HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 2nd July, 2014**

Time: **9.00 a.m.**

A G E N D A

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

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

3. Questions from Members of the Press and Public

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

5. Communications

6. Performance Management Outcomes Framework (Pages 8 - 52)
   Dr. John Radford, Director of Public Health
   (9.15 a.m.)

7. Better Care Fund (Pages 53 - 55)
   verbal update
   (letter attached from NHS England)
   (9.45 a.m.)

8. CAMHS (Pages 56 - 88)
   Naveen Judah, Healthwatch Rotherham, to present
   (10.00 a.m.)

9. RFT Patient Record System
   verbal update
   (10.30 a.m.)

10. Vaccinations and Immunisations (Pages 89 - 90)
    NHS England to report
    (10.40 a.m.)

11. Date of Next Meeting
    Wednesday, 27th August, 2014, commencing at 9.00 a.m.

HEALTH AND WELLBEING BOARD
4th June, 2014

Present:-

Councillor John Doyle	Cabinet Member for Adult Social Care **(in the Chair)**
Dr. David Clitheroe	SCE Executive Lead, Children's and Urgent Care, Rotherham CCG
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Chris Edwards	Chief Officer, Rotherham CCG
Naveen Judah	Rotherham Healthwatch
Julie Kitlowski	Clinical Chair, Rotherham CCG
Councillor Paul Lakin	Deputy Leader
Jenny Lax	South Yorkshire Police (in attendance for Jason Harwin)
Carole Lavelle	NHS England (in attendance for Brian Hughes)
Dr. John Radford	Director of Public Health
Joyce Thacker	Strategic Director, Children's and Young Peoples Services

Also in Attendance:-

Tracey Clark	RDaSH (representing Chris Bain)
David Hicks	Rotherham Foundation Trust (in attendance for Louise Barnett)
Councillor Rushforth	Cabinet Member for Education and Public Health
Janet Wheatley	Voluntary Action Rotherham

Apologies for absence were received from Chris Bain, Louise Barnett, Kate Green, Jason Harwin, Brian Hughes, Martin Kimber, Chrissy Wright and Councillor Ken Wyatt.

S103. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

There were no questions from the member of the public.

S104. MINUTES OF PREVIOUS MEETING

Resolved:- That the minutes of the meeting held on 23rd April, 2014, be approved as a correct record.

Arising from Minute No. S96 (Admiral Nurses), it was noted that the CCG were currently undertaking a community transformation project in an attempt to rationalise and evaluate all the nursing services required. The discussions would also include specialist nursing for Dementia patients, case management and the use of VAR and be guided as to what services were required.

Arising from Minute No. S101 (Peer Review), it was noted that a LGA review would take place in September, 2014. Scoping meetings were to

take place in June for Board members to formulate what the review should consist of.

S105. COMMUNICATIONS

(a) Rotherham Tobacco Control Alliance

The notes of the meeting held on 17th April, 2014, were noted.

(b) Integrated Youth Support Services

A report was submitted for information on the progress achieved by the Integrated Youth Support Service and its partners in relation to progression and retention in learning and employment for young people, academic age 16-18 years.

(c) Data Sharing Protocol – Request from South Yorkshire Fire and Rescue Service

A request had been received from the South Yorkshire Fire and Rescue Service to sign up to the Data Sharing Protocol.

Resolved:- That South Yorkshire Fire and Rescue Service sign the Data Sharing Protocol.

S106. BETTER CARE FUND

Tom Cray, Strategic Director, Housing and Neighbourhood Services, presented a report which provided a brief overview of the process undertaken to date, NHS England feedback received to the bid and how the plan would now be implemented.

Discussion ensued with attention drawn to the following:-

- Attached to the report was the Risk Register and a summary of each of the 12 schemes which made up the programme

- The new Care Bill was ranked as a “red” risk as the final detail was awaited. Once known, the detail would have to be evaluated to ensure no deviation from the intended funding outcomes

- Amendment to the wording to reflect “continuing engagement with all providers”

- Concern that there was little mention of how Healthwatch would engage in the process. Reassurances were given that the role of Healthwatch, its added value and independence, had not been deliberately omitted but acknowledgement that ideally discussions should have taken place with regard to their role. However, time constraints dictated by NHS England’s deadlines had prevented them from happening. Healthwatch would have a great part to play in consulting with patients and the general public with regard to the rolling out of the plan, how it was monitored and its evaluation. As

part of Healthwatch's funding arrangement, there would be specific pieces of work required to feed into the customer experiences

- There may be a solution with regard to data sharing that would allow the whole community to access patients' records. By the end of June there would be the ability to access EMS and Patient 1 records which would be a massive step forward with a view to a single care plan

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

(2) That quarterly reports from the Better Care Fund Task Group be submitted.

S107. SPECIAL EDUCATIONAL NEEDS AND DISABILITIES

Joyce Thacker, Strategic Director, Children and Young People's Services, and Donald Rae, SEND Strategic Lead, presented an update on the preparations to implement the Special Educational Needs and Disability Reforms in Rotherham.

The Children and Families Bill was enacted in March and a new version of the SEND Code of Practice published with the final version expected shortly.

This was the largest reform of how information and support was provided to children and young people with special educational needs and disabilities for over 20 years. It brought together the different systems in Early Years, Schools and Colleges and ensured better integration with health and care. It aimed to improve the support provided so that children and young people were able to live independent and fulfilling lives in adulthood. Placing the needs of parents and young people at its heart, the new system focussed on those aged 0-25 with new duties for local authorities, Clinical Commissioning Groups and Early Years Providers, Schools (of all types) and FE Colleges. Late amendments to the Bill had increased the role of the local authority in providing Mediation Services for education, care and health as well as bringing young people within Youth Offending institutions into the scope of the Act.

Organisations in Rotherham, including parents and young people, continued to work in partnership to implement the reforms. Key tasks which needed to be completed before September, 2014 included:-

- Putting children, parents and carers and young people at the heart of the new system
- Publish a Local SEND Offer
- Establish a new SEND Assessment Pathway for all of those aged 0-25 with Special Educational Needs or a disability, including plans to transfer those with a SEN Statement or Learning Difficulty Assessment (LDA) to the new Education Health and Care Plan

- Set up a new structure with the CCG to jointly commission education, care and health services for those with special educational needs or a disability
- Ensure parents and young people can receive support through a personalised budget if they request one
- Consultation on Rotherham's SEND Aspiration and Mission

Whilst the SEND Reforms were part of national legislation, it was important to be clear about what this meant for the children and young people in Rotherham. To help this process, consideration was being given to developing a consensus about the purpose of the SEND Reforms. Building on the Government's stated aims, the following have been proposed and discussion already started with may groups with the aim of reaching a final version in July, 2014:-

Rotherham's SEND Aspiration
"Rotherham children and young people with Special Educational Needs will achieve well in their early years, at school and in college; lead happy and fulfilled lives and have choice and control"

Rotherham's Special Educational Needs and Disability Mission
"Rotherham education, health and care services will create an integrated system from birth to 25. Help will be offered at the earliest possible point, with children and young people with special needs and their parents or carers fully involved in decisions about their support and aspirations"

This was a huge piece of work for all partners. Feedback from a visit from the DfE to establish Rotherham's preparations for the reforms had stated that all the correct structures, systems and personnel were in place to take them forward and impressed by the working relationship with the CCG.

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

- The DfE had recently visited to ascertain the Authority's readiness to implement the reforms. The visit had confirmed that the key structures were in place and that relationships with parents, Health and post-16 links were strong

- The SEND Commissioning Group had been established in January to provide the direction for the SEND reforms in Rotherham

- An event was to be held in Rotherham on 4th July entitled "In It together", co-hosted and planned by Rotherham's Parents Forum, the Local Authority and Health

- Consideration was being given to extending the Rotherham Charter to services and settings supporting children and young people from birth to 25

- The reforms were a long term programme which the Authority had to have started in September

- Caution must be exercised as to how it was presented to the community to ensure expectations were not raised unrealistically

- The Commissioning Group had met recently and formal plans would be submitted to the Board. The issues to be considered further:-

  Do we understand the demographics of children and young people and SEN in Rotherham?
  Have we sufficient places whether in schools, education or health to meet their needs?

- Essential that all data was collated due to the impact it would have throughout the system

- There was a sub-regional group that met to bring issues together primarily from an education point of view

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

(2) That the Risk Register be submitted to a future Board meeting.

S108. SECTOR LED IMPROVEMENT

Dr. John Radford, Director of Public Health, gave the following powerpoint presentation:-

Sector Led Improvement Pilot
- Organisations are responsible for their own performance
- Across organisation influence on performance
- Recognise collective responsibility for performance
- Board role overview of performance across sectors
- Properly functioning, it will support management of external inspections

Public Accountability
- Public bodies are accountable to local communities
- Health and Wellbeing Board oversight
- Recognise the role of Scrutiny – accountability of all public bodies organisations to scrutiny
- Healthwatch

3 Outcome Frameworks
- Identification of performance issues
  - By organisation
  - By Scrutiny Select Commission

- Long term intractable

– Deciding when the performance would benefit from a multi-sectoral approach
– Supportive peer challenge process
– Actions
– Review

3 Levels
– Single organisation
– Across Rotherham
– Challenge – Cabinet Member/Scrutiny/Peer Cabinet Member

Multi-Organisational Pilot
– Delayed Discharges
– Breastfeeding

An example was then given of the Public Health performance clinics held on Obesity and Drug Treatment where the key actions agreed were:-

Obesity
– Better management of information needed to track improvement
– Development of wider Council policies to prevent obesity
– Better information to all Services
– Developing Single Point of access to Weight Management Services
– Targeting children in Reception years
– Increase in prevention/lower level interventions
– CAF for children identified as needing support
– Active partnership with Green Spaces

Drug Treatment
– Work with GPs to increase support
– Deliver the new recovery hub
– Targeted action at GPs with high volumes of users and new entrances – top 5 priority areas
– Improve housing advice
– Need only 20 more successful treatments to be national average

Discussion ensued with the following issues raised/clarified:-

- Performance clinics were led by a Director not directly responsible for the Service and could be widened to other organisations within Rotherham. They acted as a “critical friend”

- Performance management arrangements for BCF were clearly set out, however, the overall activity within the 6 Board priorities was not. A focus on outcomes was essential

- The 2 pilot performance clinics had involved partners

- Whilst the proposed pilot of Delayed Discharges was connected to the BCF was Breastfeeding a priority? In terms of giving every child the best start in life, breastfeeding fit with the Board's priorities as well as the Borough having lower than average breastfeeding rates. It was also an important priority in the Children and Young People's Plan

Resolved:- That the report be noted.

S109. FUTURE BOARD AGENDAS

The Chairman reported that, due to a reshuffling of Cabinet Member portfolios, he would now by the Chairman of the Board.

He outlined his proposals for future Board agendas which he proposed should consist of:-

Decision
Direction
Discussion

Issues that were for raising awareness/information/interest would be sent to Board members and would not be discussed unless there was an issue a member wished to raise.

Members of the Board were asked as to what they would like to see on future agendas:-

- Discuss 1 of the 6 priorities a month to gain a full understanding of the issues and subject it to a "so what" test

- Health inequalities/specific work with the more deprived areas of the Borough

- Standing agenda items so as to aid measurement of improvement

- SMART actions

Resolved:- That the above comments be taken into consideration when agenda setting for future meetings of the Board.

S110. DATE OF NEXT MEETING

Resolved:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 2nd July, 2014, commencing at 9.00 a.m. in the Rotherham Town Hall.

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

1.	**Meeting**	**Health and Wellbeing Board**
2.	**Date**	**02/06/2014**
3.	**Title**	**Public Health Outcome Framework**
4.	**Directorate**	**NAS**

5. Summary

For adults there are three outcomes frameworks, one each for public health, NHS and adult social care.
The frameworks set out high level domain areas for improvement, alongside supporting indicators, to track progress without overshadowing our locally agreed priorities. They help highlight common challenges at the local level across the health and care system, inform local priorities and joint action, whilst reflecting the different accountability mechanisms in place. They are therefore critical to informing the joint strategic needs assessments and the Health & Wellbeing strategy.
The purpose of the Public Health outcomes framework is to provide transparency and accountability across the health and care system, setting out opportunities for local partnerships to improve and protect health and improve services.

This is focussed on two high level outcomes:

1. Increased healthy life expectancy (takes account of quality and length of life).
2. Reduced inequalities in life expectancy and healthy life expectancy between communities (through greater improvement in the more disadvantaged).

There are 66 public health indicators across the 4 domains:

1. Improving the wider determinants of health
2. Health improvement
3. Health protection
4. Healthcare public health and preventing premature mortality

The Public Health Indicators contain shared indicators with the NHS and Social Care Outcome frameworks. They include outcome indicators for children. This overlap is illustrated in the diagram at the end of this report.

6.Recommendations

The Board note progress against comparable areas.

That the Board support the work to improve performance against the Outcome Framework and the operation of performance clinics.

That the key priority areas identified are tackled as multiagency performance clinics.

7. Proposals and details

Overarching Indicators

For avoidable mortality Rotherham is currently ranked as the best (ranked 1st out of 15) of comparable local authority areas. It is ranked 94th out of 150 local authorities nationally and is ranked as poorly performing.

1. **Improving the wider determinants of health**

Child poverty, school readiness and pupil absence are all rated red. Young people not in education or training is rated red. Sickness absence rates are high and there appears to be an excess of admissions to hospital from violent crime.
There is a high level of noise complaints and poor utilisation of outdoor space.

2. **Health Improvement**

Breast feeding rates are poor and smoking at delivery is high. This is reflected in low birth weight of term babies – a marker of poor maternal health.
Adults are inactive and smoke too much. The drug service is not withdrawing as many people from opiate dependency as comparators.
Diabetic retinopathy screening is not meeting national targets.

3. **Health Protection**

No outlying Indicators

4. **Healthcare public health and preventing premature mortality.**

About one third of the excess avoidable mortality seen in Rotherham is caused by the 3 main causes of death, cardiovascular disease (heart attack and stroke), cancer (mainly lung cancer) and respiratory disease (pneumonia and chronic lung diseases). Mortality rates appear high for communicable disease, this formed part of the analysis in the Director of Public Health annual report which identified pneumonia as contributing to both this indicator and the indicator for respiratory disease.
A detailed analysis of the mortality indicators is included in this years DPH Annual Report and this forms the basis for action planning to reduce mortality.
A separate report Reducing Potential years of Life Lost accompanies this report.

8. Finance

Not applicable

9. Risks and uncertainties

Differences in health outcomes reflect, and are caused by, social and economic inequalities in society.
Unhealthy behaviour and access to healthcare are not the only factors that cause health inequalities. Genetics, environmental influences, infectious disease play a significant part.
People in poorer areas die earlier but spend more of their shorter lives with a disability. The response needs to be across the life course and reflect need at the life stage.

Key Priority Areas

- Emergency Readmissions
- Maternal health
- Physical activity related to health
- Healthcare plans should specifically address disease causes of inequalities
- Obesity management of the metabolic consequences
- Workplace Health

10. Policy and Performance Agenda Implications
Performance Clinics
2 multi agency performance clinics have been held and one further on Breastfeeding.

Key Actions Agreed from the two performance clinics April 2014

- Obesity
  - Better management information needed to track improvement
  - Development of wider council policies to prevent obesity
  - Better information to all services
  - Developing Single Point of Access to weight management services
  - Targeting children in reception years
  - Increase in prevention/lower level interventions
  - Common Assessment Framework for children identified as needing support
  - Active partnership with Green Spaces

- Drug Treatment
  - Work with GP's to increase support
  - Deliver the new recovery hub
  - Targeted action at GP's with high volumes of users and new entrants – top 5 priority areas
  - Improve housing advice.
  - Need only 20 more successful treatments to be national average

11. Background Papers and Consultation

http://longerlives.phe.org.uk/area-details#are/E08000018/par/E92000001

http://www.phoutcomes.info/

12. Keywords: [Keywords]

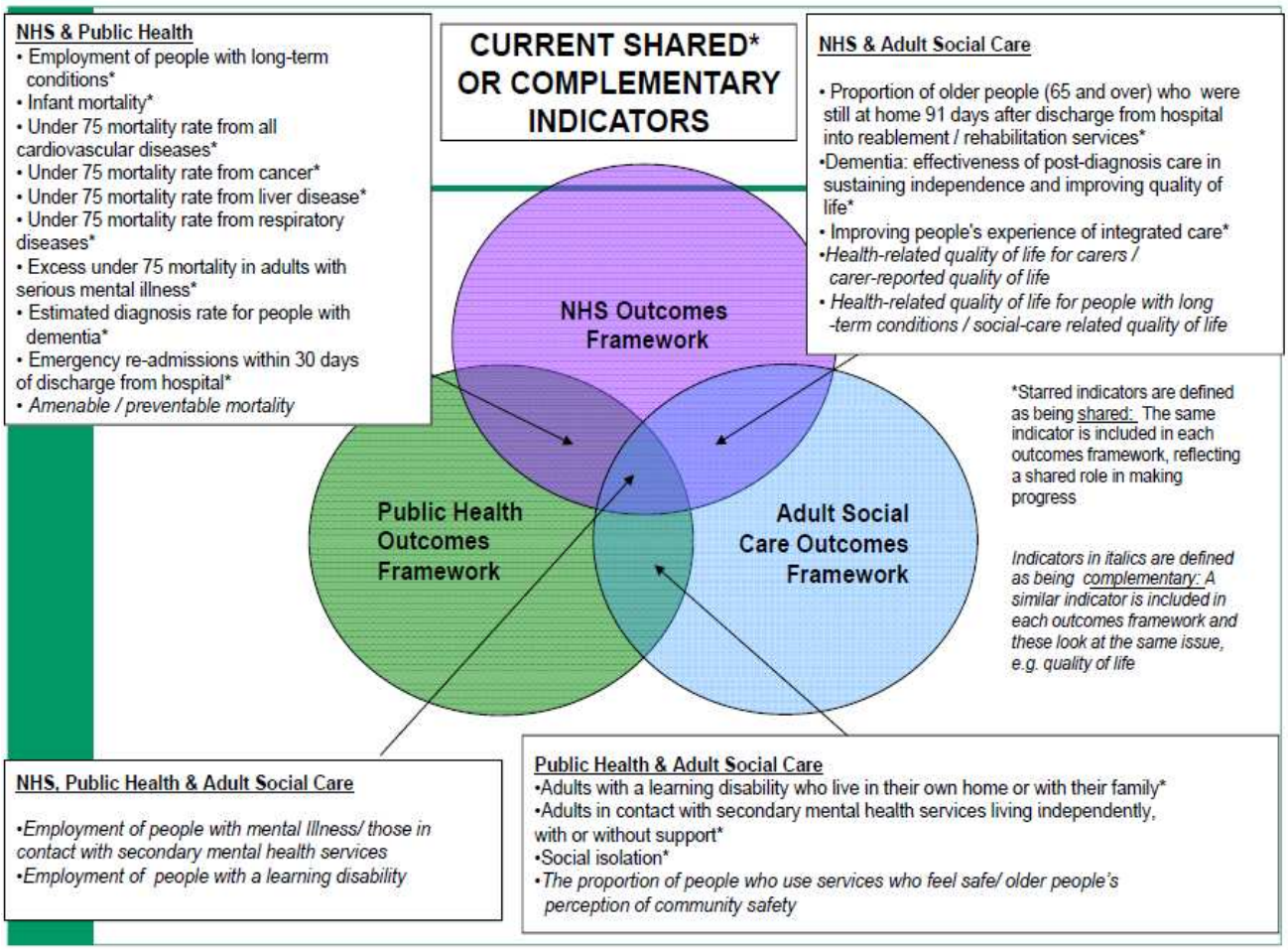
Officer: **John Radford GMC No. 2630063**

Director of Public Health

Telephone: **01709 255845**

Email: **john.radford@rotherham.gov.uk**

Web: **www.rotherham.gov.uk/publichealth**


CURRENT SHARED* OR COMPLEMENTARY INDICATORS
NHS & Public Health
• Employment of people with long-term conditions*
• Infant mortality*
• Under 75 mortality rate from all cardiovascular diseases*
• Under 75 mortality rate from cancer*
• Under 75 mortality rate from liver disease*
• Under 75 mortality rate from respiratory diseases*
• Excess under 75 mortality in adults with serious mental illness*
• Estimated diagnosis rate for people with dementia*
• Emergency re-admissions within 30 days of discharge from hospital*
• Amenable / preventable mortality
NHS & Adult Social Care
• Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services*
•Dementia: effectiveness of post-diagnosis care in sustaining independence and improving quality of life*
• Improving people's experience of integrated care*
•Health-related quality of life for carers / carer-reported quality of life
• Health-related quality of life for people with long -term conditions / social-care related quality of life
NHS Outcomes Framework
Public Health Outcomes Framework
Adult Social Care Outcomes Framework
*Starred indicators are defined as being shared: The same indicator is included in each outcomes framework, reflecting a shared role in making progress
Indicators in italics are defined as being complementary: A similar indicator is included in each outcomes framework and these look at the same issue, e.g. quality of life
NHS, Public Health & Adult Social Care
•Employment of people with mental Illness/ those in contact with secondary mental health services
•Employment of people with a learning disability
Public Health & Adult Social Care
•Adults with a learning disability who live in their own home or with their family*
•Adults in contact with secondary mental health services living independently, with or without support*
•Social isolation*
•The proportion of people who use services who feel safe/ older people's perception of community safety

Public Health Performance Measures

Performance Management

- Clear accountability for each performance measure – one accountable lead
- Targets, Action Plans and Milestones track progress and direction of travel.
- Performance monitoring - current performance, RAG status and direction of travel.
- Performance reported regularly through appropriate management arrangements
- Governance arrangements play a fundamental role managing performance/risk
- Concerns and outliers are identified to prompt necessary action incl. clinics
- *Trigger points* for a performance clinic:
  - If performance is below target/is predicted to not meet the year end target.
  - On target but due to a known event / issue, is predicted to not meet the year end target.
- The clinic will develop and agree a remedial action plan with the accountable lead
- Service improvement work takes place immediately upon agreement of the plan.
- Progress monitored and reported to provide assurances that issue is under control necessary improvements in performance are delivered.

- Latest available public health data used as a ‘can opener’ to prompt where performance clinics could take place

PHOF Scorecard Summary

110 National Public Health Outcome Framework Measures

National benchmark RAG status

- 32 indicators rated **RED**
- 27 indicators rated **AMBER**
- 35 indicators rated **GREEN**

Regional benchmark RAG status

- 23 indicators rated **RED**
- 46 indicators rated **AMBER**
- 24 indicators rated **GREEN**

Green Measures

- Wider Determinants of Health
  - 1.02i/ii School Readiness
  - 1.06i LD Settled accommodation
  - 1.06ii MH Settled accommodation
  - 1.06iii LD / MH Employment (Gap)
  - 1.10 Killed and Seriously injured casualties on England's roads
  - 1.15i/ii Statutory Homelessness - Acceptances/Households in temporary accommodation
  - 1.17 Fuel Poverty
  - 1.18i Social Isolation

- Health Improvement
  - 2.07ii Rate of emergency admissions caused by unintentional and deliberate injuries in young people aged 15-24 years
  - 2.20i/ii Cancer screening coverage (Breast/Cervical)
  - 2.22i/ii NHS Health checks - Take-up/Offered
  - 2.24i/ii/iii Injuries due to falls in people aged 65 and over

- Health Protection
  - 3.02i/ii Chlamydia diagnoses (15-24 year olds)
  - 3.03iii/iv/v/vi/vii/x/xii/xiii/xiv/xv Vaccination Coverage
  - 3.05ii Incidence of TB

- Healthcare & Premature Mortality
  - 4.1 Suicide Rate

Amber Measures

- Wider Determinants of Health
  - 1.09i Sickness absence - The percentage of employees who had at least one day off in the previous week
  - 1.18ii Loneliness and isolation Carers
- Health Improvement
  - 2.04 Teenage conceptions
  - 2.06i Excess weight in 4-5 yr olds
  - 2.07i Rate of emergency admissions caused by unintentional and deliberate injuries in children aged 0-14 years
  - 2.12 Excess weight in Adults
  - 2.13i Percentage of physically active and inactive adults - active adults
  - 2.15ii Successful completion of drug treatment - non opiate users
  - 2.18 Alcohol related hospital admissions
  - 2.23i/ii/iii/iv Wellbeing responses from Integrated Household Survey
- Health Protection
  - 3.03 viii/ix MMR vaccination coverage
  - 3.04 People presenting with HIV at a late stage of infection
- Healthcare & Premature Mortality
  - 4.01 Infant Mortality
  - 4.06i/ii U-75 mortality rate from liver disease / considered preventable
  - 4.07ii U-75 mortality rate from respiratory disease considered preventable
  - 4.14i/ii/iii Hip fractures in people aged 65 and over
  - 4.15i/ii/iii/iv Excess Winter Deaths Index

Red Measures

- **Overarching Indicators**
  - 0.1i/ii Healthy life expectancy at birth
  - 0.2i/ii Life expectancy at birth
  - 0.2vi Gap in life expectancy at birth between each Local Authority and England as a whole

- **Wider Determinants of Health**
  - 1.01ii Percentage of all dependent children under 20 in relative poverty
  - 1.02ii School Readiness (Year 1 pupils)
  - 1.09ii Sickness absence - The percent of working days lost due to sickness absence
  - 1.12i Violent crime (including sexual violence) - hospital admissions for violence
  - 1.14 The percentage of the population affected by noise
  - 1.16 Utilisation of outdoor space for exercise/health reasons

- **NOTE - Red text indicates downward trend**

- **Health Improvement**
  - 2.01 Percentage of all live births at term with low birth weight
  - 2.02i/ii Breastfeeding initiation/prevalence
  - 2.03 Rate of smoking at time of delivery per 100 maternities
  - 2.06ii Excess weight in 10-11 year olds
  - 2.13ii Percentage of physically active and inactive adults - inactive adults
  - 2.14 Smoking prevalence (adults) over 18
  - 2.15i Successful completion of drug treatment - opiate users
  - 2.17 Recorded diabetes
  - 2.21vii Access to non cancer screening programmes - diabetic retinopathy

- **Healthcare & Premature Mortality**
  - 4.02 Tooth decay iin Children aged 5
  - 4.03 Mortality rate from causes considered preventable
  - 4.04i/ii U-75 mortality rate from all cardiovascular disease/considered preventable
  - 4.05i/ii U-75 mortality rate from cancer/considered preventable
  - 4.07i U-75 mortality rate from respiratory disease
  - 4.08 mortality from communicable diseases
  - 4.11 Emergency readmissions within 30 days of discharge

Health and Wellbeing Priorities

Priority	Red	Amber	Green
Smoking	1	0	6
Alcohol	1	3	4
Obesity	3	3	3
NEETS	0	1	4
Fuel Poverty	2	0	1
Dementia	0	1	5

HWB Priorities – Red Measures

Smoking

Percentage smoking at delivery

- 2012-13 outturn (19.2%) Last Update Q3 13/14 (21.1%) against a target of 18.2%

Alcohol

Number of FPN waivers which result in attendance at binge drinking course

- 2012-13 outturn (86) Last Update Q3 13/14 (17) against a target of ?? But lower than last year

Fuel Poverty

The number of properties receiving energy efficiency measures through Community Energy Saving Programme (CESP)

- Q3 2013-14 (160) against a target of 236

The number of properties receiving energy efficiency measures through Dept of Energy & Climate Change (DECC)

- Q2 2013-14 (68) against a target of 320

Obesity

Percentage of overweight and obese children in Reception

- 2011-12 outturn (16.1%) Last Update 2012-13 (22.2%) 2013-14 not available but deterioration in direction of travel between 2011-12 and 2012-13

Percentage of overweight and obese children in Year 6

- 2011-12 outturn (33.0%) Last Update 2012-13 (35.2%) no 2013-14 not available but deterioration in direction of travel between 2011-12 and 2012-13

Healthy eating prevalence (Integrated Household Survey/ Active People Survey)

- 2011-12 Outturn 21.3% against a target of 28.7%

Identifying Outliers

- Latest available public health data used as a 'can opener' to prompt where performance clinics could take place

- The following indicators have been identified as requiring focus/action, the rationale used is that the indicator is Red or Amber with deterioration and/or in the bottom quartile regionally.
  - Obesity (1.16, 2.06i, 2.06ii, 2.13 2.17 HWB))
  - Low birth weight babies (2.01, 2.03 (HWB))
  - Breastfeeding (2.02i)
  - Drug Treatment (2.15i)
  - School Readiness (Year 1, Reception) (1.02i, 1.02ii)
  - Emergency Readmissions (4.11)
  - Sickness Absence (1.09i)
  - Smoking (2.14)
  - Mortality (4.03, 4.04, 4.05i, 4.07i, 4.08)
  - Access to non-cancer screening programmes (indicator 2.21 vii)
  - Children in poverty (1.01i)
  - Violent Crime (1.12)
  - Noise (1.14)
  - Tooth Decay (4.02)
  - Alcohol (Binge Drinking Course) HWB
  - Energy Efficiency (Fuel Poverty HWB

- Three areas identified as priority areas for first performance clinics – Obesity, Drug Treatment and Breastfeeding
- Measures in Red text – Red with a downward trend.

Performance Clinics

- The Performance Clinic will:
  - Understand activity and impact between published data and present day.
  - Provide a view of how robust current commissioning arrangements and future plans are.
  - Be attended by a panel key stakeholders who will be provided a presentation by the accountable lead and relevant officers, including external organisation where possible.
  - Be chaired by someone independent person of the service to ensure appropriate challenge

- The Performance Clinic presentation will focus on:
  - Estimated current performance – taking into account the activity in the period since the last reported performance figures.
  - Action Plans and Commissioning Plans in place and their impacts
  - Future remedial actions needed to address performance.
  - An assessment of how we know that what is in place and what is planned will have the necessary impact.

- The format will be a presentation followed by a round table discussion on the issues presented and plans for the future and will be carried out in a challenging but supportive way.

- The outcome of the clinic will be an agreement on remedial actions that are needed to address current under performance

Performance Clinics (May14)

- Obesity

Indicator	Current Score
Excess weight in 4-5 year olds	22.2% (2012-13)
Excess weight in 10-11 year olds	35.2% (2012-13)
Excess weight in adults	65.3% (2012)
Recorded diabetes	6.36 (est) (2012-13)
Utilisation of outdoor space for exercise/health reasons	10.1% (Mar 12-Feb 13)

- Drug Treatment (successful completion of)

Treatment Type	Sep-12 - Aug-13	Oct -12 - Sep-13
Opiates	5.78	5.74
Non-Opiates	46.7	46.49

Performance Clinic Panel

Obesity

- Shona McFarlane (Chair)
- Helen Chambers
- Adrian Hobson
- Kay Denton
- Joanna Saunders
- Nagpal Hoysal
- Catherine Homer
- Professor Paul Gately
- Chris Siddall
- Alan Pogorzelec
- Rachel Overfield
- Juliette Penney

Drug Treatment

- Dave Richmond (Chair)
- Janine Parkin
- Shona McFarlane
- Dave Roddis
- Anne Charlesworth
- Debbie Stovin
- Matt Pollard

Public Health
Performance Clinics Outcomes

- Two performance clinics identified April 2014 – Key Actions Agreed

- Obesity
  - Better management information needed to track improvement
  - Development of wider council policies to prevent obesity
  - Better information to all services
  - Developing Single Point of Access to weight management services
  - Targeting children in reception years
  - Increase in prevention/lower level interventions
  - CAF for children identified as needing support
  - Active partnership with Green Spaces

- Drug Treatment
  - Work with GP's to increase support
  - Deliver the new recovery hub
  - Targeted action at GP's with high volumes of users and new entrants – top 5 priority areas
  - Improve housing advice.
  - Need only 20 more successful treatments to be national average

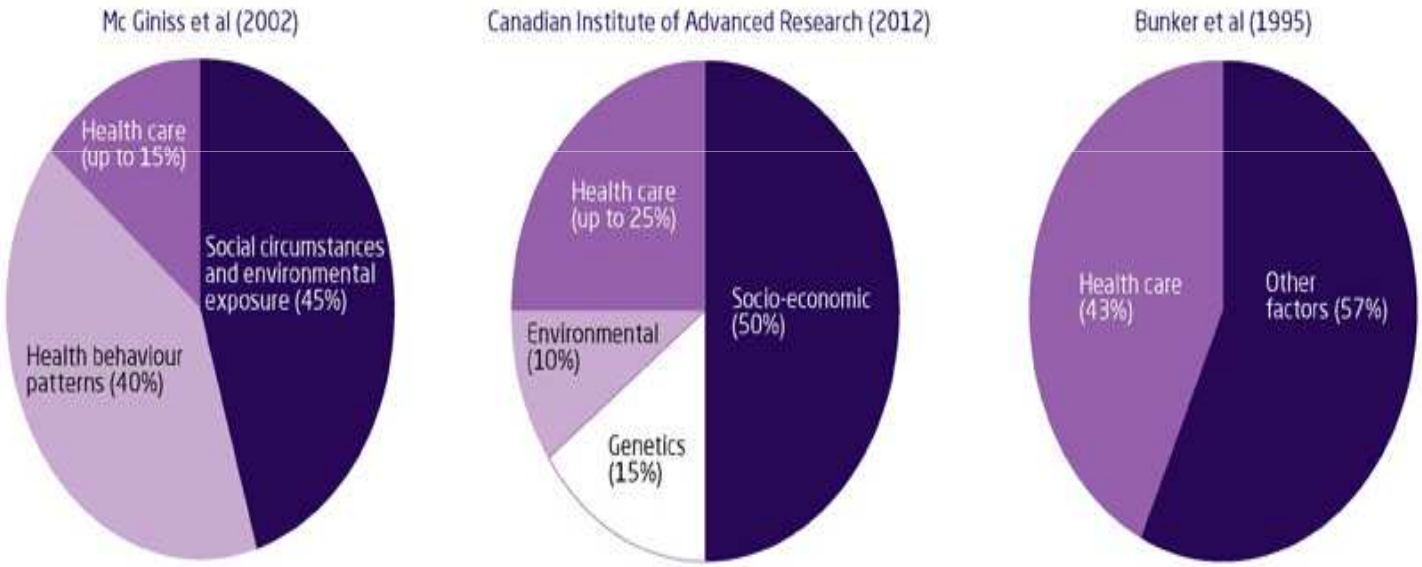
Future Performance Clinics

- Breastfeeding (1st July)

- DPH - Recommendations for future clinic:

Influences on population health

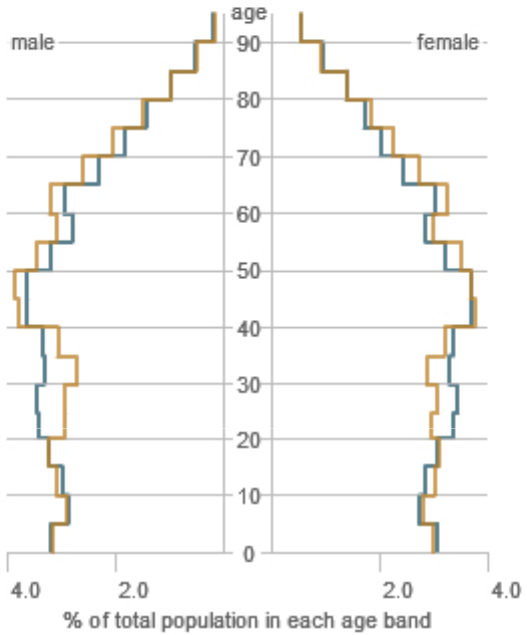
King's Fund summary:



Inequalities

- Differences in health outcomes reflect, and are caused by, social and economic inequalities in society
- Unhealthy behaviour and access to healthcare are not the only factors that cause health inequalities
- Genetics, environmental influences, infectious disease play a significant part
- Significant shift in thinking related to the magnitude of the effect of physical activity
- People in poorer areas die earlier but spend more of their shorter lives with a disability
- Response needs to be across the life course and reflect need at the life stage

2011 Census: population estimates for England and Wales



England
Total population: 53,012,456

Rotherham
Total population: 257,280

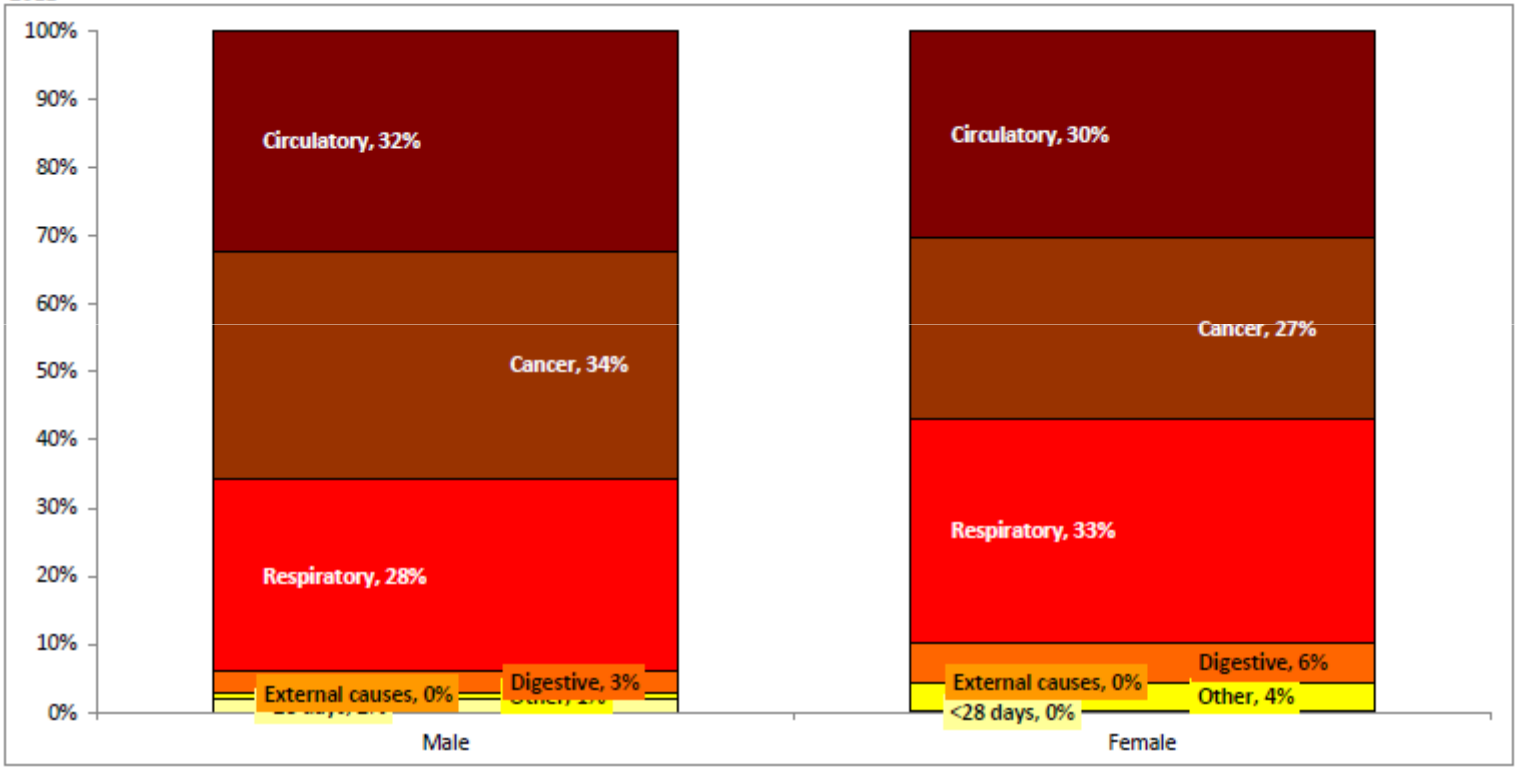
Source: 2011 Census, 2001 Mid-Year Population Estimates
Graphic by ONS Data Visualisation Centre

THE SEGMENT TOOL

SEGMENTING LIFE EXPECTANCY GAPS BY CAUSE OF DEATH

Public Health England

Chart 1: Scarf chart showing the breakdown of the life expectancy gap between Rotherham as a whole and England as a whole, by cause of death, 2009-2011



Footnote: Circulatory diseases includes coronary heart disease and stroke. Digestive diseases includes alcohol-related conditions such as chronic liver disease and cirrhosis. External causes include deaths from injury, poisoning and suicide

Analysis by Public Health England Knowledge and Intelligence Team based on ONS death registration data, and mid year population estimates

Key Priority Issues

- Emergency Readmissions
- Maternal health
- Physical activity strategy
- Healthcare plans should specifically address disease causes of inequalities
- Obesity management of the metabolic consequences
- Workplace Health

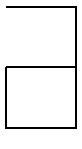
Public Health Outcome Framework Performance Measures

Measure Type Key		RAG Key	
N	National	Green	Meeting or exceding Target
C	Corporate Plan	Red	Not meeting target
P	Partnership / Political	Amber	Slight variation from target

Indicator Ref	N	C	P	Indicator Title	Good Perf	2013/14 Performance (March)	Current Published Performance	RAG National	RAG Y&H	Direction of Travel	Director	Comments / Remedial Actions
0.1i	✓			Health life expectancy at birth (male)	High	58.2 (2009-11)	58.2 (2009-11)	Red	Red		John Radford	
0.1i	✓			Health life expectancy at birth (female)	High	59.9 (2009-11)	59.9 (2009-11)	Red	Red		John Radford	
0.1ii	✓			Life expectancy at birth (male)	High	78 (2009-11)	78 (2009-11)	Red	Amber	⇔	John Radford	
0.1ii	✓			Life expectancy at birth (female)	High	81.6 (2009-11)	81.6 (2009-11)	Red	Red	⇔	John Radford	
0.2vi	✓			Gap in life expectancy at birth between each Local Authority and England as a whole (male)	-	-1.2 (2010-12)	-1.2 (2010-12)	Red	Amber	⇩	John Radford	
0.2vi	✓			Gap in life expectancy at birth between each Local Authority and England as a whole (female)	-	-1.4 (2010-12)	-1.4 (2010-12)	Red	Red	⇩	John Radford	
1.01ii	✓			Percentage of all dependent children under 20 in relative poverty (living in households where income is less than 60 per cent of median household income before housing costs)	Low	22.6% (2011)	22.6% (2011)	Red	Red	⇔	John Radford	no change to score - no update available in May PHOF refresh
1.02i	✓			School Readiness: All children achieving a good level of development at the end of reception as a percentage of all eligible children.	High	55.7% (2012-13)	55.7% (2012-13)	Green	Green		John Radford	no change to score - no update available in May PHOF refresh
1.02i	✓			School Readiness: All children achieving a good level of development at the end of reception as a percentage of all eligible children by free school meal status	High	39.9% (2012-13)	39.9% (2012-13)	Green	Green		John Radford	no change to score - no update available in May PHOF refresh
1.02ii	✓			School Readiness: Year 1 pupils achieving the expected level in the phonics screening check as a percentage of all eligible pupils	High	62.5% (2012-13)	62.5% (2012-13)	Red	Red		John Radford	no change to score - no update available in May PHOF refresh
1.02ii	✓			School Readiness: All children achieving a good level of development at the end of reception as a percentage of all eligible children by free school meal status	High	47.8% (2012-13)	47.8% (2012-13)	Red	Red		John Radford	no change to score - no update available in May PHOF refresh
1.03				Pupil Absence	Low							
1.04				First time entrants to youth justice system	Low							
1.05				16-18 NEETS	Low							
1.06i				Adults with learning disabilities in settled accommodation	High	79.63% (2013-14)	79.07% (May 14)	Green	Green		Shona McFarlane	
1.06ii				Adults receiving secondary mental health services in settled accommodation	High	78.82% (2013-14 est)	76.79% (May 14)	Green	Green		Shona McFarlane	
				Adults with learning disabilities in employment	High	5.99% (2013-14)	6.3% (May 14)	Green	Green		Shona McFarlane	
				Adults receiving secondary mental health services in employment	High	4.9% (2013-14 est)	5.64% (May 14)	Green	Green		Shona McFarlane	
A				People in Prison with a mental illness							John Radford	
1.09i	✓			Sickness absence - The percentage of employees who had at least one day off in the previous week	Low	2.9% (2009-11)	2.9% (2009-11)	Amber	Amber		John Radford	no change to score - no update available in May PHOF refresh
1.09ii	✓			Sickness absence - The percent of working days lost due to sickness absence	Low	2.3% (2009-11)	2.3% (2009-11)	Red	Red		John Radford	no change to score - no update available in May PHOF refresh
1.10	✓			Killed and seriously injured casualties on England's roads	Low	29.7 (2010-12)	29.7 (2010-12)	Green	Green	⇧	John Radford	no change to score - no update available in May PHOF refresh
1.11	✓			Rate of domestic abuse incidents reported to the police, per 1,000 population	Low	22.9 (2011-12)	27.1 (2012-13)	-	-		John Radford	Updated from May PHOF refresh - Score refers to SY police not Rotherham singularly
1.12i	✓			Violent crime (including sexual violence) - hospital admissions for violence	Low	75.2 (10/11 - 12/13)	75.2 (10/11 - 12/13)	Red	Amber	⇧	John Radford	no change to score - no update available in May PHOF refresh
1.12iii	✓			Violent crime (including sexual violence) - violence offences per 1,000 population	Low	7.6 (2012-13)	7.6 (2012-13)	-	-		John Radford	no change to score - no update available in May PHOF refresh
1.12iii	✓			Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population	Low	0.54 (2012-13)	0.54 (2012-13)	-	-		John Radford	no change to score - no update available in May PHOF refresh
1.13i	✓			The percentage of offenders who re-offend from a rolling 12 month cohort	Low	26.3% (2011)	26.3% (2011)	-	-		John Radford	no change to score - no update available in May PHOF refresh
1.13ii	✓			The average number of re-offences committed per offender from a rolling 12 month cohort	Low	0.67 (2011)	0.67 (2011)	-	-		John Radford	no change to score - no update available in May PHOF refresh
1.14i	✓			The percentage of the population affected by noise	Low	8.7% (2006-07)	8.7% (2011-12)	Red	Red	⇧	John Radford	Updated from May PHOF refresh
1.15i	✓			Statutory Homelessness - homelessness acceptances	Low	1.1 (2011-12)	1.2 (2012-13)	Green	Green	⇧	John Radford	Updated from May PHOF refresh
1.15ii	✓			Statutory Homelessness - households in temporary accomodation	Low	0.3 (2011-12)	0.2 (2012-13)	Green	Green	⇧	John Radford	Updated from May PHOF refresh
1.16	✓			Utilisation of outdoor space for exercise/health reasons	High	10.1% (Mar 12-Feb 13)	10.1% (Mar 12-Feb 13)	Red	Red	⇩	John Radford	no change to score - no update available in May PHOF refresh
1.17	✓			Fuel Poverty	Low	10.1 (2011)	10.1 (2011)	Green	Green		John Radford	no change to score - no update available in May PHOF refresh
1.18i				Loneliness and isolation in adult social care users		39.5% (2012 13)	39.5% (2012-13)			⇩	John Radford	(User Survey)
1.18ii				Loneliness and isolation in adult carers		53.2% (2012 13)	53.2% (2012-13)				John Radford	(Carer Survey)
2.01	✓			Percentage of all live births at term with low birth weight	Low	3.5% (2011)	3.5% (2011)	Red	Amber	⇩	Joanna Saunders	no change to score - no update available in May PHOF refresh
2.02i	✓			Breastfeeding initiation	High	58.5% (2012-13)	59.91% (2013-14)	Red	Red	⇩	Joanna Saunders	
2.02ii	✓			Breastfeeding prevalence at 6-8 weeks	High	29.7% (2012-13)	29.7% (2012-13)	Red	Red	⇔	Joanna Saunders	no change to score - no update available in May PHOF refresh
2.03	✓			Rate of smoking at time of delivery per 100 maternities	Low	21.1 (Q3 13-14)	19.37 (Q4 13-14)	Red	Red	⇧	Joanna Saunders	
2.04	✓			Teenage conceptions (under 18)	Low	40.9 (2011)	30 (2012)	Amber	Amber	⇧	Joanna Saunders	Updated from May PHOF refresh
2.06i	✓			Excess weight in 4-5 year olds	Low	22.2% (2012-13)	22.2% (2012-13)	Amber	Amber	⇩	Joanna Saunders	no change to score - no update available in May PHOF refresh
2.06ii	✓			Excess weight in 10-11 year olds	Low	35.2% (2012-13)	35.2% (2012-13)	Red	Red	⇩	Joanna Saunders	no change to score - no update available in May PHOF refresh
2.07i	✓			Rate of emergency admissions caused by unintentional and deliberate injuries in children aged 0-14 years	Low	102.3 (2012-13)	102.3 (2012-13)	Amber	Amber	⇧	Joanna Saunders	no change to score - no update available in May PHOF refresh
2.07ii	✓			Rate of emergency admissions caused by unintentional and deliberate injuries in young people aged 15-24 years	Low	117.90 (2012-13)	117.90 (2012-13)	Green	Green	⇧	Joanna Saunders	no change to score - no update available in May PHOF refresh

2.08	✓			Emotional well-being of looked after children	High	15.3 (2011-12)	15.2 (2012-13)	-	-		Joanna Saunders	Updated from May PHOF refresh
2.12	✓			Excess weight in adults	Low	65.3% (2012)	65.3% (2012)	Amber	Amber		Joanna Saunders	no change to score - no update available in May PHOF refresh
2.13i	✓			Percentage of physically active and inactive adults - active adults	High	52.4% (2012)	52.4% (2012)	Amber	Amber		Joanna Saunders	no change to score - no update available in May PHOF refresh
2.13ii	✓			Percentage of physically active and inactive adults - inactive adults	Low	33.6% (2012)	33.6% (2012)	Red	Amber		Joanna Saunders	no change to score - no update available in May PHOF refresh
2.14	✓			Smoking prevalence (adults) over 18	Low	22.7% (2012)	22.7% (2012)	Red	Amber	⇧	Joanna Saunders	no change to score - no update available in May PHOF refresh
2.15i	✓			Successful completion of drug treatment - opiate users	High	5.78% (Sept 12-Aug-13)	5.55% (Nov'12 - Oct'13)	Red	Red	⇩	Anne Charlesworth	rolling 12 months data - data runs 2 month's behind, last update refers to Mar 14
2.15ii	✓			Successful completion of drug treatment - non opiate users	High	46.7% (Sep 12-Aug-13)	42.49% (Nov'12 - Oct'13)	Amber	Amber	⇩	Anne Charlesworth	rolling 12 months data - data runs 2 month's behind, last update refers to Mar 14
2.16				People entering prison with substance dependence issues who are previously not known to community treatment							Joanna Saunders	Data source needs further development nationally.
2.17	✓			Recorded diabetes	Low	6.36 (est) (2012-13)	6.36 (est) (2012-13)	Red	Red	⇧	Joanna Saunders	no change to score - no update available in May PHOF refresh
2.18				Alcohol related hospital admissions			704 (2012-13)	Amber	Amber	⇧	Joanna Saunders	
2.20i	✓			Cancer Screening coverage - breast cancer	High	79.9% (2013)	79.9% (2013)	Green	Green	⇩	Joanna Saunders	no change to score - no update available in May PHOF refresh
2.20ii	✓			Cancer Screening coverage - cervical cancer	High	76% (2013)	76% (2013)	Green	Amber	⇩	Joanna Saunders	no change to score - no update available in May PHOF refresh
2.21vii	✓			Access to non cancer screening programmes - diabetic retinopathy	High	66.7% (2011-12)	66.7% (2011-12)	Red	Red	⇔	Joanna Saunders	no change to score - no update available in May PHOF refresh
2.22i (4.1.4)	✓	✓		Take up of NHS health check programme by those eligible - health check offered	High	1648 (Quarter 4)	1648 (Quarter 4)	Green	Green	⇧	Jo Abbott	next update due July 14
2.22ii (4.1.5)	✓	✓		Take up of NHS health check programme by those eligible - health check take up	High	1648 (Quarter 4)	1648 (Quarter 4)	Green	Amber	⇩	Jo Abbott	next update due July 14
2.23i	✓			Percentage of respondents less satisfied with life	Low	6.6% (2012-13)	6.6% (2012-13)	Amber	Amber	⇧	Joanna Saunders	no change to score - no update available in May PHOF refresh
2.23ii	✓			Percentage of respondents feeling their life is less worthwhile	Low	5.5% (2012-13)	5.5% (2012-13)	Amber	Amber	⇧	Joanna Saunders	no change to score - no update available in May PHOF refresh
2.23iii	✓			Percentage of respondents feeling less happy yesterday	Low	11.2% (2012-13)	11.2% (2012-13)	Amber	Amber	⇧	Joanna Saunders	no change to score - no update available in May PHOF refresh
2.23iv	✓			Percentage of respondents feeling more anxious yesterday	Low	22.2% (2012-13)	22.2% (2012-13)	Amber	Amber	⇧	Joanna Saunders	no change to score - no update available in May PHOF refresh
2.24i	✓			Injuries due to falls in people aged 65 and over	Low	1833 (2011-12)	1570 (2012-13)	Green	Green	⇧	Joanna Saunders	Updated from May PHOF refresh
2.24ii	✓			Injuries due to falls in people aged 65 and over (aged 65-79)	Low	996 (2011-12)	749 (2012-13)	Green	Green	⇧	Joanna Saunders	Updated from May PHOF refresh
2.24iii	✓			Injuries due to falls in people aged 65 and over (aged 80+)	Low	5598 (2011-12)	3953 (2012-13)	Green	Green	⇧	Joanna Saunders	Updated from May PHOF refresh
3.01	✓			Fraction of mortality attributable to particulate air pollution	Low	5.4% (2011)	5.4% (2011)	-	-		Jo Abbott	no change to score - no update available in May PHOF refresh
3.02i	✓			Chlamydia diagnoses (15-24 year olds) - Old NCSP data	Low	2555 (2011)	2555 (2011)	Green	Green	⇩	Jo Abbott	no change to score - no update available in May PHOF refresh
3.02ii	✓			Chlamydia diagnoses (15-24 year olds) - CTAD	Low	3376 (2012)	3376 (2012)	Green	No Regional data for comparison		Jo Abbott	no change to score - no update available in May PHOF refresh
3.03i	✓			Hepatitis B (12 Months)		-					Jo Abbott	
3.03i	✓			Hepatitis B (24 Months)		-					Jo Abbott	
3.03iii	✓			Dtap/IPV/Hib vaccination (12 Months)	High	96.4% (2012-13)	96.4% (2012-13)	Green	Amber	⇔	Jo Abbott	no change to score - no update available in May PHOF refresh
3.03iii	✓			Dtap/IPV/Hib vaccination (24 Months)	High	97% (2012-13)	97% (2012-13)	Green	Amber		Jo Abbott	no change to score - no update available in May PHOF refresh
3.03iv	✓			MenC vaccination coverage	High	95.8% (2012-13)	95.8% (2012-13)	Green	Green	⇔	Jo Abbott	no change to score - no update available in May PHOF refresh
3.03v	✓			PCV vaccination coverage	High	96% (2012-13)	96% (2012-13)	Green	Amber	⇔	Jo Abbott	no change to score - no update available in May PHOF refresh
3.03vi	✓			Hib/MenC booster vaccination coverage (2 years)	High	95% (2012-13)	95% (2012-13)	Green	Amber	⇔	Jo Abbott	no change to score - no update available in May PHOF refresh
3.03vi	✓			Hib/MenC booster vaccination coverage (5 years)	High	95% (2012-13)	95% (2012-13)	Green	Amber	⇧	Jo Abbott	no change to score - no update available in May PHOF refresh
3.03vii	✓			PCV booster vaccination coverage	High	93.9% (2012-13)	93.9% (2012-13)	Green	Red	⇔	Jo Abbott	no change to score - no update available in May PHOF refresh
3.03viii	✓			MMR vaccination coverage (2 years)	High	93.2% (2012-13)	93.2% (2012-13)	Amber	Red	⇔	Jo Abbott	no change to score - no update available in May PHOF refresh
3.03ix	✓			MMR vaccination coverage one dose (5 years)	High	94.5% (2012-13)	94.5% (2012-13)	Amber	Amber	⇧	Jo Abbott	no change to score - no update available in May PHOF refresh
3.03x	✓			MMR vaccination coverage two doses (5 years)	High	91.2% (2012-13)	91.2% (2012-13)	Green	Amber	⇧	Jo Abbott	no change to score - no update available in May PHOF refresh
3.03xii	✓			HPV vaccination coverage	High	91.5% (2012-13)	91.5% (2012-13)	Green	Green	⇧	Jo Abbott	no change to score - no update available in May PHOF refresh
3.03xiii	✓			PPV vaccination coverage	High	73.4% (2012-13)	73.4% (2012-13)	Green	Green	⇩	Jo Abbott	no change to score - no update available in May PHOF refresh
3.03xiv	✓			Flu vaccination coverage (over 65s)	High	75.7% (2012-13)	75.7% (2012-13)	Green	Green	⇔	Jo Abbott	no change to score - no update available in May PHOF refresh
3.03xv	✓			Flu vaccination coverage (at risk individuals)	High	55% (2012-13)	55% (2012-13)	Green	Green	⇧	Jo Abbott	no change to score - no update available in May PHOF refresh
3.04	✓			People presenting with HIV at a late stage of infection	Low	58.1 (2010-12)	58.1 (2010-12)	Amber	Amber	⇔	Jo Abbott	no change to score - no update available in May PHOF refresh
3.05ii	✓			Incidence of TB	Low	8.6 (2010-12)	8.6 (2010-12)	Green	Amber	⇔	Jo Abbott	no change to score - no update available in May PHOF refresh
3.06	✓			Public Sector organisations with a board approved sustainable development management plan	High	100% (2011-12)	100% (2012-13)	-	-		Jo Abbott	Updated from May PHOF refresh
D				Comprehensive agreed interagency plans for responding to public health incidents							Jo Abbott	
4.01	✓			Infant Mortality	Low	4.48 (2009-11)	4.8 (2010 -12)	Amber	Amber	⇩	Nagpal Hoysal	Updated from May PHOF refresh
4.02	✓			Tooth decay iin Children aged 5	Low	1.5% (2011-12)	1.5% (2011-12)	Red	Amber		Nagpal Hoysal	no change to score - no update available in May PHOF refresh

4.03	✓			Mortality rate from causes considered preventable (provisional)	Low	202.7 (2010-12)	202.7 (2010-12)	Red	Amber	⇧	Nagpal Hoysal	no change to score - no update available in May PHOF refresh
4.04i	✓			U-75 mortality rate from all cardiovascular disease (provisional)	Low	92.1 (2010-12)	92.1 (2010-12)	Red	Amber	⇧	Nagpal Hoysal	no change to score - no update available in May PHOF refresh
4.04ii	✓			U-75 mortality rate from all cardiovascular disease considered preventable (provisional)	Low	63.3 (2010-12)	63.3 (2010-12)	Red	Amber	⇧	Nagpal Hoysal	no change to score - no update available in May PHOF refresh
4.05i	✓			U-75 mortality rate from cancer (provisional)	Low	168.7 (2010-12)	168.7 (2010-12)	Red	Red	⇧	Nagpal Hoysal	no change to score - no update available in May PHOF refresh
4.05ii	✓			U-75 mortality rate from cancer considered preventable (provisional)	Low	96.8 (2010-12)	96.8 (2010-12)	Red	Amber	⇧	Nagpal Hoysal	no change to score - no update available in May PHOF refresh
4.06i	✓			U-75 mortality rate from liver disease - (provisional)	Low	18.3 (2010-12)	18.3 (2010-12)	Amber	Amber	⇧	Nagpal Hoysal	no change to score - no update available in May PHOF refresh
4.06ii	✓			U-75 mortality rate from liver disease considered preventable (provisional)	Low	15.5 (2010-12)	15.5 (2010-12)	Amber	Amber	⇧	Nagpal Hoysal	no change to score - no update available in May PHOF refresh
4.07i	✓			U-75 mortality rate from respiratory disease - (provisional)	Low	45.3 (2010-12)	45.3 (2010-12)	Red	Red	⇔	Nagpal Hoysal	no change to score - no update available in May PHOF refresh
4.07ii	✓			U-75 mortality rate from respiratory disease considered preventable (provisional)	Low	20.1 (2010-12)	20.1 (2010-12)	Amber	Amber	⇩	Nagpal Hoysal	no change to score - no update available in May PHOF refresh
4.08	✓			mortality from communicable diseases (provisional)	Low	91 (2010-12)	91 (2010-12)	Red	Red	⇧	Nagpal Hoysal	no change to score - no update available in May PHOF refresh
4.10	✓			Suicide rate	Low	6.1 (2010-12)	6.1 (2010-12)	Green	Green	⇩	Nagpal Hoysal	no change to score - no update available in May PHOF refresh
4.11	✓			Emergency readmissions within 30 days of discharge	Low	12.8 (2010-11)	13.4 (2011-12)	Red	Red	⇩	Nagpal Hoysal	Updated from May PHOF refresh
E				Health related quality of life for older people							Nagpal Hoysal	
4.14i	✓			Hip fractures in people aged 65 and over	Low	465.9 (2011-12)	577 (2012-13)	Amber	Amber	⇧	Nagpal Hoysal	Updated from May PHOF refresh
4.14ii	✓			Hip fractures in people aged 65 and over (65-79)	Low	213.4 (2011-12)	277.5 (2012-13)	Amber	Amber	⇩	Nagpal Hoysal	Updated from May PHOF refresh
4.14iii	✓			Hip fractures in people aged 65 and over (80+)	Low	1602 (2011-12)	1445 (2012-13)	Amber	Amber	⇧	Nagpal Hoysal	Updated from May PHOF refresh
4.15i	✓			Excess Winter Deaths Index (single year, all ages)	Low	8.1 (Aug 11-Jul12)	8.1 (Aug 11-Jul12)	Amber	Amber	⇧	Nagpal Hoysal	no change to score - no update available in May PHOF refresh
4.15ii	✓			Excess Winter Deaths Index (single year, age 85+)	Low	26.7 (Aug 11-Jul12)	26.7 (Aug 11-Jul12)	Amber	Amber	⇩	Nagpal Hoysal	no change to score - no update available in May PHOF refresh
4.15iii	✓			Excess Winter Deaths Index (three years aggregated, all ages)	Low	11.5 (Aug 11-Jul12)	11.5 (Aug 11-Jul12)	Amber	Amber	⇧	Nagpal Hoysal	no change to score - no update available in May PHOF refresh
4.15iv	✓			Excess Winter Deaths Index (three years aggregated, age 85+)	Low	20.4 (Aug 11-Jul12)	20.4 (Aug 11-Jul12)	Amber	Amber	⇔	Nagpal Hoysal	no change to score - no update available in May PHOF refresh



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 31-03-14	50%	50%	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 31-03-14	5	5	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 31-03-14	50%	50%	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 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	Percentage of overweight and obese children in Reception	16.1%	22.2%			2013-14 due Dec 2014			R	15%	12%	Joanna Saunders
	Percentage of overweight and obese children in Year 6	33.0%	35.2%			2013-14 due Dec 2014			R	30%	25%	Joanna Saunders

	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	Percentage of key public sector staff undertaking Making Every Contact Counts											
	Referrals of children to Healthy Weight Framework interventions	313	286	No target		Q2 13/14	114	No target	G			Joanna Saunders
	Completed Healthy Weight Framework interventions by children	144	119	No target		Q2 13/14	53	No target	G			Joanna Saunders
	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 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	Healthy eating prevalence (Integrated Household Survey/ Active People Survey)	21.3%		No target		2011-12	21.3%	28.7%	R			Joanna Saunders
	Increased prevalence of diagnosed diabetes	6.20%	6.35%			2012-13	6.35%	No target	G			Dominic Blaydon

	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	Percentage of key public sector staff undertaking Making Every Contact Counts											
	Referrals of adults to Healthy Weight Framework interventions	2884	2253	No target		Q2 13/14	573	No target	A			Joanna Saunders
	Completed Healthy Weight Framework interventions by adults	1414	1067	No target		Q2 13/14	269	No target	A			Joanna Saunders
	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												
Key Measure	Indicator	2010 Baseline	2011-12			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
	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
Quarterly Proxy Measure	Indicator	2011-12 Baseline	2012-13			Current Position				2013-14 Target	2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Period	Outturn	Target	RAG			
	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%	89.4%	89%	G	01-04-13 to 31-03-2014	90.7%	90.0%	G	90%	90%	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 31-03-2014	98.6%	97.5%	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 31-03-2014	93.2%	93%	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.

ROTHERHAM BOROUGH COUNCIL – REPORT HEALTH & WELLBEING BOARD

1.	**Meeting**	**Health & Wellbeing Board**
2.	**Date**	**02/06/2014**
3.	**Title**	**Reducing Potential Years of Life Lost**
4.	**Directorate**	**Public Health**

5. Summary

Over 7,000 potential years of life are lost among Rotherham residents from causes considered amenable to healthcare. This is about 1,600 years higher than expected when compared with the national average. The main direct causes are circulatory disease, cancer and respiratory disease.

Rotherham Clinical Commissioning Group (RCCG) have committed to reducing Potential Years of Life Lost that are considered amenable to healthcare by 200 years per year over the course of their 5-year strategy.

The key to achieving this aim is partnership action to make the most of the services that have already been commissioned.

6. Recommendations

HWBB members to:

- note the actions that the CCG intend to pursue to reduce potential years of life lost
- support the CCG in implementing these actions

7. Proposals and details

Although life expectancy at birth has improved in Rotherham, the gap with England hasn't narrowed. There is also an inequality between the life expectancy experienced by the most and least deprived areas within the borough.

The root causes of these inequalities are the wider determinants of health; however, these determinants result in ill health which is the direct cause of death. In Rotherham, the direct causes of the bulk of the inequalities in life expectancy are circulatory disease, cancer and respiratory disease. This is the case for both the gap between the borough and the England average and within the borough between the most and least deprived areas.

Potential Years of Life Lost (PYLL) reflects deaths in people aged under 75. Some of these deaths could have been avoided had effective healthcare been provided when they were alive. About 7,000 PYLL are lost each year in Rotherham through causes considered amenable to healthcare. This is over 1,600 years more than

might be expected based on the England average. Rotherham CCG have commited within their 5-year strategy to reduce amenable PYLL by an average of 200 years per year.

The main drivers of the excess of PYLL in Rotherham are the same as the drivers of inequalities in life expectancy; namely, circulatory disease, cancer and respiratory disease. Figures describing within borough inequalities in PYLL are not published; however, the drivers are likely to be the same.

Within the new commissioning landscape, tackling amenable premature mortality will require a coordinated partnership approach involving RCCG, NHS England South Yorkshire and Bassetlaw Area Team (SYBAT), Rotherham Metropolitan Borough Council Public Health (RPH), The Rotherham NHS Foundation Trust (TRFT), General Practice (GP) and the wider membership of the Rotherham Health and Wellbeing Board (HWBB). To support this, NHS England (NHSE) in partnership with the Commissioning Assembly, NHS Improving Quality and Public Health England have developed a toolkit of potential local actions across the system that RCCG could lead or support actively in order to narrow the gap. The full shopping list of potential actions can be found at http://www.england.nhs.uk/ourwork/sop/red-prem-mort/.

The tables on the following pages outline the proposed interventions that have been prioritised based on their likely impact in reducing PYLL in Rotherham. The interventions are geared towards prevention and early intervention and supporting people with long term conditions. In addition, they are likely to benefit our most disadvantaged citizens the most and will help to reduce health inequalities.

Reducing mortality from cardiovascular disease

Circulation problems account for nearly a 1,000 of the excess of years of life lost from causes amenable to healthcare.

Intervention	Where we currently stand	Proposed intervention	Responsibilities	Potential gain
All HWBB Partners actively promoting NHS Health Checks	GP delivered NHS healthcheck programme; previously one of the best performing in the country; however, current performance in decline and significant between practice variation.	RPH to adapt national marketing materials to promote awareness of programme. GPs to support improved uptake by adapting invitation method to their specific populations. GPs to ensure clinical follow-up of people identified as having or being at risk of cardiovascular disease are engaged in and in receipt of appropriate lifestyle and/or pharmacological intervention. RCCG and SYBAT to make use of relevant levers to facilitate improvement in GP quality in relation to the NHS Health check.	HWBB RPH GP RCCG and SYBAT	1404 QALYs gained based on national uptake assumption of 80% (gain is shared between preventable and amenable mortality)
Making (sure) Every Contact Counts (MECC) through effective referral into stop smoking services	MECC adopted in principle by the NHS in Rotherham however this has not translated into increased referral into lifestyle services.	RCCG to ensure referral of current smokers to smoking cessation is a fundamental part of all pathways in and out of secondary care. RCCG to consider commissioning a national referral systems to facilitate above.	RCCG TRFT	165+ QALYs gained based on 2,350 extra referrals to stop smoking services (gain shared between reduction in CVD, Respiratory and Cancer mortality)
Improved detection and management of atrial fibrillation (AF)	There are relatively high rates of undiagnosed cases of AF and treatment varies across the country. National Enhanced Service for anticoagulant monitoring.	RCCG to work with local practices to target people at risk of AF and ensure appropriate pharmacological interventions in line with NICE guidelines. RCCG to consider promoting use of the Guidance on Risk Assessment in AF (GRASP-AF) tool by local GPs.	RCCG GP	70 fewer PYLL
Increased utilisation of cardiac rehab	Cardiac rehabilitation available for all patients following heart attack; uptake is higher than average but still some scope for further improvement. At present, patients with heart failure (HF) have no cardiac rehab following acute admission.	RCCG to commission increased capacity in cardiac rehabilitation units and use contracting levers to encourage providers to increase access to rehabilitation for currently under-represented groups including women and people from certain ethnic groups.	RCCG TRFT	26 fewer PYLL. Intervention also has potential to reduce readmissions for exacerbation of HF.

Reducing mortality from respiratory disease

Respiratory disease accounts for over 300 of the excess years of life lost from causes amenable to healthcare.

Intervention	Where we currently stand	Proposed intervention	Responsibilities	Potential gain
Participate in pilot of care bundle for community acquired pneumonia.	In-hospital mortality for pneumonia is low; however, pneumonia is a major cause of inequalities.	RCCG to commission care bundle which ensures: • Perform and assess Chest x-ray within 4hrs of admission • Assess oxygen and prescribe target range for oxygen • Use of CURB 65 to risk stratify (Confusion of new onset, Urea >7mmol/l, Respiratory rate 30/min or more, Blood pressure <90mmHg systolic or 60mmHg or less diastolic, and age 65 or over) • Administer appropriate antibiotics within 4hrs of admission	RCCG TRFT	208 fewer PYLL.
Earlier and more accurate diagnosis of Chronic Obstructive Pulmonary Disease (COPD)	Although Rotherham has excellent treatment services for people with COPD, there is evidence that undiagnosed cases exist and that some patients have been incorrectly labelled as having COPD. Nationally, about a third of admissions for exacerbation of COPD is in people not previously known to have it.	RCCG to consider opportunities for systematic and opportunistic case finding of people with COPD. RCCG and GPs to consider the need for ensuring those performing and interpreting spirometry for diagnostic purposes have attained a nationally recognised level of competence.	RCCG GP	10 fewer PYLL
Maximising uptake of pneumococcal and seasonal flu vaccination	The World Health Organisation recommends at least 75% of the over 65 population needs to be immunised for seasonal flu. Rotherham achieved this in 2012/13; however, uptake in other risk groups of a younger age was only 55%.. Pneumococcal Polysaccharide Vaccination (PPV) uptake was over 73% in 2012/13. Given the prevalence of respiratory problems within the borough, a higher level of coverage for sesonal flu and PPV in all target groups may be justifiable.	SYBAT and RCCG to consider how to enhance local coverage of the Seasonal Flu and PPV. GPs to support improved uptake by adapting invitation method to their specific populations.	SYBAT RCCG GP	

Reducing mortality from cancer

Cancer accounts for nearly 300 of the excess years of life lost from causes amenable to healthcare.

Intervention	Where we currently stand	Proposed intervention	Responsibilities	Potential gain
Monitor variation in referral and diagnosis rates amongst local practices and work with local GPs to understand the reasons behind variance	There are significant variations in the patterns of GP referrals and outcome rates in relation to the diagnosis of cancer.	RCCG and SYBAT to undertake an analysis of referral patterns and outcomes at practice level, working with practices that have poorer outcomes to understand why there is variance. GPs can then be supported with tailored and focussed support around raising symptom awareness including use of best practice from other parts of the cancer network and Rotherham PH.TV.	RCCG TRFT GP RPH	Not quantifiable.

8. Finance

NICE have set a benchmark of £20,000 to £30,000 per Quality Adjusted Life Year as the upper limit of affordability for treatments available on the NHS. Using this benchmark, PYLL from causes amenable to healthcare could cost the local economy up to £210 million per year. The excess of PYLL in Rotherham over the England average equates to a cost to the local economy of about £48 million per year.

By focussing on getting the most out of existing services, the reduction in PYLL could be achieved at little or even no cost.

9. Risks and uncertainties

Where possible, estimates of potential reductions in PYLL have been calculated. These are all based on national average assumptions. Therefore, the actual reductions may be different. Given the excess of mortality locally, it's most likely that the reduction in PYLL will be greater.

10. Policy and Performance Agenda Implications

PYLL is monitored routinely as a part of the CCG Outcome Indicators and NHS Outcomes Framework; however, year on year changes can fluctuate up and down. Therefore, more frequent monitoring of PYLL is unlikely to provide assurance of improvement.

Suitable existing metrics include health check coverage and is published at least quarterly. Coverage of seasonal flu and pneumococcal vaccination coverage is also published annually. Smoking referrals from secondary care that result in a quit is a possibility that needs to be worked up further.

The CCG would need to consider how to monitor the impact of other interventions it decides to implement; however, qualitative measures of progress against action plans would be a reasonable option.

11. Background Papers and Consultation

12. Keywords: [Keywords]

Officer: **John Radford MRCGP GMC No. 2630063**

Director of Public Health

Telephone: **01709 255845**

Email: **john.radford@rotherham.gov.uk**

Web: **www.rotherham.gov.uk/publichealth**

Publications Gateway Reference: 01685

Quarry House
Quarry Hill
Leeds
LS1 7UE

To: Regional Directors and
Clinical Leads - Clinical Commissioning Groups
Accountable Officers - CCGs
cc: National Directors
Area Directors
Regional Directors of Operations and Delivery
Regional Directors of Finance
Area Directors of Finance

4 June 2014

Dear colleague

Resubmission of operational plans

Following discussions over the past few weeks, we have agreed that we should ask for resubmission of operational plans for 2014/15 and 2015/16. This is to enable the plans to better reflect changes as a result of assurance conversations and changes being made to financial and Better Care Fund (BCF) plans.

This letter outlines the process for resubmission and sets out the key dates for commissioners. We expect Regional and Area Teams to be working with commissioners (CCGs and direct commissioners) to ensure that the plans collected as part of this resubmission represent the most robust set of plans possible. Where plans are not changed, original plans will stand.

Operational Plans

Following submission of these plans on 4 April 2014 and recent assurance discussions, resubmissions should focus on the following areas:

- Activity plans, particularly on elective activity plans to ensure they deliver the RTT standards, and on non-elective plans to ensure they are compatible with BCF plans. Changes by commissioners to the provider/commissioner return should be explicitly agreed with providers.
- IAPT plans where CCGs are just missing the 3.75% ambition, many due to rounding, and also where plans are under ambitious or unrealistic compared to current performance.
- Dementia, similarly to IAPT, where plans are unambitious or unrealistic compared to current performance.

Unify will re- open on **Monday 9 June 2014** for the resubmission of operational plans.

High quality care for all, now and for future generations

Better Care Fund

Revised BCF plans were submitted on 4 April and have been subject to an assurance process led by Area Teams together with Local Government regional peers. While the assurance process has demonstrated some improvement on the draft plans submitted in February, it has also shown that further work is required on many local plans, particularly around the metrics and finance data, and on the extent of provider engagement in the planning process. In light of this, Ministers confirmed that no BCF plans would be formally signed off in April and that further time should be taken for CCGs and Councils, working with Health and Wellbeing Boards (HWBs), to refine their plans during June.

In addition to resolving issues with the completeness and robustness of data submitted, there are a number of areas on which further information is required from CCGs and HWBs in order to ensure a rigorous assurance process ahead of any plans being recommended for sign off. This includes providing a more detailed breakdown of planned investments and savings, clarification on the impact of the BCF on total emergency admissions, and agreement on the consequential impact on the acute sector. It will be particularly important to demonstrate that adequate savings will be achieved to manage the risk of unplanned activity.

Further guidance and a data collection template will be issued by the end of the week along with clarification on next steps and timetable, with the data required by **27 June**.

Finance

CCGs are asked to submit their most up- to-date financial plans for the period 2014/15 – 2018/19 and submit these to the following email address by **20 June**: NHSCB.financialperformance@nhs.net

Updated templates were issued on Tuesday 3 June. These include a requirement for additional information on the non-elective marginal rate and update the 2013/14 carried forward surplus (where applicable).

The 2013/14 carried forward has been changed in the following circumstances:

- Where the surplus has decreased or a deficit increased between M9+ and M13, the bought forward value has been changed to reflect this.
- Where CCG in deficit has reduced the deficit between M9+ and M13, the bought forward value has been changed to reflect this.
- Where a CCG in deficit at M9+ has moved to a surplus position at M13, the bought forward value has been changed to reflect a breakeven position.
- The position for CCGs in surplus at M9+ increasing the surplus at M13 remains unchanged in that the brought forward surplus value is the M9+ value.
- The change to the bought forward surplus must not have a detrimental effect on drawdown.

Please also complete the additional information requirement on the 2014/15 contracts tab with any other changes agreed with the relevant Area Team and Region.

All but a handful of CCGs have already loaded budgets into ISFE, and the majority of the loaded budgets are consistent with the latest submitted finance plans on 1 May. Could all CCGs please ensure that budgets are loaded and agreed to latest plans by 9 June. This will enable CCGs and the national team to report the financial position at month 2 accurately.

Particular focus should be given in plans to the following:

- Ensuring that the drawdown of prior year surpluses in 2014/15 is minimised.
- Ensuring that investment in Mental Health services does not reduce in absolute cash terms from 2013/14 levels and that plans are in place to make progress towards parity of esteem for 2014/15, including the financial settlements between CCGs and providers.
- Developing greater consistency between financial plans and the Better Care Fund, with regards to the distribution of funds and financial benefits.
- Ensuring that plans are phased appropriately, and match the budgets that will be initially loaded.
- Updating contract information to reflect agreements with providers and the subsequent impact of the Better Care Fund.

<u>Timescale</u>

The deadline for uploading finance budgets for 2014/15 is **Monday 9 June 2014**.

The deadline for re-submission of finance plans, outcome ambitions, NHS Constitution, quality premium and other related measures is **Friday 20 June 2014**.

The deadline for the activity measures (elective, non elective, outpatients) and the Better Care Fund information is **Friday 27 June 2014**.

The date for submission of five year strategic plans remains unchanged at **20th June.**

Yours sincerely,

Sarah Pinto-Duschinsky
Director of Operations & Delivery

Ann Johnson
Director of Financial & Corporate Performance

healthwatch Rotherham

Children and Adolescent Mental Health Services

Produced by Parents and Healthwatch Rotherham

May 2014

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Foreword

Healthwatch Rotherham presents this report in partnership with a group of local parents. In common with all projects undertaken by this service the Board has to first authorise it. The authorisation relies on a standard evaluation model based both on quantitative and qualitative evidence. Furthermore, in most cases, the issue must be seen to have a link to one of the 6 priorities that direct the work of Rotherham's Health and Well Being Board.

It has to be noted that the views of the public do go back a period of 2 years but are remarkably consistent throughout the period under consideration.

I would personally like to thank the parents and carers who were forthcoming with their views.

A special word of appreciation has to be said to the group of parents and carers who gave up their time in helping with preparation, mode of consultation and the consultation process itself.

This has been very much a partnership effort with parents and carers which I believe makes this is a very powerful document.

I look forward to seeing the impact of this report on service delivery.

Naveen Judah

Healthwatch Rotherham Chair

I joined the focus group because things have got to change. RDaSH CAMHS is not working for our young people and their families. My son has had several breakdowns and has talked of suicide each time, I asked CAMHS for help. Their help was to say it was a parenting issue; this is definitely not the case. As a qualified counsellor I find it appalling that our young people with mental health issues are left for their families to sort out, without the help or support of professionals. My hopes for the future are that CAMHS becomes a service which is inclusive, holistic, and family centred, honest and open. I would like to see much better practice and the therapies/actions promised, carried out.

I hope the work we have carried out is not in vain and will bring about much needed change.

Sian Powell

Parent and focus group lead

Executive summary

Summary

Healthwatch Rotherham represents and makes known the views of local people on health and social care services. From November 2013 to February 2014 Healthwatch received 14 comments from parents and children. The majority of the comments expressed concern and dissatisfaction in the services they and their children had or were receiving from Rotherham and Doncaster South Humber Partnership Trust (RDaSH) Children and Adolescent Mental Health Service (CAMHS).

Nationally health and social care provision is being evaluated in light of the 'Francis report'. Sir Robert Francis QC chaired the public inquiry into the Mid Staffordshire NHS Foundation Trust published in February 2013. The report identified numerous warning signs which cumulatively, or in some cases singly, could and should have alerted the system to the problems developing at the Trust.

Nationally CAMHS is being reviewed. In 2007, as part of the Children's Plan, the Government announced an independent review of child and adolescent mental health services (CAMHS).

The three key changes proposed by the independent review of CAMHS were:

- Everybody (from specialist mental health professionals to the wider children's workforce and parents and carers) needs to recognise the contribution they make to supporting children's emotional wellbeing and mental health;
- Local areas have to understand the needs of all of their children and young people and engage effectively with children, young people and their families in developing approaches to meet those needs; and
- The whole of the children's workforce needs to be appropriately trained and, along with the wider community, well informed

In Rotherham, stakeholders have come together to produce and deliver the Rotherham Emotional Wellbeing & Mental Health Strategy for children and young people. This strategy will inform service planning and commissioning for the next 5 years.

On the 19th February 2014 the Healthwatch Rotherham Board was presented with local evidence plus national guidance which is currently being reviewed by commissioners and providers.

The Healthwatch Rotherham Board agreed there was sufficient evidence to warrant further investigation into the culture of CAMHS.

The aims of this investigation are to:

- Seek views on how local people believe the culture of CAMHS is affecting service delivery
- Obtain views and ideas as to how things could be done better
- To share the views of local people with the provider and commissioners of CAMHS
- Ensure local people in Rotherham know about this activity

To enable Healthwatch to achieve the above aims, three methodologies were used.

- A purpose designed survey
- A public two day event gathering views on themed topics
- A review of the Healthwatch Rotherham Database

The three methodologies were purposely designed to collect the views of the citizens of Rotherham and were triangulated to draw overall themes and ideas. This report has been produced to affect change within Rotherham's CAMHS.

The findings from the three methodologies were derived from thematic analysis using frequency of comment/ideas as an indicator of priority.

Results

In almost all of the statements made and within the free text from the survey it can be concluded that there is a high level of dissatisfaction with the service provided by CAMHS, with two exceptions, Statement 8, "facilities here are comfortable", this relates to the surroundings in which people find themselves whilst visiting CAHMS, and for which a large majority of people gave a positive response. Statement 9 "it is quite easy to get to the place where the appointments are" again, this drew a positive response. However, in all other statements, which relate to interpersonal contact and quality of contact the majority of people were unable to agree with the sentiments expressed in those statements and it is in these areas that issues exist.

The people who attended the two public events did not feel part of CAMHS processes, including care planning, crisis planning and discharge. They did not feel listened to or valued, their strengths and knowledge of the child are not acknowledged. They do feel blamed for the problems they and their child are experiencing, judged and alienated throughout their contact with CAMHS. The attendees believe they have a lot they can offer to CAMHS as a whole service and as part of their child's care. They require clarity on how the service is delivered and what they can expect. They have difficulties in accessing support, with long waiting times and appointments being cancelled at short notice. They told us that complaints were difficult to make and not acknowledged, although staff advise people to make them.

The comments collected on the Healthwatch Rotherham Database since July 2013 indicates that people are unclear about what CAMHS provides. There are problems with long waiting times for initial and follow up appointments and difficulties in access to the service. People believe there is a lack of communication between CAMHS and

other services, with failures to pass on information about what CAMHS is or is not doing to support a child and the family's needs. The people using CAMHS do not feel listened to or involved in the CAMHS processes. Complaints are not acknowledged or dealt with in a timely manner. CAMHS is providing support to children to effect change but this is not consistent.

Findings

The findings of this report are drawn from the three methodologies applied to investigate the current culture of RDaSH CAMHS. The main themes of comment were.

- Child and Family centred approach
- Communication
- Appointments
- Long term support
- Contact with staff
- Complaints

In each of these themes a high level of dissatisfaction was expressed. All three methodologies highlighted that

- Parents/carers do not feel listened to
- Parents/carers feel blamed for the problems they and their child are experiencing
- Parents/carers do not feel included or able to participate
- There is no clarity on what people can expect from CAMHS and what services they provide
- People find it difficult to make a complaint
- Complaints are not handled consistently or in a timely manner.
- Waiting times to be seen are too long leaving families feeling unsupported
- When Children are discharged from services this does not always include families and they are unaware they have been discharged
- There is no crisis planning leaving families feeling unsupported and not sure what to do.

Ideas and practical solutions

The results of each of the methodologies highlight the frustration of not being included or listened to. This indicates that they feel they have something to offer the service but their skills that are not being utilised. The people who attended the public events have provided some suggestions to how CAMHS could be improved.

Child and Family Centred approach

- Staff training to enable them to adapt how their services are delivered, increasing individual care/treatment plans and flexible working.
- To work with the whole family throughout the CAMHS processes, acknowledging their strengths and needs.

Communication

- The attendees would like to see improvements in communication suggesting that care/action planning is agreed by all and that actions are completed.

Appointments

- The attendees suggested that there be a standard time frame to be seen within. They suggest if a GP refers when there is a crisis then to be seen within a week.
- They also suggest that appointments to be booked with the family.

Long term support

- A CAMHS board which has parent/carer members
- Not to discharge without crisis planning
- Not to discharge without parents/carers being involved
- To allow self referral to CAMHS within12 months of discharge
- Long term support groups both child friendly and for parents

Contact with staff

- To work with the parents/carers acknowledging their strengths
- Use terms and words are easy to understand
- For staff to explain who they are and what qualifications/skills they have

Complaints

- Make it clear how to complain
- For all staff to record, log all types of complaint, verbally and by letter

The suggestions which have been made, try to address governance and practical issues within CAMHS. They have not addressed all areas of dissatisfaction. The suggestions made indicate that the families desire collaborative governance within the service and to be empowered to work with CAMHS to resolve their individual child and family problems.

RDaSH CAMHS Response

Rotherham Doncaster and South Humber NHS Foundation Trust

June 2014

Our Response to the Rotherham Healthwatch report regarding Children & Young People's Mental Health Services

We are extremely sorry about the experiences the parents and carers that assisted with report have received from RDASH CAMHS. As an organisation and a CAMHs service we take your recommendations seriously and wish to work in partnership with you to improve the service we offer to ensure families, children and young people have a positive experience of our service in the future.

We are currently in the process of delivering a quality improvement plan within the service and will strengthen the plan to reflect the concerns and recommendations highlighted to ensure that parents, children and young people and carers in the future receive a more welcoming and positive experience of CAMHS.

The work that Rotherham Healthwatch have carried out will help us shape the required improvements and we would like to assure the parents and families that their feedback is extremely valuable. We share the hopes and aspirations of the contributors of the report and aim to make the suggested improvements to ensure the service in the future is inclusive, holistic, and family-centred.

We are pleased with the positive feedback regarding are facilities at Kimberworth Place. However the findings within the report are disappointing, especially as they are the collective views of parents and carers who contributed to the report. This feedback is of serious concern to the organisation as it deters from our Trust values and does not reflect the competencies we expect of our staff and the services we deliver.

Improvements Underway

Work is already underway to improve services. Examples of the work we have completed over the last 6 months include the following:

- All CAMHs staff members have received refresher training in a child and family centred approach. Work continues to make sure that this improves the experience of all families, children and young people. This will be monitored through personal service user feedback after each clinical session and the use of 'experience of services' feedback questionnaires that we have made widely available in the reception area of Kimberworth Place. The actions we take to address the feedback received from feedback will be on display in the

waiting area to ensure families, children and young people can see that their views are important and have been acted upon.

- To improve communication, we have recently completed an audit of letters, including discharge letters and have identified this as an area of improvement in terms of the information contained in them.

- To improve access, in agreement with our commissioners, the CAMHS service is working towards a 3 week wait from referral to assessment unless an urgent appointment is required, when the child or young person will be seen on the same day.

- The service has recently introduced Self-referral for young people 14-18 years. The service is accessed via Youth Start and young people have access to a CAMHS clinician.

- Once discharged, children who require further support or the need to re-access the service can contact the duty team to discuss concerns, additional support and re-referral back into CAMHS. This is a new and ongoing piece of work and we would wish to work with families to establish how this may address the concerns regarding self-referral back to CAMHS within12 months of discharge.

- We treat each complaint as an opportunity to learn, we are undertaking a detailed piece of work to ensure all complaints are treated in a timely, sensitive and constructive way.

In addition, we have also been working with our partners in Rotherham to develop the Emotional Well Being & Mental Health Strategy for Children & Young People. The Strategy has been produced to support the Local Authority, commissioners and service providers to improve the emotional health and wellbeing of children and young people and our involvement in this will help us to focus the improvements we are undertaking on the areas that will have most impact for children, young people and their families.

We recognise that the work we have underway will need to continue to deliver the improvements needed. We will consider the findings, ideas and practical solutions in this report and further develop our actions to include these. We would welcome the opportunity to work with Rotherham Healthwatch, the families and young people who have contributed to this report and partner agencies to improve our services.

Christine Bain
Chief Executive
Rotherham Doncaster & South Humber NHS FT

The Current Context and our research findings

Background

Healthwatch Rotherham represents and makes known the views of local people on health and social care services. For Healthwatch to carry out its role, it undertakes engagement activities within the Rotherham Borough. Views, opinions and experiences of local people are trend analysed, these trends are then fed into the Healthwatch Rotherham Board. The Board then directs the service using a decision support tool. The support tool takes into account the local evidence and strategic relevance, to ensure that further investigations into issues are a local priority for the people and for those who influence change.

Local Evidence

From November 2013 to February 2014 Healthwatch received 14 comments from parents and children. The majority of the comments expressed concern and dissatisfaction in the services they and their children had/were receiving from Rotherham and Doncaster South Humber Partnership Trust (RDaSH) Children and Adolescent Mental Health Service (CAMHS). On analysis of the data captured from the pubic engagement and NHS Complaints Advocacy Service, Healthwatch identified that there were numerous issues within RDaSH CAMHS that might need addressing. In February Healthwatch was approached by two parents who wished to make separate formal complaints about CAMHS but agreed that in partnership with Healthwatch Rotherham they would bring together the local community and use a collective voice to raise their issues and affect change.

Strategic relevance

Nationally health and social care provision is being considered in light of the 'Francis report'. Sir Robert Francis QC chaired the public inquiry into the Mid Staffordshire NHS Foundation Trust published in February 2013. The report identified numerous warning signs which cumulatively, or in some cases singly, could and should have alerted the system to the problems developing at the Trust.

http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

The focus of the Francis report is on provision to patients, although not highlighted, the provision of services to Children in the community including Children and Adolescents Mental Health Services (CAMHS) are affected by the findings and recommendations of this report.

In 2007, as part of the Children's Plan, the Government announced an independent review of child and adolescent mental health services (CAMHS). The review was led by Jo Davidson, Director of Children and Young People's Services in Gloucestershire. Its final report was published in November 2008 and made 20 recommendations in relation to services that promote emotional wellbeing and mental health.

The three key changes proposed by the independent review of CAMHS were:

- Everybody (from specialist mental health professionals to the wider children's workforce and parents and carers) needs to recognise the contribution they make to supporting children's emotional wellbeing and mental health;
- Local areas have to understand the needs of all of their children and young people and engage effectively with children, young people and their families in developing approaches to meet those needs; and
- The whole of the children's workforce needs to be appropriately trained and, along with the wider community, well informed.

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_110930.pdf

In Rotherham, stakeholders have come together to produce and deliver the Rotherham Emotional Wellbeing & Mental Health Strategy for children and young people. This strategy will inform service planning and commissioning for the next 5 years, the stakeholders being

- Rotherham Metropolitan Borough Council
- Rotherham Clinical Commissioning Group
- Representatives from the Voluntary sector
- The Rotherham NHS Foundation Trust
- Rotherham Doncaster and South Yorkshire NHS Foundation Trust (RDaSH)
- Healthwatch Rotherham

The focus of the strategy is on all services provided to children and young people commissioned to deliver a level of support to children in relation to emotional wellbeing and mental health. The Rotherham Clinical Commissioning Group has commissioned an independent organisation: Attain, to undertake a review of RDaSH services in Rotherham, including CAMHS. The aims of the review are to inform planning and commissioning of future services in Rotherham.

Decision making

On the 19th February 2014 the Healthwatch Rotherham Board was presented with local evidence plus national guidance which is currently being reviewed by commissioners and providers.

The Healthwatch Rotherham Board agreed there was sufficient evidence to warrant further investigation into the culture of CAMHS. The duplication of work being carried out by Attain was raised as a concern, however the Board was assured that the methodologies applied to this investigation, would bring a deeper understanding from the parents perspective.

It was agreed that Healthwatch Rotherham would work with local families to capture the views of local people regarding the culture of CAMHS, concentrating on their experiences over the last 2 years.

Methodology

The aims of this investigation are to:

- Seek views on how local people believe the culture of CAMHS is affecting service delivery
- Obtain views and ideas as to how things could be done better
- To share the views of local people with the provider and commissioners of CAMHS
- Ensure local people in Rotherham know about this activity

To enable Healthwatch to achieve the above aims, three methodologies were used.

- A purpose designed survey
- A public two day event gathering views on themed topics
- A review of the Healthwatch Rotherham Database

The three methodologies were purposely designed to collect the views of the citizens of Rotherham and were triangulated to draw overall themes and ideas. This report has been produced to affect change within Rotherham's CAMHS.

The findings from the three methodologies were derived from thematic analysis using frequency of comment/ideas as an indicator of priority.

Survey

The results from the survey have been analysed. The survey opened on the 1st April 2014 closed on the 1st May 2014.

Participants were asked to indicate if they; strongly agree, agree, not sure, disagree or strongly disagree, with predetermined statements. The statements were formulated by the reference group, made up of six parents of children who had/have contact with CAMHS. Each of the members described their family's journey. From these six experiences themes and 'I' statements were formed for the survey.

The statements used, refer to the following areas

- Child and Family centred approach
- Communication,
- Appointments
- Long term support,
- Contact with staff,

At the end of the survey people were asked to complete 'free text' spaces to give qualitative data. The free text section asked people to tell us any further comments they would like to make.

Public events

The parent reference group designed and planned two public events. The events were held at Springwell Gardens on the Monday 7th April and the Saturday 12th April 2014. Open invitations to the event, were advertised publicly for families and children to attend who had experiences and had views of the RDaSH CAMHS over the last two years. Participants were invited via the survey sent out to people on the Healthwatch Rotherham database, social media and website. Healthwatch also contacted people who have used the NHS Advocacy service.

Attendees to the events were supported by one of the reference group members to enable them to raise their views based on the themes below.

- Child and Family centred approach
- Communication
- Appointments
- Long term support
- Contact with staff
- Complaints

The Healthwatch Database

The Healthwatch Rotherham database holds a list of over 1,000 members who wish to have their views and opinions heard and/or want to be informed of changes in health and social care in Rotherham. We also hold comments which citizens of Rotherham have made in relation to services by which they have been affected.

The comments collected by Healthwatch Rotherham staff and volunteers have been collected since July 2013. The comments are from conversations with the public at events and members of the public visiting the Healthwatch office in the town centre These comments are from none lead conversations.

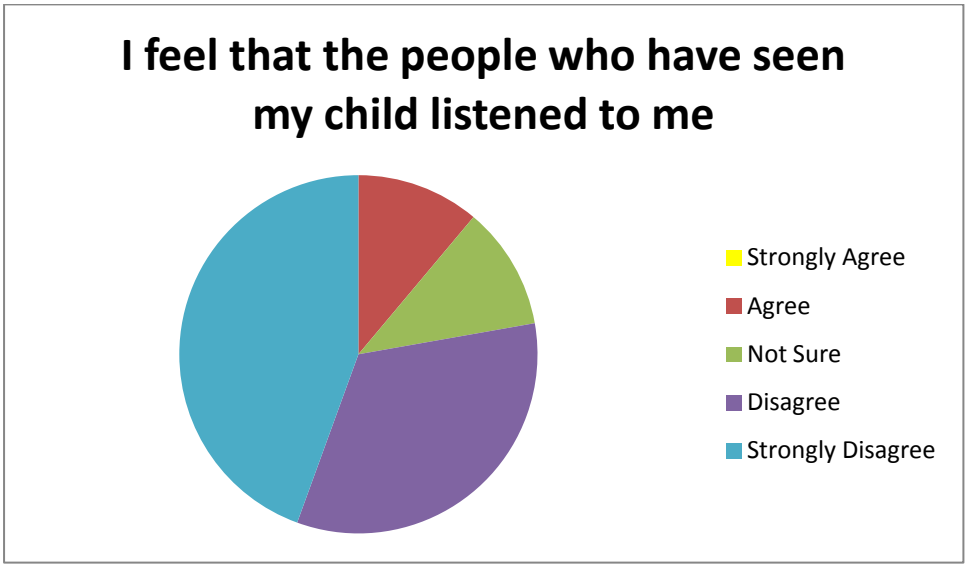
In addition to the comments collected from the public, the database collects information from national surveys, patient opinion, and the local media. All comments collected are in relation to Rotherham services.

Results

Survey

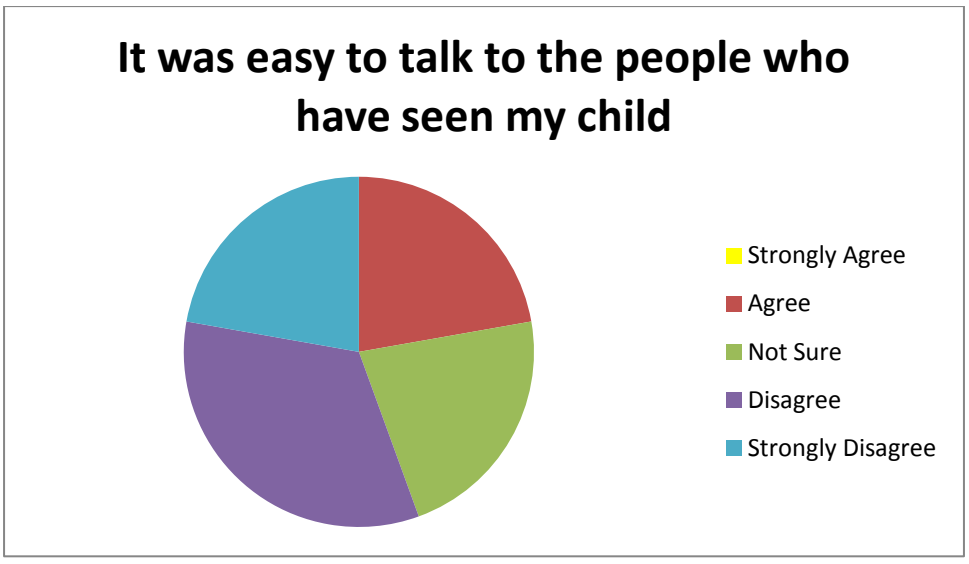
In total 12 people completed the CAMHS Survey between the 1st April 2014 and 1st May 2014.

Statement 1:



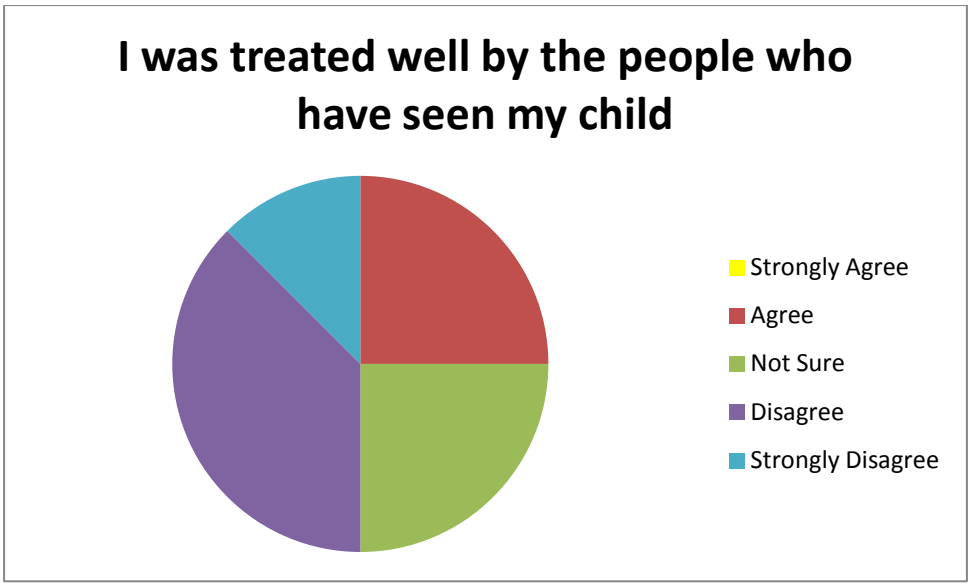
The result show that the majority of people disagreed or strongly disagreed with this statement.

Statement 2:



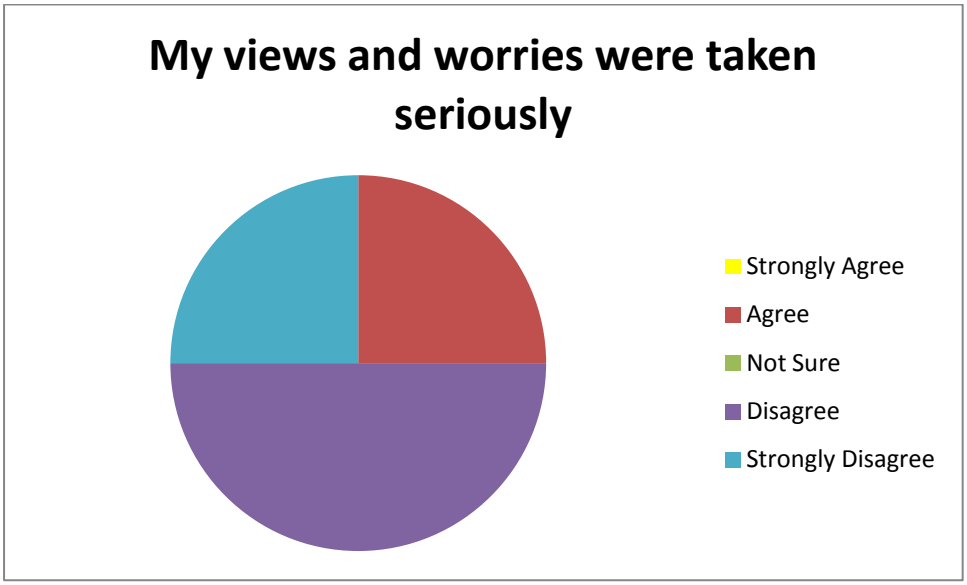
The results show that the majority of people either disagreed or strongly disagreed with the statement.

Statement 3:



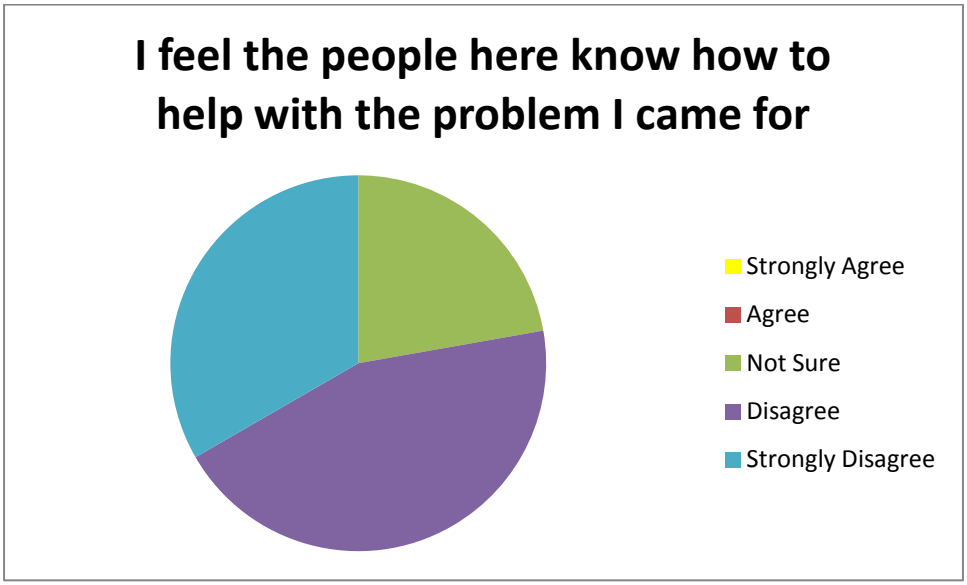
The results show that half of all people commenting on this statement either disagreed or strongly disagreed. A quarter of the people agreed, the rest were not sure.

Statement 4:



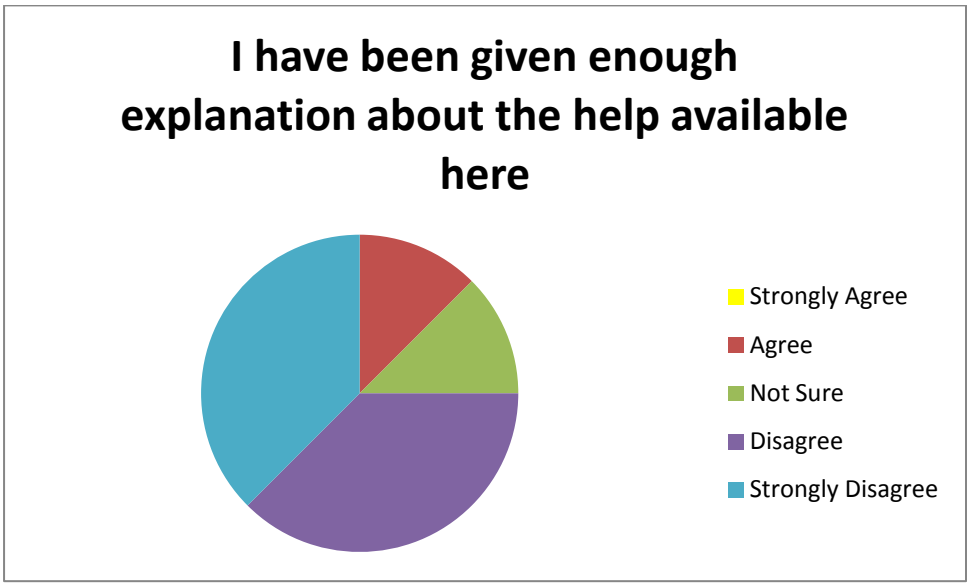
The results show that half of the people disagreed, a quarter strongly disagreed the other quarter agreed that their views and worries were taken seriously.

Statement 5:



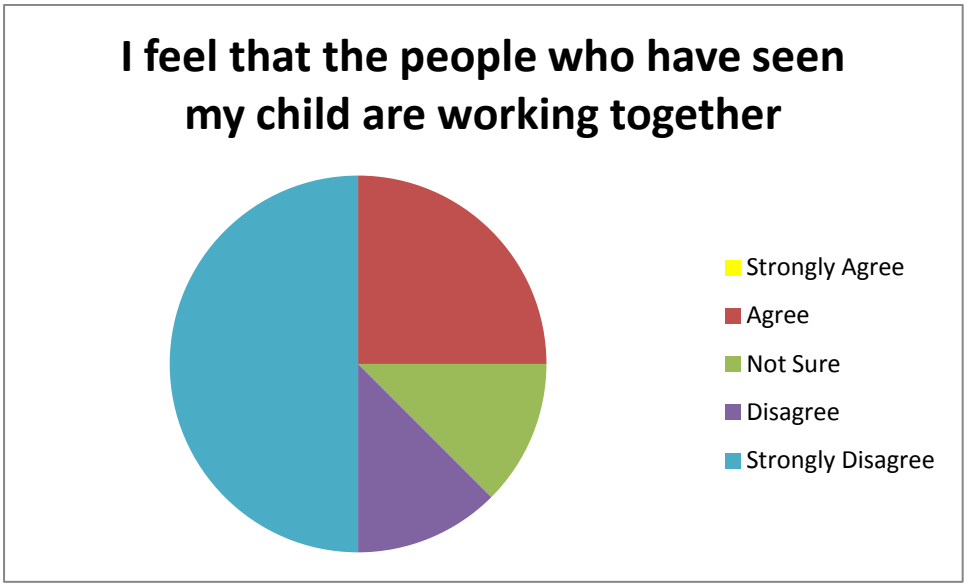
The results here show that the majority of the people disagreed with this statement

Statement 6:



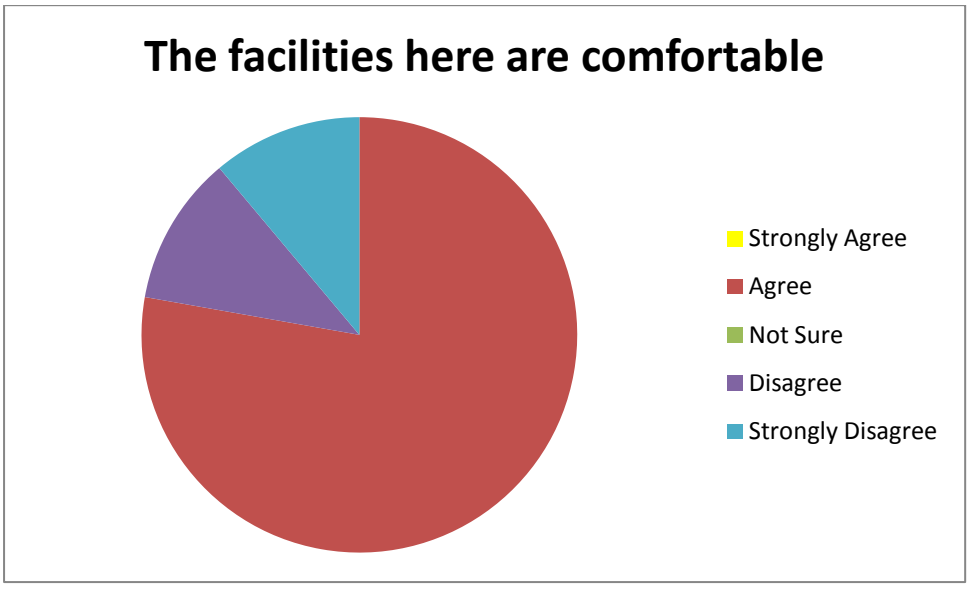
The results here show that three quarters of the people either disagreed or disagreed strongly with this statement.

Statement 7:



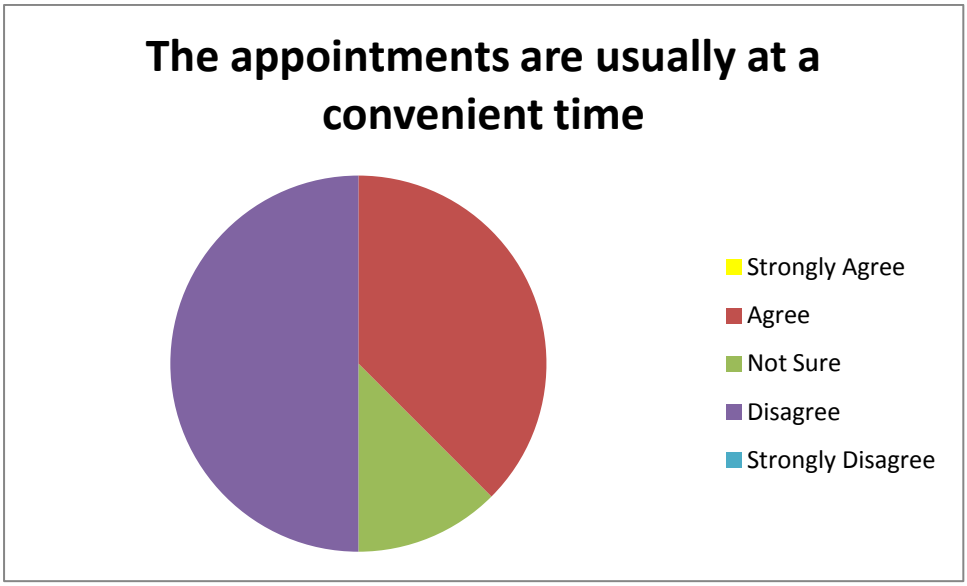
This statement shows that half the people commenting on this statement strongly disagreed, however a quarter were in agreement.

Statement 8:



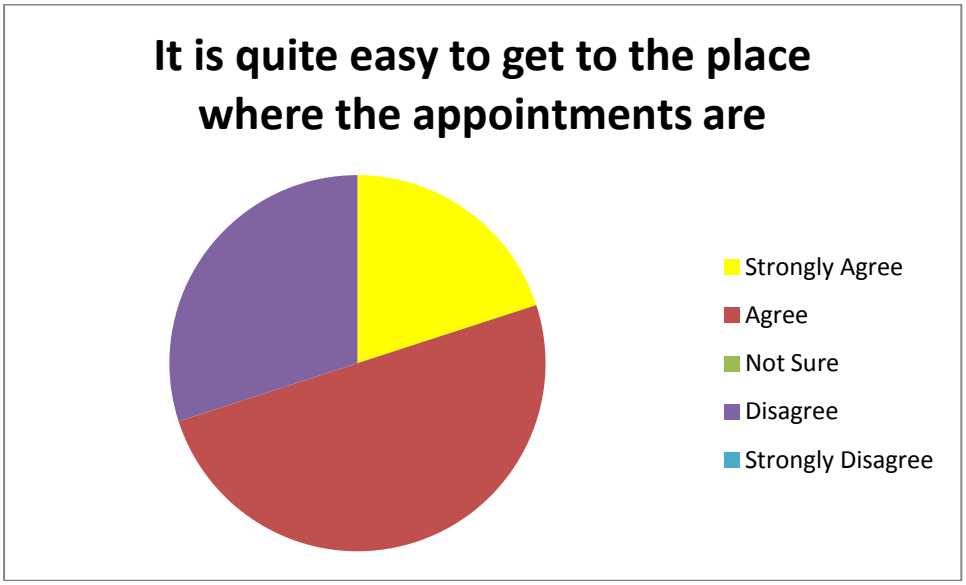
This shows that a majority of people commenting on this statement were in agreement

Statement 9:



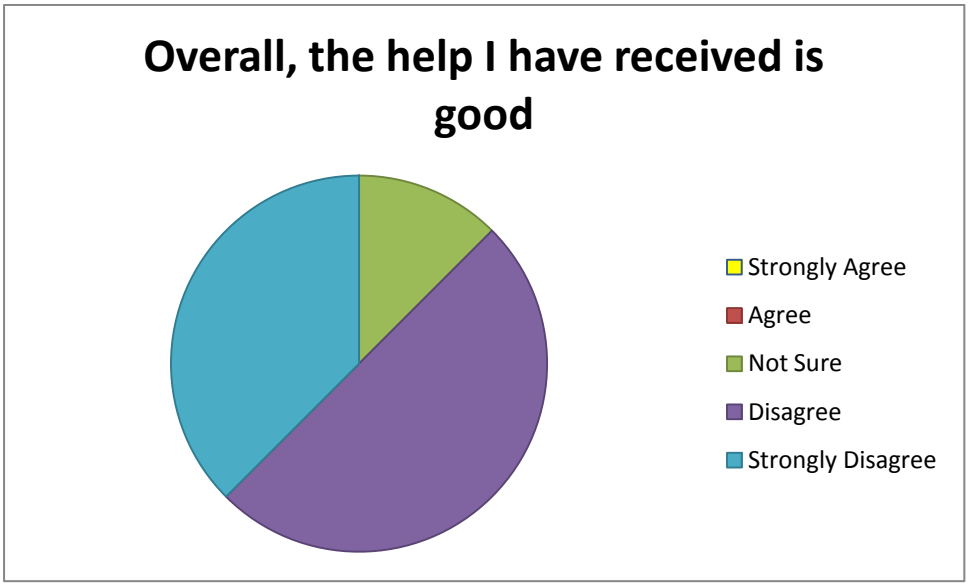
In this statement, half of the people commenting, disagreed, although over a quarter were in agreement

Statement 10:



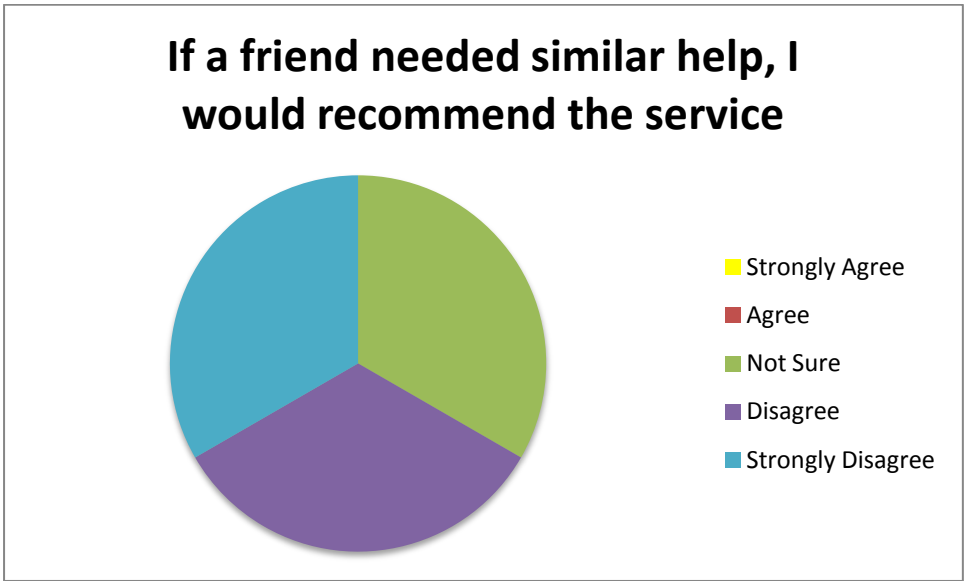
This statement shows there is an equal split in the numbers agreeing and disagreeing

Statement 11:



A majority of people disagreed with this statement

Statement 12



The majority of people disagree with this statement, over a third were not sure.

Summary of the free text

The participants of the survey were asked ‘any other comments you would like to make’. 7 people added free text comments. The data collected indicates that people do not feel listened to or understood by CAMHS. They find the services are difficult to access. Time delays in seeing families and lack of crisis planning leave families feeling unsupported. Discharge from services is inadequately planned leaving people unsure what is happening.

‘My daughter self-harms and I need to know how to handle it, I don’t feel I know enough about what to do.’

Summary

In almost all of the scenarios presented above and the free text it can be concluded that there is a high level of dissatisfaction with the service provided by CAMHS, with two exceptions, Statement 8, “facilities here are comfortable”, this relates to the surroundings in which people find themselves whilst visiting CAHMS, and for which a large majority of people gave a positive response. Statement 9 “it is quite easy to get to the place where the appointments are” again, this drew a positive response. However, in all other statements, which relate to interpersonal contact and quality of contact the majority of people were unable to agree with the sentiments expressed in those statements and it is in these areas that issues exist.

Public Events

The public events were held at Springwell Gardens in Rotherham over two days. 15 parents/carers and 2 CAMHS service users attended providing 134 comments. The attendees were asked to comment on 6 topics.

- Child and Family centred approach
- Communication
- Appointments
- Long term support
- Contact with staff
- Complaints

Each attendee was asked to state their issues, suggestions and positive experiences based on these topics. The comments received have been summarised.

Child and Family Centred Approach

Issues

The attendees do not feel they or their child is central to the service's approach.

'The strategies/therapy used/offered did not take into account my daughter's communication difficulties....CAMHS refused to adapt the therapy or change it'

They feel they are not listened to, judged and felt blamed for the problems they and their child were/are experiencing.

'feel criticised as a single parent. Being told by CAMHS** 'he has no male role model that could be the problem**'...'

The attendees do not feel central to the care planning or able to contribute in the CAMHS process.

'...everything is to suit CAMHS, child and family have to 'fit in', with their way'

The attendees do not feel their whole needs as a family or other stresses are considered or acknowledged.

'I am a carer for my father....''CAMHS don't consider the impact of the child's behaviour on the rest of the family members'

Positives

There were no positive comments on this topic.

Suggestions

- Staff training to enable them to adapt how their services are delivered, increasing individual care/treatment plans and flexible working.
- To work with the whole family throughout the CAMHS processes, acknowledging their strengths and needs.

Communication

Issues

Attendees felt CAMHS fails to communicate with, the child, the family, other services, and between CAMHS workers.

The most common noted frustration is the back dating of letters, parents receiving letters dated months before they receive them in the post. This leads to confusion and being the last to know.

A large number of the comments people made suggested that the families do not believe that agreed actions are carried out in a timely manner, leaving the families to chase up workers and pull together care plans.

'they rely on parents to coordinate everything' 'parents have to chase up. They don't contact you, all one sided'

Attendees told us they do not know what to do in an emergency and they are not informed of discharge from the service. The families told us they were not involved in the discharge planning.

'Discharges, what do I do in an emergency? This is not communicated to parents'

The attendees also commented what they view as poor communication between staff in CAMHS and other agencies. The families feel they have to repeat information at appointments because it was not recorded the first time. This leads to wasted appointments and frustration from the child and family.

Suggestions

- The attendees would like to see an improvement in communication suggesting that care/action planning is agreed by all and that actions are completed.

Appointments

Issues

The attendees told us of the long wait for appointments for both routine and emergencies. Attendees feel they have to chase up the service to ensure they get an appointment.

'I waited a year between appointments'...'long wait for appointment letters'

They told us of the constant changing of appointments at short notice.

'Changed last minute without notification'

The access to appointments was raised as an issue, appointments running late and problems getting the child to the appointment.

'If a child is school refusal they find it near impossible to access appointments. You miss 3 then you have to be re referred'

Positives

There was no positives recorded for this topic

Suggestions

- The attendees suggested that there be a standard time frame to be seen within. They suggest if a GP refers when there is a crisis then to be seen within a week.
- They also suggest that appointments to be booked with the family.

Long term Support

Issues

The most common issues the attendees told us was the lack of discharge planning, crisis planning and clarity of what action was going to be taken.

'No long term support planning, no signposting, and discharge without any meeting with family'... 'police became involved due to child's behaviour. I then called CAMHS who told me my child had been discharged. I had not been told anything. Nothing given to me in writing. No warning.'

Overwhelmingly the attendees told us they had been discharged at some point in there contact with CAMHS and had not been told.

Positives

There were no positive comments on this topic

Suggestions

- A CAMHS Board which has parent/carer members
- Not to discharge without crisis planning
- Not to discharge without parents/carers being involved
- To allow self referral to CAMHS within12 months of discharge
- Long term support groups both child friendly and for parents

Contact with staff

Issues

The attendees told us that they feel judged, not listened to and blamed for the problems they and their children are experiencing.

'staff question motives for wanting a diagnosis for child'.. .'.... belittle us'..' staff don't listen, always blaming issues on parenting'..' staff can be patronising,

The attendees told us they don't feel confident in the staff knowledge and experience in working with them and their children.

'***too many case workers involved not qualified to deal with'... 'little understanding...'..'staff not knowledgeable about issues...'***

The attendees expressed they do not feel valued or part of the processes. They feel they are excluded from being able to be part of the processes.

'...if we know something won't work with our children, we are being negative'...'parents disabilities are not taken into account...'

Positive

- Staff encourage parents to complain
- The manager is proactive in contacting parents

Suggestions

- To work with the parents/carers acknowledging their strengths
- Use terms and words are easy to understand
- For staff to explain who they are and what qualifications/skills they have

Complaints

Issues

The attendees told us they were not clear how to make a complaint. They feel that the service does not make it easy to make a complaint.

'passed from pillar to post'

When parents have tried to make a complaint the service has not acknowledged this.

'made complaints but these have never been acknowledged'

Positives

There were not positive comments on this topic

Suggestions

- Make it clear how to complain
- For all staff to record, log all types of complaint, verbally and by letter

Summary

The attendees do not feel part of CAMHS processes, including care planning, crisis planning and discharge. The do not feel listened to or valued, their strengths and knowledge of the child are not acknowledged. They do feel blamed for the problems they and their child are experiencing, judged and alienated throughout their contact with CAMHS. The attendees believe they have a lot they can offer to CAMHS as a whole service and as part of their child's care. They require clarity on how the service is delivered and what they can expect. They have difficulties in accessing support, with long waiting times and appointments being cancelled at short notice. They told us that complaints were difficult to make and not acknowledged, although staff advise people to make them.

Database

Since July 2013 to April 2014, Healthwatch Rotherham has received a number of comments regarding the Child and Adolescent Mental Health Services (CAMHS) in Rotherham. Those comments are listed within this report. 20 Unique comments were received during this period.

The comments received are from family members of the service users. Comments received come via telephone calls received , people visiting the Healthwatch Rotherham Shop or from outreach engagement events.

The comments received are grouped together around some main themes

- Appointments
- Long term support,
- Contact with staff,
- Complaints

Appointments

"Been trying to get referred from CAMHS to adult mental health since October 2013. Now been the the reason her daughter has to go to doctors for referral and not CAMHS. Believe she should have been told this last year not this week.
Been chasing around for medication while in this transition process from child to adult mental health services.
If it had not been for help from Rotherham college, she fears daughter might have self harmed herself again."

"A guest using mental health services has been waiting over a year for a secondary assessment."

Long term Support

"I am very frustrated and disappointed with the lack of provision for my son who has been diagnosed with autism by CAHMS but there is no treatment and no where to go. The consultant has refused to refer my my son outside of the area where further treatment support is available. I have spoken with my GP who agrees that my son should be referred. I don't know where to go or what to do"

"3 years ago my daughter was referred to CAHMS by the GP assessment for autism recently my daughter started to self harm and I went back to CAMHS saying "please you need to do something"

My daughter was reassessed 3 x 45 sessions where no background

information i.e her Dad has aspergers syndrome, was requested and CAHMS discharged my daughter.

"Son has recently been the subject of an assessment by Rotherham CAMHS Being kept out of the decision making process by the various services involved and she was distinctly unhappy that both CAMHS and her Social Worker had, according to her, paid little attention to her views about xxx behaviour in the home."

"Getting help after diagnosis for child .Got diagnosed but had to go on internet to get more information, was given diagnosis over the phone "attachment and bonding" because CAMHS would not see her because of behaviour.
Was told to go to school to get a further referral - but child is doing well at school"

Unhappy with the service offered over the past three years a feels that the service is not fit for purpose and that there is no consistency"

Contact with Staff

"Some camhs staff give impression they don't seem interested"

Complaints

"There are many parents of children with autism and other mental health problems on the Facebook who she knows who do not have good things to say about CAMHS. They all feel there is a lack of help once diagnosis is given. There is no help and people fear making complaints in case they require CAMHS to help and there is no other place to go."

"***Over the last 13 months I have rang on numerous occasions to complain to no avail but I didn't keep a record of these days. Most recently though after the mother of all breakdowns I telephoned on 10th to yet again complain at the ridiculous amount of time we have been in system and the fact that the mental health issues were being overlooked. I spoke to the duty manager, who said he would ring back with an appointment, but never bothered. On 11th I put the complaint in writing and actually delivered it myself to camhs so I know it got there. On 19th had to visit my own gp with X as still no response from camhs. The gp said would ring camhs to tell them that there were mental health issues which also needed addressing and tell camhs to ring me. I did receive a phone call from one of the workers that day just to say there was nothing he could do right then but would ring in the morning. On morning of 20th received another call from xxx to say that as I felt the mental health issues needed addressing would offer an appointment however will not be offering one until 1st xx and it***

would be within 3 weeks appointment. I questioned him on the fact that the duty manager the previous week had said she would ring with an appointment to be told no record of that. I asked him if I could speak to a duty manager to be told no one on site he was acting as a duty manager but wasn't one?I said that the service was unacceptable and asked to speak with whoever the complaint I sent in last week should have gone to. He said there was no record of any complaint, there was no one in to deal with complaints and he could not advise me on who should be dealing with it anyway.He then told me to ring the switchboard, which I did to find out he was stood in the same room as them and was then advised that xxxx was on site who apparently deals with complaints and that she would ring me back. Again she hasn't bothered to ring me. Its completely unacceptable treatment."

Positive

Young person talked about the loss of his dad to alcoholism and that he felt that services had let his dad down as they kept telling him to control his drinking and only have one, he said that his dad was never able to just have one. The young person is receiving help to stop smoking which he said has increased since he lost his dad. He also has good support from CAHMS and feels that he is becoming more able to deal with his issues.

Summary

The comments collected since July 2013 indicates that people are unclear about what CAMHS provides. There are problems with long waiting times for initial and follow up appointments and difficulties in access to the service. People believe there is a lack of communication between CAMHS and other services, with failures to pass on information about what CAMHS is or is not doing to support a child and the family's needs. The people using CAMHS do not feel listened to or involved in the CAMHS processes. Complaints are not acknowledged or dealt with in a timely manner. CAMHS is providing support to children to effect change but this is not consistent.

Findings

The findings of this report are drawn from the three methodologies applied to investigate the current culture of RDaSH CAMHS. The main themes of comment were.

- Child and Family centred approach
- Communication,
- Appointments
- Long term support,
- Contact with staff,
- Complaints

In each of these themes a high level of dissatisfaction was expressed. All three methodologies highlighted that

- Parents/carers do not feel listened to
- Parents/cares feel blamed for the problems they and their child are experiencing
- Parents/carers do not feel included or able to participate
- There is no clarity on what people can expect from CAMHS and what services they provide
- People find it difficult to make a complaint
- Complaints are not handled consistently or in a timely manner.
- Waiting times to be seen are too long leaving families feeling unsupported
- Discharge from services does not always include families and they are unaware they have been discharged
- There is no crisis planning leaving families feeling unsupported and not sure what to do.

Ideas and practical solutions

The results of each of the methodologies highlight the frustration of not being included or listened to. This indicates that they feel they have something to offer the service but their skills are not being utilised. The people who attended the public events have provided some suggestions to how CAMHS could be improved.

Child and Family Centred approach

- Staff training to enable them to adapt how their services are delivered, increasing individual care/treatment plans and flexible working.
- To work with the whole family throughout the CAMHS processes, acknowledging their strengths and needs.

Communication

- The attendees would like to see an improvement in communication suggesting that care/action planning is agreed by all and that actions are completed.

Appointments

- The attendees suggested that there be a standard time frame to be seen within. They suggest if a GP refers when there is a crisis then to be seen within a week.
- They also suggest that appointments to be booked with the family.

Long term support

- A CAMHS Board which has parent/carer members
- Not to discharge without crisis planning
- Not to discharge without parents/carers being involved
- To allow self referral to CAMHS within12 months of discharge
- Long term support groups both child friendly and for parents

Contact with staff

- To work with the parents/carers acknowledging their strengths
- Use terms and words are easy to understand
- For staff to explain who they are and what qualifications/skills they have

Complaints

- Make it clear how to complain
- For all staff to record, log all types of complaint, verbally and by letter

The suggestions which have been made, try to address governance and practical issues within CAMHS. They have not addressed all areas of dissatisfaction. The suggestions made indicate that the families desire collaborative governance within the service and to be empowered to work with CAMHS to resolve their individual child and family problems.

RDaSH CAMHS Response

Rotherham Doncaster and South Humber NHS Foundation Trust

June 2014

Our Response to the Rotherham Healthwatch report regarding Children & Young People's Mental Health Services

We are extremely sorry about the experiences the parents and carers that assisted with report have received from RDASH CAMHS. As an organisation and a CAMHs service we take your recommendations seriously and wish to work in partnership with you to improve the service we offer to ensure families, children and young people have a positive experience of our service in the future.

We are currently in the process of delivering a quality improvement plan within the service and will strengthen the plan to reflect the concerns and recommendations highlighted to ensure that parents, children and young people and carers in the future receive a more welcoming and positive experience of CAMHS.

The work that Rotherham Healthwatch have carried out will help us shape the required improvements and we would like to assure the parents and families that their feedback is extremely valuable. We share the hopes and aspirations of the contributors of the report and aim to make the suggested improvements to ensure the service in the future is inclusive, holistic, and family-centred.

We are pleased with the positive feedback regarding are facilities at Kimberworth Place. However the findings within the report are disappointing, especially as they are the collective views of parents and carers who contributed to the report. This feedback is of serious concern to the organisation as it deters from our Trust values and does not reflect the competencies we expect of our staff and the services we deliver.

Improvements Underway

Work is already underway to improve services. Examples of the work we have completed over the last 6 months include the following:

- All CAMHs staff members have received refresher training in a child and family centred approach. Work continues to make sure that this improves the experience of all families, children and young people. This will be monitored through personal service user feedback after each clinical session and the use of 'experience of services' feedback questionnaires that we have made widely available in the reception area of Kimberworth Place. The actions we take to address the feedback received from feedback will be on display in the

waiting area to ensure families, children and young people can see that their views are important and have been acted upon.

- To improve communication, we have recently completed an audit of letters, including discharge letters and have identified this as an area of improvement in terms of the information contained in them.

- To improve access, in agreement with our commissioners, the CAMHS service is working towards a 3 week wait from referral to assessment unless an urgent appointment is required, when the child or young person will be seen on the same day.

- The service has recently introduced Self-referral for young people 14-18 years. The service is accessed via Youth Start and young people have access to a CAMHS clinician.

- Once discharged, children who require further support or the need to re-access the service can contact the duty team to discuss concerns, additional support and re-referral back into CAMHS. This is a new and ongoing piece of work and we would wish to work with families to establish how this may address the concerns regarding self-referral back to CAMHS within12 months of discharge.

- We treat each complaint as an opportunity to learn, we are undertaking a detailed piece of work to ensure all complaints are treated in a timely, sensitive and constructive way.

In addition, we have also been working with our partners in Rotherham to develop the Emotional Well Being & Mental Health Strategy for Children & Young People. The Strategy has been produced to support the Local Authority, commissioners and service providers to improve the emotional health and wellbeing of children and young people and our involvement in this will help us to focus the improvements we are undertaking on the areas that will have most impact for children, young people and their families.

We recognise that the work we have underway will need to continue to deliver the improvements needed. We will consider the findings, ideas and practical solutions in this report and further develop our actions to include these. We would welcome the opportunity to work with Rotherham Healthwatch, the families and young people who have contributed to this report and partner agencies to improve our services.

Christine Bain
Chief Executive
Rotherham Doncaster & South Humber NHS FT

Children's Programmes

Age	Programme	Uptake %	Public Health Outcomes Framework indicator
1year	DTP/IPV/Hib	96.4	94.7
1year	Men C	84.5	93.9
1year	PCV	96.1	94.2
1year	Neonal Hep B	Data not available	100
2year	DTP/IPV/Hib	97.3	96.1
2year	MMR	93	91.2
2year	Hib/Men C Booster	94.5	92.3
2year	PCV booster	93.3	91.5
2year	Neonal Hep B	Data not available	100
5year	DTP/IPV/Hib	96.5	None
5year	DTP/IPV/Hib booster	91.9	None
5year	MMR dose 2	90.7	86
13years	HPV (3 doses)	91.5	86.8
	Rotavirus		

Adult's programmes

65yrs +	Seasonal Flu	76.9	73.4
<65yrs	At risk seasonal flu	56.3	51.3
Pregnant	Seasonal Flu	43.6	None
65+ &At risk	PPV	73.4	68.3
Pregnant	Pertussis	65.02	50%
	Shingles		

Rotherham Vaccinations and Immunisations
2013/14 Annual Data

Comments
Schedule has changed from 2 doses to 1 dose but IT system still counts dose 2 as missed so this is a data artefact
New local service specification from April 2014 includes data collection
New local service specification from April 2014 includes data collection
2012/13 data as programme not yet complete for 13/14
Data not yet available

This is South Yorks and Bassetlw overall figure as not available by Borough Highest performing area in North of England consistently for last 12 months
Data not yet available