HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 23rd April, 2014**

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. Questions from the Press and Public

4. Minutes of Previous Meeting (Pages 1 - 9)

5. Communications (Pages 10 - 27)
   - Public Health Commissioning Plan
   - National Child Measurement Data

6. Admiral Nurses

7. Better Care Fund (Pages 28 - 87)

8. Public Health Outcomes Framework (Pages 88 - 105)

9. Health and Wellbeing Board Performance Management Framework (Pages 106 - 116)

10. Director of Public Health Annual Report (Pages 117 - 170)

11. Health and Wellbeing Strategy Refresh Timetable

12. Health and Wellbeing Board Peer Review Challenge

13. Date of Next Meeting
    - Wednesday, 4th June, 2014, commencing at 9.00 a.m.

HEALTH AND WELLBEING BOARD
26th March, 2014

Present:-

Councillor Ken Wyatt	Cabinet Member, Health and Wellbeing **(in the Chair)**
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Councillor John Doyle	Cabinet Member, Adult Social Care
Chris Edwards	Chief Officer, Rotherham CCG
Naveen Judah	Healthwatch Rotherham
Dr. Julie Kitlowski	Rotherham CCG
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families
Dr. David Polkinghorn	GP Executive Member, Rotherham CCG
Dr. John Radford	Director of Public Health
Joyce Thacker	Strategic Director,

Also in Attendance:-

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

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

S83. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

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

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

S84. MINUTES OF PREVIOUS MEETING

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

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

S85. COMMUNICATIONS

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

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

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

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

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

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

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

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

S86. NATIONAL ENERGY ACTION FUEL POVERTY

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

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

What happened?

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

What people said

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

Unintended Outcomes

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

Recommendations for the Health and Wellbeing Board

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

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

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

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

Catherine and Kath were thanked for their presentation.

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

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

S87. BETTER CARE FUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

S88. HEALTHWATCH ROTHERHAM PROGRESS UPDATE

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

The following points were highlighted:-

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

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

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

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

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

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

S89. PROMOTING HEALTH CHECKS

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

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

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

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

Discussion ensued with the following points raised/clarified:-

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

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

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

- The Guidance also contained advice on diet and exercise

- A number of cardiovascular deaths could have been prevented

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

- Statins were not a surrogacy for a lifestyle

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

S90. MENTAL HEALTH AND LEARNING DISABILITY SERVICES - FUNDAMENTAL REVIEW

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

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

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

All reports would be completed by the end of May.

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

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

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

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

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

S91. 2014/15 MEETING DATES AND TIMES

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

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

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

S92. DATE OF NEXT MEETING

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

**ROTHERHAM BOROUGH COUNCIL –
REPORT TO HEALTH AND WELLBEING BOARD**

1.	**Meeting**	**Health and Wellbeing Board**
2.	**Date**	**01/04/2014**
3.	**Title**	**Public Health Commissioning Plan**
4.	**Directorate**	**Public Health**

5. Summary

The purpose of this paper is to set out the local framework for the use of the Public Health Grant to support the Council's statutory functions of health improvement, health protection and healthcare public health advice to the Rotherham Clinical Commissioning Group. The Public Health Grant to Local Authorities needs to be employed to make the most impact on the Public Health Outcomes Framework (PHOF) indicators and the Health and Wellbeing Strategy. This paper sets out the framework for the future delivery of Public Health Services. The paper is split into three areas which outline the commissioned activities, statutory functions and future opportunities. Public Health needs to have a mix of proactive and reactive commissioned activities to make the most impact on Public Health in the short, medium and long term.

6. Recommendations

That the Health and Wellbeing Board notes;

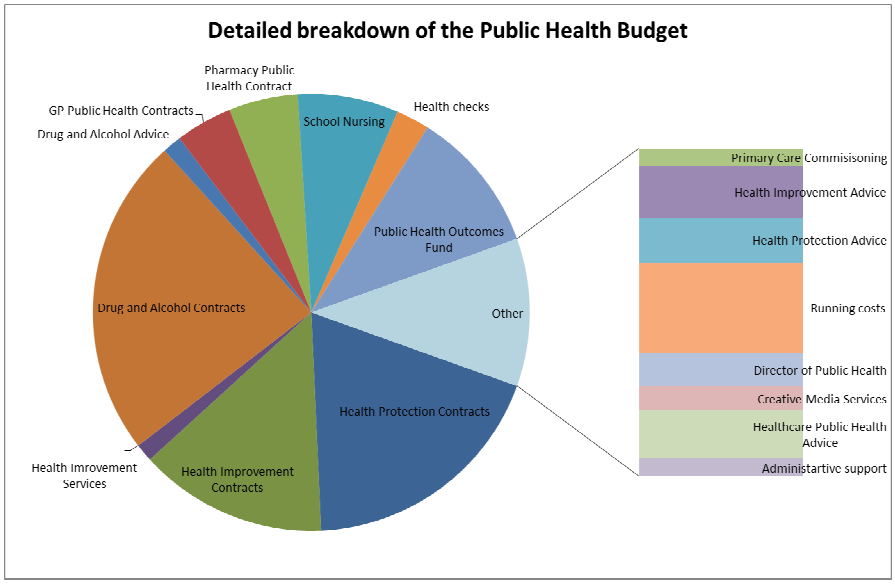
- **the Public Health Commissioning Plan and its proposed impact on the public health priorities and areas for improvement.**
- **the prioritisation of Public Health Outcomes Framework priorities in the reallocation of resources to Council services to deliver improved health for Rotherham people .**

7. Proposals and details

Public Health has reviewed the Commissioned Services and statutory functions as part of our transfer to the Local Authority from April 2013. This has resulted in efficiency savings which are to be reallocated as part of the Public Health Commissioning Plan. The Commissioning Plan will be completed alongside the updated risk register to ensure that all public health activity is coordinated to achieve better health outcomes for the people of Rotherham.

A visual breakdown of Public Health spend is shown in Figure 1.

Figure1:



The structure for Public Health commissioning for 2014 onwards is set out in three ways;

- Delivering the statutory functions
- Commissioned activity
- Delivering the Public Health Outcomes Framework and Health and Wellbeing Strategy

7.1 Delivering the statutory functions

Public Health has three statutory functions which need to be delivered by appropriately trained, qualified and competent public health staff; these are health improvement, health protection and healthcare public health advice to the Rotherham Clinical Commissioning Group through a Memorandum of Understanding (MoU). The MoU includes Creative Media Service support. There is also an additional section on Primary Care Commissioning and Drug and Alcohol Service co-ordination and commissioning.

7.1.1. Health Protection
Health protection provides the coordination, planning and responses to threats and incidents arising from communicable diseases. It includes our infection control lead, the commissioning and service improvement of the sexual health services and adult safeguarding. Value: £210,190.

7.1.2 Healthcare Public Health
Healthcare public health provides public health Intelligence, leadership and technical advice that encompasses quality, clinical effectiveness, support for commissioning, audit and evaluation, service planning, efficiency, clinical governance, support to research governance and sustainable approaches to prioritisation across the healthcare sector. Value: £228,600.

7.1.3 Health Improvement
Health improvement provides the commissioning and service improvement for health promoting healthy behaviours and tackling unhealthy behaviours, e.g. obesity, smoking, physical activity, infant health, mental health and wellbeing. Value: £245,222.

7.1.4 Public Health Services
There are two public facing support services within the Health Improvement statutory function; they are the Health Trainers, Value: £126,500 and the Rotherham Occupational Health Advisory Service (ROHAS), Value: £60,634.
There is also the Creative Media Services team within Public Health which provides advice and creative products for all of the Public Health team and to RCCG. It delivers social marketing support for public health campaigns and manages Rotherham Public Health TV which runs across GP surgeries and health settings. Value: £114,240.

7.1.5 Primary Care Commissioning
We have responsibility for contracting public health activity with 36 GP Practices and 62 Pharmacies. Value: £82,944.

7.1.6 Drugs and Alcohol
We have responsibility for the strategic planning, coordination and delivery of the alcohol and drug prevention and treatment services across Rotherham. This includes rehabilitation of offenders, control of blood borne viruses, needle exchange and supervision of drug and alcohol rehabilitation programmes in General Practice and Community Pharmacies. Value: £200,035.

7.1.7 Public Health Administration Support
Public health administration team provide business support to the team. Value: £82,332

7.1.8 Statutory function costs
The total cost of supporting the statutory functions is £1,294,717 which is 10.63% of the full allocation.

7.2 Commissioned activity

Public health commissioned activity covers a range of mandated local authority services, NHS services and services delivering Health and Wellbeing Strategy priorities. These include; sexual health services, drugs and alcohol services, tobacco control, school nursing, weight management, teenage pregnancy, NHS Healthcheck, school nursing, dental public health, and public mental health. All services have been reviewed and service specifications/contracts reissued or tendered. Rotherham Public Health is keen to develop value for money service specifications to ensure that Rotherham communities have access to quality services.

7.2.1 Commissioned services and programmes (from 2013/14 budget book)

Sexual health

- Specialist Genito-urinary Medicine (GUM) £1,420,000
- Non-contracted activity (Out of area) £120,000
- Contraception and sexual Health (CaSH) £700,000
- Condom distribution £14,000
- Sexual health grants £15,000
- Chlamydia screening £350,000
- HIV Prevention Services £45,000

Tobacco Control

- Stop Smoking Services and tobacco control £815,450

Drugs and Alcohol

- Adult Drug & Alcohol Services (incl criminal justice) £2,606,733

- GP Primary Care drug service £225,000
- Specialist Young People's Drug and Alcohol Service £216,304
- Tier 2 Alcohol Provision (Lifeline) previously NAS £124,000
- Peer support and service user involvement £66,000
- Specialist midwifery service £94,000
- IT in pharmacies NEO £7,000
- Drug Improvement Grants £15,000

Obesity

- Tier 2 Adult weight management £120,000
- Tier 2 Children's weight management £170,000
- Tier 3 Adult and Children weight management £428,000

- Tier 4 children's weight management £76,000

School Nursing

- School Nursing Service £1,056,000

NHS Healthcheck

- NHS Healthcheck £350,000

Oral health promotion

- Oral health promotion £78,000
- Epidemiology £12,500

Teenage pregnancy

- Targeted Youth support (IYSS) £180,000
- Teenage Pregnancy Care pathway Project £43,000

Public mental health

- Mental health promotion £30,000

7.2.2 Primary Care Commissioned Services

There are public health contracts with General Practice and Pharmacies.

- GP Public Health Services include, intrauterine coil fitting, chlamydia testing, long acting contraception, stop smoking, community drug treatment and alcohol screening and treatment. The values of these contracts are £596,000.
- Community Pharmacy Public Health Services include drug programmed and needle exchange, Emergency Hormonal Contraception, and Nicotine Replacement Therapy. This funding covers the costs of the providing and dispensing the products. The values of these contracts are £724,000.
- Primary Care Commissioning also contract of the Chlamydia service and Healthchecks within Primary Care, both valued at £350,000 per service, see 7.2.1.

7.3 Public Health Outcomes Fund

Public Health has a ring fenced budget to deliver public health activities to improve and protect the health of the Rotherham population. Rotherham Public Health budget benchmarks below comparator Local Authorities and has received an uplift of 2.8% which is equivalent to total grant of £54 per head of the population served for 2014/15.

Area	Grant per head 2013/14	Uplift 2014/15	Grant per head 2014/15
Barnsley	58	4.9%	60
Doncaster	65	2.8%	66
Wakefield	61	2.8%	62
Rotherham	**53**	**2.8%**	**54**

The size of the Public Health grant has been set taking account of estimates of baseline spending, including from PCT resources and a fair shares formula based on the recommendations of the Advisory Committee for Resource Allocation.

The proposed £1.5m of savings and uplift will be reallocated to delivering the Public Health Outcomes Framework objectives from April 2014 onwards. We plan to invest the Public Health unallocated grant in services across the Council that contribute to improvements to the Public Health Outcomes Framework, see appendix 2.

It is proposed that identified Council programmes will have simple Service Level Agreements (SLA) developed to ensure that the activity commissioned delivers against the Public Health Outcomes Framework. It is anticipated that this approach will drive improvement by focusing on the Public Health outcomes through service development.

The service level agreements will be performance managed by the Public Health team as part of their strategic programmes of activity in line with the policy agreed by Cabinet on the monitoring of the PHOF. This will ensure that there is a coordinated programme of activity between the three areas of the commissioning plan. The performance management of the SLAs will be aligned to the PHOF to create synergy and avoid duplication.

9. Risks and uncertainties

Applications for funding under the Grant will need to demonstrate they are meeting the statutory public health duties of the Council, the Health and Wellbeing Strategy or improving population health outcomes as measured by the Public Health Outcome Framework. Services will need to demonstrate improvements in PHOF targets to continue to be funded year on year. The level of grant funding for Public Health will influence the amount of funding available for this work.

10. Policy and Performance Agenda Implications

The delivery of the Public Health Commissioning Plan supports 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. It is essential to invest in activities that will promote health within the Rotherham population and prevent ill health.

11. Background Papers and Consultation

- **Public Health Commissioning Intentions 2014 -15**
- **Public health efficiencies**
- **Public health performance – PHOF**

12. Keywords: Savings, Efficiencies, Outcomes, Public health

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Appendix 1: Delivering the Public Health Ouctcomes Framework

Summary

New contributions
(Appendix 2)

Directorate	2013/14	2014/15	Comments
NAS	£0.00	£496,000.00	
CYPS	£67,000.00	£448,000.00	
EDS	£683,000.00	-£100,000.00	minus £100K from 2014/15 for Sports Dev
Total	£750,000.00	£844,000.00	

Existing contributions
(Appendix 3)

Directorate	2013/14	2014/15	Comments
NAS	£164,000.00	£40,000.00	
CYPS	£353,000.00	£15,000.00	
EDS	£0.00	£0.00	

Full contributions

Directorate	2013/14	2014/15	Comments
NAS	£164,000.00	£536,000.00	
CYPS	£420,000.00	£463,000.00	
EDS	£683,000.00	-£100,000.00	
Public Health contribution	£1,267,000.00	£899,000.00	
Total commitment		**£2,166,000.00**	

Appendix 2: RMBC Budget realignment 2013/14 – 2014/15

PH outcome contribution to RMBC

PH Outcome contribution	Value 2013/14	Value 2014/15	SLA value for 2014/15
School readiness (1.02i)	£400,000.00		£400,000.00
Physically active adults (2.13i, 2.13ii)	£147,000.00	-£100,000.00	£47,000.00
Utilisation of outdoor space for exercise /health (1.16)	£41,000.00		£41,000.00
Utilisation of outdoor space for exercise /health (1.16)	£95,000.00		£95,000.00
People presenting with HIV (3.04)		£49,000.00	£49,000.00
Mortality rate from causes considered preventable (4.03)	£8,000.00	£39,000.00	£47,000.00
Domestic abuse (1.11)		£146,000.00	£146,000.00
Successful completion of drug treatment (2.15i, 2.15ii)		£30,000.00	£30,000.00
Successful completion of drug treatment (2.15i, 2.15ii)		£32,000.00	£32,000.00
Injuries due to falls (2.24i) Killed and seriously injured (1.10) Fuel poverty (1.17)		£64,000.00	£64,000.00
Population affected by noise (1.14i)		£50,000.00	£50,000.00
Fraction of mortality attributed to particulate air pollution (3.01)		£80,000.00	£80,000.00
Self-reported wellbeing (2.23 i-iv) Fuel poverty (1.17) Excess winter deaths(4.15)		£20,000.00	£20,000.00
children in poverty (1.01) Infant mortality (4.01), School readiness (1.02i)	£59,000.00	£123,000.00	£182,000.00
16-18 NEETs (1.05)		£70,000.00	£70,000.00
Under 18/16 conceptions (2.04) children in poverty (1.01)		£216,000.00	£216,000.00
Statutory homelessness (1.15)		£25,000.00	£25,000.00
TOTAL	**£750,000.00**	**£844,000.00**	**£1,594,000.00**

Appendix 3: Existing contributions to RMBC services

Service name	Budget code	Directorate	2013/14	2014/15
Healthy Schools		CYPS	£150,000.00	
IYSS Health Grant		CYPS	£180,000.00	
Breast Buddies (peer support)		CYPS	£23,000.00	
Ministry of Food		NAS	£40,000.00	
Lifeline (tier 2 alcohol services)		NAS	£124,000.00	
Trading standards tobacco control		NAS		£40,000.00
Young people's education and prevention activity - tobacco control		CYPS		£15,000.00
Total each year			**£517,000.00**	**£55,000.00**
Total existing contribution				**£572,000.00**

Rotherham Public Health

National Child Measurement Programme data
Update to include 2012/13

Marcus Williamson
Rotherham Public Health
January 2014

Rotherham Metropolitan Borough Council
Where Everyone Matters

Key Findings (2012/13)

Rotherham

The percentage of obese children in Year 6 (21.2%) was over twice that of Reception year children (9.6%). (Charts 1-2, Table 1)

Among Reception year children, the prevalence of overweight pupils (12.6%) was greater than the prevalence of obese (9.6%). In Year 6, the opposite was true with prevalence of overweight children (14.0%) being lower than that of obese children (21.2%). (Charts 1-2, Table 1)

Reception Year

Rotherham percentages by weight category were very similar to England (Chart 2)

Percentages for Rotherham are higher than Yorkshire & Humber, and England for % obese, and higher or the same for % overweight and obese combined.

Rotherham now ranks as 172nd of 324 local authorities for overweight and obese combined (215th for obese alone)

Rotherham percentages are statistically not significantly different to England. (Table 2)

Year 6

Rotherham percentage of obese children was greater than England and the healthy weight percentage lower (Chart 2)

Percentages for Rotherham are higher than Yorkshire & Humber, and England for both % obese and % overweight and obese.

Rotherham now ranks 267 out of 324 local authorities for % obese (significantly higher than England average), and 251st for % overweight and obese combined (not significantly different to England) (Table 2)

Rotherham Public Health
Rotherham Metropolitan Borough Council
C2 Riverside House, Main Street Rotherham S60 1AE
Telephone: 01709 255840 • Email: publichealth@rotherham.gov.uk • Web: rotherhampublichealth.co.uk

Key Findings - Trend

Reception

Percentages for Rotherham for obese and overweight/obese combined increased sharply in 2012/13 to cancel out most of the decrease achieved between 2009/10 and 2011/12. The percentage for overweight and obese combined is now the same as the England average at 22.2% (Charts 1,3)

England overall is showing a small but steady improvement in overweight and obese since 2009/10. (Chart 1,3)

The prevalence of underweight children in Rotherham was increasing up to 2011/12 but fell in 2012/13 to virtually the same level as the England average (Rotherham 0.8%, England 0.9%).

For England overall the prevalence of underweight children has remained around 1.0%. (Chart 1)

Year 6

For Year 6 the prevalence of obesity and overweight combined in Rotherham has fluctuated over the 7 year period. It increased in 2012/13 to 35.2% (from 33.0% in 2011/12). This was made up of an increase of 1.5% in the overweight group and 0.7% in the obese group. The increase in the percentage of overweight in 2012/13 ended the generally decreasing trend since 2007/08. (Chart 1)

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Key Findings – Trend (continued)

Year 6 (continued)

For England the prevalence of overweight and obese combined has increased steadily over the 6 years 2006/07 to 2011/12 from 31.6% to 33.9%. This is based on a fairly static prevalence of overweight children (14.2% to 14.7%) but an increasing level of obese children (17.5% in 2006-07 increasing to 19.2% by 2011/12) However, England overall, has seen a small decrease between 2011/12 and 2012/13 in both the overweight and obese categories (Chart 1)

The prevalence of underweight children fell in Rotherham in 2012/13 to 1.6% after increasing from 1.1% to 2.2% between 2007/08 and 2011/12. For England overall this has remained constant at 1.3%.

Chart 3 highlights how the prevalence of overweight and obese children combined for Year 6 has increased in Rotherham in 2012/13 to above that of England after the encouraging decrease in 2011/12.

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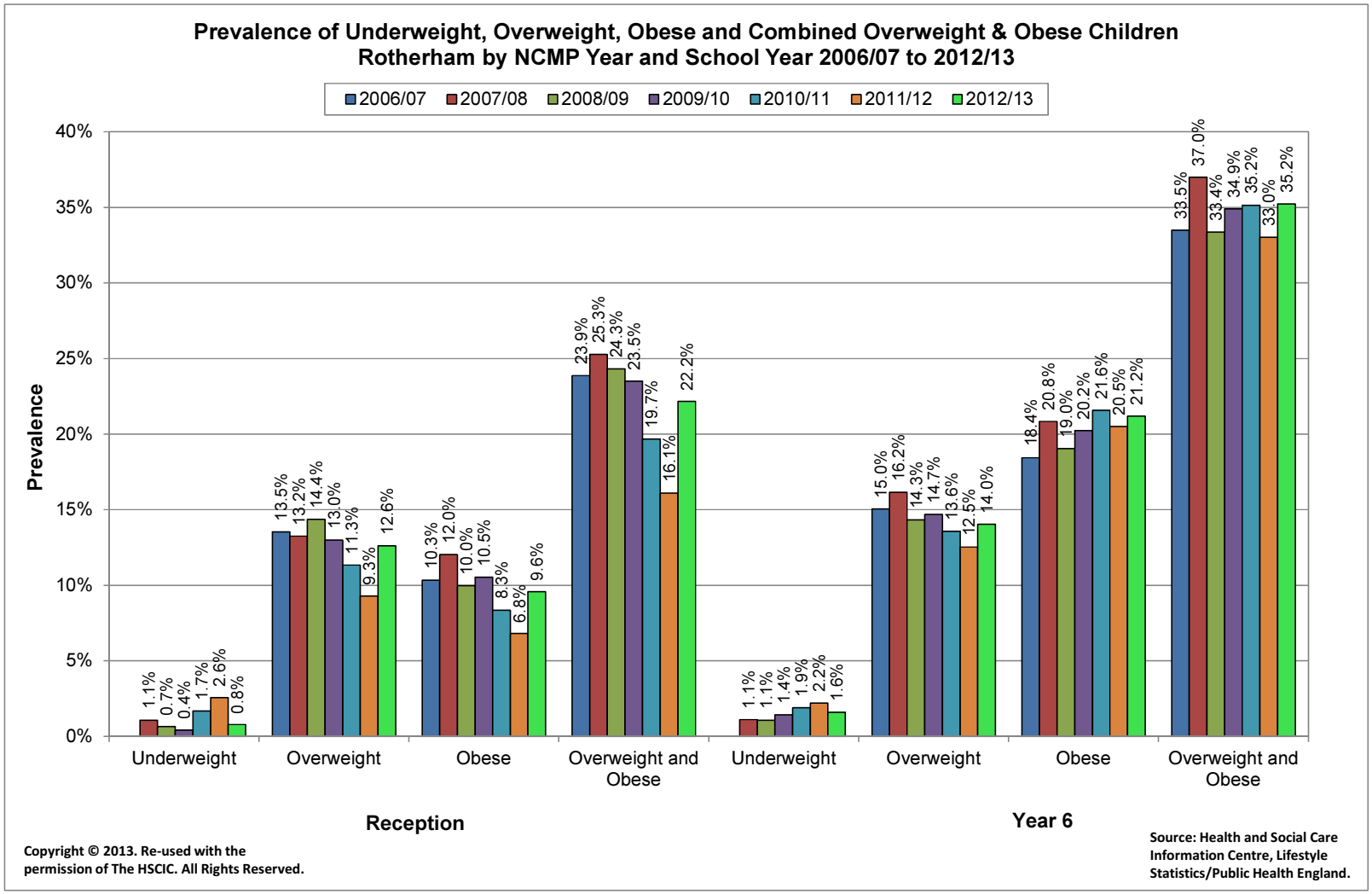

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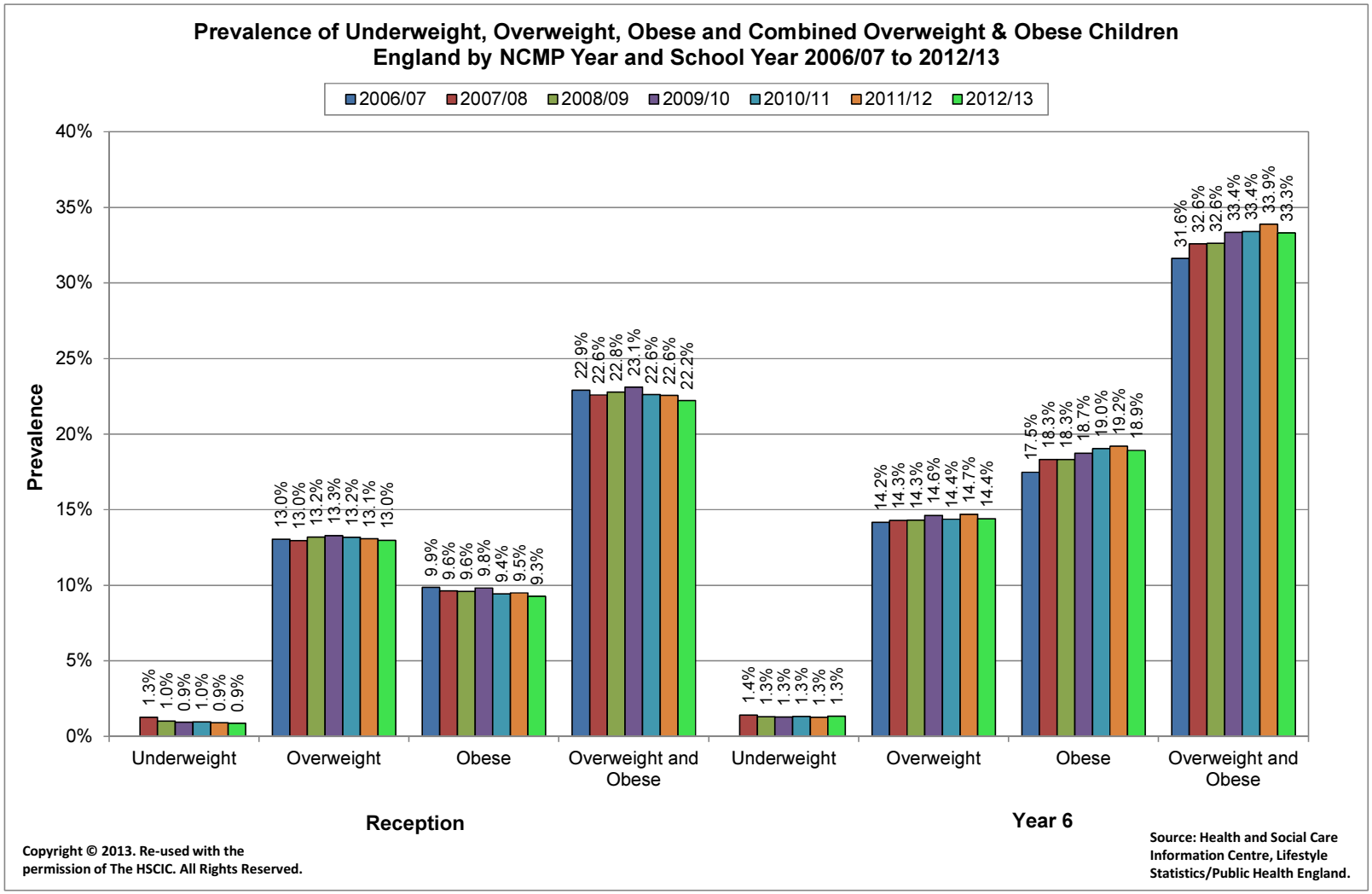

Source: Health and Social Care Information Centre, Lifestyle Statistics/Public Health England.

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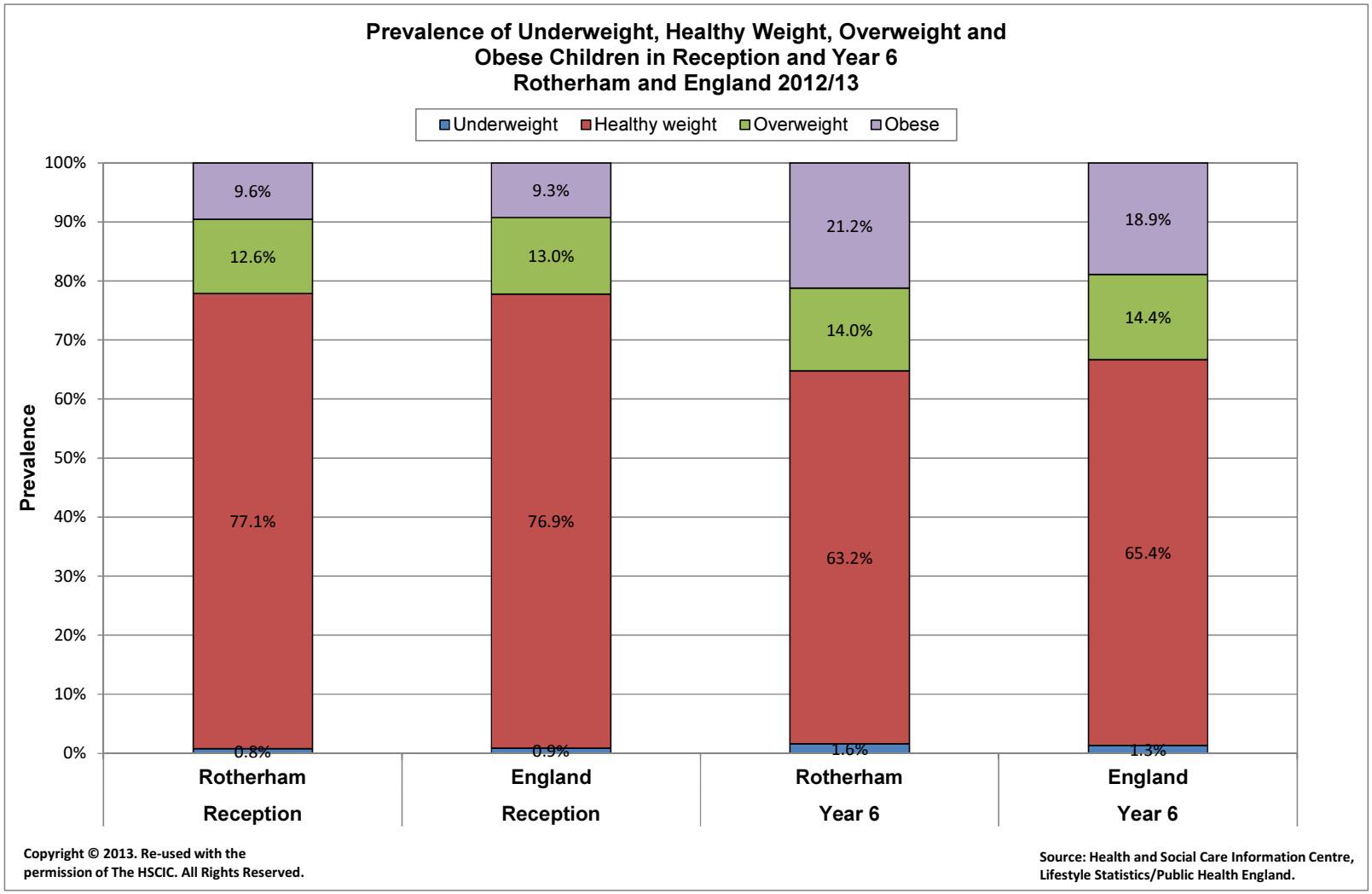

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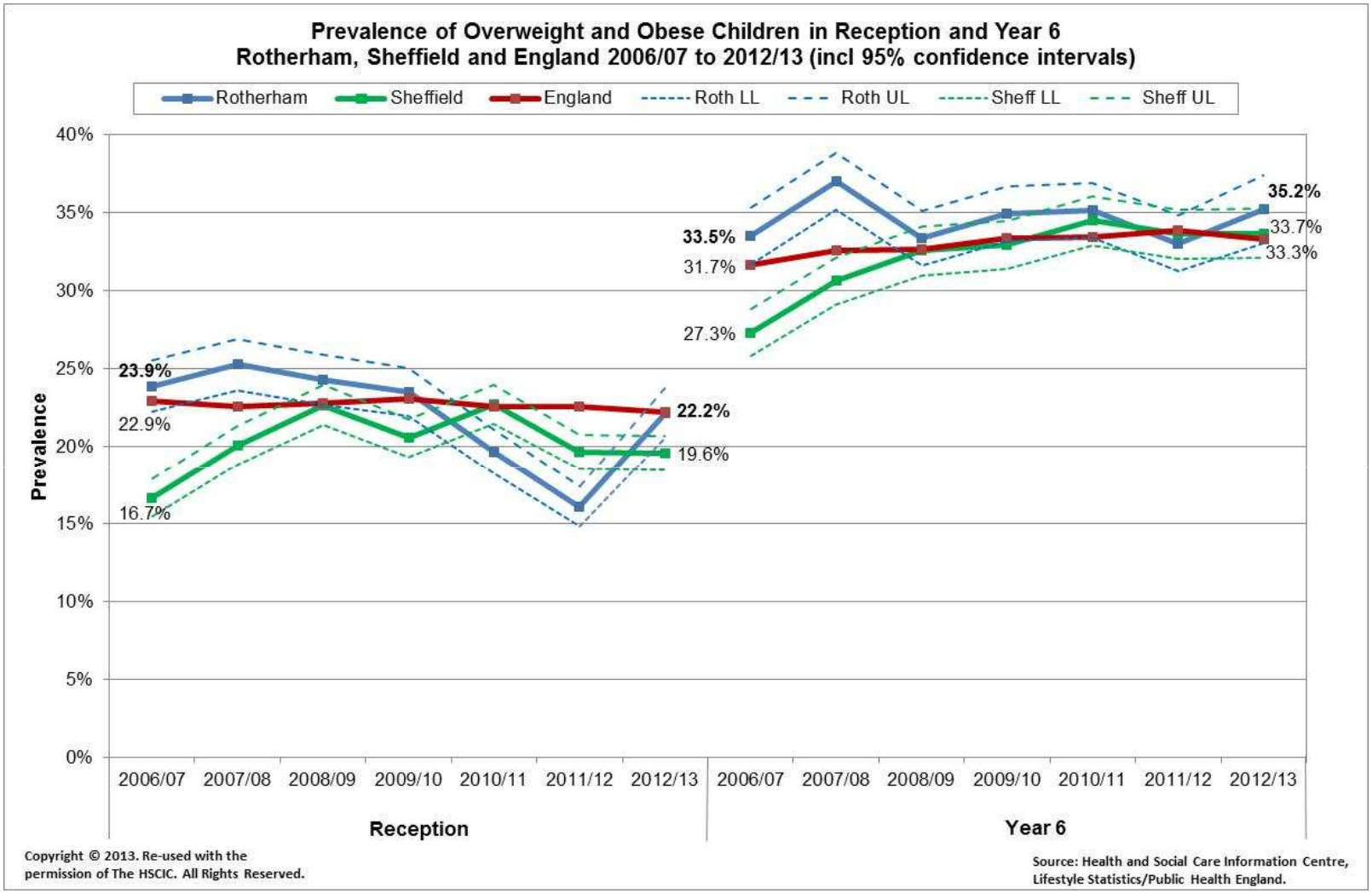

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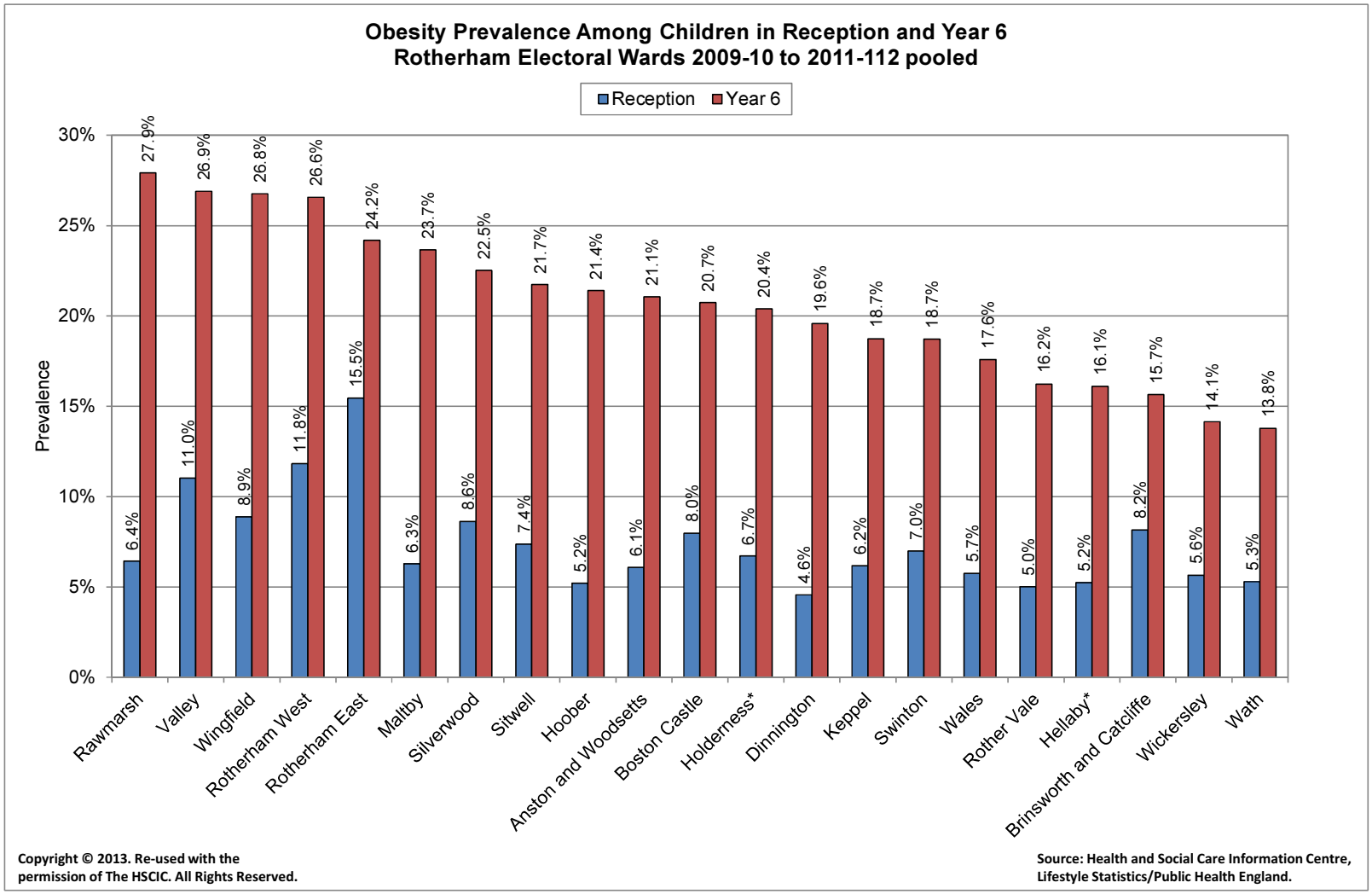

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Rotherham Better Care Fund Plan

April 2014

Local Authority
Rotherham Metropolitan Borough Council

Clinical Commissioning Group
Rotherham Clinical Commissioning Group

Date agreed at Health and Wellbeing Board
3 April 2014

Date submitted
3 April 2014

Finance

Minimum required value of BCF pooled budget	2014/15	**£20,101,000.00**
	2015/16	**£20,318,000.00**
Total agreed value of pooled budget:	2014/15	**£23,099,000.00**
	2015/16	**£23,316,000.00**

Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**Rotherham Clinical Commissioning group**
By	Chris Edwards
Position	Chief Officer
Date	3 April 2014

Signed on behalf of the Council	**Rotherham MBC**
By	Martin Kimber
Position	Chief Executive
Date	3 April 2014

Signed on behalf of the Health and Wellbeing Board	**Rotherham Health and Wellbeing Board**
By Chair of Health and Wellbeing Board	Cllr Ken Wyatt
Date	3 April 2014

1. Plan Details

1.1 How we have engaged health and social care providers in the development of this plan, and the extent to which they are party to it

The Rotherham health and social care community has a strong track record of working together in partnership to achieve meaningful change for local people. We can evidence that we continuously work with people using services, to understand and learn from them, and to improve their experience. Their views and experiences are reflected in this plan.

Against this backdrop and using principles already established it is easy to see how our partnership around integration can be developed, strengthened and sustained.

Health providers

The Rotherham Health and Wellbeing Board has representation from the main local health providers (Rotherham Foundation Trust and Mental Health Trust) and the voluntary sector (Voluntary Action Rotherham) from the launch of the Board in 2012. They are each represented at board meetings, and their contribution has been embedded through the key theme groups, and the ongoing discussions regarding BCF. This involvement has ensured they have been engaged right through the process and are fully signed up to the principles and vision of the BCF, whilst being aware of the potential impact on services and the local community.

Healthwatch Rotherham are key partners at the board, bringing added value and independence through their direct relationship with the voluntary and community sector (VCS), and with people using services.

In addition to this, the BCF has been embraced by The Adults Partnership Board (APB), which acts as a commissioner/provider interface on jointly commissioned services. The board is coordinated jointly by the council and Rotherham CCG and includes representation from Rotherham Foundation Trust, RDaSH (Rotherham, Doncaster and South Humber Mental Health Trust) and the voluntary/community sector. The Adult Partnership Board agrees commissioning plans which address outcomes identified in the local Health and Wellbeing Strategy, examines national policy and directive and conducts impact assessments for Rotherham, making recommendations about commissioning priorities to the Health and Wellbeing Board. The APB has a key role in overseeing performance on jointly commissioned services including: registered nursing care homes; community therapy: equipment; and enabling services; intermediate care; and services for older people with mental health problems. The Rotherham urgent care working group, including its task and finish groups have cross system membership, and the BCF outline plans have been considered carefully at this forum. These discussions will continue as the action plans are shaped and revised, and developed into detailed implementation.

Local health providers understand that Rotherham CCG has identified a range of services which will be transferred into the BCF, and that the commissioning arrangements, including future specifications and targets for these services are likely to to change significantly. Locally the BCF will affect services delivered by Rotherham

Foundation Trust (RFT) and key voluntary sector partners. All provider organisations have expressed a willingness to work under the new commissioning framework, recognising the potential opportunities to improve outcomes for Rotherham people. RFT is committed to delivering integrated health and social care pathways and regard the BCF as a vehicle through which these can be achieved.

Key local healthcare providers have been engaged through monthly clinically led QIPP (Quality, Innovation, Productivity and Prevention) groups where pathway redesign, innovation and efficiency are key deliverables. Therefore the clinical areas where savings are planned from acute care have been generated over the last twelve months from a multi-disciplinary group of clinicians and officers of the CCG, local authority and appropriate provider. Appendix 11 shows the workstreams through which the QIPP savings are being delivered.

Voluntary sector providers

Rotherham commissioners have a long established relationship with the local voluntary and community sector (VCS), both as partners in working to improve social capital locally, and directly as provider organisations. Commissioners engage formally through the Council Contracting for Care and Provider Forums, partnership and consultation meetings; and through the Adult Social Care Consortium and Health Networks. The VCS has a strong local voice with elected members and trust boards, and are seen as true partners where opportunities for not-for-profit organisations and charities to unlock funding streams not accessible to public services present themselves. We understand the remit and the influence of the VCS extends far beyond that of our public services and interfaces with people in our communities who do not use statutory services and who arrange their own care.

Voluntary sector partners have engaged with us variously in delivering a wide range of services, some of which are included in our BCF plan and form part of integrated care pathways in stroke, dementia care, carer support, and crisis services for people with mental health problems, We see the BCF as a catalyst and enabler to embed voluntary sector services into other condition specific care pathways, and maybe more importantly, as a key partner in prevention and early detection - signposting and offering advice and support to people who may be at risk of needing acute interventions, and offering more sustainable and meaningful activity to offset or delay entry into health and social care pathways. The BCF plan supports this specifically through the social prescribing project (Action Plan reference: BCF05).

Social care providers

Rotherham Council formally commissions social care services from over 100 independent providers delivering registered care (care homes and domiciliary care services) and smaller scale specialised services, and operates a robust framework of contract management and quality assurance (including gathering intelligence from and working closely with CQC and other commissioners) to make sure that services are safe, good quality, relevant, and value for money. In addition, growing numbers of customers purchase their own support services directly using Direct Payments, and these service providers are regulated through formal review arrangements with appropriate and proportionate scrutiny. The council operates a risk register and applies appropriate incentive to contracts with providers to encourage innovation, added value, and high standards, and has a good record of positive engagement with the sector.

Local social care providers – the full range of independent sector organisations - have been engaged specifically on the implications of the BCF and to better understand some of the issues and good practices already taking place. This was undertaken using an online survey circulated to a wide database of local providers, consisting of those who are already engaged in work with commissioners, and those who are registered on the Rotherham E-Marketplace (Connect to Support), and holding a round-table discussion for a smaller group. The round-table provided an opportunity to use their experiences to explore potential solutions and enabled providers with a local focus to engage with the priorities for the BCF plan. A number of common themes have been identified which have informed the plan (see Appendix 1).

1.2 How we have engaged patients, service users and the public in the development of this plan, and the extent to which they are party to it

Our Better Care Fund vision is based on our Health and Wellbeing Strategy and on what Rotherham people have told us is most important to them. Rotherham partners have a commitment to make sure that the views and reported experience of people who use local services are heard and acted upon, and a "right first time" principle applies to the delivery of services whether they are provided directly by us or commissioned. We engage with inspirational local people in a number of forums, both formally brokered (eg the Council's Customer Inspection Team; the Rotherham Learning Disability Partnership Board; Rotherham Speak Up) and informal (eg Rotherham Older People's Forum, the Carers4Carers Mental Health Support Group; and Tassibee Womens' Group) to understand the barriers for local people in accessing the most appropriate support, staying safe; and keeping well. We have used a variety of methods to capture the views and experiences of local patients, service users and their carers to inform our local plans.

Specifically service users and the public have been engaged in the development of the BCF submission, including:

- Healthwatch Rotherham - commissioned by the Health and Wellbeing Board to consult with the local community and engage them in the envisaged transformation of services between December 2013 - January 2014
- During January 2014 Rotherham Council consulted with a group of mystery shopper volunteers regarding the proposed vision, priorities and their views of health and social care services

Responses from a range of consultation exercises and surveys previously completed have also been collated, and used to help shape our vision and priorities, including; Joint Health and Wellbeing Strategy consultation July – August 2012, ASCOF Adult Social Care User Survey 2011/2, Personal Social Services Annual Survey of Adult Carers in England 2012/13, 'Making It Real' Programme consultation in 2013, which assisted with developing Rotherham's "I" statements; Health Inequalities consultation 2011, and staff consultation regarding the hospital admission to discharge process. In addition, the Council continually works to improve services through customer insight activities and learning from customer complaints, ensuring that service users are at the heart of service delivery. The Council consults with and recruits customers for all major social care commissioning exercises, and undertakes rigorous customer evaluation to establish quality in the registered care sector. The annual Local Account is also used to inform members of the public how the Council is meeting the needs of service users and improving outcomes.

Rotherham CCG co-ordinates a Patient Participation Network, bringing together patient representatives from GP Practices across Rotherham. Patient Participation Groups have been meeting throughout the year, providing feedback on local health services. The Patient Participation Network meets on a quarterly basis, bringing together patients' views from across the local health economy. As part of an exercise to develop the patients' view of the CCG's five year strategy, the network identified a number of priorities that could be addressed as part of the Better Care Fund Plan.

Our local NHS Provider Trusts have robust, monitored, and publicised arrangements that consult with and seek participation from people using their services, families and friends.

Through the service user, patient and public engagement described above, we have been able to identify a number of common areas for improvement including:

- Patients and service users do not always feel central to decision making, they want to be in the driving seat when it comes to their own care
- Services, local groups and organisations are not accessible due to a lack of information and advice, availability 7 days a week and long waiting times
- There needs to be better education and information available for people, particularly those with long term conditions
- People often feel unclear of expectations regarding the service they should receive and customer pathways due to a lack of advice and support and conflicting information. They are also not always signposted to appropriate services. Better staff training and education is required
- There is a lack of communication and information sharing resulting in poor joined up working between patient/service user, family and carers, health and social care services, GP, hospital, providers and partners
- Service users feel that they have to chase health and social care professionals, causing delay in the delivery of care and support
- Service users and patients would like an allocated key worker/professional; inconsistency of workers makes individuals feel unsafe
- There needs to be more of a focus on preventative, community/home-based services to reduce the number of people going into hospital and residential and nursing care. Nursing services are also critical for home-based support.
- Better after care is required. Examples provided included people felt alone, socially isolated, found it difficult to access services, no support for carers who are left behind
- Service users have a level of distrust using independent sector health and social care providers

Further information regarding the specific outcomes from all of the consultation activity can be found in Appendix 1.

1.3 Future engagement and consultation planned from April 2014

We have developed a consultation and engagement plan (appendix 8), which has been used from the start of this process and will ensure continued engagement as we move into transition and implementation of the BCF plan.

The council has a well-developed process for engagement with adult social care providers and has an ongoing programme for the year which includes engagement to explore the implications of BCF and Care Bill. A planned presentation to adult social care providers on the 7 May 2014 will bring together both pieces of work and will result in

a co-produced action plan for the year. The Market Position Statement for Older People's services (Appendix 6) has been published and provides clear direction for existing and new providers, this will be updated and evaluated periodically, and an additional position statement will be available later in the year that will scope activity and intentions across all adult care sectors and with close collaboration with health commissioners.

We have produced two public-facing documents which we will use to share with local people our plans, how they align with our local priorities and what our proposed changes will mean for local people ('Plan on a page' Appendix 10 and 'What will the BCF deliver for the people of Rotherham' Appendix 9).

1.4 Related documentation

Ref.	Document or information title	Synopsis and links
A1	**Findings from consultations**	A summary of all the consultations which have taken place as part of the BCF planning and wider health and wellbeing agenda.
A2	**Rotherham Better Care Fund action plan**	Includes the detail and intended outcomes (including related 'I Statements') of the schemes to be delivered through the BCF, and shows how these align with the local health and wellbeing strategy priorities and objectives,
A3	**Health and Wellbeing Strategy**	The joint strategy which sets out the priorities of the health and wellbeing board for 2013 – 2015.
A4	**Joint Strategic Needs Assessment**	Assessment of the health and social needs of the Rotherham population. http://www.rotherham.gov.uk/jsna/
A5	**Overarching information sharing protocol**	This protocol complements and supports wider national guidance, professional body guidance and local policies and procedures to improve information sharing across services in Rotherham. Signed up to by HWB September 2012.
A6	**Market Position Statement for Older People**	The Market Position Statement has been developed by Rotherham Council to inform current and potential providers of social services in the borough of the direction of social care services for older people over the next few years.
A7	**Risk Register**	Detailed log of risks and mitigating actions which will be used to monitor and review the

		impact of the BCF plan and identify any unintended consequences,
A8	**Consultation Plan**	Plan for continued consultation and engagement with service users, patients and providers.
A9	**What will the BCF plan deliver for the people of Rotherham**	A public document which provides an overview of the BCF planned schemes, 'I Statements', and case studies demonstrated the what the changes will mean for local people.
A10	**BCF 'Plan on a page'**	2 page document which demonstrates how the BCF actions align with the health and wellbeing strategy and outcome measures.
A11	**Workstreams delivering savings**	Table showing the workstreams through which QIPP savings are being delivered.
A12	**Governance Frameworks**	Diagrams demonstrating the decision making structure, as well as the framework for delivery and performance.

2. Vision and Schemes

2.1 Our vision for integrated health and care services for 2019

The Rotherham Health and Wellbeing Strategy sets out our overarching vision to improve health and reduce health inequalities in the borough. Through the strategy, the Health and Wellbeing Board has made a commitment to more integrated, person-centred working, to improve health outcomes for local people.

The Better Care Fund plan will contribute to 4 of the strategic outcomes of the local Health and Wellbeing Strategy:

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

- **Expectations and aspirations**: All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community

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

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

Local 'I Statements'

Our vision for integration is based on the experiences, values and needs of our service users, patients and carers. Through mapping these and understanding the journeys people take in and out of health and social care, we have identified a number of 'I statements' which demonstrate the outcomes local people want from better integrated, person-centred services. From 2015/16 our Better Care Fund plan will work towards the following:

'I am in control of my care'

People want to feel central to decision making and development of their care plans, they want all professionals and services to communicate with each other to understand their care needs and ensure they receive the most appropriate care for their circumstances, and they want to be provided with the right information to help them to manage their conditions and make informed choices about their own health and wellbeing.

'I only have to tell my story once'

Service users, patients and carers want all organisations and services to talk to each other and share access to their information, so that they only ever have to tell their story once.

'I feel part of my community, which helps me to stay healthy and independent'

People want to feel independent and part of their community and want organisations to provide better information and support to help them to do this, understanding that this reduces social isolation and avoids the need for more formal care services later on.

'I am listened to and supported at an early stage to avoid a crisis'

People want support, advice and information at an early stage to help them look after their mental health and wellbeing, avoiding the need for more intense, high-level services when they reach crisis point.

'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing'

People want a greater focus on preventative services and an increased capacity in community activity to prevent high intensity use of services and more formal care, and to help them better manage their conditions. They also want services to be available 7 days a week and information and advice to be more accessible. Understanding the journeys that people take into health and care services will help us to provide more appropriate information and support at times when people need it most.

'I feel safe and am able to live independently where I choose'

People want to stay independent and in their own home or community for as long as possible. They want to feel safe to do this and know that the right support is available when and where they need it.

Customer experiences will be closely monitored throughout the delivery of the BCF action plan via the 6 'I statements'. This will involve the council's Performance and Quality Team contacting relevant service users and patients, upon delivery of each of the BCF actions and obtaining their views regarding service/s they are receiving. This will help us to see the real customer journey and to learn and improve service delivery based on customer feedback.

Through surveys, telephone and face to face interviews, the team will develop a number of case studies, to identify the positive and negative impacts that the BCF plan has had on customer experiences. Rotherham Council has in place a Customer Inspection Service, with individuals who are customers and experts by experience. This group will support the assessment of the impact of the BCF plan and help us to see the implementation through the eyes of the customer. These experts by experience will also help us to identify where further improvements are needed. All feedback will be used to further enhance and improve the customer experience.

Our vision – a customer perspective

As a result of the changes we will make, we expect that all service users, patients and their carers will have confidence in the care they receive and feel supported to live independently, manage their conditions and participate in their community. They will feel well and less likely to rely on acute services, resulting in a reduction in overall pressure on the hospital and health budgets. Although, when acute care is the best option for people, they are helped to move quickly back into their community when they are ready to do so. We will see a greater shift from high cost reactive care, to lower cost, high impact preventative activity.

Integrated commissioning

To achieve this, we have agreed a number of actions that will begin this journey and result in changes short and medium term. We have a tradition of shared commitment to delivering joined up services, as demonstrated by our well-established Joint Adult Community Mental Health Services; Joint Learning Disability Service; Joint Residential and Nursing Care Service, and a joined up approach to Safeguarding of Vulnerable People; Intermediate Care Service; Stroke Recovery Services; dedicated Step- Up/Down placements; and Integrated Community Equipment Services, all supported either by pooled budgets and/or partnership agreements overseen by dedicated joint commissioning staff. Currently the majority of commissioning activity is undertaken separately by experienced officers in the council (including Public Health) or in the CCG (and colleagues in the Regional Commissioning Support Unit), though key partner decisions, broad commissioning intentions; and efficiency programmes are shared through our joint consultation forums: the Adult Partnership Board; Chief Executives Group; Rotherham Partnership Board; and HWBB.

Our longer term, 5 year plan, will see health and social care teams working in an increasingly integrated way and our commissioning plans aligning more comprehensively to meet the priorities set by the HWBB, to achieve maximum efficiencies, preserve service quality, and reach beyond critical, acute or “eligible” social care to impact on the prevention agenda. We will move to a whole-system commissioning model, which has services commissioned in line with our health and wellbeing strategy principles that are coordinated across all agencies to ensure they are person-centred and we maximise local spend. We will scope and routinely share information on commissioning activity, share respective commissioning plans and timetables, align wherever possible, and develop joint market facilitation arrangements so that market providers receive a consistent and transparent message from the Rotherham health and social care community. Our integrated approach extends to public health services; complimentary public health activity focuses on primary prevention and supporting and developing the healthy ageing agenda. The synergy between BCF and public health will help to maximise the improvements across the pathway from prevention to early diagnosis/help.

2.2 Our aims and objectives for integrated care and how the fund will secure improved outcomes in health and care in Rotherham.

Our aim is for an integrated system, that provides care and support to people in their home or community, which focuses on prevention, early intervention and maximising independence. To do this, we have identified a number of key objectives set out in our health and wellbeing strategy which have been used to inform our plan. We have demonstrated below where these will impact on the specific outcome measures of the BCF:

To deliver our vision on Prevention and Early Intervention	
What we will do	**Related measures**
We will coordinate a planned shift of resources from high dependency services to early intervention and prevention	N1, N2, N4, N5, L1
Service will be delivered in the right place at the right time by the right people	N1, N2, N3, N4, N5, L1

To deliver our vision on Expectations and Aspirations	
What we will do	**Related measures**
We will ensure all our workforce routinely prompt, help and signpost people to key services and programmes	N1, N2, N3, N4, N5, L1
We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions	N1, N2, N3, N4, N5, L1

To deliver our vision on Dependence to Independence	
What we will do	**Related measures**
We will change the culture of staff from simply 'doing' things for people to encouraging and prolonging independence and self-care	N1, N2, N3, N4, N5, L1
We will support and enable people to step up and step down through a range of statutory, voluntary and community services, appropriate to their needs	N1, N2, N3, N4, N5, L1

To deliver our vision on Long-term Conditions	
What we will do	**Related measures**
We will adopt a coordinated approach to help people manage their conditions	N1, N2, N3, N4, N5, L1
We will develop a common approach to data sharing so we can provide better support across agencies and put in place a long-term plan for the life of the individual	N3, N4, N5, L1

Outcome measures (key):

- **N1 Admissions into residential care**
- **N2 Effectiveness of reablement**
- **N3 Delayed transfers of care**
- **N4 Avoidable emergency admissions**
- **N5 Patient and service user experience**
- **L1 Emergency readmissions**

The 4 vision themes and objectives of the health and wellbeing strategy described above are being delivered through a set of workstreams, jointly led by the council and CCG. The proposed schemes to deliver the BCF described in the following section will form part of this broader work and contribute to achieving these objectives. Although the BCF plan is only part of the picture, we feel it will significantly contribute to the strategic outcomes that the Health and Wellbeing Board have already signed-up to through the local strategy, which is why we have closely aligned the two pieces of work. By ensuring the BCF plan is closely aligned to the objectives of the Health and Wellbeing Strategy, we are able to identify specific funded activity that will improve outcomes for local people through a better integrated system, which will ultimately help us to achieve our vision.

2.3 A description of our planned changes

Achieving our vision will mean significant change across the whole of our current health and care landscape. Commissioners and providers welcome the opportunity to adapt and change the way they do things. The following actions demonstrate the commitment both the council and CCG have made to transforming services and working in a more integrated way for the benefit of Rotherham people.

The local BCF action plan is transformational and signifies a major shift in the way we commission health and social care services. For example:

- The development of an integrated Rapid Response Service is one example of how the BCF will ensure a consistent and integrated response to people who have an urgent need.
- By responding quickly with the full range of support we will be better able to reduce hospital admissions and delay admission to residential care.
- An integrated falls and bone health care pathway will reduce the impact of falls related injuries and save costs further down the care pathway.
- Finally the introduction of person held care record will ensure that health professionals can make informed decisions about treatment options and most the appropriate place of care.

An action plan is attached as Appendix 2.

What we want to achieve: Rotherham people will get help early to stay healthy and increase their independence

We will use the BCF to put in place the following schemes:

BCF01 Mental Health Service

The mental health liaison service will be provided through a multidisciplinary team working to support the care of older people with mental health needs and younger people with dementia. The team will work in partnership with care homes and general wards in the hospital. Its minimum function will be to reduce admissions into mental health wards by supporting people effectively in the community, and also to support timely discharges from hospital.

We have identified the following key objectives for developing the service.

- Improve the provision of mental health liaison across CAMHS, Adults and Older People services
- Reduce avoidable emergency admissions and re-admission to The Rotherham NHS Foundation Trust (TRFT).
- Reduce the number of admissions and length of stay for older people with dementia or adults with mental health problems.
- Improve outcomes and patient experience for people with mental health illness accessing TRFT.
- Raise the profile and increase awareness of mental health and dementia within TRFT as an aspect of holistic health.
- Improved compliance of TRFT with the legal requirements of the Mental Health Act (2007) and Mental Capacity Act (2005).
- Improve access to mental health services through 7 day working.
- Improve parity of esteem.
- Ensure people with mental health problem receive the right treatment in the right location at the right time

How will we do this?

- Commission a 7-day a week with extended hours (9.00am – 8.00pm) for mental health liaison service for adults with mental health problems and older people with dementia.
- Raise the profile and awareness of mental health within TRFT as an aspect of holistic health. This will be achieved through the increase prominence of mental health services at TRFT and the delivery of training programme to TRFT staff.
- Ensure there is effective liaison and improved pathway of care with other parts of the health / social care system, including Rotherham GPs, Crisis and inpatient teams (TRFT, Woodlands, Swallownest etc.), specialist mental health teams (adult and older people), social services, emergency service and non-statutory agencies, Alcohol Liaison service, Substance misuse services.
- Pilot the introduction of an additional CAMHS consultant into the service to support 7/7 working.
- Provide expert advice on capacity to consent for treatment in complex cases, including advice regarding the use of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS).

Who will benefit?

Customers will benefit from being provided with more skilled and appropriate support when they do need to experience a hospital admission, and will also benefit from having care provided to them where they live. The coordinated assessment and care plan should result in more person centred care and better outcomes for people using services. Those who will benefit include:

- People with dementia and their carers
- Adults with mental health problems and their carers
- Children and young people with mental health problems and their carers
- Staff in TRFT, RDaSH, social care and working in the Emergency Care Centre
- NHS England interface with Rotherham services, such as RDaSH, social care and TRFT

BCF02 Falls Prevention

Rotherham will set out a systematic approach to falls and fracture prevention. We have identified four key objectives for developing the service

1. Improve patient outcomes after hip fractures through compliance with core standards
2. Respond to a first fracture, through falls and fracture services in acute and primary care settings
3. Early intervention to restore independence, through falls and fracture care pathways
4. Prevent frailty, promote bone health and reduce accidents through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards

How will we do this?

Engaging all key partners to comprehensively scope and apportion lead responsibility for the actions needed, and establish an intelligence network to collect evidence to be presented at a bi-yearly clinic around falls prevention, pro-actively engaging care sector providers through the Shaping the Future Forum. To link this work to the Dependence to Independence Workstream and the partnership approach around risk management.

- Identifying patients presenting with fragility fracture and assess them to determine their need for bone active therapy to prevent future osteoporotic fracture
- Ensuring that people at high risk of falls and fracture are given comprehensive assessment and evidence based intervention
- Introducing a care management pathway with clear lines of referral for an integrated approach to bone health, fracture liaison and falls prevention
- Reducing year on year increase in falls that result in hospital admission and serious injury and to reduce the numbers of people who sustain fractured neck of femur following a fall.

Who will benefit?

There will be separate care pathways for each of these cohorts;

- People at risk of an injurious fall — Primary and community care
- People who have had a recent fragility fracture — A&E and Fracture Clinic
- People with an injurious fall who have complex needs — Case management

BCF03 Joint call centre Incorporating telecare and telehealth

This workstream provides a joint vision for the development of telehealth and telecare services in Rotherham. It sets out the principles for care pathway development, maps current telecare provision and puts forward proposals for joint commissioning activity.

The overall objective of developing a joint telecare/telehealth strategy is to optimise the care of patients with long term conditions. Rotherham MBC and Rotherham CCG recognise that technology is an enabler for optimisation but not the whole solution. Pathways should be developed in conjunction with national guidelines and strategies for the management of long term conditions. All pathways should be systematically reviewed with clinicians in order to draw on their local expertise.

How will we do this?

Rotherham CCG and Rotherham MBC will work to together to develop telecare prescriptions for GP Practices participating in the case management programme. We will introduce integrated telecare and telehealth packages which can be offered as part of a self-management programme for patients with a long term condition. We will scope the potential for development of a joint telecare/telehealth hub. Specifically we examine the potential for combining the Rothercare Service with the Care Coordination Centre.

Who will benefit?

The main benefit of this initiative is its potential to deliver improvement in outcomes for people who have a high dependency on health and social care services. A combined approach to care coordination, telehealth and telecare allows local practitioners to maintain contact with vulnerable patients. It can help improve the reach of health and social care, supporting those who are often 'invisible' from main acute services.

This initiative is more likely to ensure that intervention is early and appropriate. It makes more efficient and effective use of available clinical teams by reducing unnecessary home visits. It involves people far more in the management of their own healthcare and could lead to significant reductions in A&E usage and unplanned admissions

BCF04 Integrated Rapid Response Service

Rotherham will extend the current Fast Response Service so that it is capable of meeting the holistic needs of adults with long term conditions who experience an exacerbation. The new service will incorporate community nursing, social work support, enablement and commissioned domiciliary care. The main aims of the service will be to;

- Prevent avoidable admission to hospital for people with long term conditions
- Support discharge from hospital for those who are medically stable
- Ensure that patients receive the most appropriate level of care that can meet their needs
- Ensure that patients receive seamless care that is patient focused and clinically safe
- Provide a service from 7am until 2am, 7 days a week including bank holidays
- Ensure safe and effective handover of care to mainstream primary and community services.

How will we do this?

We will enhance the current Fast Response Service so that it incorporates social workers, reablement workers and it will work in a streamlined way with commissioned domiciliary care providers. The new Integrated Rapid Response Service will assess patients who are medically stable but need additional support to remain at home. The service will meet all the health and social care needs of eligible patients for up to 72 hours at which point there will be a hand-off to mainstream services.

Under this enhanced service model the GP will retain overall medical responsibility for patients. The team will have access to the Fast Response beds located at Lord Hardy Court. If it is not possible to meet the needs of the patient at home, the Integrated Rapid Response Service will be able to arrange transfer to one of the Fast Response beds for recovery and recuperation.

Who will benefit?

In order to qualify for support from the Integrated Rapid Response Service the patients has to be 18 years or over. They have to have a Rotherham GP and they must be medically stable at the time of referral.

The patient may require rehabilitation. They may be a falls risk or have poor mobility. Patients who require IV Therapy would be eligible for the service as would those experiencing an exacerbation of a medical or long term condition.

BCF05 Seven day community, social care and mental health provision to support discharge and reduce delays

Rotherham will extend current provision so that appropriate services are available 7 days/week. This will enable timely discharge from hospital and avoid unnecessary admissions to hospital or residential care.

Emergency care should not be used when patients would benefit from care in other settings. We will ensure that community health and social care services deliver a high quality, responsive service both in and out of hours. We will focus on improving diagnostics and urgent care. Through good partnership working, we will ensure that community services deliver a high quality, responsive service both out of hours. We will ensure that when someone has an urgent care need out of hours the quality of health provision is maintained and that patient outcomes are good.

How will we do this?

Rotherham will review and evaluate existing arrangements against potential increase in demand arising from 7-day working across community, social care and mental health. We will increase social work capacity and, through jointly agreed specifications, we will commission future domiciliary care capacity, to support discharge at weekends. We will enhance and integrate out of hours services, and review commissioning arrangements, so that they are more responsive.

Who will benefit?

7 day services have the potential to drive up clinical outcomes and improve patient experience through, reducing the risk of morbidity and excess mortality following weekend admission in a range of specialties. Case studies reveal the potential for:

- improved quality, efficiency and innovation through

- Admission prevention;
- Speed of assessment, diagnosis and treatment;
- Safety and timing of supported discharge;
- Reduced risk of emergency readmission;
- Better use of expensive plant and equipment;
- Avoidance of waste and repetition
- Service rationalisation to enable safe consultant staffing levels.

What we want to achieve: All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community

We will use the BCF to put in place the following schemes:

BCF06 Social prescribing

The social prescribing project has had a successful start and has been recognised nationally as good practice. The plans included in the Better Care Plan will extend availability. The project acts as a portal for health professionals to access voluntary and community support services, to enable existing third sector providers and groups to complement the formal support that people with long term conditions receive. They are able to provide flexible, appropriate services that help people to self-manage.

How will we do this?

Through funding community navigators, employed by VAR, the local community and voluntary service, people with long terms conditions are able to access through their GP the following services:

- Condition management programmes: education, managing pain and fatigue, healthy eating, exercise, emotional support, support to self-care, understanding care pathways, self-help groups.

- Health and wellbeing: craft groups, music sessions for people with dementia, community garden projects, peer support groups, healthy cooking clubs, walking groups, specialist yoga and assistive technology support.

- Employment, education or wider community participation: one to one support, group work, social activities, training, apprenticeship s, support to access community facilities, travel support, community transport.

The service employs dedicated workers whose role includes liaison with providers and support to enable referred patients to access the prescribed service. This may include a

short period of one to one support to access available services, taking someone to a self-help group or organised activity.

Who will benefit?

GPS will benefit from being able to support patients to follow through on self-help activities. Customers will benefit from being able to access a wider range of support that enables them to regain or gain independence, and the community benefits from having a wider range of people actively engaged. The third sector is fully engaged into patient care pathways. It contributes to a reduction in formal social care packages and reduces admission to hospital.

BCF07 Joint residential and nursing care commissioning and assurance team

What are we trying to achieve?

Approximately 1500 Rotherham people live in care homes in Rotherham, under a diverse set of funding arrangements. Rotherham currently has more available placements than demand requires, and this suggests a degree of fragility for the sector. The intention of this workstream is to develop a joint approach towards quality assurance of residential and nursing care homes. Rotherham CCG and Rotherham MBC will work closely to develop an integrated care home support service that fulfils the following functions;

- Reduce A&E referrals, ambulance journeys and hospital admissions from residential care
- Address health training needs of care home staff
- Ensure appropriate access to falls prevention services
- Promote healthy living initiatives
- Review health aspects within care homes and ensure they are contract compliant
- Improve communication and align local routes for delivering improvements in care home standards and quality.

How will we do this?

Rotherham will carry out a review of existing services to examine where joint working arrangements can best apply. We will explore the potential for developing an integrated Care Home Support Service, incorporating the current functions of the team with responsibilities for contract compliance. Health and social care staff will work closely together to improve quality and monitor performance. Where the team identifies issues with care quality or where a training need is identified for staff, the service will directly intervene. Interventions can include; the development of remedial improvement plans, co-ordinating tailored training programmes and case management support for complex residents.

Who will benefit?

The development of an integrated Care Home Support Service will ensure that care home contracts are monitored effectively and that health related concerns are properly picked up within the local authority contracts. Residents will benefit because quality and performance issues will be identified early, enabling Homes to take remedial action before concerns regarding safeguarding start to arise. Care Home Providers will benefit from a unified approach to contract monitoring and a consistent message from commissioners. They will understand better the local intentions, which will assist them to make positive and informed business continuity decisions in a local market that is under the development of this type of integrated support provision will support good practice and protect residents.

BCF08 Learn from experiences to improve pathways

We want a clearer understanding of the journey through health and social care services for people with long term conditions. We want to answer the following questions about our local services:

- Is our care proactive, holistic, preventive and patient-centred
- Are people playing an active role in their care? Are they engaged, informed and empowered?
- Do health and social care professionals adopt a partnership approach with their customers
- Are clinicians competent in supporting shared decision-making and goal setting
- Can we reduce duplication of input between health and social care
- Is the risk stratifications tool identifying high intensity users of health and social care services
- Is there a link between care planning for individuals and commissioning for local populations
- Do we have a diverse range of quality providers to call on that allow sufficient choice and flexibility to meet the specialist needs and preferences of people in our communities

How will we do this?

We will gain this understanding by:

1. Undertaking a deep dive exercise which maps the care pathway of a specified number of high intensity uses of health and social care services, using customer journey tools to enable a better understanding of the customer experience of services.
2. Carrying out a full evaluation of the risk stratification tool and developing a mechanism for identifying high intensity users of health and social care services
3. Involving customers and carers in refreshing the JSNA so that demand is better understood and partners have as much intelligence as possible on which to base their commissioning activity.
4. Health and Social Care Market Facilitation Programme

Who will benefit?

This piece of work will ensure that we are targeting resources at the correct cohort of people. It will inform plans to reduce duplication within care pathways and it will support a partnership approach to care delivery. It will promote partnership working between the patient and health & social care professional. It will also support partnership working on a case and individual level between health and social care services.

What we want to achieve: Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances

We will use the BCF to put in place the following schemes:

BCF09 Personal health and care budgets

The council has a positive record in delivering personalised services, including personal budgets and direct payments. Collaborative work between the Council, CCG, and CSU has resulted in the early delivery of personal health budgets for people in receipt of fully funded health care, so the health and social care economy is on track to deliver personal health budgets by 1st April 2015. Through the Better Care Fund, it is our aspiration to continue to deliver on these agendas and to extend our current plans to a wider group of individuals, ensuring that they have choice and control.

How will we do this?

As the personalisation agenda is rolled out, the CCG will review its the payment mechanisms for community services to ensure that where patients choose alternative services over commissioned services, the CCG does not pay twice. Where commissioned services are no longer required we will seek to decommission services without destabilising existing providers. There is potential for a much wider range of providers which require the appropriate oversight to ensure quality requirements are being achieved, and RMBC and the CCG will work together to present a consistent approach to the care market, and develop streamlined and flexible contract management arrangements.

Over the next year we will roll out training to offer personal health budgets (PHB) to all patients in receipt of a domiciliary Continuing Healthcare package, including notional budgets. We will monitor the impact of PHB roll out on expenditure. We will hold stakeholder development sessions to build strong partnerships between RMBC, Rotherham CCG and Commissioning Support Unit colleagues. Finally we will develop a service level agreement with RMBC, subject to agreement of final costs.

Who will benefit?

Customers and their families will benefit from being able to choose the way in which their services are delivered, offering increased choice and control. Service providers will benefit from positive engagement with customers and the ability to work in a more person centred way.

BCF10 Self-care and self-management

The purpose of this workstream is to ensure that self-management is embedded in all aspects of health and social care. A good system of self-management will support the development of knowledge, skills and confidence in self-care support. Health and social care services should support people with long term conditions to actively participate in care planning. Care plans should include actions for the person receiving support aimed at improving or maintaining their condition. High-risk patients with long term conditions should have a person held record, which includes their care plan. Case managers should ensure planned follow up on goals. Scheduled appointments should be in place to plan care, treatment or support.

Some specialist teams such as the Home Care Enabling Service, Intermediate Care , Falls Service, Breathing Space and the Community Stroke / Neurological Conditions Teams and community matrons are built on an ethos of self-management. These services have the clinical systems in place to support self-care. However many mainstream health services still focus on direct support rather than support with self-management.

How will we do this?

Rotherham will evaluate the current patient skills programme and reconfigure. We will bring all self- management programmes under a single banner “Rotherham Patient Skills Programme”. We will extend the current patient skills programme so that it supports patients on the GP case Management Programme. We will develop specialised psychological support services for people with long term conditions, so that they are better able to self-manage**.**

Rotherham will set up a local self-management network, responsible for promoting self-management and acting as an interface between the statutory, voluntary and independent sectors. We will develop a multi-agency practitioner development programme, equipping works with the skills to assist in self-management. Finally Rotherham will introduce a person held record for people with a long term condition, enabling them to monitor their condition and track the progress of their care plan.

Who will benefit?

Every person in Rotherham with a long-term condition should have an opportunity to participate in a collaborative care planning process with effective self-management

support. People who recognise that they have a role in self-managing their condition, and have the skills and confidence to do so, experience better health outcomes. With effective support and education, evidence shows that these skills can be developed and strengthen, even among those who are initially less confident, less motivated or have low levels of health literacy. Professionals gain new knowledge and skills, leading to greater job satisfaction.

BCF11 Person-centred one-page plan

Each individual in contact with services will have a person-held one page plan that informs them, their family and professionals involved with their care of their story, their plan and what they can do to keep themselves healthy, safe and living in the community. It will outline about what is important to that individual, Building on the success of the case management pilot, which has seen every person in the pilot being provided with a care plan that is held in the home, the document will be agreed with the customer and will be developed in line with current best practice
How we will do this

How will we do this?

We work with customers and patients to develop an agreed format. This will then be tested with a small group of customers and once the result is effective and meets customers' needs, will be rolled out through the case management process, through social work assessments and other routes.

Who will benefit?

Customers will only have to tell their story once, and will be able to work with their GP or other professional on developing a plan that reflects their needs, and also includes their self-care or self-management plan, plus a plan that informs, when needed, other professionals to ensure that they receive the care they need where they need it. This plan will ensure that people's needs are met. The case management pilot has resulted in a number of people having person held plans in their homes, and this has been welcomed by the ambulance service who have found them useful and have been able to use them to support decision making – the person centred one page plan will build on this.

BCF12 Care Bill preparation

The Care Bill present significant challenges to the Local Authority and partners , in relation to a duty to provide effective advice, information and guidance services, extended rights for carers, statutory responsibilities for safeguarding adults, deferred payments and care accounts including new responsibilities in relation to people who fund their own care and an increased focus on personalisation. The council will identify the cost and activity pressures resulting from this new legislation.

How will we do this?

There is a Care Act Steering Board in place which has five workstreams each focussing on key elements of the Act, The Steering Board will work with customers, providers, and partners to determine the actions needed, and will then guide the action plans to deliver effective change by 1 April 2015.

Who will benefit?

The Care Act will ensure that there is a consistent approach nationally in relation to the eligibility for adult social care, portability of assessment, and the delivery of more personalised services., It will ensure that carers are supported. The action plan will ensure that staff needs for training, development and information are met at a time of significant legislative change.

What we want to achieve: Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life

We will use the BCF to put in place the following schemes:

BCF13 Review existing jointly commissioned services

All jointly commissioned services will be reviewed to establish if they provide value for money and are aligned with the BCF vision and principles. Where services are not efficient and effective, services will be reconfigured or decommissioned. There is a recognition that the shift from care in hospital to the community will impact on social care services. Where this impact is apparent the Better Care Fund will provide additional support to social care services through the service review process.

How will we do this?

Rotherham will develop a 3 year review programme for all services funded through the Better Care Fund. We will also develop a robust review process which enables commissioners to form a clear picture of the strategic relevance and performance of existing services. We will set out joint governance arrangements for making decisions on review recommendations. Finally we will put in place a proper performance framework for BCF services which demonstrates the effectiveness of services against BCF criteria

Who will benefit?

Reviewing the current portfolio of BCF services will ensure that there is proper alignment between health and social care locally. Commissioners from the local authority will have a direct influence over the configuration of services that were historically commissioned by health. Local Authority commissioners already have a good dialogue and contract

management arrangements with the care market and involve health partner commissioners in its engagement/ market facilitation programme, to present a united approach to commissioning and procurement of services wherever possible. The BCF presents an opportunity to understand more thoroughly the models and drivers for commissioners from each organisation and to improve future collaborative commissioning for the health and social care community.

All commissioned services can be realigned to deliver a combination of health and social care outcomes rather than being totally focused on the targets of a single organisation. This inevitably benefits the patient as it moves both CCG and Council commissioners towards a position where they are commissioning fully integrated health and social care services.

BCF14 Data sharing between health and social care

All Rotherham NHS correspondence uses the NHS number as primary identifier, and the council has a plan already in development to enable this to be used on social care systems. It is proposed that use of the NHS number as a unique identifier across all health and social care will create the starting point for the development of shared IT capacity locally. We aim to provide information sharing capacity between and across health and social care that is effectively governed and safe.

How will we do this?

Through the BCF there is a commitment to ensure that all providers have access to integrated person-held records, which include all health and social care plans, records and information for every individual. To enable this to happen we will develop portal technology to share data in a secure way that is in the best interest of people who use care and support. Accompanied with effective use of new technology it will liberate practitioners and transform the way they work.

Who will benefit?

The BCF Plan has highlighted actions related to the use of technology and information that, if fully implemented, could deliver significant benefits to the health and social care economy. These benefits include improvements to quality and efficiency as well as patient experience and satisfaction.

As well as delivering efficiencies, there are also tangible benefits such as the improvements in the quality of care delivered, the accuracy of data collected, improved data flow between health and social care and the increased flexibility the practitioners have in managing their time and location of work.

The BCF Plan will ensure greater efficiency in accessibility of patient information. Increased accessibility will enable faster transfer of medical history in a medical emergency or when visiting a new practitioner. Researchers and public health authorities, with the permission and consent of the patient, will be able to collect and analyse up-to-date patient data. Such access is imperative in emergency situations, and also allows public health officials to easily conduct outbreak and incident investigations. Improved accessibility will also enable health care providers to reduce costs associated with duplicate testing, appointment reminders and laboratory results.

2.4 Our plan's impact on mental health services

The mental health liaison service is a key component of the BCF plan, which will be in addition to existing services and will transform how patients with mental health issues are treated in the Rotherham urgent care system. This will also improve patient experience and health outcomes

A key change in 2014 will be increased clinician to clinician discussions between CCG GPs and mental health service clinicians to ensure that quality improvements can still be made in the increasingly challenging financial situation.

There will be an increased focus on the mental health of people with other long term conditions. The Older people, Adults and Alcohol liaison services will be part of an increased emphasis on the mental health needs of people accessing acute hospital services. The GP case management, over 75s and social prescribing schemes describe the increased multiagency and voluntary sector inputs we will deliver to 20,000 people with long term conditions and who are at risk of hospital admission.

An action log was produced in December 2013 setting out details of as follows:

- An increased focus on quality for Rotherham residents in both adult services and CAMHS;
- Older and Adult Mental Health Liaison Services and Alcohol Services. These services which started in 2013 will be evaluated and enhanced if they provide value for money and deliver the required outcomes;
- Dementia
    - Achieving timely diagnosis and treatment and improving the care pathway, and reviewing scanner capacity;
    - Develop a one-stop clinic for dementia diagnosis;
    - Improving support to carers
    - Work with partners to review dementia day care service provision across health and social care
    - Social prescribing support is improving support to carers, it is helping more hidden carers to be identified and get support earlier
- Establish an adult autism diagnosis process
- Work to implement Mental Health Payment by results. This will require primary and secondary care clinicians to work together on benchmarking and care pathways;

2.5 What our changes will mean for local people

We have developed a set of personas and 'case studies' which demonstrate what the changes we are making through the BCF will mean for local people. These have been aligned to our 'I Statements' providing us a basis for monitoring our changes once the plan is full into implementation.

Case studies can be seen in Appendix 9, which we will also use to share with the public what our proposed changes are and what this will mean for them as patients, services users and/or carers.

2.6 How the BCF aligns to other local plans

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.

2.7 Our timescales for delivery

We have identified lead officers for each of the BCF schemes in our plan, who will be responsible for developing more detailed action plans for each scheme, demonstrating the expected timescales and delivery mechanisms.

This will be supported by the BCF operation officer group, which will begin this work during its first meeting in April 2014.

We have identified the budget and where this will be spent during the transition year 2014/15, which will include reviewing a number of services to ensure the BCF plan is ready to be fully implemented from 2015/16.

2.8 Implications of our plan on the acute sector

NHS Rotherham CCG's share of the national efficiency challenge is around £80 million over five years and is referred to as QIPP (Quality, Innovation, Productivity and Prevention). QIPP has two components:

1. Provider QIPP: Efficiencies passed onto health service providers. For the last three years and for the foreseeable future, providers have been expected to provide the same services with less funding. For example in 2014/15 providers will be given 2.1% uplift for inflation but are then expected to make 4% efficiencies. The efficiency requirement is **£8.8m** in 2014/15 and the 5 year plans are as follows

QIPP Plans 2013/14	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
4% Efficiency	(8,750)	(8,993)	(8,993)	(8,993)	(8,993)

2. System Wide QIPP: NHS financial allocations are expected to rise by around 1-2% each year over the next 5 years. The underlying rate of growth in health service activity and costs prior to 2010 was around 6%. Without QIPP we anticipate growth will continue at around 6% a year because of the ageing population, rising expectations and new medical technologies.

In addition to the £8.8m above, there are two key areas for acute savings:

Unscheduled Care – reducing avoidable admissions - £1.3m
Historically, Rotherham health community has been an outlier for emergency admissions to hospital. This is not fully explained by the higher than average levels of morbidity and

there is evidence that individual clinicians involved in hospital admissions such as GPs, ambulance staff, and accident and emergency doctors have different thresholds for admission. Whilst hospital admission may seem like the safest and easiest way of dealing with an emergency, for many people high quality care at home or in a community setting could be a better, safer option. The CCGs strategy provides more alternatives to hospital admission, treat people with the same needs more consistently and deal with more problems by offering care at home or close to home. There are important links between this area and plans to improve community services such as further developing the care coordination centre and providing alternative levels of care.

Clinical Referrals - £3.4m
The CCG will continue its approach based on clinical leadership and peer influence. Work with GPs and referring clinicians and providers will ensure referrals and elective and non-elective procedures are kept within affordable limits. If the current consensual, educationally based approach continues to be successful it will mean that Rotherham can maintain short waiting times and avoid unnecessary restrictions on the numbers of types of procedures that are available to patients.
Key to the work is effective communication with all clinicians in Rotherham, by face to face meetings, working with GP localities and hospital specialists through the Hospital Management Team and Medical Staff Committee, educational events, monthly newsletters, top tips for important pathways and by providing benchmarking information.
Patient experience will be enhanced by improving the quality of referral information to consultants, high quality discharge letters back to GPs with advice and management plans.

Alternative ways of getting secondary care opinions such as expanding the current virtual haematology will be more convenient for patients. The changes will ensure that patients receive care as close to home as possible.

Details of how savings are to be invested is covered under section 3.1

Quality Impact Assessments (QIAs)

QIAs are an integral part of the annual planning cycle and are completed by the healthcare provider, proposed by the Chief Nurse and Medical Director and adopted by the Trust's Board. The Commissioner reviews the QIAs in advance and views are taken on board prior to the final submission. The CCG must also report through to NHS England the assurance level it has of provider efficiency savings and the extent to which quality and safety is optimised. This process will be completed in April 2014.

2.9 Governance arrangements for progress and outcomes

The CCG and RMBC have co-terminus boundaries and already have a layer of governance and delivery mechanisms in place. There is clear agreement to the need to maintain a simple clear governance framework which does not add to the burden of any of the agencies or partnership mechanisms.

The delivery of the BCF will be fully integrated with the delivery of the Health and Wellbeing Strategy and as a result, the existing mechanisms with some adaptation will be fit for purpose to ensure effective scrutiny, accountability and delivery.

The framework shown in Appendix 12 demonstrates the decision making structure and how the BCF plan will be delivered through the various groups.

The Health and Wellbeing Board will:

- Monitor performance against the BCF Metrics (National/ Local) and receive exception reports on the BCF action plan
- Agree the Better Care Fund Commissioning Strategy
- Agree decisions on commissioning or decommissioning of services, in relation to the BCF

The BCF Task group will monitor delivery of the Better Care Plan through quarterly meetings, ensuring performance targets are being met, schemes are being delivered and additional action is put in place where the plan results in any unintended consequences. The Task Group will report directly to the HWBB.

2.10 Audit and assurance process

To provide an independent review of the BCF, including the source and use of the funds, a local audit and assurance process has been agreed. The final report of which will be shared with the respective members of both organisations and the Task Group.

Scope of the Audit: that the BCF has:

- Been developed with the national planning guidance in mind
- Is fit for the purpose, in that it clearly sets out indicative budgets for the CCG and RMBC and identifies those areas for which each party will have commissioning responsibility
- Provided a clear audit trail of where funds are invested in contracted services
- Provided a clear audit trail to substantiate claims made against the risk pool;
- Provided a clear audit trail supporting the financial reporting to the CCG, RMBC and BCF Task Group
- Reflected a diligent approach by both parties to quantify and manage current and future budgets and identify future risks
- Reflected good internal control.

3. National Conditions

3.1 Our local definition of protecting adult social care services

NHS savings of £7.6m will be used to fund transformation – this is illustrated in the table below:

BETTER CARE FUND 2014-15	EXISTING SOCIAL CARE	PROTECTING & TRANSFORMING SOCIAL CARE	EXISTING HEALTHCARE	PROTECTING & TRANSFORMING HEALTH-CARE	TOTAL
	£000s	£000s	£000s	£000s	£000s
Funded from Health	6,214	1,151	5,840		13,205
Additional funding from Health Savings		2,336		4,105	6,441
TOTAL from Health	6,214	3,487	5,840	4,105	19,646
Funded from Local Authority	3,305	148			3,453
TOTAL Funding	9,519	3,635	5,840	4,105	23,099

The savings are to be invested as follows:

- Growth monies of £1.3m have been allocated from NHS England for social care in 2014-15 which will be utilised to protect social care (£1.1m) and provide support to advice, Mental Capacity and IT (£0.2m);
- In relation to concerns around the impact of CCG transformation in mental health and integrated fast response, we have proposed a risk pool for 2014/15 to protect both parties against unintended consequences. This is estimated at approximately £x00k and will require auditable information in year to support the claims from either party;
- There is a potential unintended impact on the Occupational Therapy service of the successful social prescribing initiative which is estimated at £100k by RMBC colleagues;
- The transformation of the intermediate care residential beds including therapy services estimated at £320k;
- Support the development of 7-day working in social care by £240k to provide additional social work capacity to supplement the existing emergency duty support at weekends;
- For data sharing – both parties agreed to increase the allocation in this area in 2014/15; CCG contribution £250k and RMBC £148k;
- £511k for transformation of S256 care Individual case management of high risk patients and over 75s - £2.2m;
- Hospice at home - £771k;
- Social prescribing - £500k
- Mental Health liaison - £375k rising to £1m in 2015/16

There are a number of ways in which the Rotherham BCF will protect social care services. Firstly, services such as Community Occupational Therapy, Intermediate Care and The Rotherham Equipment Service are all fully integrated health social care services, which are measured against the adult social care outcome framework. Placing them under the umbrella of BCF will secure these services for the future, save costs further down the care pathway, and allow for growth in social care services where transformation in other parts of the system require it.

Key to the delivery of integrated person centred services, in the context of reduced revenue and increased demand for health and social care services, is a core offer of social care services including:

- Advice, guidance and information sharing
- Preventive services such as telecare/assistive technology, reablement, intermediate care – all designed to support independence
- Ongoing care provision including personalised services which offer choice and control to the individual to enable them to lead as independent a life as possible
- Good quality domiciliary and residential care

This approach will transform the way patients with high needs access services and will ensure more joined up working between health and social care.

It is known that cuts to social care services increase pressure on the NHS, and protecting the NHS is a key priority for central government. Without the support that is achieved through the Better Care Fund, social care reductions will negatively impact on the local NHS community. RMBC has taken the following actions to date:

- A rational approach to setting reasonable fees for provider services, including tackling high cost fees for learning disability residential placements and supporting the quality of care in older people's residential care services
- Increases in charges for care
- A greater use of reablement services that offer support to people to enable them to remain independent
- Implementation of personalised support, alongside effective commissioning of services

To date it is clear that these efforts have enabled the council to manage increasing demand due to demographic pressures – these approaches cannot be effective indefinitely, and in 2013/14 there are indications that demand, despite the actions taken to reduce demand through reablement etc., is beginning to increase significantly.

In order to prevent further cuts to services, it is essential that the BCF is used to support those care services which in turn protect the NHS.

3.2 How social care services will be protected within our plan

The Better Care Fund brings together the NHS and local authority resources that are already committed to existing core activity. The Better Care Fund will be used in the first instance to protect the funding to existing services, allowing the local council to maintain its current eligibility criteria, under Fairer Access to Care Services (FACS). Current services will be reviewed and evaluated to ensure that they address the key aims of the Better Care Fund. Where they are not seen to be delivering against this, they will be re-commissioned or de-commissioned and the funding reinvested in services that support improvements in health and wellbeing, independence, and prevents admission to care services or hospital, as well as information and signposting services for people who are not eligible for services, to prevent or delay their need for such services.

The BCF will ensure we do not have to raise the eligibility criteria for assessment, care management, and commissioned support, with the potential that this investment will need

to increase to maintain the offer in the light of developing 7 day services and additional responsibilities that the Care Bill will bring when enacted in 2015.

3.3 Seven day services to support discharge

There is a commitment in our plan to the achievement of 7 day working in all parts of the health service, parity of esteem for people living with mental health issues and better care for people requiring integrated health and social care services. This is a key element in our contract negotiations with providers.

There is also a commitment from the CCG to support GP practices in transforming the care of patients aged over 75 in line with national planning guidance. This is being developed in year to complement our strategy for vulnerable people which is also included in our plan.

Existing services, including out of hours support by social workers, access to enabling care and intermediate care, will be reviewed and strengthened where necessary in response to emerging patterns of demand.

3.4 Information and data sharing

All Rotherham NHS correspondence uses the NHS number as primary identifier, and the council has a plan already in development to enable this to be used on social care systems. It is proposed that use of the NHS number as a unique identifier across all health and social care will create the starting point for the development of shared IT capacity locally.

Through the BCF there is a commitment to ensure that all providers have access to integrated person-held records, which include all health and social care plans, records and information for every individual. To enable this to happen we will develop portal technology to share data in a secure way that is in the best interest of people who use care and support.

The BCF Plan has highlighted actions related to the use of technology and information that, if fully implemented, could deliver significant benefits to the health and social care economy. These benefits include improvements to quality and efficiency as well as patient experience and satisfaction.

The BCF Plan will deliver improvements in data sharing across health and social care. Accompanied with effective use of new technology it will liberate practitioners and transform the way they work. As well as delivering efficiencies, there are also tangible benefits such as the improvements in the quality of care delivered, the accuracy of data collected, improved data flow between health and social care and the increased flexibility the practitioners have in managing their time and location of work.

The BCF Plan will ensure greater efficiency in accessibility of patient information. Increased accessibility will enable faster transfer of medical history in a medical emergency or when visiting a new practitioner. Researchers and public health authorities, with the permission and consent of the patient, will be able to collect and analyse up-to-date patient data. Such access is imperative in emergency situations, and also allows public health officials to easily conduct outbreak and incident investigations. Improved

accessibility will also enable health care providers to reduce costs associated with duplicate testing, appointment reminders and laboratory results.

We are committed to adopting systems that are based upon open APIs (Application Programming Interface).

All Rotherham NHS platforms are Information Governance Toolkit compliant and Rotherham CCG has achieved assurance on Caldicott 2 compliance in March 2014.

Underpinning the developments outlined above, the Health and Wellbeing Board has collectively signed up to an overarching information sharing protocol (appendix 5), which provides a framework for information sharing for all partner organisations.

3.5 Joint assessment and accountable lead professional

There is an initiative in place to improve the case management of the 5% (12,000) of patients at risk of hospitalisation which is key to our unscheduled care efficiency plan. In 2013/14 the pilot was solely for patients identified by a computer tool as being at the highest risk of admission to hospital. In 2014/15 the tool will still be used to identify the first 3% of patients eligible to be on the scheme. An additional 2% of each practices population will be eligible for the scheme, this will also include all patients in nursing and residential homes and other patients selected on the basis of clinical judgment.

Within the case management programme the accountable professional is the GP. In Rotherham the Case Management Programme places GPs at the centre of care coordination. Over the next 12 months we will transform community services to ensure that patients can access high quality, safe sustainable community services including multi-disciplinary community teams and specialist community services that target specific conditions.

We are embarking on a programme of integration across acute/community services and also across health/social care. This will ensure that packages are fully integrated and contain clear lines of accountability

In light of the planning guidance requirement to provide addition GP services for patients over the age of 75 the CCG will add an additional component to the Locally Enhanced Scheme (LES) to provide services for all 20,000 people in Rotherham over 75. The CCG will make the case management and over 75 services funding recurrent so that practices can make permanent appointments as the current shortage of locums is affecting the stability of current services.

The BCF Plan will deliver significant benefits through delivery of integrated services and joint assessment. The development of a joint assessment framework will help prevent harm and crises to individuals at risk. It will do this by promoting a shared understanding of risk amongst health and social care professionals. Case management processes, led by one person, will improve co-ordination, reduce duplication and support communication across organisational boundaries. The clear lines of accountability resulting from identifying a case manager will encourage creative approaches to assessment which are more person-centred. The benefits of shared assessment in hospital will include improved patient information on admission and better communication between wards. It will encourage holistic working and overcome professional boundaries. There will be an

improved understanding of other professional roles, increased expertise and improved decision-making through information sharing.

4. RISKS

We have set out below the most important risks that we believe are associated with the delivery of the BCF plan. This includes our 'mitigating actions plan' which demonstrates the agreed commitment to share the risks between both partners, and ensure robust arrangements are in place to identify and manage risks and unintended consequences.

These risks and mitigating actions will be managed by the BCF Task Group, which will meet on a quarterly basis to review the BCF plan, reporting to the Health and Wellbeing Board where necessary.

A more detailed risk register is included as appendix 7.

Risk	Risk rating	Mitigating Actions
Introduction of the Care Bill resulting in an increase in cost of care provision from April 2015, impacting on social care services and funding	**High**	Working group established and initial impact assessment undertaken of the potential effects of the Care Bill.
Unintended consequences of achieving savings in one area of the system could result in higher costs elsewhere.	**Medium**	All partners have made a commitment to ensure that if evidence of these consequences is seen, cash will flow to the right place across the system that all partners will benefit from. Both partners have agreed a 'risk pool' to form part of the BCF plan, which can be used if the plan results in any unfunded consequences on any part of the system. The BCF plan will be monitored on a quarterly basis by the Task group, and any consequences will be reviewed. We will consider turning this risk green in-year based on this process if both partners are comfortable with progress.
Governance is deemed by NHS England not to meet requirements to deliver the BCF change	**Medium**	Task group to agree the most appropriate governance structure for BCF, which includes the HWBB as the accountable body.
Performance targets are unachievable	**Medium**	Metrics agreed following robust process testing for "statistically significant" impact and

		investments made through BCF where appropriate.
Failure to receive 50% of the pay-for-performance element at the beginning of 2015/16.	**Medium**	HWBB to ensure plan meets the national requirements and is fully adopted by April. Performance management framework in place to monitor progress throughout 2014/15 to ensure meet agreed targets.
Failure to receive the remaining 50% of the pay-for-performance element mid 2015/16 due to not meeting the in-year performance targets.	**Medium**	Performance management process in place, accountable to the HWBB
Shifting of resources could destabilise current service providers.	**Low**	Joint working with stakeholders to develop implementation plans and timelines that include contingency planning. Assessment of the potential impacts on the provider to be collated as integral to the implementation plan CCG to receive Quality Impact Assessments in March from providers regarding their respective efficiency plans. Local authority will continue to engage with providers through the Shaping the Future events programme to ensure potential impact is understood and planned for.

This template is to be used for part 2 of HWB BCF plans and replaces the original template available on the NHS England BCF webpage. The new version contains more information in the metrics section and is locked in order to assist in the NHS England assurance process .

This new template should be used for submitting final BCF plans for the 4th April

Association

Finance - Summary

##

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 /£	Minimum contribution (15/16) /£	Actual contribution (15/16) /£
Rotherham MBC	Y	£ 3,453	£ *1,968*	£ *3,670*
NHS Rotherham CCG	Y	£ 19,646	£ *18,350*	£ *19,646*
BCF Total		**£ 23,099**	**£ 20,318**	**£ 23,316**

Approximately 25% of the BCF 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.

The BCF plans are based on robust methods of working which will be further enhanced by targeted investment to deliver the outcomes. Failure to reduce emergency admissions or social care costs will be mitigated in the first instance by any underspends in the BCF funds and CCG/RMBC contingency plans thereafter.

Contingency plan:		2015/16	Ongoing
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Proportion of older people (65 & over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Delayed transfers of care from	Planned savings (if targets fully		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please add rows to the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£
BCF01 - Mental Health Service	MH FT	£ 1,128		£ 400		£ 1,128		£ 400	
BCF02 - Falls prevention	RFT	£ 903		£ 320		£ 914		£ 320	
BCF03 - Joint call centre incorporating telecare and telehealth	RFT/RMBC	*In year workstream to inform future BCF				*In year workstream to inform future BCF			
BCF04 - Integrated rapid response team	RFT/RMBC	£ 1,226		£ 435		£ 1,226		£ 435	
BCF05- 7 day community social care and mental health provision to support discharge and reduce delays	RFT/RMBC	£ 4,802				£ 4,802			
BCF06 - Social Prescribing	Voluntary Sector	£ 605		£ 214		£ 605		£ 214	
BCF07 - Joint residential and nursing care commissioning and assurance team	RCCG/RMBC	*In year workstream to inform future BCF				*In year workstream to inform future BCF			
BCF08 - Learn from experiences to improve pathways and enable a greater focus on prevention	RFT/RMBC	£ 27				£ 27			
BCF09 - Personal health and care budgets	RMBC	£ 1,643				£ 1,643			
BCF10 - Self-care and self management	RFT	£ 50				£ 50			
BCF11 - Person-centred services	Primary Care	£ 3,239		£ 1,148		£ 3,239		£ 1,148	
BCF12 - Care Bill preparation	RMBC	£ 275				£ 275			
BCF013 - Review existing jointly commissioned integrated services	RMBC	£ 7,938				£ 7,938			
BCF14 - Data sharing bewteen health and social care		£ 250				£ 250			
Disabled Facilities Grant	RMBC	£ 1,013				£ 1,219			
Total		£ 23,099	£ -	£ 2,517	£ -	£ 23,316	£ -	£ 2,517	£ -

Association

Outcomes and metrics

Please provide details of how your BCF plans will enable you to achieve the metric targets, and how you will monitor and measure achievement

Template 1 provides further details of how our BCF plans will enable Rotherham to achieve the metric targets and these will be monitored monthly through our operational group.
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population - We plan to reduce admissions rate by 12%
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services - We plan to increase these services by 4%.
Delayed transfers of care from hospital per 100,000 population (average per month) We plan to reduce delayed transfers rate by 7%
Avoidable emergency admissions (composite measure). We plan to reduce avoidable admissions by 15% over the 5yr strategic planning period with a 3% reduction in 2014/15.
Emergency readmissions - there is a plan to reduce the rate of emergency readmissions where clinically appropriate by 4%. This is supported by community services which are currently being reviewed to ensure that seven day and locally designed services are in place.

A range of outcomes and benefits from our schemes will be provided via our action plans. All measures will benefit from aspects of :
- Integrated rapid response team - will provide a joint approach to an integrated rapid response service, ensuring a coordinated response is provided to individuals' needs, which supports them to remain independent while reducing admissions to residential care and hospital.
- 7-day community, social care and mental health provision to support discharge and reduce delays, ensuring appropriate services are available 7 days a week to enable timely discharge from hospital, and avoid unnecessary admissions to hospital or residential/nursing care.
- Social Prescribing pilot findings that deliver on prevention, avoidance and delaying access to formal care services with the outcomes of the need for more formal care services being reduced.
- Learning from experiences (of high social care and health users) to improve pathways and enable a greater focus on prevention that sustains users within the community.
- Care Bill preparations, will result in Rotherham adult social care being able to meet the increased demand and maintain / protect the existing level of service.
- Review existing jointly commissioned integrated services (S75 and S256 agreements and pooled budget arrangements) will deliver value for money for customers and provide effective services through de-commissioning/re-commissioning as appropriate.

In addition other actions will impact on specific metrics from the six national and local suite including outcomes resulting from our actions regarding:
- Review of Mental Health provision resulting in greater investment in community based and primary care preventative activity which addresses mental health issues much earlier.
- Falls prevention service improvements identify that where a person is more at risk of a fall, they are provided with the right advice and guidance to help them prevent it.
- Personal health and care budgets provision will be maximised to individuals so they are provided with the right information and feel empowered to make informed decisions about their care.
- Self-care and self-management working with voluntary and community groups to co-design, co-develop and co-produce improved health and care outcomes, so that Individuals are provided with the right information and support to help them self-manage their condition/s.
- Person-centred services recorded on a person held plan (using NHS number) will mean individuals will only need to tell their story once and key details are available (in home and on shared portal initially, building to shared IT capacity) which enables integrated, person-centred service delivery.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

National metric to be used

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

Each metric will have a performance management and assurance process in place. The overall performance management will take place at the Health and Wellbeing Executive (Holds HWB and BCF overview, supports HWB) and will be monitored by the Health and Well Being Board.

Each metric will have:

A designated senior lead ASC/Health operational manager, who will be responsible for delivery of the overall measure performance and has the 'power' to direct available resource to meet service demands within agreed limits.
An agreed action plan, with milestones and target delivery profiles
An appropriate frequency of reporting to Senior Management Teams/Executives/Boards etc
An agreed quality assurance of reported performance
An agreed remedial action plan process when a 'trigger' is activated
An agreed escalation process with sufficient 'power' to direct available resource to meet service demands within agreed limits
Satisfaction testing of outcomes achieved, which when coupled with any complaints learning will lead as appropriate to further improvements being factored into on-going arrangements

Permanent admissions - Delivery of this metric will be lead by Rotherham MBC
Reablement - Delivery of this metric will be lead by Rotherham MBC
Delayed Transfers - Delivery of this metric will be lead by Rotherham NHS
Avoidable emergency admissions - Delivery of this metric will be lead by Rotherham NHS
Emergency readmissions - Delivery of this local metric will be lead by Rotherham NHS

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Not applicable

Please complete all pink cells:

Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	739.6	N/A	650.7
	Numerator	345		317
	Denominator	46645		48720
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	86.70	N/A	90.00
	Numerator	110		117
	Denominator	130		130
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	124.6	119.9	114.8
	Numerator	2282	2207	1415
	Denominator	203503	204480	205444
		Apr 2013 - Dec 2013 (9 months) 9	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	2634.8	1193.9	1368.3
	Numerator	6807	3115	3570
	Denominator	258352	260908	260908
		Apr 2012 -Mar 2013 (12 months) 12	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience *For local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used*		National measure to be used *(State time period and select no. of months)* 1	N/A	National measure to be used *(State time period and select no. of months)* 1
Local measure *Emergency readmissions within 30 days of discharge from hospital (all ages) PHOF 4.11 NHSOF 3b - Note this is a local variation to national measure, and calculates from patients registered with a Rotherham GP, not local authority population.*	*Metric Value*	12.1	11.9	11.6
	Numerator	2290	2995	2934
	Denominator	18932	25250	25250
		Apr 2013 - Dec 2013 (9 months) 9	*Apr 2014 - Mar 2015 (12 months)* 12	*Apr 2015 - Mar 2016 (12 months)* 12

Appendix 2 Rotherham Better Care Fund Action Plan

Ref.	Scheme	Outcome	Action	Measure/s	Finance	Lead
Prevention and Early Intervention (PE) – Rotherham people will get help early to stay healthy and increase their independence						
PE1 We will co-ordinate a planned shift of resources to high dependency services to early intervention and prevention						
BCF01	**Mental Health Service**	A jointly agreed plan which results in a reduction in formal, high intensity use of services (including acute services and police intervention) and a greater investment in community-based and primary care preventative activity which addresses mental health issues much earlier on. This new service will be addition to existing services and will transform how patients with Mental Health issues are treated in the Rotherham urgent care system. This will also improve patient experience and health outcomes.	Commission mental health liaison provision, ensuring it is aligned to health and social care priorities for prevention and early intervention. Increase funding available for social care packages including short term support time and recovery packages provided through Direct Payment, to enable where appropriate a link with personal health budgets to support longer term recovery .	Admissions to residential and care homes Avoidable emergency admissions Patient/service user experience Emergency readmissions	£1.1m .	**Deputy Chief Officer CCG** **Strategic Commissioning Manager, RMBC**
BCF02	**Falls prevention**	Older people are aware of the risks of falls and have opportunities to remain active and healthy in their community. Where a person is more at risk of a fall, they are provided with the right advice and guidance to help prevent them.	Review the falls service to ensure its primary focus is delivering a preventive community-based service, as well as targeting those most vulnerable, who are most at risk of fracture neck of femur.	Admissions to residential and care homes Effectiveness of reablement Avoidable emergency admissions Patient/service	£0.9m	**Head of Urgent Care and Long-term Conditions, CCG**

				user experience Emergency readmissions		
BCF03	**Joint call centre incorporating telecare and tele-health**	A coordinated response is provided to individuals' needs and an increased use of assistive technologies to support independence and reduce hospital admissions.	Undertake a scoping exercise to identify efficiencies and improvements in practice that can be delivered though integrated / joint working between the Rothercare Community Alarm Centre and the Care Coordination Centre. Review the service to incorporate increased use of assistive technology and extended use of telehealth and tele-coaching to support people to stay at home, and explore increased use of assistive technology to reduce costs within mainstream social care services including domiciliary care and residential care	Admissions to residential and care homes Effectiveness of reablement Avoidable emergency admissions Patient/service user experience Emergency readmissions	This will require scoping of the existing service and a transfer of funds	**Head of Urgent Care and Long-term Conditions, CCG** **Director of Health and Wellbeing, RMBC**
PE2 Services will be delivered in the right place, at the right time, by the right people						
BCF04	**Integrated rapid response team**	A coordinated response is provided to individuals' needs, which supports them to remain independent while reducing admissions to residential care and hospital.	Implement a joint approach to an integrated rapid response service, including out of hours, capable of meeting holistic needs of identified individuals to reduce hospital admission. Incorporate community nursing, enabling and commissioned domiciliary care, to be funded the through the BCF to protect social care services from the impact of additional community based support packages.	Admissions to residential and care homes Effectiveness of reablement Delayed transfer of care Avoidable emergency admissions	£1.2m	**Head of Urgent Care and Long-term Conditions, CCG** **Strategic Commissioning Manager, RMBC**

			Additional assessment time (social care support) to be provided through the BCF as part of the response, in order to enable throughput through the Fast Response service, either into funded packages or through the social care prescribing offer into community based prevention activity.	Patient/service user experience Emergency readmissions		
BCF05	**7-day community, social care and mental health provision to support discharge and reduce delays**	Appropriate services are available 7 days a week to enable timely discharge from hospital, and avoid unnecessary admissions to hospital or residential/nursing care.	Review and evaluate existing arrangements against potential increase in demand arising from 7 day working across the community, social care and mental health. This will require an increase in social work support to support discharge, and increases in domiciliary care funding for packages to protect social care services. Fund a pilot project, social care staff working with Community Nurses to intervene early to avoid admission to hospital and residential care, supported by the outcomes of the project identified at BCF06	Admissions to residential and care homes Effectiveness of reablement Delayed transfer of care Avoidable emergency admissions Patient/service user experience Emergency readmissions	£4.8m	**Head of Urgent Care and Long-term Conditions, CCG** **Adult SS Service Manager, RMBC**
Expectations and Aspirations (EA) – All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community						
EA1 We will ensure our workforce routinely prompt, help and sign-post people to key services and programmes						

BCF06	**Social Prescribing**	The need for more formal care services is reduced, creating an opportunity to shift investment into community activity that fosters independence and encourages local people to participate in their community. This service won a National Award from NHS England for best practice and will transform services from being reactive to a pro-active multi agency approach for Rotherham patients with high needs.	Review social prescribing service to ensure it is delivering on prevention, avoidance and delaying access to formal care services, and commit to mainstream this service subject to findings.	Admissions to residential and care homes Effectiveness of reablement Delayed transfers of care Avoidable emergency admissions Patient/service user experience Emergency readmissions	£0.6m	**Assistant Chief Officer, CCG**
BCF07	**Joint residential and nursing care commissioning and assurance team**	Reduction in the cost of contract compliance increased monitoring of nursing standards, reduced admissions to hospital and improved hospital discharges. Reduced cost of significant service failure and safeguarding though a more proactive/ preventive/ coordinated approach.	Implement a joint approach to a single LA and CCG team whose purpose is to commission and assure quality of service in residential and nursing care homes, with clear links to GP case management and an integrated response from health services.	Avoidable emergency admissions Patient/service user experience Emergency readmissions	This will require a review of existing services and creation of a jointly commissioned/ managed team supported by but not necessarily funded by the BCF	**Head of Urgent Care and Long-term Conditions, CCG** **Strategic Commissioning Manager, RMBC**
EA2 We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions						

BCF08	**Learn from experiences to improve pathways and enable a greater focus on prevention**	A shift in investment from high-cost, high-intensity users of health and social care, to low cost high impact community initiatives which focus on prevention. A co-produced (between health, public health and social care) risk stratification tool to identify high intensity users.	Undertaken a deep dive exercise conducted on cases of high social care and health users. Map the journey through health and social care services to identify opportunities to improve pathways and explore where better preventative action earlier on may help avoid or delay access to health and care services in the future. Carry out a full evaluation of Rotherham's risk stratification tool, and develop a mechanism for identifying high intensity users of health and social care services.	Admissions to residential and care homes Effectiveness of reablement Delayed transfers of care Avoidable emergency admissions Patient/service user experience Emergency readmissions	£0.03m	**Head of Urgent Care and Long-term Conditions, CCG** **Director of Health and Wellbeing, RMBC**
Dependence to Independence (DI) – Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances						
DI1 We will change the culture of staff from simply 'doing' things for people to encouraging and prolonging independence and sel-care						
BCF09	**Personal health and care budgets**	Individuals are provided with the right information and feel empowered to make informed decisions about their care.	Commitment to giving personal budgets to as many people as possible, and will develop our plans to do this. Extend our current plans for personal health budgets, working with patients, service users and professionals.	Admissions to residential and care homes Effectiveness of reablement Patient/service user experience	£1.6m	**Head of Contracting and Service Improvement, CCG** **Adult SS Service Manager, RMBC**
BCF10	**Self-care and self-management**	Individuals are provided with the right information and support to help them self-manage their condition/s.	Develop self-care and self-management, working with voluntary and community groups to co-design, co-develop and co-	Admissions to residential and care homes	£0.05m	**Head of Urgent Care and Long-term**

		Professionals are equipped with the right skills to enable self-care / self-management and promote independence.	produce improved health and care outcomes, including the areas of transitions from young people's services into adult care. Develop patients and practitioner skills programmes that can be implemented across health and social care. Development of integrated workforce development programmes and risk management courses aimed at promoting an ethos of self-management. Develop specialised psychological support services for people with long term conditions so that they are better able to self-manage their condition.	Effectiveness of reablement Avoidable emergency admissions Patient/service user experience Emergency readmissions		**Conditions, CCG** **Director of Health and Wellbeing, RMBC**
DI2 We will support and enable people to step up and step down through a range of statutory, voluntary and community services appropriate to their needs						
BCF11	**Person-centred services**	Each individual has a single, holistic, co-produced assessment, meaning they only need to tell their story once and key details are available (in home and on shared portal initially, building to shared IT capacity) which enables integrated, person-centred service delivery. This approach will transform the way patients with high needs access services and will ensure more joined up working between health and social care.	Develop and implement a person centred, person held plan, in partnership with key stakeholders.	Patient/service user experience	£3.2m	**Head of Urgent Care and Long-term Conditions, CCG** **Director of Health and Wellbeing, RMBC**

BCF12	**Care Bill preparation**	Rotherham adult social care is able to meet the increased demand and maintain / protect the existing level of service.	Identify the cost and activity pressures resulting from the implementation of the care bill, including increased assessments, carers assessment and support, information advice and guidance capacity, and resulting administrative and operational costs. Develop a plan to meet these pressures.	The Care Bill will impact on all BCF outcome measures	£0.3m	**Director of Health and Wellbeing, RMBC**
Long-term Conditions (LTC) – Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life						
LTC1 We will adopt a co-ordinated approach to help people manage long-term conditions						
BCF13	**Review existing jointly commissioned integrated services**	All jointly commissioned services provide value for money and are aligned with the BCF vision and principles. Where services are not efficient and effective, a plan is developed to de-commission/re-commission as appropriate.	Undertake a project to review all existing S75 and S256 agreements and pooled budget arrangements. KPMG (both organisations' External Auditors) to provide independent view. Where this will impact on current services being provided, ensure that social care is funded to ensure that the current levels of outcomes being met are maintained. This will be achieved through an increase in the appropriate budgets ie residential care, home care	All integrated services impact on BCF outcome measure/s	£7.9m	**Chief Finance Officer, CCG** **Strategic Commissioning Manager, RMBC**
LTC2 We will develop a common approach to data sharing so we can provide better support across agencies and put in place a long-term plan for the life of the individual						
BCF14	**Data sharing between health and**	All providers have access to integrated person-held records, which include all health and social	Develop portal technology to share data in a secure way that is in the best interest of people who use	Delayed transfer of care	£0.3m	**Customer Relationship Manager,**

	social care	care plans, records and information for every individual.	care and support. Use of the NHS number as a unique identifier across health and social care will create the starting point for the development of shared IT capacity.	Avoidable emergency admissions Patient/service user experience Emergency readmissions		**CCG** **Systems Developmen t Manager, RMBC**

Appendix 7 Rotherham Better Care Fund Risk Register

Risk	Risk Impact		Score	RAG	Risk Owner	Mitigating Actions
	Likelihood	Impact				
Not meeting the required deadlines for completion of BCF Plan	1	2	2	Green	HWBB	Timeline and responsibilities for completion of template agreed
Loss of key leaders in Task Group or Officers Group	3	3	9	Green	Martin Kimber/ Chris Edwards	Leadership groups formal membership and substitutes agreed
Plan for BCF not agreed by Task Group	2	2	4	Green	Tom Cray/ Chris Edwards	Work Plan developed through multi agency officer group and agreed with leadership team and Health and Wellbeing Board
Unable to agree local performance indicator	1	2	2	Green	Task Group	Local Indicator agreed from the list of 9 to reflect a critical strand of work in Rotherham
Financial information on joint and single budget contributions not agreed	2	2	4	Green	Keely Firth/ Mark Scarrott	Work to progress through financial budgets and align with each organisation
Insufficient or ineffective consultation undertaken	3	3	9	Green	Tom Cray/ Chris Edwards	A communication and consultation strategy developed to ensure significant sharing of information re BCF and future impact. To include customers, patient reps, providers and stakeholders. A forward plan for consulting and engaging with the public and providers is also included in the local plan.
NHS England deem the BCF plan is not innovative enough to deliver change	3	3	9	Green	HWBB	Challenge process built into formal discussions and agreement of the plan
Governance is deemed by NHS England not to meet requirements to deliver the BCF change	3	2	6	Green	HWBB	Task group to agree the most appropriate governance structure for BCF, which includes the HWB as the accountable body.

Shifting of resources could destabilise current service providers.	**3**	**3**	**9**	**Green**	HWBB	Joint working with stakeholders to develop implementation plans and timelines that include contingency planning. Assessment of the potential impacts on the provider to be collated as integral to the implementation plan. CCG to receive Quality Impact Assessments in March from providers regarding their respective efficiency plans hence the amber score. Local authority will continue to engage with providers through the Shaping the Future events programme to ensure potential impact is understood and planned for.
Performance targets are unachievable	**3**	**4**	**12**	**Amber**	Scott Clayton/Ian Love	Metrics agreed following robust process testing for "statistically significant" impact and investments made through BCF where appropriate. Note: The baseline year for targets had neither adverse weather or any major outbreaks, this could have an impact on achieving targets in subsequent years, appropriate monitoring of performance throughout the year to ensure they continue to be achievable.
Unintended consequences of achieving savings in one area of the system could result in higher costs elsewhere.	**4**	**3**	**12**	**Amber**	Martin Kimber/. Chris Edwards	All partners have made a commitment to ensure that if evidence of these consequences is seen, cash will flow to the right place across the system that all partners will benefit from. Both partners have agreed a 'risk pool' to form part of the BCF plan, which can be used if the plan results in any unfunded consequences on any part of the system. The BCF plan will be monitored on a quarterly basis by the Task group, and any consequences will be reviewed. We will consider turning this risk

						green in-year based on this process if both partners are comfortable with progress.
Failure to receive 50% of the pay-for-performance element at the beginning of 2015/16.	**3**	**4**	**12**	**Amber**	HWBB	HWB to ensure plan meets the national requirements and is fully adopted by April. Performance management framework in place to monitor progress throughout 2014/15 to ensure meet agreed targets.
Failure to receive the remaining 50% of the pay-for-performance element mid 2015/16 due to not meeting the in-year performance targets.	**3**	**4**	**12**	**Amber**	HWBB	Performance management process in place, accountable to the HWB
Introduction of the Care Bill resulting in an increase in cost of care provision from April 2015, impacting on social care services and funding.	**5**	**4**	**20**	**Red**	Shona McFarlane	Working group established and initial impact assessment undertaken of the potential effects of the Care Bill.

BCF Appendix 8

Better Care Fund Consultation Plan

Objective	Communication method used	Delivered by	Delivered to	Timescales	Feedback Mechanism	Progress
Consultation pre development of the plan						
Initial consultation to obtain individuals views regarding integrated support and care	Survey using the healthwatch database and survey monkey Semi structured interviews Report key findings from comments which relate to people who have used more than one service (Collected from July 13 – December 13)	Rotherham Healthwatch	Healthwatch members and individuals who have accessed the advocacy service and had experiences of poor care	To be concluded by 24th January 2014	Report to task Group on findings on 31st January 2014	**COMPLETE** – evaluation report submitted to RMBC and finding used to inform the development of the BCF action plan
Gather existing information available regarding patient and service user experiences via previous: • Consultation exercises • Surveys	RMBC - Annual ASCOF – Adult Social Care User Survey RMBC – Social Services Survey of Adult Carers Health and Wellbeing consultation	Tanya Palmowski and Claire Green (Performance and Quality Team) and Dominic Blaydon (CCG)	Services users, patients, carers, VCS,	24th January 2014	Report to task Group on findings on 31st January 2014	**COMPLETE** – existing information available has been gathered and summarised and the findings have been included within the Better Care Fund consultation document. The findings have also been used to inform the development of BCF action

BCF Appendix 8

• Case studies	RMBC Learning from customers - Complaints, compliments and lessons learnt					plan
	RMBC Local Account					
	Public Health - Health Inequalities consultation					
	RMBC - Staff consultation previously conducted with RMBC and Health staff to identify improvements to the hospital admission to discharge process					
	CCG – Patient Participation Network					
To consult with providers on a range of issues around better joined up working with Health.	Survey via survey monkey to be distributed via email	RMBC Commissioning Team	305 Health and adult social care providers	28th January 2014	Report to task Group on findings on 31st January 2014	**COMPLETE** – 40 providers responded
	Provider Focus Group –	RMBC Commissioning Team and Kate Green (Policy Officer)	Health and adult social care providers	28th January 2014		**COMPLETE** – 9 providers attended
	Evaluation of findings	RMBC Commissioning and Kate Green (Policy Officer)		29th January 2014		**COMPLETE** – the findings have been summarised and included within the BCF consultation document. The findings have also been used to inform the development of the BCF action plan

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Consultation with RMBC customer inspectors on the vision, priorities and experiences of health and social care	Surveys completed over the telephone	RMBC Tanya Palmowski and Claire Green (Performance and Quality Team)	RMBC Customer inspectors representatives	Consultation between 20th – 24th January. Analysis by 28th January 2014	Report to task Group on findings on 31st January 2014	**COMPLETE** – The RMBC customer inspectors were asked various questions focussed around the proposed vision and obtain their views on what needs to change to improve services. The findings have been summarised and included with the BCF consultation documents and used to inform the development of the BCF action plan.
Consultation on the proposals						
Consultation with patients and service users on the BCF proposed actions, targets, I statements and case studies	Survey/Workshops	Tanya Palmowski and Claire Green (Performance and Quality)	Service users and patients	Dates tbc	Evaluation of findings to task group	
Consultation with health and social care providers on the implications of the BCF and Care Bill to bring together both pieces of work, resulting in a co-produced action plan for the year.	RMBC Shaping the Future of Care event	RMBC Commissioning and Kate Green (Policy Officer)	Social Care providers	07th May 2014	Evaluation of findings to task group	
Consultation with health providers on the implications of the BCF	Provider Focus Group	Dominic Blaydon	Health and Social Care providers	Dates tbc	Evaluation of findings to task group	
Consultation via Healthwatch on the proposed BCF actions, targets, I statements and case studies	Survey/workshops/interviews	Healthwatch	Healthwatch members and individuals who have accessed the advocacy service and had experiences of poor care	Dates tbc	Evaluation of findings to task group	

BCF Appendix 8

Consultation during delivery of the plan						
I statements - Monitor customer experiences following delivery of each of the actions contained within the BCF plan	Surveys/Telephone interviews/Face to face interviews/case studies	Tanya Palmowski and Claire Green (Performance and Quality)	Service users and patients	Dates tbc	Evaluation of findings to task group	
Consultation with patients and service users on progress	Survey/workshops	Tanya Palmowski and Claire Green (Performance and Quality)	Service users and patients	Dates tbc	Evaluation of findings to task group	
Consultation with providers on progress	Provider Focus Group/Shaping the Future of Care event	RMBC Commissioning and Kate Green (Policy Officer)	Health and Social Care providers			
Consultation via Healthwatch on progress	Survey/workshops/interviews	Healthwatch	Healthwatch members and individuals who have accessed the advocacy service and had experiences of poor care	Date tbc	Evaluation of findings to task group	

WHAT WILL THE BETTER CARE FUND PLAN DELIVER FOR THE PEOPLE OF ROTHERHAM

Better Care Fund Targets:

- *More people will have been supported to live independently in the community and the number of people admitted into residential and nursing care will have reduced by 12%.*
- *We will have increased the number of people who are still at home 91 days after hospital discharge by 4%*
- *The number of people who are unnecessarily delayed from being transferred from hospital back into the community will have reduced by 7%*
- *Avoidable admissions to hospital will have reduced by 3%*
- *Emergency re-admissions within 30 days of discharge will have reduced by 4%*

Better Care Fund Actions:

- ***BCF01*** *- Increased community based preventative support for people with mental health needs*
- ***BCF02*** *- A preventative community based Falls Service which targets those most vulnerable and those most at risk*
- ***BCF03*** *- Increased access to and use of assistive technology to support people to live independently in the community*
- ***BCF04*** *- A joint health and social care Rapid Response Team, including out of hours, providing a direct route to community based services and reducing the need for hospital admissions*
- ***BCF05*** *- A 7-day a week joint community, social care and mental health service which is there to promptly support people back into the community who need to be discharged from hospital*
- **BCF06** *- Increased use of voluntary and community based services by GP's, reducing the need for individuals to access formal care services and supporting independence*
- ***BCF07*** *- Improved standards in residential and nursing care through the development of a joint quality assurance team*
- ***BCF08*** *- Improved customer pathways as a result of listening to their experiences, providing better preventative services to support more people in the community*
- ***BCF09*** *- Increased the use of personal health and care budgets to help more customers have choice and control about the support they receive*
- ***BCF10*** *- Provided Information and support to help people-self-manage their conditions and stay independent*
- ***BCF11*** *- Each person has a single, health and social care plan which means they need to only tell their story once*
- ***BCF12*** *- Social Care Services meet the new requirements and demands of the Care Bill to ensure that people of Rotherham are supported when they need it most*
- ***BCF13*** *- Joint health and social care services deliver the best outcomes for the people of Rotherham*
- ***BCF14*** *- Customers see that health and social care information about themselves is shared and supports them to receive a better joined up service*

WHAT WILL THE BETTER CARE FUND PLAN DELIVER FOR THE PEOPLE OF ROTHERHAM

Brian is a 65 year old man and lives alone in a rented property. Brian has recently retired under ill-health. He has suffered with bi-polar disorder for a number of years which affects his mood; sometimes he can feel very depressed whilst other times he is overactive. Brian's sister recognises that he is increasingly showing signs of depression so she takes him to see the GP.

Brian was referred to the Mental Health Liaison Team promptly by his GP to ensure he is supported early to prevent his health and wellbeing deteriorating and reaching crisis point. The service encourages Brian to be actively involved in his support plan which keeps him in control enabling him to manage his condition more effectively. Brian has a person held record which sets out his goals. Brian has a schedule of appointments with his support worker which encourages him to live independently and safely in the community. He is also supported to access a Personal Health Budget to meet his long term needs, giving him control over the care and support he receives. This prevents Brian from reaching crisis and ensures that his condition is managed in a way that promotes better quality of life.

Without intervention Brian would be prone to neglecting himself when feeling depressed. This would impact on his general health and wellbeing and quality of life. He would also become increasingly dependent on other crisis intervention services including the Police and A&E.

Brian said 'I am listened to and supported at an early stage to avoid *crisis.'*

Emma is 42 years old and lives with her daughter who is her main carer. Emma has Multiple Sclerosis, which is a long term health condition. She was recently involved in a car accident. Emma was admitted to hospital to treat a broken leg and head injury. Emma is due to be discharged from the hospital back home.

The Social Care and Mental Health Community Team work 7 days a week to ensure Emma care and support needs will be met upon discharge from hospital. As Emma wishes to return home, the team recommends the Home Enabling Service. Emma is also referred to a specialist brain injury service.

Back home Emma receives support from the Home Enabling Service. The team helps Emma on a short term basis to mobilise safely and regain her confidence and independence. The Home Enabling Team and brain injury service recognise that Emma has ongoing care needs due to her brain injury and refer her for a social care assessment. Longer term social care support is provided to Emma through a jointly agreed support plan. This helps her maintain her independence and enable her to live at home, as she chooses. The brain injury service provides information and advice to Emma's carer to enable her to encourage Emma's recovery and provide practical day to day support at home. Without this intervention, Emma would have experienced a longer stay in hospital and as a result her long term health and quality of life could have been affected.

Emma said 'I am able to access information, advice and support

Harry is a full time Carer for his wife who suffers with dementia and has been feeling depressed and isolated. Harry is also worried about the couple's finances. This has meant that Harry has been making regular visits to the GP surgery as a coping mechanism.

Upon visiting the GP it was identified that Harry was at risk of a breakdown and the GP made arrangements for a Multi-disciplinary Team meeting (which includes various representatives including; GP, Voluntary Action Rotherham, Social Worker). The meeting resulted in Harry being provided with various information and advice about local support groups for those suffering with dementia and their careers and being signposted to financial support services.

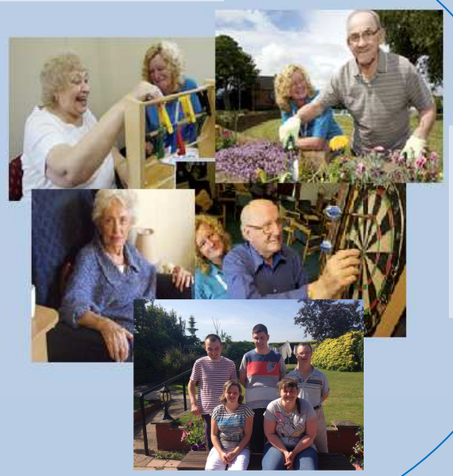
Harry and his wife now attend a regular dementia café and support sessions which have prevented them from feeling isolated and accessing formal care services. Harry also receives 3 hours respite a week, to allow him to socialise within the community and he no longer has concerns about their finances. Through the support received and self-help Harry and his wife have been able to stay independent and improve their health and wellbeing.

Harry stated 'I feel part of my community, which helps me to stay healthy and independent.'

'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing' (BCF05, 08, & 12)

'I feel part of my community, which helps me to stay health and independent' (BCF06 & 10)

I am listened to and supported at an early stage to avoid a crisis' (BCF01 & 12)



'I am in control of my care' (BCF09, 10 & 11)

'I feel safe and am able to live independently where I choose' (BCF02, 04, 07 & 03)

'I only have to tell my story once' (BCF11, 13 &14)

Jackie is 35 and suffers from rheumatoid arthritis. Due to a long term condition Jackie spends a lot of time in hospital, which can last for several weeks. Jackie is at breaking point and wants to spend more time at home, managing her condition, so she contacts her GP for help.

Jackie's GP arranges for her to receive a joint health and social care assessment of her needs. During the assessment it is agreed that a personal health and care budget would provide Jackie with choice and control over the support she receives.

Jackie is involved in developing her support plan and provided with information regarding various local groups that could support her, to manage her condition. Discussions also take place regarding things that Jackie could do for herself, to reduce the support she requires, for example staying healthy.

Using the personal health and care budget, Jackie decided to appoint a personal assistant to support her with daily tasks and purchased a gym pass to improve her health and wellbeing. Jackie also attends a number of activities in her local community. Through involvement in self-managing her condition Jackie's health is significantly improved.

Jackie stated 'Through my personal health care budget I am in control of my care.'

Dorothy is 73 years of age and lives with her husband in their own property. Dorothy has recently suffered a number of falls due to dizziness. This has had a significant impact on the couple's quality of life and independence. At 11pm one evening Dorothy fell. Her husband knew to ring the out-of-hours number due to previously contacting Assessment Direct for information and advice.

The Rapid Response Team visits immediately to listen to both Dorothy and her husband's concerns. Dorothy's social care needs are assessed and it is recommended that she would benefit from some equipment to help her to move safely around the house. A number of referrals are made to specialist services to make sure Dorothy's health and wellbeing needs are met. This includes the GP for further tests to be undertaken to diagnose the cause of Dorothy's dizziness. A referral was also made to a team specialising in falls prevention - the community based Falls and Fracture Service due to her being at risk of future falls.

The specialist assessments resulted in Dorothy being provided medication to prevent her dizziness, a falls belt and several grab rails being installed around the house to help Dorothy to move safely and independently. Dorothy was also provided with Rothercare Alarm System to provide her and her husband with peace of mind and reassurance that support is just a call away. Dorothy received a 12 week exercise programme and information and guidance to prevent future falls and following this she attended a community exercise programme to help maintain her functional ability, strength and balance. Each intervention has prevented Dorothy from falling again and potentially being admitted to hospital.

Dorothy said 'I feel safe and am able to live independently where I choose.'

George is 72 years of age and lives alone. George has diabetes and his health recently deteriorated, resulting in him being admitted to hospital. George is discharged from hospital and various support services are put in place.

Upon returning home George takes to his bed and is at risk of developing bed sores. The district nurse visits George and although she has never met him before, she has full access to his health and social care records and is able to make informed decisions regarding the treatments he requires.

6 weeks after discharge, a Social Worker visits George to review his care and support. During the review George says that he would like more support to help him within the community and it is agreed that a direct payment would give him the flexibility required, giving him more choice and control. The Social Worker has access to all George's records and works with him to develop a support plan, to meet all his longer term health and social care needs. The Social Worker develops a person centred plan which includes self-care/management to help George manage his condition.

George now has a managed direct payment which is paid directly to a provider and receives both home care and community support to help him with shopping and visiting the local café. Through improved joint working and data sharing George's customer/patient experience is significantly improved. Health and Social Care staff were also able to deal with Georges needs in a more timely manner.

George stated 'I only had to tell my story once.'

Rotherham Better Care Fund (BCF) Plan

Rotherham Metropolitan Borough Council

NHS Rotherham Clinical Commissioning Group

Rotherham Health & Wellbeing Strategy Vision

To improve health and reduce health inequalities across the whole of Rotherham

Priority areas

- ***Prevention and Early Intervention (PE)***
- ***Expectations and Aspirations (EA)***
- ***Dependence to independence (DI)***
- ***Long Term conditions (LC)***

Strategic Outcomes

- ***PE –*** *Rotherham people will get help early to stay healthy and increase their independence*
- ***EA –*** *All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community*
- ***DI –*** *Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances*
- ***LC –*** *Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life*

Outcome measures

- ***N1 Admissions into residential care -*** *Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 (We will support more people to live independently in the community and reduce the number of people admitted to residential and nursing care by 12%)*
- ***N2 Effectiveness of reablement*** *- Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services (We will increase the number of people who are still at home 91 days after hospital discharge by 4%)*
- ***N3 Delayed transfers of care*** *- Delayed transfers of care from hospital per 100,000 population (average per month) (We will reduce the number of people who are unnecessarily delayed from being transferred from hospital back into the community by 7%)*
- ***N4 Avoidable emergency admissions*** *- Avoidable emergency admissions (We will reduce avoidable admissions to hospital by 3%)*
- ***N5 Patient and service user experience*** – tbc
- ***L1 Emergency readmissions (****We will reduce emergency re-admissions within 30 days of discharge by 4%)*

Rotherham BCF Plan Actions and Schemes

PE– Rotherham people will get help early to stay healthy and increase their independence

PE 1 – We will co-ordinate a planned shift of resources from high dependency services to early intervention and prevention (N1, N2, N4, N5, L1):

- *BCF01 – We will review Mental health provision (N1, N4, N5, L1)*
- *BCF02 – We will review the Falls prevention service (N1, N2, N4, N5, L1)*
- *BCF03 – We will deliver a joint call centre incorporating telecare and tele-health (N1, N2, N4, N5, L1)*

PE 2 – Services will be delivered in the right place at the right time by the right people (All outcome measures):

- *BCF04 – We will create an integrated rapid response service (All outcome measures)*
- *BCF05 – We will strengthen 7 day social care provision in hospitals (All outcome measures)*

DI – Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances

DI 1 – We will change the culture of staff from simply 'doing' things for people to encouraging and prolonging independence and self-care (All outcome measures)

- *BCF09 – We will develop personal health and care budgets (N1, N2, N5)*
- *BCF10 – We will develop self-care and self-management (N1, N2, N4, N5, L1)*

DI 2 – We will support and enable people to step up and step down through a range of statutory, voluntary and community services, appropriate to their needs (All outcome measures)

- *BCF11 – We will develop and implement person centred services (N5)*
- *BCF12 – We will make preparations for the implementation of the Care Bill (All outcome measures)*

EA – All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community

EA 1 - We will ensure all our workforce routinely prompt, help and signpost people to key services and programmes (All outcome measures):

- *BCF06 – We will review the Social prescribing pilot (All outcome measures)*
- *BCF07 – We will implement a joint residential and nursing commissioning and assurance team(N4, N5, L1)*

EA 2 - We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions (All outcome measures):

- *BCF08 – We will learn from experiences to improve pathways and enable greater focus on prevention (All outcome measures)*

LTC– Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life

LTC 1 – We will adopt a co-ordinated approach to help people manage their conditions (All outcome measures)

- *BCF13 – We will review existing jointly commissioned integrated services (All outcome measures)*

LTC 2 - We will develop a common approach to data sharing so we can provide better support across agencies and put in place a long-term plan for the life of the individual (N3, N4, N5, L1)

- *BCF14 – We will develop technology to share data between health and social care including use of the NHS number and shared IT capacity (N3, N4, N5, L1)*

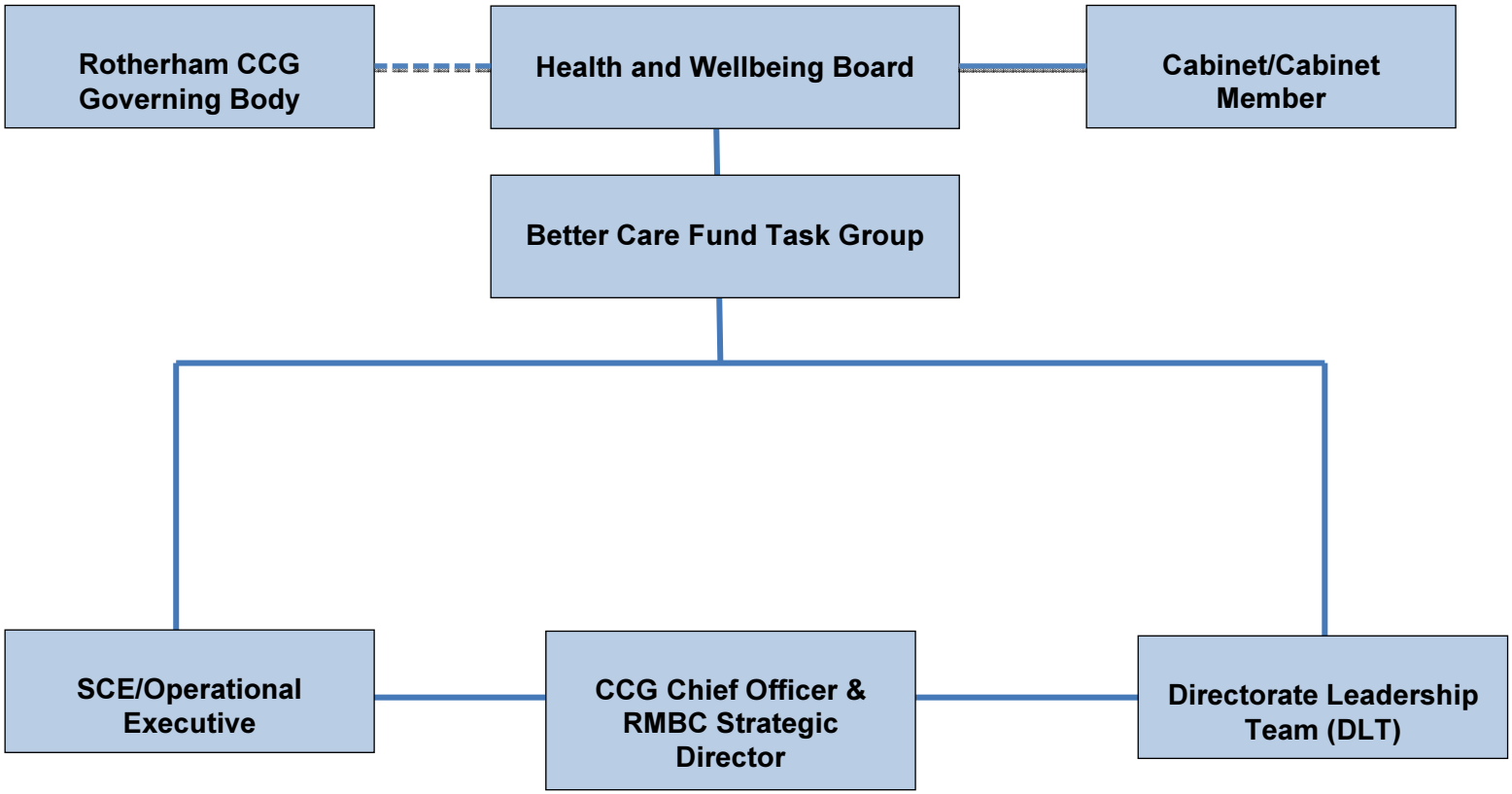
BCF Appendix 11

QIPP Workstreams

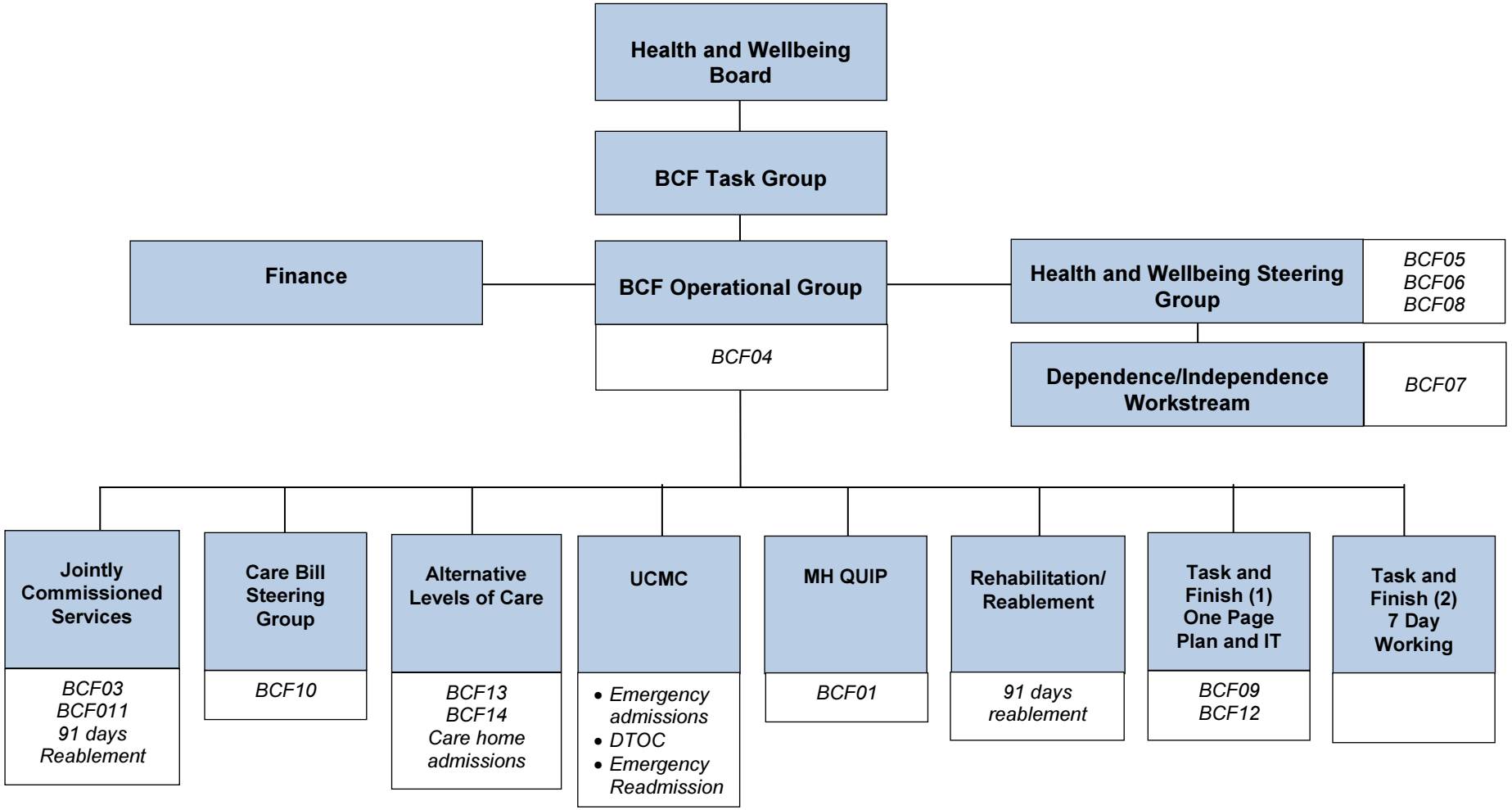
	Workstream	Project
1	**Benchmarking, trend analysis, and two way communication with all clinicians**	1. Regular review of trends in GP referrals, consultant referrals, A&E referrals, other referrals and elective activity. 2. Specialty specific discussion of areas identified by benchmarking or changing trends. 3. GP communication/education; bite size newsletter, SCE newsletter, protected learning time, top tips/map of medicine guidelines, GP peer led visits. 4. Communication with TRFT clinicians
2	**Two way dialogue with all clinicians on benchmarking, trends and improved care pathways**	1. Better information on self-care 2. More fast track services such as the successful fast track gynaecology service 3. More one stop services
3	**Outpatient follow up reduction programme**	1. Reduction in Follow ups 2. Secondary to primary care Locally Enhanced Service
4	**Diagnostics**	1. Reduction in duplicate and inappropriate diagnostic testing
5	**Care Pathways (with Urgent Care Working Group and Mental Health QIPP Committee)**	1. COPD 2. Cardiology / CVD 3. Children's care pathways 4. A review of pain management services 5. Alcohol (with mental health QIPP group) 6. Falls (with UCWG) 7. Dementia (with Mental health QIPP group)
6	**Safe effective non face to face 'referrals'**	1. Review of current virtual Haematology and consideration of extension to other specialties 2. Explore other ways of safe, effective non face to face contacts

BCF Appendix 12

Better Care Fund Governance Framework



Action Plan, Finance and Performance



ROTHERHAM BOROUGH COUNCIL – HEALTH AND WELLBEING BOARD

1.	**Meeting**	**Health and Wellbeing Board**
2.	**Date**	**23/04/2014**
3.	**Title**	**Public Health Outcomes Framework**
4.	**Directorate**	**Public Health**

5. Summary

The Councils has new statutory functions that include health protection and health improvement. Public Health England monitors these responsibilities through the Public Health Outcomes Framework (PHOF). Members require assurance that the Framework is being monitored and appropriate action is being taken to address the outcomes.

The Council's wider responsibilities for population health require a coordinated approach, including all 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 partner's action plans to address under performance and complete a report card on each indicator. Where the Indicator is an outlier the report card will be reported to the appropriate planning or commissioning group.

Agreement needs to be reached on which performance measures are regularly reported to the Health and Wellbeing Board. These should be indicators that are closely linked to the six locally determined priorities which follow our Health and Well Being Strategy. If these high level indicators show no improvement or are significantly underperforming the Board will agree actions to be taken or hold a performance clinic with partners to develop a remedial action plan to engage action. Where a performance clinic is held this will report to Cabinet. The emphasis of the performance clinics will be on innovation and doing things differently to drive improvement and change.

Indicators outside of these top six strategic issues will be addressed elsewhere within the local performance framework. 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

- **Cabinet agree the proposed framework to address performance on the Public Health Outcome Framework**
- **Cabinet agree the reporting structures**
- **Cabinet support this as a mechanism to deliver the Health and Wellbeing Strategy aim of moving services to 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 underperformance. 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 child poverty continues to be a significant challenge for the Borough
    - The 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 for unintentional injury need to be reviewed.
    - The number adults who are inactive and/or smoke continue to be high.
    - Performance is poor on diabetic retinopathy screening (the major cause of avoidable blindness).
    - Self-reported measures for wellbeing as a mental health and wellbeing indicators appears to be low. This is of concern particularly in relation to the increase in local suicides.
    - Injuries to older people from falls are a concern.

3. **Health Protection**
    - Rotherham has high rates of chlamydia infection which results in infertility. Chlamydia is used as a marker of other sexually transmitted diseases.
    - HPA vaccination uptake has recently been improved.
    - Although the completion of TB treatment appears low the number of TB cases in Rotherham is very small.

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 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).

Premature mortality reflects social disadvantage and societal and individual behaviours that put people at increased risk.

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 Report card – 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 injured casualties on England's roads	EDS	RMBC EDS SY Police Schools	
	Domestic abuse	NAS	RMBC NAS SY Police All Health	

Domain	Indicator	Reported to	Partner organisations	Public Health lead
			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 NAS	RMBC NAS RMBC CYPS CVS	
	Excess weight in adults	NAS	RMBC NAS CCG	

Domain	Indicator	Reported to	Partner organisations	Public Health lead
			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 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	
	Hip fractures in over 65s	NAS	RMBC NAS RFT CCG	
	Excess winter deaths	EDS NAS	RMBC NAS RFT	

Domain	Indicator	Reported to	Partner organisations	Public Health lead / contact
			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; Average; Worse; Not compared

Trend key: Improving; Stable; Worsening

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	Better	
1.03 - Pupil absence	2011/12	5.57	5.34	5.81	616514.00	11065292.00	Persons	5-15 yrs	Better	Improving
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	Better	Improving
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	Worse	Stable
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	Not compared	
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	Not compared	
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	Not compared	
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	Not compared	
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	Average	
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	Worse	
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	Better	
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	Worse	
1.12ii - Violent crime (including sexual violence) - violence offences	2011/12	8.95	8.58	9.32	2278.00	254600.00	Persons	All ages	Better	
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	Average	
1.13ii - Re-offending levels - average number of re-offences per offender	2010	.65	.62	.68	1885.00	2893.00	Persons	All ages	Better	
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	Worse	
1.15i - Statutory homelessness - homelessness acceptances	2011/12	1.10	.91	1.32	117.00	106000.00	Undefined	Undefined	Better	Worsening
1.15ii - Statutory homelessness - households in temporary accommodation	2011/12	.32	.22	.45	34.00	106000.00	Persons	All ages	Better	Worsening
1.16 - Utilisation of outdoor space for exercise/health reasons	Mar 2009 - Feb 2012	13.70	7.76	19.63			Persons	16+ yrs	Average	
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	Average	Worsening

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		**Trend key:**		Improving	
					Average				Stable	
					Worse				Worsening	
					Not compared					

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		**Trend key:**		Improving	
					Average				Stable	
					Worse				Worsening	
					Not compared					

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		
4.03 - Mortality rate from causes considered preventable (provisional)	2009 - 11	159.76	151.70	168.12	1529.00	773148.00	Persons	All ages		
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		
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		
4.05i - Under 75 mortality rate from cancer (provisional)	2009 - 11	124.09	116.89	131.62	1132.00	711417.00	Persons	<75 yrs		
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		
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		
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		
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		
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		
4.08 - Mortality from communicable diseases (provisional)	2009 - 11	39.75	36.42	43.29	572.00	773148.00	Persons	All ages		
4.10 - Suicide rate (provisional)	2009 - 11	4.27	2.92	6.02	34.00	773148.00	Persons	All ages		
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		
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		
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		
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		
4.12ii - Preventable sight loss - glaucoma	2011/12	12.66	7.38	20.28	17.00	134234.00	Persons	40+ yrs		
4.12iii - Preventable sight loss - diabetic eye disease	2011/12	3.16	1.27	6.52	7.00	221216.00	Persons	12+ yrs		
4.12iv - Preventable sight loss - sight loss certifications	2011/12	58.20	49.26	68.30	150.00	257716.00	Persons	All ages		
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		
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		
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		

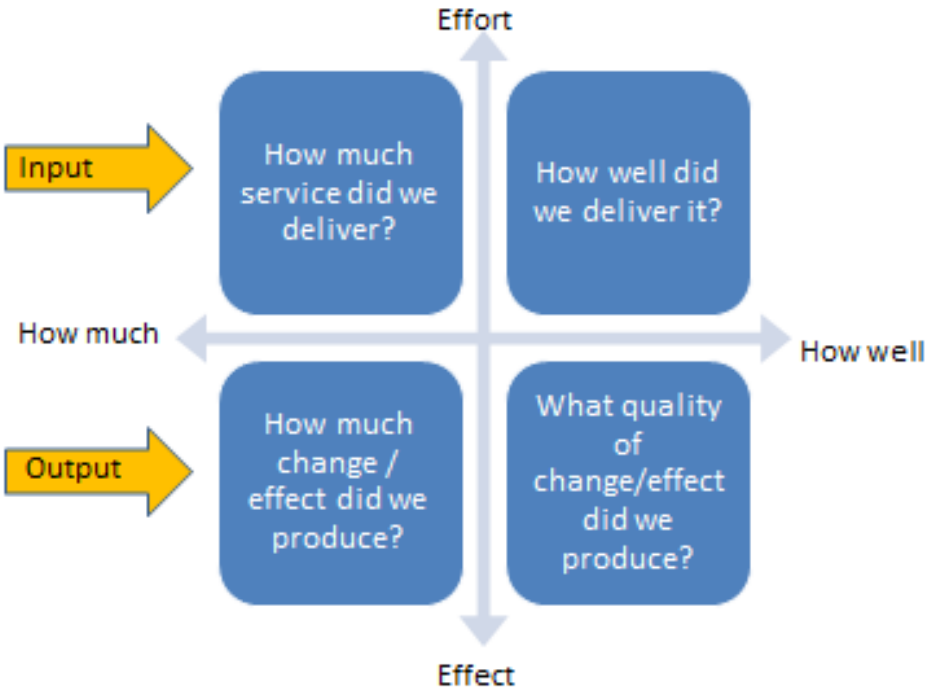
Appendix 3 – Performance clinic structure and process

Each indicator will have a current performance assessment and list of preventative activities developed to monitor preventative activity and actions on a report card.
Where the Indicator is an outlier the report card will be reported to the appropriate planning or commissioning group
Public Health Outcomes that are significantly 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 2 hours, creating a robust action plan that ensures efforts result in improved outcomes.

Report Card

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 Safer Rotherham Partnership
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



Health and Wellbeing Strategy Reporting Framework

Priority 1 - Smoking

High level aspiration - Rotherham: a smoke free town

Goal 1 - Preventing initiation of tobacco use amongst children and young people

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Key Measure	Percentage smoking at delivery 20.1% (12/13 Qtr 2) to below the national average by 2015	20.8%	19.2%	19.1%	A	Q3 13/14	21.1%	18.2%	R	17.9%	16.7%	Alison Iliff
	Percentage of young people (Year 7 & 10) smoking (CYPS lifestyle survey) (regular smokers)	2%/14%	2%/14%	No target		2013	1%/9%	See notes		1.9%/13.5%	1.8%/13%	Alison Iliff

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Quarterly Proxy Measure	Participation in Responsible Retailer Scheme in CAP areas	New Measure for 2013-14				01-04-13 to 01-12-13	29%	20%	G	50%	75%	Alan Pogorzelec
	Number of enforcement interventions taken in relation to the sale of tobacco to children	New Measure for 2013-14				01-04-13 to 01-12-13	4	2	G	5	5	Alan Pogorzelec
	Schools with anti-tobacco policies approved by Head	New Measure for 2013-14				Q4 13/14	55%	50%	G	50%	100%	Alison Iliff

Goal 2 - Reducing Harm to Adults from tobacco consumption

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Key Measure	Percentage of adults 18 and over smoking (integrated household survey)	23.3%	22.7%	N/A	N/A	2012	22.7%	23%	G	22%	22%	Alison Iliff

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Quarterly Proxy Measure	Percentage of key public sector staff undertaking Making Every Contact Counts									75%	100%	
	Participation in Responsible Retailer Scheme in CAP areas	New Measure for 2013-14				01-04-13 to 01-12-13	29%	20%	G	50%	75%	Alan Pogorzelec
	Number of enforcement interventions taken in relation to illicit and / or counterfeit tobacco	New Measure for 2013-14				01-04-13 to 01-12-13	8	5	G	5	5	Alan Pogorzelec

Priority 1 - Smoking

General A new tobacco control programme has been commissioned to begin in April 2014 comprising a new Doncaster and Rotherham Smokefree Service, smoking in pregnancy support further embedded within midwifery, enhanced enforcement of illicit tobacco and age of sale legislation, youth prevention activity and social marketing for tobacco control across Rotherham, Doncaster and Sheffield. Performance of the new services will be monitored against service specifications and nationally collected data.

Goal 1 **KM 1 (smoking at delivery)**

Baseline data may be affected by high percentage where mother's smoking status not known (quarters Q1 and Q2 2011/12)
Targets adjusted to match national ambition decrease of 21.7% between 2009/10 and 2014/15 (to be achieved between Q3 2010/11 and 2014/15) (31/05/13)(AI)
Quarterly position shows high variation, so suggest notice is predominently taken of outturn figure, which will show year to date or, at Q4, the whole year's picture.
Year to date is 20.1% against a target of 18.2%.

KM 2 (young people smoking)

Data shown as Y7/Y10. Baseline represents 2011 Survey data, 2012-13 represents 2012 and Current Position represents 2013. Survey is conducted and reported annually.
When information issued about data collection mechanism for PHOF indicator "Smoking at age 15", this KM will be amended.

QPM 3 (anti-tobacco policies)

New measure for 2013-14. Whole school review audit used to establish baseline of schools with policies. As at quarter 4 2013-14 this was 55%.
Denominator = 120 schools (24/06/13). Denominator figure = 120 schools (Primary – 95 LA and 3 Academies, Special 6 LA, Secondary 11 LA and 5 Academies). (AI)
Work is continuing to contact schools without up to date whole school reviews, to ask if they have a smoke free policy. If the answer is no, we are sending the Rotherham Healthy Schools model smoke free policy for their information and asking if they would adapt it for their own use.

Goal 2 **KM 1 (adults smoking)**

2011-12 represents 12 months April 11-Mar 12. 2012-13 and Current Position represent Jan-Dec 2012.

QPM 1 (making every contact count)

Under development.

Goal 1 - QPM 3	**13/14**			**14/15**			
Trajectory for schools with no-smoking policies:	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	40%	45%	50%	65%	72%	90%	100%

Priority 2 - Alcohol

High level aspiration - Rotherham: a place where people drink responsibly

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

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Key Measure	Percentage of Year 10s reporting that they drink alcohol (CYPS Lifestyle Survey) (regular drinkers)	30%	12%			2013	11%			0%	0%	Kay Denton

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Quarterly Proxy Measure	Percentage of key public sector staff undertaking Making Every Contact Counts											
	Community Alcohol Partnerships across the Borough	New Measure for 2013-14				Q3 13/14	2	No target	A	No target	11	Mel Howard
	Participation of retailers in Responsible Retailer scheme in CAP areas	New Measure for 2013-14				01-04-13 to 01-12-13	29%	20%	G	50%	75%	Alan Pogorzelec

Goal 2 - Reducing Harm to Adults from alcohol consumption

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Key Measure	Reduce hospital admissions due to alcohol related illness		1,069	No target		Q3 13/14	291	267	A	1,069	20% less	Anne Charlesworth

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Quarterly Proxy Measure	Percentage of key public sector staff undertaking Making Every Contact Counts											
	Community Alcohol Partnerships across the Borough	New Measure for 2013-14				Q3 13/14	2	No target	A	No target	11	Mel Howard
	Participation of retailers in Responsible Retailer scheme in CAP areas	New Measure for 2013-14				01-04-13 to 01-12-13	29%	20%	G	50%	75%	Alan Pogorzelec
	Number of FPN waivers which result in attendance at binge drinking course		86	No target		Q3 13/14	17	No target	R			
	Number of brief interventions in general practice		8,749	No target		Q3 13/14	8,101	3,000	G	12,000	16,000	Anne Charlesworth
	Number of brief interventions in community settings (Lifeline plus Health Trainer statistics)	2,673	3,192	No target		Q3 13/14	1,785	1,000	G	4,000	8,000	Anne Charlesworth
	Number of brief interventions in hospital settings											Anne Charlesworth

Priority 2 - Alcohol

Goal 1 **KM 1 (Year 10s reporting drinking)**

Represents those reporting drinking regularly. Baseline represents 2011 Survey data and 2012-13 represents 2012 Survey data. Survey is conducted and reported annually.
The 2011 baseline figure of 30% was set before the category of 'social/infrequent' was added to the question on frequency of drinking in 2012;
'regular' was classed as 'at least once per week' to be able to compare with national survey data (In 2012 Rotherham was 12% compared to 11% for England)
In the 2014 Rotherham Lifestyle survey it has been suggested that the alcohol question mirrors the national categories to compare them more accurately.
As it is **not** against the law to drink alcohol if you're age 5 or over , the target of 0% could be considered a little unrealistic/ambitious and one set to fail;
perhaps we should aim to try to reduce the % of young people drinking to be equal or lower than the national average, which may be still be challenging.

QPM 2 (community alcohol partnerships)

A full analysis of the 2 pilot CAPs will be undertaken in the summer. As an alternative to further CAP's an alcohol toolkit is in its draft format to be shared across the borough.

Goal 2 **KM 1 (hospital admissions due to drinking)**

Data represents number of admissions to Rotherham Foundation Trust by Rotherham CCG patients.
The team to deliver this piece of work has now been selected, work was scheduled to begin in October/November but this was delayed until quarter 4.
Due to the late start to the work the 2013-14 target was adjusted to maintain 2012-13 level with the 20% reduction set as the 2014-15 target.
Quarter 3 admissions tend to be higher but the target was unadjusted therefore the indicator is ranked as amber. A reduction is anticipated in quarter 4.

QPM2 (community alcohol partnerships)

(see Goal 1 QPM2)

QPM 4 (Fixed Penalty Notice waivers)

(At Q2) This figure has dropped significantly. SYP are aware and agreed to take steps to improve awareness across borough. From December SYP will also use conditions on cautions to ensure those with alcohol related offending engage in the education workshop.
(At Q3) Although there is an increase on previous quarter SYP are continuing to promote this action within all settings.

QPM 5 (brief interventions in general practice)

This is a significant increase, the contract specifications changed from 1/4/2013 to 'any' patient aged 18 or over (from specified diagnosis group).
Q1 + Q2 = Year Target exceeded. Please also note due to late submissions quarter 1 figure now stands at 7,263.

QPM 6 (brief interventions in community settings)

Community brief interventions includes Lifeline and Health Trainer provision - in 2012-13 this was 1952 and 1240 respectively.
Its anticipated that this will hit target within quarter 4 - the new service specification came into place in November 2013.

QPM 7 (brief interventions in hospital settings)

The team to deliver this piece of work has now been selected, work will begin in October/November.
Brief Interventions carried out by the Alcohol Liaison Service will be available from Q4 onwards.

After consideration, it was decided that Best Bar None would not be progressed as responsible retailer should do the same job without the cost that is incurred.

Priority 3 - Obesity

High level aspiration - Rotherham: a place where being a healthy weight is the norm

Goal 1 - Preventing obesity in children and young people

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Key Measure	Percentage of overweight and obese children in Reception	16.1%	22.2%			2013-14 due Dec 2014			R	15%	12%	Joanna Saunders
Key Measure	Percentage of overweight and obese children in Year 6	33.0%	35.2%			2013-14 due Dec 2014			R	30%	25%	Joanna Saunders
Quarterly Proxy Measure	Percentage of key public sector staff undertaking Making Every Contact Counts											
Quarterly Proxy Measure	Referrals of children to Healthy Weight Framework interventions	313	286	No target		Q2 13/14	114	No target	G			Joanna Saunders
Quarterly Proxy Measure	Completed Healthy Weight Framework interventions by children	144	119	No target		Q2 13/14	53	No target	G			Joanna Saunders
Quarterly Proxy Measure	Percentage of applications for fast food outlets approved that are within close proximity to a school or in a deprived area (in accordance with policy)											Helen Sleigh

Goal 2 - Reducing harm to adults from obesity

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Key Measure	Healthy eating prevalence (Integrated Household Survey/ Active People Survey)	21.3%		No target		2011-12	21.3%	28.7%	R			Joanna Saunders
Key Measure	Increased prevalence of diagnosed diabetes	6.20%	6.35%			2012-13	6.35%	No target	G			Dominic Blaydon
Quarterly Proxy Measure	Percentage of key public sector staff undertaking Making Every Contact Counts											
Quarterly Proxy Measure	Referrals of adults to Healthy Weight Framework interventions	2884	2253	No target		Q2 13/14	573	No target	A			Joanna Saunders
Quarterly Proxy Measure	Completed Healthy Weight Framework interventions by adults	1414	1067	No target		Q2 13/14	269	No target	A			Joanna Saunders
Quarterly Proxy Measure	Increased greenspace utilisation and access	13.7%	10.1%			Update due late 2014			A	15%	16%	Chris Siddall

Priority 3 - Obesity

Goal 1 **KM1 &2 (overweight and obese children)**

Data published annually in December.

QPM 2/QPM 3 (Healthy Weight Framework interventions)

Activity figures presented are enrolments and completions. The latter is a subset of the former and the duration of the treatment may go beyond the reporting cut-off.

Q2 2013-14 represents revised data since the January Board submission. Q1 2013-14 revised data: Referrals 110, Completed 49. (Q3 data incomplete)

QPM 4 (fast food outlets)

Planning policy relating to this is currently out for consultation

Goal 2 **KM 1 (healthy eating)**

Baseline represents modelled data for 2006-2008 based on Health Survey for England data.

Indicator being developed nationally for Public Health Outcomes Framework on which target can be set

First wave results to include dietary questions will be published in Summer 2014.

KM 2 (diagnosed diabetes)

Prevalence data published annually. This is ranked green from the view that practices are identifying people with diabetes.

QPM 2/QPM 3 (Healthy Weight Framework interventions)

Activity figures presented are enrolments and completions. The latter is a subset of the former and the duration of the treatment may go beyond the reporting cut-off.

Q2 2013-14 represents revised data since the January Board submission. Q1 2013-14 revised data: Referrals 591, Completed 299. (Q3 data incomplete)

QPM 4 (greenspace utilisation)

Baseline represents survey period March 2009 - February 2012. Indicator is based on annual survey data

2012-13 represents period March 2012 - February 2013.

Priority 4 - NEET

High level aspirations outcome - Our commitment is that by 2016 all Rotherham's young people will participate in education or training up to the age of 18.

Goal 1 - Reduce percentage of Academic Age 16 - 18 Young People who are Not in Employment, Education or Training (NEET)

Key Measure	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
	Percentage of Academic Age 16 - 18 Young People who are NEET	7.6%	7.4%	7.1%	A	March 2014	6.2%	7.5%	G	7.1%	7.0%	Collette Bailey

Goal 2 – Reduce percentage of Academic Age 16 - 18 Young People whose current situation is Not Known

Key Measure	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
	Percentage of Academic Age 16 - 18 Young People whose current situation is Not Known	4.8%	3.9%	5.0%	G	March 2014	4.6%	5.0%	G	5.0%	5.0%	Collette Bailey

Goal 3 – Increase percentage of Young People Participating (reporting to commence April 2013)

Goal 2 - Reducing harm to adults from obesity

Key Measure	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
	Percentage of Academic Year 12 participating	89.0%	N/A	N/A	N/A	March 2014	94.9%	92.0%	G	92.0%	95.0%	Collette Bailey
	Percentage of Academic Year 13 participating	80.0%	N/A	N/A	N/A	March 2014	86.7%	82.0%	G	82.0%	85.0%	Collette Bailey

Goal 4 – Reduce percentage of RMBC Corporate Responsibility LAC/CL Young People (Academic Year 12 -14) who are Not in Employment, Education or Training

Key Measure	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
	Percentage of RMBC Corporate Responsibility LAC/CL Young People (Academic Year 12 -14) who are NEET	28.0%	25.3%	N/A	N/A	March 2014	24.5%	24.0%	A	24.0%	20.0%	Collette Bailey

Priority 4 - NEET

Goal 1/2 **KM1 (NEET/ Young people whose situation is not known)**

2011-12 Baseline is the 2011/12 reported data and Outturn 2012-13 is the 2012 reported data (Nov-Jan averages)(from DfE)

Goal 2 The tracking of young people is posing a problem nationally for all authorities as it is such a resource intensive exercise.

Goal 3 **KM 1&2 (academic year 12/13 participating)**

Baseline taken from the Annual Activity Survey for 2012.

Goal 4 **KM 1 (RMBC corporate responsibility NEET)**

This cohort comprises 25 individual young people, of whom 15 (60%) are aged 18 and 19. This age group are able to claim benefit in their own right, and live independently, therefore are an extremely hard group to engage in any form of learning. We, as a service, are endeavouring to work more closely with Job Centre Plus to provide a more coherent approach to this group. A further 2 (8%) are of Y13 academic year, one of whom is refusing to engage, whilst the other is being supported by the service. The remaining 8 (32%) have all recently left compulsory education and have a range of complex needs. Two young people in this group are resident outside the Rotherham area but are still being supported by the service, one is a Teenage parent, one is Not yet ready for work or learning, one has never engaged despite persistent attempts, whilst the other 3 are currently engaging with the service and moving towards a learning outcome.

NB - DoE changed the count for NEET as at April 2013 - currency will no longer apply and therefore the adjustment set to NEET % has been amended.
This is projected to inflate the NEET % by approximately 1%.
Participation is defined as

- full-time education, such as school, college or home education
- an apprenticeship
- part-time education or training if they are employed, self-employed or volunteering full-time (which is defined as 20 hours or more a week).

Priority 5 - Fuel Poverty

High level aspiration - Everyone in Rotherham can afford to keep warm and keep well

Goal 1 - Reducing the effects of Fuel Poverty

	Indicator	2010 Baseline	2011-12			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Key Measure	Percentage of the population needing to spend more than 10% of household income to achieve adequate levels of warmth in the home and meet their other energy needs.	18.2%	Data Released in 2014			01/01/2011-31/12/2011	16.7%	17.2%	G			Catherine Homer

	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
Quarterly Proxy Measure	The number of properties receiving energy efficiency measures through Community Energy Saving Programme (CESP)		1,049	1,285	R	Q3/4 13/14	160	236	R	236	CESP superceded by GD/ECO	
	The number of properties receiving energy efficiency measures through Carbon Emissions Reduction Target (CERT)		1%	1%	G	CERT schemes have come to an end (31st March 2013) and have been superseded by Green Deal / ECO						
	The number of properties receiving energy efficiency measures through Dept of Energy & Climate Change (DECC)	To be delivered July 2013 onwards				Q2 13/14	68	320	R	320	252	
	The number of properties receiving energy efficiency measures through Green Deal / Energy Company Obligation (ECO)	1st year of collection anticipated in 4th quarter 2013-14				Qtr 1-3 2013/14	3,111					

Priority 5 - Fuel Poverty

Goal 1 **KM 1 (spending more than 10% of household income to keep home warm)**

Current Position represents 2011 calendar year. Baseline represents 2010 calendar year.

QPM 1 (energy efficient measures through CESP)

Is currently achieving the quarterly target. The pot of money initially secured to complete the DECC works in 2012-13 has now been allowed to roll over into 2013-14.

The programmed work is now scheduled to be completed in Q1 of next year and the total number of houses this will assist is set to exceed 1,285 .

A delay in commencing the continued CESP works meant that the final scheme was not completed until quarter 3/4 2013-14. A revised target of 236 properties completed in 2013/14 to meet deficit between target for 2012/13 and achieved outturn for that year. The anticipated target of 1,285 will not be met as CESP has come to an end.

QPM 2 (Properties receiving DECC funded works)

It was anticipated that 320 properties would benefit from works in 2013/14. The outturn for the year was 68 properties receiving measures, all completed by quarter 2.

A 2014/15 target is 252 properties with a target for quarter 1 2014/15 being 57. The remaining 195 properties will be delivered by 31st March 2015.

QPM 4 (energy efficient measures through Green Deal/ECO)

Revised figure is for all housing sectors. A target will be established following discussions with partner Green Deal Providers.

Priority 6 - Dementia

High level aspiration - Enabling people with dementia to live independantly for longer

Goal 1 - Earlier detection of dementia in order to provide effective care

	Indicator	2011 Baseline	2012-13 Outturn	2012-13 Target	2012-13 RAG	Current Position Period	Current Position Outturn	Current Position Target	Current Position RAG	2013-14 Target	2014-15 Target	Accountable Lead
Key Measure	QOF identified prevalence as a % of calculated 'true prevalence'	59.50%				Q4 2012-13?	59.50%			64.99%	69.99%	Kate Tufnell

	Indicator	2011-12 Baseline	2012-13 Outturn	2012-13 Target	2012-13 RAG	Current Position Period	Current Position Outturn	Current Position Target	Current Position RAG	2013-14 Target	2014-15 Target	Accountable Lead
Quarterly Proxy Measure	Number of referrals to memory clinic			550		Apr-Nov13	404	366	G			Kate Tufnell
	Number of assessments undertaken in memory clinic			500		Apr-Nov13	455	375	G			Kate Tufnell
	Number of new plans of care in place for people with dementia	new - data not available										Kate Tufnell
	% of patients seen within 18 weeks (Referral to Treatment - Memory Clinic Pathway)			95%			67%		A	95%	95%	Kate Tufnell
	Timeliness of social care assessment within 28 days (all adults)	83.2%	93.7%	93%	G	01-04-13 to 22-12-13	84.1%	92.0%	A	94%	94%	Michaela Cox
	Care package assessments responded within 28 days for people with dementia											
	Acceptable waiting times for care packages within 28 days	97.5%	97.5%	97.5%	G	01-04-13 to 22-12-13	97.0%	95.0%	G	97.5%	97.5%	Michaela Cox
	Annual reviews of care package assessments for people with dementia											
	Percentage of clients receiving a review	93.0%	93.1%	93%	G	01-04-13 to 22-12-13	67.4%	65.0%	G	93%	93%	Michaela Cox
	A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life	Proposed indicator										Kate Tufnell

Priority 6 - Dementia

Goal 1 **QPM 5 (timeliness of social care assessment)**

Currently amber. Working through action plan outcome of End to End review should see impact starting to take effect from May 2014.

General guide to column headings:
2011-12 Baseline:- 2011-12 Outturn
2012-13: Outturn for full year 2012-13 or year end position as applicable.
Current position: Year To Date or latest figure as applicable.
2013-14 Target:- Will be the 2013-14 Target
2014-15 Target:- Will be the 2014-15 Target

For a number of indicators, no 2013-14 target has been set and targets have been proposed for 2013 onwards
For new indicators, we are seeking Board support and commitment to data collection
A number of local measures are also in the National Outcomes Frameworks - achievement of these will be key to getting the Health Premium Incentive and meeting NHS and DH targets
There are limitations on the availability of data for several indicators, including some key local measures that are also in the Public Health Outcomes Framework.

Welcome to the Rotherham Director of Public Health Annual Report 2014.

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Rotherham Public Health

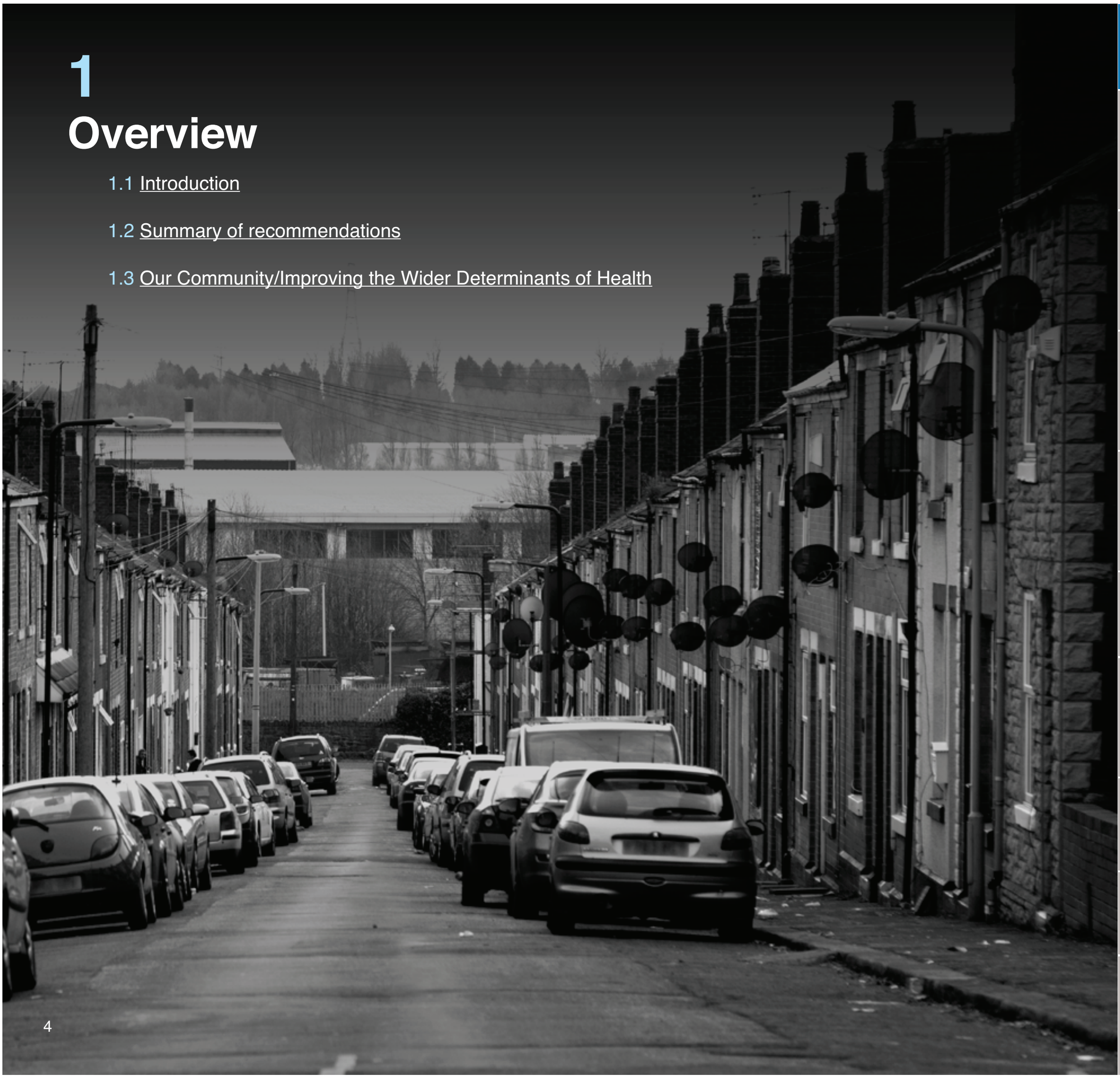
Rotherham Director of Public Health

Annual Report 2013/14

Rotherham Metropolitan Borough Council
Where Everyone Matters

Contents

1 Overview



1.1 Introduction

Rotherham Council has new Public Health responsibilities to improve health and reduce health inequalities, responsibilities shared with the NHS and Rotherham Clinical Commissioning Group. This report sets out to develop a common understanding of the reason for these inequalities and the interventions needed to address them.

The analysis of preventable mortality and illness across Rotherham is therefore aimed at policy makers in the Council, Cabinet, Health and Wellbeing Board and Clinical Commissioning Group.

We need to develop the public sector into a wider public health workforce for the promotion of healthy behaviours. Making Every Contact Count (MECC) is an evidence based framework that looks at disease prevention and lifestyle behaviour change. A significant difference can be made through directing people to local services, brief interventions for behaviour change and through intensive actions throughout the public sector.

Rotherham's Health and Wellbeing Strategy prioritises the lifestyle factors that contribute to health inequalities. Inevitably altering long term trends in behaviour requires the long view. This report focuses on some of the actions we can take now to address the main causes of death in Rotherham.

In compiling this report I have used two national reports from Public Health England: the Rotherham Health Profile 2013 and the Public Health Outcomes Framework. I have combined this national work with information from the Joint Strategic Needs Assessment and from local disease and death surveillance.

The focus of the report is the actions we need to take to reduce health inequalities, particularly the causes of premature death and the growing problem of disability brought on by long term diseases or conditions.

In Rotherham we need to focus particularly upon

- *Cardiovascular disease*
- *Cancer*
- *Liver disease*
- *Respiratory disease*
- *Mental health*

In Rotherham, like the rest of England, we have an obesity crisis with one in three children in Year 6 being overweight or obese. This early onset of obesity means that people are carrying excess weight earlier in their lives and, consequently, are suffering the complications of obesity at an increasingly younger age.

The delivery of a significant reduction in mortality and disability requires all partners to integrate risk reduction into practice.

1.1 Introduction

Obesity is a significant contributor to the high levels of disability seen in Rotherham. At the moment much of the effort in the NHS is directed towards managing the consequences of obesity such as high blood pressure, diabetes and arthritis. For the damage caused by alcohol and smoking, we similarly focus too much on the consequences and not the preventative strategies.

This report highlights the growing evidence about the effects of air pollution on health particularly particulate air pollution and increased risk of heart disease and supports efforts to reduce exposure in the air quality corridor along the M1.

As a new responsibility of local government in Rotherham, this report highlights key Public Health challenges for the Borough.

John Radford
Director of Public Health

1.2 Summary of recommendations

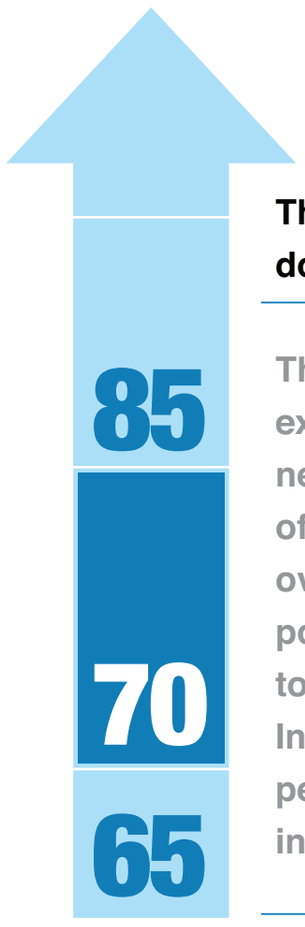
- The Health and Wellbeing Board needs to ensure a common framework for preventative management of multiple conditions including mental ill-health and musculoskeletal disease and to ensure we integrate risk factor management and rehabilitation in all disease management and care delivery.
- Rotherham Children's Board and the Council work with schools and the voluntary and community sector to reduce the impact of poverty on the Borough's children.
- Rotherham's secondary schools should be encouraged to adopt stay-on-site policies at lunchtimes.
- The Health and Wellbeing Board needs to consider the relationship between its long term goals in the Health and Wellbeing Strategy and the need to take action now to reduce the three main causes of inequality: cancer, especially lung cancer, cardiovascular and respiratory deaths.
- We must offer everyone aged 40-74 a health check every five years screening 20% of the eligible population annually with a 90% uptake.
- Physical activity should be commissioned as a direct intervention to prevent morbidity in long term conditions.
- Stopping smoking should be the key priority for the Borough in tackling excess cancer deaths
- Rotherham CCG should actively promote awareness of early signs and symptoms of cancer and how and where to seek help as this could quickly save lives
- Faster referral pathways and lowered thresholds for referral by GPs, particularly for lung cancer, are required to ensure a higher proportion of lung cancers are detected through the 2 week wait system.
- Rotherham CCG should continue to prioritise reducing the use of prescribed non-steroidal anti-inflammatory drugs.
- Reducing the volume of alcohol consumed in the Borough needs to be the agreed theme for the introduction of Making Every Contact Count (MECC), whilst maintaining quick and easy access to services that can respond to those identified as risky drinkers.
- Services and GPs should be active in making the hepatitis vaccine available to risk groups and should provide better screening for early detection and treatment.
- Hepatitis prevention needs to be a priority for environmental health and for the sexual health and the drugs service.
- Rotherham MBC should develop a Rotherham Mental Health Strategy outlining local action to promote wellbeing, build resilience and prevent and intervene early in mental health problems.
- Mental health promotion messages should be an agreed theme within Making Every Contact Count (MECC).
- Rotherham MBC should note the significant effect of air quality on mortality and that improvement in air quality, particularly reducing levels of PM 2.5 to PM 10 should be a priority for the Borough.
- Rotherham CCG and NHS England should consider flu vaccination a priority for Rotherham. Achieving 90% uptake of flu vaccination in the extension of immunisation to all children under 18 this September should be a priority for the Health and Wellbeing Board.
- Rotherham CCG should implement the local actions outlined in the Chief Medical Officers 2013 Annual Report on Antimicrobial Resistance.

1.3 Our Community/Improving the Wider Determinants of Health

The population of Rotherham continues to grow

269,000
by 2021

The age profile will be increasingly dominated by the elderly.



The number of people over 65 is expected to grow by 13% over the next eight years; however, nearly all of that growth will be in people aged over 70. The rate of growth in the population aged over 85 is projected to be twice as fast as in the over 65s. In the decade to 2030, the number of people aged 50 plus is anticipated to increase by a further 50%.

A striking feature of the changing demography of Rotherham is the increasing number of people living alone. Potential consequences of this include lack of capacity to cope at home with illness, loneliness and mental ill-health. Mental ill-health is the biggest cause of illness and incapacity in the Borough.

The number of people in Rotherham depending on out of work benefits *(job seekers' allowance, employment support allowance and other income related benefits)* is well above the national rate. Although the rate of young adults not in education, employment or training is improving, it is still above average. These issues are strongly linked to levels of disability particularly mental ill-health.

Levels of recorded crime have been falling for some years and have levelled out more recently. While violent crime is rare, there has been a recent growth in acquisitive crimes such burglary, vehicle crime and shoplifting. The wider economic situation gives rise to a concern that this trend will continue.

People in Rotherham are less likely to be active, more likely to smoke and be overweight or obese than the England average.

There is a socio-economic gradient in that people living in more deprived areas of the borough are more likely to have unhealthy behaviours; deprived areas are also more likely to have people with multiple unhealthy factors leading to increased long term illness.

2

Public Health Outcomes Framework

2.0 Introduction

The Public Health Outcomes Framework[1] (see Appendix 1) sets out a structure for public health in a way that can be measured locally. The outcomes and the indicators used are important in helping us understand how well public health is being improved and protected in Rotherham[2].

The framework concentrates on two high-level outcomes to be achieved across the public health system, and groups further indicators into four 'domains' that cover the full spectrum of public health.

The outcomes reflect a focus not only on how long people live, but on how healthy they are at all stages of life.

[1]Department of Health (2013) Improving outcomes and supporting transparency: A public health outcomes framework for England 2013-2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263658/2901502_PHOF_Improving_Outcomes_PT1A_v1_1.pdf

[2]Public Health England (2013) Rotherham Profile http://www.nepho.org.uk/pdfs/public-health-outcomes-framework/E08000018.pdf

2.1 Overarching Indicators

The Public Health Outcomes Framework overarching outcomes set the vision for the whole health system of what Government wants to achieve for the public's health.

The two high level outcomes are:

- *increased healthy life expectancy at birth, ie taking account of the quality of health as well as the length of life*
- *reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)*

This framework is not therefore just about extending life: it also covers the factors that contribute to healthy life expectancy, including what happens at the start of life and how well we live across the course of our lives. The main two outcomes together underpin the overall vision to improve and protect health while improving the health of the poorest fastest.

The high level outcomes are supported by two measures that are important for Rotherham; they tell us how well we are doing in improving health.

Healthy Life Expectancy at Birth is the average number of years a person would expect to live in good health based on existing local mortality rates and prevalence of self-reported good health. In Rotherham healthy life expectancy is 58.2 years for men and 59.9 for women. This is at the lower end of healthy life expectancy in England, with the best area in the country having a healthy life expectancy of 70.3 years for men and 72.1 years for women.

Life Expectancy at Birth is the average number of years a person would expect to live based on existing local mortality rates.

Rotherham life expectancy at birth

The lowest and highest rates in England

What do these Indicators tell us?

Life expectancy in Rotherham is worse than in most of England but also, and equally importantly, that people in Rotherham develop poorer health on average 5 or 6 years before the majority of people in England.

2.1 Overarching Indicators

Men expected to live their life in good health

75% Rotherham

80% England Average

women expected to live their life in good health

73% Rotherham

77% England Average

On average, people in Rotherham will develop long term conditions around 8 years before the new state pension age of 67.

Why is this important?

This disability burden has significant implications for public services locally, on the need for health and social care and for employment opportunities. This is because, on average, people in Rotherham will develop long term conditions around 8 years before the new state pension age of 67. This means more working age people living with long term conditions such as heart disease, diabetes, dementia, chronic mental health disability and surviving after cancer treatment.

At the moment there are more than 13,000 people in Rotherham with diabetes, and 5,400 on GP stroke registers; by 2025 there will be over 4,500 people in Rotherham living with dementia. In addition we know that much of the disability reported relates to musculoskeletal disease and mental ill-health. The outcome indicators highlight that 31% of Rotherham people report a low level of happiness and 42% high anxiety.

Most of the risk factors for the development of long term health conditions – smoking, obesity and lack of exercise (inactivity) – are well known. The World Health Organisation has long identified physical inactivity as one of the leading causes of death; in 2002 it estimated inactivity is responsible for 30% of ischaemic heart disease, 21-25% of breast and colon cancer and 27% of diabetes[3]. 52.4% of Rotherham adults report themselves as active, nearly 4% less than the English average of 56%. 33.6% report themselves as inactive, significantly above the England figure.

[3]World Health Organisation (2010) Global recommendations on physical activity for health http://whqlibdoc.who.int/publications/2010/9789241599979_eng.pdf?ua=1

2.1 Overarching Indicators

Musculoskeletal Conditions

Musculoskeletal conditions pose an enormous burden on individuals and have significant economic consequences for us. Up to 1 in 5 adults complain of musculoskeletal pain and discomfort at any one time, particularly back and lower limb pain and discomfort. They are a major cause of high health service utilisation. Musculoskeletal disorders are also among the most common problems affecting the elderly. The resulting loss of mobility and physical independence can be particularly devastating in this population.

The prevalence of physical disability is higher in women than men. It rises with age; around 60% of women aged over 75 living in the community report some physical limitations. In individuals of working age, back pain and generalised widespread pain are a common cause of sick leave and long-term work absence, a big problem for the individuals affected and with huge economic consequences.

Around 15-20% of consultations in primary care are for these and other musculoskeletal symptoms. Many of these people are referred to physiotherapists, occupational therapists or to medical specialists such as rheumatologists, orthopaedic surgeons or rehabilitation. Total joint replacements (mainly of the hip or knee) are one of the most common elective operations for older people in Rotherham.

This mixture of an increasingly older population with multiple long term illnesses, physical limitations on mobility and mental ill health needs to be at the forefront of our plans for improving health across the Borough.

2.2 Transforming Health and Social Care Services

GPs are now central to the commissioning of health services and meeting the community needs of their patients. Rotherham Hospital has struggled in the last few years to maintain its services within the funding available and faces further challenges with 24 hour working and increasing specialisation. Specialist services, such as neurology, are increasingly being delivered to Rotherham people in Sheffield. Adult social care also faces unprecedented pressure on its budgets to maintain services at the current level.

The changes in demographic need and the increase in multiple conditions, including mental health conditions, mean that we need to consider what hospital services in Rotherham should look like to best support people to be:

- *economically active*
- *independent*
- *treated as a whole rather than as a series of clinical conditions*

We need to consider how the hospital supports GPs and social care to deal with the health consequences of multiple health problems as well as tackling the underlying causes of ill health, and how it can:

- *be forward thinking and not simply responsive*
- *use social and physical support to maintain good health*
- *use high quality diagnostic support and clinical intervention to keep people at home*

Recommendation

The Health and Wellbeing Board needs to ensure a common framework for preventative management of multiple conditions including mental ill-health and musculoskeletal disease and to ensure we integrate risk factor management and rehabilitation in all disease management and care delivery.

3 Children and Young People's Health

3.1 Young people's health

Child poverty is the biggest barrier to improving outcomes for children and young people.

In Rotherham about 11,480 children (23.1%) live in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is <60% median income), this poses an immense challenge to give those children the best start in life.

The improvement in educational attainment in Rotherham as measured by GCSE results, from 54% in 2008 to 60% (1% above the England average), is stunning. It is a great achievement for Rotherham, its schools and the Council, but most of all for Rotherham children.

However, pupil absences from school are high at 5.11% for those aged under 16 (expressed as the percentage of half days missed by pupils due to authorised and unauthorised absences).

The proportion of 16-18 year olds not in education, employment or training (NEET) is 7.4 %, higher than the England average of 5.8%. Disengagement at this time can have a significant and lasting impact on the young person's health and wellbeing.

Rates of sexually transmitted infections are high, measured using chlamydia diagnoses as a marker condition, and indicate high levels of unprotected sexual activity in 15-24 year olds.

Under 18 conceptions are also high, although the most recent figures for Rotherham show significant improvement.

11,480 (23.1%)

children live in low income families

60%

educational attainment in Rotherham (1% above average)

To continue the improvement in educational attainment a reduction in pupil absence will need to be achieved.

7.4%

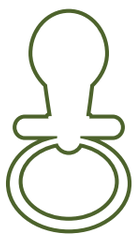
16-18 year olds not in education, employment or training

3.2 Maternal and infant health

Infant mortality, the rate of deaths in infants aged under 1 year per 1,000 live births, is 5.1 in Rotherham, not significantly different from the England rate at 4.3[4]. However, 3.5% of babies at term are of low birth weight, significantly higher than the England average. Both infant mortality and low birth weight are key markers of child and maternal health in a local population.

Significant inroads have been made in reducing smoking in pregnancy, the main avoidable cause of low birth weight and infant mortality. Rates of smoking at delivery in Rotherham have dropped from 26.1% in 2009/10 to 19.2% in 2012/13. While this rate is still significantly higher than the national average it demonstrates the impact intensive local interventions are making.

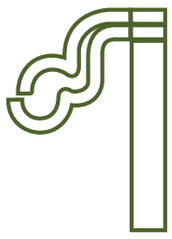
Infant mortality per 1,000 live births



5.1 Rotherham

4.3 England

Drop in rates of smoking



26.1% in 2009/10

19.2% in 2012/13

Breastfeeding initiation and maintenance are continuing challenges for us to give children the best start in life. Both are significantly worse than the England average.

[4]Adapted from data from the Office for National Statistics (ONS) licensed under the Open Government Licence v2.0.

3.3 Obesity in children

The data for obesity in children is more detailed than that available for adults because of the comprehensive National Child Measurement Programme, which weighs and measures all children in Reception and Year 6. We know from this information that childhood is an important time in the development of obesity, as levels more than double between Reception (aged 4-5 years) and Year 6 (aged 10-11 years).

This is a startling finding; why does it happen? It must be as a consequence of the lifestyle and diet choices of the children, their parents, their school and local environment. School stay-on-site policies have been shown to reduce the consumption of unhealthy food during the school day[5].

Healthy weight children in Reception

81.3% Rotherham

76.5% England average

Obese children at Year 6

20.5% Rotherham

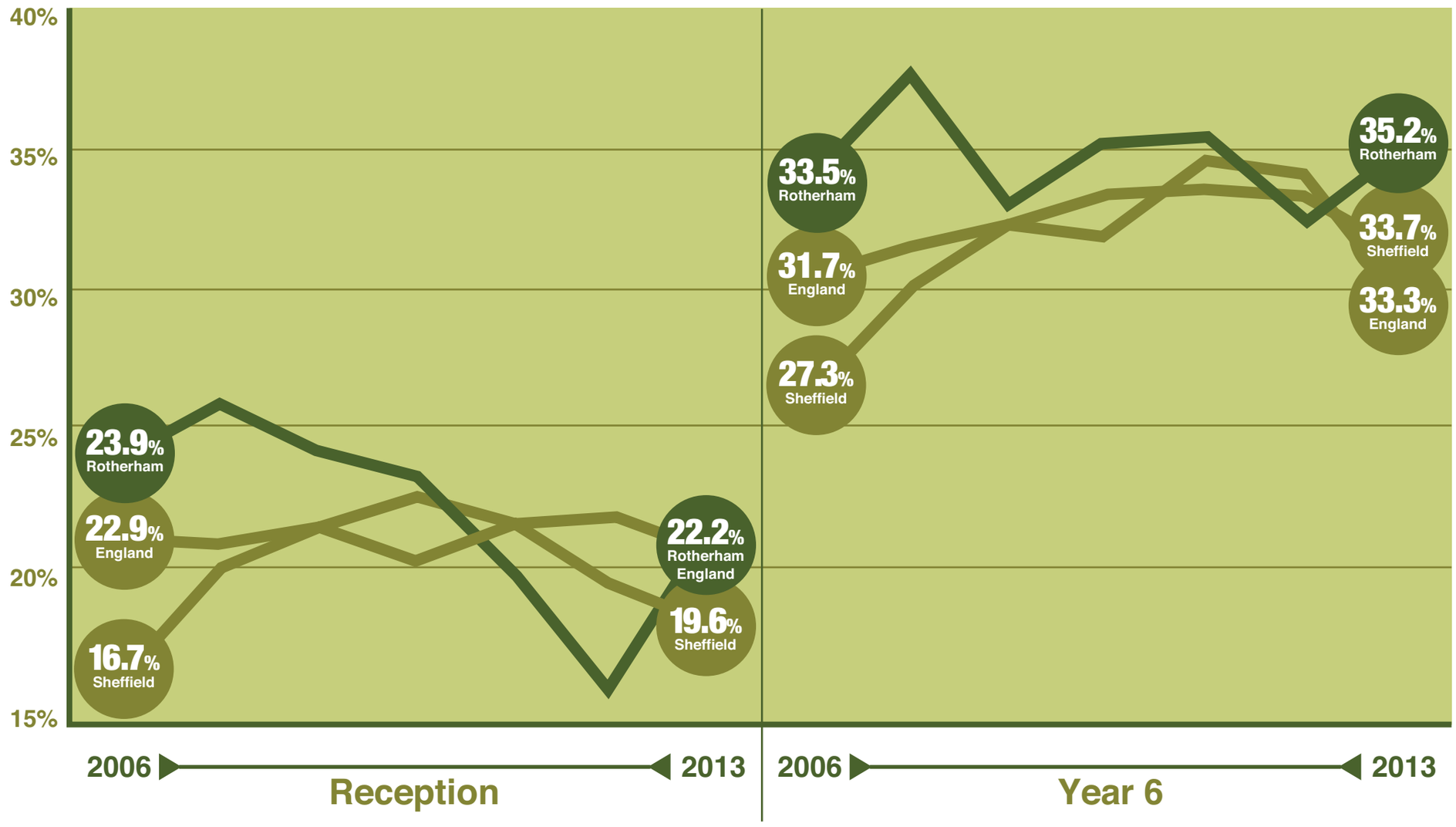
19.2% England average

A further marker of dietary intake is oral health; local children have poor dental health with an average of 1.4 bad teeth (England average 0.94).

[5]Crawford et al (2012) A Feasibility Study to Explore the Nutritional Quality of 'Out of School' Foods Popular with School Pupils
http://www.gcph.co.uk/assets/0000/3539/Out_of_school_foods_report_-_final.pdf

3.3 Obesity in children

Prevalence of overweight and obese children in reception and year 6 Rotherham, Sheffield and England 2006/07 to 2012/13



Recommendations

- *Rotherham Children's Board and the Council work with schools and the voluntary and community sector to reduce the impact of poverty on the Borough's children.*
- *Rotherham's secondary schools should be encouraged to adopt stay-on-site policies at lunchtimes.*

Source: Health and Social Care Information Centre, Lifestyle Statistics/Public Health England.

4 Life Expectancy and Cause of Death

4.0 Introduction

Mortality is measured using the age-standardised rate of mortality. Age-standardisation adjusts death rates to take into account how many old or young people are in the population being looked at. When rates are age-standardised, differences in the rates over time or between geographical areas do not simply reflect variations in the age structure of the populations. This is important as many diseases predominantly affect the elderly so a higher rate in one area is likely to reflect the fact that it has a greater proportion of older people.

In Rotherham the age-standardised rate of mortality from causes considered preventable is 159.8 per 100,000 population, substantially above the England average.

This indicator is broken down into its component indicators:

under 75 years mortality from

- *cardiovascular disease*
- *cancer*
- *respiratory disease*
- *liver disease*

all ages mortality rate from

- *infectious disease*
- *suicide*

Each component is analysed here and this analysis needs to direct our local actions to reducing premature death rates.

Mortality from most of these conditions can be effectively reduced by taking regular exercise, not smoking, eating a balanced diet and limiting alcohol consumption. It must be recognised that individual behaviour change is difficult and needs support. A multifactorial approach that addresses all risk factors yields most benefit. This is because tackling multiple risk factors in individuals has cumulative effect in reducing the chance of death.

Analysing the life expectancy gap between Rotherham and England helps understand the key causes of mortality contributing to inequalities in life expectancy and should inform the Health and Wellbeing Strategy.

- *30% of the gap is caused by circulatory disease, heart attacks and stroke*
- *26% by cancer with over half of this explained by lung cancer deaths*
- *33% of the gap is caused by excess respiratory deaths*

Although the contribution of liver and gastro-intestinal disease to inequalities is relatively small at the moment, it is the increasing trend in the numbers of these deaths that is of concern. Similarly in an analysis of the contribution of air pollution to mortality it is the underlying contribution of air pollution to all deaths that is important. In both cases these deaths are potentially avoidable.

4.1 Breakdown of the life expectancy gap

Table 1: Breakdown of the life expectancy gap between Rotherham as a whole and England as a whole, by cause of death, 2009-2011

		Male			Female		
Broad cause of death	Cause of death	Number of deaths in Rotherham	Number of excess deaths in Rotherham	Contribution to the gap (%)	Number of deaths in Rotherham	Number of excess deaths in Rotherham	Contribution to the gap (%)
	Coronary heart disease	685	137	28.8	536	144	30.3
	Stroke	206	6	3.3	310	.....	.....
Circulatory diseases	Other circulatory diseases	225	.....	.....	260	.....	.....
	Lung cancer	310	69	15.4	235	47	13.0
Cancer	Other Cancers	886	96	18.2	780	38	13.5
	Pneumonia	241	88	18.0	303	87	14.1
	Chronic obstructive airways disease	191	19	1.6	194	34	7.6
Respiratory diseases	Other respiratory diseases	156	44	8.6	191	70	11.4
	Chronic liver disease including cirrhosis	62	4	1.7	36	4	1.5
Digestive diseases	Other digestive diseases	114	6	1.5	170	24	4.2
	Suicide	26	.....	.....	8	.....	.....
External causes	Other external causes	97	.....	.....	67	.....	.....

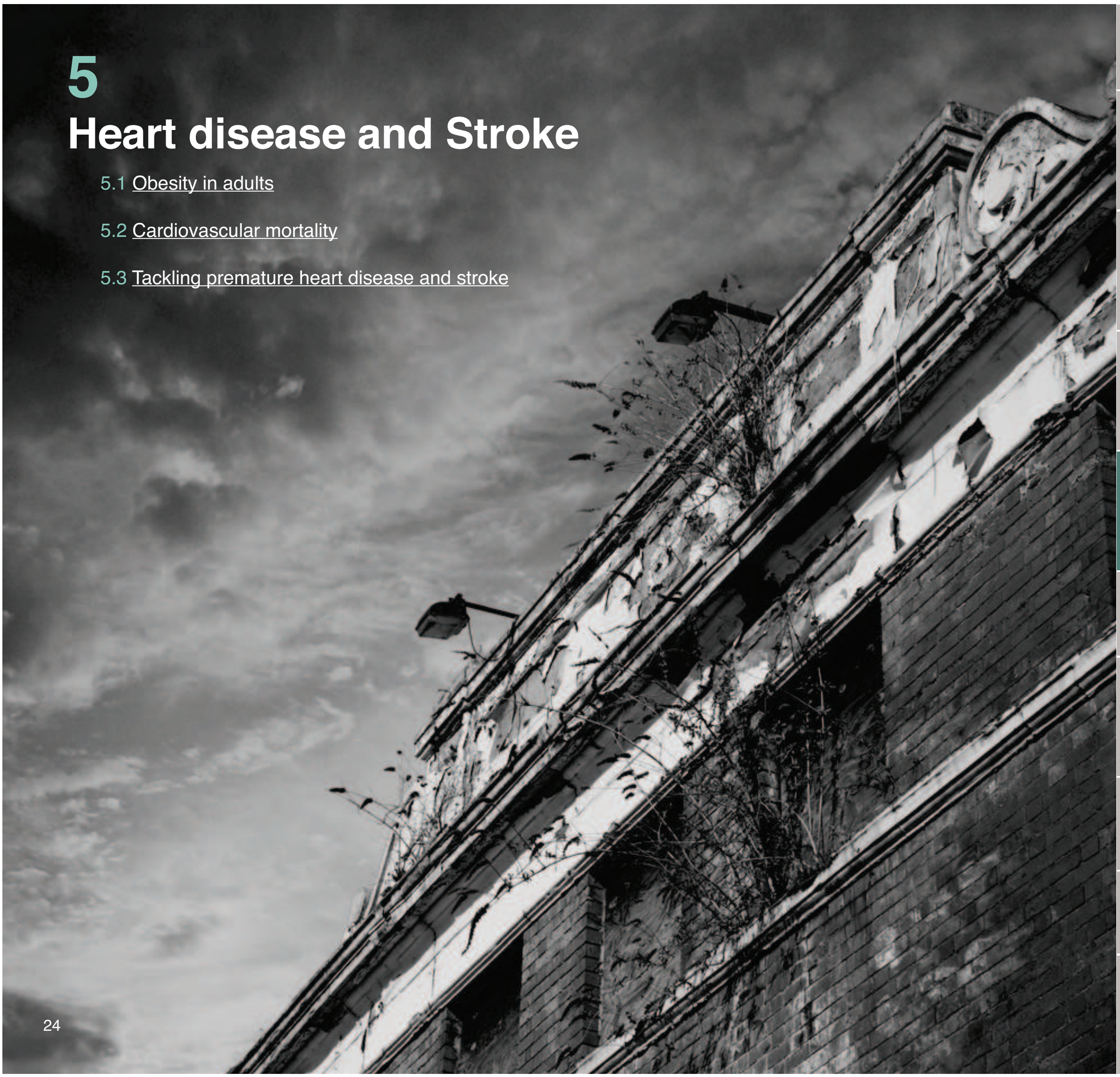
4.1 Breakdown of the life expectancy gap

Broad cause of death	Cause of death	Male: Number of deaths in Rotherham	Male: Number of excess deaths in Rotherham	Male: Contribution to the gap (%)	Female: Number of deaths in Rotherham	Female: Number of excess deaths in Rotherham	Female: Contribution to the gap (%)
	Infectious and parasitic diseases	24	.....	.....	35	.....	.....
	Mental & behavioural disorders	133	4	0.6	264	3	0.9
Other causes	**Other**	310	11	0.3	484	25	3.2
Neonatal mortality	**Deaths under 28 days**	18	2	1.9	13	0	0.3
TOTAL		3684		100	3885		100.0

Recommendation

The Health and Wellbeing Board needs to consider the relationship between its long term goals in the Health and Wellbeing Strategy and the need to take action now to reduce the three main causes of inequality: cancer, especially lung cancer, cardiovascular and respiratory deaths.

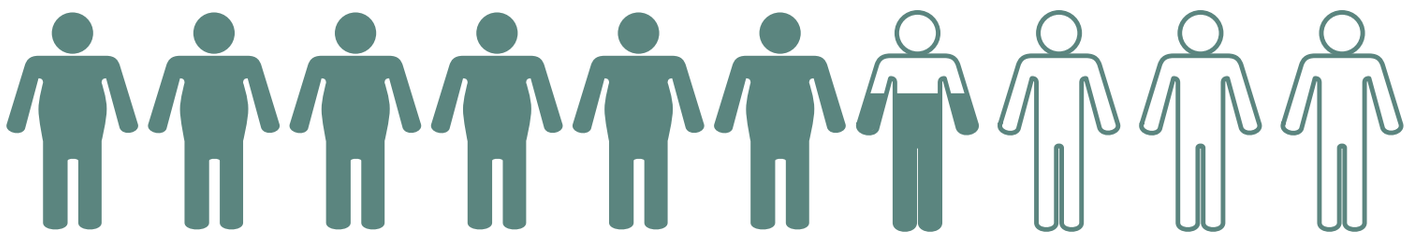
5 Heart disease and Stroke



5.1 Obesity in adults

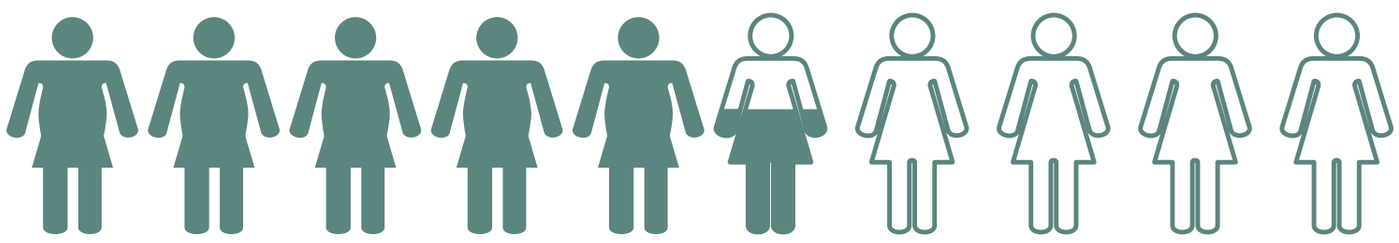
In Rotherham, like the rest of England, the majority of the adult population is now overweight or obese.

More than 6 out of 10 men are overweight or obese



66.5%
Overweight or obese

More than 5 out of 10 women are overweight or obese



57.1%
Overweight or obese

Obesity has been increasing rapidly over the last few years, so now more of the population are obese or morbidly obese than they were in the 1990s. Since then the proportion of the population that is a healthy weight has dropped by around 10%.

5.1 Obesity in adults

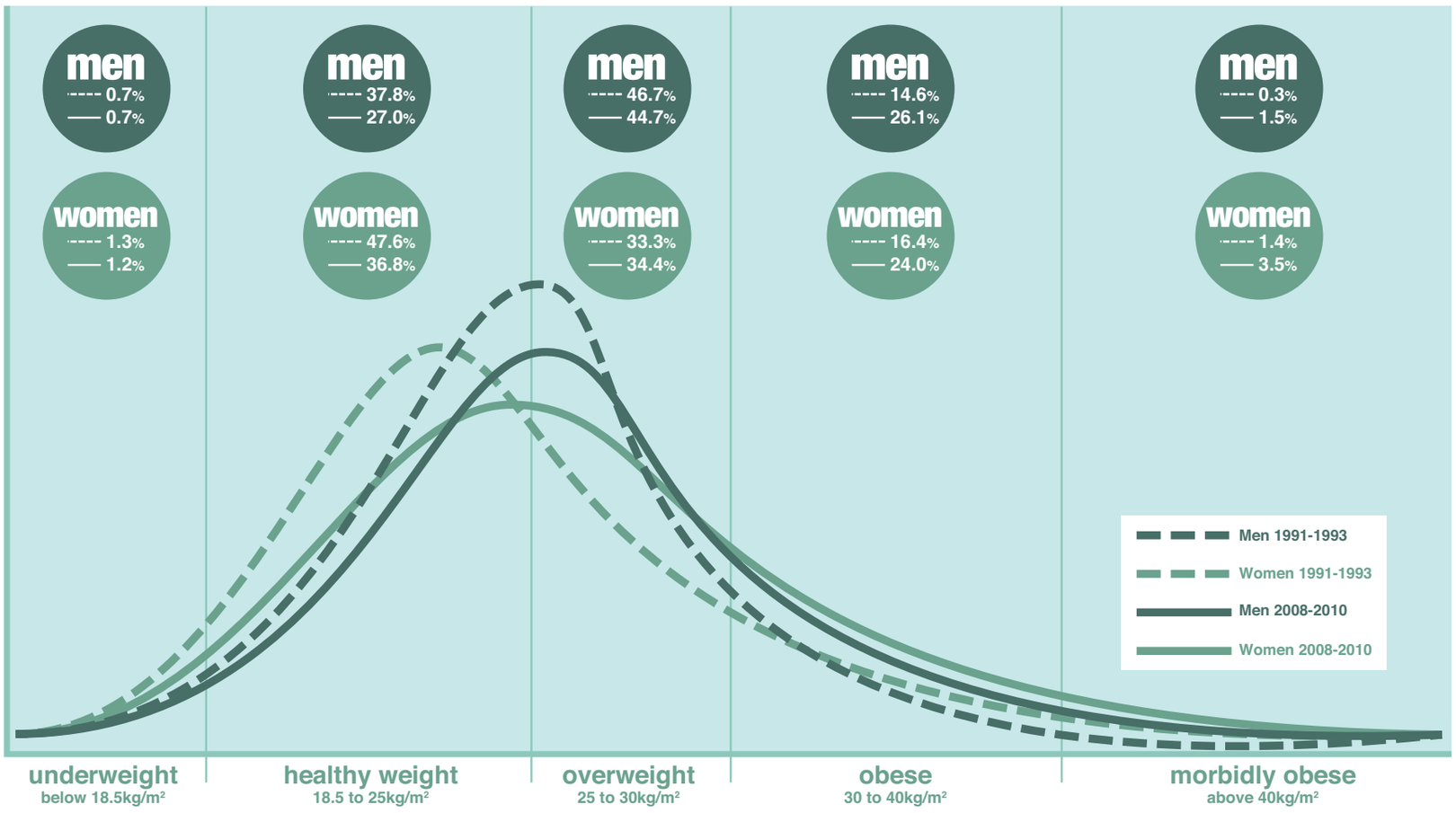
This graph shows how in the last 10 years we have simply all got fatter. Seeing this sort of change in such a short space of time will have a huge effect on people's health.

This shift of the whole population to a greater (weight) is one of the fastest and most important demographic changes we have ever seen. Obesity is a key risk factor for high blood pressure and diabetes, both of which can lead to coronary heart disease and stroke; obesity is therefore a key factor fuelling premature deaths from circulatory disease. Modern preventative medicine is directed towards reducing the complications of chronic disease (tertiary prevention) rather than tackling the underlying cause.

In Rotherham the prevalence of obesity in adults (over 16 years of age) is significantly worse than the England average, with the latest local estimate of 28.5% of adults in Rotherham classified as obese, compared to an average of 23% in England.[6]

Change in the adult BMI distribution, health survey for England (population weighted)

NOO (National Obesity Observatory) - % of adults aged 18+ years.



[6]Public Health England (2014) Prevalence of underweight, healthy weight, overweight, obesity, and excess weight among adults at local authority level for England http://www.noo.org.uk/visualisation

5.2 Cardiovascular mortality

The age-standardised rate of mortality from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years of age is 72 per 100,000 population, 18% above the England average. The actual number of under-75 deaths from cardiovascular disease in Rotherham is large and each year is equivalent to the number of people who could fit on nine double-decker buses.

A large proportion of these deaths remain preventable. Heart disease and stroke mainly affects people older than fifty years and age is the main determinant of risk. Apart from age and gender, three modifiable risk factors – smoking, raised blood pressure and raised cholesterol – make a major contribution to cardiovascular risk, particularly in combination. These risk factors account for 80% of all cases of premature coronary heart disease (CHD)[7] and these risks appear to be increased by outdoor air pollution. The risk of a future CVD event can be calculated from these risk factors and people at highest risk can be identified by their GP. Obesity contributes directly to two of these factors: high blood pressure and cholesterol. Obesity needs addressing directly rather than simply treating the symptoms of high blood pressure and raised cholesterol.

Excess body fat directly reduces life expectancy; it increases the likelihood of diseases, particularly heart disease, type 2 diabetes, obstructive sleep apnoea, certain types of cancer and osteoarthritis. The main effect is the complex interaction of obesity, diet, cholesterol, high blood pressure and the risk of heart disease and stroke. As your body mass index increases, in general, cholesterol levels and triglyceride levels increase and your risk of a heart attack or stroke increases[8]. These risks are further increased if you smoke or are exposed to air pollution.

The NHS Health Check programme is key to our Health and Wellbeing Strategy aims of tackling the risk factors that lead to early mortality from cardiovascular disease.

At the core of the NHS Health Check is a behavioural and physiological risk assessment that offers the opportunity to manage the risk factors and reduce cardiovascular disease. There is a very strong evidence base that brief interventions by GPs will deliver significant behaviour change. As part of the local council Public Health offer to Rotherham people, interventional behaviour change services offered include weight management services, stop smoking services, health trainers and specialist and GP alcohol services.

In Rotherham, General Practice is at the centre of the NHS Health Check programme. I think that this is right and that this offers Rotherham GPs the best opportunities to build a preventative approach into their daily practice. We have one of the best performing NHS Health Check programmes with 57% of people in Rotherham having completed a first Health Check since 2006. We will, however, need a step change in performance to achieve the new target of screening everyone aged 40-74 every five years.

[7]Emberson JR, Whincup PH, Morris RW et al. (2003) Re-assessing the contribution of serum total cholesterol, blood pressure and cigarette smoking to the aetiology of coronary heart disease: impact of regression dilution bias. European Heart Journal 24: 1719–26.
[8]Thelle et al. Br Heart Journal 1983;49:205-13.

5.3 Tackling premature heart disease and stroke

If you are worried about heart disease or stroke

- Increase your level of physical activity. *Obesity is primarily caused by excessive food energy intake and lack of physical activity.*

- Reduce your energy intake *by reducing portion size, cutting out high calorie foods and not eating between meals.*

- Cut down on saturated fats *in the diet, they increase cholesterol and triglyceride levels. Pies, pasties, sausages, burgers, processed kebabs, cheese and pastries and the use of cooking oil all contribute saturated fat to the diet. Reducing saturated fat is key to weight loss and reducing harmful levels of lipids in the blood.*

- Eat low energy unprocessed foods *and increase your intake of dietary fibre. Avoid foods or drinks with a high sugar content.*

- Eat a 'rainbow' of fruit and vegetables, *having at least 5 portions every day.*

- Get a health check.

Recommendations

We must offer everyone aged 40-74 a health check every five years screening 20% of the eligible population annually with a 90% uptake.

Physical activity should be commissioned as a direct intervention to prevent morbidity in long term conditions.

6 Cancer

6.0 Introduction

Cancer incidence in Rotherham is higher than the average with lung and colorectal cancers being especially high. This reflects the higher than average prevalence of smoking and other lifestyle risk factors. Tackling tobacco use and obesity are priorities for sustaining the long-term reduction in premature cancer deaths.

Smoking is the single most important factor in causing avoidable cancer deaths. Over 90% of lung cancer is caused by smoking and it is also a significant contributory factor for head and neck, stomach, bladder and kidney cancers[9]. Obesity is causal in an increased risk of breast and ovarian cancer.

The age-standardised rate of mortality from all cancers in persons less than 75 years of age

124.1
per 100,000 population

15%
above England average

Smoking prevalence in adults

23.3%
Rotherham

20.3%
England average

We know that in many Rotherham communities more than 40% of adults smoke.

[9]Lung cancer risk factors, Cancer Research UK 2013, available from http://www.cancerresearchuk.org/cancer-info/cancerstats/types/lung/riskfactors/lung-cancer-risk-factors

6.1 Improving Early Detection of Lung Cancer in Rotherham

Lung cancer is the leading cause of death from cancer in both men and women. It is responsible for about a sixth of the inequality in life expectancy between Rotherham and England. At a local level, it is responsible for a sixth of the inequality in male life expectancy and a twelfth of the inequality in female life expectancy between the most and least deprived quintiles.

Put another way, there is an excess of 81 deaths from lung cancer in the most deprived 20% of Rotherham citizens compared with the least deprived 20%[10] and this represents 70% of the excess deaths from lung cancer in Rotherham compared with England.

Overall survival at 1 and 5 years after diagnosis is poor compared with other cancers. This is believed to be due to the relatively late stage of presentation with disease by Rotherham people. However, disease caught and treated at an early stage is associated with good survival rates.

While controlling tobacco use is the key to sustaining a long-term reduction in lung cancer incidence, taking steps to reduce mortality from lung cancer is also an important near-term goal for reducing years of life lost and narrowing health inequalities.

[10]The Segment Tool, PHE 2014, available from http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Segment/TheSegmentTool.aspx

6.2 Tackling Premature Cancer deaths

The detection of cancer through the urgent 2-week-wait pathway from GP to hospital in Rotherham is worse than average; this is combined with a worse than average referral rate from general practices.

This suggests that people may be putting off seeking help when they have the early signs and symptoms of cancer, that they may not know what are important early signs and symptoms of cancer or that GPs faced with the high levels of lung conditions in the community are not recognising significant changes in symptoms.

Awareness raising to encourage people to seek help when they have early signs or symptoms of cancer – particularly lung and breast – is a priority for achieving a short term reduction in premature cancer deaths.

Recommendations

Stopping smoking should be the key priority for the Borough in tackling excess cancer deaths

Rotherham CCG should actively promote awareness of early signs and symptoms of cancer and how and where to seek help as this could quickly save lives

Faster referral pathways and lowered thresholds for referral by GPs, particularly for lung cancer, are required to ensure a higher proportion of lung cancers are detected through the 2 week wait system.

7

Liver Disease and Other Digestive Disease

7.0 Introduction

Deaths from liver and other digestive diseases contribute over 4% to our inequalities.

The main threat to life from gastrointestinal disease is bleeding either from duodenal or gastric ulcers or bleeding from varicose veins caused by liver cirrhosis. A significant avoidable factor in the cause of gastrointestinal bleeding is the use of non-steroidal anti-inflammatory drugs which predispose patients to ulcers.

In liver cirrhosis blood cannot flow easily through a damaged cirrhotic liver so it finds an alternative route to circulate around the oesophagus and rectum, and these distended varicose veins burst with catastrophic results.

Recommendation

Rotherham CCG should continue to prioritise reducing the use of prescribed non-steroidal anti-inflammatory drugs.

7.1 Liver Disease

Liver cirrhosis is now the fifth most common cause of death in the UK. There is an increasing trend in both the incidence and prevalence of cirrhosis with an estimated 45% increase in incidence of cirrhosis between 2000 and 2010. Just over half of all cirrhosis is associated with alcohol consumption; the other major causes are obesity and hepatitis.

In England and Rotherham we are facing a steep increase in liver cirrhosis and the complications of liver disease – bleeding from the gastro-intestinal tract and the effect on people's brains from the build-up of toxic chemicals leading to coma and death (hepatic encephalopathy).

The age-standardised rate of mortality from liver disease in persons less than 75 years of age

15.7
per 100,000 population

9%
above England average

7.2 Hepatitis

Hepatitis is mainly caused by viruses Hepatitis B and C, which are transmitted via blood, other body fluids or sexually.

Controlling hepatitis through vaccination of at risk groups and preventing transmission from contaminated needles and syringes in those who inject drugs is a public health priority for the Borough.

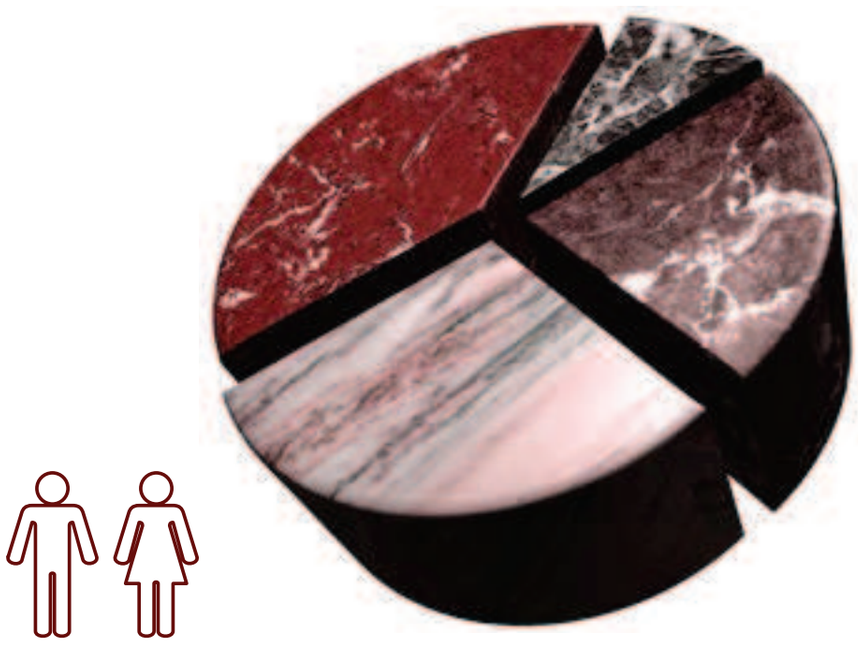
7.3 Alcohol

Alcohol is not only important as a cause of liver cirrhosis, it also contributes to deaths from cancer, heart disease, accidents and mental ill-health.

We can predict that within the adult population of Rotherham 7,086 individuals are dependent on alcohol, with a further 10,432 drinking at harmful levels and 51,569 drinking above low risk.

Using national Alcohol Concern[11] calculations based on hospital activity statistics (2009/10) for Rotherham there were 53,689 alcohol related hospital attendances at Rotherham Hospital. Of these, 28,827 were in A&E, 18,275 in outpatients and 6,587 inpatient stays were related to alcohol. The majority of inpatients (2,658) were aged 55-74.

Public Health England estimate of local societal cost of alcohol use in 2011/12



£28.29m crime and licensing

£21.75m NHS

£39.02m workplace

£9.90m social services

£97.80m TOTAL COST*

*Total cost excludes crime related healthcare costs

[11]Alcohol Concern (2013) The real cost of alcohol: a map of alcohol harm across England. http://www.alcoholconcern.org.uk/campaign/alcohol-harm-map

7.3 Alcohol

In 2012/13 Rotherham had 591 people in receipt of specialist treatment for alcohol dependency; 77% of those in treatment live with children. In addition many more children have parents with harmful and risky drinking patterns, which means the number of children impacted by their parents' alcohol dependency is significant.

Only a small number of those we believe to have problematic drinking are seeking treatment. This may be for a number of reasons including a lack of awareness of the risks. This is why increasing use of an evidence based screening tool is at the centre of the Health and Wellbeing Strategy.

Our local strategy has been to promote screening for risky drinking within GP practices. In 2011/12 2,780 screenings were undertaken. We are committed to increase this, both in the GP setting and in the community. Increasing take up of the NHS Health Check will also lead to an increase in the number of alcohol screenings carried out.

High risk drinking levels in the 28 days prior to entering treatment

80% Rotherham

75% Nationally

Consumption in the 28 days prior to treatment

23% 401 - 600 units

37% over 600 units

600 units over a 28 day period is the equivalent to:

5% Lager* a day

*Pints

Many of those with harmful drinking are not seeking or accepting services until their alcohol consumption is very high

7.4 Tackling liver disease

If you are worried about liver disease

- Be aware of the alcohol percentage content of what you drink, as well as understanding what a unit of alcohol is
- Seek help to reduce or stop drinking alcohol altogether
- Avoid risky behaviour. *Get help to reduce the risks if you use illicit intravenous drugs. Don't share injecting equipment used to inject drugs. If you choose to have sex, use condoms*
- Get vaccinated. *If you're at increased risk of contracting hepatitis or if you've already been infected with any form of the hepatitis virus, talk to your doctor about getting the hepatitis B vaccine*
- Use medications wisely. *Only use prescription and non-prescription drugs when you need them and take only the recommended doses. Don't mix medications and alcohol. Talk to your doctor before mixing herbal supplements or prescription or non-prescription drugs*
- Avoid contact with other people's blood and body fluids. *Hepatitis viruses can be spread by accidental needle sticks or improper clean-up of blood or body fluids. It's also possible to become infected by sharing razor blades or toothbrushes*
- Choose a healthy diet and maintain a healthy weight. *Obesity causes non-alcoholic fatty liver disease, which includes fatty liver cirrhosis.*

Recommendations

Reducing the volume of alcohol consumed in the Borough needs to be the agreed theme for the introduction of Making Every Contact Count (MECC), whilst maintaining quick and easy access to services that can respond to those identified as risky drinkers.

Services and GPs should be active in making the hepatitis vaccine available to risk groups and should provide better screening for early detection and treatment.

Hepatitis prevention needs to be a priority for environmental health and for the sexual health and the drugs service.

8 Mental Wellbeing

8.0 Introduction

Suicide is the most devastating outcome of both long term mental illness and people's response to economic hardship and distress.

As a consequence of the economic austerity, suicide rates nationally have shown a reversal from previous years when there had been a steady decline. Locally Rotherham has also seen an increase in the number of death registrations classified as suicides/ deaths of undetermined intent. These deaths fell sharply between 2007 and 2010 but have increased in 2011 and 2012. Rotherham's suicide rate for 2012 is now above the England average.

Suicide amongst males is at its highest in Rotherham since 2002 with more middle aged men (30-44 and 45-59 year old age groups) taking their own life. The latest suicide prevention strategy for England[12] and a recent report from The Samaritans[13] have both identified middle aged men, especially those from poorer socio-economic backgrounds as one of the high-risk groups who were a priority for suicide prevention.

Young males must continue to be a priority group for suicide prevention both nationally and locally. In Rotherham the expected number of suicides amongst 15-19 year olds would be one or two every two years.

In 2013 the Suicide Prevention Group received notification of 17 deaths

Between 2011 and 2013 we have had four deaths amongst 15-19 year olds. This has devastating consequences for the families of these young people.

[12]HM Government (2012) Preventing suicide in England: A cross-government strategy to save lives
https://www.gov.uk/government/publications/suicide-prevention-strategy-launched
[13]Samaritans (2012) Men, Suicide and Society: Why disadvantaged men in mid-life die by suicide.

8.0 Introduction

Mental health problems are related to deprivation, poverty and inequality as the social and economic determinants of poor health. People with long term mental health problems are also more likely to be in the most disadvantaged sections of society. Austerity increases the risk factors for poor mental health of the whole population, in addition to the people affected and their families[14]. The population groups most affected are those on low income, those who face loss of income and/or housing. In Rotherham the underlying economic determinants of mental health are worse than the national average. Rotherham's strong sense of community is a solid local factor that helps people cope.

Suicide is not the best measure of a population's mental health because it does not explain the incidence and prevalence of mental health problems. Depression represents 12% of the total burden of non-fatal global disease and by 2020 the World Health Organisation predicts this will be second, after cardiovascular disease, in terms of the world's disabling diseases. Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for patients, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs. However there are still limitations to using data on diagnosis as a measure of a population's mental health and wellbeing as it relies on people identifying and admitting to having a mental health problem and then accessing services. In fact the population's mental health can be measured by a variety of health and non-health measures. The New Economics Foundation explains that wellbeing can be explained by how people feel, how they function and how they evaluate their lives. In Rotherham more people report low satisfaction with life nowadays, low happiness and high anxiety levels than the national average.

The prevalence rate for depression amongst adults aged 18 plus in Rotherham

14.9% Rotherham

11.68% England average

[14]WHO (2011) Impact of economic crises on mental health

8.1 Tackling mental ill-health

Research shows that when we improve wellbeing and prevent mental health problems it will improve many of the factors influencing both overall life expectancy and healthy life expectancy. This requires commitment across the public sector to develop a Rotherham Mental Health Strategy which will outline local action to promote wellbeing, build resilience and prevent and intervene early in mental ill-health in Rotherham.

Recommendations

Rotherham MBC should develop a Rotherham Mental Health Strategy outlining local action to promote wellbeing, build resilience and prevent and intervene early in mental health problems.

Mental health promotion messages should be an agreed theme within Making Every Contact Count (MECC).

8.2 Suicide Prevention

In Rotherham we have a multiagency Suicide Prevention and Self Harm Group which provides a coordinated approach to suicide prevention and self-harm in Rotherham. The group leads on:

- Increasing local understanding *of suicide and suicide prevention amongst the statutory and voluntary sector and local community groups.*
- Reviewing deaths, *observing local trends and taking appropriate action where necessary to reduce access to the means of suicide.*
- Introducing interventions which reduce risk in high risk groups, *for example the development of specific pathways of care for groups like veterans, people experiencing domestic abuse, young people.*
- Implementing the bereavement support pathway *for adults and children and young people who are bereaved by suicide.*
- Supporting local media in delivering sensitive messages about suicide, *using the opportunity to advertise help and support.*
- Continuing to train the wider workforce to be able to identify and respond when people are at risk of suicide. *In Rotherham we have developed the CARE pathway for suicide intervention (Change, Ask, Respond and Explain).*
- Continuing to provide training on mental health, *wellbeing and resilience to frontline staff.*

[15]New Economics Foundation (2012) Measuring Well-Being: A Guide for Practitioners

9

Respiratory Disease

9.1 Air Quality

The age-standardised rate of mortality from respiratory disease among people aged less than 75 years is 30.4 per 100,000 population, significantly higher than the England average. Deaths from pneumonia, account for around 30% of respiratory disease deaths.

Apart from smoking the main avoidable factor in respiratory disease is air pollution as a result of contamination of the outside air by particles. Industrial exposure to dust and smoke is common in people who worked in Rotherham's mines or steelworks in the past and this is particularly pertinent if they are or have been a smoker, worsening their respiratory symptoms.

Clean Air Acts and the decline in heavy industry have vastly improved the visible quality of the air we breathe over the last 60 years.

However, the size of smoke and exhaust particles we breathe in air has decreased, with the majority of this fine particulate matter coming from vehicle exhausts. Fine-particulate matter with a diameter of 10 to 2.5 microns or less (known as PM_{10} or $PM_{2.5}$), penetrate deeply into the alveolar region of the lung and from there can pass directly into the blood. It is associated with an increased risk of heart disease.

In a recently published study in the BMJ[16] long-term exposure to fine particulate air pollution was associated with increased mortality from coronary events, even within concentration ranges well below the present European annual mean limit value. This will result in added mortality risk for those with other risk factors for heart disease such as smoking or obesity.

[16]Cesaroni G et al (2014) Long term exposure to ambient air pollution and incidence of acute coronary events: prospective cohort study and meta-analysis in 11 European cohorts from the ESCAP Project. BMJ 2014;348:f7412

9.2 Air pollution and its effects on health

The Public Health Outcomes Framework uses data from the Committee on the Medical Effects of Air Pollutants (COMEAP) and from local monitoring to assign the fraction of overall mortality to particulate air pollution.

It is the absolute number of deaths this affects that is significant; calculations by Public Health England attribute 1 in 20 deaths to air pollution. These figures are estimates, but the effect on those living in poor air quality zones is likely to be significant.

A 5$\mu g/m^3$ increase in annual mean $PM_{2.5}$ exposure is associated with a 13% increased risk of coronary events a 10$\mu g/m^3$ increase in PM_{10} with a 12% increase in risk.

These problems are not fairly distributed in our society – people in the most deprived neighbourhoods, who often don't have access to a vehicle themselves, are typically exposed to the highest levels of pollution as they live closer to major roads or heavy industry. Actions to reduce air pollution will lead to a reduction in health inequalities in the Borough.

Rotherham's fraction (average for an urban area) compared to non-urban area.

5.39% Rotherham

4.05% North Yorkshire

The combination of the historical burden of respiratory disease from heavy industry, higher than average smoking and the new and emerging evidence about air pollution are significantly impacting on health inequalities in the Borough.

9.3 Tackling air pollution

- *A lot of the air pollution problems affecting Rotherham residents come from the traffic on the M1 motorway. Actions to reduce the speed of traffic on the motorway, and to improve traffic flow to reduce the number of cars running stationary (especially on on-ramps and off-ramps) are likely to help reduce air pollution.*

- *Reductions in the number of vehicle journeys will reduce air pollution. The council is working through a number of mechanisms to achieve this, from improving public transport, to measures that encourage cycling and walking.*

- *Actions that reduce energy use in homes will reduce domestic production of air pollution. The council has an extensive program to improve insulation in council operated properties.*

Recommendations

Rotherham MBC should note the significant effect of air quality on mortality and that improvement in air quality, particularly reducing levels of PM 2.5 to PM 10 should be a priority for the Borough.

10 Mortality from Infectious Disease

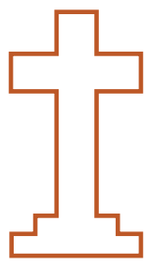
10.0 Introduction

According to the Public Health Outcome Framework data Rotherham has a high rate of death for infectious disease. This contributes significantly to our health inequalities. According to death registrations between 2009 and 2011 the vast majority of these deaths, 516 over the three years, were for pneumonia and influenza and it is these deaths that account for Rotherham's communicable disease death rate being significantly higher than England's.

Pneumonia and influenza deaths are included within the respiratory category in Table 1, contributing to 14% of the inequality in mortality.

Pneumonia deaths are heavily weighted to the elderly and those with pre-existing lung or other chronic disease.

Deaths from infectious disease per 100,000 population



39.8 Rotherham

22.9 England

The over-85 age group has the greatest percentage of pneumonia deaths, but the rate in Rotherham is lower than that in England.

Over **50%** for Rotherham

Over **60%** for England

Rotherham has a higher percentage of pneumonia deaths within the over-65 age group than England average.

10.1 Tackling pneumonia and communicable disease

Smoking is the major avoidable factor in lung damage predisposing to pneumonia. However influenza infections are also a significant and avoidable factor in causing pneumonias.

Influenza, or flu, is a respiratory illness associated with infection by influenza virus. Symptoms frequently include headache, fever, cough, sore throat, aching muscles and joints. Deaths from flu are usually caused by secondary bacterial infections causing pneumonia in those with conditions that make them more susceptible.

Death rates from flu are 0.4 per 100,000 population; these rise to between 10 and 20 per 100,000 for some at risk groups. Risk groups include those with chronic lung and heart conditions, asthma, neurological conditions and liver disease and the elderly. Improving vaccine uptake rates in risk groups will protect them from the complications of flu.

Apart from stopping smoking, influenza is therefore the most important modifiable risk factor for death from pneumonia/ communicable disease.

Influenza immunisation has been recommended in the UK since the late 1960s, with the aim of directly protecting those in clinical risk groups who are at a higher risk of influenza associated morbidity and mortality. In 2000, the policy was extended to include all people aged 65 years or over. In 2010, pregnancy was added as a clinical risk category for routine influenza immunisation. In 2012, the Joint Committee on Vaccination and Immunisation (JCVI) recommended that the programme should be extended to all children aged two to 18 years. The phased introduction of this extension began in 2013 with the inclusion of children aged two and three years in the routine programme. From September the programme is being extended to all children aged 12-18 in schools. This is designed not only to protect children but to disrupt transmission of the virus to and reduce deaths within vulnerable risk groups.

Pneumococcal vaccines also protect against the most common types of pneumonia by reducing the number of cases that occur and also by reducing the severity of infection when it does occur. They are recommended for all those aged 65 and over.

It is also essential that we ensure high rates of vaccination and immunisation uptake for both this and the flu vaccine in those aged 65 years and over, as essential components of a safe and effective community health system which will contribute to the reduction in morbidity and mortality associated with pneumonia.

10.2 Antibiotic Resistance

People suffering life threatening bacterial infections (including pneumonias) need effective antibiotics.

Antibiotic resistance is not a new problem; in the past we have simply developed new antibiotics to replace ones to which bugs have become resistant. There has now been no new class of antibiotic discovered since 1987.

It is therefore vital that we look after the antibiotics that we do have. Many people, however, do not complete their course and this can lead to antibiotic resistance. Furthermore, doctors and nurses should only prescribe antibiotics when they are really needed and only use recommended antibiotics for specific conditions – not for ordinary coughs and colds. When a GP tells us that it's a virus and that antibiotics won't help, we all need to listen and not demand to be given antibiotics.

The Chief Medical Officer in her 2013 Annual Report highlighted the worldwide crisis in the development of antibiotic resistance.

Recommendations

Rotherham CCG and NHS England should consider flu vaccination a priority for Rotherham. Achieving 90% uptake of flu vaccination in the extension of immunisation to all children under 18 this September should be a priority for the Health and Wellbeing Board.

Rotherham CCG should implement the local actions outlined in the Chief Medical Officers 2013 Annual Report on Antimicrobial Resistance.

Appendix 1
Public Health Outcomes Framework indicators

1. Improving the wider determinants of health	1.01	Children in Poverty
	1.02	School readiness
	1.03	Pupil Absence
	1.04	First Time Entrants Into Youth Justice System
	1.05	16-18 year olds not in education employment or training
	1.06	Adults with learning disability / mental health who live in stable and appropriate accommodation
	1.07	People in prison who have a mental illness
	1.08	Gap in the Employment for those with LT health conditions including those with learning difficulties/disability or mental illness
	1.09	Sickness absence rate
	1.10	Killed or seriously injured casualties on England's roads
	1.11	Domestic abuse
	1.12	Violent crime (including sexual violence) offences / hospital admissions
	1.13	Re-offending
	1.14	The percentage of the population affected by noise
	1.15	Statutory homelessness
	1.16	Utilisation of outdoor spaces for exercise/health reasons
	1.17	Fuel poverty
	1.18	Social isolation
	1.19	Older people's perception of community safety
2. Health Improvement	2.1	Low birth weight of term babies
	2.2	Breastfeeding (initiation and 6-8 weeks)
	2.3	Smoking status at time of delivery
	2.4	Under 18 conceptions
	2.5	Child development at 2-2.5 years
	2.6	Excess weight at 4-5 and 10-11 year olds
	2.7	Hospital admissions caused by unintentional and deliberate injuries in children and young people
	2.8	Emotional wellbeing of looked after children
	2.9	Smoking prevalence – 15 year olds
	2.10	Hospital admissions as a result of self-harm
	2.11	Diet
	2.12	Excess weight in adults
	2.13	Percentage of physically active and inactive adults
	2.14	Smoking prevalence – adult (over 18s)
	2.15	Successful completion of drug treatment

Appendix 1
Public Health Outcomes Framework indicators

	2.16	People entering prison with substance dependence issues who are previously not known to community treatment
	2.17	Recorded diabetes
	2.18	Alcohol related hospital admissions
	2.19	Cancer diagnosed at Stage 1 and 2
	2.20	Cancer screening coverage
	2.21	Access to non-cancer screening programmes
	2.22	Take up of the NHS Health Check Programme
	2.23	Self-reported wellbeing
	2.24	Injuries due to falls in the over 65s
3. Health Protection	3.1	Fraction of mortality attributed to particulate air pollution
	3.2	Chlamydia diagnoses (15-24 year olds)
	3.3	Population vaccination coverage
	3.4	People presenting with HIV at a late stage of infection
	3.5	Treatment completion for tuberculosis
	3.6	Public sector organisations with board approved sustainable development management plan
	3.7	Comprehensive agreed interagency plans for responding to public health incidents
4. Healthcare public health and preventing premature mortality	4.1	Infant Mortality
	4.2	Tooth decay in children aged 5
	4.3	Mortality from causes considered preventable
	4.4	Mortality from all cardiovascular diseases (including heart disease and stroke)
	4.5	Mortality from cancer
	4.6	Mortality from liver disease
	4.7	Mortality from respiratory diseases
	4.8	Mortality from communicable diseases
	4.9	Excess under 75 mortality in adults with serious mental illness
	4.10	Suicide rate
	4.11	Emergency admissions within 30 days of discharge from hospital
	4.12	Preventable sight loss
	4.13	Health related quality of life for older people
	4.14	Hip fractures in over 65s
	4.15	Excess winter deaths
	4.16	Dementia and its impacts

For an up to date performance scorecard please visit the Public Health Outcomes Framework website at www.phoutcomes.info