HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 27th November, 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 and Matters Arising (Pages 1 - 12)

4. Communications

For Discussion

5. Integration Transformation Fund (Pages 13 - 46)

6. Public Health Outcomes Framework (Pages 47 - 65)
   - John Radford, Director of Public Health to report

7. Flu Vaccination Programme
   - Verbal report

8. Frequency and Format of Board Meetings

9. Matters arising from information items circulated

10. Date of Next Meeting
    - Wednesday, 18th December, 2013 at 1.00 p.m.

HEALTH AND WELLBEING BOARD
16th October, 2013

Present:-

Councillor John Doyle	Cabinet Member, Adult Social Care **(in the Chair)**
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Chris Edwards	Chief Operating Officer, Rotherham CCG
Jason Harwin	South Yorkshire Police
Naveen Judah	Healthwatch Rotherham
Dr. Julie Kitlowski	Rotherham CCG
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families Services
Dr. David Polkinghorn	Rotherham CCG
Dr. John Radford	Director of Public Health
Janet Wheatley	Voluntary Action Rotherham
Councillor Ken Wyatt	Cabinet Member Health and Wellbeing/Finance

Also Present:-

Dr. Trisha Bain	Rotherham Foundation Trust
Chris Bland	Rotherham Local Pharmaceutical Committee
Dominic Blaydon	
Claire Burton	Commissioning, RMBC
Kate Green	Policy Officer, RMBC
Dr. Nagpal Hoysal	Public Health
Ian Jerams	RDaSH
Laura Sherburn	NHS England
Dorothy Smith	Children, Young People and Families services
Chrissy Wright	Commissioning, RMBC

Apologies for absence were submitted by Karl Battersby, Brian Hughes, Chris Bain, Gordon Laidlaw, Tracy Holmes, Martin Kimber, Shona McFarlane, Michael Morgan and Joyce Thacker.

S39. SOUTH YORKSHIRE POLICE

The Board considered a proposal that South Yorkshire Police be formally represented on the Board.

Discussion ensued on the proposal and the benefits of having Police representation. Cognisance was taken of previous requests received from other partner organisations for membership of the Board that had been refused.

Resolved:- (1) That, by exception, South Yorkshire Police be appointed as a member of the Health and Wellbeing Board.

(2) That a review of the Board's Terms of Reference and membership be undertaken in May, 2014.

(Jason Harwin, South Yorkshire Police, was welcomed to the meeting as a formal Board member.)

S40. MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

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

S41. COMMUNICATIONS

(a) Rotherham Foundation Trust
Dr. Trisha Bain reported that an Interim Chief Executive (Louise Barnett) had been recruited and would be taking up the appointment on 18th November, 2013. A Deputy Chief Executive had also been recruited.

(b) British Heart Foundation
Councillor Wyatt reported receipt of a letter from Simon Gillespie, Chief Executive, British Heart Foundation, offering support towards Rotherham's application for the Local Government Chronicle Award in the category of Public-Public Partnerships, for the strong partnership Rotherham had created for the Heart Town.

Resolved:- That a copy of the letter be circulated to all members of the Board.

S42. HEALTH AND WELLBEING BOARD SELF-ASSESSMENT

Kate Green, Policy Officer, reported on the responses that had been received from Board members to the self-assessment questionnaire.

The report summarised the 13 responses received and outlined the key comments/issues raised which included:-

- Whether members of the public, front line staff and manager understood the Board's governance structure or appreciated the Board's significance
- Clarity required regarding decision making and where the Board fit within certain Service areas
- The breadth of the membership and effective collaborative working were particular strengths of the Rotherham Board
- There were good examples of integrated working but a need to share commissioning and budget plans to ensure alignment of priorities and spending
- Positive work in key areas but no evidence as yet of any significant changes being made
- Consideration should be given to the frequency of meetings and the contents of the agendas to allow focus on key priorities
- Providers were able to make significant contributions to the work of the Board and were often key to the delivery of the Strategy

Discussion ensued on the responses received:-

- The Chair had now limited the number of presentations to be made at a Board meeting. Presentations would be made if a decision was required or guidance on the direction of travel; other presentations would be sent electronically to enable members to consider the information prior to a meeting and issues arising included on the next Board agenda

- Consideration given to presenting issues differently

- Neighbouring Boards met bi-monthly with the intervening month being a workshop style meeting

- Sharper focus on performance management

- More time required for focussed debate. A lot of time was spent analysing problems but now needed to look at solutions

Resolved:- That consideration be given to the points made above with regard to the style and content of future meetings.

S43. HEALTH AND WELLBEING BOARD - ANNUAL REPORT

Kate Green, Policy Officer, submitted an update on the 6 strategic outcomes of the Health and Wellbeing Strategy. Each workstream lead had attended a Board meeting to present their action plan and progress.

The report provided an overview of progress on key actions and future challenges. The Board was requested to consider how it wished to receive future progress reports and any necessary actions required to ensure workstream leads achieved their outcomes.

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

- Workstream 1 – Prevention and Early Intervention
  There was a comprehensive refresh of the Obesity Framework and contracts. Consideration was being given to streamlining the pathways to make it much more effective

- Workstream 2 – Expectations and Aspirations
  There had been a small amount of funding identified. If there were any areas of work that required small amounts of funds for projects how could a workstream lead take that forward?

- How were the workstreams to be performance managed?

Resolved:- (1) That the progress made on each of the workstreams be noted.

(2) That the membership of the Health and Wellbeing Steering Group be reviewed and consideration given to the inclusion of NHS England, RDaSH and VAR.

S44. JOINT STRATEGIC NEEDS ASSESSMENT REFRESH

Chrissy Wright, Strategic Commissioning Manager, submitted a report setting out the progress to date to achieve the refresh of the Joint Strategic Needs Assessment by early 2014. The refreshed document must now include user's perspectives and a Directory of Assets which includes community assets, physical infrastructure, networks and individuals and as such would meet the latest Government guidance on JSNA content.

An online format was proposed including a breakdown of information across separate pages within the website and links to further information (Rotherham.gov.uk/jsna). In due course, there would be an opportunity for users to register with the site for updates and when new information was published and content was refreshed. This would also provide a mechanism for monitoring and evaluation of the impact of the JSNA across the Borough.

The refresh had included work to extend the content of the JSNA including:-

- Roma population needs analysis
- Women's health
- LGBT needs analysis
- Eye Health
- Domestic Abuse

A presentation was given of the online format.

Discussion ensued on the report:-

- The Board needed to agree a point in time that all partners could base their commissioning/spending plans for 2014/15

- The online facility was a requirement of the Guidance

- The importance of the JSNA was to give a position in time, however, what happened beyond that time was even more important and why there needed to be a mechanism for challenging and appraisal of future planning. Partners could then co-ordinate better on forward planning groups and what could be done to challenge the provision and ascertain if the best options were being utilised

- Canklow was proposed as the pilot area for the development of an asset register where all individual community assets would be mapped and evaluated before branching out across the Borough

- Consultation on the refresh document was a requirement, not just with stakeholders but also with the public

Resolved:- (1) That the progress made in achieving a refresh of the JSNA be noted.

(2) That all partners commit to being full participants in the ongoing development of the document.

(3) That all partners be informed as soon as possible as to what information was required to populate the JSNA to enable it to be submitted to the 18th December Board meeting so as to fit with partner organisations' deadlines for submission of their 2014/15 commissioning/spending plans.

(4) That consultation upon the refreshed document commence in early 2014.

S45. PERFORMANCE MANAGEMENT FRAMEWORK

Consideration was given to a report, presented by the Director of Public Health, containing the second formal performance report to the Health and Wellbeing Board about each of the six priority measures that the Board determined were key to the delivery of the Joint Health and Wellbeing Strategy. Performance details in respect of each one of the priority measures were included in the submitted report.

Discussion took place on the report including:-

- The Planning Service's request for the Board's view with regard to fast food outlets near schools/within deprived areas

- Inclusion in the report of why certain Priorities were not meeting their outcomes

Resolved:- (1) That the report be received and its contents noted.

(2) That the Planning Service be informed of the Board's 6 Priorities.

(3) That the performance report format in future include analysis of failing to meet outcomes particularly in comparison with statistical neighbours and nationally.

S46. SOCIAL CARE SUPPORT GRANT

Dominic Blaydon, Head of Long Term Conditions and Urgent Care, reported on the transfer to the Council of the Social Care Support Grant.

NHS England would transfer £481M for 2013/14 to the Authority via an agreement under Section 256 of the 2006 NHS Act. The agreement would be administered by the NHS England Area Team and would only pass over to the Authority once the agreement had been signed by both parties.

The Grant must be used to support Adult Social Care Services that delivered a health benefit. The Guidance required NHS England to ensure that the Local Authority agreed with its local health partners on how the funding was best used. Health and Wellbeing Boards would be the forum for discussions between the Area Teams, CCGs and local authorities on how the funding should be spent. It would also be a condition of the transfer that the local authority and RCCG had regard to the Joint Strategic Needs Assessment for their local population.

It was proposed that the funding focus on:-

- Additional short term residential care places or respite and intermediate care
- Increased capacity for Home Care Support, investment in equipment, adaptations and telecare
- Investment in Crisis Response Teams and Preventative Services to avoid hospital admission
- Further investment in Reablement Services to help regain their independence.

Resolved (1) That the programme of expenditure as set out in the Appendix submitted be approved.

(2) That the development of a light touch performance framework for the Grant be approved.

S47. HEALTHWATCH ROTHERHAM OUTCOMES FRAMEWORK AND WORK PLAN

Claire Burton, Operational Commissioner, submitted a report on the Outcomes Framework and work plan for Healthwatch Rotherham.

Parkwood Healthcare Ltd. had been awarded the Healthwatch Rotherham contract which commenced on 1st April, 2013. Contract monitoring arrangements had been established including an outcomes framework which required performance against the outcomes to be achieved, as detailed within the contract, to be monitored and reported against on a monthly basis.

The work plan detailed the specific pieces of work that Healthwatch would undertake, or contribute to, in line with their role. It was based upon the Health and Wellbeing Strategy priorities as well as local intelligence gathered with regard to health and social care services in Rotherham.

There was capacity within the work plan for Healthwatch to respond to the number of ever increasing enquiries/issues from members of the public or to undertake specific consultation with members of the public as determined appropriate.

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

- Volume of monthly reporting required – this was due to Healthwatch being new and the complexities surrounding it. Their database would produce quarterly monitoring reports

- Healthwatch was crucial as the patient voice increased

- Quality assurance was as critical as the Service itself

- Healthwatch was very new and at the time the document had been drawn up the Chair had not been in position. It was recognised, however, that the Healthwatch Manager had been involved in its development. It was a working document and would be reviewed regularly.

Resolved:- (1) That the Outcomes Framework and Work Plan, 1st September, 2013 to 31st March, 2014, for Healthwatch Rotherham be approved.

(2) That exception reports on performance and programme against the Outcomes Framework and Work Plan be submitted as and when necessary.

(3) That liaison take place with the CCG with regard to the possibility of Healthwatch Rotherham setting up an e-mail group that could be used as a feedback facility.

(4) That members of the Board e-mail Naveen Judah with any proposals that Healthwatch could undertake on their behalf.

S48. ANNUAL LOCAL SAFEGUARDING CHILDREN'S BOARD REPORT AND BUSINESS PLAN

The Board received the Rotherham's Local Safeguarding Children Board Annual Report 2012/13 which was was submitted for information.

S49. NUMBER OF GP AND DENTAL PRACTICES IN ROTHERHAM

In accordance with Minute No. S87 of the meeting held on 8th May, 2013, information was submitted regarding the GP and Dental Practices for information.

S50. DATE OF NEXT MEETING

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

Project Initiation Document

Overall Project Name	Development of an Integrated Health, Social Care and Education Service for children with disabilities and/or special educational needs.		
Project Sponsor	Joyce Thacker		
Organisation	RMBC, Children and Young People's Services (CYPS)		
Project Manager	To be appointed		
Organisation	To be confirmed		
Start Date	November 2013	**Completion Date**	April 2015

Workstream Project Name	Involving families with children with disabilities or special educational needs in the development of the new integrated SEN service.		
Project Sponsor	Project Manager (to be appointed)/Joyce Thacker		
Project Manager	Naveen Judah, Chair of Healthwatch Rotherham Board		
Organisation	Healthwatch Rotherham		
Start Date	November 2013	**Completion Date**	April 2013 (initial work)

Name	**Role**
Melanie Hall	Project Lead
To be confirmed	Project Officer

Background to the proposed work
The SEND green paper proposes major reforms to the way children and young people with disabilities or identified as having a special educational need are given help. The proposals in the Green Paper are wide-ranging and cover the circumstances of the child with the most complex needs to a young person who is falling behind at school. These proposals are part of a wider set of reforms that will benefit this group of families and their children. By 2014, children and young people who would currently have a statement of SEN or learning difficulty assessment will need a single assessment process and 'Education, Health and Care Plan' for their support from birth to 25 and therefore all the services would work together with the family to agree this which reflects the family's needs and ambitions for the child's future covering education, health, employment and independence. The new service to be developed as part of the overall project will ensure high quality early identification and intervention for all children where they need it, and will provide an effective integrated support for children with a range of, or the most complex of needs. It is expected that this new integrated service will be more accessible to parents and less costly to run with more information being available about the services and expertise available locally. The overall project will build on the work that has already been undertaken in determining the requirements in the SEND green paper. This work stream project will involve a range of staff such as health visitors, staff from early years settings and those currently working with children and young people with special educational needs such as the children's disability team and the portage

service. So the organisations involved include RMBC, CCG, and Public Health.

The project links to the Health and Wellbeing Strategy priorities – starting Well, Developing Well, Living and Working Well and will help tackle in the longer term the issues identified within Ageing and Dying Well.

Background Documents
Children and Families Bill 2013
SEND green paper
Health and Wellbeing Being Strategy 2012-2015

The details of this specific consultation and engagement project are detailed below in the objectives and project scope.

Objectives

These objectives are specific to Healthwatch Rotherham:

1. To work with the overall project manager in developing an integrated health, social care and education service for children and young people with disabilities and/or a special educational needs.

2. To engage with existing services such as SEN Team, Portage Service, Health Visitors, to undertake a desk top exercise of recent consultation with parents and/or children with disabilities and/or special educational needs in Rotherham and determine the key findings and action taken from such consultation (so not to duplicate).

3. To facilitate the involvement of children, young people and their parents/carers in the development of an integrated SEN Service.

4. To undertake consultation with children, young people with disabilities and/or special educational need and their families to influence the development of the new service.

5. By undertaking such consultation HWR will be helping parents shape the new service and contribute to the development and improvement of individual pathways for children and young people with specialist educational needs.

6. HWR to present the findings of the consultation in the form of an evidenced based report with recommendations to the Project Board and to CYPS.

7. The consultation will also enable the overall project to make a judgement about the quality and range of existing information available for parents and the report will make recommendations as to how such information could be improved.

Scope

1. Utilise the existing consultation undertaken by SEN services identifying the key issues and actions taken as a result.

2. Engage with existing SEN parent /carer groups both locally and nationally to determine current issues.

Scope
3. Undertake consultation with children, young people and their parents/carers about the existing SEN Services and obtain their views on:- (a) the current services they receive both good and bad; (b) how existing services can be made better based on their experiences; (c) how helpful the current information provision is and what could be better (c)what gaps there are in the current services. (d) the priorities for the new service that they feel would meet their needs better. 4. Engage where appropriate professionals working with children and young people about their views on the current SEN Services and priorities for the new service. 5. Collate the findings from the engagement/consultation and highlighting key findings, making recommendations for changes / new provision. 6. Feedback to those consulted including how their views have influenced the changes to the service. 7. Report on progress of this project to the overall Project Manager and maintain regular communication.

Deliverables
1. A detailed project plan developed by HWR about the consultation to be undertaken approved by the Project Manager and Sponsor. 2. A report on the key findings of the consultation undertaken and how this can influence the new integrated service.

Business benefits
The new service is shaped by parents and young people. The consultation undertaken is independent from the existing SEN services. Previous consultation undertaken is collated ensuring parents don't suffer from consultation fatigue. Parents and young people are empowered to put their views forward and recognise how they can influence change. Parents feel confident to challenge any poor or dated practice and make recommendations for change. The project will contribute to achieving financial and resource efficiencies in the new service and value for money. All stakeholders contribute to the overall effectiveness of the new integrated service.

Assumptions
Healthwatch Rotherham has the capacity to undertake this project within their existing resources.

Assumptions
Assistance from existing Disability/SEN Services to determine current position and understanding of consultation already undertaken.

Constraints
Timescales for consultation project in the context of the wider project.

Risks
Consultation does not highlight changes required against the green paper requirements. Buy-in from other statutory organisations required eg. Health Services.

Stakeholders

Stakeholder	Interest in project	Governance role	Communication
Service Users SEN	Will be affected by the outcome	Must be kept informed	Participate in consultation
Health and Wellbeing Board	Key level of influence in outcome	Decision making body	Regular update reports through project manager.
Councillor Lakin	Key level of influence in outcome	Must be kept informed. Decision at each stage.	Highlight reports through project manager.
Senior Managers across Health and Social Care	Key level of influence in outcome	Must be kept informed part of developments.	Keep informed of developments
Strategic Commissioning, Manager	Will provide resources/assistance as required	Must be kept informed	Keep informed
Community Engagement Teams	Will support the consultation.	Must be kept informed	Keep informed
RMBC Communication Team	Will support the consultation in relation to publicity	Must be kept informed	Keep informed
CYPS Directorate Leadership Team (DLT)	Findings of the consultation.	Decision making body	Report.

Staff Resources
Project Lead 0.5 days a week for oversight Project Officer 5 days per week Project Officer (commissioning team) 0.5 days a week for support if required

Outline estimates of time and cost
A separate project plan to be developed by HWR.

Publications Gateway Reference No: 00542

4W12
Quarry House
Quarry Hill
Leeds LS2 7UE

To: NHS Commissioners: CCG leaders and NHS England Area Directors

CC: Chief Executives of NHS providers
Chief Executives of upper tier Local Authorities
Chair and Chief Executive of LGA
ALB Chief Executives
Permanent Secretary, Department of Health
NHS England National and Regional Directors

10 October 2013

Dear Colleague

Planning for a sustainable NHS: responding to the 'call to action'

Earlier this year, we published a landmark document: *The NHS belongs to the people – a call to action.* This document sets out the challenges facing the NHS and makes the case for developing bold and ambitious plans for the future. Commissioners have embraced the *call to action* and are leading discussions locally about how the NHS needs to change. Commissioners now face the task of crystallising the conclusions of these discussions into comprehensive plans.

We heard from the NHS Commissioning Assembly last month about the importance of giving early advice to commissioners, so I am writing to set out my assessment of the challenges facing us as commissioners and the key actions that need to be taken. We will be issuing planning guidance later in the year, but I thought it would be helpful to highlight ten key points at this stage:

1. **Improving outcomes** - commissioners need to place improving outcomes for patients at the heart of their work. For that reason, commissioners should prioritise an approach to planning which combines transparency with detailed patient and public participation**.** We need to construct, from the bottom up, quantifiable ambitions for each domain of the NHS Outcomes Framework. We will, therefore, be asking CCGs and NHS England Area Teams to work together to determine local levels of ambition, based on evidence of local patient and public benefit, against a common set of indicators that place our duty to tackle health inequalities front and centre stage. This will ensure that we can clearly articulate the improvements we are aiming to deliver for patients across seven key areas:

- Reducing the number of years of life lost by the people of England from treatable conditions (e.g. including cancer, stroke, heart disease, respiratory disease, liver disease);
- Improving the health related quality of life of the 15 million+ people with one or more long-term conditions;
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital;
- Increasing the proportion of older people living independently at home following discharge from hospital;
- Reducing the proportion of people reporting a very poor experience of inpatient care;
- Reducing the proportion of people reporting a very poor experience of primary care;
- Making significant progress towards eliminating avoidable deaths in our hospitals.

2. **Strategic and operational plans** – given the scale of the challenges we are facing, we are asking commissioners (CCGs and NHS England commissioners) to develop ambitious plans that look forward to the next five years, with the first two years mapped out in the form of detailed operating plans. Taking a five year perspective is crucial, as commissioners need to develop bold and ambitious plans rather than edging forward on an incremental basis one year at a time. It will be essential for commissioners to work closely with providers and social care partners as they develop these plans, and we are in dialogue with the relevant national bodies to define fully aligned planning processes to facilitate this.

3. **Allocations for CCGs**– we want to provide certainty to commissioners. To this end, we intend to notify CCGs of their financial allocations for both 14/15 and 15/16 to help them plan more effectively. We are currently working with a subgroup of the Commissioning Assembly to finalise proposals for future allocation formulae for CCGs and direct commissioning, but stability is a key consideration and the pace of change is likely to be slow, given that we are operating with very limited financial growth overall.

4. **The tariff** – we recognise the importance of stability of tariff as well as its accuracy and responsiveness to the needs of patients. Together with Monitor, we intend to minimise changes to the structure of the tariff for 14/15. By December we plan to jointly publish our priorities for tariff in 15/16, giving commissioners and providers the maximum amount of time to assess any impact on the financial position of their services and respond systematically to tariff signals.

5. **The integration transformation fund** – the financial settlement for 15/16 includes the creation of an integration transformation fund (ITF). This will see the establishment of a pooled budget of £3.8bn, which will be committed at local level with the agreement of Health & Wellbeing Boards. (Locally, CCGs can decide to place additional resources into the ITF if they wish). The ITF is a 'game changer': it creates a substantial ring-fenced budget for investment in out-of-hospital care. However, it will also require us to make savings of over £2bn in existing spending on acute care. This implies an extra productivity gain of 2-3% across the NHS as a whole in 15/16. We will work with Monitor

to determine how this is reflected in the expectations placed on commissioners (in the form of QIPP savings from demand management, pathway change, etc) and providers (in the form of the efficiency deflator incorporated in tariff). We are currently exploring the feasibility of bringing forward an element of the 15/16 saving requirement into 14/15 to avoid a financial 'cliff edge' in 15/16.

6. **Developing integration plans** – the NHS will only be sustainable in 15/16 if we put the ITF to the best possible use and reduce significantly the demand for hospital services. It is my view that investment should be targeted at a range of initiatives to develop out of hospital care, including early intervention, admission avoidance and early hospital discharge - taking advantage, for example, of new collaborative technologies to give patients more control of their care and transform the cost effectiveness of local services. This will require investment in social care and other Local Authority services, primary care services and community health services. We are currently exploring how an accountable clinician can be identified to coordinate the out-of-hospital care of vulnerable older people and the ITF might be used to accelerate this initiative. We will write to you over the next few days (jointly with the Local Government Association) with more details on the process for developing integration plans.

7. **Working together** – a critical ingredient of success for the transformation fund will be the quality of partnership working at local level. Health & Wellbeing Boards will need to have strong governance arrangements for making transparent and evidence-based decisions about the use of the ITF. The Chief Executive of NHS England will remain the accounting officer for the ITF, accountable to parliament for its use, and in that context I am asking NHS England Area Directors to take a close interest in the effectiveness of local arrangements for governance and implementation.

8. **Competition** – there has been considerable discussion about the impact of competition rules on commissioners over recent months. The key requirement for commissioners is to determine how to improve services for patients including how to use integrated care, competition and choice. Commissioners should adopt transparent decision making processes which use competition as a tool for improving quality, rather than as an end in itself. NHS England and Monitor will support commissioners who adopt this approach to competition.

9. **Local innovation** – while we will set a national framework for planning we want to encourage local innovation and don't want to be overly prescriptive. Within the scope of the new tariff rules for 14/15 agreed with Monitor, we will welcome innovative local approaches that enable change to happen on the ground. For example, commissioners could add additional resources to the transformation fund or they could agree local variations to the national tariff in line with the recently published 14/15 national tariff system rules, where they can demonstrate that it is in the interests of patients to do so. Commissioners could explore new contracting models, such as giving acute providers responsibility for patients 30-100 days following discharge from hospital and introducing prime contractor arrangements for integrated care.

10. **Immediate actions** – I would encourage commissioners to focus on three immediate tasks. First, you should progress the development of five year plans and engage local people in this work. Second, you should strengthen your local partnership arrangements so that you are well placed to make decisions about the use of the ITF. Third, you should identify the things that will make the greatest difference to patients locally and maintain a relentless focus on putting them into action at pace.

Over the coming months we will be publishing further material to help commissioners navigate their way through the planning process. This will include detailed planning guidance, financial allocations and 'commissioning for value' packs for CCGs which will help each CCG to identify where there is the greatest opportunity.

We are committed to working in partnership with CCGs, and I would encourage feedback from CCGs via the Commissioning Assembly planning and finance working group chaired by Paul Baumann, NHS England's Chief Financial Officer. More immediately, however, I advise you to press ahead with development of your plans, and I hope the points I have highlighted in this letter will help you make early progress. The challenges facing both commissioners and providers are significant, and it is essential we start to address them without delay.

Yours faithfully

Sir David Nicholson
Chief Executive

17 October 2013

To: CCG Clinical Leads
Health and Wellbeing Board Chairs
Chief Executives of upper tier Local Authorities
Directors of Adult Social Services

cc: CCG Accountable Officers
NHS England Regional and Area Directors

Dear Colleagues

Next Steps on implementing the Integration Transformation Fund

We wrote to you on 8 August 2013 setting out the opportunities presented by the integration transformation fund (ITF) announced in the spending review at the end of June. While a number of policy decisions are still being finalised with ministers, we know that you want early advice on the next steps. This letter therefore gives the best information available at this stage as you plan for the next two years.

Why the fund really matters

Residents and patients need Councils and Clinical Commissioning Groups (CCGs) to deliver on the aims and requirements of the ITF. It is a genuine catalyst to improve services and value for money .The alternative would be indefensible reductions in service volume and quality.

There is a real opportunity to create a shared plan for the totality of health and social care activity and expenditure that will have benefits way beyond the effective use of the mandated pooled fund. We encourage Health and Wellbeing Boards to extend the scope of the plan and pooled budgets.

Changing services and spending patterns will take time. The plan for 2015/16 needs to start in 2014 and form part of a five year strategy for health and care. Accordingly the NHS planning framework will invite CCGs to agree five year strategies, including a two year operational plan that covers the ITF through their Health and Wellbeing Board.

A fully integrated service calls for a step change in our current arrangements to share information, share staff, share money and share risk. There is excellent practice in some areas that needs to be replicated everywhere. The ingredients are the same across England; the recipe for success differs locality by locality.

Integrated Care Pioneers, to be announced shortly, will be valuable in accelerating development of successful approaches. We are collaborating with all the national partners to support accelerated adoption of integrated approaches, and will be launching support programmes and tools later in 2013.

Where does the money come from?

The fund does not in itself address the financial pressures faced by local authorities and CCGs in 2015/16, which remain very challenging. The £3.8bn pool brings together NHS and Local Government resources that are already committed to existing core activity. (The requirements of the fund are likely to significantly exceed existing pooled budget arrangements). Councils and CCGs will, therefore, have to redirect funds from these activities to shared programmes that deliver better outcomes for individuals. This calls for a new shared approach to delivering services and setting priorities, and presents Councils and CCGs, working together through their Health and Wellbeing Board, with an unprecedented opportunity to shape sustainable health and care for the foreseeable future.

Working with providers

It will be essential for CCGs and Local Authorities to engage from the outset with all providers, both NHS and social care, likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. CCGs and Local Authorities should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the fund includes agreement to the service change consequences.

Supporting localities to deliver

We are acutely aware that time is pressing, and that Councils and CCGs need as much certainty as possible about how the detail of the fund will be implemented. Some elements of the ITF are matters of Government policy on which Ministers will make decisions. These will be communicated by Government in the normal way. The Local Government Association and NHS England are working closely together, and collaborating with government officials, to arrive at arrangements that support all localities to make the best possible use of the fund, for the benefit of their residents and patients. In that spirit we have set out in the attached annex our best advice on how the Fund will work and how Councils and CCGs should prepare for it.

The Government has made clear that part of the fund will be linked to performance. We know that there is a lot of interest amongst CCGs and Local Authorities in how this “pay-for-performance” element will work. Ministers have yet to make decisions on this. The types of performance metrics we can use (at least initially) are likely to be largely determined by data that is already available. However, it is important that local discussions are not constrained by what we can measure. The emphasis should be on using the fund as a catalyst for agreeing a joint vision of how integrated

care will improve outcomes for local people and using it to build commitment among local partners for accelerated change.

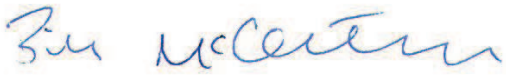
Joint local decision making and planning will be crucial to the delivery of integrated care for people and a more joined up use of resources locally. The ITF is intended to support and encourage delivery of integrated care at scale and pace whilst respecting the autonomy of locally accountable organisations.

This annex to this letter sets out further information on:

- How the pooled fund will be distributed;
- How councils and CCGs will set goals and be rewarded for achieving them;
- Possible changes in the statutory framework to underpin the fund;
- The format of the plans for integrated care and a template to assist localities with drawing up plans that meet the criteria agreed for the fund;
- Definitions of the national conditions that have to be met in order to draw on the polled fund in any locality; and
- Further information on how local authorities, CCGs, NHS England and government departments will be assured on the effective delivery of integrated care using the pooled fund.

Leads from the NHS and Local Government will be identified to assist us to work with Councils and CCGs to support implementation. More details on this can be found in the annex. We will issue a monthly bulletin to Councils and CCGs with updates on the Integration Transformation Fund.

Yours faithfully



Carolyn Downs
Chief Executive
Local Government Association

Bill McCarthy
National Director: Policy
NHS England

NHS England Publications Gateway Ref. No.00535

Annex

Advice on the Integration Transformation Fund

What is included in the ITF and what does it cover?

Details of the ITF Fund

The June 2013 SR set out the following:	
2014/15	2015/16
An additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned	£3.8bn pooled budget to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the ITF will be created from the following:
£1.9bn NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. Composed of:
• £130m Carers' Breaks funding
• £300m CCG reablement funding
• £354m capital funding (including c.£220m of Disabled Facilities Grant)
• £1.1bn existing transfer from health to social care

1. The Integration Transformation Fund will be £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users. In 2014/15 an additional £200m transfer from the NHS to social care in addition to the £900m transfer already planned will enable localities to prepare for the full ITF in 2015/16.

2. In 2014/15 use of pooled budgets remains consistent with the guidance[1] from the Department of Health to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with this:

3. *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*

4. *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

discussions between the Board, clinical commissioning groups and local authorities on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.

5. *In line with our responsibilities under the Health and Social Care Act, NHS England is also making it a condition of the transfer that local authorities and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*

6. *NHS England is also making it a condition of the transfer that local authorities demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

7. In 2015/16 The fund will be allocated to local areas, where it will be put into pooled budgets under joint governance between CCGs and local authorities. A condition on accessing the money in the fund is that CCGs and local authorities must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

How will the ITF be distributed?

8. Councils will receive their detailed funding allocation following the Autumn Statement in the normal way. When allocations are made and announced later this year, they will be two-year allocations for 2014/15 and 2015/16 to enable planning.

9. In 2014/15 the existing £900m s.256 transfer to Local Authorities for social care to benefit health, and the additional £200m will be distributed using the same formula as at present.

10. The formula for distribution of the full £3.8bn fund in 2015/16 will be subject to ministerial decisions in the coming weeks.

11. In total each Health and Wellbeing Board area will receive a notification of its share of the pooled fund for 2014/15 and 2015/6 based on the aggregate of these allocation mechanisms to be determined by ministers. The allocation letter will also specify the amount that is included in the pay-for-performance element, and is therefore contingent in part on planning and performance in 2014/5 and in part on achieving specified goals in 2015/6.

How will Councils and CCGs be rewarded for meeting goals?

12. The Spending Review agreed that £1bn of the £3.8bn would be linked to achieving outcomes.

13. In summary 50% of the pay-for-performance element will be paid at the beginning of 2015/16, contingent on the Health and Wellbeing Board adopting a plan that

meets the national conditions by April 2014, and on the basis of 2014/15 performance. The remaining 50% will be paid in the second half of the year and could be based on in-year performance. We are still agreeing the detail of how this will work, including for any locally agreed measures.

14. In practice there is a very limited choice of national measures that can be used in 2015/6 because it must be possible to baseline them in 2014/5 and therefore they need to be collected now with sufficient regularity and rigour. For simplicity we want to keep the number of measures small and, while the exact measures are still to be determined, the areas under consideration include:

    - Delayed transfers of care;
    - Emergency admissions;
    - Effectiveness of re-ablement;
    - Admissions to residential and nursing care;
    - Patient and service user experience.

15. In future we would hope to have better indicators that focus on outcomes for individuals and we are working with Government to develop such measures. These can be introduced after 2016/7 as the approach develops and subject to the usual consultation and testing.

16. When levels of ambition are set it will be clear how much money localities will receive for different levels of performance. In the event that the agreed levels of performance are not achieved, there will be a process of peer review, facilitated by NHS England and the LGA, to avoid large financial penalties which could impact on the quality of service provided to local people. The funding will remain allocated for the benefit of local patients and residents and the arrangements for commissioning services will be reconsidered.

Does the fund require a change in statutory framework?

17. The Department of Health is considering what legislation may be necessary to establish the Integrated Transformation Fund, including arrangements to create the pooled budgets and the payment for performance framework. Government officials are exploring options for laying any required legislation in the Care Bill. Further details will be made available in due course. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected and will be helpful in taking this work forward.

How should councils and CCGs develop and agree a joint plan for the fund?

18. Each upper tier Health and Wellbeing Board will sign off the plan for its constituent local authorities and CCGs. The specific priorities and performance goals are clearly a matter for each locality but it will be valuable to be able to:

    - Aggregate the ambitions set for the fund across all Health and Wellbeing Boards;

- Assure that the national conditions have been achieved; and

- Understand the performance goals and payment regimes have been agreed in each area.

19. To assist Health and Wellbeing Boards we have developed a draft template which we expect everyone to use in developing, agreeing and publishing their integration plan. This is attached as a separate Excel spread sheet.

20. The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the ITF. We strongly encourage Councils and CCGs to make immediate use of this template while awaiting further guidance on NHS planning and financial allocations.

21. Local areas will be asked to provide an agreed shared risk register, with agreed risk sharing and mitigation covering, as a minimum, steps that will be taken if activity volumes do not change as planned. For example if emergency admissions increase or nursing home admissions increase.

What are the National Conditions?

22. The Spending Review established six national conditions:

National Condition	Definition
Plans to be jointly agreed	The Integration Plan covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and Local Authorities should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.
Protection for social care services (not spending)	Local areas must include an explanation of how local social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 2 to 6,

National Condition	Definition
	above.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The forthcoming national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England will provide guidance on establishing effective 7-day services within existing resources.
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas will be asked to: • confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing open APIs (ie. systems that speak to each other); and • ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas, and will make this available alongside the planning template. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health).

National Condition	Definition
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas will be asked to identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning.
Agreement on the consequential impact of changes in the acute sector	Local areas will be asked to identify, provider-by-provider, what the impact will be in their local area. Assurance will also be sought on public and patient engagement in this planning, as well as plans for political buy-in.

How will preparation and plans be assured?

23. Ministers will wish to be assured that the ITF is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

24. To maximise our collective capacity to achieve these outcomes and deliver sustainable services we will have a shared approach to supporting local areas and assuring plans. This process will be aligned as closely as possible to the existing NHS planning rounds, and CCGs can work with their Area Teams to develop their ITF plans alongside their other planning requirements.

25. We will establish in each region a lead local authority Chief Executive who will work with the Area and Regional Teams, Councils, ADASS branches, DPHs and other interested parties to identify how Health and Wellbeing Boards can support one another and work collaboratively to develop good local plans and delivery arrangements.

26. Where issues are identified, these will be shared locally for resolution and also nationally through the Health Transformation Task Group hosted by LGA, so that the national partners can broker advice, guidance and support to local Health and Well Being Boards, and link the ITF planning to other national programmes including the Health and Care Integration Pioneers and the Health and Well Being Board Peer Challenge programme. We will have a first review of readiness in early November 2013.

27. We will ask Health and Well Being Boards to return the completed planning template (draft attached) by 15 February 2014, so that we can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the ITF.

Publications Gateway Reference No: 00658

To: CCG Clinical Leads
CCG Accountable Officers
Chief Executives of NHS Trusts
Chief Executives of NHS Foundation Trusts
Chief Executives of Local Authorities
Directors of Adult Social Services
CSU Managing Directors

cc: NHS England Regional and Area Directors
Monitor Regional Directors
NHS TDA Directors of Delivery and Development

1 November 2013

Dear Colleagues

Strategic and operational planning in the NHS

The NHS faces an unprecedented level of future pressure. This is the definitive conclusion of the recent 'Call to Action' and 'Closing the Gap' reports issued by NHS England and Monitor respectively, which warns of substantial impending challenges driven by an ageing population; increase in long-term conditions; and rising costs and public expectations within a challenging financial environment.

In order to respond to these significant challenges the NHS is likely to have to change; all parties - CCGs, foundation and non-foundation trusts - need to play a leading role. They must develop and implement bold and transformative long-term strategies and plans for their services, otherwise many will become financially unsustainable and the safety and quality of patient care will decline.

This long-term transformation will only be achieved through our commitment to create a fully integrated service between the NHS and local government. NHS England and the Local Government Association have recently written to outline the next steps for implementing the £3.8bn Integration Transformation Fund for 2015/16, which will have significant implications for commissioners and providers alike. But changing services and spending patterns will take time. The plan for 2015/16 needs to start in 2014 and form part of a five year strategy for health and care. This is why Health and Wellbeing Boards must also play a leading role in developing local strategic plans and why the LGA is a co-signatory of this letter.

All four bodies, NHS England, NHS Trust Development Authority, Monitor and LGA consider robust planning to be of paramount importance to both providers and commissioners. Robust plans should be coherent long term strategic plans,

underpinned by medium-term detailed operational plans that are consistent in their intentions across local health economies and are developed applying consistent ground rules as articulated in national policy e.g. standard national contract and Payment by Results. Given the scale of the challenges we are facing, we are moving away from incremental one year planning and instead asking bodies to develop bold and ambitious plans which cover the next five years, with the first two years mapped out in the form of detailed operating plans. This is crucial to enabling us to take a longer term, strategic perspective of the direction of travel across the health and social care landscape.

We recognise it is our role and responsibility to provide the right framework for this to happen. We have recently engaged with a range of stakeholders to understand the needs of the sector. We have heard the importance of making the planning process as rigorous and consistent as possible, to ensure alignment and agreement to the key dates across all parties and to release information and guidance as early as possible.

We have taken this feedback on board and we have taken, or will take, the following actions:

- provide draft guidance now as to the process and expectations (as set out in Appendix 1) and full guidance in December, including a joint set of assumptions agreed by all parties;
- align our respective timelines in regards to the planning process. The detail of this joint timetable is set out in appendix 2;
- each body is revisiting their own process to consider how these can be adapted to better facilitate operational and strategic planning; and
- further support will be provided and this will be communicated separately by each body as appropriate.

The initial guidance gives some of detail of the planning process so that commissioners, providers and local authorities know the expectations of them and can start working together over the coming months before final guidance is issued in December.

Sir David Nicholson	**David Bennett**	**David Flory CBE**	**Carolyn Downs**
Chief Executive	Chair and Chief	Chief Executive	Chief Executive
NHS England	Executive	NHS Trust Development	Local Government
	Monitor	Authority	Association

Appendix 1: Initial guidance – key objectives of planning process and changes made

1. **Improving outcomes –** improved outcomes must be at the heart of the strategic and operational planning process. All bodies should prioritise an approach to planning which combines transparency with detailed patient and public participation.

   We need to construct, from the bottom up, quantifiable and deliverable ambitions for each domain of the NHS Outcomes Framework. We will, therefore, be asking providers and commissioners to work together to determine local levels of ambition, based on evidence of local patient and public benefit, against a common set of indicators.

   Setting levels of ambition against the NHS Outcomes Framework is intended to galvanise the whole commissioning system around a clear and common purpose, aligning the development of our long term strategy and the *Call to Action* with the development of our 5 year strategic and 2 year operating plans and allowing us to articulate the improvements we are collectively aiming to deliver for patients across the seven ambitions.

2. **Quality, Expectations and Sustainability –** while we want the five year plans to reflect local need and be ambitious we are keen to ensure that actions are taken as early as possible in order to deliver the maximum benefit over the period. With that in mind we shall expect more granular detail covering the first two years that set out the measures that will be used to demonstrate progress against improving outcomes while delivering patients' rights and pledges under the NHS Constitution and operating with robust financial control.

3. **Joint assumptions –** a number of planning assumptions are included under the relevant headings in this document, and further joint planning assumptions will be published in December. NHS England, Monitor and the NHS TDA also have planning expectations that relate to the organisations which each of us oversee and these are set out in Appendix 3.

4. **Tariff –** Monitor and NHS England plan to publish the 2014/15 tariff in December.

   The 2014/15 tariff guidance has been strengthened to confirm that where a Trust is being reimbursed at less than 100% of the national tariff, both the provider and commissioner will be jointly engaged in the reinvestment decision. The scope of this improved arrangement includes the non-payment for emergency readmissions and the marginal rate emergency tariff and we would expect to see plans that demonstrate how this funding has been transparently re-invested in appropriate demand management and improved discharge schemes.

5. **Allocations –** we will be able to notify CCGs of their financial allocations for both 14/15 and 15/16 in the week commencing 16 December and will also provide broad assumptions regarding allocations for years 3 – 5 to the same timescale.

6. **Efficiencies**

	2014/15	2015/16 – 2019/20
Efficiencies -	4.0%*	Published in December

* Subject to consultation

7. **Cost Inflation**

	2014/15	2015/16 – 2019/20
Weighted average cost inflation	2.1%*	Published in December

* Subject to consultation

8. **Price deflation – tariff**

	2014/15	2015/16 – 2019/20
Average tariff deflation	1.9%*	Published in December

* Subject to consultation

Any further forward guidance provided in December will be indicative only and will not represent a commitment to future tariff pricing beyond 2014/15, which will be subject to consultation in future years.

9. **CQUIN –** NHS England is refreshing the CQUIN scheme and associated guidance for 2014/2015. It is proposed that the final CQUIN scheme will be agreed and published in December 2013.

10. **Integration Transformation Fund –** the Local Government Association and NHS England published further guidance on 17 October 2013 on how CCGs and councils should work together to develop their plans for the pooling of £3.8 billion of funding, announced by the Government in the June spending round, to ensure a transformation in integrated health and social care.

    The 'Integration Transformation Fund' is a single pooled budget to support health and social care services to work more closely together in local areas. The publication provides further advice, ahead of the formal planning guidance in December, on how the Fund will operate. The publication also includes a draft plan submission template.

    Whilst the fund itself does not address the financial pressures faced by local authorities and CCGs, it can act as a catalyst for developing a new shared approach to delivering services and setting priorities.

    It is essential, therefore, that CCGs and Local Authorities engage from the outset with all providers likely to be affected by the use of the Integration Transformation Fund so that plans are developed in a way that achieves the best outcomes for

local people. Commissioner and provider plans should have a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. CCGs and Local Authorities should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services.

This new shared approach to delivering services needs to be reflected in the planning units chosen for the development of 5 year strategic plans.

11. **Joint working –** it will be essential for all health (commissioners and providers) and social care practitioners to work together with other partners to develop locally owned and agreed plans. We expect the shape of size of planning units to depend on local arrangements, but all relevant parties should be included and national coverage is required.

    To support mutual working between commissioners and providers, we expect local organisations to share their own assumptions with each other. For commissioners, this will mean ensuring plans reflect the local Health and Wellbeing Strategy and have been discussed with providers. Providers will need to be satisfied that their plans reflect the commissioning intentions of CCGs and NHS England's Area Teams.

12. **Unit of planning –** as CCG sizes and local configurations differ, a larger unit of planning is required for the development of consistent and integrated long-term strategic plans**.** Each statutory body (CCG, Trust, FT) must produce its own operational plan that reflects the wider strategic plan. For the five year strategic plans CCGs will work with Trusts and local government to identify and communicate the larger footprint within which they will sit. The guidance is that each CCG should only sit in one larger footprint. This unit of planning will consist of at least one CCG and CCGs will contribute to a larger footprint where one CCG is too small. CCGs will be required to nominate their choice of planning unit to NHS England by 8 November 2013 through Area Team Directors of Operations and Delivery.

    Table 1 – unit of planning guidance

Each commissioner is asked to cast its strategic plan in a wider footprint that meets the following characteristics:
• each CCG to belong to one unit only; • the unit has been locally agreed and has clear clinical ownership and leadership; • it is based on existing health economies that reflect patient flows across Health & Wellbeing Board(s) and local provider footprints with no CCG to be split across boundaries; • it includes significant local trusts (e.g. where CCG spend is > 25%) and some trusts may participate in more than 1 unit of planning;

• it has sufficient scale to deliver geography wide clinical improvements; • it enables the pooling of resources to reduce risk associated with large investments; • it does not cut across existing locally agreed collaboration agreements; and • engagement has been secured from Local Authorities.
The Integration Transformation Fund will need to be identified within each plan so that the CCG can identify its contribution to the amount and approach to be agreed by its Health & Wellbeing Board(s).

13. **Support –** we recognise that producing fully integrated and assured strategic plans is a challenging task and to support this programme NHS England, NHS TDA, Monitor and LGA are exploring the possibility of a joint approach to support packages.

14. **Proposed assurance / challenge process –** the assurance processes used in the 2013/14 planning will be enhanced. For 2014/15 planning we are including an additional step to ensure that commissioner and provider plans are aligned by reconciling activity and revenue figures between CCGs, foundation and non-foundation trusts. The assurance on alignment will be conducted jointly between NHS England, Monitor, NHS TDA and LGA. Please note that every step will be taken not to prejudice the position of any provider or commissioner, no information will be shared without first contacting the appropriate party. This exercise is to highlight risk where parties within the local health economy are planning on a directional inconsistent basis.

15. **Further guidance –** further detailed guidance will be issued in December 2013 and will be tailored to providers and commissioners respectively.

Appendix 2: Key dates

Key dates – NHS England

Planning Units received from CCGs	8 November 2013
Final guidance, templates and tools issued	w/c 16 December 2013
Allocations issued	w/c 16 December 2013
1st Submission	14 February 2014
Contracts signed	28 February 2014
Refresh of plan post contract sign off	5 March 2014
Dispute resolution for 2014/15 with NHS TDA	From 5 March 2014
Plans approved by Boards	31 March 2014
Submission of final 2 year plans and draft 5 year	4 April 2014
Submission of final 5 year plans • Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014	20 June 2014

Key dates – Monitor

Final guidance, templates and tools issued	w/c 16 December 2013
Planned publication date of the 2014/15 National tariff Payment System (subject to the outcome of a statutory consultation process)	December 2013
Contracts signed	28 February 2014
Submission of final 2 year plans	4 April 2014
Submission of final 5 year plans • Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014	20 June 2014

Key dates – NHS TDA

Final Guidance, templates and tools issued	w/c 16 December 2013
Initial, high level plans	13 January 2014
Contracts signed	28 February 2014
Full plan collection	5 March 2014
Dispute resolution for 2014/15 with NHSE	From 5 March 2014
Plans approved by Boards	31 March 2014
Submission of final 2 year plans	4 April 2014
Submission of 5 year LTFMs and IBPs • Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014	20 June 2014

Key dates – LGA

HWBs to return completed template on the ITF	15 February 2014

Appendix 3: Assumptions

Further guidance to commissioners on the feasibility of bringing forward an element of the 15/16 saving requirement into 14/15 to avoid a financial 'cliff edge' in 15/16, in order to fund strategic change, will be given by December.

Table 2 – NHS England specific assumptions

CCGs	
Demographic growth	Local determination using ONS age profiled weighted population projections
Non-demographic growth	Local determination based on historic analysis and evidence.
Price inflation - prescribing	Local determination - would expect this to be in a range of 4% to 7% per annum increase
Price inflation – continuing health care	Local determination - would expect this to be in a range of 2% to 5% per annum increase
Business rules	• Minimum 0.5% contingency fund held • 1% surplus carry forward • 2% underlying surplus • 2% non-recurrent spend • Local determination of impact of ITF on plans
Primary care	
Demographic growth	Local determination based on resident population in line with crude population projections
Price increase	1.3% per annum increase
Business rules	• Minimum 0.5% contingency fund held • 1% surplus carry forward • 2% underlying surplus • 2% non-recurrent spend
Direct commissioning (excluding Primary Care and Public Health)	
Demographic growth	Local determination using ONS age profiled weighted population projections for population covered by Area Teams
Non-demographic growth	Local determination based on historic analysis and evidence
Business rules	• Minimum 0.5% contingency fund held • 1% surplus carry forward • 2% underlying surplus • 2% non-recurrent spend

Public health	
Demographic growth	Local determination using ONS age profiled weighted population projections for population covered by Area Teams
Price increase	0% per annum increase
Business rules	• Minimum 0.5% contingency fund held • 0% surplus carry forward • 0% underlying surplus • 0% non-recurrent spend

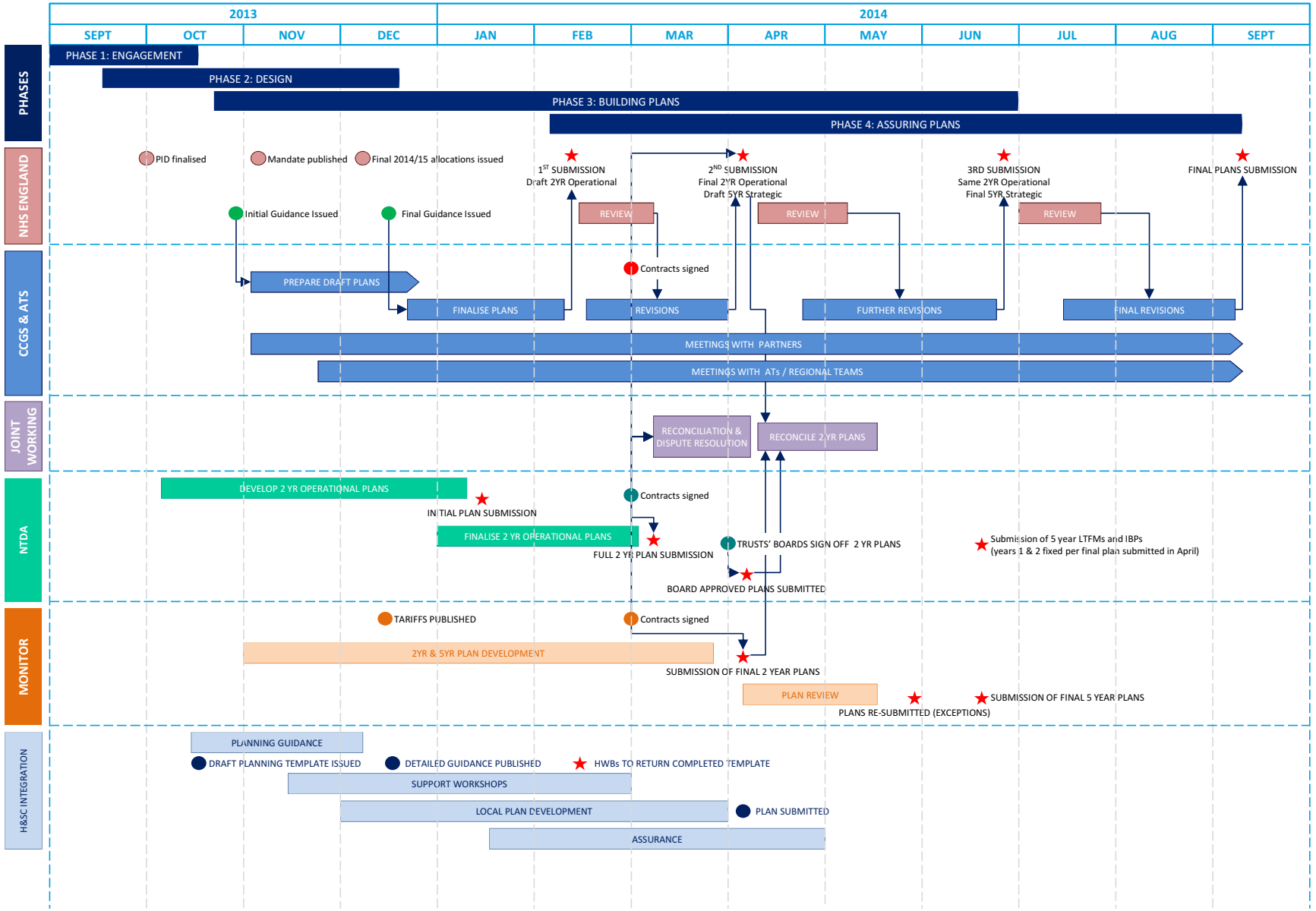
Table 3 – NHS TDA specific assumptions

Business Rules	• Minimum 0.5% contingency fund held • 1% surplus requirement or for those NHS Trusts in formal recovery the planned outturn should be consistent with the recovery plan signed off by the NHS TDA

Table 4 – Monitor specific assumptions

Business rules	Monitor does not require foundation trusts to deliver a surplus. The provider licence requires foundation trusts to have regard to the desirability of maintaining an acceptable continuity of service risk rating. In practice, a lower risk rating will prompt Monitor to ask whether there is a risk to the continuity of services. Where foundation trusts plan for a lower risk rating, they should explain their rationale to Monitor.

Appendix 4 - Joint Timeline



Integration Transformation Fund

Draft Plan Submission Template

Local Authority	<Name of Local Authority>
Clinical Commissioning Groups	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
Boundary Differences	<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>
Date agreed at Health and Well-Being Board:	<dd/mm/yyyy>
Date submitted:	<dd/mm/yyyy>
Minimum required value of ITF pooled budget: 2014/15	£0.00
2015/16	£0.00
Total agreed value of pooled budget: 2014/15	£0.00
2015/16	£0.00

Authorisation and Sign Off

Signed on behalf of the Clinical Commissioning Group	<Name of ccg>
By	<Name of Signatory>
Position	<Job Title>
date	<date>

Signed on behalf of the Clinical Commissioning Group	
By	<Name of Signatory>
Position	<Job Title>
date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Local Authority	
By	<Name of Signatory>
Position	<Job Title>
date	<date>

Signed on behalf of the Health & Wellbeing Board	
By Chair of the HWB:	<Name of Signatory>
Position	<Job Title>
date	<date>

Service provider engagement

Please describe how health and social care providers have been involved in the development of this pla, and the extent to which they are party to it

Patient, service user and public engagement

Please describe how patients, services users and the public have been involved in the development of this plan, and the extent to which they are party to it

Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition

Vision for Health and Care Services

##

Integration Aims & Objectives

##

Description of Planned Changes

##

Implications for the Acute Sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

National Conditions

1 Protecting social care services

Please outline your agreed local definition of protecting social care services.

Please explain how local social care services will be protected within your plans.

2 7-day services to support discharge

##########

3 Data-sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please confirm that you are commited to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK))

##########

4 Joint-assessments and accountable lead professional

##########

Outcomes and metrics

Please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Outcome measures- Examples only	Current Baseline (as at….)	14/15 Projected delivery (full year?)	15/16 Projected delivery (full year?)
Delayed transfers of care			
Emergency admissions			
Effectiveness of reablement			
Admissions to residential and nursing care			
Patient and service-user experience			
<Local measure>			
<Local measure>			
<Local measure>			

Finance

Please summarize the total health and care spend for each commissioner in your area. Please

Organisation	2013/14 spend	2013/14 benefits	2014/15 spend	2014/15 benefits	2015/16 spend	
Local Authority Social Services						
CCG						
Primary Care						
Specialised commissioning						
Local Authority Public Health						
Total						

Please summarize where your pooled budget will be spent. NB the total must be equal to or more than your total ITF allocation

ITF Investment	2014/15 spend	2014/15 benefits	2015/16 spend	2015/16 benefits
Scheme 1				
Scheme 2				
Scheme 3				
Scheme 4				
Scheme 5				
Total				

Approximately 25% of the ITF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully		
	Maximum support needed for other		
Outcome 2	Planned savings (if targets fully		
	Maximum support needed for other		

Key Risks

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk Rating	Mitigating Actions
Risk 1		
Risk 2		
Risk 3		
Risk4		

ROTHERHAM BOROUGH COUNCIL – REPORT TO HEALTH AND WELLBEING BOARD

1.	**Meeting**	**Health and Wellbeing Board**
2.	**Date**	**27 November 2013**
3.	**Title**	**Public Health Outcomes Framework**
4.	**Directorate**	**Public Health**

5. Summary

The council has new statutory functions that include health protection and health improvement. Public Health England monitor these responsibilities through the Public Health Outcomes Framework (PHOF). The council's wider responsibilities for population health require a coordinated approach, including partners. The PHOF focuses on the causes of premature mortality. The Rotherham Health and Wellbeing Strategy (HWBS) supports early intervention and prevention as part of improving performance against the PHOF and the key lifestyle factors that influence avoidable mortality. The Outcomes Framework needs to be reviewed quarterly to drive improvements in performance. Public health will lead this agenda and report to cabinet by exception. Priority measures include those for avoidable mortality, which also features a as key outcome for the Integrated Transformation Fund. Public Health will agree with partners action plans to address under performance. There will be a discussion at the Health and Wellbeing Board where indicators are significantly underperforming; following this a performance clinic will be held with partners to develop a remedial action plan to engage action by partners. The emphasis of the performance clinics will be on innovation and doing things differently to drive improvement and change. This should align with the operation of the Integrated Transformation Fund.

The actions will refocus activity on early intervention and prevention agenda for long term and sustainable impact. The report provides a framework for this process and an initial progress report

6. Recommendations

- **To review and agree the proposed framework to address under performance**
- **To review and agree the reporting structures**
- **To support the mechanism to deliver the HWBS aim of moving to the prevention and early intervention.**

7. Proposals and details

In November 2012 the Public Health Outcomes Framework, improving outcomes and supporting transparency was released (Department of Health, 2012a).

The framework focused on the two high-level outcomes, which were intended to be achieved across the public health system and beyond. These two outcomes are:

1. Increased healthy life expectancy.
2. Reduced differences in life expectancy and healthy life expectancy between communities.

There are 66 indicators identified, that are grouped into four domains to deliver the two high level outcomes:

- improving the wider determinants of health (19)
- health improvement (24)
- health protection (7)
- healthcare public health and preventing premature mortality (16)

To improve the two high level outcomes will require the collective efforts from all parts of the public health system, and across public services and wider society. The framework focuses on the respective role of local government, the NHS and Public Health England, and their delivery of improved health and wellbeing outcomes for the people and communities they serve. It requires a robust partnership approach, which includes identifying leadership for each indicator.

The performance framework has a clear link to the Health and Wellbeing Strategy and the Integrated Health and Social Care Fund (IHSCF). The effectiveness of the local management of the IHSCF will be judged against impact on avoidable mortality as measured in the PHOF.

We propose public health work with key partners to address areas of under performance. This approach is aimed to be clear and transparent to all partners, to help the RMBC performance team with the development of the management and accountability structure for the indicator sets. In Appendix 1 the table outlines the performance management lead and where there are cross overs with the current performance management of social care and children's services (boxes shaded in grey).

The current performance against the England average has highlighted several areas where there is under performance and a downward trend. This information is shown in Appendix 2. There needs to be an agreed reporting structure to ensure performance is monitored effectively.

The wide range of indicators requires feedback to a range of Directorate Leadership Teams in RMBC. The DLT teams will receive exceptions reports will be submitted are highlighted on Appendix 1. There will be a comprehensive monitoring process initiated tor those outcomes off track, including performance clinics to review change. This process will be directed by multiagency the Health and Wellbeing Steering group. The performance clinic will involve all the key partners and will use the

Friedman (2009) outcome based accountability approach to develop remedial actions which will make long term sustainable change. There will be a strong focus on addressing the prevention and early intervention opportunities within the remedial action plan to make long term impact (see appendix 3). It is recognised that population based indicators are slow and challenging to change. The PHOF should be used to drive forwards the priorities in the Health and Wellbeing Strategy.

Commentary on Public Health Outcomes – Current Performance by domain:

1. **Improving the Wider Determinants**

    - The children in poverty outcome has old data – needs reviewing
    - Safer Rotherham partnership need to consider the link between high admission rates for violent crime and the apparently low crime rates in Rotherham.

2. **Health Improvement**

    - Breastfeeding rates are poor and smoking at delivery remains high. Both indicators impact on the health of mother and infant including long term issues such as school performance and obesity.
    - Hospital admissions on unintentional injury needs to be reviewed.
    - The number adults who are inactive and/or smoke continues to be high.
    - Performance is poor on diabetic retinopathy screening.
    - Self-reported measures for wellbeing as a mental health and wellbeing indicators appears to be low.
    - Injuries to older people from falls are a concern.

3. **Health Protection**

    - Rotherham has high rates of chlamydia infection which results in infertility.
    - HPV vaccination uptake needs to be improved.
    - The completion of TB treatment remain low.

4. **Healthcare Public Health**

    - The position on infant mortality is good considering the performance on breastfeeding and smoking at delivery

- Under 75s mortality for all the avoidable causes (except liver disease are significantly above the national average
- Emergency admissions and readmissions are a continuing problem
- Preventable sight loss is a concern.

All of the above issues will be subject to an action plan to explore the reasons for under performance and identify measurable outputs. Some may also require a performance clinic.

8. Finance

There will be some activity funded by the Public Health budget, however many of the wider determinant elements will be funded by a range of partner organisations and from other Directorates within the Council. There will be opportunities for Integrated Health and Social Care Fund to be delivering prevention activity which addresses avoidable mortality outcomes which is a key objective of the Fund.

9. Risks and uncertainties

There are currently a number of new indicators which have new data collection methods being developed. The full outline of the indicators is available in the Public Health Outcomes Framework, Improving outcomes and supporting transparency Part 2 document (Department of Health 2012b)

10. Policy and Performance Agenda Implications

The framework will deliver the ambitions of the Health and wellbeing Strategy and the Public Health White paper, Healthy Lives Healthy People: Our strategy for public health in England.

Regional and national comparisons can be found on http://www.phoutcomes.info/

11. Background Papers and Consultation

Department of Health (November 2012a) Improving outcomes and supporting transparency: Part 1A Public Health Outcomes Framework for England 2013 -16. HMSO: London

Department of Health (November 2012b) Improving outcomes and supporting transparency: Part 2 – summary technical specifications of public health indicators. HMSO: London

Friedman, M. (2009). Trying hard is not good enough: How to produce measurable improvements for customers and communities. FPSI Publishing: Charleston.

12. Keywords: Performance framework, Outcomes, Public Health, Early Intervention and Prevention

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Appendix 1 – Public Health Outcome – PH leads, Partners and reporting structure

Appendix 2 – Public Health Outcomes Framework Scorecard – October 2013

Appendix 3 – Performance Clinic Framework

Appendix 4 - Friedman (2009) Performance Management Effort and Effect Matrix

Appendix 1: Public Health Outcomes Framework – PH leads, Partners and reporting structure

Domain	Indicator	Reported to	Partner organisations	Public Health lead
Improving wider determinants of health	Health and Wellbeing – Prevention and Early Intervention			John Radford (with the support of Public Health Specialists)
Improving the wider determinants of health	Children in Poverty	CYPS	RMBC CYPS CVS Schools Job Centre	
	School readiness	CYPS	RMBC CYPS Schools RFT (HV/SN)	
	Pupil Absence	CYPS (monitored and managed by SW team)	RMBC CYPS RFT (HV/SN) Schools GPs	
	First Time Entrants Into Youth Justice System	CYPS (monitored and managed by SW team)	SY Police RMBC IYSS RDaSH	
	16-18 NEETS	CYPS (monitored and managed by SW team)	RMBC IYSS Job Centre plus	
	People with mental illness or disability in settled accommodation	NAS (in ASCOF monitored and managed by DR team)	RMBC NAS RDaSH CCG Job Centre	
	People in prison who have a mental illness	NAS	RMBC CCG RDaSH SY Police	
	Employment for those with LT health conditions including those with learning difficulties/disability or mental illness	NAS (in ASCOF monitored and managed by DR team)	CCG RMBC NAS Job centre RDaSH	
	Sickness absence rate	Resources NAS	All partners	
	Killed or seriously	EDS	RMBC EDS	

Domain	Indicator	Reported to	Partner organisations	Public Health lead
	injured casualties on England's roads		SY Police Schools	
	Domestic abuse	NAS	RMBC NAS SY Police All Health partners CVS	
	Violent crime (including sexual violence)	NAS	RMBC PH SY Police RFT CCG	
	Re-offending	NAS	SY Police RMBC NAS	
	The percentage of the population affected by noise	NAS	RMBC NAS	
	Statutory homelessness	NAS	RMBC NAS CVS	
	Utilisation of green spaces for exercise/health reasons	EDS	RMBC EDS RMBC NAS CVS	
	Fuel poverty	EDS	RMBC EDS RMBC NAS CVS	
	Social connectedness	NAS (in ASCOF monitored and managed by DR team)	RMBC NAS CVS	
	Older people's perception of community safety	NAS (in ASCOF monitored and managed by DR team)	RMBC NAS SY Police	

Domain	Indicator	Reported to	Partner organisations	Public Health lead
Health Improvement	Health and Wellbeing – healthy lifestyles			Joanna Saunders (with the support of Public Health Specialists)
Health Improvement	Low birth weight of term babies	CYPS	RMBC CYPS RMBC NAS CCG RFT	
	Breastfeeding	CYPS (monitored by SW team – performance managed by PH)	RMBC CYPS RMBC NAS CCG RFT	
	Smoking status at time of delivery	CYPS	RMBC CYPS RMBC NAS CCG RFT	
	Under 18 conceptions	CYPS	RMBC CYPS RMBC NAS CCG RFT	
	Child development at 2-2.5 years	CYPS	RMBC CYPS RMBC NAS CCG RFT	
	Excess weight at 4-5 and 10-11 year olds	CYPS (monitored by SW team – performance managed by PH)	RMBC CYPS RMBC NAS CCG RFT	
	Hospital admissions caused by unintentional and deliberate injuries in under 18s	CYPS	RMBC CYPS RDaSH CCG RFT	
	Emotional wellbeing of LAC	CYPS	RMBC CYPS RMBC NAS CCG RFT	
	Smoking prevalence – 15 year olds	CYPS	RMBC CYPS RMBC NAS RMBC EDS Schools	
	Hospital admissions as a result of self-harm	CYPS	RMBC CYPS RMBC NAS CCG RFT RDaSH	
	Diet	CYPS	RMBC NAS	

Domain	Indicator	Reported to	Partner organisations	Public Health lead
		NAS	RMBC CYPS CVS	
	Excess weight in adults	NAS	RMBC NAS CCG RFT Weight Management Providers	
	Proportion of physically active and inactive adults	EDS	RMBC EDS RMBC NAS CVS DC Leisure	
	Smoking prevalence – adult (over 18s)	NAS	RMBC NAS Stop Smoking services	
	Successful completion of drug treatment	NAS	RMBC NAS Drug treatment providers	
	People entering prison with substance dependence issues who are previously not known to community treatment	NAS	RMBC NAS Prison Serrvice	
	Recorded diabetes	NAS	RMBC NASA CCG RFT GP Practices	
	Alcohol related hospital admissions	NAS	RMBC NAS RFT	
	Cancer diagnosed at Stage 1 and 2	NAS	RMBC RFT	
	Cancer screening coverage	NAS	RMBC NAS NHS England RFT	
	Access to non-cancer screening programmes	NAS	RMBC NAS NHS England RFT	
	Take up of the NHS Health Check Programme	NAS	RMBC NAS GP Practices	
	Self-reported wellbeing	NAS	RMBC NAS	
	Falls and injuries in the over 65s	NAS	RMBC NAS CCG RFT – Falls	

Domain	Indicator	Reported to	Partner organisations	Public Health lead
			service RMBC EDS Providers	

Domain	Indicator	Reported to	Partner organisations	Public Health lead / contact
Health Protection	Health and Wellbeing – Prevention and early intervention			Jo Abbott (with the support of Public Health Specialists)
Health Protection	Air pollution	EDS NAS	RMBC EDS RMBC NAS	
	Chlamydia diagnoses (15-24 year olds)	CYPS	RMBC CYPS RFT Schools	
	Population vaccination coverage	NAS	RMBC NAS NHS England PH England CCG	
	People presenting with HIV at a late stage of infection	NAS	RMBC NAS CCG RFT GP Providers	
	Treatment completion for tuberculosis	NAS	RMBC NAS CCG RFT	
	Public sector organisations with board approved sustainable development management plan	EDS	All partners	
	Comprehensive agreed interagency plans for responding to public health incidents	NAS EDS	RMBC NAS RMBC EDS RFT CCG	

Domain	Indicator	Reported to	Partner organisations	Public Health lead / contact
Healthcare public health and preventing premature mortality	Health and Wellbeing – Long term conditions			Nagpal Hoysal (with the support of Public Health Specialists)
Healthcare public health and preventing premature mortality	Infant Mortality	CYPS	RMBC CYPS RMBC NAS RFT CCG	
	Tooth decay in children aged 5	CYPS	RMBC CYPS RMBC NAS RFT	
	Mortality from causes considered preventable	NAS	RMBC NAS RFT CCG	
	Mortality from all cardiovascular diseases (including heart disease and stroke)	NAS	RMBC NAS RFT CCG	
	Mortality from cancer	NAS	RMBC NAS RFT CCG	
	Mortality from liver disease	NAS	RMBC NAS RFT CCG	
	Mortality from respiratory diseases	NAS	RMBC NAS RFT CCG	
	Mortality from communicable diseases	NAS	RMBC NAS RFT CCG	
	Excess under 75 mortality in adults with serious mental illness	NAS	RMBC NAS RFT CCG	
	Suicide	NAS CYPS	RMBC NAS RMBC CYPS RFT CCG SY Police CVS (Samaritans)	
	Emergency admissions within 30 days of discharge from hospital	NAS	RMBC NAS RFT CCG	
	Health related quality of life for older people	NAS	RMBC NAS RFT CCG	

Domain	Indicator	Reported to	Partner organisations	Public Health lead / contact
	Hip fractures in over 65s	NAS	RMBC NAS RFT CCG	
	Excess winter deaths	EDS NAS	RMBC NAS RFT CCG	
	Dementia and its impacts	NAS	RMBC NAS RFT CCG RDaSH CVS	

Appendix 2 – Public Health Outcomes Framework scorecard – October 2013

Public Health Outcomes

Report date:	28-Oct-13		**Position Key:**		Better		**Trend key:**		Improving	
					Average				Stable	
					Worse				Worsening	
					Not compared					

Indicator	Time Period	Value	Lower CI	Upper CI	Count	Denominator	Sex	Age	Position	Trend
1.01 - Children in poverty	2010	23.14	22.77	23.51	11480.00	49610.00	Persons	<16 yrs		
1.03 - Pupil absence	2011/12	5.57	5.34	5.81	616514.00	11065292.00	Persons	5-15 yrs		
1.04i - First time entrants to the youth justice system	2012	434.88	356.08	521.72	110.97	25517.00	Persons	10-17 yrs		
1.05 - 16-18 year olds not in education employment or training	2012	7.40	6.94	7.98	730.00	9802.33	Persons	16-18 yrs		
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	2011/12	76.40			545.00	715.00	Persons	18-64 yrs		
1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation	2010/11	63.40			620.00	980.00	Persons	18-69 yrs		
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	2012	6.00					Persons	16-64 yrs		
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	2011/12	61.30					Persons	18-64 yrs		
1.09i - Sickness absence - The percentage of employees who had at least one day off in the previous week	2009 - 11	2.92	2.13	3.98		1367.00	Persons	16+ yrs		
1.09ii - Sickness absence - The percent of working days lost due to sickness absence	2009 - 11	2.34	1.71	3.19		5612.00	Persons	16+ yrs		
1.10 - Killed and seriously injured casualties on England's roads	2009 - 11	30.75	26.96	34.93	237.00	770679.00	Persons	All ages		
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	2009/10 - 11/12	86.93	80.08	94.20	603.00	763069.00	Persons	All ages		
1.12ii - Violent crime (including sexual violence) - violence offences	2011/12	8.95	8.58	9.32	2278.00	254600.00	Persons	All ages		
1.13i - Re-offending levels - percentage of offenders who re-offend	2010	25.79	24.23	27.41	746.00	2893.00	Persons	All ages		
1.13ii - Re-offending levels - average number of re-offences per offender	2010	.65	.62	.68	1885.00	2893.00	Persons	All ages		
1.14i - The percentage of the population affected by noise - Number of complaints about noise	2011/12	8.71	8.35	9.08	2245.00	257716.00	Persons	All ages		
1.15i - Statutory homelessness - homelessness acceptances	2011/12	1.10	.91	1.32	117.00	106000.00	Undefined	Undefined		
1.15ii - Statutory homelessness - households in temporary accommodation	2011/12	.32	.22	.45	34.00	106000.00	Persons	All ages		
1.16 - Utilisation of outdoor space for exercise/health reasons	Mar 2009 - Feb 2012	13.70	7.76	19.63			Persons	16+ yrs		
1.18i - Social Isolation: % of adult social care users who have as much social contact as they would like	2011/12	41.80	38.20	45.40		595.00	Persons	18+ yrs		

Public Health Outcomes

Report date:	28-Oct-13		**Position Key:**		Better		**Trend key:**		Improving	
					Average				Stable	
					Worse				Worsening	
					Not compared					

Indicator	Time Period	Value	Lower CI	Upper CI	Count	Denominator	Sex	Age	Position	Trend
2.01 - Low birth weight of term babies	2010	3.32	2.74	4.03	99.00	2978.00	Persons	>=37 weeks gestational age at birth		
2.02i - Breastfeeding - Breastfeeding initiation	2011/12	61.46	59.68	63.21	1794.00	2919.00	Female	All ages		
2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	2011/12	30.20	28.58	31.86	911.00	3017.00	Persons	6-8 weeks		
2.03 - Smoking status at time of delivery	2010/11	22.36	20.89	23.90	659.00	2947.00	Female	All ages		
2.04 - Under 18 conceptions	2011	40.91	35.45	46.98	201.00	4913.00	Female	<18 yrs		
2.06i - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2011/12	16.10	14.84	17.44	494.00	3068.00	Persons	4-5 yrs		
2.06ii - Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2011/12	33.03	31.29	34.81	902.00	2731.00	Persons	10-11 yrs		
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2011/12	130.68	120.45	141.55	602.00	46066.00	Persons	<15 yrs		
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2011/12	157.88	144.33	172.36	499.00	31606.00	Persons	15-24 yrs		
2.08 - Emotional well-being of looked after children	2011/12	15.30				175.00	Persons	4-16		
2.13i - Percentage of physically active and inactive adults - active adults	2012	52.38	47.58	57.18		416.00	Persons	16+ yrs		
2.13ii - Percentage of active and inactive adults - inactive adults	2012	33.57	29.03	38.11		416.00	Persons	16+ yrs		
2.14 - Smoking prevalence - adults (over 18s)	2011/12	23.31	21.21	25.40		1563.00	Persons	18+ yrs		
2.15i - Successful completion of drug treatment - opiate users	2011	7.85	6.47	9.49	96.00	1223.00	Persons	18-75 yrs		
2.15ii - Successful completion of drug treatment - non-opiate users	2011	50.48	43.77	57.17	106.00	210.00	Persons	18-75 yrs		
2.17 - Recorded diabetes	2011/12	6.21	6.10	6.31	12715.00	204899.00	Persons	17+ yrs		
2.20i - Cancer screening coverage - breast cancer	2012	80.83	80.37	81.29	22854.00	28273.00	Female	53-70 yrs		
2.20ii - Cancer screening coverage - cervical cancer	2012	77.48	77.15	77.80	49536.00	63934.00	Female	25-64 yrs		
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy	2011/12	66.65	65.72	67.57	6660.00	9992.00	Persons	12+ yrs		
2.22i - Take up of NHS Health Check Programme by those eligible - health check offered	2012/13	17.87	17.60	18.14	13694.00	76637.00	Persons	40-74 yrs		
2.22ii - Take up of NHS Health Check programme by those eligible - health check take up	2012/13	51.60	50.76	52.44	7066.00	13694.00	Persons	40-74 yrs		
2.23i - Self-reported well-being - people with a low satisfaction score	2011/12	26.09	24.29	27.89		3681.00	Persons	16+ yrs		
2.23ii - Self-reported well-being - people with a low worthwhile score	2011/12	21.13	19.44	22.82		3657.00	Persons	16+ yrs		
2.23iii - Self-reported well-being - people with a low happiness score	2011/12	31.33	29.36	33.30		3681.00	Persons	16+ yrs		
2.23iv - Self-reported well-being - people with a high anxiety score	2011/12	42.27	40.21	44.33		3657.00	Persons	16+ yrs		
2.24i - Injuries due to falls in people aged 65 and over (Persons)	2011/12	1833.17	1717.42	1954.36	1039.00	45130.00	Persons	65+ yrs		
2.24i - Injuries due to falls in people aged 65 and over (males/females)	2011/12	1409.12	1251.17	1581.36	293.00	20085.00	Male	65+ yrs		
2.24i - Injuries due to falls in people aged 65 and over (males/females)	2011/12	2257.22	2090.51	2433.23	746.00	25045.00	Female	65+ yrs		
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79	2011/12	996.46	894.52	1106.77	353.00	33513.00	Persons	65-79 yrs		
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+	2011/12	5598.37	5163.89	6058.12	686.00	11617.00	Persons	80+ yrs		

Public Health Outcomes

Report date: 28-Oct-13

Position Key: Better; Average; Worse; Not compared

Trend key: Improving; Stable; Worsening

Indicator	Time Period	Value	Lower CI	Upper CI	Count	Denominator	Sex	Age	Position	Trend
3.01 - Fraction of mortality attributable to particulate air pollution	2010	5.70					Persons	30+ yrs		
3.02i - Chlamydia diagnoses (15-24 year olds) - Old NCSP data	2011	2554.98	2382.97	2736.13	819.00	32055.00	Persons	15-24 yrs		
3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD	2012	3375.94	3176.39	3584.74	1067.00	31606.00	Persons	15-24 yrs		
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2011/12	96.15	95.41	96.77	2971.00	3090.00	Persons	1 yr		
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2011/12	96.72	96.03	97.29	3004.00	3106.00	Persons	2 yrs		
3.03iv - Population vaccination coverage - MenC	2011/12	95.44	94.64	96.12	2949.00	3090.00	Persons	1 yr		
3.03v - Population vaccination coverage - PCV	2011/12	95.86	95.10	96.51	2962.00	3090.00	Persons	1 yr		
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	2011/12	95.30	94.50	95.99	2960.00	3106.00	Persons	2 yrs		
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years)	2011/12	90.15	89.03	91.17	2692.00	2986.00	Persons	5 yrs		
3.03vii - Population vaccination coverage - PCV booster	2011/12	93.75	92.85	94.55	2912.00	3106.00	Persons	2 yrs		
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	2011/12	92.92	91.96	93.77	2886.00	3106.00	Persons	2 yrs		
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	2011/12	93.50	92.56	94.33	2792.00	2986.00	Persons	5 yrs		
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	2011/12	89.48	88.33	90.53	2672.00	2986.00	Persons	5 yrs		
3.03xii - Population vaccination coverage - HPV	2011/12	82.10	80.23	83.84	1422.00	1732.00	Female	12-13 yrs		
3.03xiii - Population vaccination coverage - PPV	2011/12	74.61	74.21	75.02	33013.00	44245.00	Persons	65+ yrs		
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2011/12	76.02	75.62	76.42	33756.00	44402.00	Persons	65+ yrs		
3.03xv - Population vaccination coverage - Flu (at risk individuals)	2011/12	53.62	53.04	54.21	15075.00	28112.00	Persons	6 months-64 yrs		
3.04 - People presenting with HIV at a late stage of infection	2009 - 11	58.62	38.94	76.48	17.00	29.00	Persons	15+ yrs		
3.05i - Treatment completion for TB	2011	78.95	56.67	91.49			Persons	All ages		
3.05ii - Treatment completion for TB - TB incidence	2009 - 11	8.51	5.26	12.85	21.67	254605.00	Persons	All ages		
3.06 - Public sector organisations with a board approved sustainable development management plan	2011/12	100.00			5.00	5.00	Undefined	Undefined		

Public Health Outcomes

Report date: 28-Oct-13

Position Key: Better; Average; Worse; Not compared

Trend key: Improving; Stable; Worsening

Indicator	Time Period	Value	Lower CI	Upper CI	Count	Denominator	Sex	Age	Position	Trend
4.01 - Infant mortality	2009 - 11	4.48	3.23	6.05	42.00	9379.00	Persons	< 1 yr	Average	
4.03 - Mortality rate from causes considered preventable (provisional)	2009 - 11	159.76	151.70	168.12	1529.00	773148.00	Persons	All ages	Worse	
4.04i - Under 75 mortality rate from all cardiovascular diseases (provisional)	2009 - 11	72.02	66.53	77.84	652.49	711417.00	Persons	<75 yrs	Worse	
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (provisional)	2009 - 11	51.24	46.68	56.13	474.00	712608.00	Persons	<75 yrs	Worse	
4.05i - Under 75 mortality rate from cancer (provisional)	2009 - 11	124.09	116.89	131.62	1132.00	711417.00	Persons	<75 yrs	Worse	
4.05ii - Under 75 mortality rate from cancer considered preventable (provisional)	2009 - 11	71.18	65.77	76.90	656.00	712608.00	Persons	<75 yrs	Worse	
4.06i - Under 75 mortality rate from liver disease (provisional)	2009 - 11	15.67	13.10	18.60	134.00	712608.00	Persons	<75 yrs	Average	
4.06ii - Under 75 mortality rate from liver disease considered preventable (provisional)	2009 - 11	13.65	11.25	16.41	116.00	712608.00	Persons	<75 yrs	Average	
4.07i - Under 75 mortality rate from respiratory disease (provisional)	2009 - 11	30.39	26.94	34.15	288.00	712608.00	Persons	<75 yrs	Worse	
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (provisional)	2009 - 11	12.39	10.26	14.82	121.00	712608.00	Persons	<75 yrs	Average	
4.08 - Mortality from communicable diseases (provisional)	2009 - 11	39.75	36.42	43.29	572.00	773148.00	Persons	All ages	Worse	
4.10 - Suicide rate (provisional)	2009 - 11	4.27	2.92	6.02	34.00	773148.00	Persons	All ages	Better	
4.11 - Emergency readmissions within 30 days of discharge from hospital	2010/11	12.78	12.41	13.16	4417.00	33255.00	Persons	All ages	Worse	
4.11 - Emergency readmissions within 30 days of discharge from hospital	2010/11	13.58	13.01	14.17	2117.00	15492.00	Male	All ages	Worse	
4.11 - Emergency readmissions within 30 days of discharge from hospital	2010/11	12.07	11.58	12.57	2300.00	17763.00	Female	All ages	Worse	
4.12i - Preventable sight loss - age related macular degeneration (AMD)	2011/12	144.03	111.16	183.58	65.00	45130.00	Persons	65+ yrs	Worse	Worsening
4.12ii - Preventable sight loss - glaucoma	2011/12	12.66	7.38	20.28	17.00	134234.00	Persons	40+ yrs	Average	Improving
4.12iii - Preventable sight loss - diabetic eye disease	2011/12	3.16	1.27	6.52	7.00	221216.00	Persons	12+ yrs	Average	Improving
4.12iv - Preventable sight loss - sight loss certifications	2011/12	58.20	49.26	68.30	150.00	257716.00	Persons	All ages	Worse	Worsening
4.14i - Hip fractures in people aged 65 and over	2011/12	465.86	408.64	528.50	268.00	45130.00	Persons	65+ yrs	Average	Worsening
4.14ii - Hip fractures in people aged 65 and over - aged 65-79	2011/12	213.41	167.85	267.47	76.00	33513.00	Persons	65-79 yrs	Average	Worsening
4.14iii - Hip fractures in people aged 65 and over - aged 80+	2011/12	1601.86	1369.59	1860.42	192.00	11617.00	Persons	80+ yrs	Average	Stable

Appendix 3 – Performance clinic structure and process

Public Health Outcomes that are off target will have a performance clinic to develop an action plan which aims to reverse the current trend. The performance clinic will bring together partners (Commissioners and Providers) to explore advantages and challenges. We will use the Effort and Effect matrix (Appendix 4) along with additional tools from the Friedman (2009) outcome based accountability. This approach should be completed within an hour, creating a robust action plan that ensures efforts result in improved outcomes.
Each indicator will have a current performance assessment and list of preventative activities developed to help the performance clinic develop a robust action plan.

4.3 Mortality from causes considered preventable	
Rationale	Preventable mortality can be defined in terms of causes that are considered to be preventable through individual behaviour or public health measures limiting individual exposure to harmful substances or conditions. Examples include lung cancer, illicit drug use disorders, land transport accidents and certain infectious diseases.
Indicator	**Age-standardised rate of mortality from causes considered preventable per 100,000 population.**
Current performance and trend	Higher than England average Rated – RED by PH England Rotherham 159.76 per 100,000 (2009/11) National 146.1 per 100,000 (2009/11) Rotherham's performance compared to other comparable areas is improving. Doncaster 175.0 per 100,000 (2009/11) Barnsley 167.4 per 100,000 (2009/11) Sheffield 155.3 per 100,000 (2009/11)
Prevention activity	Mental health first Aid Tobacco Control Weight Management Framework Safe alcohol use NHS Health Check programme and lifestyle support Affordable Warmth Strategy Public Health England's Screening programmes Early access to health services Flu vaccination programme 11 Disadvantaged area work
Remedial Actions	To be determined as part of a performance clinic e.g. Make Every Contact Count
Review Date	

Appendix 4: Friedman (2009) Performance Management Effort and Effect Matrix