Transport and Planning, Workplaces, Built Environment.

What do we need to do?

- Raise public awareness
- Get more people to engage with services
- Skill people up to live healthier lives
- Make healthy choices the easy choices
- Get everyone to recognise their role and act
- Challenge cultural and “normal for Rotherham” behaviour

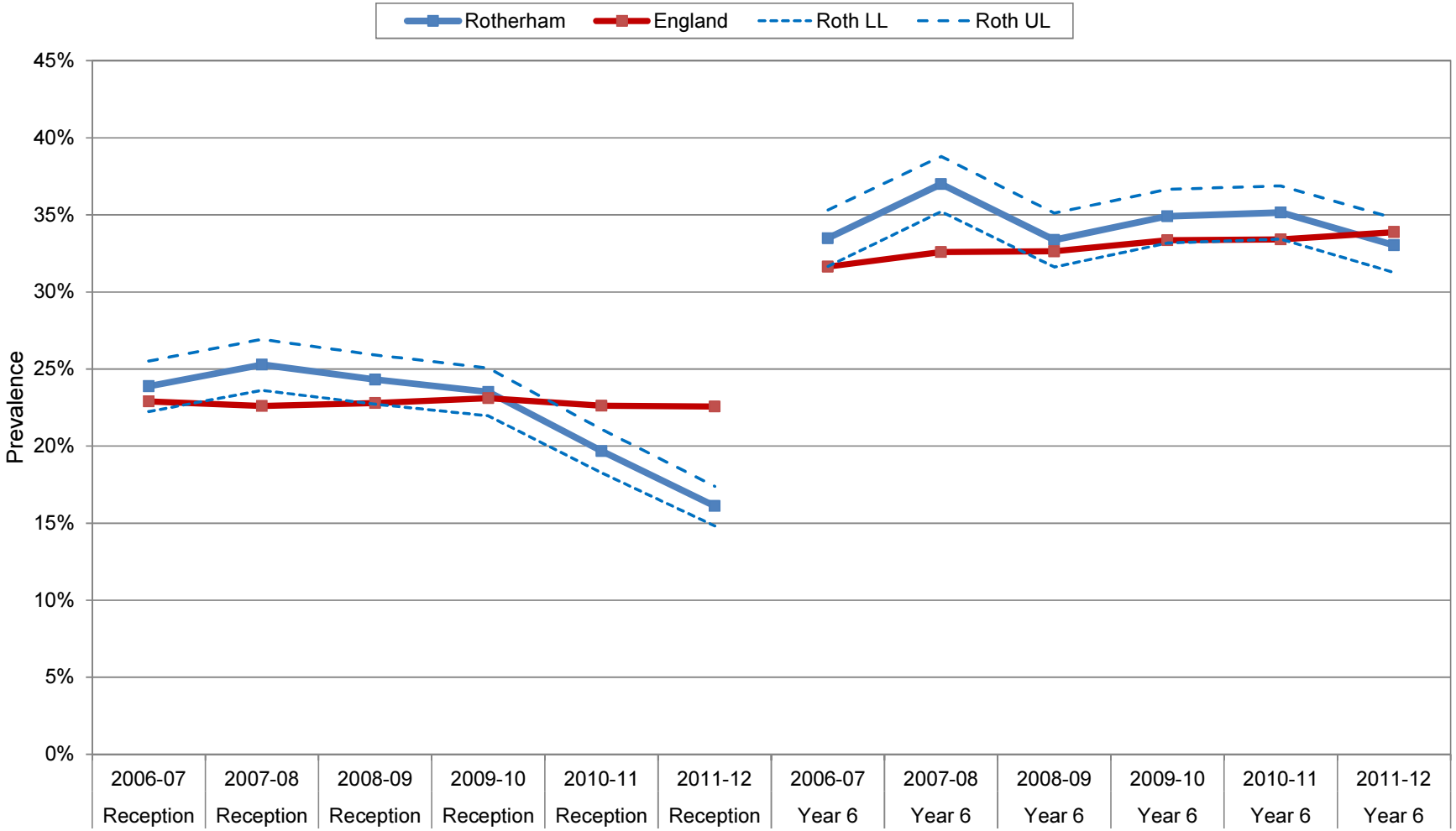
What are the current priorities?

- Raise the profile of whole population prevention activity
- Continue to provide a range of services for people who are already overweight or obese
- Maximise the resources already available – training, signposting and referral
- Agree our position on the impact of planning decisions, transport planning

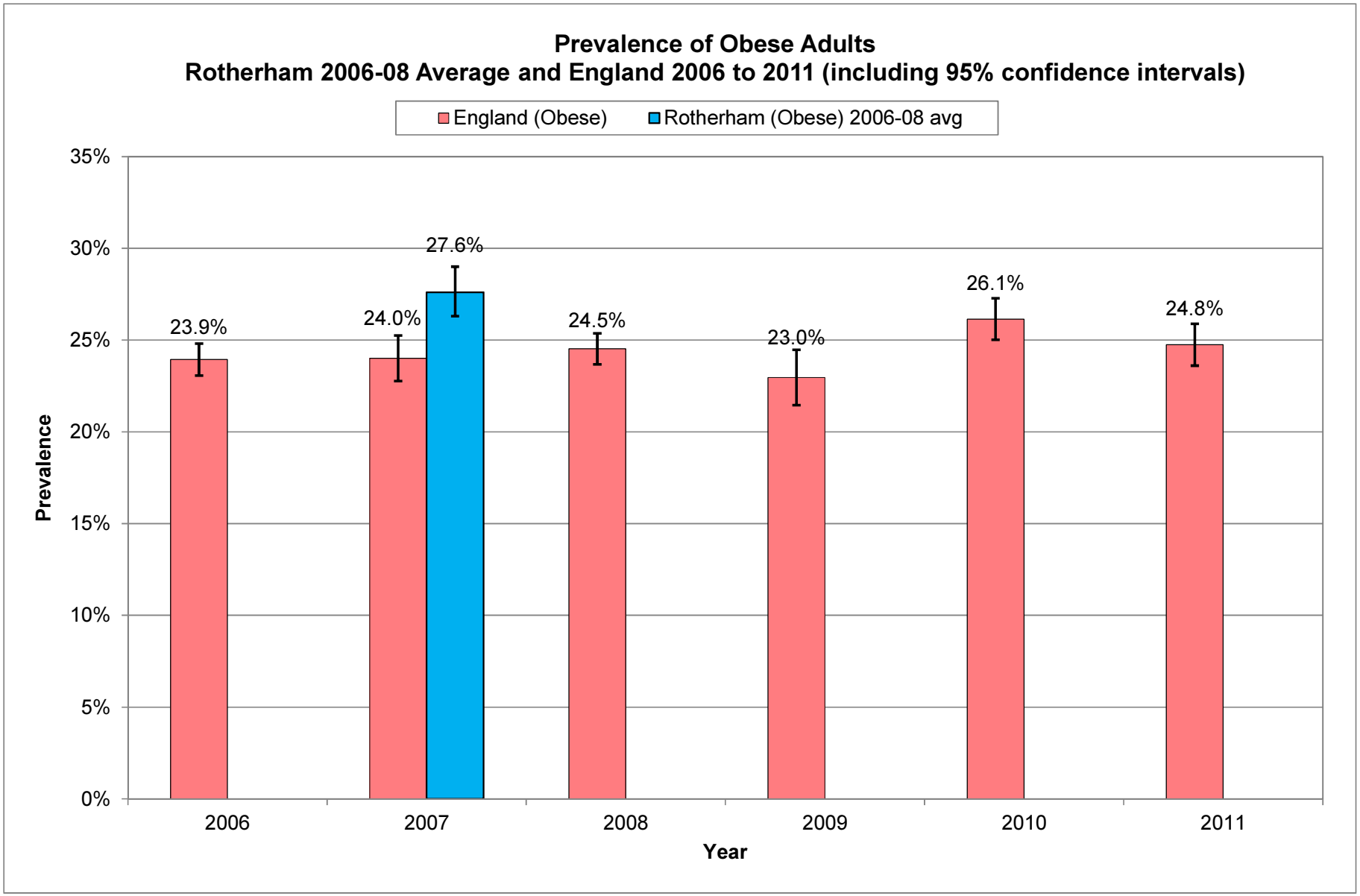
Challenges

- Preventing and treating childhood overweight and obesity in the primary school aged population
- Whole family engagement
- Changing behaviour amongst those that most need to change
- Evidence of what REALLY works
- Funding to support grassroots initiatives

Prevalence of Overweight and Obese Children in Reception and Year 6
Rotherham and England 2006-07 to 2011-12 (incl 95% confidence intervals)



Source: NCMP Dataset
NHS Information Centre.


Prevalence of Obese Adults
Rotherham 2006-08 Average and England 2006 to 2011 (including 95% confidence intervals)
England (Obese)
Rotherham (Obese) 2006-08 avg
35%
30%
25%
20%
15%
10%
5%
0%
Prevalence
23.9%
24.0%
27.6%
24.5%
23.0%
26.1%
24.8%
2006
2007
2008
2009
2010
2011
Year

What can the H&WB do?

- Making Every Contact Count! Power of partners
- Recognition of the importance of health as a driver of deprivation
- Political leadership
- Collaborative commissioning

What I want H&WB members to do

- Commit to all staff doing e-learning on MECC and giving feedback on their performance in signposting and referring to services
- Introduce planning and licensing policy to restrict availability of fast food particularly near schools or in deprived communities and promoting use of green space
- A concerted effort to address the issue in the primary school population

Thankyou!

Further details from Joanna Saunders

joanna.saunders@rotherham.gov.uk

01709 255852

Document is Restricted