HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 25th November, 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 (Pages 1 - 16)
   Minutes of meeting held on 26th August and notes of meeting held on 30th September, 2015

7. For Information (Pages 17 - 18)
   Opportunity for Board Members to report any issue that may be of interest

8. Health and Wellbeing Strategy (Pages 19 - 24)
   - Terri Roche, Director of Public Health, and Alison Illif, Public Health Specialist, to report

9. Better Care Fund (Pages 25 - 80)
   - Chris Edwards, Rotherham CCG, and Jon Tomlinson, RMBC, to report

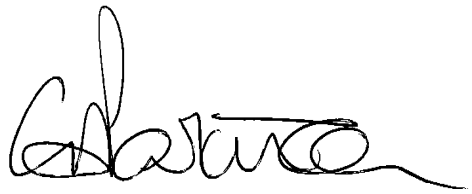
10. Suicide Prevention and Self-Harm Action Plan Update (Pages 81 - 111)
    - Ruth Fletcher-Brown, Public Health Specialist, to report

11. CQC Inspection Action Plan for Rotherham NHS Foundation Trust (Pages 112 - 119)
    Tracey McErlain-Burns and Lisa Reid, Rotherham Foundation Trust to present
    Board Members may wish to view the action plan in advance of the meeting: http://www.therotherhamft.nhs.uk/About_us/CQC_Accreditation/

12. Adult Social Care Vision and Strategy (Pages 120 - 126)
    - Professor Graeme Betts, Interim Director of Adult Care and Housing, to report

13. Date, time and venue of the next meeting
    (1) Extra Meeting – Wednesday, 13th January, 2016 at 2.00 p.m.

    (2) Wednesday, 24th February, 2016, at 9.00 a.m.



CATHERINE A. PARKINSON
Interim Director of Legal and Democratic Services.

HEALTH AND WELLBEING BOARD
26th August, 2015

Present:-

Councillor David Roche	Advisory Cabinet Member (Adult Social Care and Health) **(in the Chair for Minute Nos. 13-19)**
Dr. Julie Kitlowski	Vice-Chair, Rotherham Clinical Commissioning Group **(in the Chair for Minute Nos. 20-24)**
Stephen Ashley	Safeguarding Children's Board
Lynda Bowen	Public Health, RMBC
Sue Cassin	Rotherham Clinical Commissioning Group
Sarah Farragher	Health and Wellbeing, RMBC
Ruth Fletcher-Brown	Public Health, RMBC
Jason Harwin	South Yorkshire Police
Michael Holmes	Policy Officer, RMBC
Shafiq Hussain	Voluntary Action Rotherham
Alison Iliff	Public Health, RMBC
Gordon Laidlaw	Rotherham Clinical Commissioning Group
Stella Manzie	Commissioner and Managing Director, RMBC
Zena Robertson	NHS England (Yorkshire and Humberside)
Teresa Roche	Director of Public Health
Councillor Stuart Sansome	Chair, Health Select Commission
Kathryn Singh	RDaSH
Ian Thomas	Interim Strategic Director, Children and Young People's Services, RMBC
Councillor Gordon Watson	Deputy Leader
Conrad Woreham	Rotherham Foundation Trust
Councillor Taiba Yasseen	
Chris Bland	(Observer)
Councillor John Turner	

Apologies for absence were received from Louise Barnett (Rotherham Foundation Trust), Graeme Betts (Adult Social Services, RMBC), Tony Clabby (Healthwatch Rotherham), Chris Edwards (Rotherham Clinical Commissioning Group), Tracey McErlain-Burns (Rotherham Foundation Trust) and Janet Wheatley (Voluntary Action Rotherham).

13. DECLARATIONS OF INTEREST

Shafiq Hussain (Voluntary Action Rotherham) declared a personal interest at the meeting in relation to Minute No. 15 due to a family member working at the organisation concerned.

14. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no questions from members of the press and public present.

15. SUPPORTING BME WOMEN IN ROTHERHAM

Stella Manzie referred to the recent press coverage relating to Apna Haq, an organisation in Rotherham that for a number of years had provided floating support services. Unfortunately the organisation had been unsuccessful in securing a contract during the recent re-tendering exercise. The Council was confident that it had been a fair process and all tender submissions scrutinised very closely. Consideration was being given to possible alternative provision which the organisation may be able to provide.

16. MINUTES OF THE PREVIOUS MEETING

Resolved:- That the minutes of the meeting held on 8th July, 2015, be approved as a correct record.

The Chairman drew attention to the following matters :-

(a) Street Play – Board Members had been invited to a Health and Wellbeing Seminar to be held in Leeds on 21st September, 2015 by Play England.

The objective of the seminar was to support Health and Wellbeing and Transport stakeholders from across the North to understand how Street Play was helping to achieve Public Health outcomes in the community. The project was growing with residents in 35 local authority areas now being supported to activate Street Play in their community and more than 300 streets closed by residents for street play sessions every week in England.

(b) CaMHS were currently implementing its Transformation Plan and would need to be signed off by the Board and the CCG. The Board would hopefully do this at its 30th September meeting

(c) The British Medical Association had issued a press release on 10th August regarding GP numbers and recruitment in the context of introducing 7 day working.

The Health Select Commission had carried out a Scrutiny Review on Access to GPs (Minute No. 10 of 8th July refers). Councillor Sansome, Chair of the Select Commission, offered to circulate a copy of the Commission's final report to Board members.

Julie Kitlowski reported that Jacqui Tuffnell, Primary Care Co-Commissioning Team, was to attend a future Board meeting and present the CCG Strategy on how to attempt to manage this serious problem both

nationally and locally. The Strategy would talk about how other professionals could/should be used to step into the workforce until the appropriate number of GPs were trained/recruited. Rotherham in theory, in terms of numbers, was not under number.

A wider issue the Board ought to consider was how to make Rotherham a more attractive place to live and work not just for GPs but Public Health professionals, teachers, social workers etc.

(d) A letter had been drafted to the Local Government Association in relation to their offer for support on health and social care (Minute No. 11 of 8th July refers). The Chair and Vice was to meet with the Systems Specialist Group in September.

(e) It was noted that the Adult Social Services Working Party had arranged a series of visits including North-East Lincs and Barnsley to see good practice. An invitation to join the visits had been extended to the Health Select Commission and to Board members.

(f) It was noted that consultation on Drugs and Alcohol Public Expenditure had commenced with details on the website. Terri Roche would ascertain if partners had been notified of the revised timetable.
(Following the meeting it was established that consultation would be commencing with key stakeholders on 7th September which would include Board members, the Safer Rotherham Partnership, providers of Drugs and Alcohol Services in Rotherham, GPs, Pharmacists, LMC and LPC members, Service User Forum, Commissioning Group members and members of the Recovery Hub Management Group.

The consultation would focus upon the proposal to commission a Recovery Service that combined the current Service with the Peer Mentor Service, making efficiencies with that integration and the proposal to reduce shared care provision in Primary Care for drug users by the amalgamation of up to 11 practices (48 patients) into the remaining 17 practice clinics.

Stakeholders would receive an e-mail with a link to further information and an online survey to complete. The consultation was for 12 weeks (up to the end of November). As the on-line element was being managed by the Website Team, reminders would be issued to those who had not accessed the initial e-mail periodically.)

(g) Gordon Laidlaw would ascertain that details of the Choose Well campaign had been provided to the South Yorkshire Police emergency response telephone operators.

17. CARE QUALITY COMMISSION

Rotherham NHS Foundation Trust

Sue Cassin, Rotherham Clinical Commissioning Group, reported on the findings of the Care Quality Commission (CQC) following their inspection visit to the Rotherham NHS Foundation Trust between 23rd and 27th February, 2015.

The Trust had 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 had agreed a detailed and comprehensive action plan to address the findings and recommendations. The CCG would monitor compliance through monthly contract quality meetings and any items of concern/escalation would be forwarded to the CCG's Operational Executive to be taken up with the Foundation Trust's Board.

Zena Robertson reported that she had attended the CQC Risk Summit following publication of the report. The CQC had stated they had been encouraged at the openness and transparency of the Trust in terms of engaging with them in the inspection as well as their willingness and speed in which they put some of the mitigation around the areas that had been picked up.

Discussion ensued on the bringing of action plans together in general with the following issues raised:-

- There would be targeted themed inspections with Ofsted leading the inspections through the emerging themes of CSE and Missing and would inform the inspection regime

- Following from the Robert Francis report, NHS England had been charged to establish Quality Assurance Groups bringing Regulators, Healthwatch, commissioners together to get a view of the whole picture. Discussions were ongoing with the CCG to revamp the South Yorkshire Group due to the changes in health and social care and would look much more at care homes, Children's Services, vulnerable adults. The Group would benefit from Local Authority attendance

- The Board may be the most appropriate forum for partners' to bring their plans to facilitate a strategic discussion and partner engagement

- Compilation of a complete schedule of inspection regimes across all partners to understand the linkages and reporting arrangements

Resolved:- (1) That the arrangements for Rotherham CCG to provide assurance that the Rotherham Foundation Trust implemented changes based upon the findings of the Care Quality Commission be noted.

(2) That regular updates be submitted on progress against the plan.

(3) That the action plan be circulated to Board members and be included on the November agenda.

The Role of Health Services in Safeguarding and Looked after Children Services in Rotherham

Sue Cassin, Rotherham Clinical Commissioning Group, reported on the findings of the recent CQC review of Services for Children Looked After and Safeguarding held between 23rd and 27th February, 2015.

The CQC had tracked 84 individual cases where there had been Safeguarding concerns including 8 that had undergone a multi-disciplinary chronology denoting healthcare delivery. It looked at the pathway of the child through the system and tried to look very carefully at different pathways of different children in the system.

Each partner organisation in response to the inspection report developed their own very comprehensive action plans which fed into the overall action plan to address the CQC's 24 recommendations, some of which applied to all partner agencies and some to individual partner agencies.

A Task and Finish Group had been established prior to the visit to prepare/work closely together and had continued post-inspection to ensure the action plan addressed all of the recommendations. Each action had a lead officer and each agency organisation had their own Task and Finish Group reviewing their own actions in detail.

Terrie Roche reported that there had been many comments made by the CQC which had not formed part of the recommendations that were also being taken forward.

It was agreed that Stella Manzie discuss with Michael Holmes the appropriate reporting mechanism for inspections.

18. HEALTH AND WELLBEING BOARD COMMUNICATIONS

Further to Minute No. 10(1) (Access to GPs Scrutiny Review), Michael Holmes presented a report proposing the development of a Board Communications Plan based broadly on:-

- 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
- 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

The Health and Wellbeing Partners website 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. It could also feature Public Health and other campaigns relevant to health and wellbeing as well as blogs and other interesting content.

To ensure effective communication remained central to the Board's operation, the following would be implemented immediately:-

- The Council or Clinical Commissioning Group's communication leads to attend Board meetings on an alternating basis
- A communications summary to be prepared after each meeting incorporating messages that needed to be fed back to individual organisations via Board members and also key messages to the public about the Board that would go on the website or be publicised by the communication leads

It was also highlighted that:-

- The Choose Well brand/strapline was not being phased out due to the national Winter Campaign coming on board "Right Care First Time". The aim of the new campaign was getting people to the right place for attention at the first attempt particularly in light of the new Emergency Care Centre opening next year. Work was taking place with the voluntary sector on getting the message out as well as a proposal put together for the Behaviour Campaign to understand why people attended where they did for medical attention

- Involvement of the Planning Department regarding new housing developments and the need for the provision of new GP practices in a timely manner rather than waiting for the whole development to be completed

- The need to ensure there was no duplication of information on websites

- The website should be "added value"

- Messages should be kept simple

Resolved:- (1) That the outline Communications Plan be endorsed.

(2) That the Health and Wellbeing partner website be further developed and utilised as a central plank of Board communications.

(3) That a communications summary be prepared after each Board meeting with clear messages for all Board members to disseminate within their respective organisations/departments.

19. CHILD SEXUAL EXPLOITATION (CSE) IN ROTHERHAM

The Chairman reported that it was the anniversary of the publication of the Jay report. Some very good and positive work had been done in the last year and things were moving forward.

Ian Thomas concurred that there was a lot to celebrate but there was still a lot more to do. It had only been since the Commissioners had joined the Council in February that work had had a chance to be started. This work had included:-

- The CSE Team was now stronger and there was also a multi-agency team with Police, Barnardos and Health colleagues which was managing 73 cases at the current time, of a total of 2,300 across the service.
- New working protocols agreed with the Police
- Establishment of a Multi-Agency Risk Assessment Panel
- New governance arrangements in place that had led to improvements and how to manage operations
- Operation Clover was delivering results, as well as 4 other live operations that were not in the public domain as yet, which reflected different levels of complexity
- Taxi Licensing was much more robust
- An Ofsted visit had recently occurred to look at Services in terms of improvement and audited 6 cases across Social Care. 1 of the cases had been a CSE case and rated Good which was testament of the ongoing work
- Council had given over £500K to the voluntary sector to support victims and survivors, also partners have invested to respond to CSE
- A further £262K had been made available in the voluntary sector from the Ministry of Justice to help those people coming forward where they needed counselling and support
- 300 people supported through the above contracts
- Successful in securing DfE Innovation Funding of £1.2M across the sub-region to recruit specialist foster carers for children who experienced or were at risk of suffering CSE
- £3.1M funding for an Outreach Project – Barnardos to replicate much of what was good about the former Risky Business project

Jason Harwin gave the following update:-

- Operation Clover – so far 8 people had been charged with over 109 offences
- Over the last 12 months 54 had been charged with offences in South Yorkshire, 11 with multiple offences and 22 in Rotherham
- Abduction Notices was a tool in the Police's armoury – 36 had been issued in the last 6 months
- Linkages with survivors – once the criminal proceedings had been concluded there would be the opportunity to offer services

Resolved:- That the update be noted.

The Chair vacated the Chair at this point.

The Vice-Chair assumed the Chair.

(Julie Kitlowski in the Chair)

20. BETTER CARE FUND QUARTERLY MONITORING RETURN AND PROGRESS UPDATE

Lynda Bowen presented an update on the performance of the Section 75 Partnership Agreement and the proposed submission of the Better Care Fund Quarter 1 Performance Return to NHS England for consideration.

Since the update to the 8th July Board meeting:-

- Section 74 Partnership Agreement signed and working effectively

- Implementation of governance structure as well as the creation of a "vision" group within the BCF Executive which met to explore further opportunities for health and social care integration

- Joint review of BCF13 which had highlighted some parallel but insufficiently linked projects and areas for development. The review had now been extended to thoroughly review each element of funding to ensure greater strategic focus and prioritisation on earlier intervention, reducing non-elective emergency admissions and on value for money

- Realignment of the baseline position on the performance metrics of 2014/15

- The first quarter of the first year of BCF had now been completed (Appendix 1 of the report submitted) with performance close to target. Rotherham had met in full 4 of the 6 National Conditions and still working on 2 conditions:-

- 7 day services – continued progress on plans to provide 7 day support from the Hospital Social Worker Team and had designated support to deliver by April, 2016
- Requirement for 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 had caused delay but the condition was expected to be met in full before the end of the year

– Concern had been expressed across the country that NHS England had set submission dates for the BCF returns which required NHS data to be submitted before validation. Some slight adjustments may be needed in Quarter 2 particularly with regard to the number of non-elective admissions

NHS England had offered all authorities the opportunity to bid for practical hands-on technical or delivery assistance and support. It was proposed that Rotherham bid for assistance and support with 2 of the 6 themes – "developing underpinning integrated datasets and information systems" and "measuring success". Both would contribute to Rotherham's work on meeting national conditions.

Resolved:- (1) That the progress made including more integrated joint working between Health and Social Care and revised/strengthened governance for the Better Care Fund, be noted.

(2) That the submission to NHS England by the 28th August, 2015, deadline be approved.

21. ROTHERHAM'S NEW HEALTH AND WELLBEING STRATEGY 2015-2018

Alison Iliff, Public Health Specialist, presented the draft revised Health and Wellbeing Strategy which would run from 2015-2018 and had been informed by stakeholder and public consultation events.

It had 5 key aims each underpinned by a comprehensive action plan:-

– 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

A number of 'indicator bundles' and data sources were currently being identified which would help measure progress. A sub-group of the Health and Wellbeing Board was to be established to ensure delivery against the action plans.

The draft Strategy had been amended to incorporate comments received which included:-

- Reference to National Policy re. Children and Young People's Services
- Clear and explicit linkages between aims 2 (children and young people achieve their potential and have a healthy adolescence and early adulthood) and 3 (all Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life)
- Increased focus on early help, child neglect and how they related to CSE
- Underpinning principal around community resilience and harnessing assets in the local community

Consultation on the draft Strategy would take place prior to its final approval with the final sign off week beginning 28th September.

It was felt that the focus on mental health was critical. The Youth Cabinet had identified it as 1 of their primary priorities going forward and its known links to CSE, suicides and bullying.

The workshop style Board meeting on 30th September would hopefully provide the "so what" to the Strategy before its final sign off.

Resolved:- That any final comments on the draft Health and Wellbeing Strategy be conveyed to Alison Iliff by 4th September.

22. EXCLUSION OF THE PRESS AND PUBLIC

Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 2 of Part 1 of Schedule 12A to the Local Government Act 1972 (as amended March 2006) (information likely to reveal the identity of individuals).

23. SUICIDE PREVENTION AND SELF-HARM PLAN UPDATE

Ruth Fletcher-Brown, Public Health Specialist, presented an update on the incidents of suicides and self-harm in the Borough from January-July, 2015.

The work and training that had taken place was highlighted.

Discussion ensued on the need for a Community Response Plan for Adults and the gap in the bereavement pathway for adults when a suicide occurred.

It was noted that a further report was to be submitted to the November Board meeting.

Resolved:- That the report be noted.

24. DATE, TIME AND VENUE OF THE NEXT MEETING

Resolved:- That a further meeting be held on Wednesday, 30th September, 2015, commencing at 9.00 a.m. at Voluntary Action Rotherham.

Rotherham Health and Wellbeing Board
30th September 2015
The Spectrum (Voluntary Action Rotherham)

In attendance:

Board members (including substitutes)

Cllr David Roche (chair)
Stella Manzie (Rotherham MBC)
Chris Edwards (Rotherham Clinical Commissioning Group)
Richard Cullen (Rotherham Clinical Commissioning Group)
Janet Wheatley (Voluntary Action Rotherham)
Ian Thomas (Rotherham MBC)
Terri Roche (Rotherham MBC)
David Clitheroe (Rotherham Clinical Commissioning Group)
Jason Harwin (SY Police)
Catherine Singh (Rotherham Doncaster and South Humber NHS Foundation Trust)
Tracey McErlain-Burns (Rotherham NHS Foundation Trust)
Zena Robertson (NHS England)

Observers / support staff

John Deffenbaugh (consultant / facilitator)
Michael Holmes (Rotherham MBC)
Alison Iliff (Rotherham MBC)
Judith Wild (NHS England)
Karen Shaw (Rotherham NHS Foundation Trust)
Cllr John Turner

Apologies:

Julie Kitlowski (Rotherham Clinical Commissioning Group)
Cllr Gordon Watson
Cllr Taiba Yasseen
Graeme Betts (Rotherham MBC)
Tracy Holmes (Rotherham MBC)
Gordon Laidlaw (Rotherham Clinical Commissioning Group)

Minutes

At Cllr Roche's request, it was agreed that the agenda order be changed so that the general board items could be considered prior to the facilitated workshop session on the health and wellbeing strategy (item 3).

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

Cllr Roche mentioned that Dame Carol Black had visited Rotherham on 24th September and had been very impressed with services such as the Rotherham Institute of Obesity.

4. Local transformation plan for children and young people's mental health and wellbeing

Chris explained that the plan would set out how partners will utilise an additional £360,000 per annum from NHS England for CAMHS (child and adolescent mental health services) activity.

Due to the tight timescales, with submission due in mid-October, it was proposed that the board delegates the chair and vice-chair to sign off the plan. In the meantime, Rotherham Clinical Commissioning Group (CCG) will continue to work with partners, particularly RMBC and RDaSH (Rotherham Doncaster and South Humber NHS Foundation Trust), to finalise the plan. Chris can provide further details as required.

The board agreed to delegate approval to the chair and vice-chair.

5. Rotherham CCG commissioning plan

Chris talked through the paper. The CCG will send the draft plan to all partners for feedback in October, with the final plan to be produced early next year following the NHS spending review in December.

6. Access to GPs scrutiny review

Cllr Roche explained that at a recent council meeting the board had been criticised for taking too long to respond to the access to GPs review and for not taking a strong enough line in relation to missed GP appointments. It was suggested, for example, that the board should encourage the GPs to send appointment reminders.

It was clarified that the facility already exists to send text reminders, but it requires patients to sign-up in advance. Further discussion on GP appointments revealed that even appointments booked on the day are missed frequently, with younger people (i.e. under the age of 35) the worst offenders for missed appointments generally. It was noted that people missing appointments may often have complex problems and Jason wondered whether it was possible to share information on them in order to intervene and provide support where possible.

Cllr Roche thanked members for the information and agreed to feedback to the health select commission.

3. Health and wellbeing strategy

Cllr Roche summarised the process of developing and consulting on the new health and wellbeing strategy for 2015-18. Ian asked whether the number of women who drink alcohol during pregnancy could be included as a measure. Tracey confirmed that the question is asked during the ante-natal period, but there is no national target

so we don't have comprehensive statistics. However, Tracey agreed to investigate whether a measure could be identified.

The Rotherham Joint Health and Wellbeing Strategy 2015-18 was approved by the board. Chris pointed out that it was critical for all partners to now ensure that their strategic plans align with the new strategy.

Workshop session

John facilitated the workshop session, which was split broadly into two parts:

i. A "big picture" discussion reflecting on the board's recent progress and the major issues it faces in ensuring the strategy is delivered successfully
ii. Thoughts on the mechanics of overseeing and delivering the strategy via the board

Key points are summarised below.

i. Big picture

Group discussion feedback

- Loneliness/isolation major contributing factor to poor health and wellbeing
- Services can be efficient **and** caring; services should be seamless with people able to easily access the appropriate service
- Reduced inequalities and more opportunities for young people
- Equity of provision/outcomes (e.g. GP capacity in deprived areas and attracting GPs to Rotherham generally)
- All services need to work more effectively with primary care to tackle underlying problems
- Observed that the health and wellbeing board has good engagement from all members and that members are able to look beyond their discrete areas of responsibility
- Key issues include: childhood obesity, long-term limiting illness, investing in social capital (positive impact on mental health)
- A long-term goal should be to have more involvement in this agenda from children and young people
- Maintain focus on long-term outcomes despite short-term pressures
- Change mindset from treating people to providing care and to self-care
- Social prescribing – evaluation demonstrates its effectiveness and savings to the whole health economy so roll-out more widely
- Discourage older people from retiring and encourage them to design life around the things they enjoy doing. Having a fulfilling vocation will improve health and wellbeing.
- Celebrate successes (e.g. Rotherham Institute of Obesity) more widely and loudly
- Focus on the approach – all members able to explain clearly what the board is trying to do – consistent messages
- Be clear about the added value of the board, given that some of the detailed discussions – e.g. on Better Care Fund – will happen elsewhere. The board needs to be aware, but then to support and challenge rather than duplicating.

Plenary

- Strategy is only as good as partners' will to operationalize it.
- Strength of relationships between partners remains critical

- Partners will have to accept that sometimes doing things for the greater good will come at the expense of their individual organisations
- Increasing imperative to make the best use of resources - maximise the public sector pound
- Shift from producer driven to customer driven approach – citizens having more influence, but also taking more personal responsibility
- What leverage does the board have to make things happen?
- Arrangements in Rotherham – i.e. coterminosity of council/CCG – should make it comparatively easy to function effectively as a partnership
- Having the right culture throughout organisations is crucial in ensuring strategic decisions made at board level are implemented quickly and effectively
- Where possible, use existing groups to take forward specific pieces of work, but need to demonstrate tangible progress. Where something new is required, be clear about how best to utilise time and resources – focus on the things we don't do well and be able to evidence improvements.

ii. Delivering the strategy
Group discussion feedback
- The body overseeing strategy aims 1 and 2 (both of which are children and young people focused) could be the children and young people's trust, with Ian Thomas feeding back through the "engine room"
- Aims 3-5 ("aspirations for life") should then have a non-council lead
- The people driving the strategy need to have the right 'clout' and influence
- Use existing groups/meetings as far as possible rather than creating additional bureaucracy
- Identify common issues in JSNA (joint strategic needs assessment) and other evidence sources and work out how best to address and measure improvement in a consistent way without duplicating. Identify what we are doing well.
- Use information better – possibly "make every contact count" approach to getting out the message on "right care, first time"
- See people as an asset – don't let older people's skills and knowledge go to waste
- Look at people holistically and provide multi-agency packages of support with more use of community-based and VCS services
- Mental health and wellbeing of adults is particularly critical as it will also impact on parenting / children's development
- Focus on vulnerable people and loneliness
- Having task groups for the aims can stifle discussion – better to have a collective discussion via the "engine room" or workshops
- Need to lose any "territorial" perspective and instead make decisions in the best interest of local people, even at the expense of individual organisations
- Integrated health and social care – enabling people to stay at home (400,000 beds in the borough, only 400 in the hospital!)
Plenary
- To what extent does the strategy have a "leverage issue" that will have a compound effect if we put resources into addressing it? It was suggested that *mental health and wellbeing* in the widest sense (including confidence, self-esteem and aspirations) may be the issue.
- Another uniting issue is *trust in public services*. There's currently a failure of trust in Rotherham, which affects the way people feel about the borough and how Rotherham and the people living here are perceived. This can have a knock-on

effect on feelings of pride and satisfaction and consequently contribute to poor mental health and wellbeing. It also affects investment in the borough and recruitment of professionals.
- We need to communicate what we're doing in a way that will resonate with people e.g. there's a national GP crisis, but in Rotherham these are the specific steps we have taken to help you get an appointment quickly.
- We should be able to clearly evidence progress and seek out and respond to feedback from service users / customers
- It's important to recognise that people care much more about their experience of accessing services that national statistics or comparisons.
- Pick some achievable "quick wins" (underpinned by evidence)
- It was mentioned that GPs can spend around 40% of their time on non-medical issues
- Collectively, the board needs to champion the good work that's happening locally and reinforce positive messages, concentrating on those things that are most meaningful to the public. Need to think about how we communicate, as current messages about action on CSE don't seem to be permeating
- Don't be constrained by the usual way of doing things, including targets / indicators etc. - be creative and innovative.
- Explore the role of the "engine room" as a forum for strategic discussions
- Simple and succinct: encourage everyone to stop smoking, take a 20 minute walk each day and talk to their elderly neighbour.

Summary
- Issue around service design / support pathways
- Telling the Rotherham story – something positive and distinct
- Focus on where we'll have the biggest impact by acting together as a board
- Board members should feed in any further ideas on the most important priorities or quick wins via Michael

7. Next meeting

25th November, 9.00-11.00, Rotherham town hall (TBC)

Health and Wellbeing Board 25 November 2015

Items for Information

1. CAMHS transformation plan

At the meeting on 30 September 2015, it was noted that the Transformation Plan set out how partners would utilise an additional £360,000 per annum from NHS England for CAMHS (child and adolescent mental health services) activity.

Due to the tight timescales, with submission due in mid-October, it was proposed that the board delegates the chair and vice-chair to sign off the plan outside of the meeting. The plan has since been approved through this process.

2. Update on 'Communications'

Discussions have taken place with communications leads in the council and CCG to consider ways of improving communication and information sharing from the board to stakeholders and the public.

Internet and social media – a new Twitter account for the Rotherham board is now up and running and will be used during the November meeting to tweet updates and share information on what the board is discussing. We need to ensure this tool is used effectively to engage with the public, any further suggestions for how best to do this are welcome.

The Rotherham Health and Wellbeing Board website is now out of date and needs to be refreshed, it is being considered how best to do this, ensuring it is useful and engaging for the public and stakeholders.

Newsletter – discussions are taking place currently to develop a local newsletter to share work of board with the public and stakeholders, the board is asked to consider whether they think this would be a useful tool and any suggestions for its format.

3. Physical activity event proposal

Physical inactivity is the fourth leading contributor to ill health. Physical activity in Rotherham has recently received financial support from Sport England to develop a range of partnership projects. These include;

- Active Communities – physical activity opportunities for disadvantaged areas – hosted by Active Rotherham (RMBC)
- Active for Health – physical activity pathways for people with 7 long term conditions – hosted by Public Health (RMBC)
- Back in to Sport – physical activity programme focussed on people from BME communities – hosted by Rotherham United Community Sports Trust (RUCST).

There has also been a wide range of regional sessions/literature referencing the positive approaches and outcomes achieved by local authorities who have focused

on increasing physical activity e.g. Birmingham City Council. As a result of this there is an appetite for an event to be held locally to share good practice, with support and funding from the LGA.

Following early discussions between the Chair, Vice-chair and the LGA, a range of options have been considered, taking into account what outcomes could be achieved from hosting an event. Within Rotherham there are a range of potential areas that an event could cover, these include the following;

- Sharing good practice
- A call to action for Rotherham services to promote and signpost to physical activity opportunities
- Updating our local action plan
- Demonstrating a positive representation of Rotherham

With the above in mind it is proposed that the event has a local focus, to share statistics, good practice examples and develop a local call to action. To assist discussions and help inform local plans, an external expert (for example from Birmingham), could be invited to chair the event and provide a keynote speech; setting the scene of why physical activity is important and sharing good practice.

Finance for the event is yet to be confirmed with the LGA once the format for the event is agreed.

4. Health and Wellbeing Board member survey

The LGA have produced a survey for Health and Wellbeing Board members. A copy of this will be available at the meeting on 25 November for board members to consider whether they wish to complete this.

5. Additional Health and Wellbeing Board meeting in January

An additional Health and Wellbeing Board meeting is being scheduled for 13 January. This was proposed following discussions with the Chair, due to a large number of items for the board and no meeting originally scheduled between November and February. The January meeting will have a children and young people focus, with the following items proposed:

- Children's strategic partnership arrangements
- Health and Wellbeing Strategy – to provide context via an update from the Children's Trust Board
- Index of Multiple Deprivation – presentation looking at specific data relating to children and young people
- Early Help Strategy
- Special Educational Needs and Disability (SEND) update

ROTHERHAM METROPOLITAN BOROUGH COUNCIL – REPORT TO HEALTH AND WELLBEING BOARD

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**25 November 2015**
3.	**Title:**	**Implementing the Rotherham Joint Health and Wellbeing Strategy**
4.	**Directorate:**	**Public Health**

5. Summary

On 30th September, the Health and Wellbeing Board signed off the final version of the new Health and Wellbeing Strategy 2015-18. Following this, there have been dicussions with regards to the mechanism for implementating the strategy, which ensures a commitment across all partner organisations and maximises use of exisiting partnerships to deliver the strategy aims.

The Health and Wellbeing Board are asked to consider proposals for this implementation plan, including the way in which the action plans for the strategy aims will be developed, governance arrangements and the use of exisiting groups where appropriate. The paper also sets out details with regards to the establishment of a new Health and Wellbeing Steering Group for the Board.

6. Recommendations

6.1 To endorse the implementation plan and governance arrangements for the Health and Wellbeing Strategy 2015-18, including:
a) Nominating Board sponsors for each aim,
b) Establishing the new Health and Wellbeing Steering Group, and
c) Board sponsors nominating respresentatives to lead the strategy aims and sit on the Steering Group.

7. Proposals and Details

7.1 Background

At the facilitated workshop session on 30th September 2015, Health and Wellbeing Board members considered the major issues they face in ensuring the strategy is delivered successfully and discussed the mechanics of overseeing the strategy via the board.

Key points included:

- The importance of identifying a "leverage issue" that will have a compound effect if significant resources are allocated to addressing it. Suggestions included *mental health and wellbeing* and *trust in public services*.
- Focus on where we can have the biggest impact by acting together as a board and accept that sometimes doing things for the greater good will come at the expense of individual organisations
- Services should be seamless with people able to easily access the appropriate service, recognising that people care much more about their experience of accessing services than national statistics or comparisons
- The Children's Trust/Partnership Board, when revised, could act as the task and finish group for aims one and two of the strategy. This would reflect a desire to use existing bodies as far as possible rather than creating additional bureaucracy.
- At least one of the two task and finish groups for the strategy aims should have a non-council lead
- Explore the role of the Health and Wellbeing Steering Group as a forum for strategic discussions
- The need to clearly evidence progress and seek out and respond to feedback from service users / customers
- Collectively, the board needs to champion the good work that is happening locally and reinforce positive messages, concentrating on those things that are most meaningful to the public.

Following the workshop we have reconsidered the ongoing management of the strategy and the revised proposals are outlined below. All partners need to demonstrate their commitment to the aims of the strategy by ensuring they are reflected in their organisation's commissioning and/or delivery plans and showing how their actions will contribute to the whole system change. RMBC officer support for management of the strategy will be provided by Alison Iliff, Public Health Principal and support for the management of the board will be provided by Kate Green, Policy Officer (in Policy and Partnerships), working closely together to ensure coordination of the two functions.

7.2 Developing the strategy action plan

Aims 1 and 2 – the action plan for the Children's Partnership Board will also form the action plan for Aims 1 and 2 of the Health and Wellbeing Strategy. We envisage that the board sponsor for these two aims (who will likely also sit on the Children's Trust Board) will use the wider children's partnership to help deliver the strategy action plans.

Aims 3, 4 and 5 – a process will take place to identify any existing partnership action plans relating to these themes (eg Safer Rotherham Partnership, Rotherham Economic Growth Plan, Better Care Fund action plan) and actions that also relate to these aims in the Health and Wellbeing Strategy. Health and wellbeing outcomes that will be impacted by these actions will be identified. It is proposed that these actions will be monitored via their existing routes, but also reported to the Health and Wellbeing Board (HWBB). This will avoid any duplication caused by establishing new groups for each strategy aim whilst maximising existing partnerships and groups we already have in place across the borough.

In addition, to help identify where the HWBB can add value to specific actions, and consider what is already in place locally, a series of one-off development workshops are being proposed for aims 3, 4 and 5.

These workshops will have a wide range of representatives from partner organisations and will focus on:

- How the HWBB builds trust and commitment to delivering the strategy, maximising existing partnerships and groups in place across the borough
- Identifying specific work already underway by partners or stakeholders – avoiding duplication of activity and clarifying relationships with existing strategies and plans
- Considering evidence of what works and best practice from elsewhere
- Developing actions where the HWBB can add value.

It is proposed we trial this approach with Aim 3: Mental and Emotional Health and Wellbeing and set up a one-off workshop, hosted by the board. Exact timescales and further details to be agreed by the board.

7.3 Role of Board Members

For each of the strategy aims, a board sponsor will be nominated; this person will champion the topic, working at a strategic level to raise the profile of the work being done, driving local delivery, addressing barriers, and ensuring that strategic links and connections are made and exploited. The sponsor will retain ultimate responsibility for the delivery of their aim(s).

7.4 The Health and Wellbeing Steering Group

The Health and Wellbeing Steering Group will support and steer the work of the board; coordinating the work of the strategy and action plans, and informing the board's furture work programme. Board sponsors will be asked to nominate a representative to sit on the Steering Group for their aim; it will be expected that this person is empowered to lead work on the action plan, including recognition of the time this will take.

Role of the nominated representative will include:

- Liaising with action owners to identify progress and any barriers to implementation, then act to resolve
- Regularly updating the Board sponsor and the Steering Group

- Attending the Steering Group meetings
- Maintaining an awareness of HWBB matters, through receiving and reading all board papers.

In addition to the nominated representatives, the Steering Group will have representation from Rotherham Healthwatch to ensure its connection with local people. The Director of Public Health will chair this group.

The Steering Group will facilitate work between the nominated representatives to help find solutions to common barriers, support learning from each other and to monitor progress. The lead officer for the engine room will horizon scan to ensure any new advice, guidance and best practice relating to strategy aims are shared with the group, and will be responsible for collating the performance data and producing performance reports for the HWBB.

This group will not be responsible for specific HWBB agenda setting, but will help develop the wider work programme; taking into account the strategy delivery, national and local policy direction and other significant areas of work – which will help inform the board's agendas.

It is suggested therefore that the Steering Group is divided into two, the first as set out above with nominated leads to drive and monitor delivery of the strategy, and the second, a much smaller group, to develop the work programme for the board. This group will be chaired by the Director of Public Health, ensuring a direct link to the board and agenda setting group, and will include the two supporting officers (from Public Health and Policy and Partnerships). The Chair and Vice-chair of the HWBB will be invited to attend the second part of the sub-group on a regular basis (quarterly) to dicuss the future work plan.

Appendix A shows how the Health and Wellbeing Board and Steering Group will work together to deliver the strategy.

8. Risks and Uncertainties

If the Health and Wellbeing Strategy does not have a robust action plan and mechanism in place to ensure it is implemented and monitored effectively, there will be no confidence that the aims can be delivered within the agreed timescales.

It will be crucial that the board sponsors for the aims see the strategy as a priority, and subsequently ensure the nominated representatives for the engine room are at an appropriate level to lead the work of the strategy, make decisions where necessary and feed back to their organisation on key strategic issues.

9. Policy and Performance Agenda Implications

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.

A more up to date picture needs to be developed showing the links to other plans, partnership arrangements and existing groups across the borough. The proposed development workshops and Steering Group will be best placed to undertake this exercise.

10. Background Papers and Consultation

Health and Wellbeing Strategy workshop – notes from 30th September board meeting.

11. Contact Names

Terri Roche
Director of Public Health
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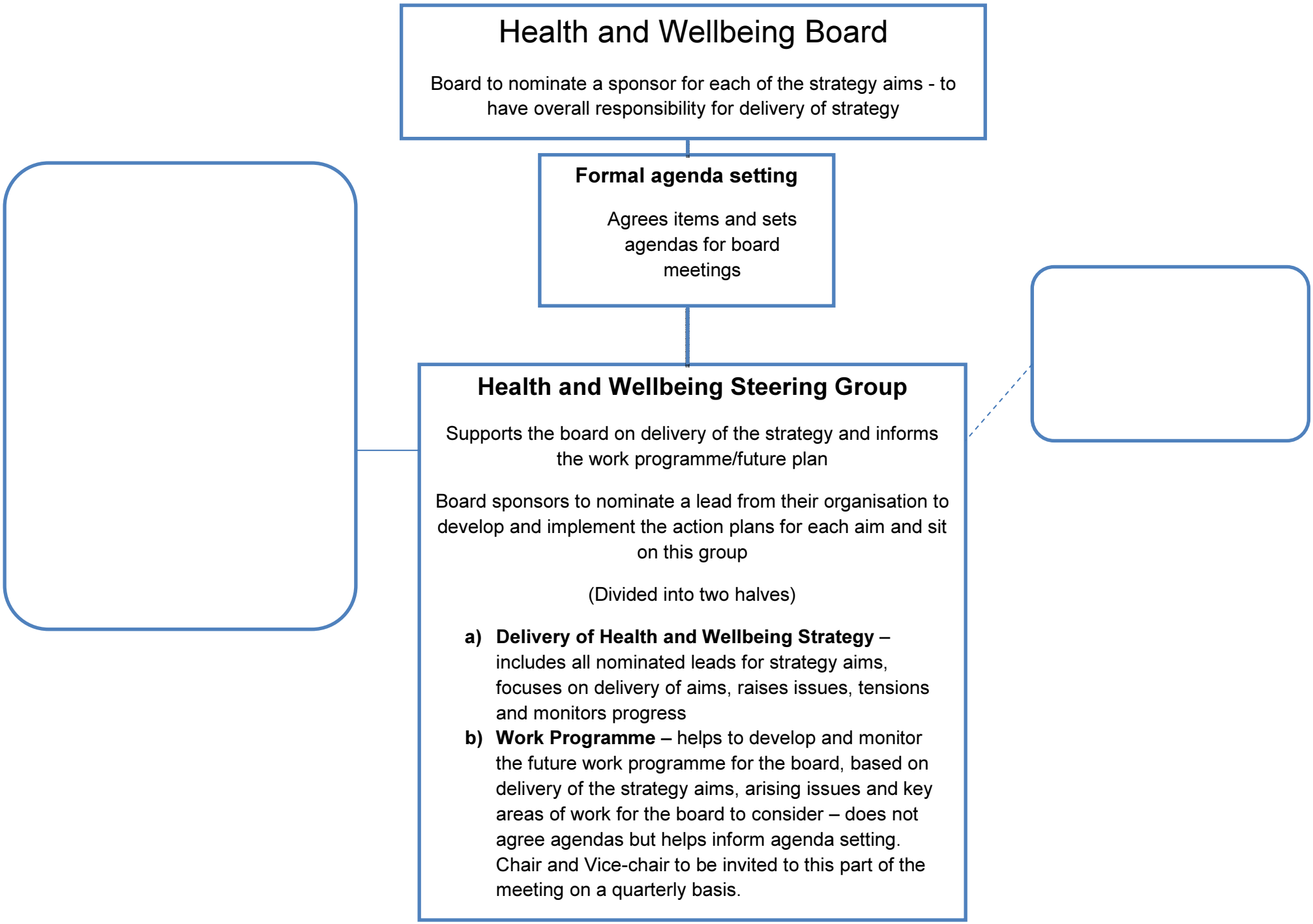
Alison Iliff
Public Health Principal
Email: Alison.iliff@rotherham.gov.uk

Kate Green
Policy Officer
Email: kate.green@rotherham.gov.uk

Appendix A Structure Diagram – Health and Wellbeing Strategy



REPORT TO THE HEALTH AND WELL BEING BOARD
25th November, 2015

Better Care Fund Quarterly Reports 1 and 2

Report Sponsor: RCCG and RMBC

1.	**PURPOSE OF REPORT** **The purpose of this report is for members to note regional feedback from NHS England on Quarter 1 report; and to agree the content of the second quarterly report to NHS England, regarding the performance of Rotherham's Better Care Fund**

2. RECOMMENDATIONS

That the Health and Well-Being Board:

2.1 Recommend that the Board approve the details for submission to NHS England on or before 27th November, 2015, at noon.

2.2 Members are asked to note regional feedback from NHS England on Quarter 1 report.

3. INTRODUCTION / BACKGROUND

3.1 On 21st January 2015, Rotherham's BCF plan was approved by NHS England. The plan sets out our schemes, and how each of the BCF schemes will be measured and managed.

3.2 A quarterly reporting template (attached as Appendix 1) covered reporting on: income and expenditure, payment for performance, the supporting metrics, and the national conditions. NHS guidance requested these reports be discussed and signed off by Health and Wellbeing Boards (HWBs).

3.3 Quarterly reports are due for submission at 5 points in the year:

- 29th May, 2015 for the period January to March 2015
- 28th August, 2015 for the period April to June 2015
- 27th November, 2015 for the period July to September 2015
- 26th February, 2016 for the period October – December 2015
- 27th May, 2016 for the period January – March 2016

The reason the reporting commences from January 2015, is due to the baseline for the quarterly Payment for Performance schedule, linked to the non-elective admissions targets.

3.4 Following the submission of the first quarter's information, NHS England have completed a regional feedback on the BCF performance. This is attached at Appendix 2. This shows that Rotherham is not an outlier in any areas of the BCF,

and also shows that in line with just under half the localities, we are still working towards meeting two of the national conditions of the BCF i.e. implementing 7 day working and using the NHS Identifier. The final slide shows key lines of enquiry for NHS England for future BCF/Integration:-

- Does the information provided indicate any localities that require significant support - and if so is this something we can work together to broker?

- Have the HWBs who had not signed Section 75s when returns were submitted on 28 August, 2015, now signed?

- Does the information on National Conditions point to any areas of concern in your region – particularly on the protection of social care and agreement of impact on the acute sector?

- What support might help the high number of HWBs who are yet to fully meet the conditions for: 7 day services, joint assessments and care planning, and use of the NHS number?

- Why do some areas appear to have paid less into their Payment for Performance fund than they should have?

- What is driving success in those areas making progress on Non-Elective Admissions and Delayed Transfers of Care?

- Are those HWBs who have indicated a desire for support getting what they need?

The above are an important focus for Rotherham in its current and future quarterly returns, and also for any bids to NHS England for future assistance and support, in Integration Fund bids.

3.5 NHS England has produced the format for submission of quarterly data returns one month prior to the submission date. Slightly different data and a minor format change have been required in the last two quarters. For the latest (Quarter 2) return, the reporting template has been considerably changed, and contains an entirely new set of measures relating to integration. These shift the focus away from compliance with national conditions to a more strategic view of the pace and development of integration.

3.6 Personal Health budgets, use of risk stratification and preventative care; and use of integrated digital records across and health and social care are now integration metrics. Rotherham can report favourably on the latter two metrics. Use of risk stratification is well advanced, and supported and combined with Rotherham's social prescribing service. Similarly, we have technical capability to use integrated records (although practice in doing so is not well advanced). Rotherham's performance on the third metric - extending the use of Personal Health budgets is in progress.

3.7 This revised quarterly report format has been completed by relevant staff, and is attached for the Health and Wellbeing Board to approve.

3.8 The quarterly return shows our plans to meet the two outstanding national conditions are on track, and our performance on most metrics (where data is available) are on target. However, our performance on preventing non-elective emergency admissions has not been to plan, and we have an actual increase, rather than the planned decrease. As a result no performance related pay has been awarded. Our plan was to have no more than 7,382 unplanned non-emergency admissions in this quarter, compared to last year's Quarter 2 performance (7,438). However, our actual performance for the quarter was 7,503 – an increase on planned levels, and an overall increase on last year's performance. However, this was a reduction on the previous quarter's performance (7,745).

4. CONCLUSION/NEXT STEPS

4.1 The quarterly format, and the timetable for submitting the quarterly and annual returns have been included within the draft Section 75 Partnership Framework Agreement for the BCF, thus ensuring both the CCG and Local authority are jointly responsible for compiling and submitting these reports to the HWB and NHS England.

4.2 The return will need to be fully completed and submitted to both theBCF Executive and Health and Wellbeing Board.

5. FINANCIAL IMPLICATIONS

5.1 There are no direct financial implications connected with the submission of this Quarterly Report. However, the report does include information on the financial pay for performance element of the BCF. This shows that in both Quarter 1 and Quarter 2, Rotherham failed to meet its target for maintaining its 2014/15 pre-elective admissions in 2015/16, and thus was not able to pay out the designated portion of the BCF. This represents around £96k up to Quarter 2. Monies were designated within the BCF risk pool for this amount, as it was anticipated there was a risk that Rotherham would not meet its challenging non elective admissions reduction target.

5.2 The quarterly return shows that the undistributed funds were spent by the CCG on acute services.

6. APPENDIX

6.1 Appendix 1: Rotherham's Quarter 2 return

6.2 Appendix 2: Review of Quarter 1 returns by NHS England

Officer Contacts: Keely Firth CFO, RCCG **Telephone No:** 302025

Officer Contacts: Jon Tomlinson, RMBC **Telephone No:** 822270

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 27th November 2015.

The BCF Q2 Data Collection

This Excel data collection template for Q2 2015-16 focuses on budget arrangements, the national conditions, payment for performance, income and expenditure to and from the fund, and performance on BCF metrics. It also presents an opportunity for Health and Wellbeing Boards to feedback on their preperations for the BCF in 16/17 and register an interest in planning support.

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.

Collecting Data for New Integration Metrics

In addition, as part of this data collection we are also asking for information to support the development of new metrics for integration. These relate to Jeremy Hunt's announcement at the Local Government Association Conference in July that a new set of metrics is needed to measure the degree to which a health and social care economy is making progress towards delivering integrated, coordinated and person-centred care. This set of metrics is currently in the development stages, and we are taking the opportunity through the Q2 reporting process to trial a small number of new measurements.

We welcome your feedback on the new collections included in the Q2 reporting template, as well as the integration metrics project as a whole: your input will be vital in designing a set of measures that can help to monitor and accelerate the move towards a more coordinated, person-centred health and care system.

Cell Colour Key

Data needs inputting in the cell
Pre populated cells
Question not relevant to you

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) Metrics - this tracks performance against the two national metrics, locally set metric and locally defined patient experience metric in BCF plans.
7) Preparations for the BCF 16-17 - this assesses your current level of planning for next year
8) New Integration metrics - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care
9) Narrative - this allows space for the description of overall progress on BCF 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 Q1 2015-16 submission and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously the 2 further questions are not applicable and are not required to be answered.

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 met through the delivery of your plan (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/). Please answer as at the time of completion.

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 Q1. Two figures are required and one question needs to be answered:

Input actual Q2 2015-16 Non-Elective performance (i.e. number of NELs for that period) - Cell M12
Input actual value of P4P payment agreed locally - Cell E23
If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box
Please confirm the Q4 15/16 plan figure that should be used either by re-entering the figure given or providing a revised one - Cell E46

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:

Forecasted income into the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual income into the pooled fund in Q1 and Q2
Forecasted expenditure from the pooled fund for each quarter of the 2015-16 financial year

Confirmation of actual expenditure into the pooled fund in Q1 and Q2

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) Metrics

This tab tracks performance against the two national, the locally set metric and locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:

An update on indicative progress against the four metrics for Q2 2015-16
Commentary on progress against the metric

Should a local and/or a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

7) Preparations for BCF 16-17

Following the announcement that the BCF will continue in 2016-17 this section assesses where you are at in terms of the level of preparation so far. There is also an opportunity to advise if you would like any support with preparation of your BCF plan and in what format you would like this to take.

8) New Integration Metrics

This tab requests information as part of the development of a new set of metrics to measure the degree to which a health and social care economy is making progress towards delivering integrated, coordinated and person-centred care.

This set of metrics is currently in the development stages, and we are taking the opportunity through the Q2 reporting process to trial a small number of new measurements. There are three metrics for which we are collecting data. The detail of each is set out below.

The data collected on these subjects will be used as part of a wider suite of metrics that will be published in beta form in the new year, with a view to launching an official set of integration metrics in the first quarter of the next financial year. This set of metrics will be used in a similar fashion to the current BCF reporting process, allowing best practice to be collected and shared, and support to be targeted towards those areas that would most benefit from it.

1. The development and use of integrated care records.
There is widespread consensus that having digital care records that are available across health and care settings will facilitate the delivery of more coordinated, person-centred care. However, it is equally clear that this is a long-term ambition that will take several years to realise. In the first instance, therefore, we will be seeking to measure early progress towards this goal by asking you slightly modified versions of the pre-existing reporting questions on use of the NHS number and open APIs.

Proposed metric: Integrated Digital Records. To be assessed via the following questions:
• In which of the following settings is the NHS number being used as the primary identifier? (To select all of the following categories which apply (Y/N) – GP / Hospital / Social Care / Community / Mental health / Specialised palliative)
• In which of the following settings is an open API (i.e. systems that speak to each other) in place? (To select all of the following categories which apply (Y/N) – GP / Hospital / Social Care / Community / Mental health / Specialised palliative)
• Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2? (Y/N)

2. Risk stratification
The second new measurement concerns the use of risk stratification tools to inform both strategic commissioning across health and social care, and case finding of those individuals who would most benefit from preventative care. Again, while this practice is recognised as an effective way to deliver more appropriate, targeted and responsive services, it is also in the relatively early stages of development. In the short term we are looking to understand how many CCGs are using risk stratification tools, and how they are being used to inform strategic commissioning decisions on the one hand and the use of care plans on the other.

Proposed metric: Use of Risk Stratification. To be assessed via the following questions:
• Is the local CCG(s) using an NHS England approved risk stratification tool to analyse local population needs? (Y/N)
• If yes: Please provide details of how risk stratification modelling is being used to allocate resources
• Based on your latest risk stratification exercise what proportion of your local residents have been identified as in need of preventative care? (%)
• What proportion of local residents identified as in need of preventative care have been offered a care plan? (%)

3. Personal Health Budgets
Finally, personal budgets in both health and social care are likely to play an important role in the evolution of the health and social care system towards a greater degree of personalisation. In the long-term we expect individuals who hold personal budgets in both health and social care to benefit from combining these into an integrated personal budget. However, at this stage we are interested to learn what progress areas are making in expanding the use of personal health budgets beyond people in receipt of continuing health care.

Proposed metric: Personal Health Budgets. To be assessed via the following questions:

• Have you undertaken a scoping exercise in partnership with local stakeholders to understand where personal health budgets would be most beneficial for your local population? (To select from drop down: No / In the planning stages / In progress / Completed)

• How many local residents have been identified as eligible for PHBs, per 100,000 population?

• How many local residents have been offered a PHB, per 100,000 population?

• How many local residents are currently using a PHB, per 100,000 population?

• What proportion of local residents currently using PHBs are in receipt of NHS Continuing Healthcare?

9) 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

1. 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

2. Budget Arrangements

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

3. 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?
Please Select (Yes, No or No - In Progress)	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
Comment	Yes	Yes	Yes	Yes	Yes	Yes

4. Non-Elective and P4P

Actual Q1 15/16	Actual payment locally agreed	Any unreleased funds were used for: Q2 15/16	Q4 2015-16 confirmed NEA plan figures
Yes	Yes	Yes	Yes

5. 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 annual totals and the pooled fund
Income to	Forecast	Yes	Yes	Yes	Yes	Yes
	Actual	Yes	Yes			
	Actual					
Expenditure From	Forecast	Yes	Yes	Yes	Yes	Yes
	Actual	Yes	Yes			

	Commentary	Yes

6. Metrics

		Please provide an update on indicative progress against the metric?	Commentary on progress
	Admissions to residential Care	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	Reablement	Yes	Yes
	If no metric, please specify	Please provide an update on indicative progress against the metric?	Commentary on progress
Local performance metric	Yes	Yes	Yes
	If no metric, please specify	Please provide an update on indicative progress against the metric?	Commentary on progress
Patient experience metric	Yes	Yes	Yes

7. Preparations for BCF 16-17

Have you begun planning for 2016/17?	Yes
Confidence in developing BCF plan?	Yes
Pool more, less, or the same amount of funding?	Yes
Support in developing plan?	Yes

If yes, support area?	Interested in support?	Preferred support medium	If preferred support medium is 'other', please elaborate
Developing / reviewing your strategic vision	Yes	Yes	Yes
Building partnership working	Yes	Yes	Yes
Governance development	Yes	Yes	Yes
Data interpretation and analytics	Yes	Yes	Yes
Evidence based planning	Yes	Yes	Yes
Financial planning	Yes	Yes	Yes
Benefits management	Yes	Yes	Yes
Other	Yes	Yes	Yes

8. New Integration Metrics

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS number being used as the primary identifier?	Yes	Yes	Yes	Yes	Yes	Yes
Open API in place?	Yes	Yes	Yes	Yes	Yes	Yes
Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes					

Is the local CCG(s) using an NHS England approved risk stratification tool to analyse local population needs?	Yes
If 'Yes', please provide details of how risk stratification modelling is being used to allocate resources	Yes
How many local residents have been identified as in need of preventative care during the quarter?	Yes
What proportion of local residents identified as in need of preventative care have been offered a care plan during the quarter?	Yes

Have you undertaken a scoping exercise in partnership with local stakeholders to understand where personal health budgets would be most beneficial for your local population?	Yes
How many local residents have been identified as eligible for PHBs during the quarter?	Yes
How many local residents have been offered a PHB during the quarter?	Yes
How many local residents are currently using a PHB during the quarter?	Yes
What proportion of local residents currently using PHBs are in receipt of NHS Continuing Healthcare during the quarter?	Yes

9. Narrative

Brief Narrative
Yes

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?
Yes	Yes
Yes	Yes
Yes	Yes

Cover and Basic Details
Q2 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:	Chris Edwards and Commissioner Stella Manzie

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	4
5. I&E	15
6. Metrics	10
7. Preparations for BCF 16-17	28
8. New Integration Metrics	25
9. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:

Rotherham

Data Submission Period:

Q2 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 Q1 data collection previously filled in by the HWB.

National Conditions

Selected Health and Well Being Board:

Rotherham

Data Submission Period:

Q2 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	Q4 Submission Response	Q1 Submission Response	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)	Commentary on progress
1) Are the plans still jointly agreed?	Yes	Yes	Yes		
2) Are Social Care Services (not spending) being protected?	Yes	Yes	Yes		
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	No - In Progress	No - In Progress	No - In Progress	31/03/16	Our enabling service has been operating as the first phase of our 7 day services plan. We have plans to implement a 7 day working hospital discharge pilot from 1.12.15 which will complete the intentions for 7 day working set out in the Rotherham BCF plan.
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	No - In Progress	No - In Progress	01/04/16	Currently we have 5,627 people receiving social care services with 3,192 of these people having an NHS number recorded. An active and current project plan is capturing the NHS number for all new referrals in our current database. Culture and process changes have been made to embed the maintenance and usage of NHS number in RMBC's day to day
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	Yes	Yes		
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	Yes	Yes		
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	Yes	Yes		

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.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the Q1 data collection previously filled in by the HWB.

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

Selected Health and Well Being Board: Rotherham

	Baseline				Plan			
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	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

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
Suggested quarterly payment (taken from above*)	£0	£0	£0	
Actual payment locally agreed	£0	£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 Unreleased Funds			
Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16

Suggested amount of unreleased funds**	£0	£0	£0	
Actual amount of locally agreed unreleased funds	£0	£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	acute care	

Confirming Q4 2015-16 Non-Elective Admissions figures

During the exercise to allow HWBs to revise their baseline and plan figures for Non-Elective admissions we only requested the confirmation of figures for the Payment for Performance period (Q4 2014/15 to Q3 2015/16). In order to ensure we have a consistent and accurate set of numbers for the financial year 2015-16 we are now asking HWBs to reconfirm their **plan** figure for Q4 2015-16. The below table has been pre-populated with the original figures for Q4 2015-16 which you submitted as part of your approved BCF plan. Please confirm the plan figure that should be used either by re-entering the figure given or providing a revised one.

	Q4 15/16 figures previously provided	Q4 15/16 confirmed figure
Plan (taken from original HWB BCF plans)	7,444	7,579
Baseline (Q4 14/15 actual - as confirmed by HWBs in July 2015)	7,491	

Footnotes:

##

Actual							Planned Absolute Reduction (cumulative) [negative values indicate the plan is larger than the baseline]				Maximum Quarterly Payment		
Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	% change [negative values indicate the plan is larger than the baseline]	Absolute reduction in non elective performance	Total Performance Fund Available	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16
7,491	7,745	7,503		-0.1%	-21	£0	-191	-135	-79	-21	£0	£0	£0

	Performance against baseline				Suggested Quarterly Payment							
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	Total Performance fund	Total Performance and ringfenced funds	Q4 Payment locally agreed	Q1 Payment locally agreed
£0	-44	-175	-65		£0	£0	£0		£0	£5,303,000	£0	£0

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

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	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	£23,316,000	
	Actual*	£5,829,000					

Q2 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	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	£23,316,000	
	Actual*	£5,829,000	£5,829,000				

Please comment if there is a difference between either annual total and the pooled fund	

Expenditure

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	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	£23,316,000	
	Actual*	£5,829,000					

Q2 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	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	£23,316,000	
	Actual*	£5,829,000	£5,829,000				

Please comment if there is a difference between either annual total and the pooled fund	

Commentary on progress against financial plan:	Some of our budgets have 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 budgerts 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 Q1 collection previously filled in by the HWB.

National and locally defined metrics

Selected Health and Well Being Board:	Rotherham

Admissions to residential Care	% Change in rate of permanent admissions to residential care per 100,000
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Admissions as at Q2 shows 213 admissions, this equates to a rate per 100,000 of 870.2, representing an in year 9.2% reduction from 2014/15 of 958.5. We project that by year end the rate will be close to target of 933.25 and represent a 2.6% reduction in change in rate, following estimated impact of seasonal adjustments ie higher rate of admissions over the winter period.

Reablement	Change in annual percentage of people still at home after 91 days following discharge, baseline to 2015/16
Please provide an update on indicative progress against the metric?	Data not available to assess progress
Commentary on progress:	This is an annual measure and collation of data is undertaken during Q3 by tracking service users offered the service during Oct to Dec 2015. Follow up actions to capture those who were still at home 91 days following discharge is completed during Q4 and finalised for submission during April/May. We will be able to provide an incremental cumulative estimate on progress from the data from analysis completed in the 3 sample months

Local performance metric as described in your approved BCF plan / Q1 return	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.
If no local performance metric has been specified, please give details of the local performance metric now being used.	
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	September data still to be included as not available as yet, but July had an increase in the rate of readmissions, although August was below the planned rate.

Local defined patient experience metric as described in your approved BCF plan / Q1 return	Inpatient Experience: The proportion of people reporting a poor patient experience of inpatient care. (Average number of negative responses per 100 patients)
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	

Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Annual measure using the National Inpatient Survey Results - latest published information shows a reduction in the rate of negative responses - 115.9 from a baseline position of 123.08.

Footnotes:

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.

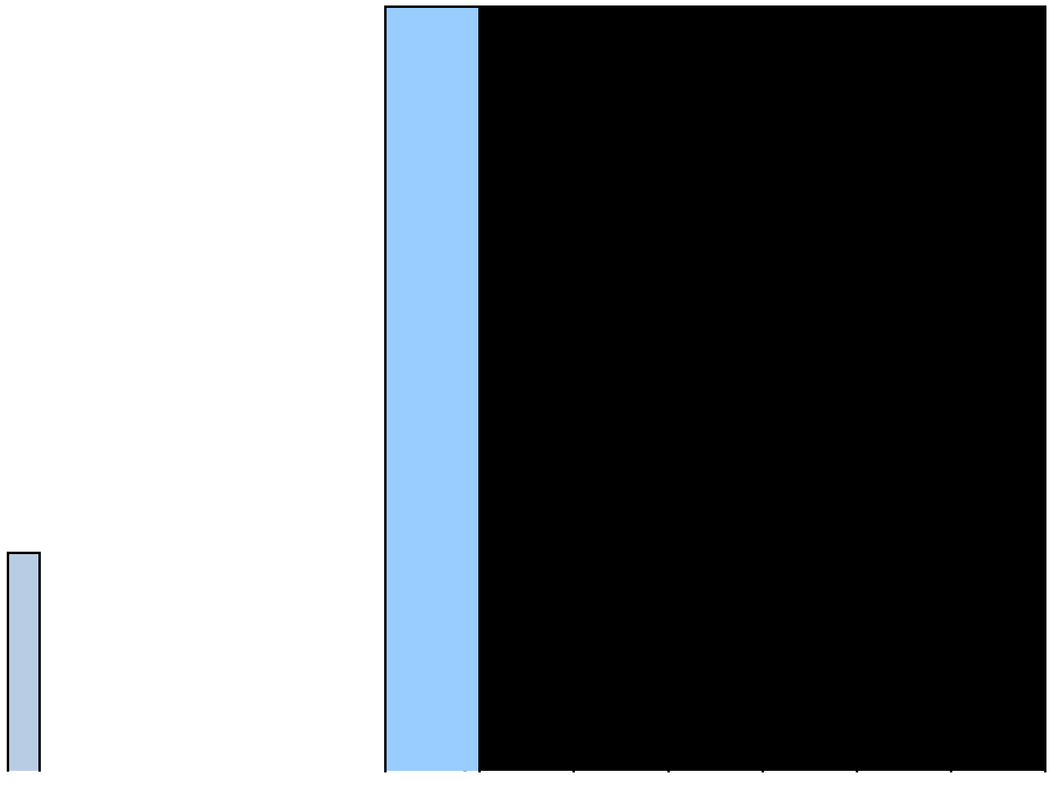
Preparations for the BCF 16-17

Selected Health and Well Being Board:	Rotherham

Following the announcement that the BCF will continue in 2016-17 have you begun planning for next year?	Yes
How confident do you feel about developing your BCF plan for 2016-17?	Moderate Confidence
At this stage do you expect to pool more, less, or the same amount of funding compared to that pooled in 15/16, if the mandatory requirements do not change?	More funding

Would you welcome support in developing your BCF plan for 2016-17?	Yes

If yes, which area(s) of planning would you like support with, and in what format?	Interested in support?	Preferred support medium	If preferred support medium is 'other', please elaborate
Developing / reviewing your strategic vision	Yes	Case studies or examples of good practice	[redacted]
Building partnership working	Yes	Case studies or examples of good practice	
Governance development	Yes	Case studies or examples of good practice	
Data interpretation and analytics	Yes	Hands on technical or delivery support	
Evidence based planning (to be able to conduct full options appraisal and evidence-based assessments of schemes / approaches)	Yes	Hands on technical or delivery support	
Financial planning (to be able to develop sufficiently robust financial plans that correctly describe the impact of activity changes, and the investments required)	Yes	Hands on technical or delivery support	



New Integration Metrics

Selected Health and Well Being Board: Rotherham

1. Proposed Metric: Integrated Digital Records

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
In which of the following settings is the NHS number being used as the primary identifier? (Select all of the categories that apply)	Yes	Yes	No	Yes	Yes	Yes
Please indicate which care settings can 'speak to each other', i.e. share information through the use of open APIs? (Select all of the categories that apply)	Yes	Yes	Yes	Yes	Yes	Yes

Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes

Comments:	API systems are all in place , however, they are not fully operationalised by all health and social care staff. More work needs to be done on transforming the culture to maximise the potential benefits of integrated working for all staff.

Narrative

Selected Health and Well Being Board:

Rotherham

Data Submission Period:

Q2 2015/16

Narrative	Remaining Characters	31,595

Please provide a brief narrative on overall progress in delivering your Better Care Fund plan at the current point in time, please also make reference to performance on any metrics not directly reported on within this template (i.e. DTOCs).

Revised and strengthened governance is in place and working effectively for the BCF. Additionally, the BCF has been subject to a programme of scrutiny this quarter, by the Health Select Commission. Members have taken an active interest in the BCF projects, and have received presentations from our partners which they have viewed enthusiastically as a result of the clear benefits and improving patient and customer experiences. A further 3 dates have been set for detailed scrutiny of a further number of BCF schemes during Autumn/Winter/Spring 2015/16.

BCF Governance continues to monitor closely specific projects of the BCF, to ensure full and accelerated implementation of the two remaining projects linked to the BCF national conditions.

The newly formed BCF Strategic group continues to take a lead in developing proposals for integration, based on the completed review of current BCF projects, and having benchmarked our proposals with other localities. Our proposals are being developed alongside partner organisations development and transformation programmes, ensuring therefore a co-ordinated approach in the locality towards further integration.

Progress in delivering local BCF plans

Summary of BCF quarterly reporting returns and key metrics for Q1 2015-16

29 September 2015
Version 7 – National, North of England

The Better Care Fund

1. Key Findings

Health and Wellbeing Boards (HWBs) submitted quarterly reports for the period April to June 2015 (Q1) to the Better Care Support Team on 28th August 2015. The information provided within these reports, combined with nationally available data (DTOCs), has been analysed to produce an update on progress on the Better Care Fund in 2015-16. The headlines are:

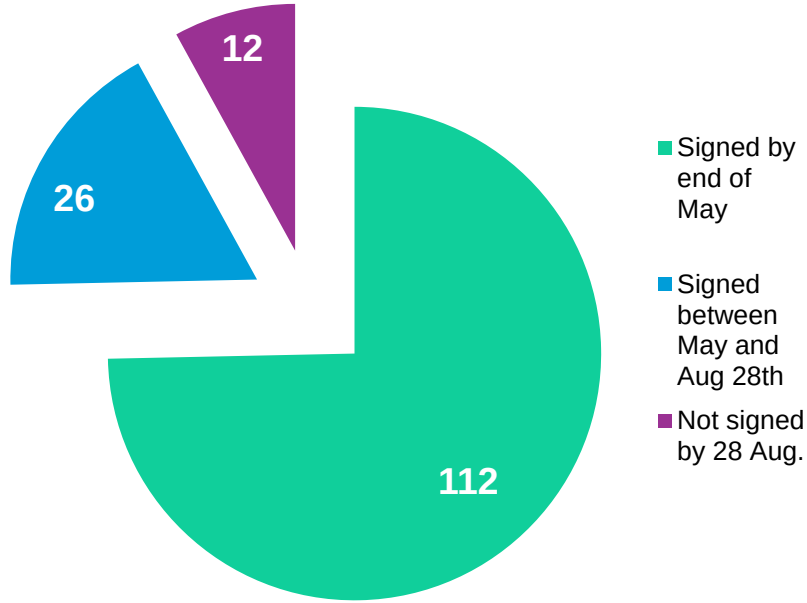
- 138/150 HWBs indicated they had signed their Section 75 agreements to formally establish the pooled fund at the time of submission on 28th August 2015. Follow up suggests that 144 are now signed, with only 2 HWBs reporting difficulty in agreements.
- Improvement in compliance with all national conditions questions;
- Significant increase in the number of HWBs using the NHS number as the sole identifier – from 75/150 to 90/150;
- 147/150 HWBs indicating that their BCF plan is protecting social care;
- HWBs are reportedly paying out £36.9m in P4P for Q4 and Q1 combined
- Non-Elective Admissions are down by 5 from baseline figures for Q1 with significant regional variation: the North are 3,614 below their baseline and the South 2,196 above
- DTOC rate has increased by 104 from the baseline period with significant regional variation: an increase by 37 in the North compared to an increase by 260 in the South
- HWBs have paid £1.347bn into pooled budgets in Q1 2015-16, with expenditure from the fund totalling £1.256bn in the same period.

SECTION A
Pooled budgets and national conditions

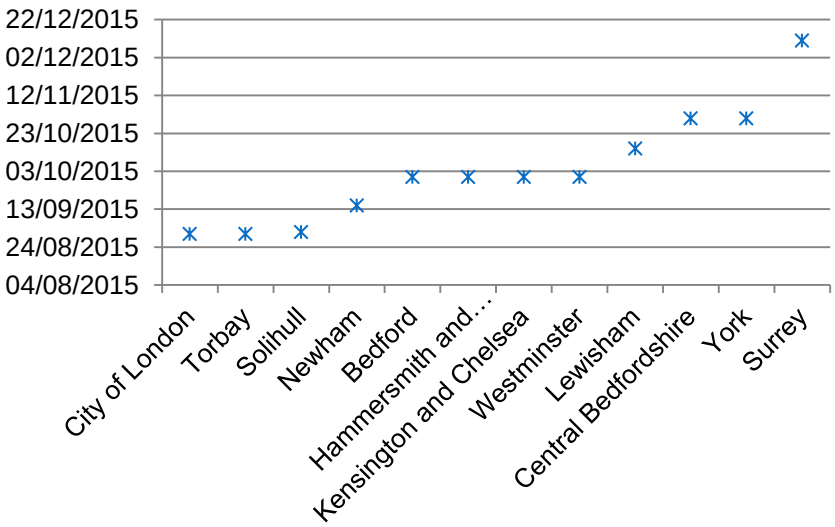
2. Pooled budgets - summary

Have funds been pooled via a Section 75 pooled budget arrangement in line with the agreed plan?

- 112/150 HWBs confirmed they had signed through the Q4 reporting in May (75%);
- A further 26 HWBs confirmed they have signed as part of their Q1 return;
- This leaves 12 HWBs who are yet to confirm that they have signed (8% of total HWBs)



The 12 HWBs who have not yet signed have indicated when they expect this to happen

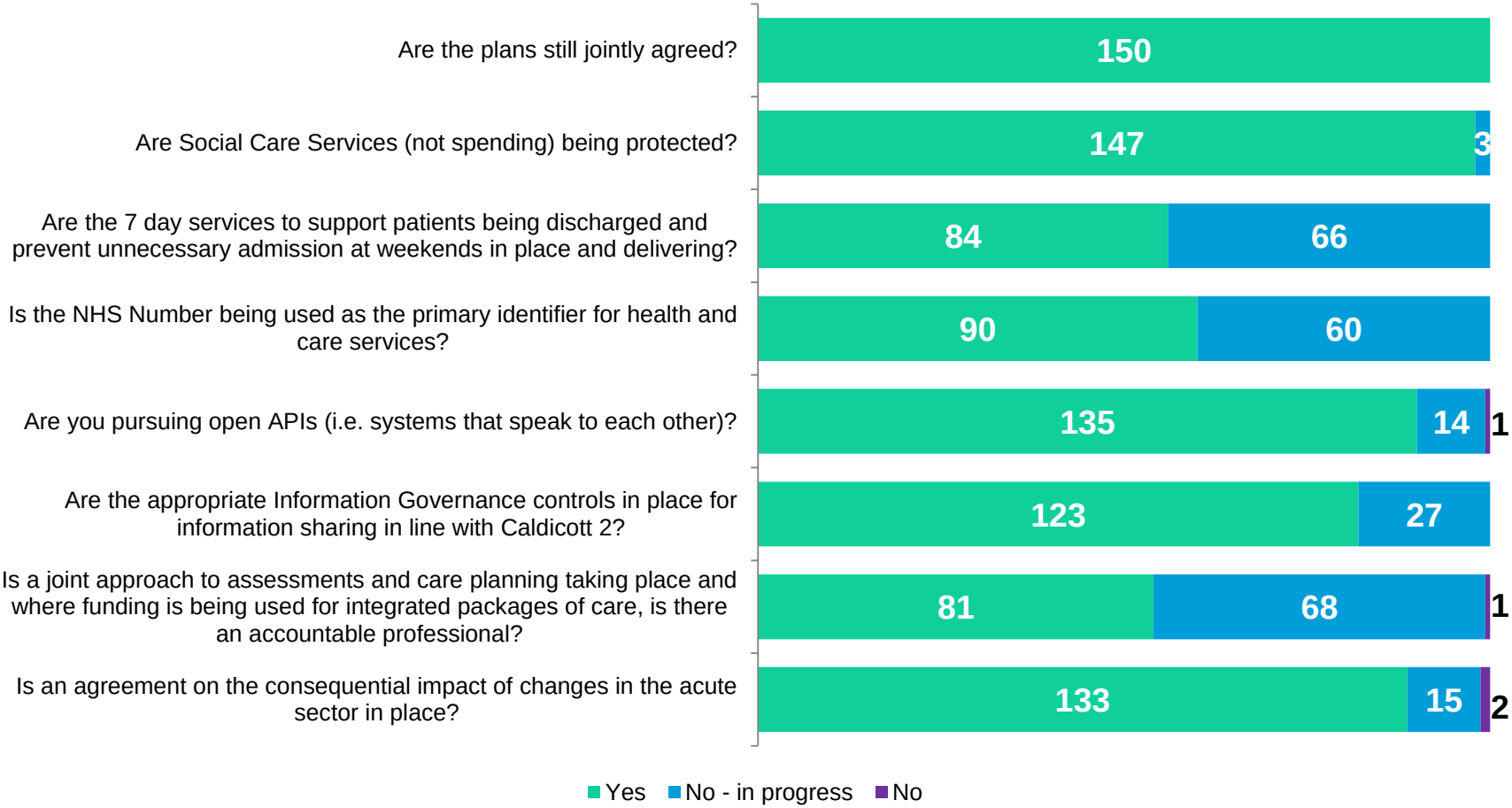


Further analysis

- Follow up has already been carried out through the Q4 stocktake process, and will be reviewed again via the Q1 process
- Surrey have indicated that the delay is caused by unresolved legal issues, although agreements have been drawn up for all their CCGs

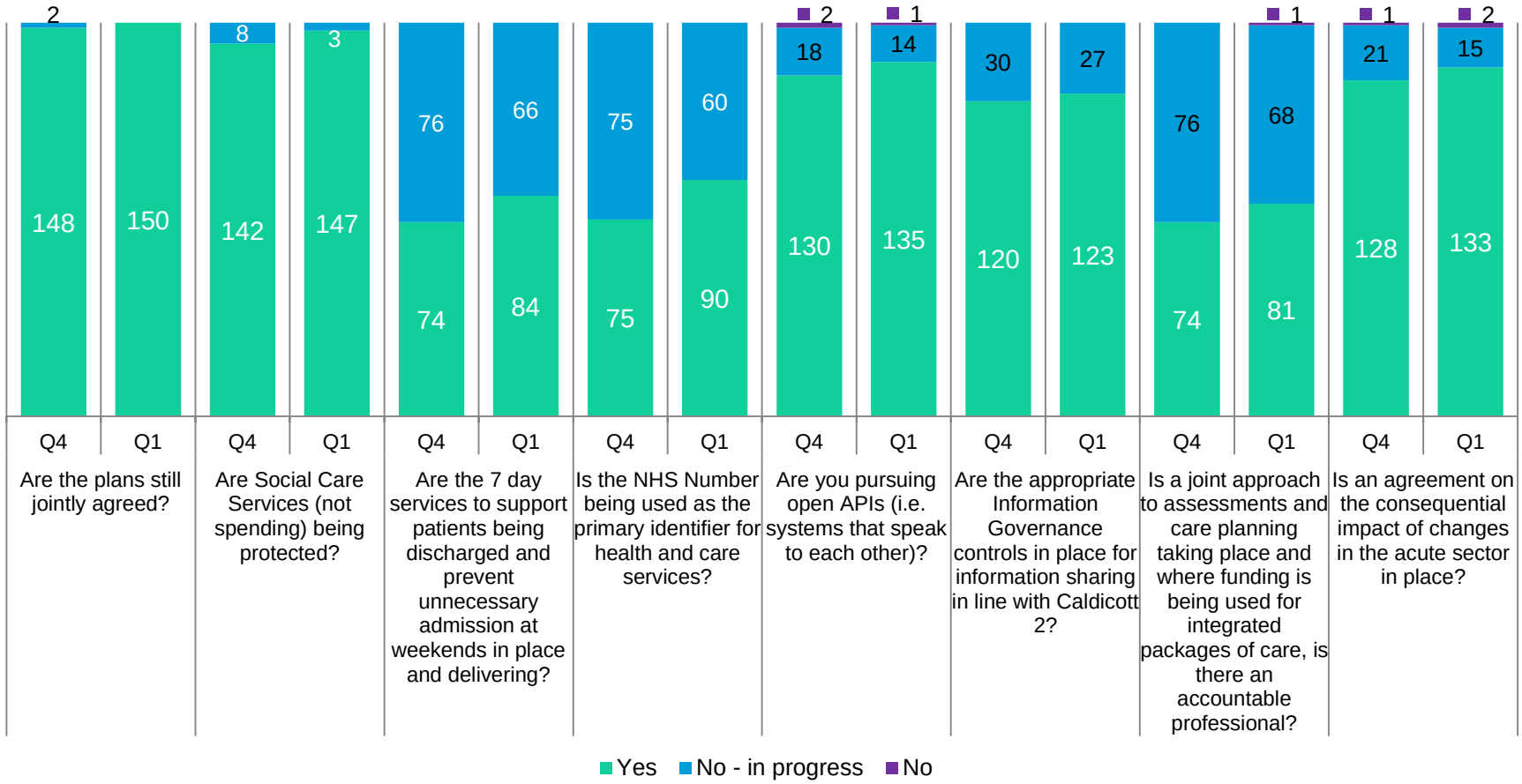
4. The national conditions - overview

Q1 returns indicate that the same conditions continue to prove more challenging – **7 day services** to support discharge and avoid admissions, use of the **NHS number** as the primary identifier, and the implementation of **joint assessments**, care planning and having an accountable lead professional.



4. The national conditions – changes from Q4

The below table shows that there has been positive movement on all national conditions between reporting for Q4 2014-15 and reporting for Q1 2015-16. However the trends remain the same. The most significant movement is seen on the condition relating to use of the NHS number.



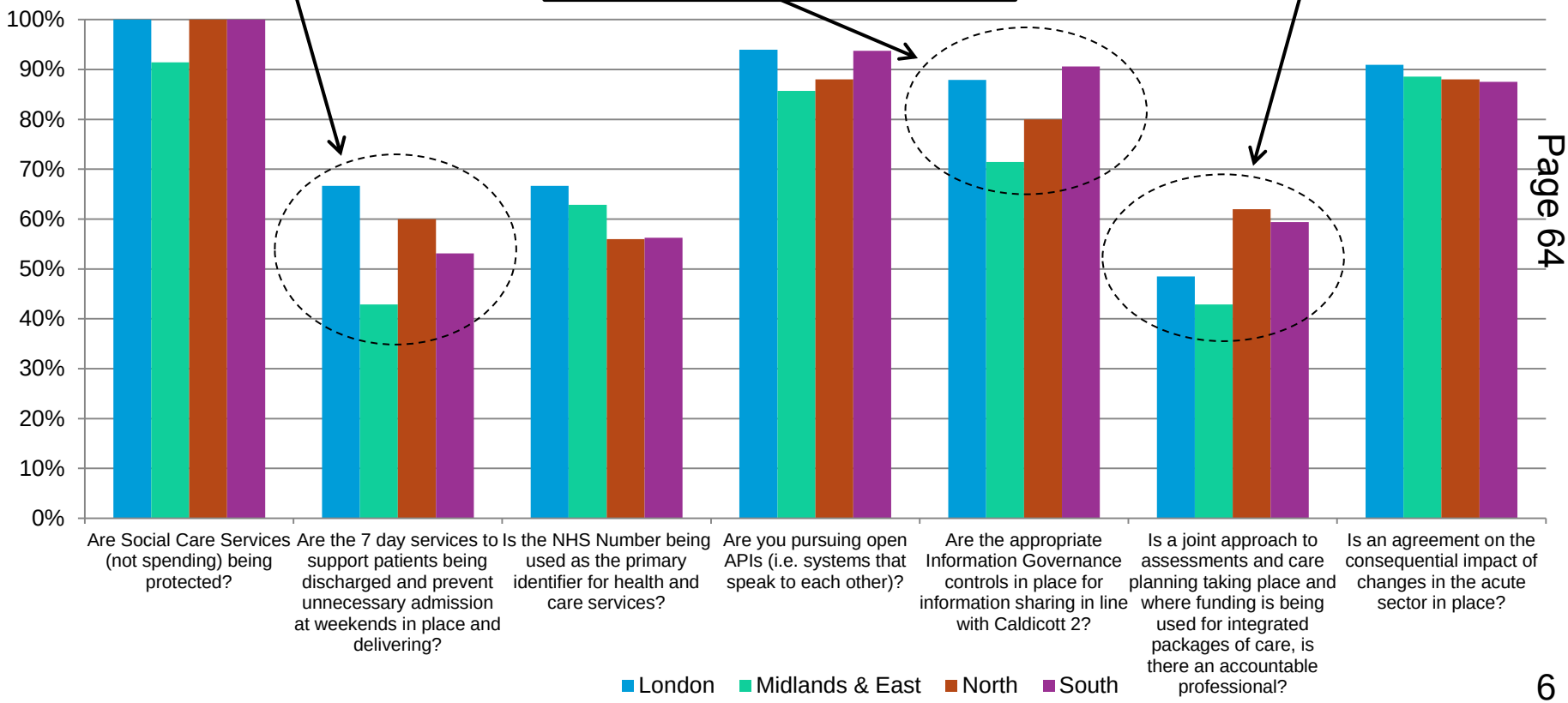
5. The national conditions – by NHSE Region

There are some noticeable variations between regions across England when looking at the % of HWBs who said 'Yes' to questions on the national conditions.

Only 43% HWBs in Mids & East felt they are on track to deliver 7DS, compared with 67% in London

Only 71% HWBs in Mids & East felt they have the IG controls in place for data sharing, compared with 88% in London & 91% in the South

Only 43% HWBs in Mids & East felt they are meeting the condition around joint assessments compare to 62% in the North



6. The national conditions – further analysis

Protection of Social Care

- 147 HWBs indicated Social Care is being protected as set out in BCF plans
- 3 HWBs indicated this is in progress but not complete, these are:
  - Staffordshire
  - Suffolk
  - Warwickshire
- Only Suffolk have indicated that this will not be met by the end of 2015-16

'No' responses

- Cumbria has no plans to pursue APIs as they are pursuing something equivalent
- Brighton and Hove will not implement joint assessments this year but will have completed this by May 2016
- Brent and Central Bedfordshire have both indicated that there is no longer a shared view of the impact of plans on the acute sector this year

Data sharing and joining up systems

- The number of HWBs using the NHS number has increased by 15 from Q4;
- There has been improvement across all 3 data sharing questions;
- 77 HWBs responded with a 'Yes' to all 3 questions;
- 4 HWBs responded with a 'No' to all 3 questions, these are: Walsall, South Tyneside, Peterborough, and Lambeth;

Question	Q4	Q1
Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	120	123
Is the NHS Number being used as the primary identifier for health and care services?	75	90
Are you pursuing open APIs (i.e. systems that speak to each other)?	130	135

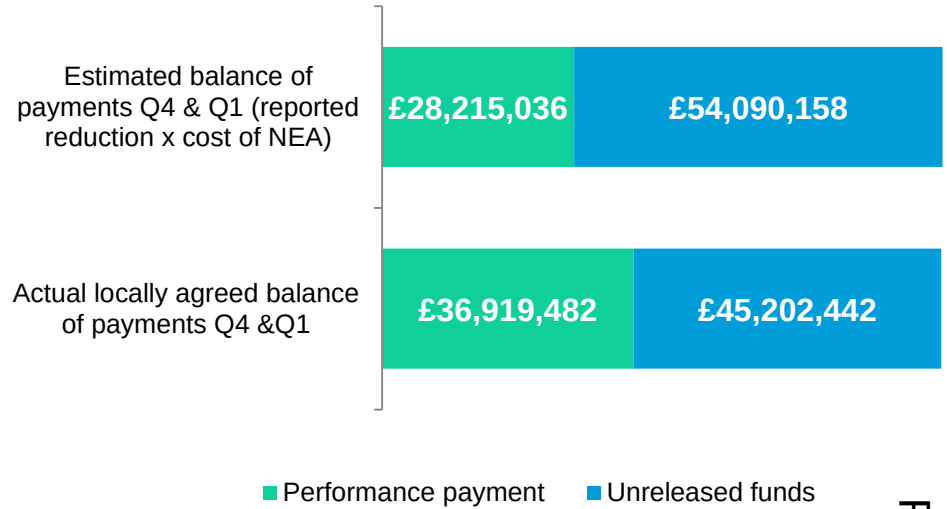
SECTION B
Metrics and Payment for Performance

7. National metrics summary

Headlines

- Total of £36.9m in P4P payments for Q4 and Q1*
- Total of 69 HWBs achieved a quarterly payment across Q4 & Q1
- Non-Elective Admissions were down by 5 from Q1 2014-15*
- 104 increase in the rate of delayed transfers of care compared to Q1 2014-15

Payment for Performance pot



National metrics summary

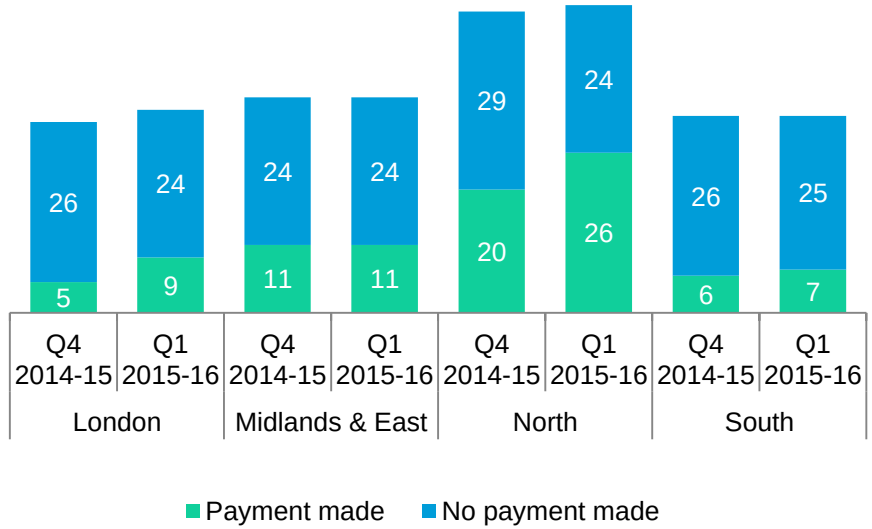
	Q1 Baseline	Q1 Plan	Q1 Actual	Variance from baseline	Variance from plan
Non-Elective Admissions	1,365,630	1,343,762	1,365,625	**-5**	**21,863**
Delayed Transfers of Care	857	786	960	**104**	**175**
No. permanent admissions of older people to care homes	Data not available				
No. of people at home 91 days after discharge	Data not available				

* NEA and P4P now measured against revised BCF targets agreed in July 2015. For this reason data reported here for Q4 2014-15 may differ from previously reported data.

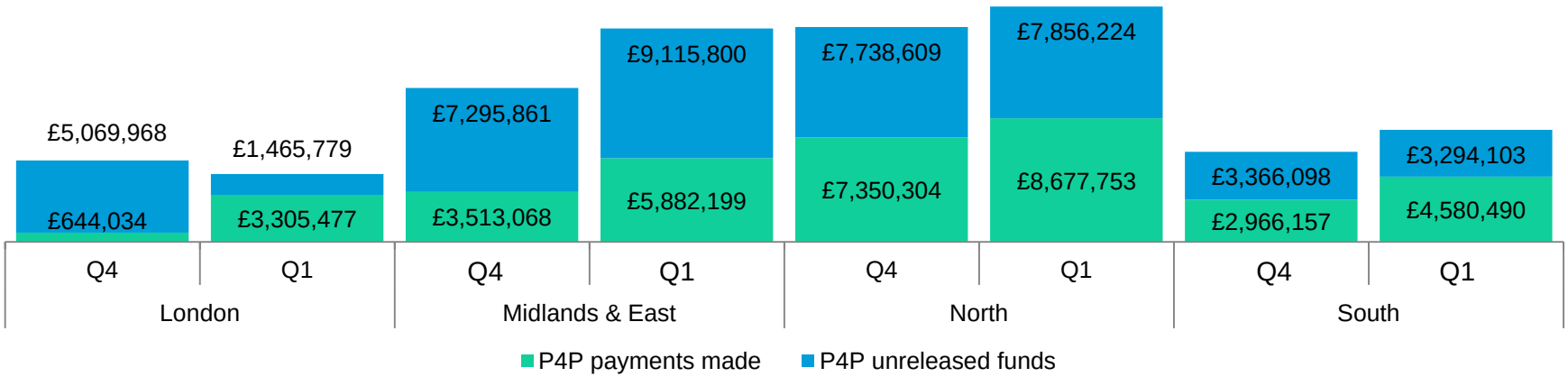
8. P4P Summary

- A total of 69 HWBs across the country achieved a P4P payment in Q4 and / or Q1
- A total of 95 P4P payments have been made so far
- This totals £36.9m paid into performance funds across the country
- There is variation in the level of P4P paid out in different regions

No. HWBs making payments, by region*



Payments vs. unreleased funds, by region

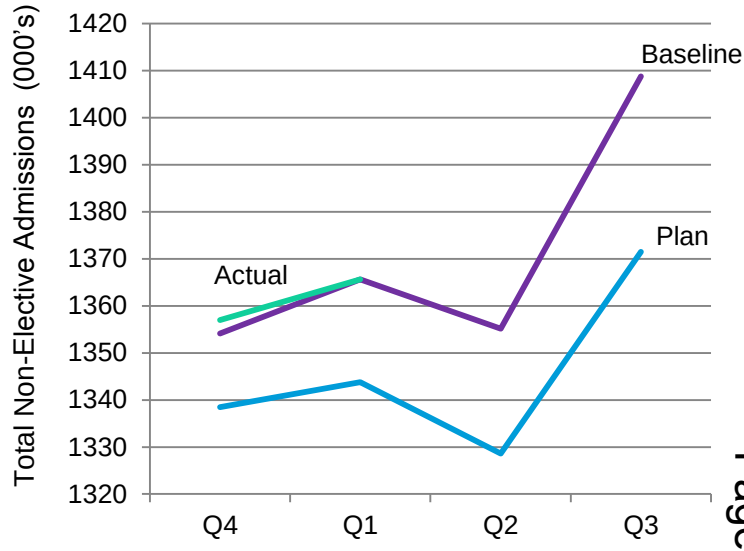


* 3 HWBs failed to provide this information for Q4 (1 North, 2 London)

9. Non-Elective Admissions - detail

- We have changed the way that we track progress on reducing Non-Elective admissions
- HWBs are now required to self-report against their revised BCF baselines and targets that were set in July 2015.
- At this point HWBs were also given the opportunity to select the most appropriate data source for them – SUS or MAR
- Self reported data for Q4 2014-15 and Q1 2015-16 suggests that there is little change from baseline at an aggregate national level, but signification regional variation

National Quarterly Performance Against Baseline & Plan*



Total Non-Elective Admissions vs baseline & plan, by region

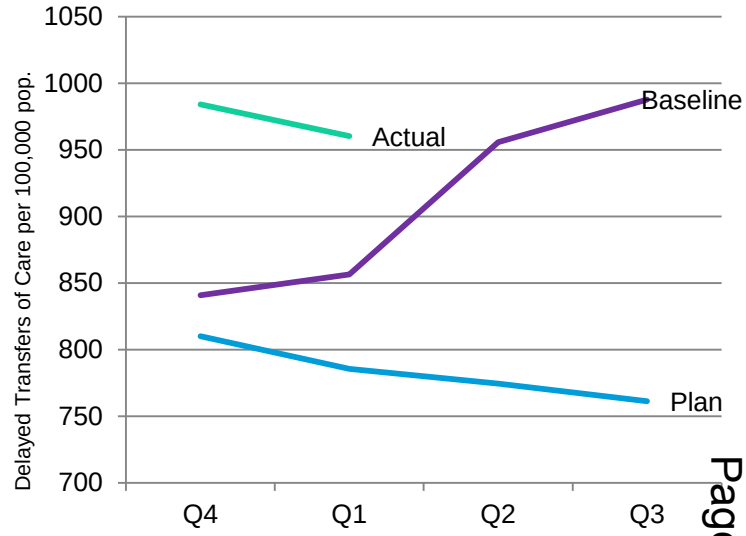
	Baseline		Plan		Actual Performance		Performance against baseline (Red = increase)		Performance against plan (Red = increase)	
	Q4 13/14	Q1 14/15	Q4 14/15	Q1 15/16	Q4 14/15	Q1 15/16	Q4 14/15	Q1 15/16	Q4 14/15	Q1 15/16
England	1,354,145	1,365,630	1,338,483	1,343,762	1,357,001	1,365,625	2,856	-5	18,518	21,863
North	434,565	433,801	426,733	423,678	434,521	430,187	-44	-3,614	7,788	6,509
Midlands and East	416,138	425,286	411,762	418,161	415,090	425,195	-1,048	-91	3,328	7,034
London	181,778	183,495	178,298	181,860	184,185	184,998	2,407	1,503	5,888	3,138
South	321,663	323,049	321,690	320,064	323,205	325,245	1,541	2,196	1,514	5,181

* 'Baseline' is actual data for Q4 2013-14 to Q3 2014-15. 'Plan' and 'Actual ' relate to the period Q4 2014-15 to Q3 2015-16.

10. Delayed Transfers of Care - detail

- The DTOC rate for Q1 increased by 104 compared to the baseline period, an increase of 174 compared to planned rate
- This reflects over performance across the country, but with the most significant deviation from plan in the South
- London were the only region to meet their plan (for Q4) and in that instance the planned levels were set above the baseline.
- Nationally the rate of DTOCs has decreased by 24 from Q4 to Q1.

National Quarterly Performance Against Baseline & Plan*



DTOCs per 100,000 pop vs baseline & plan, by region

	Baseline		Plan		Actual Performance		Performance against baseline (Red = increase)		Performance against plan (Red = increase)	
	Q4 13/14	Q1 14/15	Q4 14/15	Q1 15/16	Q4 14/15	Q1 15/16	Q4 14/15	Q1 15/16	Q4 14/15	Q1 15/16
England	841	857	810	786	984	960	143	104	174	175
North	737	744	737	721	834	781	98	37	98	59
Midlands and East	1,000	1,049	992	981	1,175	1,091	175	42	183	110
London	529	539	560	507	545	625	16	86	-15	119
South	953	941	827	793	1,185	1,202	232	260	358	409

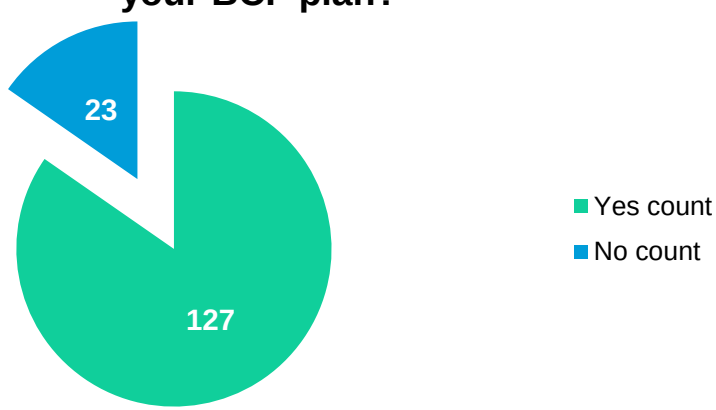
* 'Baseline' is actual data for Q4 2013-14 to Q3 2014-15. 'Plan' and 'Actual ' relate to the period Q4 2014-15 to Q3 2015-16.

11. Local metrics and patient experience

- It was a requirement of the BCF planning process for HWBs to include in their plan 1 locally defined metric and 1 locally defined patient experience metric.
- Through the Q1 process we have asked HWBs to self report against these metrics.
- Through this process HWBs were also give the opportunity to set out changes they may have made to the metrics they chose through the planning process.
- This has produced a wealth of data that the BCST will use to look further at which metrics are being tracked locally.
- At this stage we have just summarised the number of HWBs making changes to the metrics they are tracking.

Is this still the local performance metric that you wish to use to track the impact of your BCF plan?

Is this still the local performance metric that you wish to use to track the impact of your BCF plan?



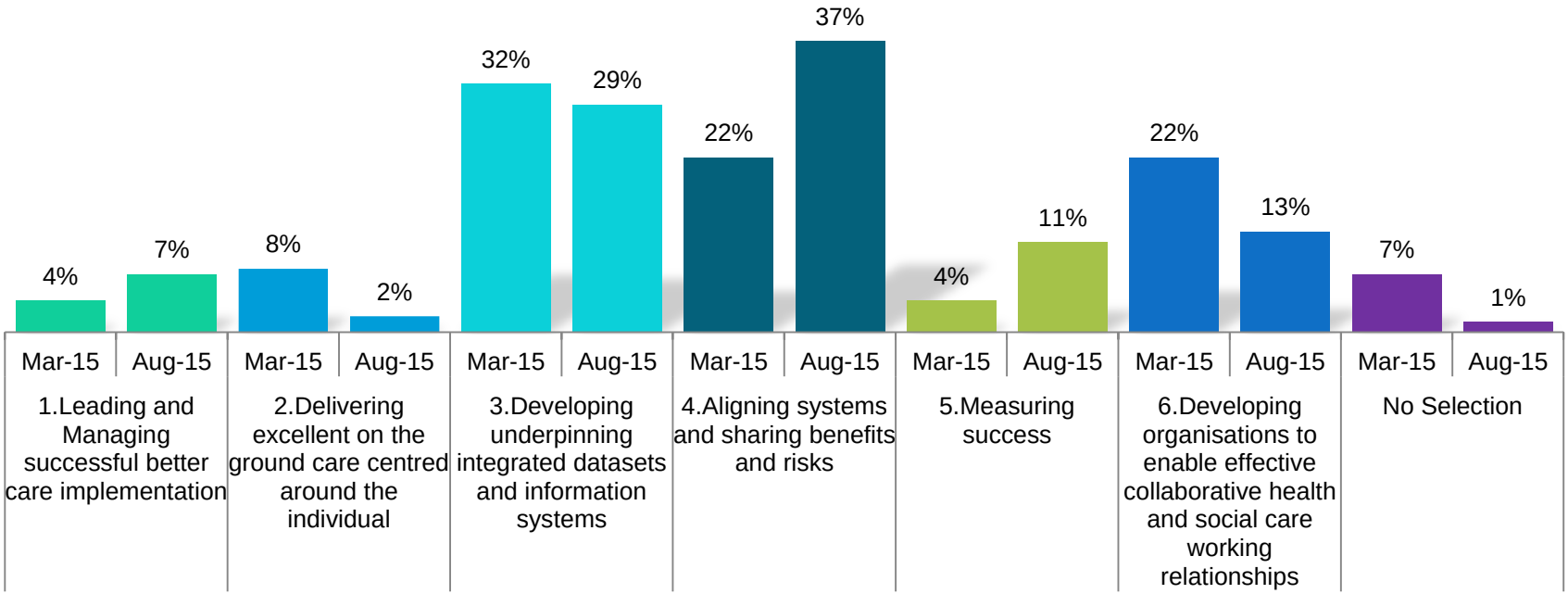
SECTION C
Support needs

12. Update on key barriers

As part of the Q1 reporting template HWBs were asked to reassess which area of integration they felt was the greatest challenge or barrier to success.

When compared to answers given to the same questions through the BCF readiness survey in March 2015 we can see an increased focus on aligning financial systems, measuring success, and leading and managing change.

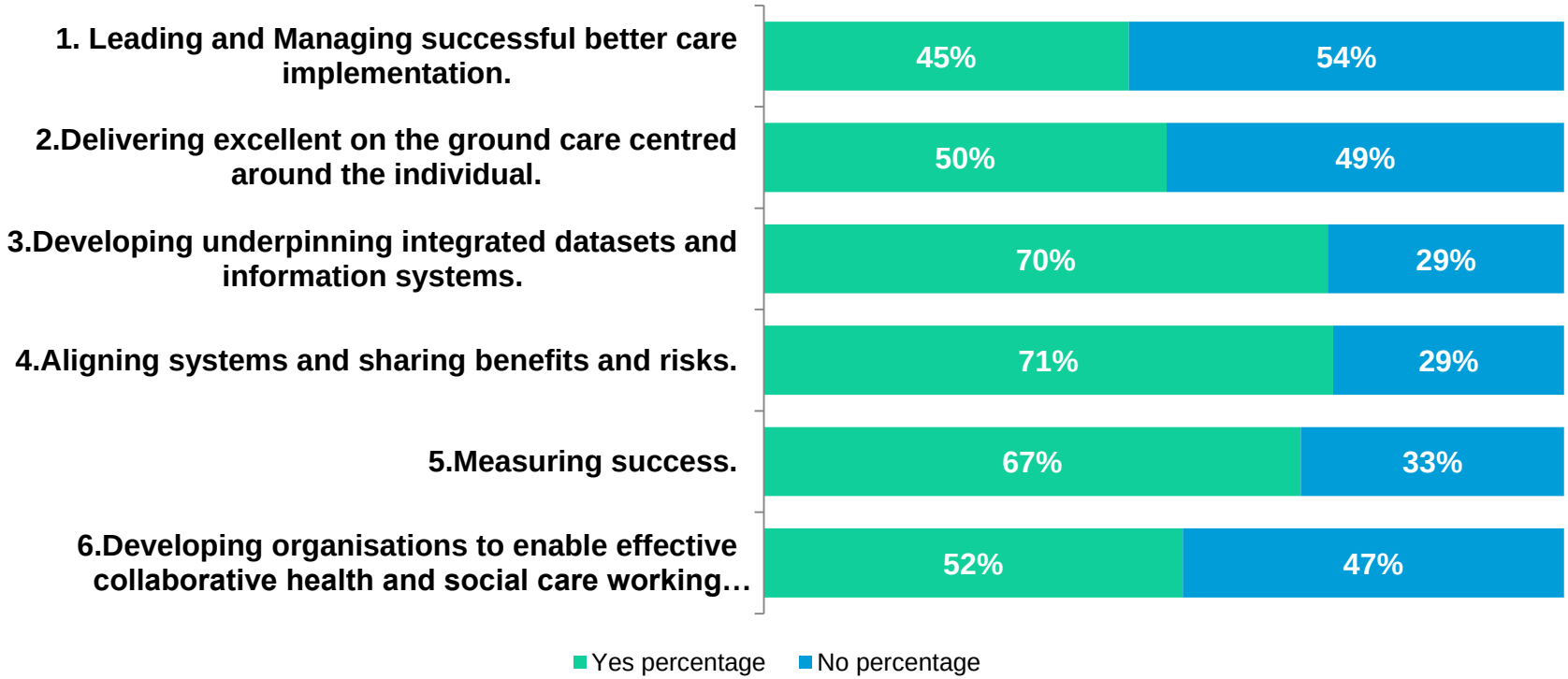
Integrating datasets and information systems, and developing organisations to work collaboratively have decreased in priority but remain significant.



13. Interest in support - by theme

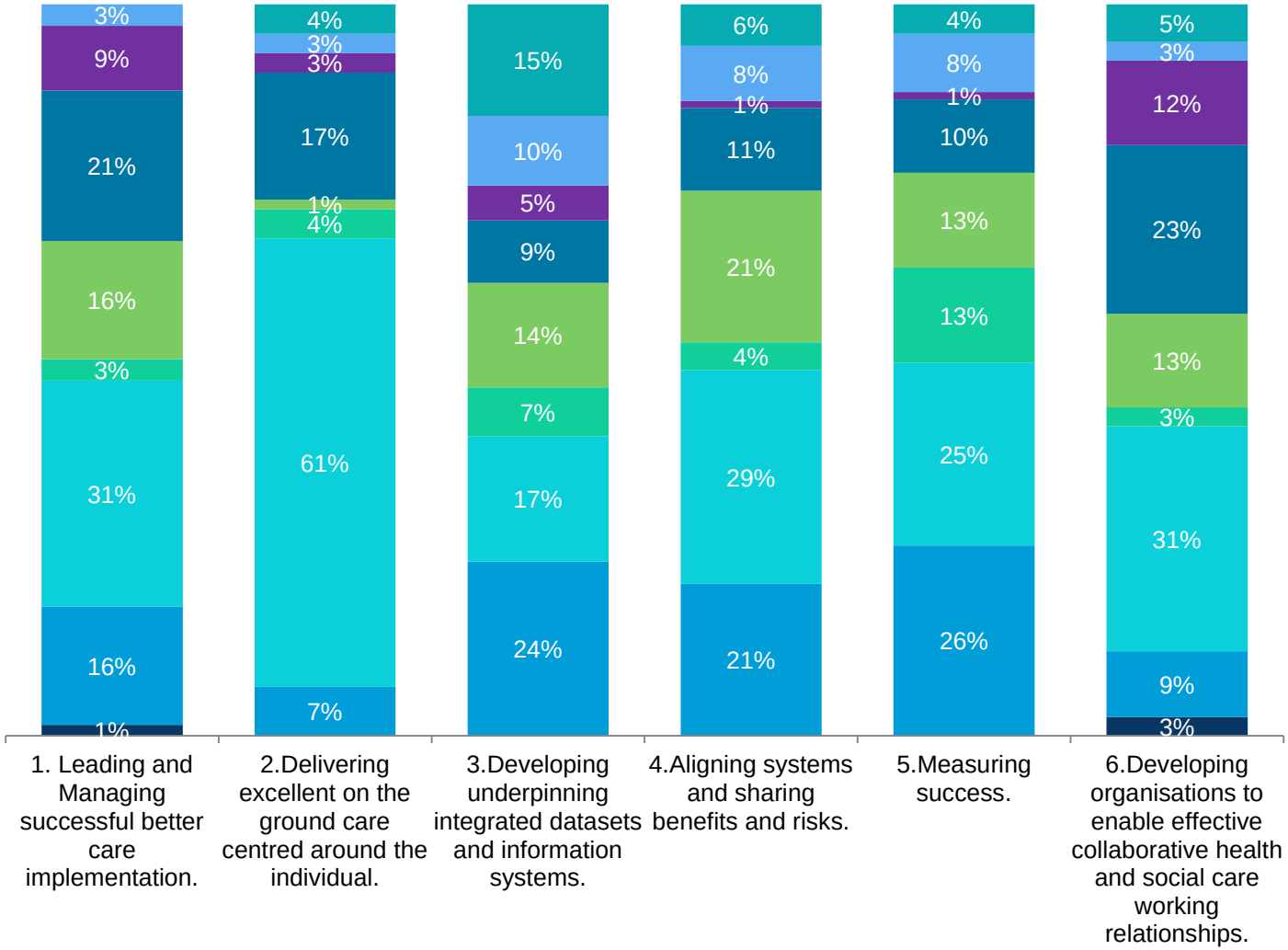
We also asked HWBs, for each theme, whether they would welcome support from the national team. The below is based on 149 HWBs who answered this question.

The results suggest there is generally a high level of interest in support on all themes, not just those the BCST has focused on to date – or those which are seen as key barriers.



14. Interest in support - by delivery method

We then asked those HWBs who indicated interest in support on a theme, what format they would most value support being provided in.



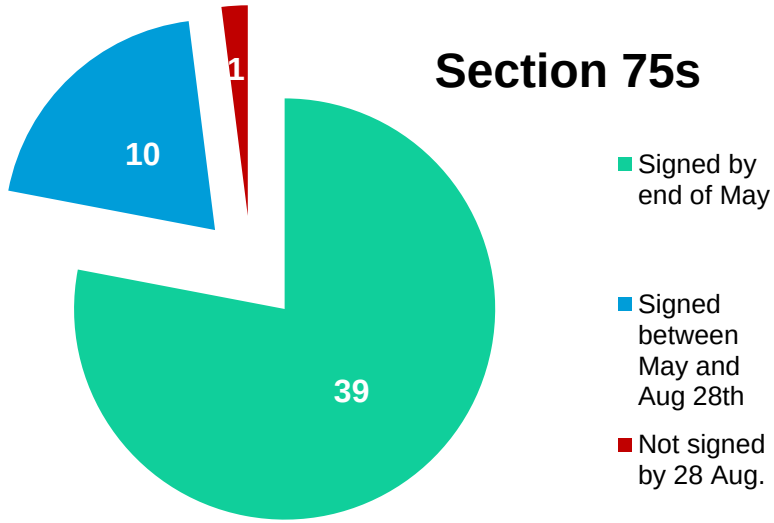
SECTION D
Regional summary headlines

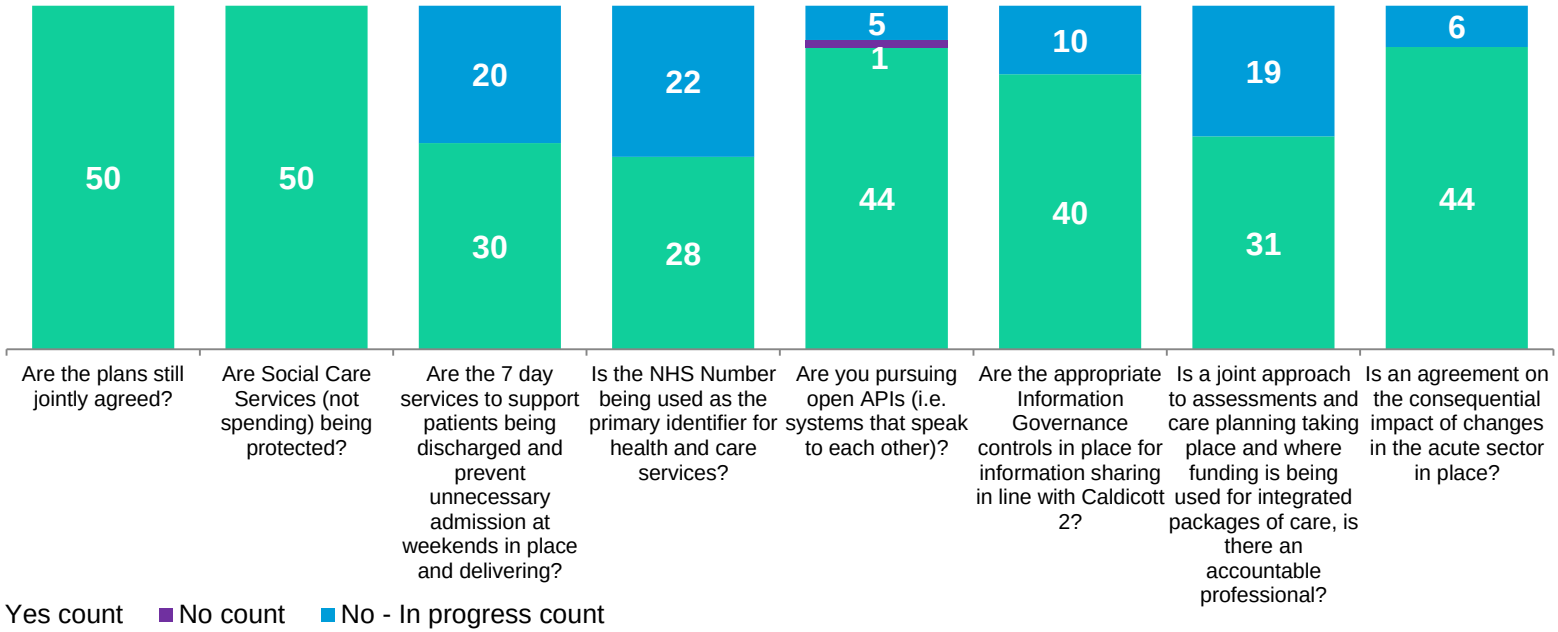
REGION
The North of England

15. Pooled budgets and national conditions

The North of England

- York is the only HWB in the North that has not yet signed a Section 75 agreement. The aim to have this signed by 31st October.
- All HWBs in the North have indicated that plans are still agreed and social care is still protected





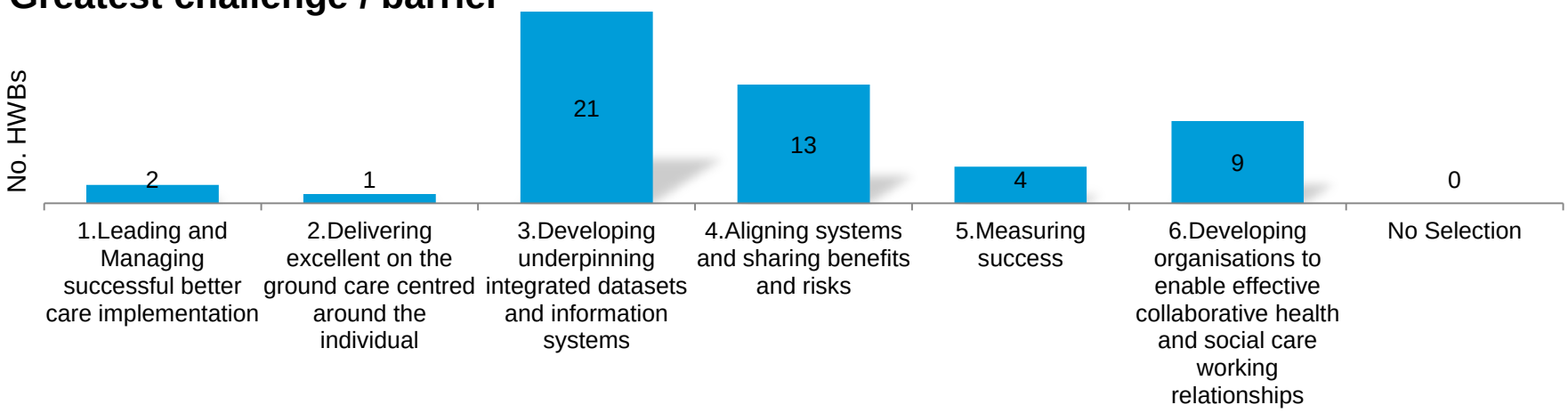
16. Points of interest – The North

- **6 HWBs have indicated no agreed impact on the acute sector**: Cheshire East, Liverpool, Manchester, Sheffield, Warrington, and Wirral
- ✓ **A total of £16.028m has been paid in P4P** across the North of England for Q4 2014-15 and Q1 2015-16, £3.617m more than would be expected based on the number of Non-Elected Admissions avoided.
- **10 HWBs have agreed a local P4P payment that is below the expected level**: South Tyneside, Blackburn with Darwen, Tameside, Bradford, Calderdale, Doncaster, Kirklees, Leeds, Sheffield, and Wakefield
- ✓ **17 HWBs in the North achieved their target for Non-Elective admissions in Q1:** Bradford, Calderdale, Cumbria, Darlington, East Riding of Yorkshire, Halton, Kingston upon Hull, Kirklees, Knowsley, Liverpool, Middlesbrough, Oldham, Redcar and Cleveland, Salford, St. Helens, Wigan, and Wirral.

17. Support Needs – the North

- HWBs in the North consider developing underpinning integrated datasets and information systems as the biggest challenge in delivering integrated care
- **15 HWBs indicated they would welcome support in all 6 areas:** Barnsley, Blackburn with Darwen, Blackpool, Bolton, Bury, Cheshire East, Cumbria, Darlington, Gateshead, Lancashire, Manchester, Middlesbrough, Redcar and Cleveland, Wakefield, Wirral
- **A number of HWBs have indicated they would welcome hands on support in one or more specific theme:** theme 3 - Bolton, Bury, Calderdale, Cheshire West and Chester, Gateshead, Manchester, Rotherham, Tameside; theme 4 - Cheshire West and Chester, Tameside; theme 5 - Bradford, Manchester, Rotherham, Tameside; theme 6 - North Lincolnshire.

Greatest challenge / barrier



Key lines of Enquiry – all regions

The data provided by local areas through the second BCF quarterly return suggests a number of areas that require follow up in order to better understand the issues behind the. The information in this pack is a snapshot but provides a guide of where to look further at the full data provided. Regional BCF leads are asked to consider the following questions after reviewing this pack:

- Does the information provided indicate any localities that require significant support - and if so is this something we can work together to broker?
- Have the HWBs who had not signed Section 75s when returns were submitted on 28 August now signed?
- Does the information on National Conditions point to any areas of concern in your region – particularly on the protection of social care and agreement of impact on the acute sector?
- What support might help the high no. of HWBs who are yet to fully meet the conditions for: 7 day services, joint assessments and care planning, and use of the NHS number?
- Why do some areas appear to have paid less into their Payment for Performance fund than they should have?
- What is driving success in those areas making progress on Non-Elective Admissions and Delayed Transfers of Care?
- Are those HWBs who have indicated a desire for support getting what they need?

Health and Wellbeing Board

1.	**Date:**	**25th November 2015**
2.	**Title:**	**Suicide Prevention and Self-Harm Action Plan Update**
3.	**Directorate** **Public Health**	**Report author: Ruth Fletcher-Brown** **Public Health Specialist** **Ruth.Fletcher-Brown@rotherham.gov.uk**

4. Summary

Following on from the special meeting of the Rotherham Health and Wellbeing Board on 18 May 2015 to consider the Independent Review of a series of suicides involving children and young people, this paper will provide a progress report on actions detailed in the Rotherham Suicide Prevention and Self Harm Action Plan.

5. Recommendations

That the Health and Wellbeing Board:

- To accept and endorse the report on actions taken by the Rotherham Suicide Prevention and Self Harm Group.
- To note the Office of National Statistics data on suicides and undetermined deaths from 2009-2014.
- To endorse the recommendations for future activity.

6. Background

6.1 Suicides are not inevitable. They are often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity. This can only be done by working collaboratively across all sectors within Rotherham. Suicide causes much distress to the families and friends affected and this has to be the prime factor for prevention and intervention work in this area. In addition it is estimated that each suicide in England costs on average £1.7 million.

6.2 The All Party Parliamentary Group (APPG) on Suicide and Self-harm published an "Inquiry into Local Suicide Prevention Plans in England" January 2015. The APPG considered that there were three main elements that are essential to the successful local implementation of the national strategy. All Local Authorities must have in place:

a) Suicide audit work to in order to understand local suicide risk.
b) A suicide prevention plan in order to identify the initiatives required to address local suicide risk.
c) A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local plan.

6.3 Under the Health and Social Care Act 2012 Public Health transferred into the Local Authority. As suicide prevention is a Public Health Outcome Framework

indicator (PHOF), the Director of Public Health established a Suicide Prevention Group in 2012. This group developed an action plan based on the Government guidance: "Preventing suicide in England A cross-government outcomes strategy to save lives": https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

The strategy outlined six areas for action:-

1. Reduce the risk of suicide in key high risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

7. Progress report

The Rotherham Suicide Prevention and Self Harm Group are able to report the following actions in the eight areas and show areas of development:

7.1 Increase local level of understanding suicide and establish reporting mechanisms to strategic partners

Actions include:

- The Rotherham Suicide Prevention and Self Harm Group meets bimonthly to review progress on action plan, receive suicide audit data and recommend any necessary response, for example high risk groups.
- The Suicide Audit Group chaired by the Public Health Specialist for Mental Health, meets bimonthly to review suspected suicides and action any public health preventative measures. Suicide data is received in real time and immediate actions, for example support for children and young people has already taken place.
- A Suicide Audit Report looking at the epidemiology of suicides from the period 2009-2014 is being prepared by RMBC, RCCG, SYP and RDaSH. It will be completed by December 2015.

7.2 Reduce risk in high risk groups- Children and young people

Actions include:

- Partner organisations signed up to the LSCB Rotherham Suicide and Self-harm Community Response Plan in September 2015.
- The Rotherham Suicide and Self-harm Community Response has been activated for serious self-harm incidents in Rotherham with good support from all Partner organisations.
- Rotherham Suicide Prevention and Self Harm Group Prevention Group are reviewing the national guidance on suicide clusters and at the next meeting in early 2016 will decide if an adult suicide response plan is needed similar to the one used for children and young people.
- Public Health Specialist for Mental Health and CAMHS Commissioners for RCCG and RMBC have ensured the Child and Adolescent Mental Health (CAMHS) pathways for universal workers (incl self-harm, emotional health

and wellbeing , ASD, ADHD, post abuse) are now on the www.mymindmatters.org.uk

- Rotherham Self-Harm Practice Guidance to be launched by end of November 2015, hard copies will be available funded by Rotherham Public Health.
- Social marketing suicide prevention campaign for men in the early stages of development and draft campaign material to be shared with the Rotherham Suicide Prevention and Self Harm Group in early 2016.
- Social marketing campaign for young people still to be developed.
- GP referral pathway for domestic abuse was updated by Rotherham CCG in November 2015.
- CARE about suicide training run by Public Health Specialist and Human Resource Officer for over 100 workers in Revenues and Benefits, some HR Officers and Trade Union Staff and approximately 40 Housing Officer Staff.
- Rotherham Public Health has funded the reprint of the CARE about suicide resource for Universal workers and the general public. This will be given to Partners to distribute to their staff and general public.

7.3 Tailor approaches to improve mental health in specific groups

Actions include:

- My Mind Matters website for young people, parents/carers and practitioners launched in July 2015.
- The new Rotherham Health and Well Being Strategy incorporate targets and actions to improve the emotional health and well-being of children and young people.
- CAMHS Transformation plan incorporates actions to look at vulnerable and at risk groups, for example Lesbian, Gay, Bisexual and Transgendered young people (LGBT)

7.4 Reduce access to means

Actions include:

- Examples of action include work by Rotherham Trading Standards who investigated Paracetamol sales at sites near to one school in Rotherham where the Rotherham Suicide and Serious Self Harm Response Plan had been activated. Further work has included messages to the general public via the Rotherham Public Health Channel regarding the safe storage of medication and work with GPs to remind patients about safe storage.

7.5 Better information and support to those bereaved by suicide

Actions include:

- The Children and Young People's Bereavement pathway is activated by South Yorkshire police, Children's Social Care when a child is either bereaved by suicide and/or witness to the death.
- Rotherham GPs have been given the link to the national bereavement resource, 'Help is at hand'. This has been circulated to all Partners on the Rotherham Suicide Prevention and Self Harm Group.
- Adult bereavement pathway is in development and it is anticipated that this will be launched early 2016.
- The Rotherham Suicide Prevention and Self Harm Group will be putting together a business case for longer term support for those bereaved by suicide.

7.6 Support media in delivering sensitive approaches to suicide and suicidal behaviour

Actions include:

- Use of Partner organisation's communications to promote messages to the general public; websites, Qmatic screens (RMBC), Rotherham Public Health Channel and twitter feeds from SYP and RMBC to highlight support to people affected by suicide.
- Local media has promoted the CARE about suicide resource and helpful organisations both local and national.
- Media summit to be held.

7.7 Data collection and monitoring

Actions include:

- Rotherham's participation in Public Health England's the real time suicide surveillance pilot from September 2015 and proposal for this to continue as a means to direct suicide prevention actions across the borough.
- Suicide Audit report being produced end of December 2015 which looks at suicides from 2009 to 2014, initial data from the Office of National Statistics can be found in Appendix 1.

7.8 Workforce Development

Actions include:

- 3 courses of Youth Mental Health First Aid funded and delivered by Rotherham Public Health. Funding for manuals and venue hire from Rotherham CCG and LSCB. Three courses held from May to November, 35 people attended this training from Statutory and Voluntary sectors.
- 2 courses of Adult Mental Health First Aid to be delivered by December 2015, Rotherham CCG funded the manuals and the venues and Rotherham Public Health funded the training costs. Fourteen people attended the November course from Statutory and Voluntary sectors.
- Rotherham Public Health and Human Resources (RMBC) delivered suicide prevention training to over 100 frontline RMBC staff between January and November. Post evaluation is currently taking place to measure changes in knowledge and confidence. Evaluation to be completed by December 2015.

8. Finance implications

The report will have financial implications:

8.1 Workforce Development: Rotherham Clinical Commissioning Group (CCG) and Rotherham Public Health are funding Mental Health First Aid (MHFA) training for adults and Youth MHFA for 2015/216 with a contribution from the LSCB for the Youth training. There are only 2 Youth MHFA Trainers in the whole of Rotherham and 3 Adult MHFA Trainers. The existing Trainers do not have the capacity to meet the demand for this internationally and nationally recognised qualification for frontline workers. If investment is not made in securing further Trainers in 2016/17 the only contribution will be from Rotherham Public Health. Funding will also be needed for the manuals, venue and catering costs. Workforce development is a priority area for funding as part of the CAMHS Transformation Plan. This will address training for suicide prevention and self-harm where it relates to children and young people.

Option 1 Funding further Instructors would cost £2737.74 per Trainer, plus travel and subsistence costs. Additional costs for course delivery would include; manuals, venue and catering costs, total approximate cost £800.

Option 2 No further Trainers in Rotherham trained and training instead bought in at a cost of £300 per person, with 16 people per course. Additional costs for course delivery would include; manuals, venue and catering costs, total approximate cost £800.

In addition further for suicide prevention courses like Applied Suicide Intervention Skills Training (£3900) and Safe Talk (£1500). Venue costs £460.

8.2 Bereavement support: Partner organisations are working on a bereavement pathway for adults. Investment is required to support the long term needs of children and adults bereaved by suicide and the Rotherham Suicide Prevention and Self Harm Group will be looking to put together a business case.

8.3 Suicide prevention campaign for young people and men: Work has commenced on the campaign for men. For any campaign to have an impact it needs to evolve throughout the year rather than be a static campaign. It should be relevant to specific times of the year when people may be more vulnerable to suicide ideation and changing risk factors. The campaigns should respond to any new trends emerging from the suicide surveillance information, for example different groups at risk. The campaigns should also respond to national events like men's health week, World Mental Health Day and National Suicide Prevention Day. Approximate costings for this work £5000 per campaign. The two campaigns prioritised for 2015/16 are men and young people.

9. Risks and Uncertainties

9.1 Research in Scotland (Scottish Public Health Observatory, 2015) indicates that there is a clear linear relationship between deprivation and the overall suicide rate. Whilst our data for Rotherham shows there is a moderate positive relationship between deprivation and suicide, the most deprived wards do have a higher concentration of suicide risk factors, for example, unemployment and mental health problems. Both the suicide audit results and the real time suicide surveillance data indicate that Rotherham suicide numbers continue to increase.

9.2 Families and communities bereaved by suicide are at higher risk of subsequent suicides than the general population. Postvention work in this area is an important in suicide prevention work.

10. Policy and Performance Agenda Implications

10.1 The actions within the Rotherham Suicide Prevention and Self-Harm Action plan are reflected in the Crisis Care Concordat and the recommendations made in the Rotherham Independent Review.

10.2 The APPG considered that there were three main elements that are essential to the successful local implementation of the national strategy. All Local Authorities must have these in place. In the APPG 2015 report Rotherham was one of two boroughs n the Yorkshire and Humber region with all three elements. With continued commitment from partner Organisations Rotherham can continue to meet all three elements.

11. Background Papers and Consultation

Appendix 1 Appendix 1 Rotherham Suicides & Undetermined Deaths 2009-2014

Rotherham Suicide Prevention and Self-Harm Action Plan 2015/16

Department of Health, Statistical update on suicide February 2015 (2015), https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405411/Statistical_update_on_suicide_acc.pdf

HM Government (2015) Crisis Care Concordat: http://www.crisiscareconcordat.org.uk/

HM Government (2015), Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives

Public Health England (PHE), (2014) Guidance for developing a local suicide prevention action plan: information for public health staff in local authorities, https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

Public Health England (PHE), (2015), Identifying and responding to suicide clusters and contagion: A practice resource, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459303/Identifying_and_responding_to_suicide_clusters_and_contagion.pdf

Samaritans (2012) Men, Suicide and Society: Why disadvantaged men in mid-life die by suicide: http://www.samaritans.org/aboutus/our-research/research-report-men-suicide-and-society

The National Mental Health Intelligence Network (NMHIN) and Public Mental Health Team launched the Suicide Prevention Profile on the Fingertips website in March 2015. This provides the latest data on suicides for local areas. You can access the tool directly from the link here: http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide.

The Scottish Public Health Observatory, (2015) Suicide and Deprivation: http://www.scotpho.org.uk/health-wellbeing-and-disease/suicide/data/deprivation

12. Contacts

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Director: Teresa Roche, Director of Public Health Email:
Teresa.roche@rotherham.gov.uk

Appendix 1 Rotherham Suicides & Undetermined Deaths 2009-2014

The data presented in this paper is sourced from the Office of National Statistics (ONS). ONS publishes suicide statistics for the UK as a whole and for England and Wales. In England and Wales, all suicides are certified by a coroner following an inquest. The death cannot be registered until the inquest is completed, which can take months and ONS is not notified that a death has occurred until it is registered. This means that suicide deaths are presented in the year they were registered which might not necessarily be the year the death occurred. For example a suicide death registered in 2013 may have been a death in 2012. It also means that inquests for some deaths occurring in 2015 have not been closed and therefore have not been registered with the ONS.

In September 2015 Rotherham took part in a real time suicide surveillance pilot. This pilot enabled Rotherham Partners like Public Health, South Yorkshire Police and the local NHS to look at suspected suicides before the verdict has been given by the Coroner. By looking at suspected suicides in real time, suicide preventative measures can be implemented as soon as possible. The data from the real time suicide surveillance will form part of Rotherham's final Suicide Audit Report which will be completed by December 2015.

In summary the data from ONS 2009- 2014 illustrates:

- The suicide trend in Rotherham compared with the Yorkshire and Humber region and England as a whole.
- Years of life lost
- Day and month deaths occurred
- Underlying cause
- Gender and age split
- Rotherham suicide rates per ward

Rotherham Residents – Mortality from Suicide and Injury Undetermined 2010-2014
• *Based on data from the Office of National Statistics supplied by the Health and Social Care Information Centre*.*
− Annual rates have been increasing since 2010.
Rotherham rates were well below Yorkshire & the Humber Region and England between 2009 and 2011, similar in 2012 then rose above in 2013 (see Chart 1)

Official data is not yet available for Yorkshire & the Humber or England for 2014 but Rotherham suicide/undetermined deaths decreased by around 20% over 2013. However, unofficially, deaths look to increase substantially based on 2015 registrations to September.

As life expectancy at birth in Rotherham is around 78 years for males and 81 and a half years for females, suicide shortens life prematurely and results in potential years of life lost. For Rotherham 2011-2013 combined 2,000 years of life were lost due to suicides. Rotherham is compared against its statistical neighbours and region in Charts 1a and 1b.

In general, Rotherham suicide/undetermined deaths were mostly males, peak age 40-49 with deaths most commonly by hanging/strangulation/suffocation. The highest numbers were to residents of Valley and Rotherham West wards. In females deaths were more likely to be 50 and over and by poisoning. Further details are below:

Overall:
• For deaths of Rotherham residents registered 2010-2014 inclusive (with 2010-2013 shown in brackets):
- 79% (77%) were male
- 91% (91%) were born in England
- 43% (44%) were in the 30-49 age group
- 72% (76%) of male deaths were aged under 50
- 65% (75%) of female deaths were aged 50 and over

Time and place:
- The highest number of deaths were of residents of the Valley and Rotherham West wards (2010-13 same)
- More suicides occurred towards the end of the week (but Tuesday highest day) (2010-13 same)
- There were very similar numbers of deaths by month between May and October otherwise variable (highest March, lowest in November, December and April)
(2010-13 similar but January and August also low months)

Methods
- 67% (69%) died by hanging /strangulation/suffocation
- 16% (14%) died by self-poisoning
- 79% (82%) of males died by hanging /strangulation/suffocation whereas the most common method for females was poisoning at 60% (50%)
- 54% (55%) died in their own home, 29% (29%) “elsewhere” (most common “elsewhere” location of death being in woods/woodland)

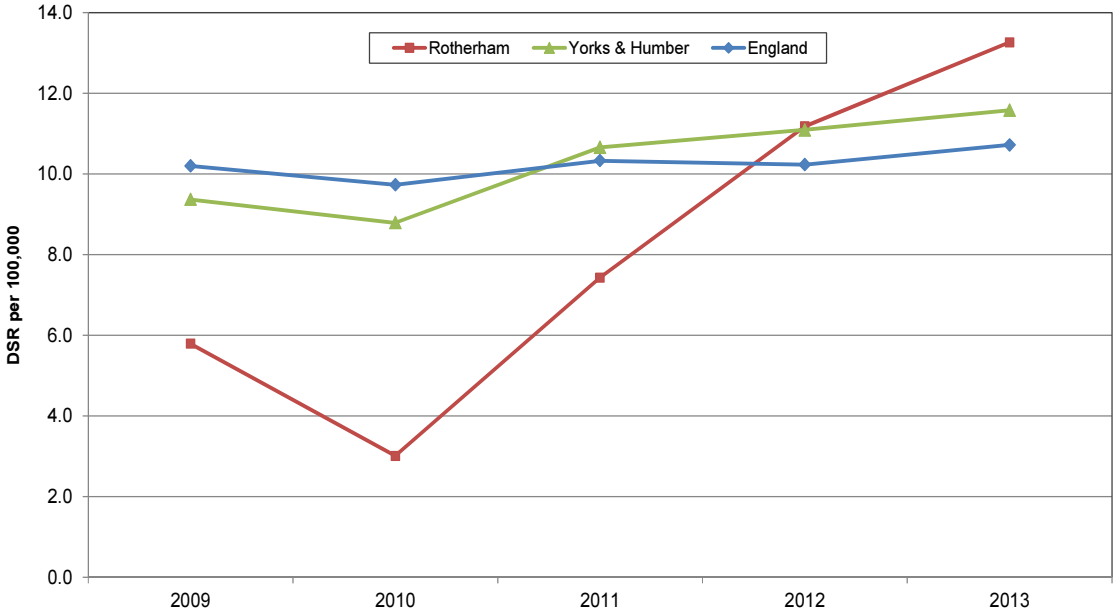
Trends
Percentages are similar between the two 5-year periods 2009-13 and 2010-14. The main change is that female deaths increased in the under 50 age groups.

Note – Details of one suicide/undetermined death not available. Affects Findings above (except for gender/age group data and annual rates)
**Mortality from intentional self-harm and injury undetermined whether accidentally or purposefully inflicted (ICD-10 X60-X84, Y10-Y34) Re-use of data subject to Open Government Licence v.3.0: http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/*

Charts

Chart 1 - Trend Data (Rates)

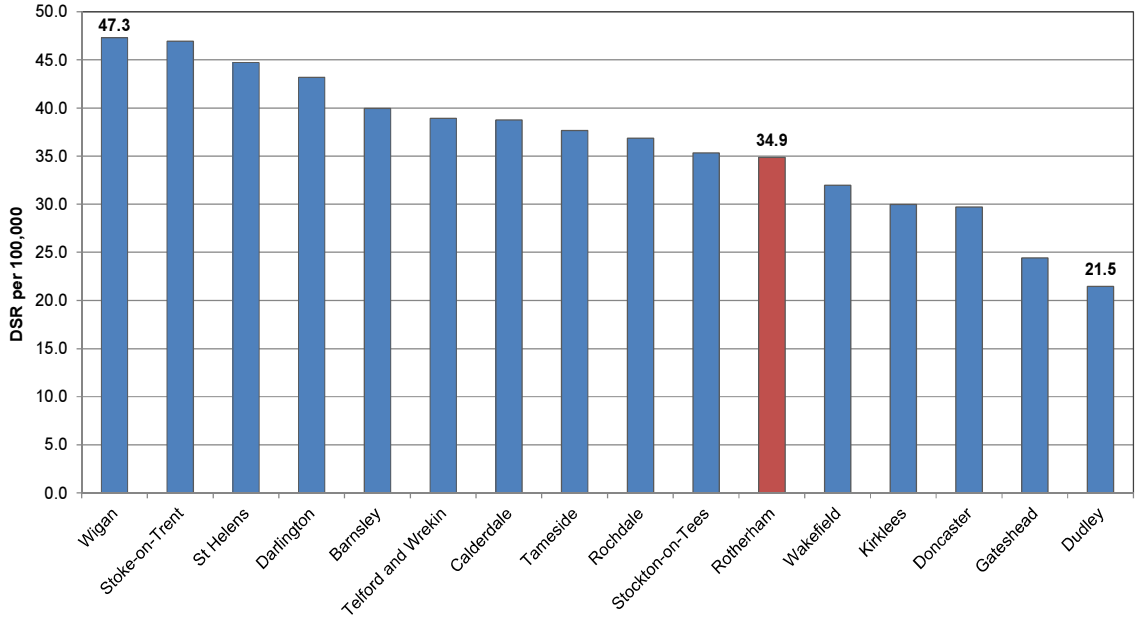
Mortality from Suicide and Injury Undetermined (Persons) (Age 15+)
Rotherham compared to Region and England - Directly Age-Standardised Rates per 100,000 by Year
Deaths Registered 2009 to 2013



Source: Office for National Statistics .

Chart 1a - Years of life Lost

Years of Life Lost due to Mortality from Suicide and Injury Undetermined (Persons 15-74 years)
Rotherham compared to Statistical Neighbours* - Directly age-Standardised Rates per 100,000
Deaths Registered 2011 to 2013 (Pooled)

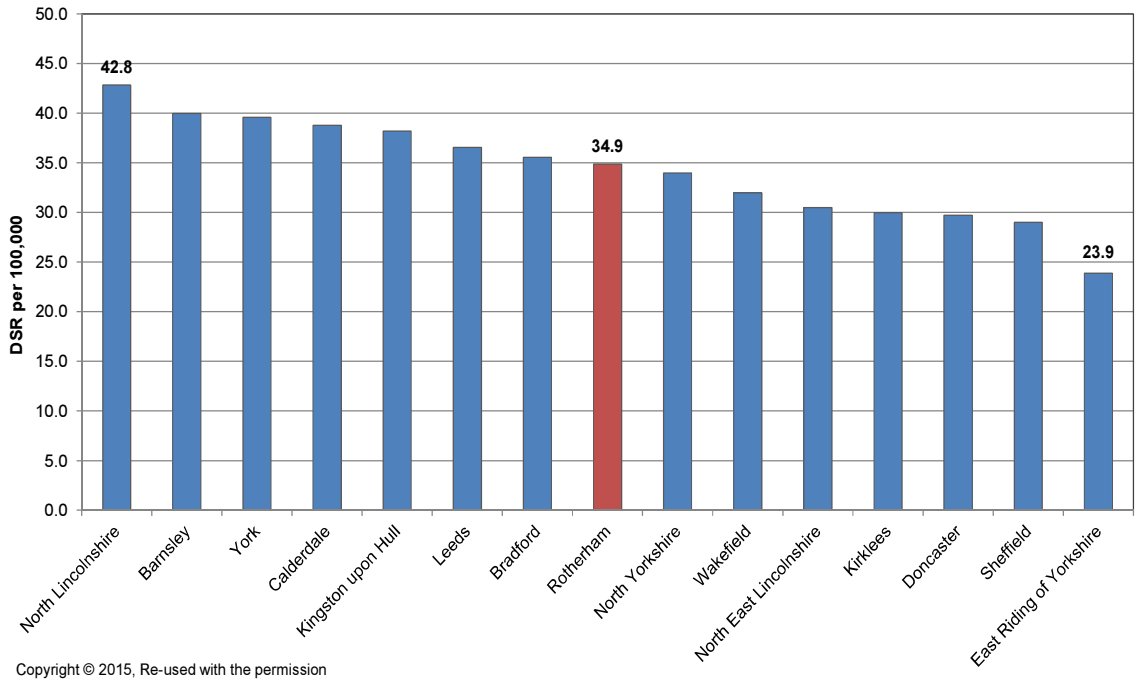


*CIPFA Classification

Source: Office for National Statistics .

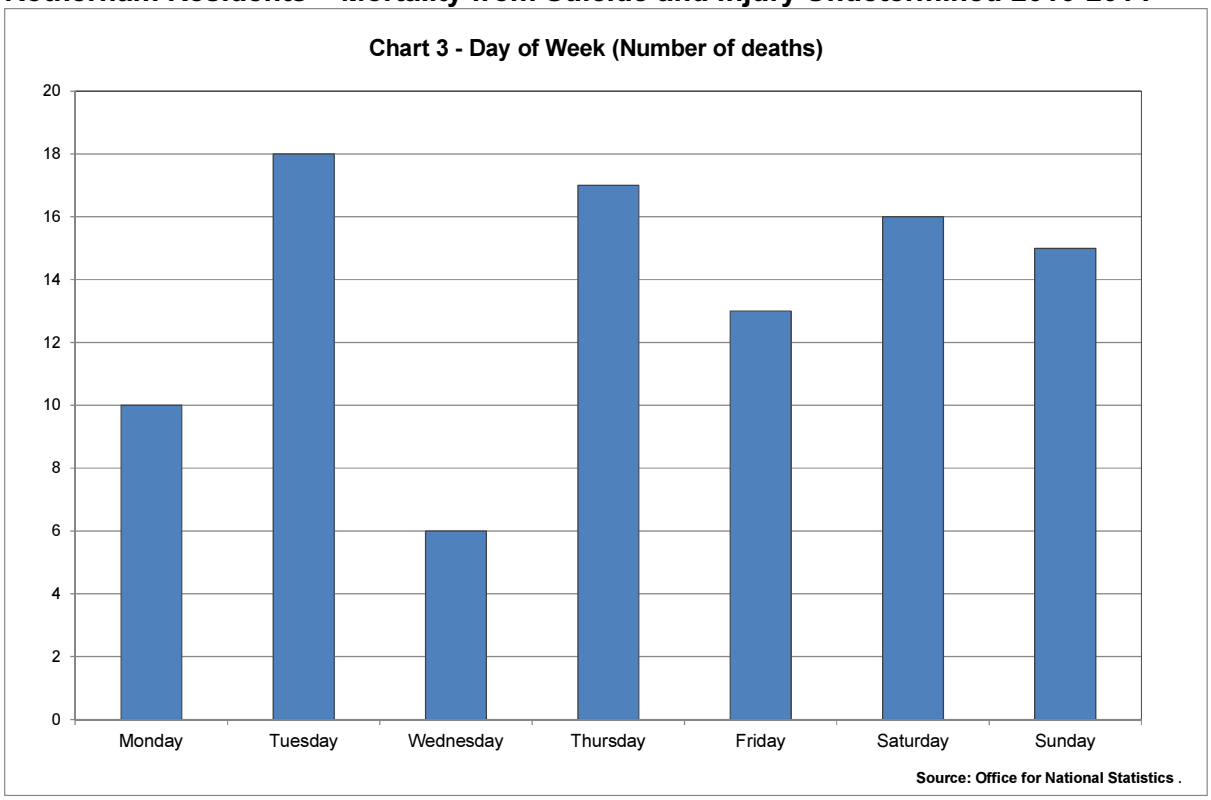
Chart 1b - Years of life Lost

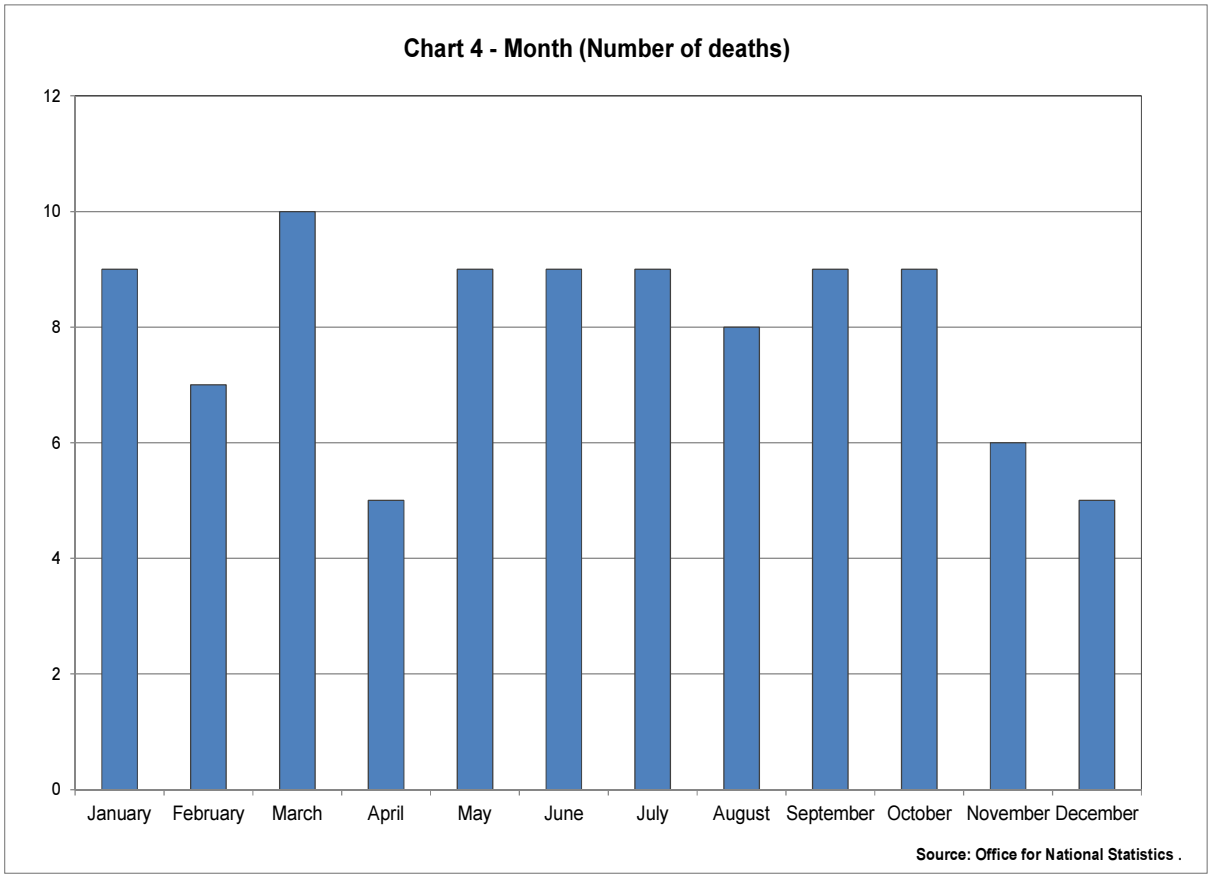
Years of Life Lost due to Mortality from Suicide and Injury Undetermined (Persons 15-74 years)
Rotherham compared to Yorkshire and Humber Region - Directly age-Standardised Rates per 100,000
Deaths Registered 2011 to 2013 (Pooled)



Source: Office for National Statistics .

Rotherham Residents – Mortality from Suicide and Injury Undetermined 2010-2014





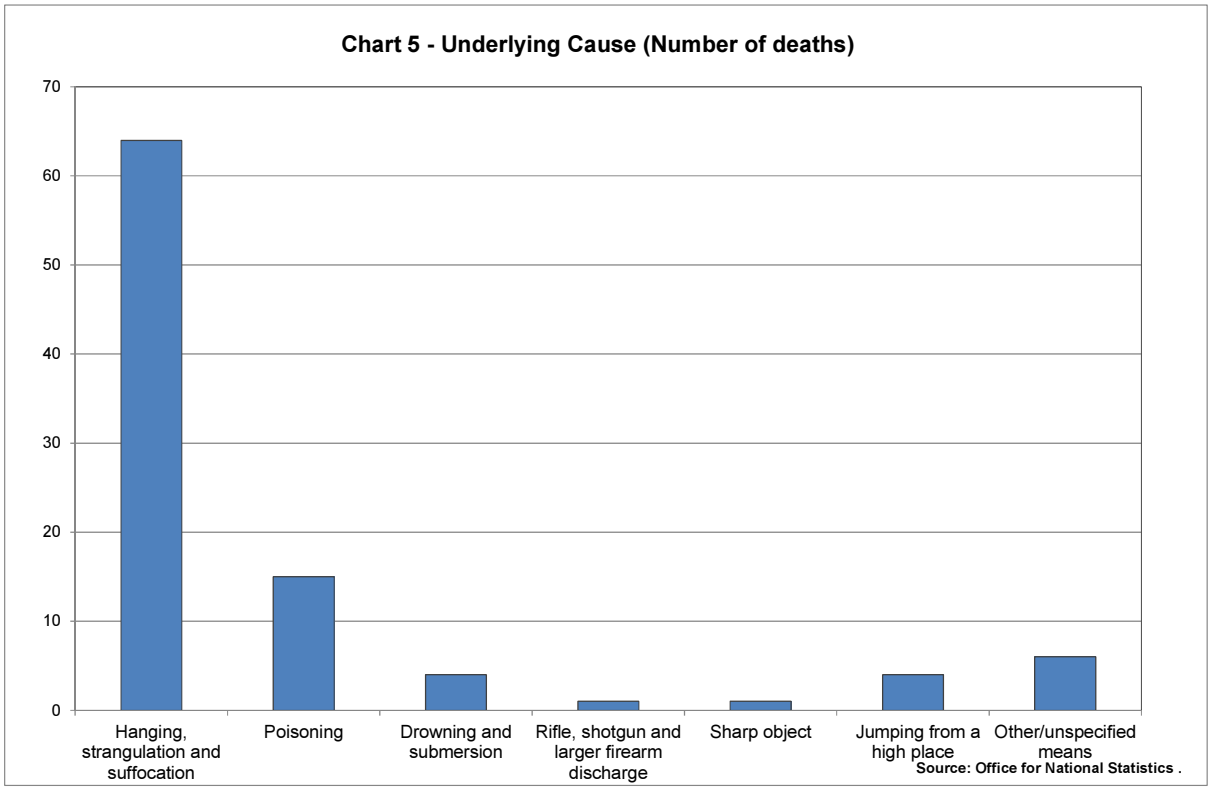


Chart 5 - Underlying Cause (Number of deaths)
70
60
50
40
30
20
10
0
Hanging, strangulation and suffocation
Poisoning
Drowning and submersion
Rifle, shotgun and larger firearm discharge
Sharp object
Jumping from a high place
Other/unspecified means
Source: Office for National Statistics .

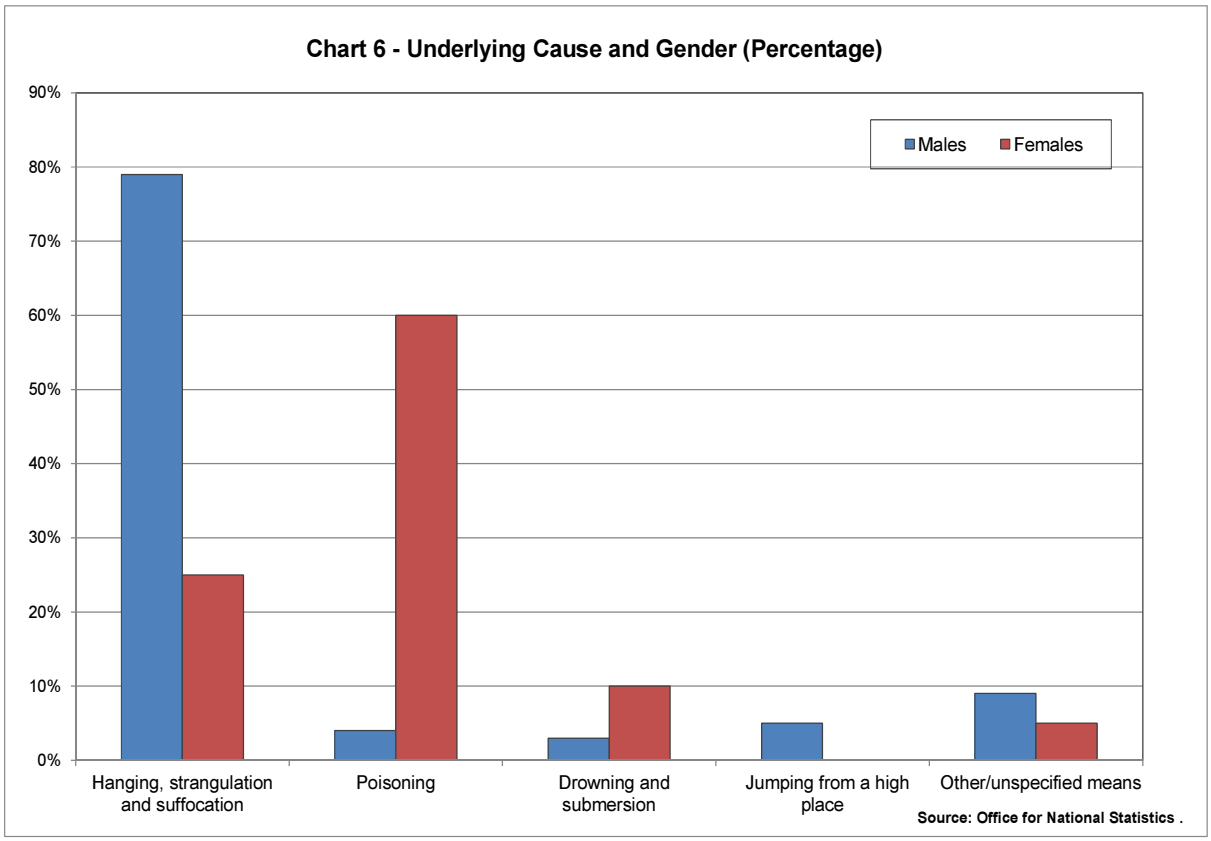


Chart 6 - Underlying Cause and Gender (Percentage)
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Males
Females
Hanging, strangulation and suffocation
Poisoning
Drowning and submersion
Jumping from a high place
Other/unspecified means
Source: Office for National Statistics .

Tables

Rotherham Residents – Mortality from Suicide and Injury Undetermined 2010-2014

Note- data for Tables 3 to 6 is missing details for one death registration which was not present in the source data.

Table 1

Gender	Count
Males	76
Females	20
Persons	96

Source - Office for National Statistics.

Table 2

Age Group	Males	Females	Persons
0-19	5	0	5
20-29	11	4	15
30-39	15	1	16
40-49	24	2	26
50-59	12	5	17
60-69	1	4	5
70+	8	4	12
All Ages	**76**	**20**	**96**

Source - Office for National Statistics.

Table 3

Ward of usual residence	Count
Anston and Woodsetts	2
Boston Castle	7
Brinsworth and Catcliffe	7
Dinnington	5
Hellaby	4
Holderness	3
Hoober	2
Keppel	5
Maltby	6
Rawmarsh	4
Rother Vale	6
Rotherham East	4
Rotherham West	8
Silverwood	4
Sitwell	4
Swinton	0
Valley	9
Wales	3
Wath	2
Wickersley	5
Wingfield	5
Rotherham	**95**

Source - Office for National Statistics.

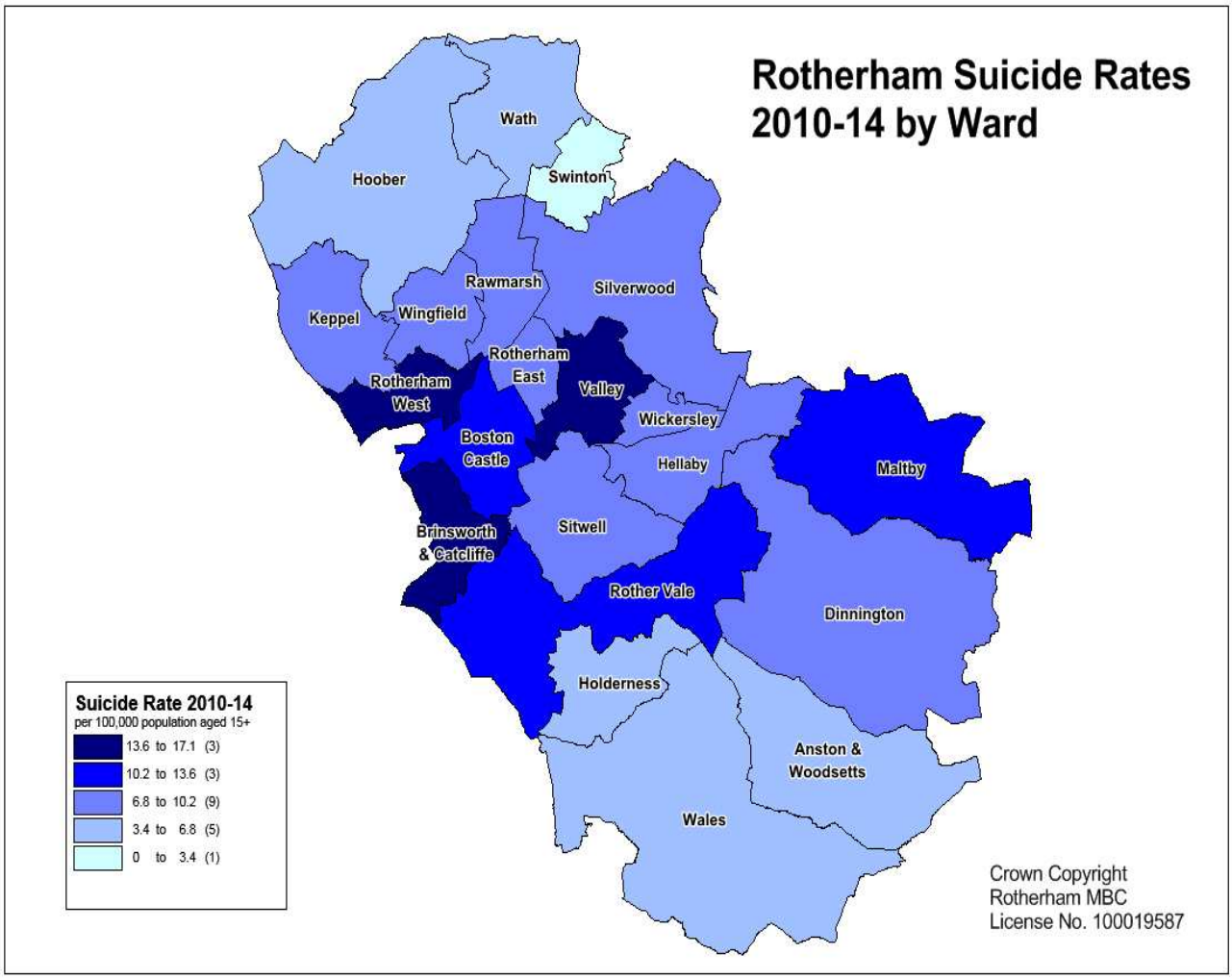

Rotherham Suicide Rates
2010-14 by Ward
Wath
Swinton
Hoober
Rawmarsh
Silverwood
Keppel
Wingfield
Rotherham
East
Rotherham
West
Valley
Wickersley
Boston
Castle
Hellaby
Maltby
Brinsworth
& Catcliffe
Sitwell
Rother Vale
Dinnington
Holderness
Anston &
Woodsetts
Wales
Suicide Rate 2010-14
per 100,000 population aged 15+
13.6 to 17.1 (3)
10.2 to 13.6 (3)
6.8 to 10.2 (9)
3.4 to 6.8 (5)
0 to 3.4 (1)
Crown Copyright
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Table 4

Day of Week	Count
Monday	10
Tuesday	18
Wednesday	6
Thursday	17
Friday	13
Saturday	16
Sunday	15
Rotherham	**95**

Source - Office for National Statistics.

Table 5

Month of Year	Count
January	9
February	7
March	10
April	5
May	9
June	9
July	9
August	8
September	9
October	9
November	6
December	5
Rotherham	**95**

Source - Office for National Statistics.

Table 6

Underlying Cause (ICD-10)	Count
Hanging, strangulation and suffocation	64
Poisoning	15
Drowning and submersion	4
Rifle, shotgun and larger firearm discharge	1
Sharp object	1
Jumping	4
Other/unspecified means	6

Source - Office for National Statistics.

Table 6 - Percentage by Cause and Gender

Underlying Cause (ICD-10)	Males	Females
Hanging, strangulation and suffocation	79%	25%
Poisoning	4%	60%
Drowning and submersion	3%	10%
Jumping from a high place	5%	0%
Other/unspecified means	9%	5%

Source - Office for National Statistics.

Relationship between Suicide and deprivation

The incidence of suicide in Rotherham at ward level 2010-14 does not have a direct linear relationship with deprivation although there are signs of some relationship. The 5 most deprived wards have a crude suicide rate of 12.7 per 100,000 which is double the average rate 6.3 per 100,000 for the rest of the Borough. There is no local relationship between deprivation and suicide in the majority of wards where deprivation is moderate to low. However, the correlation coefficient value of 0.45 indicates a moderate positive relationship overall.

A much larger study in Scotland (Scottish Public Health Observatory, 2015) shows a clear linear relationship between deprivation and the overall suicide rate. In each time period, the suicide rate was over three times higher in the most deprived decile than in the least deprived decile (24.5 deaths per 100,000 population compared with 7.5). The conclusion is that people living in the most deprived areas of Rotherham are significantly more at risk than those living elsewhere. The reality is that deprived areas have a concentration of people with suicide risk factors such as unemployment and mental health problems (see below) which is why there is a relationship.

Vulnerability to Suicide in Rotherham's Population

NHS Choices identifies a number of factors which can make people vulnerable to thoughts of suicide. Some of these are of unknown quality but others are readily quantifiable:

- Social isolation – living alone and/or not being in a relationship (couple)
- Lack of work or poor work – unemployment, long term sickness, lack of job satisfaction
- Mental health condition – disability or sickness linked to mental health
- Debt – struggling to meet outgoings, falling behind with payments
- Age and gender are relevant but Rotherham is very average in these respects.

The following table gives information about the **population aged 16+** (unless otherwise stated).

Vulnerability Factor	Number in Rotherham	Percentage of Population	English Percentage
Single People, not in couple 2011	44,826	21.8%	25.8%
People living alone 2011	30,902	14.9%	15.5%
Unemployed 2014/15 (APS)	10,050	4.8%	3.7%
Low skilled occupations 2014/15 (APS)	21,700	10.3%	9.9%
Disabled 2015 (claiming DLA)	17,520	8.3%	5.1%
Claiming DLA due to mental health condition 2015 (all ages)	2,900	1.12%	0.8%
ID 2015 Mood & Anxiety Disorders Indicator score (0 = national average)	N / A	0.515	0
Long term sick 2014/15 (APS)	12,025	5.7%	3.6%
Struggling to pay debts & bills 2014 (MAS)	65,500	31.2%	16.9%
On working age benefits 2015 (DWP)	28,010	13.3%	9.5%

Rotherham has a slightly lower percentage of its 16+ population living alone or single than the national average. Social isolation is therefore unlikely to make Rotherham more

vulnerable than average to suicides. However, other groups show a higher proportion in Rotherham, linked to disability/mental health and economic disadvantage. The largest difference is people with debt problems, who more likely than others to be depressed and even contemplate suicide, according to a report The Health Effects Indebtedness, BMC Public Health 2014.

Unemployment has been shown to be linked to higher rates of suicide (Suicides associated with the 2008-10 economic recession in England, Liverpool University, 2012 and Modelling Suicide and Unemployment 2000-2011, Zurich University, 2015). The Zurich University study using WHO data showed that 19% of suicides across 63 countries were linked to unemployment. The proportion of Rotherham's population who are unemployed is 30% above the national average so might be expected to result in more suicides. Another study (Unemployment as a risk factor for completed suicide, Sapienza University of Rome, 2014) identified underlying risk factors in unemployed people such as financial problems, lack of social support, stressful life events and high risk of personality disorders.

Allison Milner of Melbourne University, used a review and meta-analysis of other research into suicide and occupation, published by the Royal Society of Psychiatrists in 2013. This study showed significant differences by skill level, with the lowest and the second lowest skilled professions being at particularly elevated risk of suicide. This may relate to factors such as lower job satisfaction, lower pay, greater uncertainty and lack of control. Rotherham has a slightly higher than average proportion of its population in such occupations.

More significant for Rotherham is the high proportion of people who are disabled and/or have long term illnesses, related to both mental and physical health conditions. The Indices of Deprivation mental health indicator uses related hospital episodes, prescriptions, benefits and suicides. The positive score for Rotherham shows a significantly higher incidence of mood and anxiety disorders than the national average.

In 2015, Mary Hassell of St Pancras Coroners Office concluded that a man killed himself because his disability-related benefits were restricted after Work Capability Assessments found him "capable" of looking for a job. This is one example of suicides attributed to adverse welfare decisions; the DWP is reviewing such 40 cases. Disability campaigners claim that 60 to 80 suicides were linked to welfare reform. Whilst the evidence remains unclear, people on benefits are likely to be at greater risk of suicide and if their benefits are reduced or stopped, the risk is likely to increase. Rotherham has a high proportion of working age people who rely on benefits and notably long term sickness benefits. As 48% of those claiming the main long term sickness benefit ESA have mental or behavioural disorders, an underlying vulnerability exists which could be exacerbated by reductions in benefit.

A crude assessment, summing the aggregate numbers at risk, suggests that Rotherham could have about 25% more people in broad suicide risk groups than the national average.

SUICIDE PREVENTION AND SELF-HARM ACTION PLAN

2015/16

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS

Suicide is not inevitable. It is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity.

In 2012 the Government produced “Preventing suicide in England A cross-government outcomes strategy to save lives”:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

The strategy outlined six areas for action:

1. Reduce the risk of suicide in key high risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

This action plan outlines the actions agencies across Rotherham are taking to prevent suicides.

Rotherham takes suicide prevention seriously and the Director of Public Health Chairs the Suicide Prevention Group who are tasked to implement this plan. The Health and Wellbeing Board will receive a minimum of annual updates against the plan.

DRAFT - Suicide Prevention and Self-Harm Action Plan 2015/2016 Version 2

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
1. Increase local level of understanding suicide and establish reporting mechanisms to strategic partners: - **Health & Well-Being Board** - **Elected members** - **Clinical Commissioning Group** - **Safe Guarding Adults Board** - **Safeguarding Children Board** - **Rotherham Health Protection Committee**	Rotherham Suicide Prevention and Self Harm Group chaired by Director of PH to meet bi monthly Local Suicide Prevention and Self Harm Group reports to the Rotherham Health Protection Committee and the Rotherham Health and Wellbeing Board. Annually review membership of the Rotherham Suicide Prevention and Self Harm Group, ensuring voluntary sector membership.	Public Health Specialist (Mental Health)	Terms of Reference reviewed annually Update reports produced Membership reviewed annually	Terms of reference agreed including reporting mechanisms agreed and reviewed annually. Rotherham Suicide Prevention and Self Harm Group's membership reflects the partnership approach to suicide prevention.	**GREEN**
	Annual update on the epidemiology of suicides and actions taken against suicide prevention is provided to the Health and Well Being Board.	Rotherham Suicide Audit Group	April 2015	Partner activity of suicide prevention reflects local need	**AMBER**

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
2. Reduce risk in high risk groups- Children and young people	Rotherham Suicide and Self-harm Community Response Plan(2015) for children and young people to be revised to include the following : • Circles of vulnerability • Out of hours support and information • Management of severe self-harm behaviour • Letter and public information leaflet for use in schools and collages • Emerging national guidance	Consultant in Public Health Public Health Specialist (Mental Health)	Plan adapted by June 2015 Partner organisations signed up to the Rotherham Suicide and Self-harm Community Response Plan by September 2015	Rotherham Suicide and Self-harm Community Response Plan (2015) adapted and approved by Partner organisations	**GREEN**
	Rotherham Suicide and Self-harm Community Response Plan(2015) to be actioned within 24-48 hours of any event	Led by LSCB Supported by all agencies involved in Rapid Appraisal Process	In the event of a suspected death by suicide of a young person	Rapid Response process will ensure this happens. Rotherham is participating in the PHE Real Time suicide Surveillance Pilot. Rotherham Suicide Audit Group reviews all suicides.	**GREEN**

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	Ensure every school and college has been equipped with support materials in the event of self-harm or suicide. To include the following: • Template letter for schools to use to inform parent and carers • Policy for dealing with suicide or sudden death • Multi agency care pathway for emotional/ mental health issues.	Public Health Specialist (Mental Health)	June 2015	Schools and colleges using the recommended best practice	**AMBER**
	To launch the Child and Adolescent Mental Health (CAMHS) pathways for universal workers (incl self-harm, emotional health and wellbeing , ASD, ADHS, post abuse)	CAMHS Commissioners RMBC and RCCG to lead	Pathways to be launched in spring 2015	Universal workers across Rotherham working to the same pathways. Young people, parents and carers receiving consistent approach	**GREEN**
	Update the GP Top Tips and Directory of Services annually	RCCG CAMHS Commissioner	Ongoing	GPs make appropriate referrals	**GREEN**
	Support schools and colleges in identifying mental health problems in pupils through collaborative working between education and health professionals:	Public Health Specialist (Mental Health) working with CAMHS commissioners from Rotherham CCG, RMBC and CAMHS providers.	All schools and colleges received CAMHS Top Tips and Directory of Services in March 2015	Schools and colleges using CAMHS Top Tips and Directory of Services.	**GREEN**

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	- Promotion of the CAMHS Top Tips – Guidance on the referral of children and young people with emotional wellbeing issues into universal, targeted and RDaSH CAMHS services - Directory of Services – Information on services that provide emotional wellbeing support.				
	Development and launch of the Rotherham Self-Harm Practice Guidance 2015	Public Health Specialist (Mental Health) working with Rotherham Youth Cabinet and Rotherham Suicide Prevention and Self Harm Group	Guidance approved at H&WBB March 2015 Launch and promotion of guidance April 2015	Safe, timely and effective response to children and young people who harm themselves or are at risk of harming themselves.	**GREEN**
Reduce risk in high risk groups: Children and young people & middle aged men	Development of a local awareness campaign to target high risk groups. Two campaigns planned for 2015/16 based on local data: - Young people (15-21) - Males Campaigns will include social media marketing	Editorial Group to include PH Specialist (Mental Health), RMBC Communications & Media Manager, Rotherham Youth Cabinet, Rotherham Suicide Prevention and Self Harm Group.	Work Commencing April 2015		**RED**

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	techniques. Sources will include Public Health Channel, Qmatic Screens, social networking, PH website and non-health sites to promote messages. Campaigns to look at non health organisations and sites which could promote these messages				
Reduce risk in high risk groups : People experiencing domestic abuse	Promote awareness of this group amongst GPs – Development of GP Guidance / Referral pathway for people experiencing domestic abuse. Ongoing promotion of tis resource and annual review	PH Specialist, RMBC, Head of Contracts and Service improvement, CCG & RDaSH	Ongoing promotion of the flowchart and annual review July 2015	GPs better equipped to identify and support patients experiencing domestic abuse.	**GREEN**
Reduce risk in high risk groups: Rotherham residents affected by the changes to welfare reform	Training for frontline customer services using the CARE about suicide resource	PH Specialist (Mental Health), HR (RMBC), RDaSH Crisis Service working with Team Managers within RMBC to deliver training sessions for frontline customer service staff within RMBC	Training commenced February 2015. Training sessions ongoing until May 2015. .	Staff feeling better equipped to support people who may be in distress and/or expressing thoughts of suicide	**GREEN**

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
Reduce risk in high risk groups: witnesses of suicide	Develop supportive and signposting information for people who witness a suicide.	RDaSH and PH Specialist (Mental Health) with input from the Rotherham Suicide Prevention and Self Harm Group.	April 2015 leaflet send out for consultation May 2015 leaflet launched and used by frontline services for example SYP	People who witness suicides receiving timely and supportive information.	**AMBER**
3. Tailor approaches to improve mental health in specific groups	Development of the Emotional Health and Mental Health website for young people, parents/carers and professionals which will provide information on: - signposting - different mental/emotional health topics - self help - help in a crisis - looking after yourself	RMBC Commissioning & Public Health, working with Rotherham Youth Cabinet, Rotherham parents and carers and CAMHS Partnership Group.	Website developed with input from Rotherham Youth Cabinet, parents/carers and professionals March/April 2015 Launched May 2015	Comprehensive and reliable information on a variety of mental/emotional health topics including self-help guidance.	**GREEN**
	The new Rotherham Health and Well Being Strategy to incorporate targets and actions to improve the emotional health and well-being of children and young people(By Sept 2015).	Rotherham Health and Well Being Board	From April 2015 onwards	Partners all working to improve the mental health and well-being of children and young people.	**GREEN**

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	The development and implementation of the Emotional Wellbeing and Mental Health Strategy for Children and Young People 2014-2019.	RMBC and RCCG Commissioners & RMBC PH, working with Rotherham CAMHS Partnership.	Strategy has been approved by the H&WBB. Implementation is ongoing and monitored quarterly.	Improved services and support for children and young people in Rotherham regarding their emotional health and well-being.	**GREEN**
4. Reduce access to means	Suicide audit group bimonthly meetings to identify any hotspots using reports from the police and mental health services. Minutes and actions are recorded. Actions are initiated. Actions incorporated in Suicide Prevention and Self-Harm Action Plan	Attendees include: PH, RCCG, SYP & RDaSH. Meetings chaired by PH PH Specialist to work with other agencies as and when required (Local Coroner's Office, Highways Agency, Samaritans, colleagues within RMBC, local media)	Hotspot work initiated as and when areas are identified. Actions recorded and reported to the wider Suicide Prevention and Self-Harm Group.	Action taken at hotspots which could include: -installation of physical barriers and or moving ligature points -encouraging help seeking behaviours -increasing the likelihood of a third party intervention through surveillance and staff training -responsible media reporting	**GREEN**
	Local partners to share actions and learning to reduce suicide particularly after a serious incident (SI)	Provider Services for example: RDaSH, SYP TRFT	SIs discussed at each Suicide Audit meeting	Suicide prevention practice is shared across organisations	**AMBER**

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	with Suicide Audit Group and the Rotherham Suicide Prevention and Self-Harm Group.				
5. Better information and support to those bereaved by suicide	Development of the Rotherham Adult Bereavement pathway Promotion of pathway across the district which will be monitored by the Rotherham Suicide Prevention and Self Harm Group.	Public Health Specialist (Mental Health) working with the Rotherham Suicide Prevention and Self Harm Group	Development of pathway March 2015 Launch of pathway April 2015	Adult Bereavement pathway in place Improved post bereavement support for adults	**AMBER**
	To continue to promote and review the LSCB Bereavement pathway for children and young people bereaved as a result of suicide or sudden death.	Public Health Specialist working with Rotherham LSCB and the Rotherham Suicide Prevention and Self Harm Group	Launched in January 2015 Review due January 2016	Children and young people received timely and appropriate support when bereaved by suicide or sudden death.	**GREEN**
	Explore having a single point of contact for the bereaved.	South Yorkshire Police and Coroner's Office	June 2015	Bereaved families have a single point of contact.	**RED**

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
6. Support media in delivering sensitive approaches to suicide and suicidal behaviour	Develop a clear communications strategy between RMBC and its strategic partners which proactively promotes suicide prevention approaches.	RMBC Communications & Media Manager working with Communication leads from RDaSH, TRFT, SYP and RCCG.	Work commenced February 2015 and is ongoing	Agreed communications strategy across all statutory partners.	**AMBER**
	Commission a local awareness campaign to target young people (aged 15-21 years) as a high risk group	Public Health Specialist (Mental Health) and Marketing and Creative Services Manager (RMBC) working with the Rotherham Suicide Prevention and Self Harm Group.	Commencing March 2015	Media campaign launched and reviewed.	**RED**
	Hold a media summit/workshop for local media on suicide prevention.	RMBC Communications & Media Manager working with Communication leads from RDaSH, TRFT, SYP and RCCG. Support given from Public Health Specialist (Mental Health) and Rotherham Suicide Prevention and Self Harm Group.	Planning to commence April 2015	Summit/workshop held.	**RED**
	Promotion of the Rotherham CARE about suicide resource. CARE about suicide resource to be on every statutory partners'	RMBC Communications & Media Manager working with Communication leads from RDaSH, TRFT, SYP and RCCG. Support given from Public	Launched April 2014 To be on all statutory partners' websites by April 2015	Increase in confidence of universal workers and the general public to ask about suicide and take appropriate action	**GREEN**

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	website	Health Specialist (Mental Health)			
7. Data collection and monitoring	Participation of Rotherham in the Real Time Suicide Surveillance Pilot (South Yorkshire). Data is reviewed at the Rotherham Suicide Audit meetings	Rotherham Leads PH Specialist (Mental Health) and Mental Health Coordinator South Yorkshire Police (SYP).	Commenced September 2014. Review April 2015	General themes and trends reported back to Suicide Prevention and Self Harm group and actions to reduce risk reflected in action plan. Real time public health interventions for suicide prevention. Identifying at risk groups will inform commissioning cycle.	**GREEN**
	Suicide audit group bimonthly meetings to identify any hotspots using reports from the police and mental health services. Minutes and actions are recorded. Actions are initiated. RDaSH to share SIs with the Suicide Audit	Attendees include: PH, RCCG, SYP & RDaSH. Meetings chaired by PH PH Specialist to work with other agencies as and when required (Local Coroner's Office, Highways Agency, Samaritans, colleagues within RMBC, local media)	Suicide audit group to meet every bimonthly and review each death by suicide and agree follow-up actions.	General themes and trends reported back to Suicide Prevention group and actions to reduce risk reflected in action plan. Real time public health interventions for suicide	**GREEN**

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	Group to enable public health prevention actions to be identified.(Serious Incident Reports). Suicide Audit group agrees actions. Actions are reviewed at next meeting. Generic actions are reported back to the wider Suicide Prevention and Self Harm Group.			prevention. Identifying at risk groups will inform commissioning cycle.	
	Provision of epidemiological evidence to shape the development of services to support the emotional and mental health of children and young people (Needs Analaysis)	RMBC Public Health and RCCG	Annually	Services reflective of local epidemiology	**AMBER**
8. Workforce Development	Provision of 6 Adult MHFA Training during 2015/16	RCCG, RMBC PH and RDaSH	Commencing April 2015- March 2016	Improved awareness of mental health, reduced stigma and awareness of local services	**AMBER**

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	Provision of 4 Youth MHFA Training during 2015/16	PH RMBC and L&D Leads	Commencing April 2015	Improved awareness of mental health, reduced stigma and awareness of local services	**GREEN**
	To roll out further ASIST courses and other suicide prevention and self-harm courses to frontline workers	PH RMBC and L&D Leads	ASIST courses commence May 2015 Discussion re further courses commencing April 2015	Improved response to people in emotional distress	**AMBER**
	Delivery of a GP Projected Learning Time Event on mental health crisis	RCCG	2015/16	Increase awareness of the Mental Health Crisis Care Pathway	**RED**

Glossary

ASIST	Applied Suicide Intervention Skills Training
DPH	Director of Public Health
MHFA	Mental Health First Aid training
PH	Public Health
PHE	Public Health England
PHS	Public Health Specialist
RCCG	Rotherham Clinical Commissioning Group
RDaSH	Rotherham, Doncaster and South Humber NHS Foundation Heath Trust
TRFT	The Rotherham Foundation Hospital Trust

Version 2 – 11 May 2015

The Rotherham NHS
NHS Foundation Trust

CQC Improvement Action Plan




#hello my name is…

Tracey McErlain-Burns

Chief Nurse





Inspection Ratings

The Rotherham NHS
NHS Foundation Trust

Overall Rating ● Requires Improvement

Safe?	● Requires Improvement
Effective?	● Requires Improvement
Caring?	● Good
Responsive?	● Requires Improvement
Well-led?	● Requires Improvement

Overview of Ratings

● **26 Good** ● **33 Requires Improvement** ● **5 Inadequate**

Detailed ratings: Core Service Level

The Rotherham NHS NHS Foundation Trust

Community Core Services

Community Health Services for adults

Overall — Requires Improvement

Community Health Services for children, young people and families

Overall — Requires Improvement

Community End of Life Care

Overall — Requires Improvement

Community Dental Services

Overall — Good

Community Health Inpatient Services

Overall — Requires Improvement

Acute Core Services

Urgent & Emergency Services

Overall — Requires Improvement

Medical Care

Overall — Requires Improvement

Surgery

Overall — Requires Improvement

Critical Care

Overall — Requires Improvement

Maternity & Gynaecology

Overall — Requires Improvement

Services for Children & Young People

Overall — Inadequate

End of Life Care

Overall — Good

Outpatients & Diagnostic Imaging

Overall — Good

Improvement Action Plan

The Rotherham NHS
NHS Foundation Trust

- Approved at Board of Directors in July 2015
- ‘Must Do’ actions from Requirement Notices
- ‘Should Do’ actions as advised by the CQC
- 17 Must Do sections with 101 actions
- 12 Should Do sections with 126 actions
- Each section has an Executive Lead and an Operational Lead responsible for delivering all actions in that section
- A Corporate Committee has oversight of all sections of the action plan

JSNA and CQC Actions

The Rotherham NHS
NHS Foundation Trust

Starting Well	**M7:** Children's Environments **M13:** Infection Control in short break service **M14:** Medicines Management in short break service
Developing Well	**M15:** Liason between Contraception & Sexual Health Service and School Nursing Service
Living & Working Well	**M5:** Elimination of Mixed Sex Accommodation
Ageing Well	**M2:** Mental Capacity Act & Deprivation of Liberty Safeguards **M4:** Do not attempt cardio-pulmonary resuscitation

Reporting Arrangements

The Rotherham NHS
NHS Foundation Trust

- Monthly monitoring of all actions
- Updates against actions and evidence of completion of actions required from all Operational Leads monthly
- Board of Directors receives a monthly exception report of progress
- Corporate Committees monitor the progress against the sections for which they have oversight, escalating when required
- Progress is also tracked at the monthly Divisional Performance Meetings
- Weekly steering group meetings attended by all Operational Leads designed to assure the evidence of completion of actions and test that the outcome descriptors have been achieved
- Monthly progress updates on internet and intranet

Preparing for Re-inspection

The Rotherham NHS
NHS Foundation Trust

Mock Inspections: 1 completed in November, another shortly.

2 Page Staff Briefings: Pre-inspection briefings evaluated well so have been reintroduced highlighting the progress made since February 2015

Challenging available evidence: Via mock inspections, dip samples and the weekly steering group meetings

Ensuring that completed actions deliver the outcomes required by CQC: Via 121 meetings with Chief Nurse, mock inspections and dip samples

Raising Awareness: Targeted communications campaign ensuring staff are mindful that CQC could re-inspect at any time

Any Questions?

Adult Social Care in Rotherham

Outcomes and the Strategy for delivering them

This paper describes the outcomes that Rotherham Council is seeking to achieve for all adults with disabilities and older people and their carers in the borough. It describes the key elements of the strategy that will deliver the desired outcomes and the Adult Social Care Programme which underpins the strategy.

It is important to put the outcomes and strategy in the context of changes in social care which have occurred over the past twenty years. This helps to ensure that the direction of travel and improvements that have been achieved over this time can continue to be sustained and it helps to ensure we learn from past mistakes.

Outcomes - Our **ambition** is that adults with disabilities and older people and their carers in Rotherham are supported to be independent and resilient so that they can live good quality lives and enjoy good health and wellbeing

The ***strategy*** which will enable these outcomes to be delivered contains seven key elements:

- We must ensure that information, advice and guidance is readily available (eg by increasing self-assessment) and there are a wide range of community assets which are accessible
- We must focus on maintaining independence through prevention and early intervention (eg assistive technology) and reablement and rehabilitation
- We must improve our approach to personalised services – always putting users and carers at the centre of everything we do
- We must develop integrated services with partners and where feasible single points of access
- We must ensure we “make safeguarding personal”
- We must commission services effectively working in partnership and co-producing with users and carers
- We must use our resources effectively

This report next sets out the changes which have occurred which the strategy needs to address.

The context of change in social care

Nationally, the provision of social care for adults has undergone enormous change over the past generation. While the direction of travel has been reasonably consistent, the pace of change has accelerated over the past few years as the demand for more personalised services continues to grow, traditional models of care

are seen to be outdated and not delivering independence, choice and control and pressure on the system grows from more demand and less resources.

It is well-recognised that the state – national and local – has often created and maintained dependency rather than supporting independence. There is a recognition of the importance of building resilience at an individual, family and community level as this is better for people and offers a more sustainable model for the future.

Linked to this, the approach in Adult Social Care is increasingly based on an assets model – identifying with the person what they can do, what they do have, who they know and which community groups they are linked into, what their family and friends can do as carers and what the wider communities can offer.

Further, the focus in ASC is on outcomes – both for individuals and their carers and families but also for the wider community and residents. Improving the help and support for individuals who need it at any specific time benefits the whole community as they are likely to be family and friends of people requiring support or who may come to need it.

These changes have now been reinforced with the introduction of the Care Act – assessing on the basis of outcomes – health and wellbeing, quality of life, engagement in the community and so on. Equal rights for carers and the cared for which builds on years of legislation and enshrines the rights of carers.

For many years, care was based on an institutional model and as this began to change with the recognition of the scale of abuse that was taking place, more care began to be provided in the community. However, the replacement of large institutions outside of town with smaller ones based in towns was never a sustainable model as users and carers increasingly demanded “a life” not “a service”.

Therefore, there has been an increasing development of care based on a personalised model with people enabled to live in their own homes and to access services, facilities and buildings as part of the wider community. Consequently, the role of ASC has changed – rather than being focused on delivering a range of services, it has had to develop a strong partnership and influencing role. Within the Council, it has led on the development of the recognition about making all services accessible to all sections of the local population. Further, it has led on developing the recognition that all members of the community, no matter how disabled or elderly all should be valued members of the community.

Beyond the Council, ASC has become a key partner with health services and this partnership has been enshrined in different ways – eg through the Health and Wellbeing Boards and the Better Care Fund. Increasingly, integrated services are seen as the way forward in delivering more personalised and holistic care.

In considering what integrated services look like, it is essential to ensure that mental health services are seen as a key element of the integrated care and health services. It is essential to put in practice the slogan “no health without mental health”. The evidence is very clear that physical health and mental health are inextricably linked and that it is essential to treat them equally in addressing people’s care and health needs. Many studies have demonstrated the benefits in terms of improved outcomes for users through the integration of services. Integration should include the commissioning and delivery of care services and physical and mental health services.

Further, as there has been a move to maintaining people in the community there has come the recognition that there needs to be a wide range of accessible community services, facilities, buildings, activities and community engagement. ASC has been central to the development of these community assets to which older people and people with disabilities should have access. Consequently, ASC has developed strong partnerships with third sector organisations, community groups, faith groups and individuals who are delivering a wide range of activities and services in local communities.

Over time, the nature of the needs that ASC must address has changed. Improvements in health and care services have meant that people with disabilities are living longer which has brought new challenges eg caring for people with learning disabilities who have dementia. The growth in the number of very elderly people has meant that there are more older people with more complex needs and long-term conditions. While this has meant that these people require higher levels of service, there is also a recognition that more can be done to avoid them requiring intensive services and consequently, the aim is to divert people from the formal care system and to develop preventive services and rehabilitation services to enable people to regain and maintain levels of independence.

The importance of prevention and early intervention is well-recognised and this cuts across social care, physical and mental health. Further, the principle should be employed in whatever situation people live. It is essential that the person is seen in the whole – that their health and wellbeing are addressed – and that this is done in at every stage of people’s journey through life – whether they are outside of the formal care system or whether they are receiving high levels of formal care and health services. It is essential that the opportunity is taken at all times to maximise people’s independence and ability to make choices and take control of their lives.

Another major change over the recent past is the development of safeguarding for adults. While initially focused on protection and reacting to instances of abuse, the approach to safeguarding has developed to recognise that it is an integral part of the personalisation agenda helping to ensure personalisation is possible and deliverable. The recognition that safeguarding adults is everybody’s business is well-established

and the growing intolerance of hate crimes helps to ensure that older people and adults with disabilities can access wider community assets.

Another significant change is the funding available for ASC. This has grown significantly over many years but has been clawed back dramatically in the face of the economic recession. The national picture is that social care for adults is underfunded and resources have been transferred from NHS budgets to underpin adult social care budgets. Demographic pressures, rising standards and expectations have added to the challenge facing adult social care budgets and there has been enormous pressure to ensure that the available resources are used effectively and deliver best value. Consequently, new ways of delivering care have emerged – personal assistants, micro-enterprises, CICs etc.

Given these changes at a national policy level and given the groundswell of demand for change from users and carers it is essential that the vision and strategy for Adult Social Care take these changes on board and reflect them.

Vision for Adult Social Care in Rotherham

The ambition in Rotherham is that adults with disabilities and older people and their carers are supported to be independent and resilient. The outcomes that are desired for these groups are that they should live good quality lives and their health and wellbeing is maximised.

For most people, this will entail remaining in the community with friends and family. However, for some to achieve these goals, alternatives such as Shared Lives, Supported Living , Extracare Schemes etc will be necessary and for a small minority a residential placement may be necessary. The focus should be on maintaining people in the community and this requires long term support eg homecare as well as a wide range of prevention and rehabilitation services and a wide network of resources, services, groups and activities in the community.

It is essential to recognise that during the course of people's lives, there may be times when they need support and care and health services need to be prepared to intervene on those occasions. However, the aim should be to intervene appropriately with the aim of providing minimal support to enable people to maintain their independence. There is always a risk that by providing too much support people will have their independence eroded.

In order to achieve this vision, it is fundamental that a network of support is created which includes Council services, health services, private and third sector services and voluntary, community and faith groups – as well as friends, family and neighbours. Further, it needs to be recognised that as people grow older or live with a disability, it is ever more important that local facilities and services are well-developed as these are the ones they will look to first and foremost. Therefore, what is required is a partnership across Rotherham.

The strategy to deliver this vision

The development of a wide range of community resources in Rotherham's communities underpins the strategy. This network of community assets provides the support for people to live fulfilling lives engaged with their family, friends and community. This network is critical in catching people at the point they begin to "wobble" – ie when their existing ability and independence begin to drop away. This prevents their physical and mental health deteriorating and is the basic building block for the strategy and without it the pressure on the formal care and health system will overwhelm it.

Therefore, the strategy must recognise that this network of community resources needs to be developed and invested in and that it is best delivered through a partnership with the third sector. The Council and the health services, along with other partners such as the police, must work in partnership with each other and with the third sector to build the community assets which ensure people thrive and not just survive in the community.

At any point, people may feel they need advice or support for themselves of for a family member or friend. Therefore, the strategy needs to ensure that there is a front door which listens to what people are asking for and addresses these requests in a way which supports them to take control of the situation for themselves and this could mean the provision of information or advice or it could include requesting simple equipment or undertaking a self -assessment. In this way, people are supported through simple, one-off interventions which allows them to maintain in control and to maintain their independence. The aim is that a minimum of 75% of these requests are dealt with successfully at the front door.

However, for some people it may be that their needs are greater or the initial response hasn't resolved the position. In these situations people will need to be assessed. However, again the aim is to assess for the desired outcomes and to support the person to develop a solution which maximises them taking control and minimises interventions from the formal care sector. This is where preventive services such as telecare and telehealth and services such as rehabilitation and enablement become critical. But even here, it may be that the intervention that is required is support to re-engage with the local community which might be achieved through a volunteer offering support. The strategy focuses on building prevention, rehabilitation and enablement throughout the system as well as one-off interventions such as telecare which give people back control and independence.

Even when people have begun to engage with the formal care sector, it is still essential to ensure that they are engaged with the community assets. Being supported to dress and look after oneself is a means to an end of social engagement and it is essential that this is seen as important as meeting the needs of daily living.

Particularly for people with physical and mental disabilities and mental ill-health, it is essential that the focus is on enabling people to live normal lives – employment, volunteering, education, leisure activities, social activities etc etc. Part of this is taking risks and being supported to make good choices that enhance people's lives. The strategy needs to focus on developing opportunities to participate in normal activities in the community – not separated off into separate activities.

For some people as a result of disability, it will be necessary to provide more support but the aim of the strategy is to develop alternatives to traditional services. So, the strategy promotes services such as Shared Lives, supported living, extracare schemes, homes suitable for older people, key ring schemes etc. The strategy seeks to minimise the use of residential and nursing care while recognising that there is a place for it in a care and health economy. Similarly, the strategy promotes personalised services as alternatives to day services and for some this will include employment while for others this will not be possible but people can lead fulfilling lives outside of day centres.

As well as working in partnership with the third sector, care and health services need to work in partnership with each other. The strategy promotes the development of integrated commissioning and integrated delivery of services such as intermediate care. It is inconceivable that care services can be delivered outside of an effective partnership which promotes integration at every opportunity.

It is essential to recognise that in Rotherham, the CCG, the mental health trust and the hospital trust are committed to developing their services in a similar way. There is a commitment to locality working and to utilising community assets effectively. Indeed, the CCG has developed a nationally recognised scheme on social prescription. Further, the emphasis on integrated services, prevention and early intervention are all key themes in the transformation programmes the Trusts are developing.

The underpinning thrust of the strategy is the personalisation of services and this carries over into safeguarding. There is a need for a shift in culture not just in the way social workers assess for outcomes rather than services but also in regard to safeguarding. Establishing desired outcomes, putting people at the heart of safeguarding rather than processes, allowing people to take risks with support if necessary and appropriate are essential elements of the strategy.

Delivering the strategy

In order to deliver the strategy a series of interrelated commissioning strategies need to be developed. These strategies will involve Council services – especially adults, children, housing but also community development and community safety - and health services and other organisations where appropriate such as the police.

The strategy should be owned by the Health and Wellbeing Board and the Adult Safeguarding Board and it will be delivered through a range of Boards and groups. Ultimately, the DASS as the Statutory Office has responsibility for developing the strategy and ensuring it is being delivered.

Graeme Betts

6th November 2015