HEALTH AND WELLBEING BOARD

Venue: **Oak House, Moorhead Way, Bramley, Rotherham S66 1YY**

Date: **Wednesday, 26th August, 2015**

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. Apologies for absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Minutes of the previous meeting, held on 8th July 2015 (Pages 1 - 10)

7. Care Quality Commission (Pages 11 - 56)
   Inspections of:-
   - Rotherham NHS Foundation Trust (Sue Cassin, Rotherham Clinical Commissioning Group to present)
   - The role of health services in Safeguarding and Looked after Children Services in Rotherham (Terri Roche, Public Health to present)

   A review of actions being taken to respond to findings of the above inspections, following publication of the inspection reports in July

8. Health and Wellbeing Board Communications (Pages 57 - 60)
   (Commissioner Stella Manzie to present)
   Discussing how the Board can better engage the public in its work and provide relevant health-related information in an accessible way

9. Child Sexual Exploitation (CSE) in Rotherham
   Update on partners' responses to child sexual exploitation (CSE) in Rotherham (Ian Thomas to report)

   A summary of recent action taken and other relevant developments relating to CSE prevention and victim support.

10. Better Care Fund Quarterly Monitoring Return and Progress Update (Pages 61 - 76)
(Lynda Bowen to report)

This is about developing more integrated Health and Social Care Services in the Borough to provide better value for money and improve the experience of patients and care users

11. Rotherham's new Health and Wellbeing Strategy 2015-18 (Pages 77 - 110)
(Public Health to report)

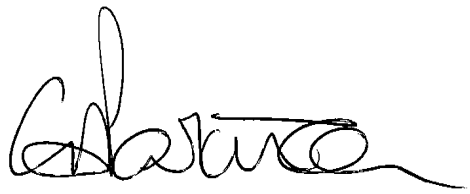
A Strategy to improve people's health and wellbeing and reduce health inequalities. It will be used to guide all health-related commissioning plans and spending decisions

12. Exclusion of the Press and Public
Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 2 of Part I of Schedule 12A to the Local Government Act 1972 (information which is likely to reveal the identity of an individual).

13. Suicide Prevention and Self-Harm Plan Update (Pages 111 - 112)
(Public Health to report)

This action plan was agreed at a special Health and Wellbeing Board meeting in May, which focused on an independent review of actions taken following a group of suicide events in Rotherham

14. Date, time and venue of the next meeting
30th September, 2015 at 9.00 a.m.



Catherine A. Parkinson,
Interim Director of Legal and Administrative Services.

HEALTH AND WELLBEING BOARD
Wednesday, 8th July, 2015

Present:-

Councillor David Roche	Advisory Cabinet Member (Adult Social Care and Health) **(Chair)**
Councillor Gordon Watson	Advisory Cabinet Member (Deputy Leader)
Councillor Taiba Yasseen	RMBC Appointed Member
Stella Manzie	Commissioner and Managing Director
Ian Thomas	Strategic Director, Children and Young People's Services
Professor Graeme Betts	Interim Director of Adult Social Services
Terri Roche	Director of Public Health
Michael Holmes	Policy Officer
Dr. Julie Kitlowski	Vice-Chair, Rotherham Clinical Commissioning Group
Chris Edwards	Chief Officer, Rotherham CCG
Chief Superintendent Jason Harwin	Rotherham District Commander, South Yorkshire Police
Tony Clabby	Chief Executive, Healthwatch Rotherham
Shafiq Hussain	Voluntary Action Rotherham
Tracey Clarke	RDaSH
Zena Robertson	NHS England (Yorkshire and Humberside)
Lynda Bowen	Public Health
Councillor Stuart Sansome	Chair – Health Select Commission (observer)

Apologies for absence were received from Jo Abbott (Public Health), Steve Ashley (Rotherham Local Safeguarding Children Board), Louise Barnett and Tracey McErlain-Burns (NHS Rotherham Foundation Trust) and Janet Wheatley (Voluntary Action Rotherham).

1. WELCOME TO NEW MEMBERS

The Health and Wellbeing Board welcomed new members to their first meeting : Councillor Yasseen, Terri Roche (Director of Public Health) and Zena Robertson (NHS England, Yorkshire and Humberside).

2. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

There were no questions from members of the public or the press.

3. MINUTES OF PREVIOUS MEETING

Resolved:- (1) That the minutes of the meeting held on 22nd April, 2015 and of the special meeting held 18th May, 2015, be approved as correct records.

(2) That the progress of the following matters be noted:-

(a) Minute No. S75 (22 April 2015 – Consultation of Drugs and Alcohol Public Expenditure) – the recovery hub located at Carnson House, close to the Rotherham town centre, will be opened very soon; the beginning of the public consultation exercise (originally scheduled for October 2014) had been delayed and Board Members will be informed of the revised timetable;

(b) Minutes of the special meeting held on 18 May 2015 – Board Members noted that there has been further dialogue between the Borough Council and the Head Teacher and the Chair of the Governing Body of School A. The dialogue had been positive and the reference to Government Ministers would be a last resort, to be used only if the dialogue with School A did not progress satisfactorily.

(c) Minutes of the special meeting held on 18 May 2015 – Board Members noted that the mental health awareness training courses being arranged are all being well-attended.

4. COMMUNICATIONS

(1) Board Members were reminded of the revised arrangement whereby Councillor David Roche, Advisory Cabinet Member for Health and Wellbeing, is the Chair of the Health and Wellbeing Board, with Dr. Julie Kitlowski, Chair of the Rotherham Clinical Commissioning Group as Vice-Chair.

(2) First anniversary of the report by Professor Alexis Jay on Child Sexual Exploitation - the Borough Council will be issuing appropriate press releases in respect of progress made since the publication of Professor Alexis Jay's report (August 2014) and in order to minimise any negative publicity. This item will be considered further at the next meeting of the Health and Wellbeing Board.

5. CARE ACT PROGRESS REVIEW

Professor Graeme Betts, Interim Director of Adult Social Care, reported on the most recent stocktake which had taken place in June, 2015, on behalf of the Association of Directors of Adult Social Services and the Local Government Association.

The stocktake had highlighted that during April and May, 2015, Rotherham had:-

- undertaken 215 Social Care Assessments, under the Care Act 2014 eligibility

- introduced the Deferred Payments Scheme in June, 2015

- 145 Carers' Assessments under Care Act 2014 eligibility

- 50 customers had requested an assessment as self-funders

The report also stated that:-

- A cap on care costs, set at £72,000 for the over-65s, would come into effect from April, 2016. How the cap would work for younger people still had to be finalised

- The Care Act's emphasis on prevention and wellbeing was driving forward changes as to how Services were accessed and delivered including improvements in:-

  : Connect to Support – now being developed to ensure customer could access Care Act 2014 compliance information and advice including a wider breadth of community-based assets;

  : Commissioning of Advocacy Support via the Council was underway and would ensure that customers could access independent advocacy which had been identified as an area of urgent need; and

  : the Liquid Logic IT System would become the Council's main operating system for Services from April, 2016 and would enable the accurate collation of data to ensure resources were targeted appropriately

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

(2) That the following actions be agreed:-

(a) details shall be reported to a future meeting of this Board, during the Autumn, 2015, explaining the timescale for implementation of the changes and including the average time taken for the processing of claims; and

(b) the ICT Strategy Group shall examine the way in which the Liquid Logic IT System shall integrate adequately with partner organisations' ICT systems.

6. RMBC INTEGRATED SERVICES - ADULT MENTAL HEALTH REVIEW

Consideration was given to a report, presented by Professor Graeme Betts, proposing that the partnership agreement between the Council and RDaSH be renegotiated due to the gradual loss of social care focus and the priority given to complex mental health issues.

A strengthened social care model was an essential element within an integrated approach to mental health. The current model of integration had failed to fully utilise the benefits of working together. It was timely to review the current partnership agreed to explore alternative integrated working with health partners.

Rotherham was working with commissioning colleagues in North Lincolnshire and Doncaster to develop a core Service Level Agreement. This would ensure that local authorities had a unified approach to commissioning services from RDaSH, that there would be a clear social care voice existing within the integrated Mental Health Service and also ensure control over the Council elements of staff and management.

Emphasis was placed on the multi-agency approach to this issue and it was agreed that South Yorkshire Police shall be included in the membership of the multi-agency group alongside the Clinical Commissioning Group, the Borough Council and RDaSH

Discussion took place on the circumstances of young people who have mental health issues and the support available from the Child and Adolescent Mental Health Services (CAMHS). Such individuals may eventually undertake the transition to Adult Social Care.

The Board agreed that the provision of mental health services required a much broader approach than has previously been the case in the Rotherham Borough area. The availability of appropriate support services from within the voluntary and community sector, for people suffering mental illness, was acknowledged and would be the subject of further consideration by this Board.

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

(2) That there shall be a partnership approach to the examination of the cases of young people in the Rotherham Borough area, who are suffering mental illness, to ensure that they shall have an orderly transition to the mental health services available from Adult Social Care.

7. HEALTH AND WELLBEING BOARD GOVERNANCE AND FORWARD PLAN

Further to Minute No. S76 of the meeting of the Health and Wellbeing Board held on 22nd April, 2015, Dr. Julie Kitlowski, as Vice-Chair of the Board, introduced the submitted report about the updated terms of

reference of the Health and Wellbeing Board and its forward plan of agenda items which would be considered at future meetings. Copies of both draft documents were appended to the report. The report and subsequent discussion highlighted the following salient issues:-

: the Vice-Chair of the Board will be someone not connected to the Borough Council;

: changes to the membership of the Board were noted, with all members (ie: elected people and paid officials) having equal status and voting entitlement;

: meetings of the Board – their frequency and use of alternative venues;

: Better Care Fund – the Board has a role in ensuring the effective delivery of Rotherham's Better Care Fund plan;

: learning from the good practice of other local authorities' Health and Wellbeing Boards;

: ensuring that all members of the Health and Wellbeing Board exercise due diligence in avoiding any conflicts of interest with regard to the issues under consideration;

: the involvement of the press and public in meetings of the Health and Wellbeing Board and the use of the various social media (eg: Twitter account) to publicise the Board's work and role;

: arrangements for the future webcasting of meetings of the Health and Wellbeing Board and the necessary equipment and facilities required (currently, webcasting would only occur for meetings held in the Council Chamber of the Rotherham Town Hall).

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

(2) That the draft terms of reference of the Health and Wellbeing Board, as now submitted, be approved.

(3) That the Health and Wellbeing Board's forward plan of agenda items for the 2015/16 Municipal Year, as now submitted, be approved.

(4) That the Health and Wellbeing Board declares its agreement, in principle, to the webcasting of the Board's future meetings and the Board shall undertake further consideration of the equipment, facilities and finances required.

8. HEALTH AND WELLBEING STRATEGY

Further to Minute No. S77 of the meeting of the Health and Wellbeing Board held on 22nd April, 2015, it was noted that the draft of the Health and Wellbeing Strategy will be distributed to all Members of the Board during July 2015. The Strategy will be considered by partner organisations and at some Borough Council internal meetings and there will be further discussion at the next meeting of this Board, prior to formal approval of the Strategy in September 2015.

9. BETTER CARE FUND

Further to Minute No. S78 of the meeting of the Health and Wellbeing Board held on 22nd April, 2015, Lynda Bowen gave an update on the performance of the Section 75 Agreement and the Better Care Fund (BCF) Plan for Rotherham.

A reporting and monitoring timetable had been developed for the Section 75 Agreement including reporting to the Health and Wellbeing Board to ensure the BCF national conditions for accountability were full met and ensured the Authority met the NHS England requirements and timescales for submitting quarterly returns.

The Section 75 Agreement set out two pooled funds comprising a total of 72 separate schemes not all of which were fully operational. The BCF Operational Group was ensuring progress was being made to implement the few remaining schemes still in the planning stage.

A joint review was underway on BCF scheme 13 which was the largest of the 16 schemes and contained some projects which may need to be refocused to relate more closely to BCF strategic priorities. Currently some major projects received a small portion of BCF funding yet had a major impact on the delivery of the BCF targets. It may be that reprioritising existing projects could see a simplified, streamlined and more effective way of reporting and monitoring how Rotherham was focussing on BCF metrics especially on reducing non-elective admissions and increasing patient and customer satisfaction.

The review of service focussed upon the appropriateness for BCF funding, patient and customer satisfaction, monitoring and metrics, accountability and reporting, value for money and Service delivery. It should be completed by the early Autumn with a report being submitted to the Board at that time.

The Quarter 4 (2014/15) monitoring report had been submitted to NHS England in accordance with the timetable. Performance had been in line with expectations and, although the target for reducing non-elective admissions had not been reached, it had been anticipated as the BCF plan was not fully implemented in the quarter.

Resolved:- (1) That the progress that had been made in projects, plans and the Section 75 Agreement for the Rotherham Better Care Fund, including closer and more integrated joint working between health and social care and revised and strengthened governance for the BCF, be noted.

(2) That the quarterly report submitted to NHS England relating to the performance of the Better Care Fund plan for Rotherham during the last quarter of 2014/15, as set out in Appendix 1 to the submitted report, be noted.

(3) That the reporting timelines for future submissions of returns to NHS England, as set out in Appendix 2 to the submitted report, be noted.

10. HEALTH SELECT COMMISSION UPDATE

The Chair introduced items which have been considered by the Borough Council's Health Select Commission, as part of the scrutiny process:-

(1) Scrutiny Review of Access to GPs

Discussion took place on the following recommendations of the Borough Council Scrutiny Review about Access to GPs, which have been referred to the Health and Wellbeing Board for response:-

(i) Health and Wellbeing Board should consider developing a Borough-wide publicity campaign to raise awareness about the impact of not cancelling unneeded appointments.

Initial Response – the Borough Council's Communications Team will prepare an appropriate document for consideration.

(ii) Health and Wellbeing Board should consider revisiting the "Choose Well" campaign to raise awareness of how to access local services and which is the most appropriate service in a range of situations.

Initial Response – a number of initiatives are already underway, including a campaign being broadcast by Radio Hallam. Details will be provided to operators of the South Yorkshire Police emergency response telephone system, enabling operators to respond with appropriate health information to '999' calls.

(iii) In light of the future challenges for Rotherham outlined in the report the Review recommends that a proactive approach is taken by the Health and Wellbeing Board to mitigate risk to the delivery of primary care

Initial Response – Rotherham has 58 GPs per 1,000 population, which is similar to the average figure for the Yorkshire and Humberside region. Therefore, Rotherham is unlikely to attract the incentive payment for the recruitment of GPs. Appropriate marketing will continue to take place in order to recruit GPs and Social Workers to the Rotherham Borough area.

The following scrutiny recommendation was also discussed:-

Rotherham MBC, when considering its response to the Scrutiny Review of supporting the local economy, should ensure health partners are invited by the Planning Department to be part of the multi-disciplinary approach to proposed new developments.

Initial Response – there should be dialogue between the Health Services and Planning Officers in terms of the design of residential areas, so as to include health benefits (eg: walking routes; fitness trails). In addition, there should be discussion about the appropriate level of provision of health services for Rotherham's new communities (eg: the Waverley development and the proposed future development of Bassingthorpe Farm, Greasbrough).

(2) Scrutiny Reviews of CAMHS

Discussion took place on the 12 recommendations of the Borough Council Scrutiny Review of CAMHS, the Child and Adolescent Mental Health Services.

It was noted that the multi-agency Mental Health Working Group will be considering a detailed response to the recommendations. Both RDaSH and the Rotherham Clinical Commissioning Group have begun joint working on the development of a clearer breakdown of costs and on the definitions of treatment, so as to inform future outcome measures.

11. LOCAL GOVERNMENT ASSOCIATION - OFFER OF SUPPORT ON HEALTH AND SOCIAL CARE

Consideration was given to correspondence from the Local Government Association concerning the range of social care improvement and health integration programmes, initiated by the Department of Health and with the aim of providing support for Health and Wellbeing Boards. The correspondence described the range of support being made available for Health and Wellbeing Boards, especially in supporting systems leaders to be effective in their role and to plan ahead.

A limited amount of funding was being provided to each region to enable co-operative working to support the delivery of the Programme. The Department of Health will also provide additional funds specifically to support the implementation of the Care Act 2014 and the NHS will allocate funding to NHS regions to support the implementation of the Better Care Fund in partnership with local government.

It was agreed that members of the Health and Wellbeing Board be invited to make suggestions of suitable projects for which bids might be made by the Board for the funding available from the Local Government Association (Michael Holmes will issue the invitation and collect responses).

12. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health and Wellbeing Board be held at Oak House, Moorhead Way, Bramley, on Wednesday, 26th August, 2015, commencing at 9.00 a.m.

THIS PAGE HAS BEEN LEFT INTENTIONALLY BLANK

Agenda Item 7

NHS Rotherham Clinical Commissioning Group

NHS Rotherham CCG

Health & Wellbeing Board 26th August 2015

Care Quality Commission (CQC) visit to The Rotherham NHS Foundation Trust 23rd to 27th February 2015. Report date of publication: 14th July 2015

Lead Executive:	**Sue Cassin Chief Nurse RCCG**
Lead Officer:	**Hilary Porter, Senior Contracts Manager, TRFT**
Lead GP:	**Dr Phil Birks, RCCG Lead GP TRFT Contract**

Purpose:

The purpose of this report is to advise the Health and Wellbeing Board on:

1. The findings of the CQC's inspection visit to The Rotherham NHS Foundation Trust (TRFT).
2. The steps to be taken by Rotherham Clinical Commissioning Group (CCG) to review and monitor TRFT's progress against their CQC action plan.

Background:

The Care Quality Commission's Quality Report on The Rotherham NHS Foundation Trust was published on 14 July 2015 and is based on their findings from an inspection visit undertaken between 23 and 27 February 2015.

The Trust achieved an overall rating of 'requires improvement' with the ratings for main services being as follows:

- Urgent and emergency services - requires improvement
- Medical care – requires improvement
- Surgery – requires improvement
- Critical care – requires improvement
- Maternity and gynaecology – requires improvement
- Services for children and young people – inadequate
- End of life care – good
- Outpatients and diagnostic imaging – good

The Trust has agreed an action plan to address the findings and recommendations of the CQC Quality Report.

Governance

The role of Rotherham CCG is to provide assurance that TRFT delivers against their agreed action plan and implements all required changes to ensure compliance with the CQC's recommendations.

The CCG will monitor compliance via monthly Contract Quality meetings which are attended by senior TRFT personnel including their Chief Operating Officer, the Medical Director and Director of Nursing, together with Senior CCG personnel including Senior Contracts Manager, Chief Nurse, GP lead and Head of Clinical Quality.

It was agreed at the Contract Quality Meeting held on 22 July 2015 that TRFT will present their CQC Action Plan to the CCG at August's Contract Quality Meeting on 19 August 2015.

TRFT's CQC Action Plan will be a standing agenda item at future Contract Quality meetings. TRFT's progress against the action plan will continue to be reviewed and monitored via the Contract Quality Group meetings until all TRFT's actions have been satisfactorily completed.

Any items of escalation/concerns Rotherham CCG Contract Quality meeting representatives may have about TRFT's progress against their CQC action plan will be escalated to the Strategic Commissioning Group (which meets six monthly) and more expediently to CCG Executive to TRFT Executive meetings and through CCG governance structures up to Governing Body level as appropriate.

Rotherham CCG will continue to update the Health and Wellbeing Board on TRFT's progress against plan until all TRFT's actions have been satisfactorily completed.

Summary

This report summarises the findings of the Care Quality Commission's Quality Report on The Rotherham NHS Foundation Trust and seeks to provide the Health and Wellbeing Board with assurance as to how Rotherham Clinical Commissioning Group will review and monitor TRFT's progress against their CQC Action Plan.

The CCG will continue to monitor compliance via monthly Contract Quality meetings. Any concerns about TRFT's failure to implement the required changes in a timely manner will be escalated to Rotherham CCG's Operational Executive to be taken up with TRFT's Board.

Rotherham CCG will provide regular updates on TRFT's progress against plan to the Health and Wellbeing Board.

Recommendations

It is recommended that the Health and Wellbeing Board:

- Note the arrangements for Rotherham CCG to provide assurance that TRFT implement changes based upon the findings of the Care Quality Commission.
- Note that Rotherham CCG will provide the Health and Wellbeing Board with regular updates on TRFT's progress against plan.

NHS Rotherham Clinical Commissioning Group

NHS Rotherham CCG

Health & Wellbeing Board 26th August 2015

Care Quality Commission (CQC) - Review of Services for Children Looked After and Safeguarding (CLAS) - 23rd to 27th February 2015 (report published 14th July 2015)

Lead Executive:	**Sue Cassin Chief Nurse RCCG**
Lead Officer:	**Catherine Hall Head of Safeguarding**
Lead GP:	**Dr Lee Oughton, Named GP Safeguarding and** **Dr David Clitherow, RCCG Lead GP Children and Young People**

Purpose:

To report on Rotherham Clinical Commissioning Group (RCCG) Children Looked After and Safeguarding (CLAS) review by the Care Quality Commission (CQC). This review was held between 23 to Friday 27 February 2015.

The report into the findings was published 14 July 2015; attached is the associated Action Plan, containing the 24 recommendations.

Background:

The year leading up to the Care Quality Commission (CQC) carrying out their CLAS review in February 2015, the RCCG, health care providers (TRFT, RDaSH, GP Practices) and stakeholders, (Rotherham Local Safeguarding Children Board NHS England and RMBC Public Health) met regularly. These meetings were to agree and share appropriate evidence in readiness for the review and for RCCG to collate that evidence in readiness for the anticipated inspection. This commitment to challenge one another in our effort to drive up standards put us in good stead when the call came on 19 February 2015 that the review was imminent.

The Care Quality Commission stated that the lines of enquiry would be centred on:

1) The experiences and views of children and their families.
2) The quality and effectiveness of safeguarding arrangements within health
   - Assessing need and providing early help
   - Identifying and supporting children in need
   - The quality and impact of child protection arrangements.
3) The quality of health services and outcomes for children who are looked after and care leavers.
4) Health leadership and assurance of local safeguarding and looked after children arrangements
   - Leadership and management
   - Governance
   - Training and supervision.

A substantial list of documents was requested and submitted to the Lead Inspector which included annual reports, audits and safeguarding standards. RCCG proactively managed a repository of multi-disciplinary information. This worked extremely well and this process will be adopted to gather the Action Plan evidence moving forward. The inspection week was coordinated by Rotherham

CCG Safeguarding Team and included a wide cross-section of the health economy.

During the review week feedback meetings were held daily with a two-fold purpose, firstly to ensure that there were no surprises at the final verbal feedback session on 27 February and secondly to ensure that any areas of challenge were responded with immediacy and effectively. This included a return visit to Child and Adolescent Mental Health Services (CAMHS), meeting with the Director of Children services to discuss RMBC expectations of maternity services and a visit to a social enterprise GP Practice who works predominately with vulnerable people and asylum seekers.

Throughout the process RCCG worked closely with partners to ensure transparency and engagement. This was to guarantee the broadest possible commitment to drive up the safeguarding children and young people agenda.

CQC tracked 84 individual cases where there had been safeguarding concerns; these included 8 cases that had undergone a multi-disciplinary chronology denoting healthcare delivery. Included in the 84 cases tracked were children who had recently been referred to social care and some cases where children and families were not referred, but were assessed as needing early help from health services.

Analysis of key issues and of risks

The CQC particularly focused upon Early Help, Children in Need, Child Protection and Children Looked After. They considered whether healthcare organisations work in accordance with their responsibilities under Section 11 of the Children Act 2004; this includes the Clinical Commissioning Group need to deliver a strong leadership and governance role and the expectation that providers and commissioners will work to continuously improve safeguarding arrangements between NHS trusts, GPs, and child and adult health services.

In total 24 recommendations were made. A SMART Action Plan addressing all 24 recommendations is required from RCCG within 20 working days of receipt of the published report. The DRAFT Action Plan is attached.

Timescales are very tight so RCCG held an inaugural meeting on 15 June 2015 to pre-empt the recommendations based on the verbal feedback and draft report. This meeting has proved invaluable as it started the process of driving forward improvements in a multi-disciplinary manner. Ownership of the safeguarding agenda is critical therefore representatives were invited to attend from TRFT, RDaSH, GP Practices, The Gate, Healthwatch, RMBC Safeguarding and Public Health and Rotherham Local Safeguarding Children Board. Meetings have been arranged to monitor, support and challenge progress – See Table 1.

Table 1 Timetable of Events.

Date	Whom	Activity	Completed
14 July 2015	CQC	Publish Final "Review of health services for Children Looked After and Safeguarding in Rotherham" document on their website. Email out to all Action Planning Group Final CQC report and Action Plan to update	Completed by CQC
20 July 2015	ALL CQC Action Planning Group	Return updated Action Plan(s) to update master copy in readiness for meeting 23 July 2013	Completed by C Hall
23 July 2015	ALL CQC Action Planning Group	All to attend meeting (or send deputy who can contribute). Agree the principles for a SMART Action Plan that meets the need to	Completed

		improve the services delivered to Rotherham children	
3 August 2015	ALL CQC Action Planning Group	Send up to date Action Plan addressing the CQC recommendations in readiness to collate all responses	Completed
10 August 2015	Sue Cassin and Catherine Hall	RCCG to email Action Plan to CQC, meeting the 20 day response timescale from CQC (**9am - 11 August 2015)**	
13.08.15, 10.09.15 22.10.15 19.11.15 & 17.12.15	Providers and commissioners of healthcare; RLSCB, RMBC and Healthwatch	Attendance agreed at monthly task and finish CQC CLAS Action Plan Peer Challenge Group. The function of the group is to ensure that actions are addressed and evidence of compliance is provided. This group will add peer challenge into the 'health economy'	

The overarching action plan addressing the recommendations (Appendix 1) is being led by RCCG Head of Safeguarding and includes all relevant partners. Partners will need to develop their own action plans and drive forward within their organisation changes and developments. For example RMBC Public Health have a number of areas that they commission, they will require additional assurance from the provider that services are fully cognisant of their expectations and will be able to deliver. The role of RCCG is to ensure that overall actions are co-ordinated and work across the health economy. This is a major ask but we are aware that working together is crucial to safeguarding children.

The action plan needs to be multi-agency to ensure that gaps do not occur because of changes and developments therefore professional challenge and buy in are crucial. In addition the action plan will be utilised at any future review of services. It will be a working document that is updated accordingly and has senior management commitment to its delivery.

Governance arrangements are critical to ensuring that all recommendations are implemented effectively. In addition to RCCG ensuring via the CQC CLAS Action Plan Peer Challenge Group that all the recommendations are embedded into practice the CCG will monitor compliance via contract quality meetings. Commissioners of services, including RCCG Children's Commissioners, have been involved at all stages and will update service specifications if required to further develop safeguarding. Healthcare providers have robust internal mechanisms including safeguarding operational and strategic fora and quality and performance meetings to drive forward changes within their organisations.

The responsibility of the CQC CLAS Action Plan Peer Challenge Group is to consider individual actions, assess the evidence provided and agree to the agencies analysis of their position. Actions will then be RAG rated following the groups decision on whether the Recommendation from the CQC report is completed or still requires further actions. The aim of the CQC CLAS Action Plan Peer Challenge Group is to provide supportive robust external challenge and unblock any barriers with achieving the goals across the health economy if requred.

In conclusion the report followed the child's journey through the 'health system' reflecting their experiences. 24 recommendations for improvement were made, these are included in the attached SMART action plan and cover both commissioning and providers of healthcare. See Appendix 1.

Patient, Public and Stakeholder Involvement:
RCCG facilitated the inclusion of NHS England Area Team; TRFT acute and community services: RDaSH children and adult mental health services; 3 GP Practices and The Gate Practice; Healthwatch; RMBC Safeguarding and Public Health and Rotherham Local Safeguarding Children Board. Each service/provider/commissioner is responsible for their individual areas identified as requiring improvement or further development and also where applicable to work jointly to protect children. RCCG will request, via contracting updates from commissioned services and will monitor and evaluate progress and barriers with the support of the Designated Professionals. The CQC final report and recommendations has been published. It has been discussed at the CCG Operational Executive and Governing Body. In order to maintain transparency RCCG is committed to sharing work with RLSCB and partner organisations including RMBC Improvement Board.
Recommendations
It is recommended that the Health & Wellbeing Board: • Note the arrangements for Rotherham CCG to maintain oversight and support the overarching leadership to facilitate a health economy approach to implementing actions based upon the findings of the Care Quality Commission. • Note that Rotherham CCG will provide the Health & Wellbeing Board with updates on progress as required.

History:	
NHS Rotherham CCG Operational Executive	10 August 2015
NHS Rotherham Strategic Commissioning Executive	12 August 2015
Rotherham Health and Wellbeing Board	26 August 2015

investor in excellence

NHS
Rotherham
Clinical Commissioning Group

Review of Health Services for Children Looked After and Safeguarding (CLAS) in Rotherham

Care Quality Commission Review

23 – 27 February 2015

ACTION PLAN

CONTENTS

KEY

SMART Actions

Specific – Specify area for improvement.

Measurable – Quantify or at least suggest an indicator of progress.

Assignable – Specify who will do it.

Realistic – State what results can realistically be achieved, given available resources.

Time-related – Specify when the action(s) will be achieved.

***** PROGRESS OF ACTIONS – BRAG RATE***

BLUE	**=**	**The task has been completed.**
GREEN	**=**	**The task is on target.**
AMBER	**=**	**The task is off target with remedial action.**
RED	**=**	**The work has yet to be/planned/started/progressed**

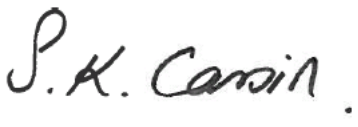
Foreword

The Care Quality Commission Children Looked After and Safeguarding (CLAS) team reviewed healthcare delivery in Rotherham (23 to 27 February 2015); a report into their findings was published 14 July 2015. This review presented commissioners and providers of healthcare in Rotherham with the opportunity to reflect on the services they deliver across the health economy to all our children, young people and their families.

The published report has provided an excellent opportunity for commissioners and providers, across Rotherham, to work together to develop or improve services. As a Rotherham wide health economy we will ensure that we are focused and committed to delivering the best possible healthcare in Early Help, Children in Need, Child Protection and Children Looked After.

To maintain oversight NHS Rotherham Clinical Commissioning Group (CCG) is supporting the overarching leadership to facilitate a health economy and all-partners approach. The commitment and determination of all partners has been critical in the drive to continuously improve our safeguarding and looked after children arrangements. Partnership working between NHS Trusts, GPs, and child and adult health services has been and will continue to be co-ordinated by Rotherham CCG. Whilst the CLAS action plan is a multi-agency, multi-disciplinary commitment the overarching action plan will be hosted by Rotherham CCG.

The overall governance arrangements will be monitored by Rotherham CCG Governing Body with an expectation that regular planned monitoring will be discussed and challenged through contract quality meetings and between Commissioner and Provider Boards. All provider Trusts have given significant consideration to their internal governance arrangements with Trust Boards being kept informed and engaged throughout, this now being embedded in ongoing processes.



Sue Cassin, Chief Nurse
NHS Rotherham Clinical Commissioning Group

Chris Edwards, Chief Officer
NHS Rotherham Clinical Commissioning Group

11 August 2015

Rotherham Review of Health Services for Children Looked After and Safeguarding: Care Quality Commission, 23 – 27 February 2015

Version Control:

Version	Date	Author	Action	Comment
1.	1 June 2015	Head of Safeguarding - RCCG	**Sent proposed SMART template to use when CQC Report is published to:** **RCCG**: Head of Safeguarding, Safeguarding & Quality Assurance Officer, Deputy Designated Nurse Safeguarding Children *CC: Head of Quality & Lead Nurse, Named GP Safeguarding* **TRFT:** Head of Midwifery, Nursing & Professions, Consultant Community Paediatrician Child Health, Named Nurse- Looked After Children & Care Leavers, Assistant Chief Nurse, Designated Doctor Safeguarding *CC: Chief Nurse* **GP Practices**: Practice Manager - Woodstock Bower Group Practice, Practice Manager – Morthen Road Group Practice, Practice Manager – Rawmarsh Health Centre, Managing Director – The Gateway Primary Care. **NHS England**: Assistant Director of Nursing (Patient Experience). **RDaSH:** Head of Quality & Standards, Nurse Consultant. *CC: Deputy Director of Nursing and Partnerships* **RMBC:** Director Safeguarding Children and Families Services, Consultant in Public Health **RLSCB:** Business Manager **Healthwatch Rotherham**: Chief Executive Officer	Response on template required by **5 June 2015**
2.	15 June 2015	Head of Safeguarding - RCCG	**Utilising draft CQC Report an Action Plan has been formulated and shared sent to:** see list above.	To be considered and returned to Safeguarding Administrative Support by **29 June 2015.**

3.	14 July 2015	Head of Safeguarding & Safeguarding & Quality Assurance Officer - RCCG	**CQC Report published with 24 Recommendations. Report and Action Plan circulated to:** see list above.	To be populated and returned to Safeguarding Administrative Support by **20 July 2015**
4.	23 July 2015	CQC Action Plan Meeting	CQC Report and Action Plan discussed along with way forward. Action Plan circulated for comments and way forward for ensuring that all Recommendations are actioned in a health economy approach. Recommendations will be peer challenged at monthly meetings. **23 July 2015 – CQC Action Plan Task & Finish Group Meeting** – those attended: **RCCG**: Head of Safeguarding, Safeguarding & Quality Assurance Officer, Deputy Designated Nurse Safeguarding Children, Named GP Safeguarding, Senior Commissioning Manager Children & Young People, Deputy Designated Nurse Safeguarding Children MASH, GP Executive & Lead for Children and Unscheduled Care, Head of Primary Care & Quality, Safeguarding Administrative Support **TRFT:** Chief Nurse, Named Nurse – Looked After Children & Care Leavers, Children's Services Lead, Named Nurse Safeguarding Children **GP Practices:** Practice Manager – Morthen Road, Primary Care Performance Manager – Gateway Primary Care **NHS England**: Senior Nurse Manager **RDaSH:** Head of Quality & Standards, Nurse Consultant, Named Professional, Director of Nursing **RMBC**: Public Health Specialist, Deputy Director Children's Services **Healthwatch Rotherham**: Chief Executive Officer	Monthly meetings agreed to track progress.
5.	3 August 2015	ALL	ALL Commissioners and Providers to return Action Plan addressing the CQC recommendations to Safeguarding Administrative Support in readiness to collate all responses and RCCG to email Action Plan to CQC, meeting the 20 day response timescale from CQC.	To be populated and returned to Safeguarding Administrative Support by **3 August 2015 at 12 noon**

6.	10 August 2015	Chief Nurse and Head of Safeguarding - RCCG	RCCG to email Action Plan to CQC, meeting the 20 day response timescale from CQC	To be emailed to CQC **by 11 August 2015**
7.		Monthly task and finish group to support and peer challenge the implementation of the CLAS Action Plan. 'CQC CLAS Action Plan Peer Challenge Group'	13 August 2015 – 1pm to 2pm at Oak House 10 September 2015 – 1pm to 2pm at Oak House 22 October 2015 – 10am to 11am at Oak House 19 November 2015 – 1pm to 2pm at Oak House 17 December 2015 – 10.30am to 11.30am at Oak House	

Recommendation 1

NHS England and Rotherham Clinical Commissioning Group (RCCG):

Recommendation 1.1

Work with GPs to ensure that they fully understand the local child protection processes, including their responsibilities around record keeping, information governance and information sharing.

(See 3.3 3.4 3.5)

Outcome: All Rotherham GP's will be aware of their responsibility to safeguard children and know where child protection plans should be stored in order to support families in protecting their children.

Agency/Service	*SMART* Action*	*Lead Officer and Key Personnel*	*Date of Action*	*Progress, Evidence, Date, BRAG***
RCCG/NHS England Independent Providers	Rotherham GPs and Practice staff will be trained in accordance with Royal Colleges Intercollegiate and RLSCB expectations. Key messages of the need for a single health record, safe storage of records and information governance to be reiterated at Practice Manager's Forum on 28 July 2015 and 29 September 2015.	Named GP and GP Practice Safeguarding Leads and deputies	Completed 28 July 2015 29 September 2015	Evidence- email from NHS Rotherham CCG Named GP Safeguarding All GP Practices to have access to Intercollegiate 2014 expectations - evidence PM forum agenda
	Safeguarding training for GPs and all GP Practice staff is provided on a biennial basis at Protected Learning Time (PLT) events and the delegate has to meet an evidence-based competence assessment through training/ discussion/demonstration in practice/other and once agreed a Certificate of Attendance and Competence is given. In addition Practice based safeguarding training has taken place 2014/2015. Learning from this is evaluated.	Chief Nurse, Named GP RCCG	Safeguarding PLT 6 November 2014	Survey monkey utilised to check learning from CSE, and safeguarding training. 23 February 2015 Benchmark Report on GP training having taken place includes PREVENT and MCA. Paper to RCCG Operational Executive regarding evaluation of safeguarding learning.

	Survey results to feed into PLT Hot Topics event 12 November 2015. Hot Topics to include Child Protection Case Conference Reports. A Safeguarding Vulnerable People Policy template will be published alongside updating Safeguarding Top Tips. This will be followed up with a survey to ascertain if the information has been embedded into GP Practices. The PLT planned for November 2016 will incorporate any actions identified from the survey, any statutory changes and CQC reports.	RCCG Safeguarding Team. Head of Primary Care Quality	To be completed 30 September 2015 10 November 2016	PLT delegate has to meet an evidence based competence assessment through training/ discussion/ demonstration in practice/other and once agreed a Certificate of Attendance and Competence is given Programme.
	Reissue advice electronically regarding policies/ procedures to reflect "*advice from Information Governance colleagues and Named GP' regarding record storage'*	RCCG Named GP and Information Governance Lead	31 July 2015	Exception reports from NHS England or CQC regarding Safeguarding issues within GP Practice.
	Working with GP's and their staff to embed GMC Guidance "Protecting children and young people: the responsibilities of all doctors" A group of Practice Managers to work with the Named GP and Head of Primary Care Quality to produce a self-audit tool for GP practices. Head of Primary Care Quality to include in peer review visits a point of prevalence audit regarding a child's journey through the system and spot checks of self audits.	RCCG GP Named Safeguarding Lead Practice Managers GP Lead for Primary Care Quality Head of Primary Care Quality	22 July 2015 30 September 2015 1 November 2015	Email guidance and information to all GP Safeguarding Leads and Deputies and GP Practice Managers: *Protecting children and young people: the responsibilities of all doctors*. This data will be accessible and collated into a Rotherham wide report.
	Anticipated Evidence: Intercollegiate Document Practice Manager Forum minutes Email Survey Monkey report GP News Bulletins Paper to RCCG Operational Executive 23 February 2015 Self-audit tool			

Recommendation 2

NHS England, Rotherham Clinical Commissioning Group (RCCG), Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) and The Rotherham Foundation NHS Trust (TRFT):

Recommendation 2.1

Ensure children and young people who have attended the emergency department following an episode of self-harm or other mental health care need and admitted on to the trust's paediatric ward are looked after by appropriately trained practitioners and that there is a clear, written risk management plan in place for each child.

(See 2.2 2.3 5.3.4)

Outcome: All children admitted on to the paediatric ward will have a mental health risk management plan undertaken by staff who have the required skills set.

Agency/Service	SMART* Action	Lead Officer and Key Personnel	Date of Action	Progress, Evidence, Date, BRAG**
CCG/TRFT/RDaSH	Emergency Centre Children's Task and Finish Group, with representation from Rotherham CCG/TRFT/RDaSH, to lead the development of the Emergency Department Self-Harm Pathway. The development of the pathway will include guidance for the development of personalised risk management plans for individual children.	Emergency Centre Children's Task and Finish Group The Chair - RCCG Lead Officer, Senior Manager CAMHS TRFT and CAMHS Provider Group	Include in 2016/17 contract Completed by 31 August 2015	Rotherham CCG CAMHS Commissioner to lead the Task and Finish Group to agree the pathway for pilot in 2015/16 and for inclusion in the 2016/17 contract. Service Manager, CAMHS to represent RDaSH on the Group. Two Pathways developed for: Child Presents with Act of Self Harm and Child Presents with acute mental health problems awaiting final ratification. Risk assessment documentation and planned to roll out training on 7, 18 and 23 September 2015 for paediatrics and ED colleagues.

	CAMHS to provide a programme of mental health training for TRFT paediatric staff to support young people with a mental health issue admitted to paediatric inpatient services.	Service Manager, CAMHS TRFT Clinical Lead	To be completed 23 September 2015	Mental Health training programme has been developed by RDaSH CAMHS, with hour long sessions delivered to TRFT paediatric staff on 9 and 20 March 2015. Forward programme of training dates have been confirmed with TRFT and planned for 7th, 18th and 23rd September 2015.
	CAMHS to appoint to a CAMHS Interface Liaison Post, agreed with Rotherham CCG. Post works across CAMHS and TRFT, including a base in TRFT emergency department.	Service Manager, CAMHS, RDaSH	Complete 31 July 2015	CAMHS Interface Liaison worker recurrently funded by Rotherham CCG. Current post holder in place on a fixed term basis from 20 July 2015 for three months. Permanent post to be recruited to from quarter 3 2015/16.
	Undertake an audit of staff awareness and positive influence on practice within 3 months from delivered mental health training	Named Nurse TRFT/ CAMHS Interface Liaison Post	31 December 2015	Audit to be undertaken and Audit report, recommendations and action plan to be developed and monitored by TRFT and RDaSH (CAMHS) Provider to Provider meeting.
	Undertake an audit, 6 months after the implementation of the risk management plans, to measure the impact for children, their families and the staff looking after them.	Paediatric Liaison Nurse TRFT/CAMHS Interface Liaison Post	1 May 2016	Audit to be undertaken and Audit report, recommendations and action plan to be developed and monitored by TRFT and RDaSH (CAMHS) Provider to Provider meeting and any further actions or improvements made.
	Anticipated Evidence: Perinatal pathway, action plan from identified gaps. Audits/pathway changes/documentation plan updates or issues will be discussed as part of regular agenda item through TRFT Contract Quality Meeting and RDaSH Mental Health and Learning Disability Quality Meeting.			

Recommendation 2.2 ***Develop a perinatal mental health pathway that is compliant with NICE guidance and reflects all services that are available to support women with perinatal mental health needs.*** **(See 2.16 5.3.7)**				
Outcome: There will be a perinatal mental health pathway established in Rotherham that supports the needs of women appropriately.				
Agency/service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
RCCG/TRFT/RDaSH	Establish a Task and Finish Group to: • Compare the current pathway against NICE guidance • Building on the work already undertaken by TRFT and look at gaps in the pathway identified in the prospective audits undertaken by TRFT • Look at any necessary changes/ additions to the pathway and implementation of the revised pathway including training	Senior Commissioning Manager, Children and Maternity (RCCG) Head of Contracts & Service Improvement – Mental Health, Learning Disability & End of Life (RCCG) Named Nurse, Children's Safeguarding Obstetrician with Special Interest Midwife with Special Interest Head of Midwifery, Nursing and Professions Locality Service Manager, Rotherham Adult Community Mental Health Services Nurse Consultant Safeguarding Children RDASH	31 October 2015	The team has direct access to a perinatal mental health specialist in Leeds and has direct access to him and his unit as required. In addition access to a trained perinatal mental health Psychiatrist in RDaSH. A process is currently in place to provide support and input regarding perinatal mental health; any further improvements will be made as a result of the Task and Finish Group. Contract variations will go via the established Contract Performance meetings and a report on changes to service will be presented to the Joint Safeguarding Meeting held at TRFT.

RMBC Public Health	Rotherham Public Health to revise service specifications for commissioned specialist midwifery services (Stop Smoking and Substance Misuse) to ensure they use the newly developed perinatal mental health pathway.	PH Principal Health Improvement (RMBC) Drug Treatment System Manager (RMBC)	31 January 2016	In place following new pathway being established. Monitored at quarterly Contract Performance meetings.
	Anticipated Evidence: Perinatal pathway, action plan from identified gaps. Implementation plan Audits/pathway changes/documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			
Recommendation 2.3 ***Ensure that health practitioners are completing referrals to children's social care that clearly assess and articulate the risk.*** **(See 3.2)**				
Outcome: Referrals received by Rotherham children's social care in relation to a child at risk of significant harm from health staff will be sufficiently comprehensive to ensure that there is no delay in a multi-agency risk assessment and analysis of need.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
Rotherham CCG/ RDaSH/TRFT	Multi-agency referral form (MARF) is in place, with agreed standards in relation to the assessment and descriptors of risk outlined in the RLSCB policies and procedures. Providers to hold bespoke MARF training sessions to reiterate the standards and ensure that referrals clearly identify and articulate risks.	Nurse Consultant, Safeguarding Children, RDaSH TRFT Named Nurses Safeguarding	Plan sessions to commence 01 September 2015	Standardised template for MARF referrals is in place. Training programme outline and details of attendees to be available from September 2015. TRFT – The MARF Form is available on The Trust Intranet Site and instructions on how to complete on the front of the form – Training on MARF Completions is already

				included in Level 3 Safeguarding training.
	MASH practitioners to complete randomized audits on behalf of health providers (i.e. RDASH, TRFT/RCHC, GP's) Reports to be produced for each provider organization by the Deputy Designated Nurse (Rotherham CCG) reporting on the results of the randomized audits)	Deputy Designated Nurse and Health MASH	31 December 2015	Deputy Designated Nurse to develop standards and audit tool to audit referrals from health in to the MASH
	Anticipated Evidence: Template, audit tool and report Audits/pathway changes/documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			
Recommendation 2.4 ***Ensure effective governance around record keeping, including use of chronologies, case note entry, sharing of information and understanding of consent.*** **(See 3.7 3.19 5.2.4 5.2.5 5.2.8 5.2.9 5.2.10)**				
Outcome: Record keeping will meet identified and agreed standards.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
All Providers and Commissioner(s)	Each organisation to review existing record keeping policy and procedure, to include record keeping standards that clinicians should be working towards.	Nurse Consultant, Safeguarding Children, RDaSH	Complete by end 30 September 2015	Reviewed policy to be presented to RDaSH Clinical Quality and Standards Group by 30 September 2015.
	Safeguarding Children teams to co-ordinate a review of their safeguarding record keeping policy. Providers to undertake clinical record keeping	Named Nurse Safeguarding Children TRFT	Complete by end 30 September 2015	Reviewed policy to be presented to Joint Safeguarding Team Operational meeting by 30 September 2015.

	audit, including the audit of: • how consent is recorded • how information sharing is reflected in records (eg is documented within policy)	Nurse Consultant, Safeguarding Children, RDaSH Clinical Audit Team, RDaSH	Complete by end 30 September 2015	RDaSH annual clinical record keeping audit to be undertaken in August 2015 including: • how consent is recorded • how information sharing is reflected in records (eg is documented within policy) Audit report, recommendations and action plan to be monitored by monthly RDaSH Clinical Quality and Standards Group from September 2015
	Anticipated Evidence: Audits/pathway changes/documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			
Recommendation 2.5 ***Ensure that pharmacists and practitioners working from the local walk in centre are aware of their role in referring young people for local screening for sexually transmitted infections or in raising safeguarding concerns and that clear pathways of care are in place.*** **(See 1.13)**				
Outcome: Children and Young People presenting at a Pharmacy have their risks and needs identified against local threshold descriptors and receive appropriate services and/or referral to address identified risks/needs.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
RMBC Public Health	All Pharmacists commissioned by RMBC Public Health will have contracts varied to include a requirement to undertake level 2 safeguarding children training. Referral pathways in relation to safeguarding and screening for sexually transmitted infections (STIs) to be disseminated to all	Consultant in Public Health, Public Health Specialist, RMBC Safeguarding	September 2015	Contracts varied to reflect training requirement – September 2015. Training available and information to be disseminated – 01 September 2015.

	Pharmacies commissioned by RMBC Public Health. Guidance and procedures to be supplied by RMBC Safeguarding. Pharmacists to undergo training.	Chair Local Pharmacy Committee		All pharmacists to ensure training is undertaken 01 September – 31 December 2015. Contracts to be monitored to show compliance by 31 December 2015.
RMBC Safeguarding, RMBC Public Health	All Rotherham Pharmacists will be provided with guidance and procedures specifically relating to referral for treatment of STIs and safeguarding children.	Consultant in Public Health, Public Health Specialists – RMBC, Business Manager – Rotherham Local Safeguarding Children's Board	01 September 2015	Referral pathways and guidance already in place. All Pharmacists will be given a 'refresher' training/information update.
NHS England Input	NHS England to develop clear concise pathways in line with local and national regulations.	Deputy Director of Nursing – NHS England Community Pharmacist Lead – NHS England	31 August 2015	6 months after implementation an audit of activity through the LSCB to ensure compliance.
	Anticipated Evidence: Pharmacist's contracts, pathways and guidance documents.			

Recommendation 3 **RCCG and Rotherham, Doncaster and South Humber NHS Foundation Trust should:**				
Recommendation 3.1 ***Ensure that children and young people who are working with CAMHS practitioners have a clearly identified lead professional and that regular communication takes place with the child's GP where there is concern.*** **(See 2.8 2.9)**				
Outcome: All children will have an identified care co-coordinator with the responsibility to identify, communicate and liaise with all individuals and services relevant to a child care.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
CAMHS	CAMHS Operational Policy to be reviewed to include: - referral process and criteria - allocation meetings - communication - information sharing between services and partner agencies - clinical/safeguarding/ managerial supervision - Tier 3 pathway - Tier 4 pathway	Service Manager, CAMHS, RDaSH	Complete 31 August 2015	Service Manager, CAMHS has begun reviewing existing CAMHS Operational Policy, to be completed 31 August 2015 and approved at Business Division Governance Group.
	CAMHS service to implement weekly care co-ordinator/lead professional allocation meeting for:	Service Manager, CAMHS, RDaSH	Complete 31 July 2015	CAMHS weekly allocation meeting commenced in July 2015. Service Manager, CAMHS to monitor electronic system for updated status of referrals.

	• initial assessments • complex cases • allocation of emergency cases for ongoing work			
	Undertake a review to ensure that existing cases are allocated to a care co-ordinator/lead professional.	Service Manager, CAMHS, RDaSH	Complete 31 August 2015	Meridien has been working with CAMHS practitioners to identify unallocated cases. CAMHS practitioners are currently allocating cases through weekly allocation meetings or closing on system as required by end August 2015.
	Care co-ordinator/lead professional to inform GP and other relevant health and social care professionals when allocated to work with a child, in line with consent to share information.	Service Manager, CAMHS, RDaSH	Complete 31 August 2015	Clinical/safeguarding supervisors to review case allocation, ongoing support to staff and child, and their communication with other relevant professionals.
	A workforce development review to be undertaken to support the transformation programme agreed with Commissioners	Service Manager, CAMHS, RDaSH and RCCG Lead CAMHS Commissioner	Complete 30 September 2015	Monthly meetings take place between RDaSH and Commissioners to discuss implementation of transformation programme
	Anticipated Evidence: Audits/pathway changes/documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			

Recommendation 3.2 ***Ensure that children and young people engaged with CAMHS have access to a clear pathway of care that includes arrangements for stepping up and down from Tier 4 services.*** **(See 2.11)**				
Outcome: There is a mental health pathway in place from referral into CAMHS through to Tier 4 admission and stepping back down to Tier 3 services.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
RDaSH, NHS England Area Team and RCCG	Agree and implement combined Tier 2/Tier 3 service specification.	Service Manager, CAMHS /RDaSH Rotherham CCG Lead CAMHS Commissioner	Complete by 31 August 2015	Tier 2/3 service specification being developed as part of RDaSH 2015/16 contract. Monthly Contract Performance Group monitors service performance.
	Rotherham CCG and RDaSH to discuss a Tier 3+ service, as outlined in Service Development Improvement Plan (SDIP) in RDaSH 2015/16 Contract, including involvement of Healthwatch as advocates.	Rotherham CCG Lead CAMHS Commissioner and Lead GP Mental Health, Service Manager, CAMHS, RDaSH	Commence discussions by 30 September 2015	2015/16 SDIP agreed between Commissioners and RDaSH in 31 March 2015. Quarterly updates on SDIP as part of contract review process and contract negotiations for 2016/17.
	RDaSH to work with RMBC / CCG / Voluntary Sector partners to continue to implement the Rotherham Multi-Agency Emotional and Wellbeing and Mental Health Strategy for Children and Young People.	RMBC Mental Health Commissioner, Rotherham CCG Lead Commissioner CAMHS, RDaSH CAMHS Service Manager	Complete by 31 March 2016	A five year multi-agency Emotional Wellbeing and Mental Health strategy is in place, with one year action plans agreed and being implemented. 2015/16 plan monitored through the quarterly CAMHS Partnership group.
	To implement and embed the NHS England Specialised Mental Health Services	Service Manager, CAMHS/ RDaSH Rotherham CCG	Complete by 31 August 2015	Adopt NHS England Specialised Mental Health Services Pathway Service Specification as included in the 2015/16

	Pathway for CAMHS Tier 4 services as included within the 2015/16 CAMHS contract.			contract Monitored through monthly Contract Performance Group Meetings.
	CAMHS service to collect data on all Tier 4 placements in line with 'Standard Operating Procedure for Children and Young People's Mental Health Service for Children and Young People that are placed in Tier 4 establishments' and report to Commissioners as part of 2015/16 contract performance monitoring.	Service Manager, CAMHS, RDaSH	Completed 31 March 2015	Standard Operating Procedure for Children and Young People's Mental Health Service for Children and Young People that are placed in Tier 4 establishments' approved in March 2015. Performance reporting on numbers of people in Tier 4 beds continues on a monthly basis and monitored through monthly Contract Performance Group meetings.
	CAMHS Interface Liaison Post to be established to work closely with inpatient partners in: - Tier 4 - Paediatrics - Adult Mental Health	Service Manager, CAMHS, RDaSH	Completed 20 July 2015	CAMHS Interface Liaison worker recurrently funded by Rotherham CCG. Current post holder in place on a fixed term basis from 20 July 2015 for three months. Permanent post to be recruited to from Quarter 3 2015/16.
	To implement and embed the RDaSH policy on Under 18 Admissions to Adult Mental Health wards.	Nurse Consultant Safeguarding Children, RDaSH Mental Health Act Manager, RDaSH CAMHS Interface Liaison Worker, RDaSH	Complete by 31 August 2015	Under 18 Admission Policy to be signed off by RDaSH Clinical Quality and Standards Group in August 2015. Database of all Under 18 Admissions to Adult Mental Health wards to be maintained and reported to CCG Lead CAMHS Commissioner in real time.
	Anticipated Evidence: Audits/pathway changes/documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			

Recommendation 3.3 ***Improve the emergency department documentation and assessment templates to ensure safeguarding processes are robust and support practitioners in the identification and recording of children of adults who are accessing services.*** **(See 2.14 3.16)**				
Outcome: The documentation of children attending Rotherham Emergency Department will support the identification of safeguarding needs.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
TRFT Emergency Department (ED) and Safeguarding Team	The existing ED and Safeguarding Joint Monthly meeting will be utilised to review an holistic model of practice based on 'Think Family Principles' documentation ensuring they are fit for purpose.	TRFT ED Clinical Nurse Specialist and ED Consultant and Paediatric Liaison, Named Doctor Safeguarding	30 September 2015	Monthly meetings already in place will further develop the governance arrangements at the August meeting to include this action.
	Evaluate the effectiveness of safeguarding pathways within Emergency Department. Adapt pathways accordingly and audit within 6 months of implementation.	TRFT ED Clinical Nurse Specialist and ED Consultant and Advanced Nurse Practitioner, Paediatric Liaison and Named Doctor Safeguarding	31 October 2015 30 April 2016	Pathways in place and monitored via Paediatric Liaison. Audit undertaken and shared with Rotherham Local Safeguarding Children Board. Visit to Doncaster Hospital Emergency Department planned for September to share good practice and to identify any further developments TRFT need to make. ED is a standing agenda item on the Safeguarding Operational Group to address any concerns.
	Anticipated Evidence: Task and finish group terms of reference, pilot pathway and evaluation of outcome. Audits/pathway changes/documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			

Recommendation 3.4 ***Implement a clear operational performance management system to demonstrate compliance with organisational requirements and effective safeguarding and child protection practice.*** **(See 5.2.6 5.2.7)**				
Outcome: All children will receive effective demonstrable safeguarding.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
RDaSH/CCG	Build upon the existing Safeguarding operational performance management system to be able to report upon and monitor additional indicators, including: • Flagging of Child in Need / Child Protection Plans on electronic systems • Use of Safeguarding Clinical Decision Making Tree • Attendance at appropriate case conferences • Submission of appropriate case conference reports	Head of Quality and Standards, RDaSH CAMHS Service Manager, RDaSH Designated Nurse, Rotherham CCG	Complete by 31 August 2015	Existing Safeguarding operational performance management system data provided by RDaSH to Commissioners includes: • Section 11 Audit completed annually by RDaSH and submitted to Commissioners. Latest audit completed in April 2015. • Safeguarding Standards - Quarterly Exception Report submitted to Commissioners. Quarter 1 2015/16 report submitted 27 July 2015. • Quarterly KPI template submitted to Commissioners. Quarter 1 2015/16 update submitted 28 July 2015 Safeguarding Commissioning for Quality and Innovation (CQUIN) continues in 2015/16, with quarterly updates provided to Commissioners. Quarter 1 2015/16 update submitted by 31 July 2015 Develop system to include additional measures by 31 August 2015 and report in KPI templates from Quarter 2 2015/16.

	Develop a Safeguarding Standard Operating Procedure (SOP) that reflects the implementation of the Safeguarding operational performance management system.	Head of Quality & Standards, RDaSH Safeguarding Children Named Nurse, RDaSH Service Manager, Adult Mental Health, RDaSH Service Manager, CAMHS, RDaSH Service Manager, Drug & Alcohol Services, RDaSH	Draft consulted upon by end 30 September 2015	RDaSH Task & Finish Group established to develop Safeguarding SOP, the first meeting to be held on 3 August 2015.
	Audit compliance with Safeguarding Standard Operating Procedure to evidence the implementation and recording outcomes from the performance management system.	Head of Quality & Standards, RDaSH	To be completed 31 December 2015	Audit report and action plan to be developed and shared with Commissioners by end December 2015. Action plan monitored internally via the Safeguarding Quality and Standards Group.
	Anticipated Evidence: Audits/pathway changes/documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality/Mental Health and Learning Disability Quality Group meetings between Commissioner and Provider.			

Recommendation 3.5 ***Ensure that CAMHs practitioners develop clear service care plans for individual children. These should explicitly underpin child protection plans where these are in place.*** **(See 3.14)**				
Outcome: Children who are subject to a child protection plan will have their need to be protected explicit in their mental health care plan.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
RDaSH	CAMHS practitioners to be alerted when a service user has a child in need / child protection plan in place. All staff to be informed of the existing safeguarding alert system on the electronic patient record (Silverlink and SystemOne), and new starters to be informed as part of electronic patient record training.	Service Manager, CAMHS, RDaSH Service Manager, Adult Mental Health, RDaSH Service Manager, Drug & Alcohol Services, RDaSH IT Training Manager, RDaSH	Complete 31 August 2015	Email sent to all Rotherham CAMHS, Know the Score and Adult Mental Health and Substance Misuse staff on 28 July 2015 to use safeguarding alert system to flag records when children are subject to a child in need or child protection plan. Documented evidence of reminder and updating of system to be provided via Team meetings during July/August 2015. Electronic patient record training programme to be updated to include use of Safeguarding Alert / flagging system by 31 August 2015.
	CAMHS practitioners develop clear personalized service care plans in line with the care co-ordination approach, as developed in recommendation 3.1, to include needs identified in child in need / child protection plans.	Service Manager, CAMHS, RDaSH Nurse Consultant, Safeguarding Children, RDaSH	Complete 30 September 2015	• Care Co-ordination approach to be developed by 31 August 2015 • Safeguarding Children Supervisors to review and comment on care plans during supervision from 01 September 2015
	Undertake an audit to identify: • that all children who are subject to a child in	Head of Quality and Standards, RDaSH	Complete 01 November 2015	Audit Report, Recommendations and Action Plan to be developed and shared

	need/child protection plan have a safeguarding alert flagged on the electronic patient record. • the needs identified in the child in need/child protection plan are explicit in the mental health care plan.			with all Commissioners and monitored through RDaSH Safeguarding Quality and Standards Group from November 2015.
	Anticipated Evidence: Audits/pathway changes/documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			
Recommendation 3.6 ***Adult mental health and substance misuse practitioners should, where appropriate, share relapse indicators with other professionals working with vulnerable families.*** **(See 3.18)**				
Outcome: A safe and holistic approach to family health care will be provided.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
RDaSH and RMBC Public Health	Review current information sharing protocols / policies to ensure all partners including RMBC Public Health, involved with RDaSH services are informed when a relapse in care has taken place in line with agreed protocols.	Head of Quality and Standards, RDaSH via Task & Finish Group	Complete by 30 September 2015	RDaSH Task and Finish Group to identify appropriate RDaSH policies and protocols to be reviewed and updated to comply with this recommendation. First meeting of the RDaSH Task and Finish Group is on 3 August 2015.
	Undertake an audit of clinical records of vulnerable families to ensure practitioners are sharing relapse indicators, where	Head of Quality and Standards, RDaSH via Task & Finish Group	Completed by 31 December 2015	Clinical Records Audit to be undertaken and Audit Report, Recommendations and Action Plan to be developed and monitored by RDaSH Safeguarding

	appropriate, with partner services in line with agreed protocols / policies.			Quality and Standards Group.
	Anticipated Evidence: Audits/pathway changes/documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			
Recommendation 4 **RCCG and The Rotherham Foundation NHS Trust should:**				
Recommendation 4.1 ***Ensure that previous attendances at the emergency department by children or young people are routinely considered as part of the safeguarding triage assessment.*** **(See 1.6)**				
Outcome: Previous attendances are routinely considered for all children.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
TRFT ED	Systems will be put in place to ensure that the attendances of a child or young person 0-18 years of age, in the previous 6 months are brought to the attention of the triage nurse and all practitioners.	ED Consultant Safeguarding Lead.	30 September 2015	Information regarding admission attendance is displayed on admission sheets. Weekly safeguarding and ED liaison meetings established to discuss and action any learning or improvements.
	The paediatric liaison nurse will review all previous attendance data when reviewing ED records.	Paediatric liaison nurse	30 September 2015	Current practice: New process established to obtain NHS Number by use of Systmone or National

				Spine. New upgrade to Symphony (ED IT system) and use of NHS Number for tracking patients.
	The IT specification (new Emergency Centre) will include the requirement for all previous attendances to be included in the GP notification letter.	Emergency Centre Project Manager	30 September 2015	
	The Trust will put in place a mechanism for practitioners to sign the ED record to confirm /affirm that they have taken account of previous attendance data in decision making.	ED Consultant Safeguarding Lead	30 September 2015	Mechanism to be agreed via the weekly Safeguarding and ED Liaison meeting established to discuss an action.
	Actions 1, 2 and 4 above will be audited in December 2015. The results of the audit will be reported to the ED Governance meeting and the Strategic Safeguarding Group.	ED Consultant Safeguarding Lead	31 December 2015 for completion of the audit with reports to the ED and Safeguarding Governance meetings in January 2016.	Audit to be undertaken and audit report, recommendations and action plan to be developed and monitored by ED TRFT Joint Strategic Safeguarding Group and actions or improvements made.
	Anticipated Evidence: Audits/pathway changes/documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			

Recommendation 4.2

Improve the identification and recording of children who are cared for by adults who attend ED following risk taking behaviours or mental health concerns and that these children are brought to the attention of paediatric liaison.

(See 1.9 1.10)

Outcome: All adults who attend ED with risk taking behaviors will have details of dependents recorded, and any concerns will be identified to Paediatric liaison to ensure that the needs of children are safeguarded.

Agency/Service	SMART* Action	Lead Officer and Key Personnel	Date of Action	Progress, Evidence, Date, BRAG**
TRFT Emergency Department (ED)	The ED booking form will be reviewed to ascertain whether it is possible to include recording of any dependents.	ED Business and Service Manager	31 August 2015	
	All ED staff will receive face-to-face instruction on what is expected of them by way of completion of the assessment of dependents.	ED Matron	30 September 2015	This will be monitored by ED Matron. New process established and put into practice from July 2015 to identify dependents following admission of an adult patient attending ED or other admitting areas with self-harm attempt or overdose.
	Audit will be undertaken in November 2015. This will measure the extent to which the question about dependents is being asked of every adult patient attending the ED with a reported history of risk taking behaviours. The audit will also assess the extent to which practitioners are then complying with LSCB policies for referrals.	Paediatric Liaison Nurse and Named Doctor for Safeguarding Children and Named Nurse for Safeguarding Adults	30 November 2015	The completion of the audit with reports to the relevant Governance meetings in January 2016.

	Anticipated Evidence: Audits/pathway changes/documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			
Recommendation 4.3 ***Improve the risk assessment for vulnerability in midwifery services, CASH and GUM to ensure that vulnerability is being identified and responded to at the earliest opportunity.*** **(See 1.15 1.18 1.19)**				
Outcome: Safeguarding risks and vulnerabilities will be identified with appropriate timely actions being recorded.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
TRFT Midwifery, CASH & GUM **Integrated Sexual Health Services (ISHS)**	Embed the new CSE Risk Assessment tool throughout Integrated Sexual Health Services (formerly known as CASH & GUM).	Head of Midwifery and CSE Specialist Nurse.	31 August 2015	BASH CSE Risk Assessment pro forma already in use. New local agreed CSE Risk Assessment tool circulated for use in TRFT commencing July 2015.
	Ensure that best practice is identified and shared with all staff in these identified areas.	Clinical Director and Matron Integrated Sexual Health Services.	30 September 2015	Representation from the ISHS and Strategic Group – both medical and nursing to share best practice. Bespoke training has been provided via the CSE Specialist Nurse on use of the CSE Risk Assessment Tool. Compliance with Safeguarding Training.

	Ensure that all relevant staff are up to date with Equality and Diversity Training.	Head of Midwifery	30 September 2015	Review of Electronic Staff Record (ESR).
	Ensure that all staff know how to access interpreting services both within and out of hours.	Head of Midwifery	31 August 2015	Letter to be sent by Head of Midwifery and information inclusion in minutes from Team Meetings.
	All midwives to complete and formally record the social vulnerability risk assessment forms both during booking **AND** repeat assessments during pregnancy. Records must be updated to reflect that social vulnerabilities have been considered even when none have been identified.	Head of Midwifery	31 August 2015	Process already in place and plans to improve compliance via education and audit of compliance in January 2016.
	All midwives will be sent a letter reminding them of the need to consider the need to complete pre-CAF.	Head of Midwifery	31 August 2015	Letter to be sent by Head of Midwifery and information inclusion in minutes from Team Meetings.
	The use of the Pre-CAF will be audited in November 2015.	Named Nurse/Named Midwife for Safeguarding Children	30 November 2015	Process to be established in partnership with the CAF Team Local Authority.
	Following implementation of agreed risk assessment tools maternity and Integrated Sexual Health Service will undertake dip sampling of records to ensure compliance.	CSE Specialist Nurse and Women's Outpatients Matron.	Dates in November 2015 to be identified.	A report will be submitted December 2015 to TRFT Operational Safeguarding meeting and Family Health Governance meeting.
	Anticipated Evidence: Audits/pathway changes/documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			

Recommendation 4.4 ***Ensure a robust communication process is in place to facilitate joint working between midwives and health visitors.*** **(See 1.21 1.22)**				
Outcome: A robust communication process must be in place to ensure the sharing of information particularly in respect of health, social or environmental concerns regarding vulnerabilities is in place and consistently used between midwifery and health visiting.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
TRFT Midwifery and Health Visiting and Public Health as the commissioners of HV/FNP from 1/10/15 and SN	The antenatal midwifery pathway will be reviewed to ensure that it leads to the consistent collection and recording of data on Systmone.	Clinical Services Managers HV Managers and Community Matrons (Midwifery)	30 September 2015	Information sharing document/ Pathway.
		Head of Health Improvement, RMBC Public Health	30 September 2015	Minutes of meeting between disciplines.
	Review GP Practice EMIS IT users pathway to ensure the inclusion of the consistent recording and sharing of information.	RCCG IT Project and Data Quality Team RMBC Public Health	30 September 2015	Audit and report to TRFT Operational Safeguarding Team.
	To review the written communication pathway from midwifery to health visitor, ensuring that it is still fit for purpose.	Clinical Services Managers HV Managers and Community Matrons (Midwifery)	30 September 2015	
	The pathways will be audited in November and December with reports to the Strategic Safeguarding Group and the Family Health Governance meeting.	Midwifery and Children's Community Matrons	31 December 2015	Audit findings will be reported via Children and Maternity Governance Groups.
	Anticipated Evidence: Audits/pathway changes/documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			

Recommendation 4.5 ***Ensure that midwives are routinely including information from general practice as part of the initial risk assessment***. **(See 1.17)**				
Outcome: Communication between midwives and GP's is strengthened ensuring a holistic assessment is undertaken on all pregnant women.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
TRFT Midwifery RCCG	An initial baseline audit will be undertaken to ascertain the gaps in information routinely being used to inform initial risk assessments and the extent to which information from GPs is adequate. A point prevalence audit will be undertaken over the course of one week in September 2015.	Head of Midwifery and Primary Care GP lead	30 September 2015	Audit findings will be reported by Children and Maternity Governance Groups.
	The results of the audit will be used to inform a review of current pathways.	Head of Midwifery Primary Care GP Lead	30 October 2015	
	All GPs and midwives will receive the results of the audit and the pathway review in correspondence jointly signed by TRFT and the Primary Care GP lead. This correspondence will outline all / any required changes to practice.	Head of Midwifery Primary Care GP Lead	10 November 2015	
	A further audit will be undertaken in January 2016.	Head of Midwifery and Primary Care GP lead	31 January 2016	Audit findings will be reported via Children and Maternity Governance Groups.

	Anticipated Evidence: Audit tool, implementation plans, assurance from TRFT operational safeguarding group. Audits/pathway changes/ documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			
Recommendation 4.6 ***Work with partners to develop a clear pre-birth protocol for expectant women to include robust plans for timely discharge of mother and baby.*** **(See 3.8 3.9)**				
Outcome: Babies born in TRFT will have a safe discharge process in place that is shared and agreed.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
TRFT Midwifery and Health Visiting, FNP, RMBC Children and Young People's Service	Managers of both services to work together to create a joint protocol for pre-birth and safe discharge arrangements.	Head of Midwifery Director of Safeguarding Children and Young Peoples Directorate	30 September 2015	Protocol developed and includes LSCB and commissioner involvement.
			30 September 2015	Implementation plan to include a pathway for exception reporting to LSCB any multi-agency deviations.
	Implementation and an audit 3 months in of the new joint protocol as above which will include a robust pathway in place so that any breeches in compliance to the protocol can be reported and action taken.	Safeguarding Midwife LSCB Audit Officer RMBC Public Health Specialist (Children and Young People) RMBC Early Help Manager	31 December 2015	
	All delays to discharge (due to care proceedings) to be escalated to the TRFT Chief Nurse on the day, and copied to the Director of	Wharncliffe Ward	Immediate	Real time reporting mechanism in place. All

	Safeguarding Children and Young People at the same time.	Manager		breaches will be shared with commissioners and the Designated Nurse to allow for practice to be further developed.
	Monthly review meetings between midwives and social workers to review all vulnerable women to be introduced. Terms of reference to be devised and a first meeting established in November 2015.	Head of Midwifery Director of Safeguarding Children & Young People's Directorate	30 November 2015	
	Anticipated Evidence: Audits/pathway changes/documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			
Recommendation 4.7 ***Ensure that practitioners working in CASH and GUM service are clear about their contribution to local arrangements for child sexual exploitation and child protection.*** **(See 3.11 3.12 5.3.5)**				
Outcome: All Integrated Sexual Health service users receive an appropriate assessment and care in relation to the identification of their needs/risks.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
TRFT Integrated Sexual Health Service **TRFT CSE Nurse CSE Multi-Agency Team Local Authority (LA)**	The Evolve Manager to visit the service and deliver awareness sessions in October and November 2015.	Integrated Sexual Health Service Manager	30 September 2015	CSE Specialist Nurse has already provided bespoke training sessions in GUM and CASH.
	All clinicians to evidence completion of CSE awareness training.	Clinical Director Matron for Integrated Sexual Health Service	30 October 2015	Review of ESR and Department records.

	An agreed multi-agency risk assessment tool to be identified and implemented.	Clinical Director, Matron for Integrated Sexual Health Service and CSE Specialist Nurse	30 September 2015	
	All staff to be trained in the use of the identified risk assessment tool and clarity provided regarding the contribution required by all agencies.	Clinical Director and Matron for Integrated Sexual Health Service CSE Specialist Nurse	30 November 2015	
	Formal meetings between the Integrated Sexual Health Service and the Evolve team to take place monthly. Terms of Reference to be agreed and the first meeting to take place no later than November 2015.	Clinical Director and Matron for Integrated Sexual Health Service Evolve Team	30 November 2015	
Children's Social Care Services and CSE Nurse TRFT	CSE Nurse to work with RMBC to ensure that young people identified as being at risk of CSE appropriate enquires are made to Integrated Sexual Health Services (ISHS) formerly known as CASH/GUM.	CSE Specialist and Nurse and RMBC C&YPS	31 July 2015	Training awareness to be rolled out from July 2015. Process in place.
	Anticipated Evidence: Risk assessment tool, Minutes, training implementation plan. Audits/pathway changes/ documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			

Recommendation 4.8

Ensure that children looked after receive timely, comprehensive and child centred initial health assessments and review health assessments that reflect the voice of the child and the child's health journey whilst they have been looked after. Assessments should include information from other health professionals working with the child and every attempt should be made to include parental health histories.

(See 4.1 4.2 4.6 4.7 4.8 4.10)

Outcome: All looked after children and young people will have a comprehensive health assessment.

Agency/Service	SMART* Action	Lead Officer and Key Personnel	Date of Action	Progress, Evidence, Date, BRAG**
Looked After Children's Team	The initial health assessment will be undertaken by a qualified medical practitioner within 20 working days of the child/young person becoming looked after. An improvement trajectory will be agreed in August 2015 between health and social care.	Looked After Children's (LAC) Health Team and social care Designated Doctor LAC Looked After Children's Health Team and social care	31 December 2015 31 August 2015	
	The review health assessment will be undertaken by a registered nurse within the statutory timescales (6monthly for under 5yr olds/12monthly for over 5yr olds).	Looked After Children's Team School Nursing Service	31 December 2015	
	In-depth audit tool will be developed to ensure the voice of the child is taken on board, to be audited in October.	Looked After Children's Team/Designated Doctor LAC	31 October 2015	
	An audit to ensure that the 'voice of the child' will be included within all health assessments by the practitioner undertaking the assessment. (eg. Not written in the 3rd person but reflective of the individuality of the child).	Looked After Children's Team Health Visitor and SN service Designated Doctor LAC	31 December 2015	
	GP's and CAMHS services will be approached for health information prior to every health assessment by the Looked After Children's Team.	Looked After Children's Team and Primary Care Lead GP	31 August 2015	

	Parental health histories will be provided by the social worker for every initial health assessment.	RMBC CYPS Social Care to Looked After Children's Team	31 August 2015	
	An audit will be undertaken by the LAC Team to ensure compliance with the above actions and a report presented to TRFT Joint Safeguarding Meeting and Corporate Parenting.	Looked After Children's Team and social care Designated Doctor LAC	31 January 2016	
	Anticipated Evidence: Reports regarding data, Audit of LAC health assessments. Audits/pathway changes/ documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			
Recommendation 4.9 ***Ensure that Health plans developed from initial health assessments and health reviews are SMART*.*** **(See 4.4)**				
Outcome: All looked after children and young people will have their health needs met.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
Looked After Children's Team/ Children and Young People's Services and RCCG	Health Plans will be formulated by a qualified health practitioner for initial health assessments ensuring that they are SMART with measurable health objectives and with timescales and effective follow-up to ensure actions had been taken – meeting the individual needs of the child.	Looked After Children's Team, Designated Dr LAC	30 September 2015	Health plans will be audited using the national audit tool.
	Health plans will be audited using the national audit tool. In-depth audit of looked after children's services to include the voice of the child commences October 2015.	Looked After Children's Team Designated Doctor LAC	30 November 2015	
	RCCG and TRFT LAC Team will provide an database to ensure that the outcome of LAC health needs are tracked in real time.	Looking After Children's Team and RCCG	30 October 2015	

	Health recommendations which contribute to the looked after child/young person's care plan will be audited by the LAC Health Team to ensure that they are child focused and SMART.	Looked After Children's Team Designated Doctor LAC	31 Jan 2016	
	Anticipated Evidence Audit tool and report to TRFT Safeguarding Operational group. Audits/pathway changes/ documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			
Recommendation 4.10 ***Improve opportunities for young people who are looked after to participate in their health reviews.*** **(See 4.9 4.13)**				
Outcome: All Looked After Children and Young people will have the opportunity to have their voice heard.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
Looked After Children's Team/Children and Young People's Services	Health staff undertaking LAC health reviews will be reminded of the need to seek consent and record the response of all young people (age appropriate) for their health review to be undertaken.	Looked After Children's Team, School Nursing Services and Clinical Service Managers	31 August 2015	E Mail to all Health Visitors and School Nurses
	Outcome scores from Strengths and Difficulties Questionnaires (SDQ's) will be routinely commented on as part of the individuals health review, allowing the young person the opportunity to track their own emotional growth and journey through their time in care and engaging the young person in their own health and wellbeing. This is to be audited in 3 months' time.	Looked After Children's Team, School Nursing Service and Clinical Service Managers	31 August 2015	Routine use of SDQ's in health assessments
		Looked After Children's Team, School Nursing Service and Clinical Service Managers	30 November 2015	Audit tool re use of SDQ's in health assessments
	Health recommendations from the assessment will be shared with the young person (age appropriate) by their health professional.	Looked After Children's Team, School Nursing	30 September	

	LAC Council to be kept informed of decisions and present any breaches to RMBC and/or LAC Health Team.	Service and Service Managers	2015	
	Anticipated Evidence: Email, SDQ's audit, attendance at LAC Council. Audits/pathway changes/ documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			
Recommendation 4.11 ***Improve the arrangements to support young people with their healthcare as they prepare to leave care and ensure that they are provided with comprehensive health care summaries.*** **(See 4.17)**				
Outcome: All looked after children and young people will receive written information relating to their health care.				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
Looked After Children's Team/Children and Young People's Service	RCGG provided the initial funding for 2015-2016 to purchase Health Passports. These will be provided for all Looked After Children and Young People by their health professional on their entry into care.	Looked After Children's Team	31 August 2015	Purchase Order completed – delivery awaited.
	Health Passports will be updated by the health professional at each health assessment. A point prevalence audit will be undertaken over the course of one week in January 2016 by the LAC Health Team or the named social worker.	Looked After Children's Team School Nursing Team	To be completed 31 December 2015	A report to the TRFT Safeguarding Operational Meeting.
	Anticipated Evidence: Email. Reports on breaches. Audits/pathway changes/ documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			

Recommendation 4.12 ***Improve the quality assurance process of paediatric liaison within the emergency department so that the TRFT and the CCG are confident that practitioners are remaining vigilant to potential safeguarding and child protection concerns.***				
Outcome: All children attending ED have a robust safeguarding assessment. **(See 1.8)**				
Agency/Service	**SMART* Action**	**Lead Officer and Key Personnel**	**Date of Action**	**Progress, Evidence, Date, BRAG****
TRFT ED and Paediatric Liaison	To review the current paediatric liaison process ensuring that it is fit for purpose.	Senior practitioner/Matron in ED, Paediatric Liaison	30 September 2015	Assurance to TRFT safeguarding operational group. Written report and action plan if appropriate.
	To provide assurance that all ED staff are trained in safeguarding children and in the use of the safeguarding assessment tool.	Senior Practitioner ED Audit Team	30 September 2015	Training data to be provided at TRFT Safeguarding Operational meeting. Exception Reports to TRFT Joint Safeguarding Meeting that Commissioners and RLSCB attend.
	Anticipated Evidence: Training data and report to TRFT Safeguarding Operational and Strategic Group. Audits/pathway changes/ documentation plan updates or issues will be discussed as part of regular agenda item through Contract Quality Meetings between Commissioner and Provider.			

THIS PAGE HAS BEEN LEFT INTENTIONALLY BLANK

Health and Wellbeing Board

1.	**Date:**	**26th August 2015**
2.	**Title:**	**Health and Wellbeing Board Communications**

3. Summary

Following discussions at the July Board meeting, in the context of the Health Select Commission's Scrutiny Review on access to GPs, this report provides the outline of a Board Communications Plan for comment and endorsement.

4. Recommendations

That the Health and Wellbeing Board:

- **Discuss and endorse the outline Board Communications Plan set out in section 5 below**
- **Agree that the Health and Wellbeing Partner website will be further developed and utilised as a central plank of Board communications**
- **Agree that a communications summary will be prepared after each Board meeting, with clear messages for all Board members to disseminate within their respective organisations/departments.**

5. Proposals and details

Background

At the previous Health and Wellbeing Board meeting on 8th July, an item on the *access to GPs* Scrutiny Review included recommendations for the Board to:

- Consider developing a Borough-wide publicity campaign to raise awareness about the impact of not cancelling unneeded appointments
- Consider revisiting the "Choose Well" campaign to raise awareness of how to access local NHS services and which is the most appropriate service in a range of situations.

In discussing these recommendations, the Board had a wider debate about communications, concluding that a report would be brought to the August meeting.

Details

It is recommended that a Board Communications Plan is developed, based on the following broad strands:

a) *Providing health messages to the general public*, including linking to and raising awareness of national campaigns and utilising an "every contact counts" approach via frontline staff.
b) *Promoting the work of the Board and its partner organisations*, including local initiatives and success stories that help to raise Rotherham's profile and improve its image.

As well as picking up the specific issues raised in the Scrutiny Review, strand a) would require close working with Public Health to dovetail with local and national campaigns.

The H*ealth and Wellbeing Partners* website, which was created last year, could be a central element of the communications plan. The site would need to be developed and maintained as an up-to-date source of information on Board meetings and delivery of activity linked to the Health and Wellbeing Strategy. In addition, it could feature Public Health and other campaigns relevant to health and wellbeing as well as blogs and other interesting content.

The Board may also wish to consider more proactive communication methods, such as a regular newsletter and/or a social media presence. There remains an intention, as discussed previously, to webcast Board meetings, though currently this would only be possible for meetings held in the Council Chamber at the Town Hall.

Finally, to ensure that effective communications remain central to the Board's operation, the following will be implemented immediately:

- The Council or Clinical Commissioning Croup's communications leads to attend Board meetings on an alternating basis
- A communications summary to be prepared after each meeting, incorporating messages that need to be fed back to individual organisations via Board members.

6. Financial implications

The main resource requirement is staff time to ensure the Communications Plan is developed and implemented, including maintenance of an up-to-date website. This can be managed by existing staff within the Council's Policy and Partnership Team, Public Health and Council and partner Communications Teams.

7. Equalities implications

The Communications Plan would need to ensure that messages reach all audiences and consider targeted initiatives for groups/communities that experience health inequalities or particular health problems.

8. Report authors

Michael Holmes, Policy and Partnership Officer, Rotherham MBC, telephone (01709) 254417; email: michael.holmes@rotherham.gov.uk

THIS PAGE HAS BEEN LEFT INTENTIONALLY BLANK

REPORT TO THE HEALTH AND WELLBEING BOARD
26th August 2015

Better Care Fund Partnership Framework Agreement Update

Report Sponsor: RCCG and RMBC

1. PURPOSE OF REPORT

The purpose of this report is to provide Board Members with an update on the performance of the Section 75 agreement and to request the Boards agree the submission of the Better Care Fund (BCF) Quarter 1 Performance Return to NHS England

2. RECOMMENDATIONS

It is recommended that:-

2.1 Members note the progress that has been made for the Rotherham BCF, including more integrated joint working between Health and Social care, and revised and strengthened governance for the BCF.

2.2 Members review the performance of the Better Care Fund plan for Rotherham during the last first quarter of 2015/6 as set out in Appendix 1. Members are asked to agree the submission of this report to NHS England on or before 28th August at noon

3. DISCUSSION

3.1 The Board last received an update on the Better Care Fund for Rotherham on 8th July 2015. At that time, the report detailed the last quarter's performance information, and presented a draft section 75 Partnership Framework Agreement which has provided the template for the Clinical Commissioning Group and Rotherham Council to work together to provide integrated services for the people of Rotherham.

3.2 Following the Health and Wellbeing Board's approval in July 2015, the Section 75 partnership framework agreement between Rotherham Clinical Commissioning Group and Rotherham MBC was signed, and is now working effectively.

3.3 Included within the Section 75 agreement was a new governance structure for the BCF. These new arrangements have been implemented and are working effectively. An additional development has been the creation of a " vision" group within the BCF Executive, which meets to explore further opportunities for health and social care integration.

3.4 The performance of the BCF and section 75 agreement is monitored by the Operations Group. Recent work has included a joint review on the BCF 13 – the

largest of the BCF work streams. The review has thus far highlighted some parallel but insufficiently linked projects, and areas for development. This review has now been extended to thoroughly review each element of funding within the BCF plan, to ensure there is greater strategic focus and prioritisation on earlier intervention, reducing non-elective emergency admissions, and on value for money. A report to the BCF operations group will be made next month.

The realignment of the baseline position on the performance metrics of 2014/5, when the BCF was in shadow format have been updated. This is in readiness for this year's start of the pay for performance element of the BCF, when the number of non-elective admissions will be measured.

3.5 The first quarter of the first year of the BCF has now been completed, and is attached at Appendix 1. The proforma was supplied by NHS England this month, and shows how Rotherham BCF is performing against metrics and National BCF conditions.

In general, performance in Rotherham has been close to target. Across the country localities have expressed concerns that NHS England has set submission dates for the BCF returns which require NHS data to be submitted before it has been validated. Accordingly, some slight adjustments, and especially to the number of non- elective admissions, may be needed in Quarter 2.

3.6 Further information on the Quarter 1 report shows that Rotherham has met in full four of the six National Conditions for the BCF, and still working on two conditions. Firstly, in relation to the national condition to have 7 day services, we continue to progress our plans to provide 7 day support from the hospital social work team; and have designated support to deliver this by April 2016. Secondly, the national condition requires the NHS number to be used as the primary identifier with health and social care IT systems. Current issues with the migration of social care data to a new database have caused delay, but it is expected this condition will be met in full before the end of the year.

3.7 Unrelated to current performance on the National Conditions, NHS England has offered all authorities the opportunity to bid for practical hands on technical or delivery assistance and support. It is suggested we bid for assistance and support with two of the six themes: "developing underpinning integrated datasets and information systems" and "Measuring success". Both of these themes would contribute to Rotherham's work on meeting National conditions. Requests for support are prioritised, but if allocated, the support is given at no cost to the authorities.

4. CONCLUSION / NEXT STEPS

4.1 The Health and Wellbeing Board is asked to endorse the quarterly format, and to ask officers to submit the return to NHS England on or before 28th August 2015.. This will ensure the locality meets the national conditions and requirements of the BCF, and does so within the timeframe for submission set by NHS England

Further reports will be brought to the Health and Wellbeing Board on the detail of the schemes funded within the BCF plan, according to the timetable in Appendix 2,

5. FINANCIAL IMPLICATIONS

5.1 The Budget for the BCF continues to be £23.9 million, There is a small overall underspend in Quarter 1, but there are plans on how it would be invested if the underspend persists.

6. CONSULTATION WITH STAKEHOLDERS

6.1 The BCF Operations group discussed and agreed the quarterly return attached at Appendix 1 on 17th August 2015. On 19th August 2015 the BCF Executive Group will also consider the document. Comments or proposed amendments from these groups will be shared with members at the Board meeting on 26th August 2015.

7. Appendices

7.1 Appendix 1- Rotherham Better Care Fund Quarter 1 report 2015/6

8. Background Papers

Section 75 Agreement Rotherham Better Care Fund

Officer Contacts: Keely Firth CFO, RCCG **Telephone No:** 302025
Officer Contacts: Lynda Bowen, RMBC **Telephone No** 07977 127771

Date: 17th August 2015

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 28th August 2015

This Excel data collection template for Q1 2015-16 focuses on budget arrangements, the national conditions, payment for performance, income and expenditure to and from the fund, and performance on local metrics. It also presents an opportunity for Health and Wellbeing Boards to register interest in support. Details on future data collection requirements and mechanisms will be announced ahead of the Q2 2015/16 data collection.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an explanation of any material variances against planned performance trajectories as part of a wider overview of progress with the delivery of plans for better care.

Content

The data collection template consists of 9 sheets:

Validations - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements- this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Non-Elective and Payment for Performance - this tracks performance against NEL ambitions and associated P4P payments.
5) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
6) Local metrics - this tracks performance against the locally set metric and locally defined patient experience metric in BCF plans.
7) Understanding support needs - this asks what the key barrier to integration is locally and what support might be required.
8) Narrative - this allows space for the description of overall progress on plan delivery and performance against key indicators.

Validations

This sheet contains all the validations for each question in the relevant sections.
All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 8 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This plays back to you your response to the question regarding Section 75 agreements from the 2014-15 Q4 submission and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously you can selection 'Not Applicable' this time.
If your previous submission stated that the funds had not been pooled via a Section 75 agreement, can you now confirm that they have?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track to be

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please provide a target date when you expect the condition to be met. Please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.
Full details of the conditions are detailed at the bottom of the page.

4) Non-Elective and Payment for Performance

This section tracks performance against NEL ambitions and associated P4P payments. The latest figures for planned activity and costs are provided along with a calculation of the payment for performance payment that should have been made for Q4. Three figures are required and one question needs to be answered:

Input actual Q1 2015-16 Non-Elective performance (i.e. number of NELs for that period) - Cell L12
Input actual value of P4P payment agreed locally - Cell D23
If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box
Input actual value of unreleased funds agreed locally

This section also requires indication of the area of spend that unreleased funds have been spent on for Q4 and Q1 using a drop-down list. If no funds were left unreleased then 'Not Applicable' should be selected.

5) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:
Planned and forecast income into the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual income into the pooled fund in Q1
Planned and forecast expenditure from the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual expenditure into the pooled fund in Q1

Figures should reflect the position by the end of each quarter. It is expected that planned income and planned expenditure figures for Q4 2015-16 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan.

6) Local metrics

This tab tracks performance against the locally set metric and locally defined patient experience metric submitted in approved BCF plans. In both cases the metric is set out as defined in the approved plan for the HWB and **the following information is required for each metric:**
Confirmation that this is the same metric that you wish to continue tracking locally
Confirmation of planned performance for each quarter of 2015-16 (against the metric being tracked locally - whether the same as within your plan or not)
Confirmation of actual performance for Q1 2015-16 (against the metric being tracked locally - whether the same as within your plan or not)
Commentary on progress against the metric and details of any changes to the metric including reference to reasons for changing

7) Understanding Support Needs

This asks what the key barrier to integration is locally and what support might be required in delivering the six key aspects of integration set out previously. This section builds upon the information collected through the BCF Readiness Survey in March 2015. HWBs are asked to:
Confirm which aspect of integration they consider the biggest barrier or challenge to delivering their BCF plan
Confirm against each of the six themes whether they would welcome any support and if so what form they would prefer support to take

There is also an opportunity to provide comments and detail any other support needs you may have which the Better Care Support Team may be able to help with.

8) Narrative

In this section HWBs are asked to provide a brief narrative on overall progress in delivering their Better Care Fund plans at the current point in time with reference to the information provided within this return.

Better Care Fund Template Q1 2015/16

Data collection Question Completion Validations

Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

Budget Arrangements

S.75 pooled budget in the Q4 data collection? and all dates needed
Yes

National Conditions

	1) Are the plans still jointly agreed?	2) Are Social Care Services (not spending) being protected?	3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	i) Is the NHS Number being used as the primary identifier for health and care services?	ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	6) Is an agreement on the consequential impact of changes in the acute sector in place?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" estimated date if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Comment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Non-Elective and P4P

Actual Q1 15/16	Actual payment locally agreed	Comments	Any unreleased funds were used for: Q4 14/15	Any unreleased funds were used for: Q1 15/16
Yes	Yes	Yes	Yes	Yes

I&E (2 parts)

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Please comment if there is a difference between the total yearly plan and the pooled fund
Income to	Plan	Yes	Yes	Yes	Yes	Yes
	Plan					
	Forecast	Yes	Yes	Yes	Yes	
	Forecast					
	Actual	Yes				
	Actual					
Expenditure From	Plan	Yes	Yes	Yes	Yes	Yes
Expenditure From	Plan					
	Forecast	Yes	Yes	Yes	Yes	
	Forecast					
	Actual	Yes				
	Actual					
	Commentary	Yes				

Local Metrics

	Same local performance metric in plan?	If the answer is No details				
	Yes	Yes				
	Plan	Plan	Plan	Plan	Actual	Actual
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16
Local performance metric plan and actual	Yes	Yes	Yes	Yes	Yes	Yes
Commentary	Yes					

	Same local performance metric in plan?	If the answer is No details				
	Yes	Yes				
	Plan	Plan	Plan	Plan	Actual	Actual
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16
Local patient experience plan and actual	Yes	Yes	Yes	Yes	Yes	Yes
Commentary	Yes					

Understanding Support Needs

Area of integration greatest challenge	Yes

	Interested in support?	Preferred support medium
1. Leading and Managing successful better care implementation	Yes	Yes
2. Delivering excellent on the ground care centred around the individual	Yes	Yes
3. Developing underpinning integrated datasets and information systems	Yes	Yes
4. Aligning systems and sharing benefits and risks	Yes	Yes
5. Measuring success	Yes	Yes
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Yes

Narrative

Brief Narrative
Yes

Cover and Basic Details
Q1 2015/16

Health and Well Being Board	Rotherham

completed by:	Karen Smith
E-Mail:	karen-nas.smith@rotherham.gov.uk
Contact Number:	01709 254870
Who has signed off the report on behalf of the Health and Well Being Board:	Commissioner Stella Manzie and Chris Edwards

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. Non-Elective and P4P	5
5. I&E	21
6. Local metrics	18
7. Understanding Support Needs	13
8. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:

Rotherham

Data Submission Period:

Q1 2015/16

Budget arrangements

Have the funds been pooled via a s.75 pooled budget?	Yes
If it has not been previously stated that the funds had been pooled can you now confirm that they have?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question which is pre-populated, the data is from the Q4 data collection previously filled in by the HWB.

National Conditions

Please select
Yes
No
No - In Progress

Selected Health and Well Being Board:

Rotherham

Data Submission Period:

Q1 2015/16

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a date **and** a comment in the box to the right

Condition	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Comment			
1) Are the plans still jointly agreed?	Yes		Rotherham HWB agreed a Section 75 partnership framework in April 2015, which established 2 pooled budgets and a revised governance framework.	1	1	1
2) Are Social Care Services (not spending) being protected?	Yes			1	1	1
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	No - In Progress	31/03/16	Our enabling service is successfully operating as a 7 day service. New resource has been procured to assist with the implementation of the workforce issues aligned to the achievement of 7 day working across our services. It is proving particularly challenging to identify and appoint staff who are suitably skilled and able to work at weekends	1	1	1
4) In respect of data sharing - confirm that:						
i) Is the NHS Number being used as the primary identifier for health and care services?	No - In Progress	31/03/16	Currently 3,500 records have an NHS no. recorded. Process commenced to obtain NHS no. for all current cases. However recent decision to replace the social care case management system has delayed work. Plan to use NHS no. as primary identifier as part of new system implementation.	1	1	1
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes		Tender documents for replacement social care system specified that this should support integration, particularly with NHS data spine service.	1	1	1
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes		The Information Governance toolkit has been submitted.	1	1	1
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes		There is always an accountable professional/practitioner once it has been identified that a person with eligible needs will be in receipt of a care package.	1	1	1
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes		When completing the BCF plan, the CCG and the Local Authority engaged with Healthwatch to discuss the planned change in service provision. Further discussion is ongoing to ensure Healthwatch continue to be active within the governance and implementation of the Rotherham BCF plan.	1	1	1

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Better Care Fund Revised Non-Elective and Payment for Performance Calculations

Selected Health and Well Being Board: Rotherham

	Baseline				Plan				Actual			
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
D. REVALIDATED: HWB version of plans to be used for future monitoring.	7,447	7,570	7,438	7,728	7,638	7,514	7,382	7,670	7,491	7,745		

	% change (negative values indicate the plan is larger than the baseline)	Absolute reduction in non elective performance	Total Performance Fund Available	Planned Absolute Reduction (cumulative) (negative values indicate the plan is larger than the baseline)				Maximum Quarterly Payment				Performance against baseline				Suggested Quarterly Payment				Total Performance fund	Total Performance and ringfenced funds	Q4 Payment locally agreed
				Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16			
D. REVALIDATED: HWB version of plans to be used for future monitoring.	-0.1%	-21	£0	-191	-135	-79	-21	£0	£0	£0	£0	-44	-175			£0	£0			£0	£5,303,000	£0

Which data source are you using in section D? (MAR, SUS, Other)	MAR	If other please specify	
Cost per non-elective activity	£1,490		

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Quarterly payment taken from above	£0	£0		
Actual payment locally agreed	£0	£0		

If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box (max 750 characters)	

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggest amount of unreleased funds	£0	£0		
Actual amount of locally agreed unreleased funds	£0	£0		

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Confirmation of what if any unreleased funds were used for (please use drop down to select):	Acute Care	Acute Care		

Footnotes:

Source: For the Baselines, Plans, data sources, locally agreed payment and cost per non-elective activity which are pre-populated, the data is from the Better Care Fund Revised Non-Elective Targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection previously filled in by the HWB. This includes all data received from HWBs as at 10am on 6th August 2015. Please note that the data has not been cleaned and limited validation has been undertaken.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Rotherham

Income

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£5,829,000	£5,829,000	£5,829,000	£5,829,000	£23,316,000	£23,316,000
	Forecast	£5,829,000	£5,829,000	£5,829,000	£5,829,000		
	Actual*	£5,829,000					

Please comment if there is a difference between the total yearly plan and the pooled fund	N/A

Expenditure

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£5,829,000	£5,829,000	£5,829,000	£5,829,000	£23,316,000	£23,316,000
	Forecast	£5,829,000	£5,829,000	£5,829,000	£5,829,000		
	Actual*	£5,829,000					

Please comment if there is a difference between the total yearly plan and the pooled fund	N/A

Commentary on progress against financial plan:	Some of our budgets have now changed against individual lines but the choreography between planning for 2015/16 and getting the original plan signed off was such that we took the judgement not to revisit the BCF budgets until 2016/17. This is intuitive to a piece of work currently being undertaken on the individual BCF objectives. It is likely that some of the schemes will change and budgets realigned.

Footnote:

Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a Q4 collection previously filled in by the HWB.

Local performance metric and local defined patient experience metric

Selected Health and Well Being Board:	Rotherham
Local performance metric as described in your approved BCF plan	Emergency readmissions < 30 days of hospital discharge (all ages) PHOF4.11NHSOF3b - NB. local variation to national measure, using patients registered with a Rotherham GP, not LA population.
Is this still the local performance metric that you wish to use to track the impact of your BCF plan?	Yes
If the answer is no to the above question please give details of the local performance metric being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local performance metric plan and actual	0	0	0	0	0	0		

Please provide commentary on progress / changes:	Please note plan and actual are shown as a percentage, but cannot change the format of the cells. Q4 2014-15 plan figure was the 2014-15 full year plan as this wasn't broken down into quarters.

Local defined patient experience metric as described in your approved BCF plan	Inpatient Experience: The proportion of people reporting a poor patient experience of inpatient care. (Average number of negative responses per 100 patients)
Is this still the local defined patient experience metric that you wish to use to track the impact of your BCF plan?	Yes
If the answer is no to the above question please give details of the local defined patient experience metric now being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local defined patient experience metric plan and actual:	123	0	0	123	0	0		

Please provide commentary on progress / changes:	Additional measure, in-patient survey done once a year, therefore no Quarter 1 2015-16 actual to report.

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

Support requests

Selected Health and Well Being Board: Rotherham

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan (please select from dropdown)?	3 Developing underpinning integrated datasets and information systems

Please use the below form to indicate whether you would welcome support with any particular area of integration, and what format that support might take.

Theme	Interested in support?	Preferred support medium	Comments - Please detail any other support needs you feel you have that you feel the Better Care Support Team may be able to help with.
1. Leading and Managing successful better care implementation	No	[redacted]	
2. Delivering excellent on the ground care centred around the individual	No		
3. Developing underpinning integrated datasets and information systems	Yes	Hands on technical or delivery support	Assistance with the implementation of the changes we would like to see would be appreciated. We are finding the software solutions are not easily aligned, and would welcome advice on how we can speed up our responses and our momentum
4. Aligning systems and sharing benefits and risks	No	[redacted]	
5. Measuring success	Yes	Hands on technical or delivery support	We would value assistance with identifying how to capture outcomes for patients/customers in specific projects using existing recording systems and databases and ensuring we avoid double counting.
6. Developing organisations to enable effective collaborative health and social care working relationships	No	[redacted]	

Narrative

Selected Health and Well Being Board:

Rotherham

Data Submission Period:

Q1 2015/16

Narrative	Remaining Characters	31,401

Please provide a brief narrative on overall progress in delivering your Better Care Fund plan at the current point in time with reference to the information provided within this return where appropriate.
Revised and strengthened governance is in place and working effectively. The newly formed Strategic Executive has recently decided the BCF plan for Rotherham is to be strengthened and extended to look at much greater integration of Health and Social Care services over the next five years. With this in mind, a newly formed Vision group has been developed comprising Strategic decision makers (Elected Members, Commissioners and the Chair of the Rotherham CCG). A paper detailing these proposals is to be developed by the autumn. The BCF plan has been subject to a thorough review in this quarter, and proposals are being developed to build on high performing schemes, and to refocus some schemes where performance is lower than expected, or where there has found to be overlap or lower than anticipated demand. A project plan is in place to strengthen reporting,and streamline metrics from the revised BCFschemes to improve overall performance of the BCF in acheiving fewer non-elective unplanned admissions this quarter and throughout the year. Elected members are particularly keen to see progress and development of the BCF schemes; and a series of 4 sessions (monthly between September 2015 and January 2016) with the Health Select Commission have been scheduled, for members to review in depth the individual schemes as well as the BCF plan as a whole.

ROTHERHAM BOROUGH COUNCIL – REPORT TO HEALTH AND WELLBEING BOARD

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**26 August 2015**
3.	**Title:**	**Rotherham Joint Health and Wellbeing Strategy**
4.	**Directorate:**	**Public Health**

5. Summary

5.1 The Health & Social Care Act (2012) requires Health and Wellbeing Boards to develop a Health and Wellbeing Strategy to set the overarching framework for health and care commissioning plans for Rotherham.

5.2 Rotherham's first Joint Health and Wellbeing Strategy ran from 2013-2015. This revised strategy will run from 2015 – 2018 and has been informed by stakeholder and public consultation events. The draft Joint Health and Wellbeing Strategy has been circulated to Board members, Advisory Cabinet, RMBC Assistant Directors, the Health Select Commission Chair and voluntary sector partners for comments.

6. Recommendations

6.1 That the Health and Wellbeing Board endorse the draft Health and Wellbeing Strategy.

7. Proposals and Details

7.1 Background

Health and Wellbeing Boards were introduced in the Health & Social Care Act (2012) to ensure a more joined up approach to plan how best to meet the health and wellbeing needs of the local population and tackle inequalities in health. It has a statutory duty to produce a Health and Wellbeing Strategy, which sets the local priorities for joint action and will inform commissioning decisions for health and wellbeing.

7.2 The draft Strategy for 2015-2018 sets out five key aims:

- All children get the best start in life
- Children and young people achieve their potential and have a healthy adolescence and early adulthood
- All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life
- Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing
- Rotherham has healthy, safe and sustainable communities and places

Each aim will be underpinned by a comprehensive action plan.

7.3 We are currently identifying a number of 'indicator bundles' and data sources that will help us measure progress. A sub-group of the Health and Wellbeing Board will be established to ensure delivery against the action plans.

7.4 We will consult on the draft Strategy prior to its final approval by the Health and Wellbeing Board. The proposed consultation timetable is below.

22 June*	Voluntary and community sector consultation session at Voluntary Action Rotherham
6 July	Discussion at Health Select Commission
20 July	Draft circulated to Health and Wellbeing Strategy Task and Finish Group
27 July	Informal consultation with Rotherham Clinical Commissioning Group and Rotherham Partnership Chief Executive Officer Group
3 August	Circulated to Health and Wellbeing Board and other partners for comments
24 August	Discussed at RMBC Senior Leadership Team
31 August	Draft discussed at Local Children's Safeguarding Board
14 September	Draft discussed at advisory cabinet
28 September	Final report signed off at Health and Wellbeing Board

* all dates indicate week commencing

8. Finance

8.1 Delivery of the Health and Wellbeing Strategy does not necessarily require any additional investment. Spending and commissioning decisions across the whole health and care system may change as a result of the identified priorities within the Strategy, but in the current climate this would be likely to be within existing financial envelopes.

9. Risks and Uncertainties

9.1 If the Health and Wellbeing Strategy is not approved by the end of 2015, Rotherham Health and Wellbeing Board will be in breach of its duty within the Health and Social Care Act (2012). The approval schedule we have established will ensure that the Strategy is approved by the end of September 2015 and can be published on the RMBC and partner websites before the end of 2015.

10. Policy & Performance Agenda Implications

10.1 The outcomes within the Health and Wellbeing Strategy are being aligned to key performance frameworks across health and social care. This will ensure that we can map action on the Strategy against progress in key performance indicators.

10.2 The Health and Wellbeing Strategy links to a number of other key Borough-wide strategies and plans including the Rotherham Improvement Plan, Rotherham Children's Improvement Board Action Plan, the Economic Growth Plan, Safer Rotherham Partnership Plan, Rotherham Housing Strategy, South Yorkshire Local Transport Plan and Rotherham CCG's Commissioning Plan.

11. Background Papers and Consultation

11.1 Health and Social Care Act (2012)
http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

Contact Names: Teresa Roche, Director of Public Health and Alison Iliff, Public Health Principal
Email: alison.iliff@rotherham.gov.uk
Telephone: 01709 255848

Rotherham Joint Health and Wellbeing Strategy

2015-2018 (draft – version 3)

Foreword

Health and wellbeing is important to everybody in Rotherham and enables people to live fulfilling lives and to be actively engaged in their community. The way individuals achieve good health will differ according to their experience, abilities and resources. Unfortunately, we know too many people in Rotherham are not in good health and that significant differences exist between our most and least deprived communities. It is only right, however, given Rotherham's situation that a key focus of the strategy is children and young people, but taking care not neglect other important aspects of health and wellbeing.

As our population grows and changes, health needs change and we need to ensure we are responsive to these changes and continue to offer services that provide high quality care and are accessible to all. We need to also ensure that we have a customer led focus in what we do.

Public sector finances are becoming increasingly stretched, which means that all partners on the Health and Wellbeing Board need to work together to find new ways to deliver services. We hope that this strategy will help to meet these challenges through a shared vision for the health and wellbeing in Rotherham.

The Health and Wellbeing Strategy provides a high level framework which will direct the Health and Wellbeing Board activity over the next three years; it will support the Board's role to provide leadership for health and wellbeing by making the most of our collective resources in the Borough. It doesn't, however, reflect everything we will consider as a Board or that the partners will deliver. It also identifies where the Health and Wellbeing Board can add value to existing strategies and plans for Rotherham. The Health and Wellbeing Strategy and the work of the Health and Wellbeing Board are about working together and I believe it is clear that the Board is now a real partnership, which can only be for the good.

The strategy contains some ambitious aims, but by working creatively, and working together, we feel that they are achievable and that we can make long-lasting changes that will improve health and wellbeing throughout Rotherham.

Cllr David Roche

Advisory Cabinet Member for Adult Social Care and Health and Chair of Rotherham Health and Wellbeing Board

1.0 Introduction

1.1 This is the second Health and Wellbeing Strategy for Rotherham, which has been produced in collaboration with Health and Wellbeing Board partners. This fulfils the duty set out in the Health & Social Care Act (2012) to set the overarching framework for health and care commissioning plans for Rotherham.

2.0 What do we mean by health and wellbeing?

2.1 Health is about feeling physically and mentally fit and well, whilst wellbeing considers whether people feel good about themselves and are able to get the most from life.

2.2 Health is not just about individuals, however, but also about populations. Population health considers how we respond to potential threats to our health, such as the impact of where and how we live our lives, and identifies how best to provide health services that are capable of meeting people's different needs[1].

2.3 People's experience of health and wellbeing is influenced by more than health and care services, and there are stark differences in the life expectancy of people living in the best and worst off parts of the borough. The quality of our built or physical environment, employment and socioeconomic status, housing, transport and access to green spaces are all wider determinants of our health and wellbeing. Black and Minority Ethnic communities generally have poorer health than the general population; whilst much of this difference can be explained by differences in socio-economic status a number of other factors also contribute, including lower take-up of healthcare, biological susceptibility to certain long-term conditions and the impact of racism and discrimination[2].

2.4 Local people can be supported to take responsibility for their health and wellbeing by having a good understanding of their own and their family's health status and the behaviour changes they can make to improve their health now or to prevent ill health developing in the future. Most health behaviours are determined during pregnancy, infancy, childhood and adolescence and by improving the health of children and young people we can start to influence the health and wellbeing of the wider population.

3.0 National context

3.1 *Fair Society, Healthy Lives: The Marmot Review* (2010) provides a framework for tackling health inequalities throughout a person's life. It provides evidence of the social gradient in health – the lower a person's social position, the worse his or her health. This social gradient

[1] Department of Health (2010). *Our Health and Wellbeing Today*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215911/dh_122238.pdf
[2] Parliamentary Office of Science and Technology (2007) Postnote: Ethnicity and Health
http://www.parliament.uk/documents/post/postpn276.pdf

in health is starkly apparent in Rotherham with significant differences in life expectancy between our most and least deprived areas. Attempting to reduce this gap, by focusing on raising the health status of the poorest fastest, will contribute to local NHS priorities to reduce the potential years of life lost as a result of ill-health.

3.2 Central to *Fair Society, Healthy Lives* is the life course approach. It recognises that disadvantage starts before birth and grows throughout life; therefore, the actions to tackle inequality in health also need to start before birth and continue through childhood and adolescence, working age and into retirement and later life.

3.3 The report highlights six policy objectives:

- Give every child the best start in life (FSHL1)
- Enable all children young people and adults to maximise their capabilities and have control over their lives (FSHL2)
- Create fair employment and good work for all (FSHL3)
- Ensure healthy standard of living for all (FSHL4)
- Create and develop healthy and sustainable places and communities (FSHL5)
- Strengthen the role and impact of ill health prevention (FSHL6)

Our Health and Wellbeing Strategy has been developed with these as guiding principles; the priorities we have identified will each link to one or more of Marmot's policy objectives.

3.4 The *Children and Families Act 2014* sets out the challenge for radical reform of services for children and young people. It seeks to improve services for vulnerable children and ensure that all children and young people can success, no matter what their background. Support for young people with a disability or a special educational need now receive support up to the age of 25. The cross-Government policy for young people aged 13-19 (25 for those with a disability or special educational need) *Positive for Youth*, sets out a shared vision for how partnership working can support families and improve outcomes for young people, particularly those who are most disadvantaged or vulnerable.

3.5 The Coalition Government announced the Better Care Fund in 2013. It redirects funding into a local single pooled budget between clinical commissioning groups (CCGs) and local authorities to drive closer integration and improve outcomes for people with health and care support needs. Local plans for how the fund will be used must be agreed by the Health and Wellbeing Board and signed off by the CCG and local authority.

3.6 The development of the Health and Wellbeing Strategy has taken two further key national policy documents into account: the *NHS 5-year Forward View* (October 2014) calls for a radical upgrade in prevention and public health, and The Care Act (2015), which aims to give people more control over their care and help people stay independent for longer.

4.0 Health and wellbeing boards and strategies

4.1 Health and Wellbeing Boards were introduced in the Health & Social Care Act (2012) to ensure a more joined up approach to plan how best to meet the health and wellbeing needs of the local population and tackle inequalities in health. The boards are managed by local authorities and bring together representatives from NHS commissioners, public health, adult and children's services, Healthwatch and elected members as the statutory board members. In Rotherham, the Health and Wellbeing Board also has representatives from Voluntary Action Rotherham, our NHS providers (Rotherham NHS Foundation Trust and Rotherham, Doncaster and South Humber NHS Foundation Trust), South Yorkshire Police and other key partners.

4.2 The Health and Wellbeing Board uses data from the Joint Strategic Needs Assessment (JSNA) and refers to other borough-wide strategies in the development of a Health and Wellbeing Strategy. This sets the local priorities for joint action and will inform commissioning decisions for health and wellbeing.

4.3 As partners we invest many millions of pounds in Rotherham which influence health and wellbeing, through investment in the economy, transport, housing and community safety as well as health and social care services, where Rotherham Clinical Commissioning Group (CCG) and the Council invest over £530m. The Health and Wellbeing Board has the opportunity to influence and challenge this investment. The current and future limits on resource require us to work more collaboratively than ever, integrating our commissioning of services to ensure that every pound spent in Rotherham on health and care supports improvements in health and wellbeing and the reduction of health inequalities. The Health and Wellbeing Board can support collaboration and integration, and has a role in breaking down barriers between agencies, focusing on getting the most out of the whole system.

5.0 How the strategy has been developed

5.1 In developing the Health and Wellbeing Strategy our aim is to identify outcomes based on strong evidence, stakeholder and public feedback, and specific areas where the Health and Wellbeing Board could have the biggest impact. We have identified specific criteria for each outcome showing what we would expect to see in the long term if the strategy is successful.

5.2 Rotherham's JSNA and Pharmaceutical Needs Assessment (PNA) provide a comprehensive and rigorous analysis of the issues that need to be considered when planning for the protection and improvement of the health and wellbeing of the people of Rotherham. The JSNA identifies the current and future health and wellbeing needs of the population, including differences in life expectancy within and between communities and the impact of ill health on the quality of life experienced by local people. It also recognises the importance of mental health and wellbeing, which is important for the resilience of individuals and communities, enabling people to take control of their health and health behaviours. The PNA outlines how pharmaceutical services can contribute to meeting the health needs of the population.

5.3 This Health and Wellbeing Strategy complements other local strategies:

- Rotherham CCG's Commissioning Plan
- Rotherham's Improvement Plan: *A Fresh Start*
- Children and Young People's Improvement Board Action Plan
- Better Care Fund plan
- Rotherham Economic Growth Plan
- Safer Rotherham Partnership Plan
- Rotherham's Local Plan
- Joint Commissioning Plan – Children and Young People
- Child Sexual Exploitation (CSE) Delivery Plan
- Emotional and Wellbeing Strategy

It adds value, capacity and resources to the current strategic priorities for the borough and reflects the priorities of local people and stakeholder organisations.

5.4 In drafting the strategy we have also taken into account views from stakeholder events with partners from the statutory and voluntary sectors within Rotherham and, via Healthwatch, from patients and the public. We have also considered the feedback from RMBC's Commissioner Roadshows. A consultation process for the draft strategy has also taken place; the timeline for this can be found at Appendix 1.

Table 1: Rotherham – at a glance[3] [to be presented as an infographic]

- The health of people in Rotherham is generally poorer than the England average
- Life expectancy for men and women is lower than the England average and is 9 years lower for men and 7 years lower for women in the most deprived areas of Rotherham compared to the most affluent areas
- Rotherham's population is changing:
  - the number of older people is increasing and people will live longer with poorer health
  - our Black and Minority Ethnic community is changing, with a higher proportion of younger people and a growing Roma community
- Deprivation is higher than average and more than 11,000 children live in poverty

- 11,700 people in Rotherham are economically inactive (neither in work nor looking for a job or available for work) due to long-term sickness
- 9.6% of benefit claimants in Rotherham are claiming Employment Support Allowance, Incapacity Benefit or disability-related benefits.
- 4060 people in Rotherham receive benefits due to their role as a carer
- Household incomes in Rotherham are lower than the Yorkshire and Humber and UK average
- 9% of homes are in fuel poverty with some localised rates near 24%

- Rotherham's breastfeeding rate is amongst the lowest in the region – contributing to levels of

[3] Public Health England (2015) *Health Profiles*

childhood obesity and paediatric hospital admissions

- 18.3% of mothers smoke during pregnancy. Smoking in pregnancy contributes to increased risk of stillbirth, low birthweight and neonatal deaths.
- 23.4% of children leaving primary school are obese.
- 5.9% of 16-18 year olds in Rotherham are not in employment, education or training, compared to 4.7% nationally
- 1550 people aged 15-24 in Rotherham were newly diagnosed with a sexually transmitted infection in 2013. This is a higher rate than the England average.

- Nearly 3 in 10 adults in Rotherham are obese (28.5%) – worse than the average for England
- 1688 hospital admissions in Rotherham during 2013/14 could be attributed to alcohol
- 35.1% of the Rotherham population are estimated to drink at a level that puts their health at risk, of which 8.9% (17,996 people) are causing themselves actual harm
- An estimated 18.9% of adults in Rotherham smoke
- There are nearly 500 smoking related deaths each year in Rotherham – significantly higher than the England average
- On average, one in four people will have mental health problems at some point in their lives.

Table 2: There have been some notable improvements in health and wellbeing in Rotherham over recent years[4]. Good progress doesn't mean, however, that we don't have more to achieve.

School readiness (children achieving a good level of development at the end of reception year) and GCSE achievement are now better than national averages.

The rate of under-18 conceptions in the borough has reduced and is now the same as the England average.

Smoking rates have been falling and we now have our lowest ever adult smoking rate. Smoking during pregnancy has reduced quicker than in any of our comparator local authorities following changes to how the service was delivered five years ago.

Rotherham's healthy weight framework to address overweight and obesity is recognised nationally as an example of best practice.

More people are having routine vaccinations and cancer screening in Rotherham than the national average.

Rotherham's performance on opiate users leaving treatment successfully has improved significantly from being one of the lowest in the country to above the national average.

Excess winter deaths have seen a significant reduction and are now below the England average.

[4] Public Health England (2015) *Health Profiles*

6.0 How we will use the strategy

6.1 The Health and Wellbeing Strategy places particular emphasis on a shared vision and leadership for improving health and care services. We will use the strategy to develop action plans that we are all signed up to, to hold each other to account and to use our resource collectively to deliver the best outcomes for Rotherham.

6.2 We have identified five key aims with associated objectives where we will look for improvement in order to demonstrate progress. This is not a final list of everything that the board and partners will do, but a set of the most pressing health and wellbeing priorities for Rotherham.

6.3 Health and Wellbeing Board members are responsible for a wide range of services that impact on health and wellbeing, and the board and strategy will also influence the direction of other strategies and plans, including planning and development, transport and economic growth. The Health and Wellbeing Strategy provides a framework for commissioning plans for the council and CCG and specifically for the development of the Better Care Fund proposals and for joint commissioning of services to ensure seamless, effective and efficient service delivery. The areas where the strategy will add weight include early help services, mental health and wellbeing, special educational needs and disability, 0-19 services, support for carers and young carers, housing and the local planning framework.

6.4 There is also an explicit relationship between the local and sub-regional partnership structures providing opportunities to influence wider determinants including air quality and economic investment.

7 Managing and monitoring the strategy

7.1 We will monitor progress on the strategy by focusing on the impact it will have on people's lives. We have identified a number of indicators and data sources for each aim that will help us measure progress.

7.2 We will establish a sub-group of the Health and Wellbeing Board that will act as an 'engine room' and make the strategy happen. It will ensure that the indicators we have selected are the best to demonstrate improvement and will seek out new guidance and evidence that could help us deliver the aims most effectively. The sub-group will have representation from Rotherham Healthwatch to help us ensure, through a process of managed public engagement, that we keep the needs of the Rotherham population at the heart of our work.

7.3 The major changes that are being sought in this strategy will take time and we expect to see gradual, but measurable, improvements.

7.4 The Health and Wellbeing Board will use its strategic influence with other key groups, such as Rotherham Together Partnership's Chief Executive Officers Group, to ensure that all partners are contributing to delivering the strategy through:

- Regular performance reports from the sub-group
- Publishing an annual 'healthcheck' on progress

8 Rotherham Health and Wellbeing Strategy Aims 2015-2018

8.1 We have identified five key aims for Rotherham that can best be tackled by a "whole system" approach, where we need the involvement of the whole health and care system to achieve improvement. We have used five questions in selecting the aims:

- Is there more that can be done to tackle this issue?
- Is it an issue that is amenable to intervention?
- Is the delivery of this issue important to all partners on the Health and Wellbeing Board?
- Is it of strategic importance?
- Would this issue lead to considerable impact across the borough, or to one of our vulnerable target groups?

8.2 Each aim will be underpinned by a comprehensive action plan. There are a number of supporting principles that will apply consistently across these action plans:

- To reduce health inequalities we need to ensure that the health of our most vulnerable communities, including those living in poverty and deprivation and those with mental health problems, learning or physical disabilities, is improving the fastest.
- Prevention of physical and mental ill-health should be our primary aim, but where it is already an issue, we should intervene early to maximise the impact of services for individuals and communities
- We will work with individuals and communities to increase resilience and enable people to better manage and adapt to threats to their health and wellbeing, using an asset-based approach that values the capacity, skills, knowledge, connections and potential within communities
- Integrating our commissioning of services wherever possible to support improvements in health and wellbeing and the reduction of health inequalities
- We need to ensure pathways are robust, particularly at transition points (e.g. from children and young people's services into adult services), to be sure that nobody is left behind
- All services need to be accessible and provide support to the right people, in the right place, at the right time

9. Aim 1: All children get the best start in life

9.1 Objectives:

- Improve emotional health and wellbeing for children and young people
- Improve health outcomes for children and young people through integrated commissioning and service delivery
- Ensure children and young people are healthier and happier

9.2 Why this is an issue?

9.3 All aspects of our development – physical, emotional and intellectual – are established in early childhood. Development in the early years (including in the womb) can have a lifelong impact on health and wellbeing, educational achievement and economic status. By placing an increased focus on health and wellbeing in those early years we hope that all Rotherham children will be able to fulfil their potential.

9.4 Early Help describes a range of interventions to identify and respond to individual needs and prevent these escalating into complex and costly issues at a later point. Delivered through partnership working across health and social care, and using a single assessment to target the early help offer, we will prevent the need for social care interventions and secure better outcomes for children, young people and their families. Early help spans a wide age range (0-19 years, or up to 25 years if the individual has a disability or special educational need) and has a critical role to play in the key transition points in a child's journey from dependence to independence.

9.5 We have, on average, more than 3,000 births in Rotherham each year and around 16,000 children aged 0-4 years. Too many of these children are not currently getting the best start in life.

9.6 The percentage of children living in poverty in Rotherham is higher than regional and England averages, with 11,320 children and young people aged 0-16 living in families whose income is less than 60% of median income (2012). Child poverty influences educational achievement (by the age of three, poorer children are estimated to be nine months' behind children from more wealthy backgrounds – and this gap continues throughout the educational stages) and health, with children in poverty almost twice as likely to live in poor housing and be affected by fuel poverty[5].

9.7 More than 500 babies are born every year in Rotherham to mothers who smoke or drink alcohol during pregnancy. These children are at significant risk of preventable health conditions and developmental delay.

9.8 Breastfed babies have fewer chest and ear infections, fewer gastrointestinal problems, are less likely to become obese and therefore of developing obesity-related problems in later life, and are less likely to develop eczema. It is therefore a concern that fewer babies in Rotherham are being breastfed and for a shorter a time than the England average.

9.9 Rotherham has higher than regional and national average levels of tooth decay in both 3 and 5 year olds, with 3 year olds having the poorest oral health in South Yorkshire. The most common dental diseases (tooth decay and gum disease) can cause pain and infection and lead to tooth loss, disruption to family life and absence from education.

[5] Child Poverty Action Group http://www.cpag.org.uk/content/impact-poverty

9.10 Rotherham Health and Wellbeing Board will:

- Work with Rotherham's Children and Young People's Improvement Board to maximise the health impact of their action plan
- Reduce the long-term ill-health implications of child poverty through supporting the implementation of Rotherham's Early Help strategy, working with families with multiple and complex needs.
- Engage with early years services in developing parenting skills and capacity, which will in turn support improvements in health and wellbeing in the early years
- Review and strengthen pathways to ensure services are delivering high quality interventions as required by the Healthy Child programme.
- Commission an integrated public health service for children and young people aged 0-19 that ensures a seamless pathway across key transitions and focuses the most intensive support on our most vulnerable children and young people.
- Ensure all pregnant mothers who smoke receive consistent specialist advice on the risks to the pregnancy and their baby and high quality stop smoking support for those who wish to quit.
- Ensure all new mothers receive accurate and consistent information and support to facilitate breastfeeding.

Table 3: Did you know?

In 2015 Broom Valley Community School won a Healthy School Good Practice Award for their oral hygiene campaign, which engaged staff, parents and children across the whole school. Practical sessions were combined with curriculum activity and presentations to parents. Parents have registered their children with a dentist and some children have attended their first dental appointment as a result of the campaign. Links with the oral health outreach team ensure parents who lacked confidence in making the changes receive additional support.

Healthy Schools Rotherham

10. Aim 2: Children and young people achieve their potential and have a healthy adolescence and early adulthood

10.1 Objectives:

- Reduce the number of young people at risk of child sexual exploitation
- Reduce the number of young people experiencing neglect
- Reduce the risk of self-harm and suicide among young people
- Increase the number of young people in education, employment or training
- Reduce the number of young people who are overweight and obese
- Reduce risky health behaviours in young people

10.2 Why this is an issue?

10.3 Whilst tackling inequalities in health needs focused action from the start of life and in the early years, the commitment needs to be maintained throughout childhood and adolescence. We need to provide good education and healthcare, and opportunities for good work and training in order to support young people to thrive. In common with all the priorities, whilst we need to ensure these are available for all children and young people within the borough, we must focus on those children and young people who are most vulnerable: those who are looked after, those with mental health problems, physical and learning disabilities and those from our most deprived communities.

10.4 This is a key period for developing individual resilience: developing a sense of purpose and self-esteem, becoming emotionally aware, taking responsibility for your own physical and emotional needs and being connected to others. Resilience enables children and young people to cope with the challenges they face and to contribute positively within their community.

10.5 The risk of child sexual exploitation (CSE) must remain at the forefront of all our plans. Health services can be well placed to identify early signs of exploitation and we must ensure that all staff have robust training in how to spot the signs and know how to respond. Young people who have been victims of CSE need access to high quality support for their emotional wellbeing.

10.6 Neglect, or the ongoing failure to meet a child or young person's basic needs, can have serious and long-lasting effects on physical and mental wellbeing. Young people who have been neglected are more likely to experience mental health problems including depression and post-traumatic stress disorder. In addition, these young people may be more likely to take risks, such as running away from home, using drugs or alcohol, or getting involved in dangerous relationships which, in turn, makes them vulnerable to sexual exploitation.

10.7 We must ensure that the Health and Wellbeing Board's work complements Rotherham's Children and Young People's Services Improvement Board action plan and contributes to the achievement of the vision for Children and Young People's Services.

10.8 Educational development and attainment are generally good in Rotherham; more children achieve a good level of development at the end of reception year and more young people achieve 5 or more GCSEs at grades A*-C (including English and maths) than the England average. However, by age 16-18 our young people are beginning to struggle, with a higher number not in education, employment or training than the England average.

10.9 During adolescence young people become more independent. With this increasing autonomy they may experiment with risk-taking behaviours. They may try alcohol, tobacco and other substances, and may become sexually active. Modelled estimates suggest 10% of 15 year olds in Rotherham smoke regularly (daily or weekly), which is higher than the England estimate. Alcohol-specific hospital admissions for under 18s, however, are significantly better in Rotherham than the England average (29.1 per 100,000 under 18 year olds in Rotherham, compared to 40.1 per 100,000 for England).

10.10 Self-harm, when somebody chooses to inflict pain on themselves, might be used because people think it will relieve tension or anxiety or to help them gain control of issues that are worrying them. Research suggests that nationally around 10% of 15-16 year olds have self-harmed. Self-harm is more common in young women, although it is on the increase among young men. Self-harm can sometimes indicate that a young person may be at risk of suicide[6]. An awareness of the signs of self-harm and suicidal thoughts is essential if we are to be able to respond to these vulnerable young people quickly and effectively. There is further discussion of mental and emotional wellbeing for people of all ages in Aim 3.

10.11 Childhood is an important time in the development of obesity, as levels more than double between Reception (aged 4-5 years – 9.7% obese, similar to the England average) and Year 6 (aged 10-11 years – 23.4% obese, higher than the England average). There will be many contributing factors to this increase: lifestyle and diet choices of the children, their parents, their school, and the local environment. School stay-on-site policies have been shown to reduce the consumption of unhealthy food during the school day.[7]

10.12 In Rotherham we have a higher diagnosis rate of new sexually transmitted infections (STIs) than the England average. Care needs to be taking in interpreting this data, however, as higher diagnosis rates may not necessarily indicate that more young people have STIs than in other areas, but may reflect local services that are accessible and young people friendly.

10.13 Rotherham Health and Wellbeing Board will:

- Work with Rotherham's Children and Young People's Improvement Board to maximise the health impact of their action plan

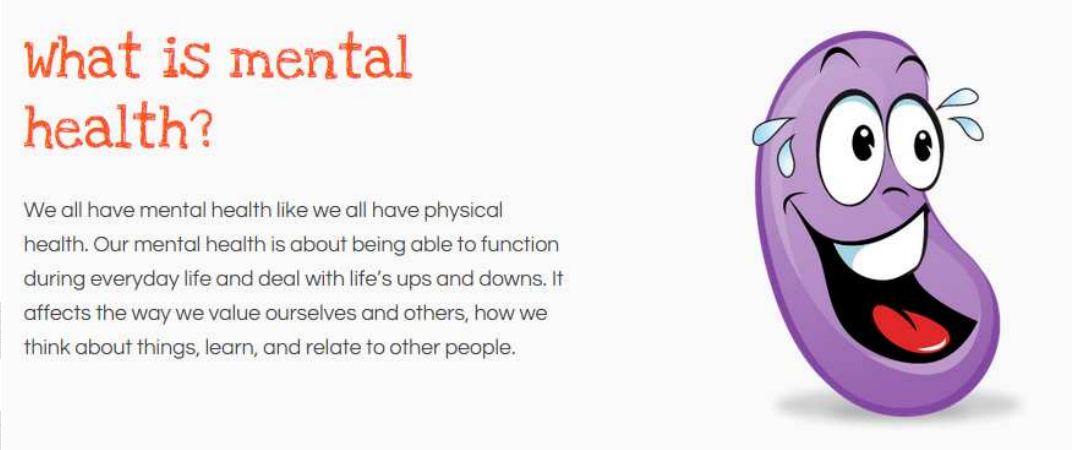
[6] http://www.youngminds.org.uk/for_children_young_people/whats_worrying_you/self-harm/what_self-harm

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

- Review and strengthen pathways to ensure services are delivering high quality interventions as required by the Healthy Child programme.
- Commission an integrated public health service for children and young people aged 0-19 that ensures a seamless pathway across key transitions and focuses the most intensive support for our most vulnerable children and young people
- Deliver on the actions in the Rotherham Sexual Health Strategy Delivery Plan
- Involve and engage young people with our work programme, for example through holding joint meetings with Rotherham Youth Cabinet
- Engage more closely with schools and colleges on the health and wellbeing agenda through cluster meetings, personal social and health education (PSHE) leads meetings and governor training and development

Table 4: Did you know?

mymindmatters.org.uk has been launched to provide information and support to children and young people, parents, carers and practitioners in Rotherham on mental health and emotional wellbeing. Taking a one-stop-shop approach, as well as separate sections for children (Wellbeenz) and young people, there is also information and practical advice for parents and professionals to ensure the whole community around the child or young person can respond appropriately and with confidence.



11. Aim 3: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life

11.1 Objective:

- Improve support for people with enduring mental health needs, including dementia, to help them live healthier lives
- Reduce the occurrence of common mental health problems
- Reduce social isolation

11.2 Why this is an issue?

11.3 Mental health problems can affect anybody at any age. It is estimated that one in four of us will suffer from mental health problems at some point in our lives. Half of those with lifetime mental illness (excluding dementia) first experience symptoms by the age of 14, and three-quarters by their mid-20s[8]. It is vital that positive mental and emotional wellbeing is a priority at every age. Therefore the actions identified within this aim apply across the life course.

11.4 Mental health problems are the biggest cause of illness and incapacity in the borough and are related to deprivation, poverty and inequality. People with long term mental health problems are also more likely to live in the most disadvantaged sections of society. Austerity and socioeconomic insecurity increase the risk factors for poor mental health[9], particularly for those on low income and those who face loss of income and/or housing. In Rotherham the underlying economic determinants of mental health are worse than the national average.

11.5 Communities that lack social support and social networks are less likely to experience positive mental health and wellbeing. For young people, the most common mental health problems are depression, anxiety and misuse of alcohol and other drugs, with one young person in ten experiencing some form of problem with their emotional and mental health in the course of a year. Older people are especially vulnerable to feelings of isolation as a result of the loss of friends and family, limited mobility or income that comes with age. Social isolation and loneliness is associated with mental health problems and can result in increased use of emergency healthcare and earlier admission to residential care. We need to ensure our communities are resilient communities, with the right services, facilities and infrastructure to enable people to confront and cope with life's challenges.

11.6 Another consequence of our ageing population is the increasing number of people living with dementia. By the age of 90, around 30% of people will be living with dementia. On average, people live for around seven years after the onset of symptoms and two years after diagnosis. Most people with dementia live at home, supported by family, neighbours, mainstream health services and the community. The impact of dementia on carers' physical and mental health must also be taken into account.

[8] The World Health Report (2001). *Mental Health – New Understanding, New Hope*. World Health Organisation, Geneva
[9] WHO (2011) Impact of economic crises on mental health

11.7 In recent years suicide rates nationally have increased following several years over which there had been a steady decline. Locally Rotherham has also seen an increase in the number of death registrations classified as suicides/deaths of undetermined intent. These deaths fell sharply between 2008 and 2010 but have increased between 2010 and 2013. Rotherham's suicide rate for 2011-13 is virtually the same as the England average.

11.8 The latest suicide prevention strategy for England[10] and a recent report from The Samaritans[11] have both identified middle aged men, especially those from poorer socioeconomic backgrounds as one of the high risk groups who are a priority for suicide prevention. Our experience of suicide in Rotherham has tended to follow national trends.

11.9 Rotherham Health and Wellbeing Board will:

- Ensure our work embeds action to promote mental wellbeing, build individual and community resilience and prevent and intervene early in mental health problems
- Deliver on the actions in the Rotherham suicide prevention and self-harm action plan
- Identify, coordinate and promote initiatives to address social isolation, working in partnership with local voluntary, community and faith sector organisations
- Review and strengthen pathways between health and social care to ensure nobody can fall through gaps in the system
- Ensure all users of mental health services have equality of access to health services and behaviour change services to support them to live healthy lives
- Require all our mainstream health services to undertake mental health awareness training and to become dementia friendly services

Table 5: Did you know?

The Rotherham Less Lonely campaign aims to reduce social isolation for the borough's older residents through a range of activities. These range from lunch clubs to one-to-one befriending to providing transport for an older person to attend a social group.

Rotherham Less Lonely receives no statutory funding, but through partnership working with statutory and voluntary sector organisations and with support from committed volunteers it is making a real difference to many of the 4,000 people in Rotherham who said they feel lonely every day of their lives.
www.rotherhamlesslonely.org

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

12. Aim 4: Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing

12.1 Objectives:

- Reduce the number of early deaths from cardiovascular disease and cancer
- Improve support for people with long term health and disability needs to live healthier lives
- Increase the opportunities for participation in physical activity
- Reduce levels of alcohol-related harm
- Reduce levels of tobacco use

12.2 ***Why this is an issue?***

12.3 Life expectancy and healthy life expectancy in Rotherham are lower than average for both men and women. Within Rotherham, life expectancy is 9 years lower for men and 7 years lower for women in the most deprived areas of the borough compared to the most affluent areas.

Table 6:

2011-2013	Life expectancy at birth	Healthy life expectancy at birth
Rotherham men	78.1 years	57.1 years
England average	79.4 years	63.3 years
Rotherham women	81.4 years	59 years
England average	83.1 years	63.9 years

[this table will be displayed as a graph in the printed version, which demonstrates the gap in a visual manner]

12.4 This inequality in health leads to almost 7,000 years of life being lost each year in Rotherham through causes considered amenable to healthcare. This is almost 1,500 years more than might be expected based on the England average.

12.5 The main drivers of the excess years of life lost in Rotherham are problems of the circulation (principally stroke and ischaemic heart disease), respiratory disease and cancer. Tackling premature mortality will require a coordinated approach from all members of the Health and Wellbeing Board.

12.6 Our concern should not, however, be just about extending life: it should also cover the factors that contribute to healthy life expectancy. The difference in health life expectancy means that people in Rotherham develop poor health around 5 or 6 years earlier than the average for England. This disability burden has significant implications for public services locally, on the need for health and social care and for employment opportunities. This is because, on average, people in Rotherham will develop long term conditions around 8 years before the new state pension age of 67. This means more working age people living with

long term conditions such as heart disease, diabetes, dementia, chronic mental health disability and surviving after cancer treatment.

12.7 The actions we are recommending through the early years, childhood and adolescence will all contribute to increasing life expectancy and healthy life expectancy, but we also need to focus on those who are already in adulthood, or who may have already developed long term conditions. The link between good work and health is particularly important here: being in work is, in itself, good for physical and mental health, but for those people of working age who may have a long term condition, we need to ensure employers continue to support them to have a fulfilling working life. Economic growth within Rotherham will play its part in reducing health inequalities.

12.8 The risk of early death and disability from the three main contributors to the years of life lost in Rotherham can be effectively reduced by reducing levels of overweight and obesity, increasing levels of physical activity, not smoking, and limiting alcohol consumption. It must be recognised that individual behaviour change is difficult and needs support. A multifactorial approach that addresses all risk factors yields most benefit. This is because tackling multiple risk factors in individuals has a cumulative effect in reducing the chance of death. Screening programmes and health assessments such as the NHS Healthcheck programme provide early identification of certain conditions and can enable referral into effective treatment programmes.

12.9 We need to ensure that people who have a long-term condition or disability and those with mental health problems receive the **right care in the right place at the right time**. Too many people are admitted to hospital unnecessarily and are kept in hospital for too long as the services to support them on discharge are taking too much time to put in place. We need to increase access to health services in the community and to reduce the proportion of care that occurs in hospital. Work to support the most vulnerable to remain independent for as long as possible is required across health and social care, as is high quality support for their friends and family who provide unpaid care. The impact of the Better Care Fund should be felt most by these Rotherham residents.

12.10 People approaching the end of their life are entitled to high quality care, wherever that care is delivered. Good end of life care should be planned with the individual and the people close to them to ensure it is tailored to their needs and wishes and includes management of symptoms, as well as provision of psychological, social, spiritual and practical support. We need to ensure that more people in Rotherham are able to exercise choice over their end of life care and the place of their death.

12.11 Rotherham Health and Wellbeing Board will:

- Ensure effective pathways are in place into screening and behaviour change services to help reduce premature mortality
- Ensure integrated commissioning and delivery across all health, social care and community organisations to deliver effective support for people with long term conditions, physical and

learning disabilities and mental health problems so that people receive the right care in the right place at the right time

- Support the delivery of Rotherham's Economic Growth Plan to increase the opportunities for residents to access good work, housing, transport and green space
- Actively participate in Rotherham's multi-agency strategy groups tackling the behavioural contributors to preventable ill-health to deliver quantifiable improvements in overweight and obesity and smoking prevalence

Table 7: Did you know?

Voluntary Action Rotherham runs a social prescribing service to help people with long term conditions access a variety of services and activities provided by local voluntary organisations and community groups. Funded by Rotherham Clinical Commissioning Group, the service sees staff from the health and voluntary sectors working with colleagues in social care to establish a coordinated care plan for people with long term conditions to improve quality of life and reduce the risk of hospital admissions.

www.varotherham.org.uk

13. Aim 5: Rotherham has healthy, safe and sustainable communities and places

13.1 Objectives:

- Develop high quality and well-connected built and green environments
- Increase the number of residents who feel safe in their community
- Reduce crime and antisocial behaviour in the borough
- Ensure planning decisions consider the impact on health and wellbeing
- Increase opportunities for people in Rotherham to use outdoor space for improving their health and wellbeing

13.2 Why this is an issue?

13.3. As previously discussed, health is influenced by more than just the healthcare we receive. The physical environment in which we live, work and spend our leisure time and how safe we feel in our communities also impacts on health outcomes.

13.4 The quality of housing, the condition of streets and public places, noise, access to green space and levels of antisocial behaviour and crime contribute to inequalities in health. Tackling these wider determinants of health will also benefit the sustainability and economic growth agenda through the promotion of active travel, public transport, energy efficient housing and increasing access to green space, as well as supporting the other aims within this strategy. For example, through community regeneration programmes we can also help to reduce social isolation and increase community resilience.

13.5 A healthy economy leads to a healthy community; it offers good jobs, incomes and opportunities which increase aspiration and, therefore, health and wellbeing. Equally, healthy, resilient people are better able to contribute to their local community, secure a better job and be more productive in the workplace, supporting a healthy economy.

13.6 Planning decisions can have significant impact on health and wellbeing. Ensuring buildings and public spaces are designed in a way that enables people to be more physically active, or using planning levers to limit the growth of fast food takeaways, for example, can contribute to the broader effort to reduce growing levels of overweight and obesity. Encouraging a vibrant high street with diverse local and independent food traders can increase choice and access to healthy, fresh food for all. Planting regimes can reduce noise pollution from major roads and improve air quality for local residents. Rotherham's Local Plan has a clear objective to create safe and healthy communities and to engage health services in key planning decisions.

13.7 Poor housing costs the NHS at least £2.5 billion a year in treating people with illnesses directly linked to living in cold, damp and dangerous homes[12]. Cold homes and poor housing can have a negative impact on physical and mental health and wellbeing and may ultimately result in excess winter deaths. Associated health inequalities can occur across the life course, from early years through to the frail elderly population.

13.8 An increasingly older population, living longer with long term conditions and disability, will require more homes with adaptations to enable them to continue with a good quality of life and to maximise their independence.

13.9 Rotherham Health and Wellbeing Board will:

- Work in partnership to maximise the health impact of:
  - Rotherham's Local Plan
  - Rotherham's Housing Strategy 2013-2043
  - Rotherham's Economic Growth Plan
  - Safer Rotherham Partnership Plan
  - South Yorkshire's Local Transport Plan

13.10 Appendix 2 contains tables indicating how this strategy will complement other key borough-wide plans.

Table 8: Did you know?

Rotherham led the work to develop national guidance and resources around cold home: Winter Warmth England. Partners including the NHS, RMBC, emergency services and voluntary sector organisations worked together to ensure that older people whose health might be at risk due to a cold home receive clear, correct, consistent and useful advice and information from local services who support them.

www.winterwarmthengland.co.uk

[12] Local Government Association (2014). Healthy Homes, Healthy Lives
http://www.local.gov.uk/documents/10180/5854661/L14+-+85+Housing+and+Health+case+studies_14.pdf/b4620ef6-87bc-4e12-964a-5cbd4433dd47

14. What we want for the future

14.1 We hope that this strategy will help to build the individual, community and economic resilience needed to enable Rotherham people to make positive choices that maintain and improve their health and wellbeing. Its delivery relies on a shared commitment from Health and Wellbeing Board members, but also from a wider range of partners – statutory and community organisations as well as individuals – to working collaboratively, shifting resources from treatment to prevention and focusing on improving the health and wellbeing of our most vulnerable communities the fastest.

14.2 The actions plans that will accompany this strategy will be living documents, regularly reviewed and updated in light of new and updated local strategies and national guidance. We will ensure that these plans also reflect ongoing feedback from Rotherham residents obtained through ongoing consultation with individuals and community groups.

14.3 If you would like to get involved in the delivery of this strategy, please contact:

Public Health: Alison Iliff	Alison.iliff@rotherham.gov.uk	01709 255848
Policy and Partnerships: Michael Holmes	Michael.holmes@rotherham.gov.uk	01709 254417
Rotherham CCG: Ian Atkinson	Ian.atkinson@rotherhamccg.nhs.uk	01709 302000

Table 9

[NB: some details within the indicator bundle still being collated]

Aims	Objectives	Indicator bundle	Reporting mechanism	Frequency of reporting
1. All children get the best start in life *Link to Marmot policy objective FSHL1*	• Improve emotional health and wellbeing for children and young people • Improve health outcomes for children and young people through integrated commissioning and service delivery • Ensure children and young people are healthier and happier	Free school meals Yr 3 upwards		
		Breastfeeding a) % of all mothers who breastfeed their babies in the first 48hrs after delivery b) % of all infants due a 6-8 week check that are totally or partially breastfed	a) PHOF 2.02i (data source: NHS England) b) PHOF 2.02ii (data source: NHS England)	Quarterly
		Children aged 5 years with one or more decayed, filled or missing teeth	CHIMAT Child Health Profile (data source: National Dental Epidemiology Survey)	Annual
		School readiness a) % children achieving a good level of development at the end of reception b) % children achieving the expected level in the phonics screening check	PHOF 1.02i and 1.02ii (data source: 1.02i DfE EYFS Profile statistical series; 1.02ii Department for Education Teacher Assessments: Phonics screening check statistical series)	Annual
		Low birth weight of term babies	PHOF 2.01 (data source: Office for National Statistics)	Annual

2. Children and young people achieve their potential and have a healthy adolescence and early adulthood *Links to Marmot policy objectives FSHL1, FSHL2*	• Reduce the number of young people at risk of child sexual exploitation • Reduce the number of young people experiencing neglect • Reduce the risk of self-harm and suicide among young people • Increase the number of young people in education, employment or training • Reduce the number of young people who are overweight and obese • Reduce risky health behaviours in young people	% 16-18 year olds not in education, employment or training	PHOF 1.05 (data source: Department for Education)	Annual
		education, health and care plans completed		
		Emotional wellbeing of looked after children: Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31 March.	PHOF 2.08 (data source: Department for Education)	Annual
		Reduced suicide and self-harm: a) Hospital admissions caused by unintentional and deliberate injuries (0-14 and 15-24 years) b) Hospital admissions for mental health conditions (0-17 years) c) Hospital admissions as a result of self-harm (10-24 years)	a) PHOF 2.07i and 2.07ii (data source: PHE Knowledge and Intelligence Team (South West)) b) CHIMAT Child Health Profile (data source: Hospital Episode Statistics) c) CHIMAT Child Health Profile (data source: Hospital Episode Statistics)	a) Annual b) Annual c) Annual
		Health assessments for looked after children		
		Number of children and young people presenting at risk of CSE		

		Number of children and young people presenting with neglect		
		School attainment at key stages 2 and 4		
3. All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life *Links to Marmot policy objectives FSHL3, FSHL4, FSHL5, FSHL6*	• Improve support for people with enduring mental health needs, including dementia, to help them live healthier lives • Reduce the occurrence of common mental health problems among adults • Reduce social isolation	Social isolation a) % of adult social care users who have as much social contact as they would like b) % of adult carers who have as much social contact as they would like	a) PHOF 1.18i / ASCOF 1Ii (data source: Adult Social Care Survey) b) PHOF 1.18ii / ASCOF 1Iii (data source: Personal Social Services Survey of Adult Carers in England)	Annual
		Suicide rate	PHOF 4.10 (data source: Public Health England, based on ONS source data)	Annual
		Excess under 75 mortality rate in adults with serious mental illness	PHOF 4.09 (data source: HSCIC)	Annual
		Estimated diagnosis rate for people with dementia	PHOF 4.16 (data source: HSCIC)	Annual
		Rate of domestic abuse incidents recorded by the police per 1,000 population	PHOF 1.11 (data source: Crime Statistics, Focus on Violent Crime and Sexual Offences. ONS)	Annual

		Social care-related quality of life a) Service users b) carers	a) ASCOF 1A (service user) (data source: Adult Social Care Survey) b) ASCOF 1D (carer) (data source: Survey of Adult Carers in England)	a) Annual b) Biennial (next scheduled 16/17)
4. Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing *Links to Marmot policy objectives FSHL3, FSHL4, FSHL6*	• Reduce the number of early deaths from cardiovascular • Improve support for people with long term health and disability needs to live healthier lives disease and cancer • Reduce levels of alcohol-related harm • Reduce levels of tobacco use	Potential years of life lost considered amenable to healthcare	NHSOF 1.1 (data source: Primary Care Mortality Database via Health and Social Care Information Centre)	Annual
		Proportion of older people (65+) still at home 91 days after discharge into rehabilitation	Better Care Fund metric. ASCOF 2Bi (data source: Adult Social Care Combined Activity Return (ASC-CAR))	Annual
		Non-elective first finished consultant episodes	Better Care Fund metric (data source: Unify 2, Department of Health)	Monthly
		Delayed transfers of care from hospital per 100,000 population (number of days delayed)	Better Care Fund metric (data source: NHS England)	Monthly
		Emergency readmissions within 30 days of discharge from hospital	Better Care Fund metric (data source: The Rotherham NHS Foundation Trust)	Monthly
		Permanent admissions of older people (aged 65+) to residential and nursing care homes, per 100,000	Better Care Fund metric ASCOF 2A part 2 (data source: Adult Social Care Combined Activity Return (ASC-CAR) and ONS)	Monthly
		% deaths not in hospital	End of Life Care group local metric (data source: ONS)	Quarterly

5. Rotherham has healthy, safe and sustainable communities and places *Links to Marmot policy objective FSHL5*	• Develop high quality and well-connected built and green environments • Increase the number of residents who feel safe in their community • Reduce crime and antisocial behaviour in the borough • Ensure planning decisions consider the impact on health and wellbeing • Increase opportunities for people in Rotherham to use outdoor space for improving their health and wellbeing	Fuel poverty	PHOF 1.7 (data source: Department for Energy and Climate Change)	Annual
		Fear of crime	South Yorkshire Police Q5 (data source: Your Voice Counts Survey)	Annual
		Proportion of service users who feel safe	ASCOF 4A (data source: Adult Social Care Survey)	Annual
		• ***?overcrowding*** • ***?HRA / housing framework*** (RMBC Adults Performance discussing housing metrics with colleagues)		
Behaviour change indicator bundle that impact across the life course and upon all aims		Overweight and obesity a) % of children aged 4-5 classified as overweight or obese b) % of children aged 10-11 classified as overweight or obese c) % adults classified as	a) PHOF 2.06i (data source: HSCIC - National Child Measurement Programme) b) PHOF 2.06ii (data source: HSCIC - National Child Measurement Programme) c) PHOF 2.12 (data source: Active People Survey, Sport	Annual

		overweight or obese	England)	
		Reduce smoking prevalence a) % women who smoke at time of delivery b) Smoking prevalence at age 15 – current smokers and regular smokers c) Prevalence of smoking among persons aged 18 years and over	a) PHOF 2.03 (data source: HSCIC) b) PHOF 2.09i and 2.09ii (data source What About YOUth (WAY) Survey) c) PHOF 2.14 (data source: Integrated Household Survey)	a) Quarterly b) Annual c) Annual
		% of people using outdoor space for exercise/health reasons	PHOF 1.16 (data source: Natural England: Monitor of Engagement with the Natural Environment (MENE) survey)	Annual

List of abbreviations:

PHOF: Public Health outcomes Framework

NHSOF: NHS Outcomes Framework

ASCOF: Adult Social Care Outcomes Framework

PHE: Public Health England

HSCIC: Health and Social Care Information Centre

ONS: Office for National Statistics

CHIMAT: Child and Maternal Health Intelligence Network

FSHL: *Fair Society, Healthy Lives*

Appendix 1: Draft strategy consultation timeline

20 July*	Draft circulated to Health and Wellbeing Strategy Task and Finish Group
27 July	Informal consultation with Rotherham Clinical Commissioning Group and Rotherham Together Partnership Chief Executive Officer Group
3 August	Circulated to Health and Wellbeing Board and other partners for comments
17 August	Discussed at RMBC Senior Leadership Team
31 August	Draft discussed at Local Children's Safeguarding Board
7 September	Draft discussed at advisory cabinet
28 September	Final report signed off at Health and Wellbeing Board

* all dates indicate week commencing

Document is Restricted