**You are hereby summoned to a meeting of the Health Select Commission to be held on:-**

**Date:- Thursday, 16 June 2016 Venue:- Town Hall, Moorgate Street, Rotherham S60 2TH**

**Time:- 9.30 a.m.**

## HEALTH SELECT COMMISSION AGENDA

1. To consider whether the press and public should be excluded from the meeting during consideration of any part of the agenda.

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

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

4. Apologies for absence

5. Declarations of Interest

6. Questions from members of the public and the press

7. Minutes of the previous meeting (Pages 1 - 16)
   Minutes of the previous meeting held on 14th April, 2016

### For Discussion

8. Director of Public Health Annual Report. (Pages 17 - 106)

   - Terri Roche and Anna Clack to report.

9. Adult Social Care - Provisional Year End Performance Report for 2015/16. (Pages 107 - 120)

   - Nathan Atkinson and Scott Clayton to report.

10. Membership of quality account sub groups.

11. Membership of the Health, Welfare and Safety Panel 2016/17

**For Information and discussion**

12. RDaSH Adult and Older People's mental health transformation update. (Pages 121 - 133)

13. Tier 4 Child and Adolescent Mental Health Services Commissioning. (Pages 134 - 135)

14. Health and Wellbeing Board Minutes: - (Pages 136 - 161)

    - 13th January, 2016;
    - 24th February, 2016.

15. Healthwatch Rotherham Issues

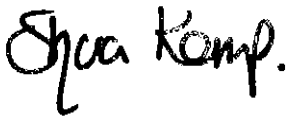
16. Date, Time and Venue of the Next Meeting and Future Dates for Agreement
    Thursday, 28th July, 2016, at 9.30 a.m. at the Town Hall, Rotherham

    Future Dates for Agreement:-

    22nd September, 2016 27th October, 2016 1st December, 2016

Membership 2016/17:-

Chairman:- Councillor Sansome
Vice-Chairman:-
Councillors Albiston, Andrews, Brookes, Cusworth, Elliot, R. Elliott, Ellis, Evans, Fenwick-Green, Ireland, Marles, Marriott, Roddison, Simpson, John Turner, Williams and Wilson.



**SHARON KEMP,**
**Chief Executive.**

# HEALTH SELECT COMMISSION
## 14th April, 2016

Present:- Councillor Sansome (in the Chair); Councillors Burton, Elliot and McNeely, Vicky Farnsworth (Rotherham Speak-Up) and Robert Parkin (Rotherham Speak-Up).

Councillor Roche, Cabinet Member for Adult Social Care and Housing, was in attendance at the invitation of the Chairman.

Apologies for absence were received from Councillors Fleming, Godfrey, Mallinder, Rushforth and John Turner.

Due to the number of apologies received the meeting was not quorate.

**89. DECLARATIONS OF INTEREST**

There were no Declarations of Interest made at the meeting.

**90. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS**

There were no members of the public and press present at the meeting.

**91. COMMUNICATIONS**

(1) Adult and Older People's Mental Health Transformation
RDaSH have arranged two further public engagement sessions on developing new models of care in Mental Health Services to be held on 10th May, 2016, at Liberty Church, Station Road, Rotherham S60 1JH. Full details were available if anyone was interested.

Commissioners Working Together Partnership
Pre-consultation with the public was underway. The first full meeting would be held towards the end of May.

The link to the website for more information is:
http://www.smybndccgs.nhs.uk/

**92. MINUTES OF THE PREVIOUS MEETING HELD ON 17TH MARCH, 2016**

The minutes of the previous meeting of the Health Select Commission held on 17th March, 2016, were noted.

Arising from Minute No. 82 (Rotherham Foundation Trust Quality Account), it was noted that:-

- further information received after the meeting had been included in the Minute regarding performance on processing prescriptions

- a remainder to those that had not as yet submitted any comments and thanks to those that already had

- TRFT Governors' Surgeries – normal communication of the surgeries was through press releases, the TRFT website, social media and referenced in communication messages. The February session had not been as actively communicated as in the past due to the uncertainty that it would go ahead due to Governor availability. However, the Trust had held limited surgeries both on the main Hospital site and the RCHC with Governors having the opportunity to speak to patients/visitors/staff and gather feedback

Arising from Minute No. 84 (RDaSH Quality Account), it was noted that the draft document had not yet been circulated to stakeholders for feedback.

## 93. ACCESS TO GPS SCRUTINY REVIEW

Terri Roche, Director of Public Health, and Jacqui Tuffnell, Head of Co-Commissioning, provided an update of the action being taken for each of the Scrutiny Review's twelve recommendations.

The Review had taken place between September, 2013 and March, 2014, with the aims being:-

- Establish the respective roles and responsibilities of NHS England and GP practices with regard to access to GPs
- Ascertain how NHS England oversees and monitors access to GPs
- Identify national and local pressures that impact on access to GPs – current and future
- Determine how GP practices manage appointments and promote access for all patients
- Identify how NHS England will be responding to changes nationally
- Consider patient satisfaction data on a practice by practice basis and to compare Rotherham with the national picture
- Identify areas for improvement in current access to GPs (locally and nationally)

Further scrutiny of the initial response from partner agencies had been carried out in January, 2015 and a mini survey with GP Practice Managers undertaken at their Forum meeting in May, 2015.

The majority of the actions in response to the twelve recommendations fell to the Rotherham Clinical Commissioning Group (CCG) and NHS England. Many had now been either completed or included within the Interim GP Strategy. There was also a workforce strategy.

Three were aimed at the Health and Wellbeing Board and, although it was clear the Board would not lead specifically on any campaigns, it had a role in bringing partners together to ensure consistent messages were

delivered. One of the ways in which this would happen would be through a revamped website, due to be completed by the end of May, 2016, and a Twitter account now set up to keep the public and stakeholders updated on partners' activity and health and wellbeing initiatives.

Consideration was given to Appendix 1 which contained the Cabinet response to the recommendations. Discussion ensued with the following issues raised/highlighted:-

- Improvements in telephone systems were taking place, for example informing people where they were in the telephone queue and additional capacity at busy times such as 8.00-9:30a.m.

- Efforts should be made to gain the support of the large number of private sector employers within the Borough to encourage their employees to keep their GP appointments as part of the prevention and care agenda
  *Prevention formed part of the quality contract and work took place with Public Health in terms of an element of associated funding which was increasing the number of Healthchecks that took place. Public Health could work with NHS England to make sure members of the public took up the national Health Screening Programme. Primary Care needed to be supported in the wider sense and may be work with voluntary and community sector who worked with particular groups*

- Are you now confident that all practices were engaging effectively with their patients? Are there any hotspots around? Any issues within any individual GP practices?
  *There were some contracts that had struggled with Patient Participation Groups and a lot of work had taken place in connecting them with the more successful ones. Healthwatch Rotherham was also helping to support them*

- Although recommendation 5 was originally rejected had it been revisited given the national specification has not yet been developed?
  *The Service was in place but the national specification awaited from NHS England*

- The Winter Communication Plan was updated and produced annually

- The comments associated with the recommendations would be helped greatly if they contained numerical information and clearly defined data that supported the comments

- Would there be an analysis of data regarding trends in the "do not attends" and the evaluation of the impact of the campaigns?
  *Linking to the Quality Contract, the sharing of the Key Performance Indicators with the Commission would pick up this point. Also the GP lead for quality in every practice would meet monthly at the CCG with*

*the CCG Clinical lead. The practices were being clustered based on their demographics and they would be expected to be progressing. It was only recently that all the data had been pulled together to show where each practice was on the map. The cluster information would be shared at the Primary Care meeting in terms of KPIs which would include non-attendance, A&E attendance, workforce and how they were doing with regard to the Quality Outcome Framework. All the information was in the public domain but there was only Rotherham pulling it altogether in one map so a comparison could be made between practices*

- Do you ever envisage returning to "sit and wait"
  *There had been a lot of discussion and public engagement with regard to "sit and wait". There were pockets of the public that would like it but the majority wanted to be seen at an appropriate time and within 5 minutes. There was a very stretched workforce within Primary Care and there were examples of where no-one had turned up for "sit and wait" so was problematic in managing capacity. From an efficiency point of view, appointments were a more efficient way of managing a practice*

- Repeat prescriptions included review dates which were often missed. Whose responsibility was it to ensure the review was undertaken?
  *Work was taking place with practices currently. There were a number of services which were reliant on review dates and reliant on the patients returning for blood pressure checks etc. Work was taking place with regard to having the technology in place for the bring forward systems*

- Consideration within the Strategy as to how to reward good practice or recognise good practice amongst employers
  *There was a balance between what the employees would want to share and how that could be recorded versus being able to record it. It was a good idea to make sure that all the campaigns were better distributed and provide evidence on the importance of allowing people the time to attend their appointments and screening. The awarding of good practice was by trying to get more people involved in the Workplace Health Charter and looking at the health and wellbeing of their workforce in the broader sense – from policies, access to healthier options in the canteen and getting the workforce to own it*

The report was noted and requested that a future update be submitted once the Strategy had started to embed.

**94. URINARY INCONTINENCE SCRUTINY REVIEW UPDATE**

Rebecca Atchinson, Public Health, presented an update on the progress to date on the Scrutiny Review's six recommendations.

The Review had taken place during May and June, 2014, and had identified recommendations which cut across the Council's Directorates. The main aims of the Review had been:-

- To ascertain the prevalence of urinary incontinence in the Borough and the impact it has on people's independent and quality of life
- To establish an overview of current continence services and costs and plans for future service development
- To identify any areas for improvement in promoting preventive measures and encouraging people to have healthy lifestyles

Progress had been challenging due to the changes in staffing within the Council over the last six months as well as technical problems with the uploading of information to the Public Health TV systems since September, 2015. Plans were now in place to move the activity forwards particularly in the area of prevention and early support agenda.

Rebecca introduced Kristy Barnfield and Joanne Mangnall from the Community Continence Service.

Consideration was given to the Appendix which contained the Cabinet response to the recommendations. Discussion ensued with the following issues raised/highlighted:-

- My GP surgery never had their television on
  *This was really disappointing and a challenge. As part of Public Health's wider training attempts were being made to try and integrate the messages into the wider pieces of work that were being carried out. A different range of ways had to be tried of encouraging both staff and the public to integrate messages that might be challenging and might not be the first thing that came to mind in their consultation with individuals. As well as Public Health messages, there was currently a piece of work being undertaken in recognising the different types of roles there were in GP practices other than a GP to be shown on televisions in surgeries. It was a missed opportunity if practices were not turning on their screens*

- Did the incontinence card give access to a toilet that shopkeepers may have? Was there any feedback on how successful it had been?
  *It was an alert card that anyone could carry but it was at the individual establishment's discretion as to whether they honoured the message on the card. The disabled toilet access was always by way of the Radar key scheme. It was known from patients' report back at clinic that there were certain shops, particularly in places like Meadowhall, that had declined patients the use of their toilets and patients were alerted in subsequent clinics sessions of areas where it might not be honoured. If a patient had a very severe bladder problem they would be told to use the Radar key, however, the number of disabled toilets was very low. If someone had a problem with faecal incontinence*

*they would always be guided to use the Radar scheme because they had washing facilities*

*There were opportunities for the Council to provide information on all of the toileting facilities across Rotherham to say have you considered x y z and pass that information and challenge back. However, it was about getting all of the contact details of who had responsibility for each of those facilities as sometimes the organisation did not have responsibility for their own toilets*

- What was the timeframe of when the televisions were likely to be coming to the GP practices?
  *It was planned for it to be up and running by the end of the month*

- Will we be doing anything with SYPTE concerning the screens and promoting the issues around urinary incontinence? Have we taken up SYPTE's offer of promoting the health issues either for incontinence issues or Right Care, Pharmacy First etc.?
  *There was an opportunity as to how Public Health shared its health measures around broader issues as well as including incontinence related issues with services such as SYPTE. The challenge was to ensure if they did not have the mediums like Public Health TV, how they were provided with access to information that they could display within their passenger areas to signpost people to further information. There was a very good website which contained resources but there was a charge so further discussions were required. The blanket approach of using Public Health TV had been used but there was an acknowledgement that there were further opportunities to get the message to the areas outside of that scope*

- It would again be appreciated if there could be some clear data as to what progress/updates there had been to ascertain how successful they had been

- Could you give some information about the training and the research project carried out by the Community Continence Service? How do you intend to promote training and the research around incontinence?
  *The training that was undertaken in Maltby was in one of the care homes focussing on the correct use of incontinence products. If they were not used correctly residents were at risk of developing skin breakdown and pressure damage. It was also known that incontinence products could be used inappropriately instead of a resident being taken to the toilet which was degrading to the individual and increased costs to the NHS. The training focussed very much on when to use a product, when to change a product and how to use it correctly and had been very well received by the staff. The problem in undertaking the training was that the turnover of staff in care homes could be quite rapid. Work had taken place with Council Officers to deliver a year's planned training which was circulated to all the care homes. Staff were evaluated at the end of each training session. The*

*uptake could be quite sporadic; there could be a session that was fully booked on the day and then poorly attended due to sickness in the care home.*

*The CCG had funded a two year Project Nurse post which had focussed on specific areas of continence care e.g. catheter related infections which could be life threatening for a small percentage of patients. That work focussed very much on the inpatient setting looking at reducing the usage of/looking at alternatives to catheters and raising awareness so that patients were alert to particular triggers that could indicate that they had a problem. A patient information book had also been developed from that work and was now issued to all patients that were discharged from hospital with a catheter. This aided smoother transition to Community Services*

*The other elements of the work related to referral pathways and looking at how patients accessed further help for continence problems which were very broad. A lot of the discussion in the Review had focussed around pelvic floor exercises but they would only address one specific element of continence problems; anyone who presented with a continence problem required a complete assessment because there could be sinister underlying pathology. The worker had identified a number of areas that required focus, on the assessment process and directing patients and had also looked at patients who were presenting at A&E with continence problems. A high percentage of patients presented at A&E with urinary tract problems which was a very simple condition and did not warrant attendance at A&E. Further work was required to understand why this happened*

- There was reference in recommendations 4 and 5 regarding training and the previous offer by Neighbourhoods and Adult Services for incontinence training to home care staff not being taken up. Was there any further information?
  *Colleagues in Neighbourhoods and Adult Services had stated that they had established that there was a training need, however, once it was set up there was no take up. One of the challenges was that sometimes people wanted training to be delivered in individual settings which was not feasible financially. There was ongoing training from the Community Continence Team when they were having contact with settings albeit may be not through planned training sessions*

- Should a person applying for a job in a care home have to produce certain certificates to show competence in that field before they were actually accepted as an employee?
  *Care Homes did take up references but it was not thought that there was a requirement on the level of certificates that had to be produced. We do need to try and set some examples of good practice and minimum standard.*

- Could you not get one person from the Home to come to a training session and they go back and train the others?
  *That approach had been tried previously, "link post", but it only worked in a very small percentage of Homes and where they had a member of staff in employment at that Home for a long period of time. It was often found that someone nominated as a link person that came to one of the sessions would have left by the time of the next session so the knowledge could not be taken forward. In some Homes there were staff that took the key role in liaising with the Community Continence Service on the delivery of pads into the Home, the monitoring of deliveries and co-ordinating assessments and would really like to adopt that approach widely but unfortunately the experience to date was that it not been effective*

- Does the Home have to pay for the pads? Should they not be charged?
  *The pads were provided free from the Community Continence Service to the Home. If a resident was in a nursing bed the registered nurses in the Home should undertake a Continence Assessment prior to the issuing of pads. If the resident was in a residential bed, the Community Nurses would work with the Home to undertake an assessment prior to issuing pads. The aim was always to assess and treat rather than just use pads*

  *The Service had to provide pads free of charge as part of the health care package but it was not an unlimited numbers of pads; they were capped at a certain number over a 24 hour period and that very much depended upon on the level of incontinence the person was demonstrating*

- Rotherham Foundation Trust was taking part in a national audit of inpatient falls compliance with Best Practice in reducing risk of falls in Acute Care and one of the things on the checklist was multi-factorial risk assessment. It was positive that the Hospital had ticked yes to three of the questions which were linked to continence - do people at risk of falling as an inpatient have an assessment of continence and toilet issues? Suggested actions where problems with continence are identified? And possible modification of any medicines that people were taking that could reduce their risk of falls? If a patient had had this assessment and issues identified would there would be follow up to your Team possibly for support and assistance?
  *The Community Continence Team had four full time equivalent Nurses and possibly had to treat approximately 12,500. The Team was not involved in inpatient continence assessment but worked very closely with key staff in the inpatient setting to develop a standard operating procedure which guided the staff through a Ward-based continence assessment and gave them a very clear referral process onto the Team.*

*The training package was open to Foundation Trust staff as well as Community and Nursing staff and nursing homes.*

Rebecca, Kristy and Joanne were thanked for their presentation.

The report was noted.

## 95. DRAFT CARERS STRATEGY

Sarah Farragher, Adult Social Care, gave the following powerpoint presentation:-

The Carers Strategy
- The Strategy is being co-produced
- There are now members of the Carers Forum on the group alongside officers from RMBC, Health and the voluntary sector
- The Strategy is progressing well and is on track for sign-off at the Health and Wellbeing Board in June
- Plan is to launch during Carers Week
- Carers Strategy Group will become the delivery group
- Carers information booked to be produced

Pledges
- That every carer in Rotherham is recognised and supported to maintain their health, wellbeing and personal outcomes
- That carers in Rotherham are not financially disadvantaged as a result of their caring role
- That carers are recognised and respected as partners in care
- That carers can enjoy a life outside caring

Carers Forum
- Re-launched in January, 2016 and operating independently of the Council

The Strategy was still in draft form and would be submitted to the June meeting of the Health and Wellbeing Board for sign-off. It would be launched during Carers Week.

Jayne Price, Carers Forum, gave the following powerpoint presentation:-

Rotherham Carers Forum
- An independent voice for Rotherham's informal carers

Over the years:-
- Long established forum – step up by dedicated and enthusiastic carers and professionals
- Been actively involved in supporting carers: meetings, information, Carers' Week, Carers' Rights Day etc.
- Changes over the years e.g. bases, officers

- Partner groups developed e.g. Carers 4 Carers, Rotherham Parents Forum Ltd. and Lost in Transition

Forum

- The Forum was a successful group which provided a place for carers to meet, listen to guest speakers, share experiences and provide a platform for informal carers
- Health and Wellbeing partners provided the resources for the Carers' Co-ordinator at Carers' Corner

Recent Challenges

- In 2014 the Carers' Co-ordinator resigned from RMBC
- Carers' Corner relocated to the RAIN building
- Where was the Constitution?
- No available assets
- Low attendance
- Many people believed that the Forum had folded

Challenges

- "Challenges are what makes life interesting and overcoming them is what makes live meaningful"

Big Task Ahead

- The Forum needed a Constitution
- Assets needed to be freed up and a new bank account opened
- The status needed to be clarified as independent
- The word needed to be out that we are still in business

Hard work paid off

- Interim Officers were elected as a Steering Group
- An interim Constitution was adopted
- A new bank account was opened
- We managed to get a cheque re-dated
- We had a fantastic re-launch with great feedback
- Our first funding bid has been successful

Where are we now

- Monthly meetings with full agendas
- We are a 'critical friend' and 'co-productive'
- Working with partners e.g. RMBC, Crossroads especially Carer Resilience, Alzheimer's Society, Rotherham Clinical Commissioning Group, Barnardo's Young Carers, Age UK Rotherham, Carers 4 Carers, Rotherham Parents Forum Ltd. – providing an 'Umbrella Forum'
- Current work involves:-
  An active contributor in the Carers' Strategy
  Being a lead in Carers' Week 2016 (1st-6th June)
  Being a member of Rotherfed

Our wish list

- Get more carers involved and find the hidden ones
- Redeveloping and re-launching the Forum has been hard work and work needs to be shared to be sustainable
- The Forum's own resources are not an infinite pot – redevelopment has been on a beg and borrow basis – support is much needed and always welcome
- Look at employing staff as work so far has been voluntary
- Move from 'interim' to permanent
- Be in a position where we can pass a fully operational and successful Forum onto future carers

www.rotherhamcarersforum.co.uk

Rotherham Carers Forum email:

enquiries@rotherhamcarersforum.co.uk

Discussion ensued on the presentations with the following issues highlighted:-

- The Midnight Memory Walk for the Hospice is on the 11th/12th June. It would be an opportunity for carers to encourage other carers they met on the walk to be part of the Carers' Forum

- How would you reach hidden carers? Some carers may be reluctant to attend meetings
  *During Carers' Week, Carers 4 Carers would be going into the Hospital giving general information and looking for hidden carers. There would also be a stall at Tesco's. Through being there and starting up a conversation with people in an informal setting it might be possible to identify those hidden carers. It was hoped to do a Carnival for Carers outside the RAIN building with various tables and people presenting how they could make carers' lives better. The theme for Carers' week this year was building carer friendlier communities.*

  *The Forum was considering how to reach those that would not attend meetings. One of the ideas was to actually go on line and build the community online so it could be an information hub and two-way forum where people could ask things. Times were a lot different now with the financial constraints but attempts were being made to address those issues*

- Young carers would be some of the hidden carers and there may have to be a different way of reaching young carers than there would be for adult carers. Would the Forum's Facebook page be geared towards the young carers?
  *The Carers' Forum had a Facebook page which currently had ninety-one members. The Forum was looking to attract people to join and*

*also to send news/any relevant information via this method as it was a good way of getting out to the young carers who tended to use social media*

*The Carers Strategy was in draft and did not contain all the young carers' information due to it not being ready in time. There was some extra work to be included that had been carried out by Paul Theaker alongside Barnardos*

*When previously presented it was stated that the Strategy was about people caring for adults regardless of their age. It was the future intention for it to become a Strategy for all Carers, including parent carers; the Carers' Forum covered all carers*

- Are you confident that the delivery of the plan will be performance managed against the action plan?
  *There was an action plan attached to the Strategy. It had not been presented to the Commission because it currently contained actions but not the accountabilities; by the time it went to the Health and Wellbeing Board it would have all the actions and responsible Officer*

- Was the role of triangle of care approach been considered?
  *The principles of the triangle of care in terms of the Act that the carer was part of everything had been embedded all the way through the Strategy*

- Was there any resilience work done about carers with GP?
  *There was a lot of work going on with the GPs at the moment. There were Carers Resilience clinics taking place which were specifically targeted at GPs. This would go into the handbook that accompanied the Strategy*

- Can you give more detail around the Carers Pathway?
  *The development of the Carers Pathway came under the "we will" so the final action plan would have the detail of how that would be done. Some of the issues the Directorate were working through was a number of things that the Carers' Forum would like to lead on but it was a voluntary organisation so a need to balance how the management of that was supported*

  *The latest draft of the Better Care Fund referred to a jointly commissioned carer service*

- Can you give some detail around the Carers Needs Assessment?
  *At the moment the Assessment was something carried out by Social Workers or Social Care Workers based historically on how things had been done. Through the implementation of the plan, Assessments would be carried out by more people and recognised by more so it would not have to be a Council Officer to enable the carer to get a service*

- Frequent reference was made to "Carers Assessment" but at the time of Scrutiny Review the document was "Carers Need Form" and "Care Plan". Members of the Scrutiny Review recommended that that name be used rather than Carers Assessment in light of the feedback from the carers who had felt that it was an assessment of them and their ability to care rather than picking up on the support they needed as carers. Has there been any discussion on that?
  *We will change it*

Sarah and Jayne were thanked for their presentation.

The report was noted.

## 96. RESPONSE TO SCRUTINY REVIEW: CHILD AND ADOLESCENT MENTAL HEALTH SERVICES - MONITORING OF PROGRESS

In accordance with Minute No. 65 of the Overview and Scrutiny Management Board, Paul Theaker, Operational Commissioner, Children and Young People's Service, and Ruth Fletcher-Brown, Public Health Specialist, reported on the current progress of the Scrutiny Review's twelve recommendations.

A full Scrutiny Review had been carried out by a sub-group of the Health and Improving Lives Select Commissions between September, 2014 and March, 2015.

NHS England's Future in Mind Report was published in May 2015 setting out a clear national ambition to transform the design and delivery of a local offer of services for children and young people with mental health needs. The Rotherham CAMHS Transformation Plan was developed in response to the Report and encompassed all local emotional wellbeing and mental health transformational developments. The response to the Scrutiny Review was, therefore, aligned to the local CAMHS Transformation Plan and the response to the Scrutiny Review was monitored through the CAMHS Partnership Group as part of the overall plan.

RDASH had been undertaking a whole CAMHS service reconfiguration and would be complete by June, 2016. The reconfiguration included the establishment of clear treatment pathways, a Single Point of Access and locality workers linked with locality based Early Help and Social Care Teams as well as schools and GPs.

Consideration was given to the Appendix which contained the response to the recommendations. Discussion ensued with the following issues raised/highlighted:-

- Part of the Select Commission's work going forward into the new municipal year could be a deep dive into recommendation 4 (whole school pilot) to ensure it was meeting its target

- The new Workers were now in place (recommendation 6). They would be contacting Schools from Friday, 22nd April and making the links with partners

- There had been a deterioration in the wait for an appointment. As of 8th April, 153 young people were waiting for an appointment into CAMHS (recommendation 8). The target was 95% of young people seen within 3 weeks – 28% at the moment. There was now a weekly meeting in place with the Assistant Director of RDASH and was monitored on a weekly basis. Part of the feedback was in terms of some of the reconfiguration work and staff not being in post but was something that the CCG and the Council were looking at very closely

- Why had that target not been met? Was there a particular period in the year? Any reason why that particular month slipped behind the target?
  *Not particularly. There were periods e.g. end of school term when a number of referrals came through from schools. The information received was that it was primarily down to the Service reconfiguration not being in place. They had employed agency workers until September so even though all staff would be in post, there would be the additional agency workers to deal with the backlog*

- Was there a duplication in cost? What kind of costs were we talking about? Once the new staff were embedded the Commission would like to see some figures. The Commission would be concerned if the desired outcomes were not achieved after the extra finance
  *There was additional cost in terms of agency workers between now and September. The Service was commissioned by the CCG so the cost was not known but could be requested and further scrutiny would be welcomed. The whole structure would be filled by June so the number was expected to reduce*

- Officers were requested to check the communication regarding the reconfiguration - was there any feedback to the Commission concerning the number of new posts which were being put into place through the restructure and the timescale against the Service RDASH was committed to provide? Was the Commission made aware that there may be slippage in Service because of the reconfiguration against the delivery aligned with the cost?

- How valid were the dates in recommendation 9? Should there be new dates given the restructure would not be complete until June 2016?
  *The restructure of RDASH had had an impact and that had been one of the factors in not meeting certain deadlines. Advice would be appreciated as to whether the Commission would wish the dates to be revised*

- One of the things that had become apparent from the meeting with the Youth Cabinet was the regularity of involvement. Would it possible for there to be regular input from the Youth Cabinet concerning the website? It would help if the young people had greater ownership because they would have on the spot information to feed in whereas if it went into CAHMS there were a lot of people it had to go through before inclusion on the website (recommendation 10)

- Could you tell me how seriously they have listened to GPs' concerns?
  *In terms of the CCG, it was the GP Leads in terms of commissioning. There was a lead GP around Children's Mental Health. A number of the issues that the Council had had with regard to access to CAMHS, young people not meeting thresholds, the bounce back etc. had been echoed by the GPs*

- Were the routine assessments carried out face-to-face in a clinic situation or were they carried out over the telephone?
  *It was one-to-one with the young person*

- Three pathways – can you just reassure us that the three will meet up together at the end? I think it is key that it does happen.
  *Yes*

- This is an area of work of service that had been difficult over a long period of time nationally and I just wondered from your perspective what do you think are going to be the barriers in achieving the progress we would like to achieve and was there anything you think that the Council could or should be doing to try and take things forward more effectively than perhaps done in the past?
  *From a Public Health point of view a priority would be the Early Intervention and Prevention Work and really investing to save by prioritising some of that work. The Future in Mind document that came out last year had a really strong focus on Early Intervention and Prevention and was looking at the transformation of CAMHS services across the board. Quite often, when thinking about the CAMHS Service, you only thought about the provision by RDASH when in actual fact everyone who had contact with children and young people had a role in terms promoting emotional health and mental wellbeing. When the local transformation plan was signed off Councillor Roche had been very keen that early intervention and prevention was a strong theme and there had been a disappointment within the Council that some of the money was not recurrent funding for prevention. This was something that would continue to be raised with the CCG*

- Locality work and model – would this include links to School Nurses?
  *As part of the CAMHS partnership work there was representation from School Nursing. In terms of linking with the locality workers, School Nurses and other partners, there were a series of meetings currently taking place to look at the issue and how they would link together with schools and other services*

- Was June too early to evaluate the benefits of the locality working model?
  *Yes it was too early for a full evaluation but the Council was very conscious that it needed to keep on top of the locality work and model in terms of its development and the contacts being made with schools etc.*

- For workstreams such as the Family Support Service and the community approach how would the Council manage those against prevention and early intervention?
  *In terms of the whole community approach, that was linked in with the schools to include that. A group consisting of schools and Officers would go out quarterly to monitor action plans as well as speaking to the community groups or partnerships the schools were working with*

*Councillor Roche commented that there would shortly be a requirement for local authorities to report their annual spend on Mental Health as a discrete budget heading.*

*He also raised concerns regarding Head Teachers' involvement in the ongoing suicide prevention work.*

Paul and Ruth were thanked for their attendance and presentation.

The report was noted.

**97. QUARTERLY BRIEFING WITH HEALTH PARTNERS**

The minutes of the meeting between the Select Commission and Health partners held on 25th February, 2016, were noted.

**98. HEALTHWATCH ROTHERHAM - ISSUES**

No issues had been raised.

**99. DATE OF FUTURE MEETING**

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 16th June, 2016, commencing at 9.30 a.m.

Rotherham Metropolitan Borough Council

Public Report
Council Meeting

**Summary Sheet**

**Council Report**
Health Select Commission 16.06.2016

**Title**
Director of Public Health Annual Report 2015

**Is this a Key Decision and has it been included on the Forward Plan?**
No not a key decision. Not on forward plan

**Strategic Director Approving Submission of the Report**
Teresa Roche, Director of Public Health

**Report Author(s)**
Anna Clack, Public Health Specialist
01709 255872
anna.clack@rotherham.gov.uk

**Ward(s) Affected**
All

**Summary**

This is my first Annual Report since joining the Council on the 29th June 2015 and the second Annual Report of the Director of Public Health in Rotherham since the Health and Social Care Act (2012) placed the responsibility for Public Health with Local Government.

The Director of Public Health has a statutory responsibility to produce an Annual Report and the Council has a statutory duty to publish it.

This report focusses on an analysis of some of the key issues that affect the health and wellbeing of Rotherham's Children and Young People, and explores the health inequalities that exist for children between Rotherham and the rest of England. This report describes Children and Young People's health through a life-course approach, from pregnancy and birth, through school years into young adulthood.

The Report aims to engage with professional stakeholders across the Borough, to work together to deliver on a clear set of recommendations that will help improve the health and wellbeing of our Children and Young People. The recommendations are aimed at all statutory and voluntary partners across the Borough.

The recommendations evolved from sections in the report which highlight ***'our ambitions for Rotherham'***. The intention of this report is to sit alongside the Health and Wellbeing Strategy and to help inform the actions taken by the Health and Wellbeing Board. It also offers some practical interventions which will improve child health and contribute to reducing the health inequalities across the Borough. Future reports will report on progress against the recommendations and associated action plan.

**Recommendations**

1.1 That the Health Select Commission receives and notes the report.

1.2 That the Health Select Commission consider and support the recommendations in the Report and seek further feedback on the progress made on the detailed action plan.

**List of Appendices Included**

**Background Papers**
The Director of Public Health Annual Report 2014 (produced by the former DPH)

**Consideration by any other Council Committee, Scrutiny or Advisory Panel**
For Consideration by Cabinet and the Health and Wellbeing Board

**Council Approval Required**
No

**Exempt from the Press and Public**
No

## *Director of Public Health Annual Report 2015*

### 1. Recommendations

1.1 That the Health Select Commission receives and notes the report.

1.2 That the Health Select Commission consider and support the recommendations in the Report and seek further feedback on the progress made on the detailed action plan.

### 2. Background

2.1 At the local level, the Health & Social Care Act (2012) gives local authorities the responsibility for improving the health of their local populations. The Act says that local authorities must employ a director of public health, and they will be supported by a new ring-fenced budget. The Act requires directors of public health to publish annual reports that can chart local progress.

2.2 This year's annual report is the first in a series that is planned to work through the life course, focusing on key health issues at different stages of our lives. The report looks at the importance of prenatal, childhood and young people's health issues.

2.3 The report identifies work already underway to tackle some of the key health issues for children and young people and highlights the areas where we need to focus our attention in the future to improve outcomes for them. From this, eight overarching recommendations have been made which prompt a partnership approach to tackle the health inequalities that exist and improve health outcomes for children and young people in Rotherham. These recommendations will be incorporated into a Specific, Measurable, Achievable, Realistic, Timely (SMART) action plan which summarises the 'what we'd like to see' actions, so that our progress will be measurable for review in the next report.

### 3. Key Issues

3.1 Data from Public Health England on the health and wellbeing of Rotherham children and young people is given in its Child Health Profile.

The main issues for Rotherham children compared to the England average are:

- Children aged 16-18 not in education, employment or training (NEET)
- First time entrants to the youth justice system
- Children in poverty
- Children in care
- Children killed or seriously injured in road traffic accidents (though this indicator is based on very small numbers of deaths and varies year on year)

- Low birth weight babies
- Obese children aged 10-11 years (Year 6)
- Children with decayed, missing or filled teeth
- Mothers smoking in pregnancy
- Breastfeeding (initiation and continuation at 6-8 weeks)

## 4. Options considered and recommended proposal

Not applicable

## 5. Consultation

5.1 Consultation with Children and Young People is referred to throughout this report including the Rotherham Lifestyle Survey, which is undertaken annually with Year 7 and Year 10 pupils.

## 6. Timetable and Accountability for Implementing this Decision

Not applicable

## 7. Financial and Procurement Implications

None

## 8. Legal Implications

None

## 9. Human Resources Implications

None

## 10. Implications for Children and Young People and Vulnerable Adults

10.1 The report addresses how we can improve the health and wellbeing outcomes for children and young people across Rotherham and provides a focus on vulnerable groups.

## 11. Equalities and Human Rights Implications

11.1 The report highlights health inequalities and their impact on health outcomes for the population. Commissioned services are required to demonstrate how they meet equalities and human rights requirements.

## 12. Implications for Partners and Other Directorates

12.1 The recommendations from the report are a “call to action” for all partners and other directorates.

## 13. Risks and Mitigation

13.1 The recommendations will be supported by a comprehensive action plan, overseen by the Director of PH, which will track progress.

**14. Accountable Officer(s)**

**Teresa Roche**
**Director of Public Health**

This report is published on the Council's website or can be found at:-

http://moderngov.rotherham.gov.uk/ieDocHome.aspx?Categories=

# Director of Public Health Annual Report

## 2015-16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Rotherham Metropolitan Borough Council

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# Acknowledgements


## I would like to thank the following colleagues who have contributed to this annual report:

**Collette Bailey,** Head of Service North and Youth Work Lead: Early Help and Families, Rotherham Metropolitan Borough Council

**Joanne Campbell,** Senior Operations Manager, Rotherham Metropolitan Borough Council

**Karen Clithero,** Acting Supervisor for the Family Nurse Partnership Team, The Rotherham Foundation Trust

**John Coleman,** Education, Health and Care Assessment Team Manager, Children & Young Peoples Services, Rotherham Metropolitan Borough Council

**Louise Collins,** Oral Health Improvement Coordinator, The Rotherham NHS Foundation Trust

**Miles Crompton,** Policy and Partnership Officer, Rotherham Metropolitan Borough Council

**Jane Moore,** Early Years Quality and Curriculum Adviser, Rotherham Metropolitan Borough Council

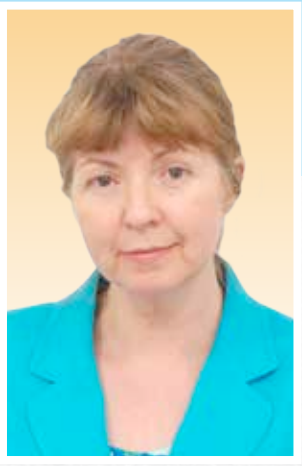
**Amanda Raven,** Senior Independent Domestic Abuse Advocate and Young Persons Domestic Abuse Advocate, Neighbourhood and Adult Services, Rotherham Metropolitan Borough Council

**Stuart Savage,** Senior Engineer, Streetpride, Environment and Development Services, Rotherham Metropolitan Borough Council

**Paul Theaker,** Operational Commissioner, Commissioning Team, Rotherham Metropolitan Borough Council

**Public Health Team:** Anna Clack, Ruth Fletcher-Brown, Gill Harrison, Richard Hart, Catherine Homer, Melanie Howard, Alison Iliff, Sally Jenks, Joanna Saunders, Sue Smith and Marcus Williamson. Particular thanks go to Anna Clack and Joanna Saunders who coordinated the production of this report as well as contributing significantly to its content.

# Foreword



Supporting good health and wellbeing for children, young people and families is central to improving health outcomes across our society. The report highlights the importance of improving safeguarding, health and wellbeing and the life chances of children and young people, especially those who are vulnerable.

This report looks forward to how health services, social care, the voluntary sector and the wider community can support our children and young people to have a better start in life, as Rotherham Council, together with the support of its partners, moves forward in its recovery journey, building a child-centred Borough.

All Directors of Public Health are required to produce an independent annual report on the health of their local population, highlighting key issues. I joined Rotherham Metropolitan Borough Council on 29 June 2015 and I am pleased to present my first annual report as Director of Public Health. The report highlights the importance of improving safeguarding, health and wellbeing and the life chances of children and young people, especially those who are vulnerable.

This year's annual report is the first in a series that is planned to work through the life course, focusing on key health issues at different stages of our lives – starting and growing well, living and working well and ageing well. The report looks at the importance of prenatal, childhood and young people's health issues.

We value the contribution of children and young people to our work and this report has been informed by a range of local consultations and surveys.

Throughout this report we refer to children and young people using the United Nations' definition: a 'child' is a person below the age of 18[1] and a 'young person' is a person between the ages of 15 and 24 years[2].

The foundation of every aspect of human development, physical, intellectual and emotional is laid down in early childhood. What happens during these early years (starting in the womb) has lifelong effect on many aspects of health and wellbeing, from obesity, heart disease and mental health, to educational

achievement and economic outcomes[3]. To thrive, our children and young people must be safe, healthy, have opportunities to enjoy life and have a sense of achievement and economic wellbeing.

Our children and young people are an asset and need to be nurtured. How we support them builds our future.

This annual report identifies work already underway to tackle some of the key health issues for children and young people and highlights the areas where we need to focus our attention in the future to improve outcomes for them.

The report is, therefore, my call to action for the whole health and social care community in Rotherham to share our knowledge, skills and expertise in a commitment to working in partnership to improve the health of our children and young people.

# Executive Summary

Directors of Public Health are required to produce an independent annual report on the health of their local population, highlighting key issues. This report describes the health experience of children and young people in Rotherham and highlights the areas where our children and young people experience poor health or worse health than the national average.

The health of the Rotherham population is generally poorer than the English average. This leads to growing pressures on health services, social care, informal care, supported housing and other services. Life expectancy, although lower than average, has been increasing. However, the average time spent in ill-health has also been increasing, resulting in a growing number of people with high levels of need.

Data from Public Health England on the health and wellbeing of Rotherham children and young people is given in its Child Health Profile[4].

The main issues for Rotherham children compared to the England average are:

- Children aged 16–8 not in education, employment or training (NEET)
- First time entrants to the youth justice system
- Children in poverty
- Children in care
- Children killed or seriously injured in road traffic accidents (though this indicator is based on very small numbers of deaths and varies year on year)
- Low birth weight babies
- Obese children aged 10 –11 years (Year 6)
- Children with decayed, missing or filled teeth
- Mothers smoking in pregnancy
- Breastfeeding (initiation)

This report describes children and young people's health through a life-course approach, from pregnancy and birth, through school years into young adulthood. It describes some of the work which is being done to address the inequalities in health experienced in Rotherham and suggests what could be done to make further improvements.

# Key Recommendations

By the end of this report you will have realised that it is very wide ranging and you will have noted that for each subject area we have reported examples of ***What are we doing about it in Rotherham?*** and ***Our ambition for Rotherham***.

However, whilst we will aim to accomplish all we'd like to see, the following recommendations have by necessity been refined from key areas that have been identified as likely to have the greatest impact for children and young people. These recommendations are eminently achievable if all the key stakeholders across Rotherham embrace the points and work together. They will sit alongside SMART (Specific, Measurable, Achievable, Realistic, Timely) actions relating to ***Our ambition for Rotherham*** in order to improve the health and wellbeing of children and young people in Rotherham.

Rotherham Metropolitan Borough Council

NHS Rotherham Clinical Commissioning Group

The Rotherham NHS Foundation Trust

RDaSH leading the way with care

Voluntary Action Rotherham

NHS Rotherham Commissioning Group

## The key recommendations from the report are:

1. Rotherham CCG to work closely with Public Health and service providers to ensure that **services** and **care pathways** for pregnant women and children and young people are integrated and take every opportunity to maximise public **health outcomes**. Particularly, reducing the risks associated with poor health behaviours (reducing smoking and alcohol use in pregnancy, increasing levels of breast feeding, reducing levels of overweight and obesity and increasing physical activity).
2. Public Health service providers and Children & Young People's services to work more closely to deliver **integrated health and early help services** for children and families
3. Partners to work together to **maximise opportunities for training** to improve health outcomes – for example by adopting Making Every Contact Count (MECC) principles and undertaking joint training on the effects of poor health behaviour on children and families

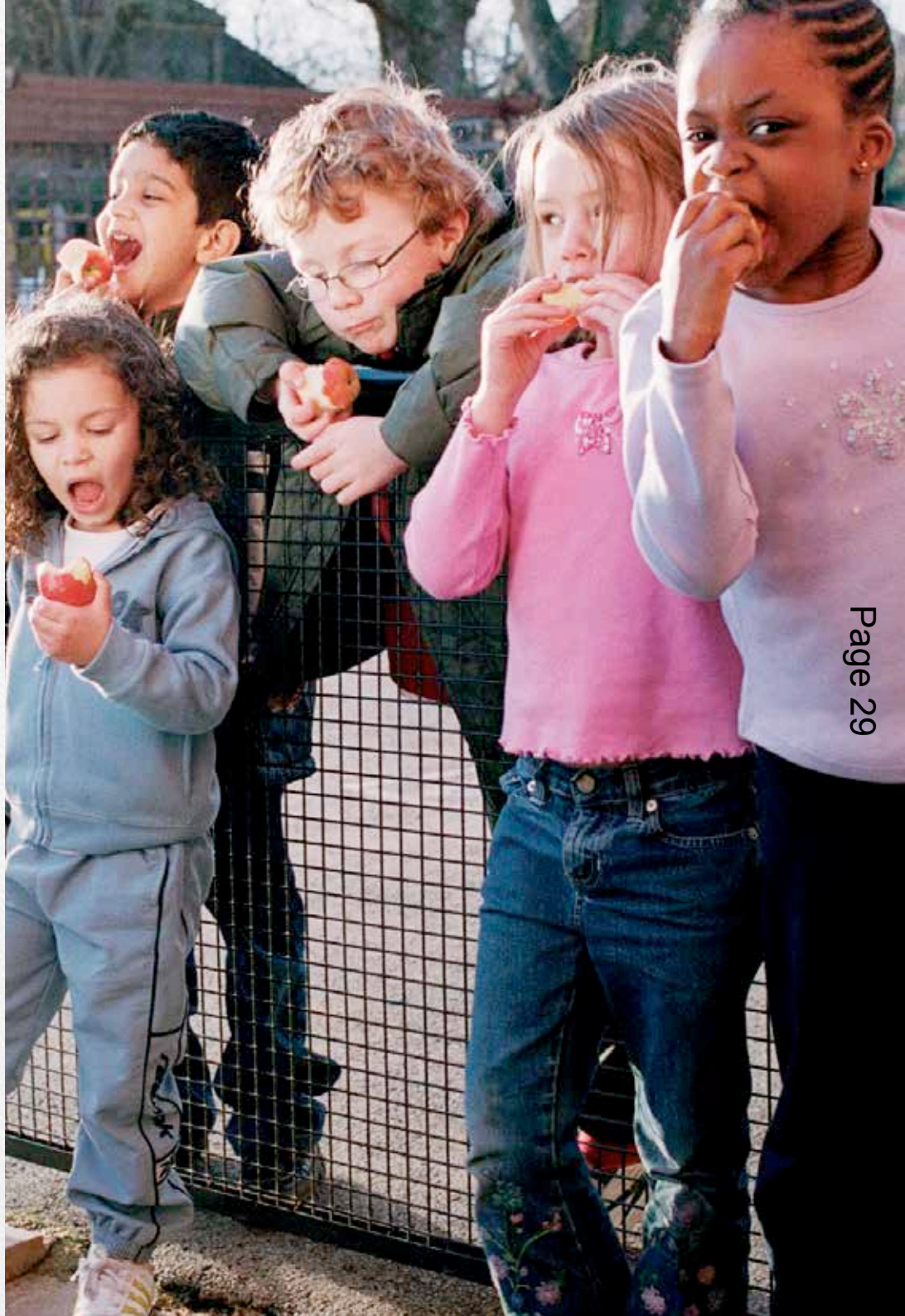
4. Schools and colleges should do more work to ensure that all children and young people are supported to **improve their mental health and wellbeing** – identifying clear pathways of support when children and young people experience mental health problems and raising awareness of self-harm and suicide prevention strategies

5. Rotherham CCG and the local service providers should ensure **better and more timely access** for children and young people experiencing **mental health problems**. This should lead to better recovery and outcomes

6. Rotherham MBC needs to work with all partners to develop a 'whole systems' approach to **tackling overweight and obesity**, including prevention and treatment strategies

7. The work programmes of the Health and Wellbeing Board and the Children & Young People's Partnership should be **integrated and add value** to the work of all partners

8. RMBC and partners review the need for a **poverty strategy** which seeks to address the economic wellbeing of families in order to reduce child poverty



# Introduction

Supporting good health and wellbeing for children, young people and families is central to improving health outcomes. The foundations for virtually every aspect of human development physical, intellectual and emotional are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing from obesity, heart disease and mental health, to educational achievement and economic status[5].

Children and young people are both shapers of, and shaped by, the world around them[6]. However, their health is strongly influenced by parents/carers, extended family members, peers and the community. It is therefore important not to view children as autonomous beings but to consider all the influencers on health decision making, choices and ability to access health and care services.

## About Rotherham

The Joint Strategic Needs Assessment (JSNA) is a key source of information on the residents of Rotherham, providing a rigorous analysis of the issues that need to be addressed. The Public Health Outcomes Framework (PHOF), published by Public Health England is the main source of public health data and measures performance against a range of public health indicators including the wider determinants of health.

A summary of Rotherham's health and wellbeing status and of the key issues concerning Children and Young People is given below, with further links to data sources (including the JSNA[7], the latest PHOF scorecard and key children's data) given in Appendix 1 at the end of the report.

## Summary of Rotherham's health and wellbeing status

The health of the Rotherham population is generally poorer than the English average. This leads to growing pressures on health services, social care, informal care, supported housing and other services. Life expectancy, although lower than average, has been increasing. However, the average time spent in ill-health has also been increasing, resulting in a growing number of people with high levels of need.

Rotherham's population was estimated at a record 260,100 in 2014[8] and is projected to grow by 2.5% to reach 266,500 by 2021. The population is becoming more ethnically diverse with the Black and Minority Ethnic (BME) population increasing from 4.1% to 8.1% between the 2001 and 2011 censuses[8]. It is projected that this level of diversity will increase further, illustrated in the more recent 2015 school census which shows that 15.7% of the borough's children and young people, are from BME backgrounds[9]. This is most evident in the central area of Rotherham where new migrant communities have settled alongside established ethnic minorities. Agencies need to take account of differing cultural needs and barriers that can limit access to services, such as poor English skills and different attitudes to health.

Rotherham is one of the 20% most deprived districts in England, which the Indices of Multiple Deprivation 2015 shows is driven mainly by high worklessness, low qualification and skill levels and poor health[10]. The inequality gap between the most deprived neighbourhoods and the rest of the borough has grown as deprivation has increased since 2007. High deprivation is reflected in high levels of financial exclusion, debt problems and fuel poverty.

Welfare reform is estimated to have taken £84 million per year from low income households in the United Kingdom[11], particularly affecting families with children and those who are long term sick, and further reductions will result from the welfare changes announced in the July 2015 budget. Pressures on household budgets have forced a growing number of people to use food banks. Rotherham is amongst the highest 8% of UK districts most affected by problem debt[12]. The majority of over-indebted people feel anxious, stressed and unhappy as a result of their situation, but only a minority are accessing advice[11].

## Children and Young People

There are 56,400 children and young people aged under 18 in Rotherham[13], (21.7% of the Borough's population, slightly above the English average of 21.3%). An analysis of the age profile predicts that the number of secondary school age children (11-17) will increase between 2016 and 2021 by 6%. As of the end March 2015 there were 1,923 Children in Need, 423 Children subject to a Child Protection Plan[14] and 410 Looked After Children in Rotherham[15]. Our high Child Protection rate and increasing complexity in the social care cases demonstrate that the needs of local children and young people and their families are rising.

Nationally there is a direct correlation between social care needs and deprivation. Nationally 19.7% of children are affected by income deprivation[16], in Rotherham this is significantly higher at 24.3% and for children living in our ten most deprived communities half of them are affected by income deprivation[17]. The Deprivation Pupil Premium also shows a similar picture with more local pupils (31.8%) eligible than the national average of 28.6%.

High rates of smoking in pregnancy are a particular concern in Rotherham affecting 18.3% of maternities compared to 11.4% in England. This contributes to complications during pregnancy and delivery and health problems throughout childhood. The number of babies born at low birth weight (8.6%) is above the English average of 7.4%, similarly infant mortality rate is 5.1 per 1,000 births, compared to England average of 4.0. The breastfeeding initiation rate of is one of the lowest in the region and this poor level of breastfeeding is associated with childhood obesity. Obesity affects 9.9% of Rotherham school children aged 4-5 and 21.6% of Rotherham children aged 10-11[18], this is broadly in-line with national averages for 4-5 year olds but much higher than the average of 19.1% of 10-11 year olds.

Levels of oral disease in five year olds are much higher than average in Rotherham at 40% compared with 28% nationally.

Within school, at Foundation level, 67.4% of Rotherham children show a good level of development which compares well against the national average of 66.3%[19].

The school census 2015 shows the most common types of special educational need to be 'Specific Learning Difficulties' (23.0%) and autism (13.6%)[20]. Behavioural difficulties account for 17%, although this is lower than the England average (21%). A growing number of children and young people have multiple disability and complex needs which continue as they make the transition into adulthood.

Whilst educational attainment in Rotherham has improved over recent years[21], children and young people in the more deprived areas often have low aspirations. Of 16-18 year olds, 5.9% are not in employment, education or training (NEETS), which is above the national average of 4.7%. Youth unemployment (ages 16-24) in Rotherham is 21.3%, again above the English average of 17.3%[22].

For young people aged 15-24, 1,550 were diagnosed with a sexually transmitted infection in 2013; this is a rate of 4,940 per

100,000, higher than the English average. However, this figure should be interpreted with caution as it could also indicate an accessible and young person friendly service where people feel comfortable in seeking treatment.

## Child Poverty

The most basic form of deprivation affecting children is low household income which impacts on a wide range of life chances. The Indices of Deprivation 2015* shows that 48,400 people or 18.7% of Rotherham's population were deprived of income (on means tested benefits or asylum seeker support) in 2013/14. Children aged 0-15 are most likely to be affected by low income with 12,050 (24.3%) of children aged 0-15 affected, 580 more than in 2008. At the neighbourhood level, the figures range from 3% to 62.5%, showing a polarisation in family income across the Borough.

*Please note that Indices of Deprivation data on income and poverty uses a different measure to that referenced within the Public Health Outcomes Framework.

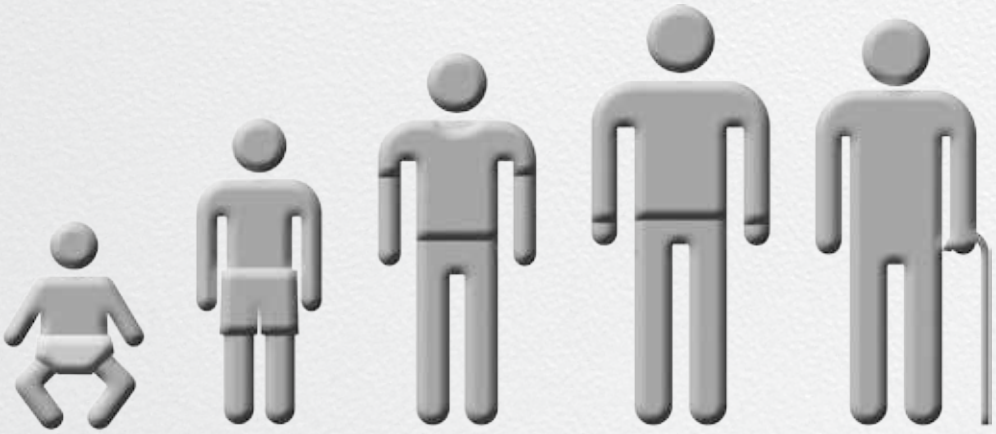
## Children living in the Most Deprived Areas

The 10 most deprived areas of Rotherham (the Super Output Areas, or SOAs, of Ferham, East Herringthorpe North, Eastwood Village, Canklow North, Eastwood East, East Herringthorpe South, Eastwood South, Maltby Birks Holt, East Dene East and Masbrough) have a combined population of 17,500, of which children aged 0-17 number 5,900 (33.6%), twice the proportion in the 10 least deprived areas. Half of children in the most deprived areas (3,000) live in families with three or more children, almost three times that observed in the least deprived. Of children in the most deprived areas, 43% are minority ethnic compared with just 4% in the least deprived. Children in the most deprived areas are 13 times more likely to live in poverty than the 10 least deprived.

Educational achievement and attainment are clearly affected by deprivation. Only 36.7% of Foundation pupils in the most deprived areas reached a good level of development in 2013 compared with 73.2% in the least deprived. The gap is wider for young people taking their GCSEs with just 31.9% attaining the headline measure (data for period 2012-14), compared with 81.7% in the least deprived.

Whilst children from across the Borough can receive some social care support, those in the most deprived areas are five times more likely to be designated as a Child In Need (Children Act 1989), than those in the least deprived areas. They are also four times more likely to be involved in some way with the team dealing with child sexual exploitation[23].

Life expectancy at birth for a baby born in the 10 least deprived areas is 9.5 years longer than for a baby born in the most deprived areas. Children in the most deprived areas are twice as likely to be disabled and more than twice as likely to live in a home where someone smokes.





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# Chapter 1: Pregnancy, birth and the early years

## Healthy Pregnancy

From the moment of conception, through to birth and the first year of life, every aspect of a baby's environment influences its physical, emotional and social development[24]. Helping women make healthy choices during pregnancy is pivotal to improving outcomes for children and young people.

During pregnancy most women want to 'do the best for baby' and this heightened motivation can provide the opportunities and incentives for tackling unhealthy behaviours and promoting healthy ones; for example, helping women to stop smoking when pregnant and encouraging them to breastfeed following the birth.

However, we know that a woman's social circumstances can limit her from making healthy choices which may in turn be reflected in poorer outcomes of pregnancy and subsequent child development[25].

A number of measures are used to assess the health of mothers and babies. These include levels of infant death, babies born weighing less than 2.5kg, the number of women smoking in pregnancy, the number of babies born to teenage parents and the number of babies who are breast-fed. Of the 3,072 (live birth) babies born in Rotherham in 2014:

- 186 were born to teenage parents (mothers aged under 20); this equates to over 60 per 1,000 live births which is higher than England at nearly 37 per 1,000 live births. Of these, 44 were to mothers aged under 18, which is a rate of 14.3 per 1,000 compared to England's 9.4 per 1,000. Rotherham is average among its comparable statistical neighbours, whose rates for under 20 births range from 47 to 75 per 1,000
- 474 (18.3%) babies were born to mothers who smoke, compared to 11.4% in England. Rotherham's comparable neighbours' rates range from 10.8% to 22.0%
- 249 (just over 8%) were low birth weight (less than 2.5kg) compared to 7% in England
- 226 (7.4%) were born pre-term (before 37 weeks in pregnancy) compared to 10.2% in England
- Only 1,745 (62.5%) babies were breastfed at birth compared to 74.3% in England. Rotherham's comparable neighbours' rates range from 52.8% to 67.2%

## Maternal nutrition and Vitamin D and Folate deficiency

A healthy and well balanced diet is an essential part of leading a healthy lifestyle and it is especially important for women who are pregnant or for women planning a pregnancy.

A healthy diet will benefit both mother and baby during pregnancy and also helps the mother to maintain a healthy weight once the baby has been born. During pregnancy women should aim to:

- Base all meals on starchy foods such as potatoes, bread, rice and pasta, choosing wholegrain where possible
- Watch the portion size of meals and snacks and how often women eat by avoiding 'eating for two'
- Eat a low-fat diet. Avoid increasing fat and/or calorie intake. Limit the intake of foods with a high fat content. Limit the amount of drinks, confectionary and other foods high in added sugars
- Eat fibre-rich foods such as oats, beans, lentils, grains, seeds, fruit and vegetables as well as wholegrain bread, brown rice and pasta
- Eat at least five portions of a variety of fruit and vegetables each day, in place of foods higher in fat and calories
- Always eat breakfast[26]

Weight gain in pregnancy is inevitable; it allows the baby to grow and gives them the best start in life. However, too much weight gain leading to maternal obesity has increased health risks for both the mother and child during and after pregnancy. The babies of women with a pregnancy BMI ≥35 have an increased risk of perinatal mortality compared with those of the general maternity population in the UK. National Institute for Health and Care Excellence (NICE) Guidance[27] states that pregnant women only need to eat an additional 200 calories per day in their final trimester, dispelling the common myth of eating for two. Maternal obesity is an increasing problem worldwide; in Rotherham over 5 % of babies born in 2013 were to mothers with a BMI of over 40.

Folic acid (also known as vitamin B9) is very important for the development of a healthy foetus and it can significantly reduce the risk of neural tube defects such as spina bifida. Taking a folic acid supplement (400 micrograms daily) is hugely beneficial for women planning a pregnancy and during the first 12 weeks of

pregnancy, even if the mother is already eating foods which have added folic acid or foods rich in folate.

Vitamin D deficiency is recognised as a significant public health problem[28]. It is likely that deficiency is common in high risk groups such as pregnant and breastfeeding women, people with darker skin and those who are not exposed to much natural sunlight.

Vitamin D supplementation in pregnancy is therefore important; low level maternal vitamin D is associated with softening of the skull in newborns, restricted infant bone growth and is a risk factor for rickets. Maternal deficiency may also contribute to pregnancy related complications such as pre-eclampsia and gestational diabetes.

In Rotherham, there is a perception amongst health professionals that there is an increase in the number of children and adults presenting with low levels of vitamin D, however, this is currently anecdotal rather than based on hard data. While exact numbers are unknown, health professionals have identified a need for further action to be taken including the promotion of vitamin D and folate and increased access to the Healthy Start programme. Healthy Start is a Government scheme aimed at improving the health of pregnant women and children under four years[29].

## What are we doing in Rotherham?

Healthy Start vitamins for women and children have been distributed through Rotherham Children's Centres, providing easy access for families in their local community. Unfortunately take up has been poor and this scheme could be improved to ensure that more eligible families take up the vitamin supplementation.

## Our ambition for Rotherham

- Public Health England to provide up-to-date local information on the number of families entitled to and accessing the Healthy Start scheme
- Development of a robust pathway by The Rotherham NHS Foundation Trust to ensure a more effective system for distribution of Healthy Start vitamins to eligible families across Rotherham

## Smoking during pregnancy

Smoking in pregnancy causes up to 2,200 premature births (babies born before full-term pregnancy), 5,000 miscarriages and 300 perinatal deaths (deaths that occur between 22 weeks in pregnancy and up to seven days after birth) every year in the UK[30]. It increases the risks in pregnancy for the mother and baby, including stillbirth and low birth-weight, and can have a longer term impact on the child's health as they grow and develop.

Smoking in pregnancy rates in Rotherham have significantly improved over the past five years but remain higher than the national and regional average. Younger women, those who have never worked and women from disadvantaged communities are most likely to smoke throughout pregnancy. Currently 18.3% of women in Rotherham continue to smoke up to the time they deliver their baby in hospital compared to 11.4% in England.


## What are we doing in Rotherham?

In 2010 we made changes to the support provided to pregnant smokers. We made it easier for the women who want to quit to access support and based our stop smoking midwives in the antenatal unit so that all pregnant smokers, whether they want to quit or not, have at least one appointment with the service. This has led to more women seeking support to quit and bigger reductions in the number of women who continue to smoke whilst pregnant than have been seen nationally or in neighbouring areas. The changes we made mean that each year around 225 fewer women in Rotherham are smoking at delivery than five years ago.

## Our ambition for Rotherham

- We would like to see the Rotherham Clinical Commissioning Group (CCG) ensure its service specification for community midwifery continues to require carbon monoxide screening of all pregnant women at booking and throughout pregnancy in accordance with the Yorkshire and Humber Stillbirth and Bereavement Recommendations (2015)[31] and ensure all smokers are given access to specialist support.

## Alcohol in pregnancy

There is growing concern (and conflicting advice) about safe levels of alcohol consumption in pregnancy and the risk of Foetal Alcohol Syndrome Disorder (FASD) in children.

NICE guidance[32] and the Royal College of Obstetrics[33] generally agree that:

*'Pregnant women and women planning a pregnancy should avoid drinking alcohol in the first three months of pregnancy. Following this, women who choose to drink alcohol during pregnancy should drink no more than one to two UK units once or twice a week.'*

However, the National Organisation for Foetal Alcohol Syndrome-UK (NOFAS) takes a different stance and promotes the message that 'the only risk-free approach is to avoid alcohol completely'[34]. This recommendation is further reinforced by the recent review of the alcohol guidelines published by the UK Chief Medical Officer[35].

NOFAS describes the effects of alcohol on a baby as being mild or severe, ranging from reduced intellectual ability and attention deficit disorder to heart problems and even death. Research does suggest that up to 7000 babies are born annually in the UK with FASD[36] and Rotherham would expect around 30-35 babies born each year to have FASD.

Without support, people affected by FASD are at a higher risk of developing secondary disabilities and social problems such as: mental health problems; dropping out of school; becoming unemployed; homeless and/or developing alcohol and drug problems.

### What are we doing in Rotherham?

Rotherham will be taking a consistent approach to messaging regarding alcohol in pregnancy, with the clear message 'No Alcohol equals No Risk'.

Public Health is leading an awareness raising campaign in 2016 to ensure that professionals and the public have a clear understanding of the risks of alcohol use during pregnancy and promote a greater understanding of FASD. This will need to encompass 'myth busting' for the family around the pregnant woman to ensure that advice is consistent. Pathways will be established to ensure that anyone who has concerns around FASD can contact a professional for advice, help and support.

## Our ambition for Rotherham

- All partner agencies (including health and social care) in Rotherham signing up to promote the 'No Alcohol equals No Risk' message
- All midwives to receive alcohol brief intervention training and offer brief intervention at routine appointments

## Sudden Infant Death Syndrome and safe sleeping

Eleven infants under the age of one have died from Sudden Infant Death Syndrome (SIDS) in Rotherham since September 2013. SIDS is the sudden, unexpected and unexplained death of an apparently well baby that cannot be explained after thorough investigation. However, there are often a number of possible causal factors and identified risk indicators that are thought to play a role in these deaths. The risk is recognised to be considerably higher for infants where indicators such as co-sleeping (baby sleeping with parent/carer on a bed, sofa or armchair), alcohol use and smoking are also present. Continuous and rolling interventions, including training for practitioners and awareness campaigns are essential and, evidence shows, are effective in reducing the number of SIDS death[37].








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## What are we doing in Rotherham?

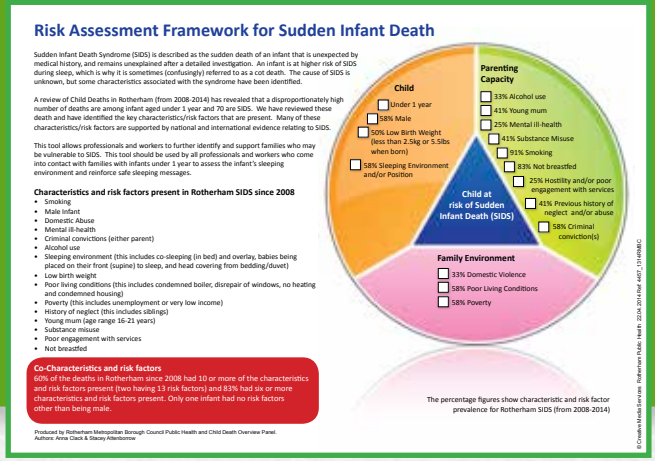
Since April 2012 Rotherham Public Health has been working with The Rotherham NHS Foundation Trust (TRFT) midwifery and health visiting service to implement a range of interventions to reduce the risk of Sudden Infant Death Syndrome (SIDS). A key intervention was the introduction of a sleep safe assessment form and observation to assess and action risks associated with SIDS.

The Rotherham sleep safe assessment involves discussion between a midwife or health visitor and a new parent of the risks relating to SIDS, and a check carried out by a health practitioner of the baby's sleeping environment, including how parents/carers put their baby down to sleep both in the day and at night. The sleep safe assessment is repeated in instances where any additional risks have been identified through further contact with services and where there has been a change in the infant's sleeping arrangements.

In the first year following the introduction of the Sleep Safe assessment and observation in Rotherham (which included robust training on SIDS and this procedure for all midwifery and child health practitioners), deaths from SIDS decreased significantly with only one death occurring in that year 2012/2013. However, since then deaths from SIDS have risen.

Rotherham Public Health supported The Rotherham NHS Foundation Trust to undertake an audit of the Sleep Safe assessment in June 2015. The findings identified some areas of development and an action plan has been drawn up. Significant work has been undertaken following the identification of areas highlighted in the action plan.

Rotherham Public Health and the Child Death Overview Panel have developed a SIDS risk assessment tool to support health and social care practitioners and workers to effectively assess the risk of SIDS in the families with whom they have contact. The Rotherham SIDS risk assessment tool has received national interest and has been replicated in a number of local authorities including Coventry and Warwick.





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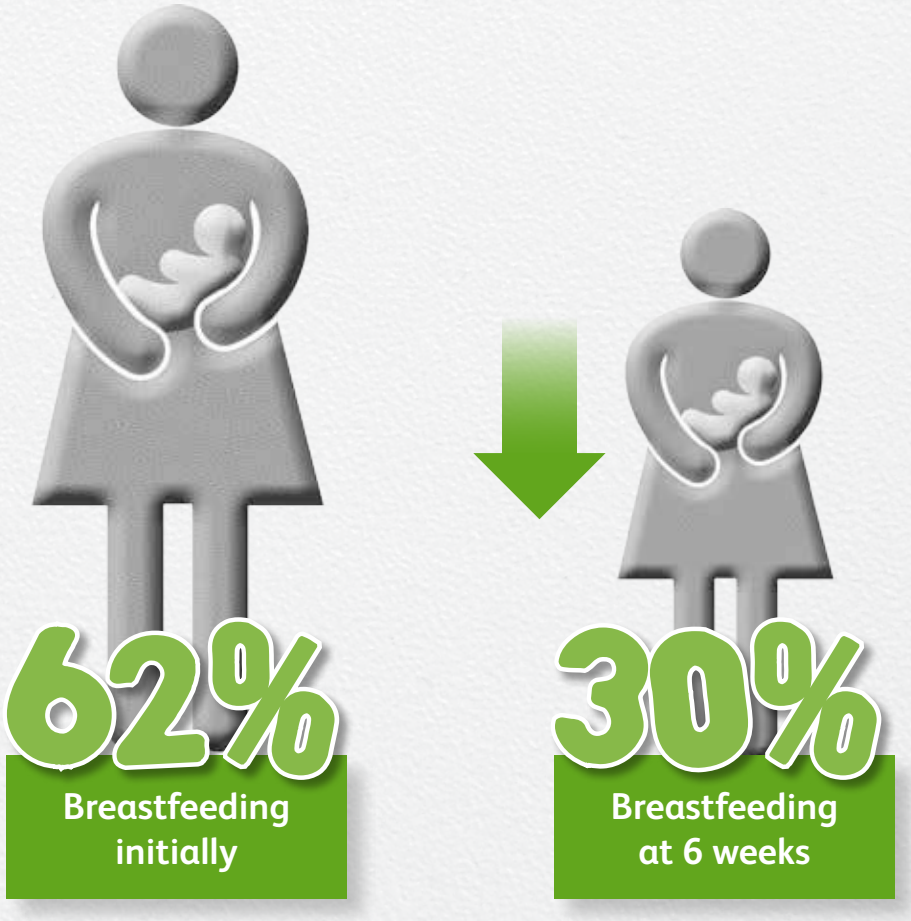
## Our ambition for Rotherham

- The development of Joint Safe Sleeping guidelines and workforce training to reduce the risk of SIDS across all partner organisations in Rotherham including NHS, Police and the Local Authority
- The Rotherham Foundation Trust to undertake a re-audit in August 2016 to ensure further progress is being made

## Breastfeeding

Breastfeeding has a major role to play in promoting health and preventing disease in the short and long term for both the infant and mother. Breastfed babies are less likely to suffer from conditions such as gastroenteritis, chest, urinary tract and ear infections, juvenile diabetes and childhood obesity. Mothers who breastfeed are less likely to develop some cardiovascular diseases, breast and ovarian cancer, and are less likely to have low bone density, which reduces the subsequent risk of fractures due to osteoporosis[38].

The Department of Health recommends that breast milk is the best form of nutrition for babies, and that all babies should be exclusively breastfed in the first 6 months of life. Moreover, babies should continue to receive breast milk along with appropriate solid foods beyond the first six months.



In Rotherham only 62% of mothers initially breastfeed when their baby is born, which is much lower than the national rate of 74%. This proportion falls further by the 6-8 week point, when only 30% of women are breastfeeding compared to 47% in England[39]. This latter measure is a key indicator of sustained breastfeeding and, given the significant long-term health benefits, we would like to see levels of breastfeeding prevalence at 6-8 weeks as close to the national average as possible.

Evidence shows that the proportion of babies that are breastfed at birth rises significantly in settings that have adopted the principles of the United Nations International Child Emergency Fund (UNICEF) Baby Friendly Initiative, by as much as 10%. The Baby Friendly Initiative provides support for healthcare facilities that are seeking to implement best practice and offers an assessment and accreditation process that recognises those that have achieved the required standard.

## What are we doing in Rotherham?

The Rotherham NHS Foundation Trust Maternity Service is working towards achievement of UNICEF Stage 3 in 2016 and will also be leading and developing peer support for women who want to continue to breastfeed their babies. This will provide support in the maternity unit and in community settings including Children's Centres.

## Our ambition for Rotherham

- The Rotherham NHS Foundation Trust should adopt the principles and achieve the UNICEF Baby Friendly Initiative standards trust-wide (including the Rotherham Health Visiting Service achieving Stage 2 standard by 2017). This will increase breastfeeding rates across the borough

# Chapter 2: Support for more vulnerable families

## Perinatal Mental Health and Postnatal Depression

The effect of a mother's mental health is as important as her physical health on the subsequent health of her child. A parent with a mental health disorder or difficulty can have a profound impact on the parent-infant relationship and, as a result, the child's own emotional development and wellbeing. Early attachment and good maternal mental health are therefore essential for children to thrive.

When a mother is mentally unwell she may find it difficult to look after herself; for example, not eating well, bathing or looking after herself in other ways. This may make it harder for her to care for her baby who requires a lot of attention and care. If help is not given to the mother at an early stage it can start to affect the attachment between the mother and baby. We know that babies are very sensitive to their environments and will be affected by how their parent/carer is feeling and behaving.

Postnatal depression is estimated to affect 10-15 % of mothers[40]. This represented approximately 450 women in Rotherham in 2014 (15 % of all women who had a baby in Rotherham).

When postnatal depression is very severe, mothers have been known to take their own life and that of their child. Maternal perinatal depression, anxiety and psychosis together carry a long term cost to society of just under £10,000 for every single birth in the country with 72 % of this cost relating to adverse impacts on the child[41].

No mother is immune to developing a mental health problem, but when mothers experience stress, poverty, exposure to violence (domestic, sexual and gender-based) and lack social support, the risk is increased. Mental health problems in the mother can make it difficult for her to function properly and give her baby the support it needs.

**10-15%**

**…of mothers are affected by post natal depression**

## What are we doing in Rotherham?

Rotherham Clinical Commissioning Group (CCG) is leading a group which is looking at improving the mental health support for women from conception up until the child's first birthday.

Rotherham Health Visitors have been trained to identify mental ill health amongst mothers which enables them to provide help and support to the mother at the earliest opportunity.

## Our ambition for Rotherham

- A National recommendation from Health Education England (HEE) and a Government mandate that every birthing unit should have access to a specialist perinatal mental health clinician
- Health Visitors to ensure that at risk women are identified at the earliest opportunity and supported/ referred appropriately as part of the Rotherham Perinatal Mental Health Pathway

## Domestic Abuse

Domestic abuse can affect anyone. The Office of National Statistics estimates that each year around 2.1million people suffer some form of domestic abuse - 1.4 million women (8.5 % of the population) and 700,000 men (4.5 % of the population)[42].

The cross-Government definition of domestic violence and abuse is:

'Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality'[43].

Domestic abuse can be psychological, physical, sexual or financial.

We know that pregnancy is not a safe time for mothers and babies. Domestic abuse can begin or get worse during pregnancy. Nearly one in three women who suffer from domestic abuse during their lifetime report that the first incidence of violence happened while they were pregnant[44].

It is distressing and frightening for children and young people who witness domestic abuse. Children living in a home where domestic abuse is happening are at risk of other types of abuse too.

If we apply national research locally we can presume that:

- 25% of children in the UK have been exposed to domestic abuse[45]; for Rotherham this equates to 12,500 under 16s or 14,100 under 18s[12]
- 62% of children in households where domestic violence is happening are also directly harmed[38]
- 40% of teenagers are in abusive dating relationships (including emotional or physical abuse) at any time[38]; for Rotherham this equates to 8,650 13-19 year olds who may be experiencing an abusive relationship[12]
- Children and young people can experience domestic abuse through seeing the abuse, hearing it from another room, seeing their parent's injuries or distress afterwards and being hurt by being nearby or trying to stop the abuse
- We know that when children and young people live with domestic abuse it will have an impact on them. It can affect their physical health, their mental health and emotional wellbeing and can interrupt their development

Teenagers can experience domestic abuse in their relationships. Nearly 75% of girls and 50% of boys have reported some sort of emotional partner abuse[46].

## What are we doing in Rotherham?

The Independent Domestic Violence Advisor (IDVA) service works with people aged 16 years and upwards, supporting victims at high risk of serious harm or murder.

Within this service there is a Young Persons Domestic Violence Advocate (YPDVA), who can support clients of any age on an advisory basis working alongside children's services and will work with victims whose perpetrator is under 16 years of age.

The Independent Domestic Violence Advisors and the YPDVA have between them supported 537 clients from April 2014 – March 2015.

Multiagency training is provided for frontline staff on domestic abuse.

There is a domestic abuse care pathway that Rotherham GPs use to identify people at risk who may be experiencing domestic abuse and to refer patients to appropriate specialist services and support.

## Our ambition for Rotherham

- Rotherham Public Health to ensure that all their commissioned services can show that staff have adequate training on domestic abuse so that staff can identify indicators of domestic abuse, know how to ask relevant questions to help people disclose and follow local referral pathways
- Rotherham Clinical Commissioning Group to ensure providers of antenatal care (in pregnancy) ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good practice, even where there are no indicators of such violence and abuse[47]
- Working with partners to ensure all health and social care providers create environments which enable people to disclose domestic abuse; for example, displaying information on domestic abuse and providing areas for private conversations
- RMBC, RCCG and NHS services in Rotherham to use national campaigns like White Ribbon Day to raise the profile of domestic abuse

## Teenage Pregnancy

Teenage pregnancy rates have fallen dramatically in the UK over the last 10 years[48]. In Rotherham, only 186 babies (6%) were born to teenage parents compared to 325 (10%) in 2008[49].

The reduction in teenage pregnancy has been achieved through a package of interventions including:

- Educating young people (providing knowledge and skills) to experience positive and healthy relationships and good sexual health
- Improving access and use of effective contraception
- Engaging and supporting those most at risk of becoming young parents
- Improving support for teenage parents and their children

While the reduction in teenage pregnancy in Rotherham is commendable, intensive support is required for a number of vulnerable young parents to help them overcome the circumstances that place them at risk.

## What are we doing in Rotherham?

In 2011 the Family Nurse Partnership (FNP) programme was introduced in Rotherham. This is a national programme which provides an intensive home visiting service for first time teen parents. FNP aims to improve pregnancy outcomes by supporting mothers-to-be to make informed choices about healthy pregnancy behaviours, as well as improving the future life course of young mothers, by supporting them to make changes to their lives and providing them and their babies with a better future[50].

The national evaluation of the FNP programme shows that it appears to improve early child development, particularly early language development at 24 months and may also help protect children from serious injury, abuse and neglect through early identification of safeguarding risks. There were also some small improvements in mothers' social support, relationship quality and self-efficacy. Young mothers were positive about the FNP programme, engaged very well with it and feel it helped to them to be good parents[51].

## Our ambition for Rotherham

- All teen parents and their children accessing local Children's Centres

## Family Nurse Partnership case study - Jade and Carl

Jade became pregnant aged 16 years. She had a family background of neglect and poor parenting, and had witnessed domestic violence. She was involved in a number of risk taking behaviours and was at risk of child sexual exploitation (CSE).

Carl, the baby's father, was known to social care and the police and had a history of abusive relationships.

The Family Nurse found it difficult to engage Jade in the pregnancy stage and initially met her in community settings including a local Children's Centre and youth cafés. Jade moved to supported accommodation and started to engage with midwifery and Independent Domestic Violence Advisor (IDVA) services. The Family Nurse explored Jade's own life story and family relationships to look at how Jade could make it different for her baby.

The programme approach supported Jade to feel listened to and understood. It was apparent that the approach taken by other services impacted on Jade's relationship and engagement with them. The relationship between Family Nurse and client and the use of programme materials supported Jade to consider her own patterns of behaviour and has supported her to end the cycle of an abusive relationship. She has also reflected on how her own child's life will be different from her own and his father's experience.

Jade has continued to engage and has become insightful regarding the impact of domestic abuse upon children. Following periods of low mood, she has built up her social contacts and enrolled at college, and appears to be maintaining positive relationships.

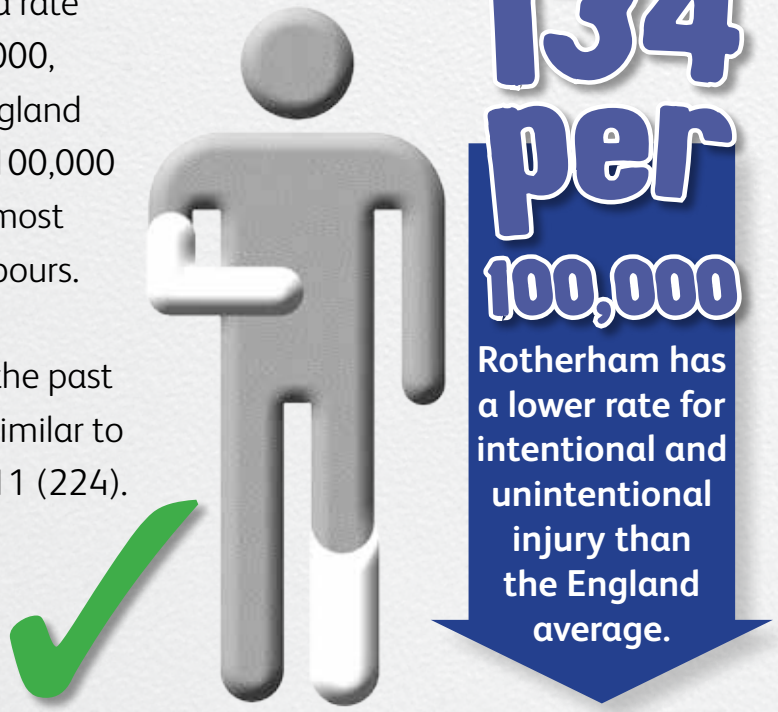
Jade's little boy is now 18 months old. He is fully immunised, achieving all development milestones and attending early years nursery provision. The attachment between Jade and her son is strong. Jade has worked hard to develop routines and skills in independent living and managing a budget to provide a stable environment for her son.

## Unintentional and deliberate injuries in children and young people

Unintentional injuries remain a major safety risk for children in the UK, particularly for children aged under five[52].

In 2013/14 there were 216 emergency hospital admissions of Rotherham children under 5 caused by unintentional and deliberate injuries (including sprains, contusions (bruising), wounds, dislocations and fractures).

This equates to a rate of 134 per 100,000, similar to the England rate of 140 per 100,000 and lower than most statistical neighbours. Numbers have fluctuated over the past 4 years but are similar to those for 2010/11 (224).




### What are we doing in Rotherham?

Home accident prevention assessments are conducted by health visiting teams and children's centres to raise awareness and reduce the risk of childhood injury.

The Rotherham NHS Foundation Trust Accident and Emergency department follows robust criteria when assessing any presented childhood injury to safeguard children and young people.

### Our ambition for Rotherham

- Rotherham Public Health will conduct an in-depth review of all data relating to unintentional and deliberate injury in Rotherham. This will help to identify the types of accidents and trends to enable more targeted preventative advice and interventions

## Early years development and ready for school

A child's life of learning begins at birth with brain development shaped by early experiences, setting the foundation for all learning that follows. The way very young children are cared for teaches them how to interact with the world and profoundly shapes who they will become. In essence, the first steps toward school readiness also lead to the resilience and positive behaviours needed for success in the workforce and in life.

However, too many pre-school aged children lack the key resources needed for a good start on the school readiness path. They fall behind, and their pre-school experience is playing catch-up, not forging ahead.

Evidence shows that high quality pre-school experience can have positive effects on children's development, giving them the best start[53].



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Rotherham's outcomes at the end of the Foundation Stage have been above national outcomes for the last three years as detailed in the table below:

| Good Level of Development % | 2013 | 2014 | 2015 |
|---|---|---|---|
| All | 56 % (52 %) | 62 % (60 %) | 67 % (66 %) |
| Boys | 46.7 % (44 %) | 55.1 % (52 %) | 59.8 % (58.6 %) |
| Girls | 65.3 % (60 %) | 69.6 % (69 %) | 75.2 % (74.3 %) |
| Free School Meal (FSM) recipients | 40 % (36 %) | 45 % (45 %) | 52 % (51 %) |
| Non-FSM | 60 % (55 %) | 67 % (64 %) | 70 % (69 %) |

England figures in brackets for comparison.

Rotherham Borough Council's priorities are to improve outcomes for boys and for those children eligible for free school meals in order to close the attainment gap between them and their higher achieving peers.

## What are we doing in Rotherham?

The introduction of Early Education Funding (EEF) for two year old children who meet the eligibility criteria (which encompasses the FSM criteria) has provided an opportunity for children at greater risk of not being school ready to access early learning at an earlier age. Of the 2 year old children in the Rotherham catchment area that are eligible for EEF, 82 % are taking up a place. This is above national levels (63 % ) and is one of the highest in the country (2015 data). This means that these children are accessing high quality early education from an earlier age, contributing to closing the attainment gap for this vulnerable group.

## Our ambition for Rotherham

- Early Years and Childcare Service working together to ensure that the assessment completed by the Health Visiting team and the 2 year old progress and health checks are integrated. Systematic joint assessment will further support the identification of children at risk of developmental delay to enable earlier intervention to maximise progress and close the attainment gap at an earlier age for children who are not achieving typical developmental milestones

# Chapter 3: Primary school years

As children grow up they become increasingly aware of health-related matters and can be expected to take on additional responsibility for their health and wellbeing. The primary school years are therefore an opportune time to educate and provide lifelong skills that promote good health and wellbeing.

It is important to highlight the essential work required with families to ensure children can take advantage of opportunities to enhance health and wellbeing of parents/carers as well as children and young people.

## Nutrition (food & drink)

National guidance for a healthy balanced diet recommends we should eat 5 portions of fruit and vegetables a day. This is important for children and young people to prevent them from developing some cancers, diabetes and cardiovascular diseases in later life.

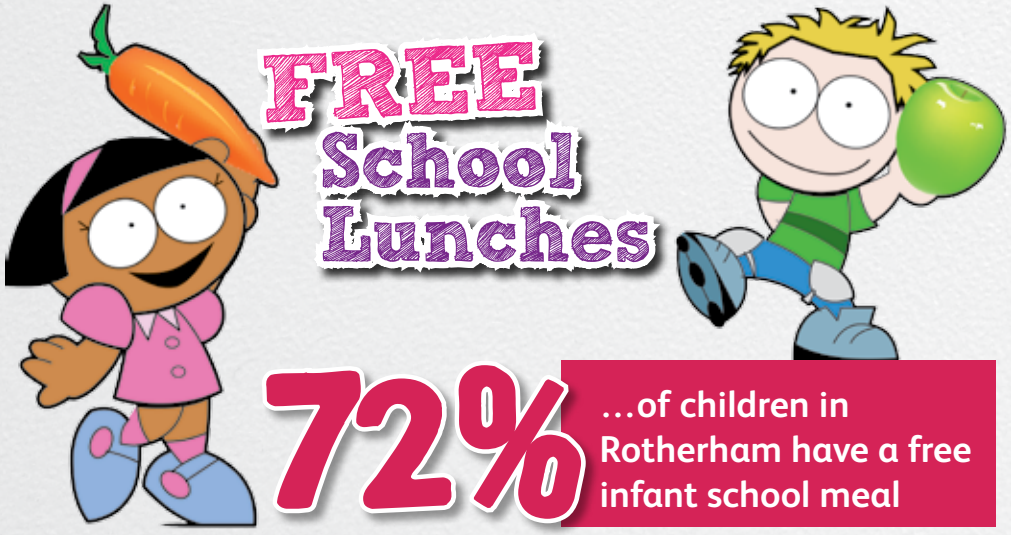
Children consume lots of sugar in their food and drink. These additional calories may also lead to heart disease and some cancers when they are older.  Sugary drinks are a major problem and can also have an impact on dental health. Twenty-eight percent of 5 year olds in England have tooth decay and of these, 24% have 5 or more teeth affected. The maximum recommended daily amounts of additional sugar (that found in drinks, cereals, puddings) for 4-6 year olds is the equivalent to 5 sugar cubes, for 7-10 year olds is 6 cubes and 11 years plus is 7 cubes. A 330ml can of cola contains 9.5 cubes of sugar and a 240ml serving of orange juice is 6 cubes.

The Change 4 Life Sugar Swaps campaign[54] has a new smart phone app that helps people find out how much sugar is in the drinks they buy. The campaign also provides recommendations for cutting down on sugary drinks: using a glass to serve drinks (rather than out of the bottle), limiting the amount of fruit juice children have, being aware of portion size for drinks, or trying sugar free drinks, low fat milk, or sparkling water.

School meals provide healthy, nutritious, high quality food. School meals promote opportunities for good eating behaviours and provide the most vulnerable children with a nutritionally balanced meal. All local authority maintained primary, secondary, special schools and pupil referral units in England must meet national school food standards; Rotherham schools meet the required standards.

The number of school meals served each day in Rotherham has risen steadily year on year. This year 14,600 pupils in primary and 4,900 young people in secondary schools have a meal provided at school by Education Catering services on a daily basis.

From September 2014, all Reception and Key Stage 1 children have been offered a free school meal. This has led to an increase in the numbers of children accessing free school meals. The uptake of this universal offer of free infant school meals in Rotherham is currently 72% and is slightly lower than comparative local authority average, which is 79% (based on information from the first 6 months following the introduction of free school meals since September 2015).



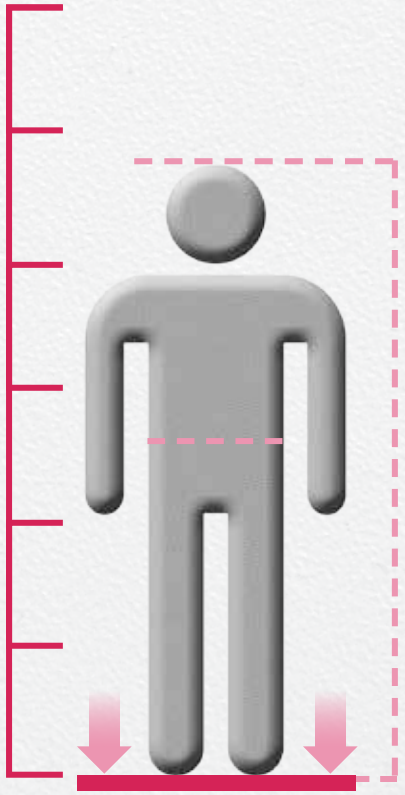

## Overweight and Obesity

Childhood obesity is particularly harmful because of the number of children concerned, the fact that it limits a child's ability to enjoy a full and active life and that it increases the risks of diabetes, cancer, heart and liver disease in later life[55].

Children who are obese are more likely to have time off school, have lower self-esteem and experience poorer health. Obese children are more likely to go on to become obese adults and have a lower life expectancy and a higher risk of poor health and disability. Cases of type 2 diabetes are increasing as a result of increased obesity caused by poor diets and lower levels of physical activity.

Each year, children aged 4-5 (Reception year) and 10-11 (Year 6) are weighed as part of the National Child Measurement Programme (NCMP). This determines how many children in these age groups are underweight, healthy weight, overweight or obese. In Rotherham 10% of 4-5 year olds were identified as obese (2014/15), higher than the England average of 9.9%. Additionally, 22% of 10-11 year old pupils in Rotherham were identified as obese, worse than the England average of 19.1%. Among 15 local authorities in the Yorkshire and Humber region, Rotherham ranks 4th highest at Reception and 2nd highest at Year 6. Rotherham ranks similarly among Children's Services statistical neighbours (5th highest at Reception, 2nd highest at Year 6).

The NCMP and the Royal College of Paediatrics and Child Health define levels of overweight at an individual level as on or above 91st centile[56].



**22%**

**…of 10 to 11 year old pupils in Rotherham were identified as obese in 2014/15**

## What are we doing in Rotherham?

Since 2009, over 1000 children have lost and maintained weight loss with the support of our RMBC commissioned services.

The benefits of the programmes go further than weight loss, with many children reporting improved confidence, self-esteem and even improved attendance at school.

The local planning framework has been revised and supports a number of actions to reduce the number of takeaways situated near to school premises.

## Our ambition for Rotherham

- We would like to promote a whole systems approach to promoting a healthy weight for children and young people across the borough through the development of a new healthy weight action plan following the publication of the National Childhood Obesity Strategy, expected in early 2016. This will enable the linking of a range of sectors and influences including planning, housing, transport, children's and adult's services, business and health which will support us to tackle obesity and improve quality of life

The case study below is from Tom, a young man attending the MoreLife Club (Tier 2) programme:

*'I have really enjoyed coming to MoreLife at Maltby Leisure Centre, I have met new friends, learnt lots of useful information on healthy eating and took part in new sports and activities'*

Some of the successes Tom has experienced since joining the club:

- Forged friendships and met new families that are like minded
- Improved self-confidence especially in regards to his appearance
- Tom and his Grandad have both completely changed their lifestyle by reducing portion sizes, healthier food choices and becoming more active
- Tom and his Grandad have both joined Maltby's gym and swim membership and attend 5 days per week
- His fitness has greatly improved and taking part in the programme has spurred Tom to carry on being active

Tom has lost 6kg in weight and 7.6% body fat.

## Physical Activity

Being active is important as it can help maintain a healthy weight as well as better cardiovascular health. It also has a positive impact on mental wellbeing, improving confidence and self-esteem as well as helping young people develop social skills through team activities.

All children and young people aged 5–18 should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day. Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week[57].

According to the Rotherham Young People's Lifestyle Survey, 23% of boys and 13% of girls in Year 7 and Year 10 reported that they engaged in vigorous physical activity for a least one hour every day. Nearly half of Year 7 and Year 10 children are taking part in vigorous exercise at least four times per week[58]. Overall 80% of Rotherham children take part in regular physical activity or sport.

It is essential that children and young people minimise the amount of time they spend sitting and watching TV, playing computer games or being sedentary and take more opportunities to walk and cycle. Low levels of physical activity in children are related to household income, with those in the lowest income brackets more likely to report low levels of activity.

## What are we doing in Rotherham?

This Rotherham Girl Can' is a developing initiative to increase physical activity and confidence in girls, utilising the positive messages in the national 'This Girl Can' campaign. New provision set up in Rotherham includes reduced cost, female only swimming sessions and female only satellite clubs based at local colleges.

As part of the strategic sports partnership in Rotherham, the children and young people's sport and physical activity sub group brings together key stakeholders to improve the physical activity and sports delivery system for children and young people. The group's achievements include developing an athletics satellite club programme, creating a junior schools football league, securing Sportivate funding for sports programmes for young people and a new primary school/PE officer.

Mega Active holiday provision delivers physical activity provision for children aged 5-14 years in the most rural and isolated areas of the borough. The sessions, run by Active Rotherham, engaged 471 young people in 2015.

Reduced rate swim passes, a Junior Gym programme and discounted sport specific satellite club programmes are offered.

The Active Ability Project is a Sport England four year funded project aimed at developing club pathways for people aged 14+ with a disability to participate in six key sports (athletics, cricket, swimming, boccia, power chair football, basketball). The project, coordinated by Active Rotherham and delivered through local clubs to ensure sustainability, engaged 93 young people in 2015.

## Our ambition for Rotherham

- The children and young people's sport and physical activity sub group driving new partnership initiatives aimed at increasing participation for young people aged 5 and over
- A call to action through the 'Rotherham Get Active' campaign to encourage providers and the public to increase physical activity participation levels
- Active Rotherham to create a self-sustaining model for future Mega Active delivery, running the camps at zero cost to the local authority with partners taking a lead on their own local programmes

## Oral Health

Oral health is a useful measure to assess the general health of a local community. It is an important part of health and wellbeing, affecting the ability to communicate, how you enjoy a variety of food, as well as your self-esteem and self-confidence.

Rotherham has high levels of tooth decay in 3 year old and 5 year old children when compared to national and regional averages. In 2013, 198 (6.1%) of 3 year old children sampled in Rotherham had 0.46 decayed, missing or filled teeth (DMFT), compared to 0.39 for Yorkshire and the Humber (Y&H) and 0.36 for England.

In 2011/12, 390 (12.6%) of 5 year old children in Rotherham had 1.44 decayed, missing or filled teeth (DMFT) compared to 1.23 for Y&H and 0.94 for England. This shows a significant deterioration within two years. Rotherham was found to have the worst oral health in South Yorkshire in both surveys.

Nationally, treatment for dental caries is the most common reason children aged 5-9 years have to be admitted to hospital for a general anaesthetic. In 2012/13 there were 1,015 admissions to hospital in Rotherham for extraction of one or more decayed primary or permanent teeth for 0-19 year olds, at a cost of £683,095[59].

There are a number of risk factors which are associated with poor oral health, including a high sugar diet and lack of dental hygiene (brushing teeth).

Evidence suggests that child oral health is related to socioeconomic status; children living in lower income households and social disadvantage experience disproportionately higher levels of oral disease.

**1015 children**

**(0-19years) admitted to hospital in Rotherham for extraction of one or more decayed teeth in 2012/13**

## What are we doing in Rotherham?

A Rotherham Oral Health Improvement Strategy and action plan has been developed using a national evidence based approach[60], which is acting as a catalyst to increase the profile of oral health.

The action plan prioritises work with children and the Rotherham Oral Health Improvement Team is working in a number of Early Years settings, including nurseries, schools and special schools.

## Our ambition for Rotherham

- Adoption of a whole setting approach for training in early years/schools (including special schools), with development of a comprehensive package of oral health preventative work, including developing policies, procedures, training, identifying school curriculum opportunities and the introduction of tooth brushing clubs
- Health practitioners promoting fluoride varnish and dental attendance. This will be incorporated into the new service specification for children and young people's public health services

## Oral Health Case study – Kimberworth Community Primary School Toothbrushing Club

Teaching staff at Kimberworth Community Primary School had concerns around the oral health of their pupils and had sourced a number of toothbrushes and toothpaste for pupils but needed help and advice to develop a toothbrush club.

The Oral Health Improvement team worked with the school to develop a programme of work including basic oral health training for all school staff involved. Bright Bites and To Be a Star teaching packs, along with the Busy Teeth resource packs were demonstrated and given to teaching staff in all year groups. The team also contacted Kimberworth Park Dental Practice whose staff provided the classroom input. They also attended a Breakfast and Stay session to talk to parents. Now the breakfast club is running a toothbrushing club and 17 out of the 18 children attending report brushing their teeth at school after breakfast. The children took part in an informal chat about the day and what they had learnt. They all said they now brushed twice a day, not once. School staff are working up the programme for submission for a Healthy Schools Award. Kimberworth Dental Practice has offered more support and the oral health team linked them into another school local to the practice.

## Immunisation

Vaccination continues to be one of the most effective ways to protect the population from a wide range of serious infectious diseases. It is a major factor in reducing health inequalities and, without vaccination, outbreaks and epidemics may occur.

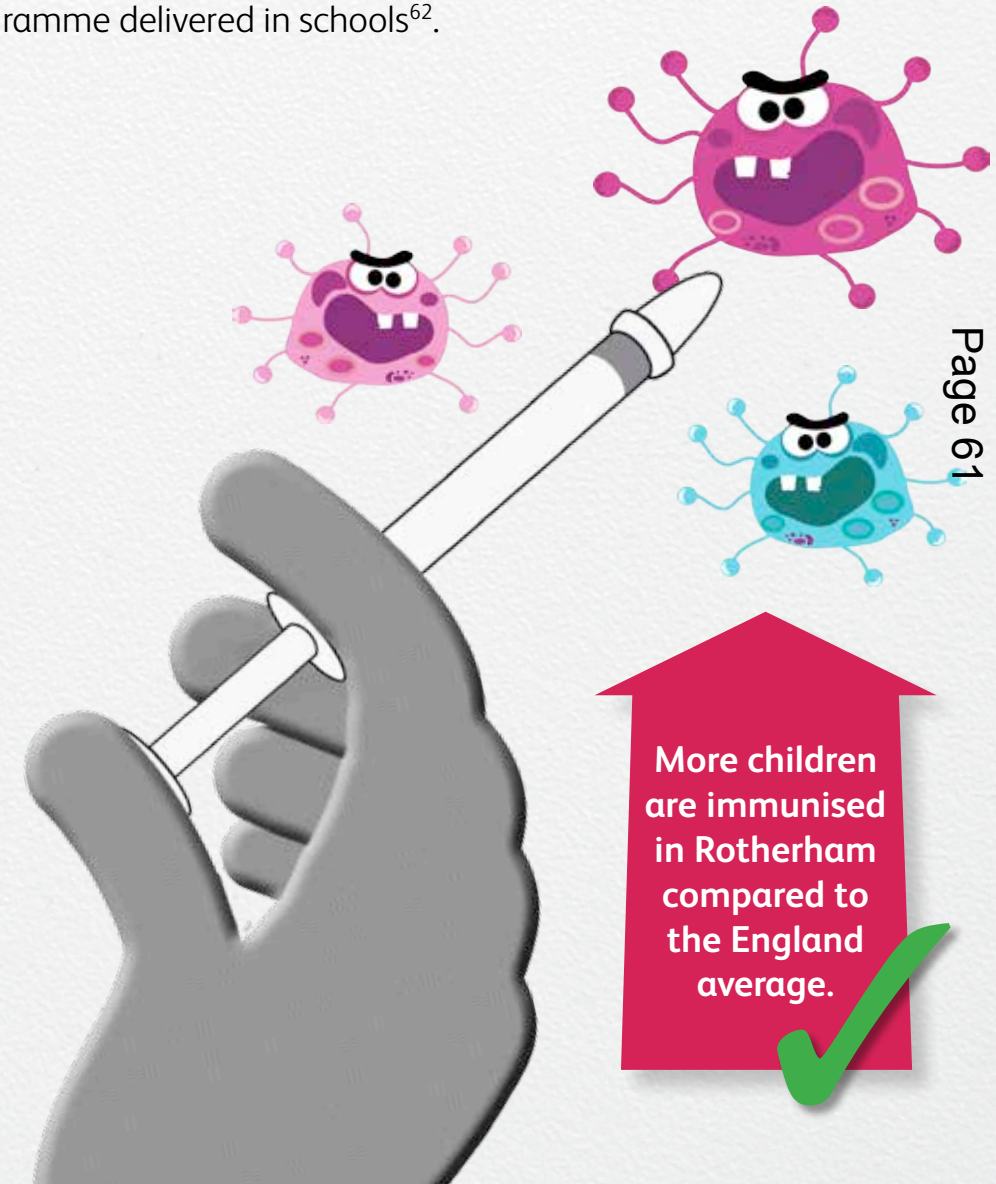
**Vaccination** is when a vaccine is given to you (usually by injection).

**Immunisation** is what happens in your body after you have the vaccination. The vaccine stimulates your immune system so that it can recognise the disease and protect you from future infection.

Despite the success of our national routine vaccination programmes[61], vaccine-preventable diseases such as measles, whooping cough and meningitis can still sometimes occur. Should our guard on vaccination slip these diseases are ready to resurge.

People in Rotherham are offered a total of 17 routine vaccinations for protection against 12 infectious diseases, many of which are part of the routine childhood immunisation schedule.

The schedule is primarily delivered through GPs, with the Human Papilloma Virus (HPV) and part of the Children's Flu vaccination programme delivered in schools[62].

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All Rotherham immunisation uptake figures for 2014/15 are above the England average with many significantly better:

## Population Vaccination Coverage 2014/15[63]

| | (Percentage immunised) | |
|---|---|---|
| **Vaccination** | **Rotherham** | **England** |
| Diphtheria/Tetanus/Polio, Pertussis, Haemophilus influenza type b (1 year old) | 96.9 | 94.2 |
| Diphtheria/Tetanus/Polio, Pertussis, Haemophilus influenza type b(2 years old) | 96.4 | 95.7 |
| Diphtheria/Tetanus/Polio, Pertussis, Haemophilus influenza type b (5 years old) | 96.2 | 95.6 |
| Diphtheria/Tetanus/Polio (5 years old) (B) | 92.1 | 88.5 |
| Meningitis C (1 year old) (1st dose) | n/a | n/a |
| Hepatitis B (1 year old) | n/a | n/a |
| Hepatitis B (2 years old) | n/a | n/a |
| Pneumococcal conjugate vaccine (1 year old) | 96.8 | 93.9 |
| Pneumococcal conjugate vaccine (2 years old) (B) | 93.6 | 92.2 |
| Measles, Mumps and Rubella (2 years old) | 93.1 | 92.3 |
| Measles, Mumps and Rubella (5 years old) (1st dose) | 95.2 | 94.4 |
| Measles, Mumps and Rubella (5 years old) (1st & 2nd dose) | 91.4 | 88.6 |
| Haemophilus influenza type b/Meningitis C (2 years old) (B) | 94.0 | 92.1 |
| Haemophilus influenza type b/Meningitis C (5 years old) (B) | 95.0 | 92.4 |
| Flu (65 and over) | 76.6 | 72.7 |
| Flu (at risk individuals) (6 months-64 years) | 53.7 | 50.3 |
| Flu (2 years old) (at risk) | 56.4 | 53.7 |
| Flu (3 years old) (at risk) | 57.4 | 56.4 |
| Flu (4 years old) (at risk) | 53.3 | 52.3 |

In Rotherham a wide range of agencies work together to ensure that there is a high uptake of routine childhood vaccinations for community-wide immunity, which is known as 'herd immunity'. This reduces the spread of an illness and provides a level of protection to vulnerable and unvaccinated people. We know that vaccination coverage levels in Rotherham compare favourably with other areas across the Yorkshire and Humber region and Rotherham rates have remained consistently above national targets.

In 2008, a new vaccine called the Human Papilloma Virus (HPV) vaccine was added to the UK Childhood Immunisation Schedule. HPV may be passed on through sexual contact which can increase your risk to cervical cancer later in life. The vaccine, delivered through the Healthy Child Programme, is given in two doses to 12-13 year olds and protects against the most common cancer-causing types of HPV.

Public health will continue to be vigilant to ensure that the national routine vaccination programmes delivered for children in Rotherham maintain high rates of uptake as essential components of a safe and effective community health system.

The Director of Public Health has a responsibility for the vaccination coverage of the population of Rotherham. To discharge this duty of care, Public Health will:

- Work alongside Public Health England to ensure that coverage reaches Department of Health vaccination targets
- Respond in a timely and effective way to any disease outbreaks
- Promote the uptake of vaccinations through partnership working

## What are we doing in Rotherham?

In 2014, Rotherham took part in the national childhood flu pilot for Year 7 and Year 8 and will continue to offer vaccination as part of the national roll out of the childhood flu programme. It is anticipated that, once fully implemented, it will ultimately avert many cases of severe flu and flu-related deaths in older adults.

## Our ambition for Rotherham

- The two dose schedule for HPV (reduced from three doses) was introduced in Rotherham schools in September 2015, bringing benefits in the uptake of the vaccine. The screening and immunisation team (NHS England) should continue to work closely with the Rotherham school nursing service and head teachers to ensure that the benefits of this vaccine are communicated and making vaccination easily available
- Working with NHS England and partners (including RMBC and Rotherham Clinical Commissioning Group) to ensure the high uptake of flu vaccine among children in Rotherham to reduce the amount of flu circulating in the community

# Chapter 4: Secondary school years

Adolescence is not only a key transition point between childhood and adulthood, it is a distinct developmental stage in its own right, characterised by dramatic physical and neurological changes, and emotional development.

Young people increasingly take on additional individual responsibilities for their own health and wellbeing. They will be making a broader range of lifestyle choices, and will draw on care, support and advice from a wider range of sources – whether they be at home or in school, further education, in the workplace, or in the wider community. Psychological support, through these formative years in particular, is crucial to help young people have more control over their own health.

## *Rotherham Young People's Lifestyle Survey*

*The Rotherham Lifestyle Survey is open to all young people in Year 7 and Year 10 of secondary school and those in Pupil Referral Units. In 2015, 3,110 young people completed the survey. Highlights from the 2015 survey included:*

- *Fruit is the most popular snack option of young people in Rotherham with 19% reporting that they chose fruit over crisps and chocolate*
- *20% reported that they considered themselves to be overweight with a further 3% reporting that they considered themselves to be very overweight*
- *75% of young people reported that they would know where to go to seek support for mental health problems*
- *80% of young people said they have never smoked*
- *More young people in Rotherham (26%) have used an electronic cigarette at least once than nationally (22%)*
- *58% of young people are obtaining their alcohol from family with their knowledge*
- *There has been a decrease in the number of Year 10 pupils who said they have had sex from 25% in 2014 to 23% in 2015 of these, 22% reported that they didn't use contraception*

## Emotional Health and Wellbeing

Mental health is something we all have, but we sometimes tend to only think about it when things go wrong and we start to notice that we are becoming unwell. Mental health influences how we all think and feel about ourselves and others. It affects our ability to form friendships, learn and cope with life events.

Children and young people who are mentally healthy:

- Develop psychologically, spiritually, intellectually and emotionally
- Initiate, develop and sustain mutually satisfying relationships
- Use and enjoy solitude
- Become aware of others and empathise with them
- Play and learn
- Develop a sense of right and wrong
- Resolve problems and setbacks and learn from them

Good mental health is so important for children and young people and we know that when children and young people do have good mental health they are likely to have much better outcomes[64].

At any one time, between 10% and 20% of children will have a diagnosable mental health problem severe enough to require Child and Adolescent Mental Health Services (CAMHS) intervention. That is about three children in every class. Around 10% of children and young people have similar, but more severe, complex or persistent difficulties, referred to as mental health disorders. The prevalence of mental health disorders has been established by detailed studies, notably the Mental Health of Children and Young People in Great Britain[65] published by the Office for National Statistics (ONS), which built on the work of a previous study in 1999. We know that 75% of adult mental health problems occur before the age of 18[66].

If children and young people do not receive early intervention and adequate treatment for their mental health problems there is a higher likelihood that they will have poorer academic achievement, face higher unemployment, premature morbidity and long term physical and mental health problems[67].

Rotherham Youth Cabinet has had mental health as a priority area in their manifesto for the last three years. In 2013 they began by looking at self-harm, talking to their peers about how to improve access for young people seeking help and support around self-harm. They also talked with and questioned providers and

service commissioners about what they were doing to support young people who self-harmed. The report had recommendations for action[68], including having clear and consistent messages about self-harm, having professionals trained and confident to be able to talk to young people about self-harm and a range of places for young people to get advice and support. These recommendations are being actioned by providers and service commissioners.

In 2014/2015, Rotherham Youth Cabinet investigated existing support networks for young people around emotional wellbeing and established ways to promote positive mental health. This included opportunities to work more closely with Rotherham, Doncaster and South Humber NHS Trust (the provider of CAMHS) and CAMHS Commissioners. Rotherham Youth Cabinet was also involved with the production of the website for young people on emotional wellbeing and mental health:
**www.mymindmatters.org.uk**


In 2015 a member of Rotherham Youth Cabinet and Rotherham Youth Parliament wrote a report on mental health services in Rotherham called Mind the Gap. The author talked to families, young people and officers. The recommendations from the report have been included in the work taking place to transform children and young people's mental health services.

### What are we doing in Rotherham?

We are making good progress on the delivery of Rotherham's CAMHS Transformation Plan, in particular the focused work on early intervention and prevention.

We are delivering training for frontline staff, including Youth Mental Health First Aid and Suicide Prevention.

Rotherham Youth Cabinet's 2015/16 Manifesto outlines their action to investigate existing support networks for young people around emotional wellbeing and establish ways to promote positive mental health. They are hosting a conference in March 2016 to promote ways young people can stay mentally healthy.

## Our ambition for Rotherham

- Rotherham Clinical Commissioning Group (RCCG) to ensure that anti-stigma and discrimination activity is regularly discussed at the Child and Adolescent Mental Health Service (CAMHS) Partnership Group meetings. Members of the CAMHS Partnership to work together on anti-stigma activities throughout the year involving young people, parents and carers.
- RMBC, RCCG, NHS services in Rotherham and the community/voluntary sector to support the Youth Cabinet to carry on their active and focussed work to address mental and emotional health and wellbeing.
- RMBC develop a workforce development strategy which details the level of training relevant to their role.

## Self-harm

Self-harm is defined in the National Institute of Clinical Excellence guidelines (2004)[69], as:

*'… an expression of personal distress, usually made in private, by an individual who hurts him or herself. The nature and meaning of self-harm, however, vary greatly from person to person. In addition, the reason a person harms him or herself may be different on each occasion, and should not be presumed to be the same'.*

*"I bottled up all my feelings and let it all out on myself instead of talking about it. Cutting myself made me feel like I could breathe again.'' (Rotherham young person)*

Self-harm is any behaviour such as self-cutting, swallowing objects, taking an overdose, hanging or running in front of a car where the intent is deliberately to cause self-harm.

Anyone can self-harm. This behaviour is not limited by gender, race, education, age, sexual orientation, socio-economics, or religion. There are a number of factors that motivate people to self-harm, including a desire to escape an unbearable situation or intolerable emotional pain, to reduce tension, to express hostility, to induce guilt or to increase caring from others. However, some people who self-harm have a strong desire to kill themselves. Yet even when the intent to die is not high, those self-harming may express a powerful sense of despair and this needs to be taken seriously.

The estimates for self-harm amongst young people vary and indeed some may be an underestimate because many young people do not disclose that they are self-harming, treating themselves at home and never coming to the attention of services. However, one survey estimates that 1 in 10 young people self-harms at some point in their teenage years[70]. Over the past 40 years, there has been a large increase in the number of young people who deliberately harm themselves. The Mental Health Foundation suggests there are 'probably two young people in every secondary school classroom who have self-harmed at some time'[71]. Most young people who self-harm do not access acute services and are first noticed by people in the community; friends, teachers and family members[72].

In Rotherham, hospital admissions due to self-harm are the second lowest out of 15 local authorities in the Yorkshire and the Humber region for 2013/14[73]. However, in Rotherham, the people working with young people and the young people themselves report that it is an issue which needs to be a priority. Young people who self-harm may feel embarrassed or ashamed and worry that people will judge them, hence they do not always disclose and seek help.

In Rotherham we have developed guidelines on self-harm[74] to be used by anyone working with children and young people. The guidelines are about providing a timely and appropriate response to children and young people who may be self-harming.

The voice and experiences of Rotherham young people who self-harm has been listened to and used to help us include things which are important to them.

## What are we doing in Rotherham?

There is an action plan in place which outlines what the Council, alongside its partners (including health, police and voluntary organisations), is doing to prevent suicides and support people who are bereaved by suicide . Actions on this plan are reported back to the Health and Wellbeing Board on a regular basis. This plan will be updated in 2016 to look at new actions and areas for work.

Our ambition for Rotherham

- The Supporting Children and Young People who Self Harm: Rotherham Self Harm Practice Guidance[75] to be distributed and in use in schools, colleges, health and youth centres
- Training sessions on the self-harm practice guidance provided to frontline staff who can cascade learning to others
- Annual review on levels of awareness and usage of the self-harm practice guidance amongst frontline staff

## Health related behaviours: Tobacco

Smoking is an addiction of childhood; more than three-quarters of adult smokers started smoking before the age of 18. If we want to reduce smoking rates overall, we need to focus on preventing young people from becoming smokers.

Figures from the national What about YOUth survey[76] show that 10 % of Rotherham's young people aged 15 smoke, with 7 % of them smoking regularly (daily or weekly). This is higher than the national average and our neighbouring boroughs.

This raises concerns about where these young people are getting their cigarettes from, as the legal age of sale is 18; access to illegal tobacco and retailers who do not routinely check for proof of age need to be tackled to reduce smoking rates among young people.

Young people are more likely to smoke if they live with other smokers, so one of the most effective ways to reduce youth smoking is to help adults to stop.  Quitting with support from our stop smoking services makes somebody four times more likely to succeed in their quit attempt.

A new concern is the increased use of electronic cigarettes, or nicotine delivery devices (NDDs), by young people. Until October 2015 there were no restrictions on the sale of these devices to young people and there remains little regulation of the products. We are also concerned that information from our local lifestyle survey suggests that, whilst only a small number of young people are regularly using NDDs, most of them do not smoke tobacco. Therefore, a device that is intended to help adult smokers switch to a less harmful alternative, may be inadvertently creating a new addiction for our young people.


## What are we doing in Rotherham?

We currently work with youth services and schools to reduce uptake of smoking. We use a 'social norms' approach, which debunks the myths around the number of young people who smoke and promotes the fact that 9 out of 10 young people don't smoke. Youth services have also been using Tobacco Free Futures Smoke and Mirrors programme, which highlights the negative practices of the tobacco industry and encourages young people to look at tobacco harm in a new way.

We have also run joint promotional campaigns with Sheffield and Doncaster Councils to highlight the risks associated with illegal tobacco and the increased access it provides to children and young people. The Stop Cigs for Kids campaign encourages anonymous reporting of anybody who is selling illegal tobacco so Trading Standards can take appropriate enforcement action.

Our ambition for Rotherham

- All Rotherham schools reviewing their smokefree policies to ensure they are in line with current legislation and implement voluntary smokefree zones outside the school gate

## Health related behaviours: Drugs and Alcohol

Drug and alcohol misuse can have a major impact on young people's education, their health, their families and their long-term chances in life. The majority of young people do not use drugs, and most of those that do are not dependent.

In the Rotherham Lifestyle survey, 63% of 11 and 12 year olds responded that they had never tried alcohol, yet this reduced to 24% among responses from those aged 14 and 15 years. Only 2% of those aged 11 and 12 responded that they drank alcohol regularly, but this increased to 10% among those aged 14 and 15.

When asked whether it was OK for young people their age to take drugs, only 3% of those aged 11 and 12 responded that it was ok compared to 12% of those aged 14 and 15. Less than 1% of 11 and 12 year olds reported that they use legal highs weekly or have tried them once. For those aged 14 and 15, cannabis was reported to be the most commonly used drug, with 9% of pupils saying that they have tried it at least once. Some reported using solvents, with over 3% having tried them once; 2% reported using them weekly and 1% using them monthly.

Among 16 and 17 year olds (Rotherham Post 16 Survey 2014 - unpublished) the picture for drug and alcohol use is very different:

- 75% reported that they drank alcohol. Of these, 44% reported that they only drank on special occasions. However, 24% reported that they drank weekly
- 57% reported that they got the alcohol from their parents
- 64% reported that they drank with friends and 32% drank alcohol with family
- 51% reported that they drank as it was fun and 30% to chill out/relax
- 74% reported that it was 'not ok' for someone their age to take drugs
- Mephedrone (commonly referred to as MCAT) was reported to be used by 9% of those aged 16 and 17 years and Spice by 6%
- When asked to pick a single drug of choice those aged 16 and 17 reported that cannabis was the preferred choice of 17%, solvents 2% and MCAT 3%
- Many had taken risks while under the influence of drugs with 39% reporting that they had walked home alone and 12% had taken sexual risks

Know The Score is the Public Health commissioned young people's substance misuse service. The service supports the case management of the small numbers of under 18s with complex substance misuse issues working alongside other health and social care professionals. The team also provides support to other professionals who are managing young people's substance misuse as part of a wider range of challenging behaviours or circumstances for young people, and deliver educational sessions aimed at providing basic levels of knowledge and signposting to services.

The young people who are accessing the Know the Score service are often very vulnerable:

- 17% were identified as a 'Child in Need' compared to 5% in similar services nationally[77]
- 26% reported as being affected by domestic abuse compared to the national figure of 17%[70]
- 13% reported being involved in sexual exploitation compared to 4% nationally
- 26% reported as being NEET compared to 17% nationally

There are a number of specific issues facing girls, including increased citation of alcohol as a problematic substance, involvement in self-harm, being affected by domestic violence and involvement in sexual exploitation.

There is growing concern about the readily available New Psychoactive Substances (NPS) in the UK that are more commonly known as 'legal highs'. These substances mimic the effects of controlled drugs, but are sold legally as they are not marketed as a substance for human consumption.

The Home Office expert panel defines NPS as 'psychoactive substances, newly available in the UK, which are not prohibited by the United Nations Drug Conventions but which may pose a public health threat comparable to that posed by substances listed in these conventions'[78].

The main NPS groups include predominantly sedative drugs, predominantly stimulant drugs, hallucinogens and psychedelic drugs, synthetic cannabinoids and dissociative drugs.

Some substances described as 'legal highs' may not actually be legal (and 'legal' can imply they are safe or regulated, when neither is true). In 2013/14, nearly a fifth (19%) of the substances found in the 'legal high' drug samples collected by the Home Office's forensic early warning system in 2013-14 were controlled drugs[79].

In February 2015 partners (of the Young Persons Substance Misuse Education and Prevention Group) in Rotherham undertook a substance misuse survey with young people aged 16 plus. Of the 551 young people who responded to the survey, 3% disclosed NPS use. The survey data has been used by the establishments who took part to inform their own response to substance misuse and targeted delivery of key messages.

The Centre for Drug Misuse Research[80] found that the main drug of choice was synthetic cannabinoids (32%) followed by stimulants (18%) and psychedelics (18%). There were 341 unique chemical, commercial or brand named NPS reported. The reported source of the substances was from a combination of the following: shops (35%), friends (30%), websites (25%), at a friend's house (25%) or from a 'dealer' (25%).

Rotherham's Know The Score service is not currently working with any young people who consider NPS as their main drug of choice. This does not reflect that there isn't a problem with NPS use in young people in Rotherham, but that the service is currently working with very complex and high level drug users. Intelligence from other young people's agencies indicates that there is use and experimentation locally. In a 'snap shot exercise' for a Youth Offending Team (YOT) worker caseload, of 30 clients, 17 reported NPS use.

## What are we doing in Rotherham?

Rotherham has been part of the Amy Winehouse Foundation Resilience Programme for schools; 8 have taken part. This is a four year programme that works to prevent the effects of drug and alcohol misuse on young people. We also aim to support, inform and inspire vulnerable and disadvantaged young people to help them to reach their full potential.

Know The Score are delivering awareness raising sessions for key staff. We are also sharing intelligence on NPS use and points of sale for Trading Standards to act upon.

## Our ambition for Rotherham

- Every secondary school and college should provide consistent substance misuse education that promotes resilience. This will be enabled by seeking support from PSHE or Pastoral leads, Head Teachers and Governing Bodies and providing each school with up to date local information and teaching packs to complement the curriculum. The local information and teaching pack will be pulled together by the Young Persons Substance Misuse Education and Prevention Group currently chaired by the RMBC Healthy Schools Consultant.
- Every partnership agency for example; education, police, fire, health, local authority and voluntary sector, should maximise their potential and the free parent/carer education resources, such as those available from Alcohol Education Trust) to educate as many parents/carers as possible in their employ or that they have contact with on alcohol use in young people, to delay the onset and prevent harm. This can be managed by the Young Persons Substance Misuse Education and Prevention Group.
- Improve the intelligence from young people and front line agencies on emerging drug trends. This will be achieved by re-aligning the current Drug Intelligence Meeting and the Young Persons Substance Misuse Education and Prevention Group undertaking further surveys of young people aged 16+. This information will be used to develop messages and can be shared widely to aid prevention and harm minimisation.

## Health related behaviours: Sexual health

The overall sexually transmitted infection (STI) rate (excluding chlamydia) for Rotherham in 2014 was 767 per 100,000 people. This is nearly one in every 100 people in Rotherham. This rate is higher than the Yorkshire and Humber rate but lower than the national rate (829 per 100,000). Of those newly diagnosed with an STI in 2014, 62% were aged between 15 and 24 years across Yorkshire and Humber.

In the Rotherham Young People's Lifestyle Survey, 25% of Year 10 pupils (14/15 year olds) said that they had had sex. This is in line with national figures that say that 31% of males and 29% of females aged between 16 and 24 say that they had had sex before they were 16[81]. Of those (in the Rotherham survey) who said that they had had sex, almost half said they had done so after drinking alcohol. In addition, 5% of those in the Rotherham survey who said they had had sex did not use any form of contraception.

Chlamydia is the most common STI in Rotherham and we have a high detection rate among our young people aged between 15 and 24 years of age. This also suggests a considerable level of unprotected sexual activity amongst our young people.

### What are we doing in Rotherham?

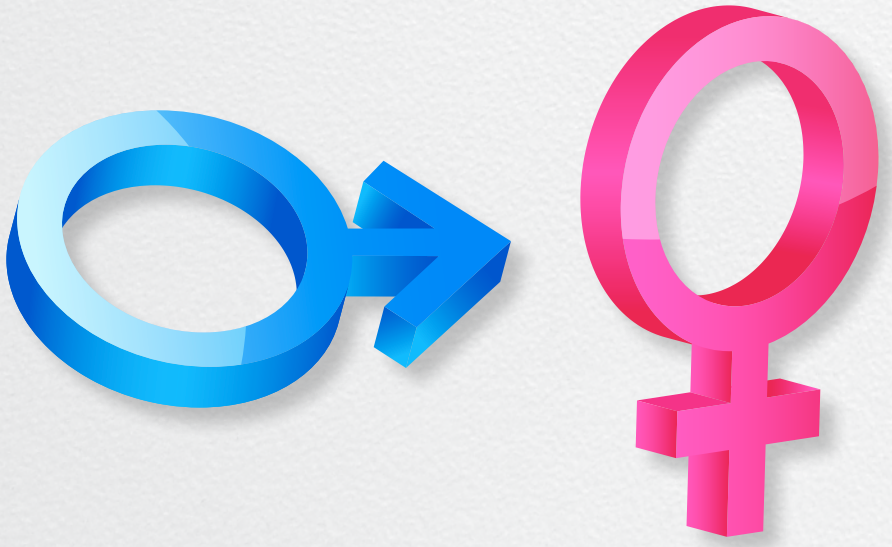
Good quality Personal, Social and Health Education (PSHE) is a key component in reducing risk taking behaviour among young people. Providing young people with opportunities to develop skills and confidence around healthy relationships is key to improving health and wellbeing. Rotherham schools are encouraged to focus on healthy relationships. PHSE should not just focus on facts about health, it should also enable young people to develop skills and understanding that will help them better manage their lives.

Rotherham Sexual Health Strategy (2015–2017) has identified key actions, agreed by all partners, to promote better sexual health for the population. These include the promotion of the importance of good quality sex and relationship education in all our schools.

Rotherham PH and RCCG have funded a Theatre in Education initiative which will be offered to all secondary schools over the next few years. 'Chelsea's Choice' is a powerful, interactive production tackling relationships, grooming and sexual exploitation.

Our ambition for Rotherham

- All schools in Rotherham should adopt a recognised 'gold standard' in relation to sex and relationship education
- All Head Teachers and Governing bodies fully supporting sexual health initiatives within their schools



Risky sexual behaviour can have a number of consequences which include unintended pregnancy and the spread of STIs which can have a range of long term consequences including pelvic inflammatory disease and cervical cancer in girls and infertility in both girls and boys. As approximately a quarter of our young people under 16 are likely to be sexually active, it is important that we make sure that they have confidence to attend sexual health services and have early access to professional advice, support and treatment

The Sexual Offences Act 2003 provides that the age of consent is 16. Sexual activity involving children under 16 is, therefore, unlawful. Children aged under 16 are particularly vulnerable to exploitation and abuse.

Sexual health services have a particular role to play in identifying risk and managing the impact of sexual abuse or exploitation. It is important that all service providers of sexual health provision in Rotherham are aware of child protection and safeguarding issues and the possibility of abuse and/or exploitation and work collaboratively to protect all children under 18 years of age.

## What are we doing in Rotherham?

In Rotherham, 15–24 year olds are screened as part of the National Chlamydia Screening Programme. Chlamydia often has no symptoms but if it is left untreated it may have serious health consequences. This means that we want to keep the detection rate of chlamydia in Rotherham high. This is because we know that there is a high background rate in the community and having a high detection rate suggests we are identifying it effectively and treating it.

Contraception is widely available to young people at the main sexual health service clinic in Rotherham town centre, at GP surgeries and at youth clinics across the Borough. We need our young people to be able to access the most effective and appropriate form of contraception for them and to have a choice of where and when they can access it.

All Rotherham service providers have robust guidelines and referral pathways in place for risk assessment and management of child sexual abuse including child sexual exploitation.

## Our ambition for Rotherham

Sexual Health services in the right locations and open at appropriate times for young people. Service providers should:

- Review where and when services are provided and consult with young people and review regular customer satisfaction feedback.
- Conduct mapping exercises of service locations, times and usage with young people after consultation and survey reviews.
- Report back findings through the Contract's Performance Management Framework.

# Chapter 5: Late adolescence

Late adolescence marks the move into adulthood where young people are reaching a level of autonomy including accepting responsibility for themselves, making independent decisions and financial independence. This key transition stage, emerging into adulthood, is where we would hope that young people are equipped with the skills and knowledge to make positive health choices and decisions. However, in necessary support of this process the local economy needs to provide opportunities and a level of aspiration and the subsequent education and employment prospects to allow young adults to flourish.

## Employment and Training

A healthy employment rate results in a lower dependence on benefits. This, in turn, leads to higher self-esteem and can help tackle some of the mental and physical health problems that worklessness can cause.

The number of young people Not in Education, Employment or Training (NEET) in Rotherham has reduced by 14% since 2013. In October 2015, 5.4% of young people in Rotherham were identified as NEET compared to 4.8% nationally. The percentage of those who are identified as 'not known' is also tracked in relation to NEET. In October 2015 Rotherham 'not known' was 6.4% compared to the national average figure of 19.4%.

Those eligible for free school meals, those who have been excluded or suspended from school, those with their own child and those who have a disability are more likely to be NEET.

### What are we doing in Rotherham?

Education, health and social care have developed a partnership approach to retain young people (Year 12 and 13) in learning and reduce the number of NEET in Rotherham.

Early Help Teams are conducting focused case work to reduce NEET at age 17 using a Youth Contract approach.

Targeted work with vulnerable 18 year olds in partnership with Early Help Teams and Job Centre Plus.

### Our ambition for Rotherham

- For education, health and social care partners to strengthen the universal offer to support vulnerable children and young people through transitions
- Information sharing with health, education, social care and job centre plus to be more systematic and robust

## Road Safety

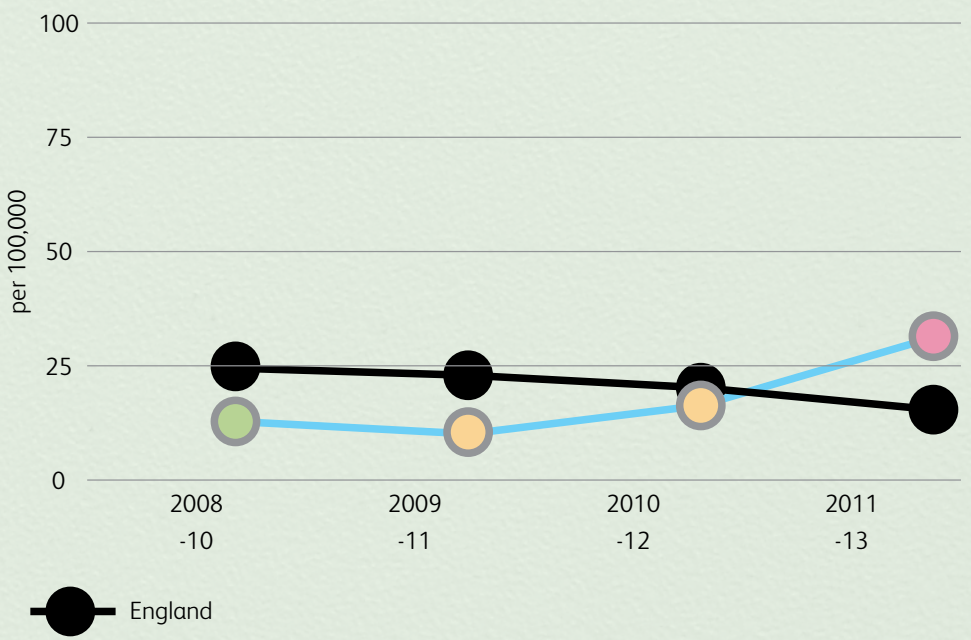
Road accidents are a leading cause of death and a significant cause of hospital admissions in the 0-17 age group. Casualties disproportionately affect children and young people from disadvantaged backgrounds: a child in the lowest socio-economic group is 5 times more likely to die in a pedestrian accident than a child in the highest socio-economic group[82].

The rate of children aged 0-15 killed or seriously injured in road traffic accidents was worse for Rotherham compared to the England average for the period 2011-13 (over 30% higher). This rate has increased by over 70% from 15.9 to 27.6 per 100,000 since 2008-10 (see chart below). Latest data for 2012-14 shows an increase to 28.2 for Rotherham but a further decrease for England to 17.9.

Of the total number of children and young people killed or seriously injured on Rotherham roads, 44% were pedestrians, 28% motor cyclists and 17% car users.

### Children killed or seriously injured in road traffic accidents

**Rotherham**




| Period | | Count | Value | Lower CI | Upper CI | Yorkshire and the Humber | England |
|---|---|---|---|---|---|---|---|
| 2008-10 | | 25 | 15.9 | 10.3 | 23.5 | 30 | 23.6 |
| 2009-11 | | 22 | 15.0 | 9.4 | 22.7 | 29.9 | 22.1 |
| 2010-12 | | 28 | 18.9 | 12.5 | 27.3 | 28.4 | 20.7 |
| 2011-13 | | 41 | 27.6 | 19.8 | 37.5 | 27.0 | 19.1 |

(Source: Department for Transport, published by Public Health England)



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It is well evidenced that developments including; education and training, improvements in vehicle technology/construction and highway engineering, the introduction of road safety policies such as speed limits, enforcement of legislation, and behavioural change have contributed to a national reduction in the numbers killed or seriously injured on Britain's roads[83].

In Rotherham a range of road safety interventions are in place to reduce the number and severity of road collisions that occur. These include speed reduction initiatives, such as 20mph limits in designated zones where children and young people are accessing play and recreation areas. Some of these initiatives are delivered in partnership with the South Yorkshire Safer Roads Partnership (SYSRP) of which Rotherham MBC is a member.


This is a multiagency partnership that exists to coordinate efforts to reduce road collision casualties in South Yorkshire and is made up of:

- Each of the four South Yorkshire districts including elected Members
- South Yorkshire Police
- South Yorkshire Fire and Rescue
- Yorkshire Ambulance Service
- South Yorkshire Safety Cameras
- Highways England
- Health service providers

Overall the number of KSIs in Rotherham reached a historical low with only 88 recorded in 2014. This reduction reflects the robust local initiatives delivered by both the local authority and the Safer Roads Partnership to improve road safety.

## What are we doing in Rotherham?

The Driver for Life education programme was developed in Rotherham and is now a South Yorkshire initiative. This education programme is aimed at drivers in the 17-24 age group, particularly young men, who are heavily represented in casualty statistics. The programme is designed to raise awareness of issues that contribute to collisions, make young people aware of their responsibilities as drivers and change attitudes and behaviour to make them safer and more considerate drivers.

There are also interventions aimed at younger children. The Crucial Crew personal safety education programme for Key Stage 2 pupils (10 and 11 year olds) aims to provide children with the knowledge, skills and strategies to make choices in everyday life to enable them to stay safe and well. The event includes a road safety session which includes teaching children how to cross the road safely using a puffin crossing and also highlights the distance needed for a vehicle to stop in an emergency[84]

## Our ambition for Rotherham

- To ensure the continued and rolling introduction of 20mph zones across Rotherham
- To ensure the Crucial Crew programme is delivered to all Key Stage 2 pupils across Rotherham

## Suicide

Suicide and suicide attempts are a major cause of preventable deaths and significant long-term health issues and disability. A death by suicide causes significant human and economic costs.

In 2012, the Government launched a strategy for the prevention of suicides called Preventing suicide in England: A cross-government outcomes strategy to save lives. Young people were identified as a group needing specific attention. Nationally the suicide rate among teenagers is below that in the general population[85].

However, we know that young people are vulnerable to suicidal feelings. In 2012/13 the ChildLine website had 18,000 visits to the pages relating to suicide; a year later this increased to 37,000[86].

In Rotherham we have had four deaths of young people up to the age of 18 between the years 2011 and 2013. We also know that several Rotherham children have been bereaved as a result of suicide, losing a parent or someone close to them.

Suicide is a complex issue and is often the result of several factors for that person.  Young people are more at risk when some of the following are happening in their lives:

- They have an existing mental health problem or behavioural difficulties
- They misuse substances
- They experience family breakdown
- Bullying
- School problems/exam pressure
- Abuse or neglect in the family
- Mental health problems within the family
- A suicide or death of someone close
- Recent loss of employment
- Are isolated or living in rural communities
- Have attempted suicide before
- Have had a recent bereavement
- A suicide of someone who is a high profile celebrity or another young person

These are just some of the reasons. In addition, young people who are care leavers, those in the Youth Justice system and Looked After Children are particularly vulnerable.

In May 2015 Rotherham Council published an independent report into the suicides of the four young people who died between 2011 and 2013[87].  The report acknowledged the very complex situation with limited national policy direction. Rotherham has gained knowledge and learning following this report and work continues, led by the Rotherham Suicide and Self-Harm Group.






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## What are we doing in Rotherham?

Rotherham Local Safeguarding Children's Board (LSCB) has a response plan which is put into action when there is a death of a young person by suicide or there is a serious self-harm incident. Partners like South Yorkshire Police, health organisations including mental health services, schools and colleges and voluntary sector partners work with RMBC on this plan. The plan looks at who else might be vulnerable and how we can support these young people, how to get support information out to people including families and carers and the wider community.

Rotherham has established a care pathway to ensure support is provided to children and young people bereaved by a sudden and traumatic death including suicide. Families that have been bereaved by a sudden death have told us that it has been very helpful to know that this support is available for their child.

Frontline workers have been able to attend Youth Mental Health First Aid Training. This is a national and international course with lots of evidence to show that it is effective.

Frontline workers have also been able to attend suicide prevention training. Reports from those attending show that they feel more confident to be able to support someone who is at risk of suicide.

We have launched the Supporting Children and Young People who Self Harm: Rotherham Self Harm Practice Guidance for everyone who works with young people.

The CARE about suicide resource is a pocket sized booklet for the general public and workers to help identify people who may be at risk of suicide and direct them to help.

## Our ambition for Rotherham

- Implementation of the actions within the Rotherham Suicide Prevention and Self Harm Action Plan
- Launch of a Rotherham social marketing campaign to target young people
- As part of the emerging Workforce Development Strategy training needs for workers on mental health including suicide prevention will be identified.

# Chapter 6: Cross cutting projects/ Transformation

## CAMHS (Child and Adolescent Mental Health Service)

In 2014 a national group called the Children and Young People's Mental Health and Wellbeing Taskforce started to look at the emotional wellbeing and mental health support for children and young people. This group wanted to look at how to make it easier for children, young people, parents and carers to access emotional and mental health help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided.

Their work led to the production of the report called Future in Mind and the following key themes were the ones they felt were important:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

Nationally funding was made available for services which support the emotional wellbeing and mental health of children and young people. All areas, Rotherham included, had to write a plan (the Transformation Plan) to show how they would improve the emotional wellbeing and mental health support to children, young people and their families in line with the themes above. This plan was coordinated by Rotherham Clinical Commissioning Group with input from RMBC, NHS services including mental health services, the voluntary sector and parents and carers, young people[88].

### What are we doing in Rotherham?

Implementation of the CAMHS Transformation Plan is now underway, which includes: up to six schools piloting a whole school approach to emotional wellbeing and mental health, drafting a workforce development strategy, improvements to crisis provision for young people and targeted work with hard to reach groups like lesbian, gay, bisexual and transgendered young people.

## Our ambition for Rotherham

- Schools taking part in the 'whole school' pilot scheme developing their own action plans to show how they are going to improve the emotional well-being and mental health of their school community working with support from other organisations like RMBC, NHS services, voluntary and community groups
- For schools involved in the pilot scheme (above) to share their learning with their cluster group
- Subsequent CAMHS Transformation funding to have a strong focus on early intervention and prevention

## Special Educational Needs and Disabilities

In 2015 there were 1040 (2.3 %) children and young people with a Statement of Special Educational Needs (SEN) or an Education, Health and Care Plan (EHC Plan or EHCP) 0.5 % below the national average of 2.8 %

The school census 2015[89] shows the most common types of special educational need to be learning difficulties (40 %) which is below the national average (44.5 %) and autism (11 %) with Rotherham above the national average by 2 %. Behavioural difficulties has been replaced with a new primary need code of Social Emotional Mental Health with Rotherham's children and young account for 12.5 % which is below the national average of 16.7 %. A growing number of children and young people have multiple disabilities and complex needs, continuing as they make the transition into adulthood.

Young people with special educational needs and/or disabilities (SEND) often face additional barriers, with the transition between children's and adult social care regularly cited as one of the most difficult experiences of young people and their families[90].

*Within Rotherham a number of issues were cited by disabled children and their parents around transition from children's social care to adult social care[91]. These included:*

- *Transition planning typically starting too late and is too focused on short-term goals*
- *Low expectations of some key health professionals*
- *Not enough suitable opportunities for young adults with SEND, including realistic options for supported employment and apprenticeships*
- *Not enough clear outcomes and limited personalisation*

## The Rotherham Vision for SEND

Our vision for our children and young people with SEND is the same as for all our children and young people; that they be safe, happy, healthy, confident and successful, contributing to a thriving, inclusive community that is welcoming to all.

Their achievements, supported by effective settings and services working in partnership with families and communities, will enable them to enjoy independence and fulfilling lives.

## What are we doing in Rotherham?

The SEND Joint Commissioning Strategy Group has developed a Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND). The strategy outlines the Rotherham SEND Joint Commissioning approach and identifies nine key areas of work that will be jointly taken forward.

## Our ambition for Rotherham

- The development of the joint SEND Education, Health and Social Care Assessment hub to ensure timely and robust education and health care plans are developed in Rotherham that focus on the outcomes that are important to, and for, children, young people and their families

# Chapter 7: Update on the 2014 Director of Public Health Annual Report

The last DPH Annual Report was produced by Dr John Radford in 2014. The following table provides a summary of the recommendations within the report and an update on what has happened since.

| Recommendation | Progress |
|---|---|
| The Health and Wellbeing Board needs to ensure a common framework for preventative management of multiple conditions including mental ill health and to ensure we integrate risk factor management and rehabilitation in all disease management and care delivery. | Rotherham Health and Wellbeing Board approved a revised Health and Wellbeing Strategy in September 2015. This strategy includes five aims to improve health and wellbeing across the life course. The strategy specifically looks to improve mental and emotional health and wellbeing and to reduce the difference in health outcomes between our most and least deprived communities. |
| Rotherham Children's Board and the Council work with schools and the voluntary and community sector to reduce the impact of poverty on the borough's children. | Within Rotherham's new Health and Wellbeing Strategy the impact of child poverty on health and educational achievement is highlighted as an area for action. Working alongside the new Children's Partnership Board, the Health and Wellbeing Board will work to minimise the long-term implications of child poverty by supporting the Early Help strategy and working with families with multiple and complex needs. |

| Recommendation | Progress |
|---|---|
| Rotherham's secondary schools should be encouraged to adopt stay-on-site policies at lunchtimes. | Rotherham's new Health and Wellbeing Strategy highlights the impact of stay-on-site policies in reducing consumption of unhealthy food during the school day. There is also some evidence that such policies reduce access to tobacco and can contribute to lower take-up of smoking among young people. |
| The Health and Wellbeing Board needs to consider the relationship between its long term goals in the Health and Wellbeing strategy and the need to take action now to reduce the three main causes of inequality: cancer (especially lung cancer), cardiovascular and respiratory deaths. | One of Rotherham's Health and Wellbeing Strategy aims is focused upon improving life expectancy and reducing the differences in health between our most and least deprived communities. Much of this difference is a result of cardiovascular disease, cancer and respiratory disease. Rotherham Clinical Commissioning Group is leading partnership work to reduce potential years of life lost to early, and often preventable, death. |

| Recommendation | Progress |
|---|---|
| We must offer everyone aged 40-74 a NHS Health Check every five years. Screening 20% of the eligible population annually with a 90% uptake. | NHS Health Checks continue to be commissioned by Rotherham Public Health and delivered by local general practices. Uptake of the Health Check is low in Rotherham, and we are currently not meeting the targets for the proportion of eligible population being offered a Health Check. A promotional campaign has been running throughout the summer of 2015 with the aim of increasing uptake. |
| | The local uptake rate is increasing year on year from 6.6% (2013/14), 13.5% (2014/15) and is currently 17.5% (as of Quarter 2 2015/16). This is approximately a 2% increase each quarter. |
| | This mirrors the Yorkshire and Humber increase per quarter and is not far off the regional performance rate of 20.2%. |
| | A promotional campaign has been running throughout the summer of 2015 with the aim of increasing uptake and awareness of the programme. |

| Recommendation | Progress |
|---|---|
| Physical activity should be commissioned as a direct intervention to prevent morbidity in long term conditions. | Rotherham Public Health, in partnership with Rotherham CCG and others, has been awarded £500K from Sport England to deliver the Active for Health Research Project. This is an innovative 3-year physical activity programme to improve the recovery of people with long term conditions including cardiac, heart failure, COPD, cancer, stroke, lower back pain and falls. This is a research project which will help to develop the evidence base for the role long term physical activity can play in rehabilitation. |
| | Physical activity continues to be promoted through the Rotherham Healthy Weight Framework. |
| Stopping smoking should be the key priority for the Borough in tackling excess cancer deaths | Services to reduce tobacco use in Rotherham were revised in 2014 to put a greater emphasis on preventing young people starting to smoke; smoking is an addiction of childhood, with more than three-quarters of adult smokers beginning to smoke before the age of 18. We also continue to offer high quality stop smoking support for people wanting to quit and to reduce the number of women who smoke during pregnancy. The percentage of adults who smoke and of women who smoke during pregnancy remain higher than the national average, but are showing a reducing trend. |

| Recommendation | Progress |
|---|---|
| The CCG should actively promote awareness of early signs and symptoms of cancer and how and where to seek help as this could quickly save lives | NHS England is leading work to implement NICE Guidance published in June 2015 on Suspected Cancer: Recognition and Referral. |
| | This includes changes to some referral routes including more 'direct to test' recommendations and a lower threshold for referral based on symptom combinations with a positive predictive value[92] (PPV) of three or more (previous guidance was based on PPV of five or more). |
| Faster referral pathways and lowered thresholds for referral by GPs, particularly for lung cancer, are required to ensure a higher proportion of lung cancers are detected through the 2 week wait system. | The lung cancer pathway has been reviewed with Rotherham Foundation Trust and faster referral pathways and lower thresholds achieved. |
| Rotherham CCG should continue to prioritise reducing the use of prescribed non-steroidal anti-inflammatory drugs. | Three of Rotherham CCG's 14 Key Prescribing Indicators (KPIs) are focused upon non-steroidal anti-inflammatory drugs (NSAIDs) and reducing their use in CVD patients. Since implementing the KPIs there has been a continued decrease in the percentage of patients with an active repeat prescription for NSAID. |

| Recommendation | Progress |
|---|---|
| Reducing the volume of alcohol consumed in the Borough needs to be the agreed theme for the introduction of Making Every Contact Count (MECC), whilst maintaining quick and easy access to services that can respond to those identified as risky drinkers. | The Making Every Contact Count (MECC), approach has not been introduced within the borough. Further discussions are needed at the Health and Wellbeing Board to determine whether this is revisited as part of the implementation of the new Health and Wellbeing Strategy. |
| | Options for identification and early intervention in respect of alcohol consumption are maximised locally with the Primary care alcohol contract offering screening and interventions in GP practices. The Lifeline alcohol service is proactively offering screening and awareness raising in the community. Health trainers actively screening and provide general awareness raising campaigns. |
| Services and GPs should be active in making the hepatitis vaccine available to risk groups and better clinical screening for early detection and treatment. | The Gate Surgery specialises in supporting those people who have difficulty accessing mainstream health and social care services, proactively working across a range of complex and interlinked issues affecting adults and families who are at a greater risk of or currently experiencing poor health, substance misuse or risk of neglect or sexual exploitation. |
| | A Hepatitis screening history is undertaken for all new clients to ensure early detection of blood borne viruses to reduce the risk of transmission and improve prognosis of the patient through vaccination and advice. |

| Recommendation | Progress |
|---|---|
| Hepatitis prevention needs to be a priority for environmental health and for the sexual health and the drugs service. | Commissioned services for drug services and the Integrated Sexual Health Services have performance indicators relating to hepatitis screening and these are monitored at formal performance meetings. A newly commissioned third sector provider (Plusme) promotes blood borne virus testing (Hepatitis B, Hepatitis C and HIV). |
| | Targeted work has been undertaken to increase the take up rates on Hepatitis B vaccination and to ensure those individuals that have agreed to it are actually receiving the vaccination. |
| Rotherham MBC should develop a Rotherham Mental Health Strategy outlining local action to promote wellbeing, build resilience and prevent and intervene early in mental health problems. | Work has not started on the development of this strategy, however, early intervention and prevention work is included in the CAMHS Transformation Plan which will focus on schools and the wider community. There is a commitment within the new Health and Wellbeing Strategy to do this work and it will start in early 2016. |
| Mental health promotion messages should be an agreed theme within Making Every Contact Count (MECC). | The Making Every Contact Count (MECC) approach has not been introduced within the borough. Further discussions are needed at the Health and Wellbeing Board to determine whether this is revisited as part of the implementation of the new Health and Wellbeing Strategy. |

| Recommendation | Progress |
| --- | --- |
| Rotherham MBC should note the significant effect of air quality on mortality and that improvement in air quality, particularly reducing levels of PM 2.5 to PM 10[93] should be a priority for the Borough. | The Council has responsibilities for monitoring, modelling, air quality action planning, and the declaration of Air Quality Management Areas in hot spots. A recent Air Quality Health Inequalities Impact Assessment has established a link between levels of deprivation, poor air quality and poor health outcomes in Rotherham. |
| | Local work includes;<br>• Measuring the levels of PM 2.5 to obtain evidence of 'hotspots' which can give us a better understanding of the local picture in Rotherham<br>• Submitting a bid to DEFRA for funding to install a ''Green Screen'' to reduce levels of air pollution and protect health at a local primary school located next to a busy main road in an Air Quality Management Areas. Although unsuccessful on this occasion, further funding opportunities are being pursued<br>• Exploring opportunities to mitigate the effects of air quality arising from new developments in the borough |

| Recommendation | Progress |
|---|---|
| Rotherham Clinical Commissioning Group and NHS England should consider flu vaccination a priority for Rotherham. Achieving 90% uptake of flu vaccination in the extension of immunisation to all children under 18 this September should be a priority for the Health and Wellbeing Board | The Screening and Immunisation Team (SIT) coordinate the NHS England-commissioned screening and immunisation programmes across South Yorkshire and Bassetlaw. |
| | Uptake in the following programmes is generally good and improving:<br>• Childhood immunisation programmes delivered through NHS primary care<br>• Programmes for children and adults 'at risk' of serious complications of diseases due to other underlying health conditions<br>• Programmes delivered for healthcare workers and RMBC frontline staff |
| | The 2015/16 seasonal flu vaccination programme is underway, with a focus on the extension of the childhood flu vaccination programme, which will be delivered to all children in years 1 and 2. |
| | We anticipate that the children's programme, once fully implemented, will avert many cases of severe flu and flu-related deaths in older adults and people in clinical risk groups. We should continue, however, to work hard to ensure that we are communicating the benefits of the vaccine among all recommended groups and making vaccination as accessible for as many as possible. |

| Recommendation | Progress |
| --- | --- |
| Rotherham Clinical Commissioning Group should implement the local actions outlined in the Chief Medical Officers 2013 Annual Report on Antimicrobial Resistance. | Each Clostridium Difficile and Methicillin- Resistant Staphylococcus Aureus case is reviewed and scrutinised at a monthly Post Infection Review panel, chaired by Rotherham CCG, with microbiology, infection prevention and control, medicines management and public health in attendance. The panel's responsibility is to determine whether the case was unavoidable and if there had been any lapses in the quality of care. Learning is embedded into future practice, with a particular focus on appropriate antibiotic prescribing. |
| | The Rotherham Foundation NHS Trust leads a multiagency Antimicrobial Stewardship Group which monitors and implements a range of interventions to ensure we are prescribing fewer antibiotics and making sure they are only prescribed when needed. Part of its wider role includes promoting better hygiene measures to prevent infections and measures to tackle the next generation of healthcare associated infections. |
| | Rotherham CCG has appointed a lead nurse with responsibility for infection prevention and control who will work closely with the medicines management team, infection prevention and control teams based in the hospital, community and public health. |

# Chapter 8: Key Recommendations of Report

1. Rotherham CCG to work closely with Public Health and service providers to ensure that **services** and **care pathways** for pregnant women and children and young people are integrated and take every opportunity to **maximise public health outcomes**. Particularly, reducing the risks associated with poor health behaviours (reducing smoking and alcohol use in pregnancy, increasing levels of breast feeding, reducing levels of overweight and obesity and increasing physical activity)
2. Public Health service providers and Children & Young People's services to work more closely to deliver **integrated health and early help services** for children and families
3. Partners to work together to **maximise opportunities for training** to improve health outcomes – for example by adopting Making Every Contact Count (MECC) principles and undertaking joint training on the effects of poor health behaviour on children and families
4. Schools and colleges should do more work to ensure that all children and young people are supported to **improve their mental health and wellbeing** – identifying clear pathways of support when children and young people experience mental health problems and raising awareness of self-harm and suicide prevention strategies
5. Rotherham CCG, Public Health and the local service providers should ensure **better and more timely access** for children and young people experiencing **mental health problems**. This should lead to better recovery and outcomes
6. Rotherham MBC needs to work with all partners to develop a 'whole systems' approach to **tackling overweight and obesity**, including prevention and treatment strategies
7. The work programmes of the Health and Wellbeing Board and the Children, Young People and Families Partnership Board should be **integrated and add value** to the work of all partners

We will develop a comprehensive action plan to support the delivery of the recommendations over the coming year. Working together with partners the actions will contribute to improvements in the health and wellbeing of children and young people in Rotherham.

# Appendix 1: Data sources

## The Joint Strategic Needs Assessment (JSNA)

**http://www.rotherham.gov.uk/jsna/** is a key source of information on the residents of Rotherham.

Much of the data included above is from Profile data published by Public Health England e.g. from the Rotherham Child Health **http://www.rotherham.gov.uk/jsna/downloads/file/98/child_health_profile_2015** and Public Health Outcomes Profile (PHOF) **http://www.phoutcomes.info/** for Rotherham.

Data within the Profiles is generally sourced from the Office for National Statistics or the Health and Social Care Information Centre. Re-use of this data is subject to the Terms and Conditions of the data source.

## Data from Public Health England



## Data from the Office for National Statistics



## Data from the Health and Social Care Information Centre

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Rotherham Metropolitan Borough Council

Public
Health Select Commission

**Summary Sheet**

**Council Report**
Health Select Commission 16 June 2016

**Title**
Adult Social Care – Provisional Year End Performance Report for 2015/16

**Is this a Key Decision and has it been included on the Forward Plan?**
No

**Strategic Director Approving Submission of the Report**
Graeme Betts, Interim Strategic Director of Adult Care and Housing

**Report Author(s)**
Scott Clayton, Interim Performance & Quality Team Manager

**Ward(s) Affected**
All

**Executive Summary**

This report outlines the provisional year end 2015/16 Key Performance Indicator (KPI) results for the Adult Social Care (ASC) elements of the Directorate. We are providing our earliest ever indicative year end performance report to help inform members and staff of how Adult Social Care has performed over the last year and to identify areas for improvement or further development. There is a need to incorporate partner data ahead of final year end processing and submission of the applicable statutory statistical returns, so the final position may change and therefore will be covered off in a follow up report.

The Council has seen continued improvements across the range of twenty two national Adult Social Care Outcomes Framework (ASCOF) measures reported in 2015/16. 19 out of 22 comparable measures are recording an improvement since 2014/15. This positive set of national indicator results is encouraging. The direction of travel is beginning to evidence that implementation of new service delivery models (moving away from traditional services), lead to better outcomes for people and increasing satisfaction levels, sustained over the year.

A key highlight is that satisfaction levels recorded from the annual Adult Social Care User Survey results, have reported an improvement across 7 of the national indicators.

**Recommendations**

**It is recommended that Members note:**

1 The content of provisional year end performance results.

2 That a further report showing final submitted results and benchmark comparisons against regional and national data will be reported once available in late Summer/Autumn 2016.

**List of Appendices Included**

Adult Social Services Performance Measures provisional year end 2015/16

**Background Papers**

No background papers

**Consideration by any other Council Committee, Scrutiny or Advisory Panel**

None

**Council Approval Required**

No

**Exempt from the Press and Public**

No

**Title: Adult Social Care – Provisional Year End Performance Report for 2015/16**

## 1. Recommendations

**It is recommended that Members note:**

1.1 The content of provisional year end performance results.

1.2 That a further report showing final submitted results and benchmark comparisons against regional and national data will be reported once available in late Summer/Autumn 2016.

## 2. Background

2.1 Each Council with Adult Social Services Responsibility (CASSR) have to submit relevant national statutory returns to the Health and Social Care Information Centre (HSCIC) throughout the reporting year. Most but not all 'returns', reflect the activity for the financial year end and are submitted during the May/June period.

2.2 From the Council's submitted data, the HSCIC are able to identify and publish a range of ASCOF measures. Some ASCOF's have a joint responsibility element so may be included in either Public Health Outcome Frameworks or NHS Outcome Frameworks. They may therefore be submitted through partner processing submissions rather than the Council's. These will need to be added to complete the full results.

2.3 2015/16 has been a transitional year where the Directorate has been seeking to change existing customer journey and business processes, in order to improve the customer experience and deliver better personalised outcomes. The results over the performance areas included in the report to date have been positive, showing improvements in many indicator areas.

2.4 2015/16 is the second year of the new national Short and Long Term (SALT) reporting annual return, and the Council's initial draft year-end figures provide a useful first insight to Adult Social Care performance. However, we need to recognise that they remain subject to change, following national ratification of local partner data (RDaSH Mental Health performance) and Health partner submissions.

2.5 The Adult Social Care 2015/16 KPI suite of indicators had a mixture of continuous improvement or maintenance targets. These reflect the anticipated impact of new service delivery models and structures, as part of the Adult Social Care development programme.

2.6 Attached for reference as appendix A, is a refreshed (as at 25th May 2016) provisional scorecard, of year end performance.

**Footnote:** The **#** prefix denotes the indicator reference number detailed in Appendix A

2.7 Over the coming months we will be able to analyse regional and national data as it becomes available, to evaluate if this improvement has also been reflected in the Council's rankings when compared to other councils, in its nearest neighbours (IPF) group or other councils in the Yorkshire and Humber region. However, this comparable data is shared on a restricted basis until after national publication of the data, which is usually during October/November.

## 3. Key Issues

3.1.1 **Performance Highlights 2015/16** – from the 22 national ASCOF year-end provisional performance data.

- **86%** (19 of 22) ASCOF measures are showing improvement – this includes 100% ( 7 of 7) User Survey measure results

- **50%** (11 of 22) 2015/16 targets being met - including User Survey 71% (5 of 7)

  It is worth noting the continued positive direction of travel for user views from the national user survey results. The Council sent out over 1000 user surveys to customers and had over 400 returned. This is a positive response rate (over 40%), which demonstrates that the Council is improving engagement with its customers.

3.1.2 The SALT tables' highlights include:

- **Short Term** shows a 14% increase in request for service, over 5650 requests were made – almost 700 more than 2014/15 from **new** clients aged 18-64.
- **Short Term** shows a 5.9% increase in request for service, over 9000 requests were made – almost 500 more than 2014/15 from **new** clients aged over 65.
- **Short Term** requests for care to maximise independence (mainly enabling and intermediate care type services) remained broadly similar.
- **Long Term** shows an upward trend across the data with percentage increases ranging from 1% for over 65's accessing long term support during the year and almost 10% of service users receiving long term support at year end.

3.1.3 The table below shows the outturns and Direction of Travel (DoT) relevant to each measure comparing the 2014/15 and 2015/16 results.

**Footnote:** The **#** prefix denotes the indicator reference number detailed in Appendix A

| ASCOF Measure (# score card ref and abbreviated text description name) | Good performance High/Low/Other | 2014/15 (rounded) | 2015/16 (rounded) | DoT |
|---|---|---|---|---|
| #1 Social Care Quality Of Life | High | 18.5 | 18.8 | ⇧ |
| #2 proportion of Service Users who have control over their daily life | High | 73.9% | 74% | ⇧ |
| #3a Proportion of adults receiving long term community support who receive services via self-directed support | High | 76.4% | 75.7% | ⇩ |
| #4 Proportion of Carer's in receipt of carer specific services via Self Directed Support (SDS) | High | 0% | 29.2% | ⇧ |
| #5a proportion of adults on service receiving Direct Payments | High | 17.4% | 17.5% | ⇧ |
| #6 Proportion of Carer's on service receiving Direct Payments | High | 0% | 29.2% | ⇧ |
| #8 Adults with Learning Disability (LD) on long term service in employment | High | 6.0% | 5.6% | ⇩ |
| #9 Adults with Mental Health (MH) in employment | High | 4.9% | 5.3% | ⇧ |
| #10 Adults with LD on long term service in settled accommodation | High | 78.3% | 78.4% | ⇧ |
| #11 Adults with Mental Health in independent living (settled accommodation) | High | 73.1% | 74.4% | ⇧ |
| #12 Service users have as much social contact as they would like | High | 40.2% | 46% | ⇧ |
| #14 Permanent Admissions 18-64's per 100,000 population | Low | 12.3 | 20.0 | ⇩ |
| #15 Permanent Admissions 65+ per 100,000 population | Low | 933.3 | 819.5 | ⇧ |
| #16 Re-ablement – still home after 91 days | High | 83.5% | 89.6% | ⇧ |

**Footnote:** The **#** prefix denotes the indicator reference number detailed in Appendix A

| | | | | |
|---|---|---|---|---|
| (effectiveness) – BCF measure | | | | |
| #17 Re-ablement – still home after 91 days (offered the service) | High | 1.5% | 1.7% (estimate) | ⇧ |
| #18 Average delayed transfer of care (DToC) all delays | Low | 9.5 | 8.4 | ⇧ |
| #19 Average delayed transfer of care (DToC) delays that were NHS or ASC responsible or both | Low | 2.3 | 1.6 | ⇧ |
| #20 The outcomes of short-term support: sequel to service | High | 85.2% | 86.1% | ⇧ |
| #21 Overall satisfaction of people whom use services with their care and support | High | 65% | 70% | ⇧ |
| #24 People who use services who find it easy to find information and support | High | 76.8% | 78% | ⇧ |
| #26 proportion of people who use services who feel safe | High | 61.5% | 66% | ⇧ |
| #27 proportion of people who use services who say that those services have made them feel safe and secure | High | 81.6% | 85% | ⇧ |

3.2 The information is already being used to inform the 2016/17 performance KPI suite and aligned targets.

3.3 **Improved ASCOF measures that met target**

- #4 Proportion of Carer's in receipt of carer specific services via Self Directed Support (SDS). First year that services for carers now being provided rather than provided for the cared for person.
- #6 Proportion of Carer's on service receiving Direct Payments. First year provision as above.
- #15 Permanent Admissions 65+ – 401 admissions (68 fewer than last year) and equates to a rate of 820 approx. per 100,000 population – note. This is also a Better Care fund (BCF) measure.
- #18 Average delayed transfer of care (DToC) all delays.
- #19 Average delayed transfer of care (DToC) delays that were NHS or ASC responsible or both

**Footnote:** The **#** prefix denotes the indicator reference number detailed in Appendix A

- #20 The outcome of short-term support: sequel to services

**User Survey: Improved ASCOF measures that met target**

- #1 Social Care Quality Of Life
- #12 Service users have as much social contact as they would like
- #21 Overall satisfaction of people whom use services with their care and support
- #24 People who use services who find it easy to find information and support
- #27 proportion of people who use services who say that those services have made them feel safe and secure

3.4 **Other improved ASCOF measures**

- #5a proportion of adults on service receiving Direct Payments (note also included as a future challenge measure. Expected that significant improvement will result from planned reviews from quarter 1 of 2016/17.
- #9 Adults with Mental Health (MH) in employment
- #10 Adults with LD on long term service in settled accommodation – below target. Some planned service transfers from 24 hour care to supported living in 2016/17 will improve this measure next year.
- #11 Adults with Mental Health in independent living (settled accommodation)
- #16 Re-ablement – still home after 91 days (effectiveness) – BCF measure
- #17 Re-ablement – still home after 91 days (offered the service)

**User Survey: Other improved ASCOF measures**

- #2 proportion of Service Users who have control over their daily life
- #26 proportion of people who use services who feel safe

3.5 **The 2016/17 challenging measures**

- #3a Proportion of adults receiving long term community support who receive services via self-directed support – less than 1% below target.
- #5a proportion of adults on service receiving Direct Payments (see above)
- #8 Adults with Learning Disability (LD) on long term service in employment. A total of 40 people were in employment (was 43 in 2014/15), longer term strategy proposals are being explored to address this.
- #14 Permanent Admissions 18-64's – 31 admissions in 2015/16, well above target of 18 (last year had 20 admissions). Review at Qtr. 3 recognised that the impact of at least 6 of the admissions resulted from existing customers losing full cost Continuing Health Care (CHC) funding. In the previous year only 2 of last year's 20 admissions were down to this

**Footnote:** The **#** prefix denotes the indicator reference number detailed in Appendix A

reason. Other Physical Disability and Mental Health pressures also challenged this measure. Benchmarking data at Qtr. 3 from Yorkshire and Humber suggested this is not impacting on other Local Authority's in region at the same level. However latest year end projections show more local authorities in the region are also seeing increases in admissions.

### 3.6 The 2016/17 challenging measures - Local Measure analysis

- In addition to statutory measures the Council also has some discretionary ones.

- No formal targets were assigned to a range of local management information indicators for 2015/16. However, outturns show that the impact of the changes made within Adult Social Care (in this transition year) experienced lower levels of performance for reviews, waiting times for assessment and packages of care, than in previous years. The target setting for 2016/17 will take account of how the Directorate intends to demonstrate the recovery and improvement journey for these areas. Note that measures are not included in the Appendix A document.

- A range of measures will also be reported in the Council's Corporate Plan for 2016/17.

## 4. Options considered and recommended proposal

4.1 Health Select Commission to receive the final Year End Performance Report for 2015/16 when all partner data is available. Complete data returns are anticipated to be available late Summer/Autumn 2016.

## 5. Consultation

5.1 Not required as national Adult Social Care Outcomes Framework (ASCOF) measures are determined by Department of Health.

## 6. Timetable and Accountability for Implementing this Decision

6.1 Not applicable in this instance – no decision.

## 7. Financial and Procurement Implications

7.1 Relevant data from the ASCOF measures may be used to determine future commissioning strategies and this may require procurement activity.

## 8. Legal Implications

**Footnote:** The **#** prefix denotes the indicator reference number detailed in Appendix A

8.1 No implications as ASCOF measures have been collected and submitted to the Health and Social Care Information Centre.

## 9. Human Resources Implications

9.1 None identified

## 10. Implications for Children and Young People and Vulnerable Adults

10.1 ASCOF measures relate to adult social care and therefore performance indicates impacts (positive and negative) on users of adult care services.

## 11 Equalities and Human Rights Implications

11.1 ASCOF measures are primarily headline output performance measures and therefore it is difficult to interpret equalities and human rights implications based on the report content.

## 12. Implications for Partners and Other Directorates

12.1 Performance data from partner organisations will enable a whole system approach to be taken and this will become more apparent in the final report for 2015/16.

## 13. Risks and Mitigation

13.1 None identified.

## 14. Accountable Officer(s)

Approvals Obtained from:-

Graeme Betts, Interim Strategic Director Adult Care and Housing

Nathan Atkinson, Assistant Director Strategic Commissioning

Scott Clayton, Interim Performance & Quality Team Manager

This report is published on the Council's website or can be found at:-

http://moderngov.rotherham.gov.uk/ieDocHome.aspx?Categories=

**Footnote:** The **#** prefix denotes the indicator reference number detailed in Appendix A

# Adult Social Services Performance Measures ASC-MT - 2015/16 year end submission

**Appendix A - 2015/16 Year end report**

**15/16 Decision Key**

| | |
|---|---|
| **A** | Retain - National Measure still required |
| **B** | Retain - but apply amended national measure definition |
| **C** | Retain - but develop as a 'local' measure |
| **D** | Delete no longer required or fit for purpose |
| **E** | Replace with measure TBC |

| | |
|---|---|
| | Annual reported indicator |

**Measure Type Key**

| | |
|---|---|
| N | |
| C | |
| P | |

**Direction of Travel Key**

| | |
|---|---|
| ⇧ | Indicator has improved |
| ⇔ | Indicator shows no change |
| ⇩ | Indicator has deteriorated |

revised at submission

| Indicator Ref | N | C | P | PHOF | Indicator Title | Good Perf | Freq. | 2014/15 Performance | Proposed 15/16 Target | DOT (14/15 - 15/16) | 15/16 Performance | Head of Service | Accountable Officer | Decision Code | Comments / Remedial Actions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 ASCOF-1A | ✓ | | ✓ | | Social Care related quality of life | High | Annual | 18.5 | 18.7 | ⇧ | 18.8 | Sam Newton | Michaela Cox | A | Annual Score collected in ASC User Survey. Rotherham ranks on current 14/15 data 13th(Y&H). |
| 2 ASCOF-1B | ✓ | | | | Proportion of people who use services who have control over their daily life | High | Annual | 73.9 | 76.8 | ⇧ | 74 | Sam Newton | Michaela Cox | A | Annual Score collected in ASC User Survey.Rotherham ranks on current 14/15 data 13th (Y&H) |
| 3 ASCOF-1C Part 1A (2.2.1) | ✓ | ✓ | | | Proportion of Adults receiving long term community support who receive services via self-directed support (Excluding Mental Health) | High | Monthly | 99.56% | | | 97.06% | Sam Newton | Sarah Farragher | A | Current performance excludes MH data. DOT based on last refresh |
| 3a ASCOF-1C Part 1A (2.2.1) | ✓ | ✓ | | | Proportion of Adults receiving long term community support who receive services via self-directed support (Including Mental Health) | High | Monthly | 76.40% | 76.40% | ⇩ | 75.70% | Sam Newton | Sarah Farragher | A | Rotherham ranks 11th Y&H based on initial 14/15 data. . Decision to be made to determine the inclusion of MH clients in receipt of professional support only. MH data (215/1019 = 21.09%) |

Improvement Actions: 27/10/2015 = 79.6%, but still on target

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 | ASCOF-1C Part 1B (2.2.1) | ✓ | ✓ | | | Proportion of Carer's in receipt of carer specific services who receive services via self-directed support | High | Monthly | 0.00% | 80.00% | ⇧ | 29.2% | Sam Newton | Sarah Farragher | A | Rotherham ranks 13th Y&H based on initial 14/15 data. February 2016 - confirmation from operational managers that all carer services are provided via direct payment, indicator score will therefore be 100% |
| 5 | ASCOF-1C Part 2A (4.1.1) | ✓ | ✓ | | | Proportion of Adults on service receiving direct payments (Excluding Mental Health) | High | Monthly | 17.40% | | | 19.29% | Sam Newton | Sarah Farragher | A | 14/15 analysis - Mental Health 149/992 15.02%, ASC 421/2276 18.5% Current performance excludes MH data. Indicator now calculated excluding managed direct payments following anlaysis of further guidance.There are currently 492(High 479/lLow 421) clients in receipt of direct payments included in this indicator.DOT based on last refresh. There are 652 clients with an open managed DP (High 652 Low 610). |
| | Local - Finance Direct Payments | | | | | Number of Adults (inc Carers) receiving Direct Payments in year (Excluding Mental Health) | | | 1224 (inc MH) | | | 1605 | | | | 1540 (From Client Services tables) 65(From Carer Services tables) |
| 5a | ASCOF-1C Part 2A (4.1.1) | ✓ | ✓ | | | Proportion of Adults on service receiving direct payments (Including Mental Health) | High | Monthly | 17.40% | 19.50% | ⇧ | 17.5% | Sam Newton | Sarah Farragher | A | Rotherham ranks 11thY&H based on revised14/15 data. Awaiting update from RDaSH (15/16 data). Decision to be made to determine the inclusion of MH clients in receipt of professional support only. MH data (130/1019 = 12.75%) |

| | Indicator Ref | N | C | P | PHOF | Indicator Title | Good Perf | Freq. | 2014/15 Performance | Proposed 15/16 Target | DOT (14/15 - 15/16) | 15/16 Performance | Head of Service | Accountable Officer | Decision Code | Comments / Remedial Actions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Improvement Actions: 27/10/2015 = 18.1%, but below target | | | | | | | | | | | | | | | | |
| 6 | ASCOF-1C Part 2B (4.1.1) | ✓ | ✓ | | | Proportion of Carers on service receiving direct payments | High | Monthly | 0.00% | 69%TBC | ⇧ | 29.2% | Sam Newton | Sarah Farragher | A | Rotherham ranks 13th Y&H based on initial 14/15 data. Report to be written to monitor performance in year. February 2016 - confirmation from operational managers that all carer services are provided via direct payment, indicator score will therefore be 100% |
| 7 | ASCOF-1D | ✓ | | ✓ | | Carer Reported Quality of Life | High | Biennial | 8.3 | - | | - | Sam Newton | Michaela Cox | A | Biennial collection from Carer's Survey next scheduled 16/17. Rotherham ranked joint 2nd (with 4 other authorities) in Y&H region based on initial 14/15 data. |
| 8 | ASCOF-1E (4.1.2) | ✓ | ✓ | | ✓ | Adults with learning disabilities on long term service in employment | High | Monthly | 6.03% | 6.60% | ⇩ | 5.6% | Sam Newton | Darren Rickett | A | Rotherham ranks 8th Y&H based on initial 14/15 data. Current Performance 39/709 (confirmed in year, 1 client not had employment confirmed) |
| 9 | ASCOF 1F (Ex NI 149) (4.1.3) | ✓ | ✓ | | ✓ | Adults receiving secondary mental health services in employment | High | Monthly (Est) | 4.90% | 5.40% | ⇧ | 5.27% | Sam Newton | Alison Lancaster | A | 2014/15 score from restricted data release.Rotherham ranks 14th Y&H based on restricted 14/15 data release. Current performance based on January's MH submitted data, new reporting systems implented to replace MHLDDS. DOT based on last refresh. . DOT based on last refresh. |
| Improvement Actions: Close monitoring of MH local calculation and official published figure from MHLDS.P&Q to review data received from RDaSH to ensure national and local reporting are in line. | | | | | | | | | | | | | | | | |
| 10 | ASCOF-1G | ✓ | | | ✓ | Adults with learning disabilities on long term service in settled accommodation | High | Monthly | 78.30% | 81.00% | ⇧ | 78.4% | Sam Newton | Darren Rickett | A | Rotherham ranks 10th Y&H based on initial 14/15 data. Current Performance 542/709 (confirmed in year,7 clients not had settled accommodation confirmed) DOT based on last refresh |
| Improvement Actions: Query impact of CHC loss of 100% funding - analysis shows 1 client thus low impact. P&Q to monitor with LD Service. Indicator to be discussed alongside the employment measure at 07/01 meeting. | | | | | | | | | | | | | | | | |
| 11 | ASCOF 1H (Ex NI 150) | ✓ | | | ✓ | Adults receiving secondary mental health services in settled accommodation | High | Monthly (Est) | 73.10% | 75.00% | ⇧ | 74.35% | Sam Newton | Alison Lancaster | A | 2014/15 score from restricted data release. Rotherham ranks 5th Y&H based on restricted 14/15 data release. Current performance based on January's MH submitted data, new reporting systems implented to replace MHLDDS. DOT based on last refresh. |
| Improvement Actions: | | | | | | | | | | | | | | | | |
| 12 | ASCOF-1Ii | ✓ | | | | Proportion of people who use services , who reported that they had as much social contact as they would like | High | Annual | 40.20% | 41.90% | ⇧ | 46% ~~45%~~ | Sam Newton | Michaela Cox | A | Annual Score collected in ASC User Survey. Rotherham ranks on initial 14/15 data 13th (Y&H). |
| 13 | ASCOF-1Iii | ✓ | | ✓ | | Proportion of carers, who reported that they had as much social contact as they would like | High | Annual | 45.50% | - | | - | Sam Newton | Michaela Cox | A | Biennial collection from Carer's Survey next scheduled 16/17. Rotherham ranked 3rd in Y&H region based on initial 14/15 data. |
| | ASCOF 1J | ✓ | | | | **PLACEHOLDER** Adjusted Social care-related quality of life - impact of social care services | | Annual | | | | | | | | Placeholder for 15/16, live measure from 2016/17 |

| Indicator Ref | | N | C | P | PHOF | Indicator Title | Good Perf | Freq. | 2014/15 Performance | Proposed 15/16 Target | DOT (14/15 - 15/16) | 15/16 Performance | Head of Service | Accountable Officer | Decision Code | Comments / Remedial Actions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 14 | ASCOF-2A Part 1 | ✓ | | | | Permanent admissions to residential and nursing care homes (18-64) | Low | Monthly | 12.30 | 11.62 (18 admissions) | ⇩ | 20.03 | Sam Newton | Darren Rickett | A | 14/15 performance based on 20 admissions. No change in score due to revised population data (MYE 2014) Rotherham ranks 9th Y&H based on initial 14/15 data. Current performance based on 31 admissions (comprised from both Revs and Payments and AIS data). Admission rate has been impacted by a signifcant increase in PD admissions (13) compared with 3 in 14/15 and 1 in 13/14. Action plan to mitigate further significant increase required. Admissions breakdown by client group; LD 10, PD 13, MH 8. |
| Improvement Actions: New panel will allow review of placements and future actions to be discussed at 14/12 meeting. Data provided from Revenues and Payments details 10 clients as new admissions due to loss of CHC funding. | | | | | | | | | | | | | | | | |
| 15 | ASCOF-2A Part 2 (2.2.3) | ✓ | ✓ | ✓ | | Permanent admissions to residential and nursing care homes (65+) | Low | Monthly | 958.5 - updated due to new population data (975.1 intial 14-15) | 933.25 (446 Admissions) | ⇧ | 819.52 (401 admissions) updated 22/4/16 | Sam Newton | Michaela Cox | A | 14/15 performance based on 466 submitted admissions published actual shows as 469 (due to roundings etc) . Actual admissions from completion of validation work = 498 Rotherham ranks 14th Y&H based on initial 14/15 data. Current February (comprised from both Revs and Payments and AIS data) score based on 359 (includes 27 Full Cost) 14/15 admissions included 67 full cost and 22 property disregard clients. |
| Improvement Actions: Switching impact of Self Funders to local authority contracts which changes client status to a full cost client which counts as an admission - Comissioning providing guidance. Data provided from Revenues and Payments details 41 clients counted as a new admission due to loss of CHC funding. | | | | | | | | | | | | | | | | |
| 16 | ASCOF-2Bi | ✓ | | ✓ | | Proportion of older people (65+) who were still at home 91 days after discharge (effectiveness of the service) | High | Annual | 83.50% | 90.00% | ⇧ | 89.60% | Sam Newton | Sarah Farragher | A | Annual Score (data collected Oct - Mar) Rotherham ranks on current 14/15 data 7th (Y&H) Initial Annual Score (data collected Oct - Mar) Final outurn excluding inappropriate referrals - 121/135 Rotherham 15/16 score ranks 4th (Y&H) based on 14/15 benchmarking. |
| Improvement Actions: | | | | | | | | | | | | | | | | |
| 17 | ASCOF-2Bii | ✓ | | | | Proportion of older people (65+) who were still at home 91 days after discharge (offered the service) | High | Annual | 1.50% | 2.00% | ⇧ | 1.66 (est) | Sam Newton | Sarah Farragher | A | Rotherham ranks on current 14/15 data 11th (Y&H) Annual Score (data collected Oct - Mar). 14/15 score now available as part of restricted data release. Performance based upon 14/15 discharges Rotherham 15/16 score ranks 11th (Y&H) based on 14/15 benchmarking. |
| Improvement Actions: | | | | | | | | | | | | | | | | |

| Indicator Ref | | N | C | P | PHOF | Indicator Title | Good Perf | Freq. | 2014/15 Performance | Proposed 15/16 Target | DOT (14/15 - 15/16) | 15/16 Performance | Head of Service | Accountable Officer | Decision Code | Comments / Remedial Actions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 18 | ASCOF-2C Part1 (ex NI131) | ✓ | | | | Average delayed transfers of care from hospital per 100,000 population | Low | Monthly | 9.50 | 9.50 | ⇧ | 8.39 | Sam Newton | Michaela Cox | A | 2014/15 performance data from restricted release (scores are rounded) No change in score due to revised population data (MYE 2014) , Rotherham ranks 9th in Yorkshire and Humber. Current performance based on February data which equates to an average of 17.09 days delayed. March data will be published 12th May. Rotherham data subject to change due to RDaSH resubmissions |
| Improvement Actions: DTOC meeting held 10th December to discuss current performance, issues raised in regards to out of area funding and other authority delays. Query sent to RDASH to confirm that non-Rotherham residents are excluded from delay submission as per national guidance. Response received confirming data will be re-submitted to exclude all OOA patients. | | | | | | | | | | | | | | | | |
| 19 | ASCOF-2C-Part2 | ✓ | | | | Average delayed transfers of care from hospital which are attributable to adult social care or both health and adult social care per 100,000 population | Low | Monthly | 2.30 | 2.30 | ⇧ | 1.61 | Sam Newton | Michaela Cox | A | 2014/15 performance data from restricted release No change in score due to revised population data (MYE 2014) (scores are rounded),Rotherham ranks 8th in Yorkshire and Humber.Current performance based on February data which equates to an average of 3.27 days delayed . March data will be published 12th May. Rotherham data subject to change due to RDaSH resubmissions |
| 20 | ASCOF-2D New for 2014-15 | ✓ | | | | The outcomes of short-term support: sequel to service | High | Annual | 85.20% | 74.00% | | 86.1% | Sam Newton | | A | New Indicator for 2014/15 . This indicator will reflect the proportion of new clients who received short term service in year with an outcome of no further request made for support/ongoing service. Indicator provides evidence of a good outcome in delaying dependency or supporting recovery.Rotherham ranks 2nd in Yorkshire and Humber. Report to be written to monitor performance in year. Target based on national median score. Initial refresh of SALT return has highlighted potential recording issues which require investigation |
| | ASCOF-2E | ✓ | | | | **PLACEHOLDER** Effectiveness of reablement service | | Annual | | | | | | | | Placeholder for 15/16 |
| | ASCOF-2F | ✓ | | | | **PLACEHOLDER** Dementia - a measure of the effectiveness of post diagnosis care in sustaining independence and improving quality of life | | Annual | | | | | | | | Placeholder for 15/16 |
| 21 | ASCOF-3A | ✓ | | | | Overall satisfaction of people who use services with their care and support | High | Annual | 65.00 | 65.00 | ⇧ | 70 | Sam Newton | Michaela Cox | A | Annual Score collected in ASC User Survey. Rotherham ranks on current 14/15 data 9th (Y&H). |
| 22 | ASCOF-3B | ✓ | | | | Overall satisfaction of carers with social services | High | Biennial | 48.60% | - | | - | Sam Newton | Michaela Cox | A | Biennial collection from Carer's Survey next scheduled 16/17. Rotherham ranked 2nd in Y&H region based on initial 14/15 data. |
| 23 | ASCOF-3C | ✓ | | | | The proportion of carers who report that they have been included or consulted in discussions about the person they care for | High | Biennial | 75.30% | - | | - | Sam Newton | Michaela Cox | A | Biennial collection from Carer's Survey next scheduled 16/17. Rotherham ranked 8th in Y&H region based on initial 14/15 data. |
| 24 | ASCOF-3D part 1 | ✓ | | | | The proportion of people who use services who find it easy to find information about support | High | Annual | 76.80 | 76.80 | ⇧ | 78 | Sam Newton | Michaela Cox | A | Annual Score collected in ASC User Survey. Rotherham ranked 6th in Y&H region based on initial 14/15 data. |
| 25 | ASCOF-3D part 2 | ✓ | | | | The proportion of carers who find it easy to find information about support | High | Biennial | 71.60% | - | | - | Sam Newton | Michaela Cox | A | Biennial collection from Carer's Survey next scheduled 16/17. Rotherham ranked 6th in Y&H region based on initial 14/15 data. |

| Indicator Ref | | N | C | P | PHOF | Indicator Title | Good Perf | Freq. | 2014/15 Performance | Proposed 15/16 Target | DOT (14/15 - 15/16) | 15/16 Performance | Head of Service | Accountable Officer | Decision Code | Comments / Remedial Actions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ASCOF-3E | ✓ | | | | **PLACEHOLDER** Effectiveness of integrated Care | | Annual | | | | | | | | Placeholder for 15/16 |
| 26 | ASCOF-4A | ✓ | | ✓ | | The proportion of people who use services who feel safe | High | Annual | 61.50 | 68.30 | ⇧ | 66 | Sam Newton | Sam Newton | A | Annual Score collected in ASC User Survey. Rotherham ranks on initial 14/15 data 15th (Y&H) |
| 27 | ASCOF-4B | ✓ | | | | The proportion of people who use services who say that those services have made them feel safe and secure | High | Annual | 81.60 | 84.50 | ⇧ | 85<br>~~84~~ | Sam Newton | Sam Newton | A | Annual Score collected in ASC User Survey. Rotherham ranks on initial 14/15 data 8th (Y&H) |
| | ASCOF-4C | ✓ | | | | **PLACEHOLDER** Proportion of completed safeguarding enquiries where people report that they feel safe | | Annual | | - | | | | | | Placeholder for 15/16. Plans for roll out as live measure to be communicated Autumn 15 as part of 16/17 ASCOF Framwork document. |

Rotherham Doncaster and South Humber NHS Foundation Trust

# Rotherham Transformation Update



Agenda Item 12

RDaSH leading the way with care

Rotherham Doncaster and South Humber NHS Foundation Trust

# Priorities for Change

## Engagement

- 16 events
- Over 450 involved
- Patients, Carers
- RDaSH & RMBC staff
- GPs
- Commissioners & Stakeholders

## What we learned

- Locality focus

**Access to services:**

- Geographic access
- Routes into and through services
- Named contacts

**In service:**

- Waiting times
- Bouncing between teams
- Generic v specialism
- Volume/flow

**Learning Disabilities**

- Extended remit
- Move from inpatients to community

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Rotherham Doncaster and South Humber NHS Foundation Trust

# Defining our Objectives

## Vision

To provide all age care which is delivered in an integrated way ensuring patients receive care as close to the community in which they live and empowering our staff to work innovatively to deliver quality services

Key deliverables for:

- Patients
- Carers
- Staff

## Principles

- Trust wide, locally focused
- Patient focused/ Needs led
- Maintains care pathways
- Maintains / improves quality
- Releases QIPP savings
- Supports commissioners
- Promotes integrated working

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Rotherham Doncaster and South Humber NHS Foundation Trust

# Taking the work forward

**Internal**

- Gateway Group
- Pathway Group
- Service Design & Management Configuration

**Partnership**

- Dementia Task & Finish
- IAPT Task & Finish
- Social Care Task & Finish
  - Integrated Working
  - Co-location
- Integrated Locality Pilot
- Hospital Liaison



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# Care Groups

Rotherham Doncaster and South Humber NHS Foundation Trust

**Rotherham**

Adult Mental Health Services
Older People's Mental Health Services
Learning Disabilities (Community)
Drug and Alcohol Services

**Doncaster**

Adult MH
Older Peoples MH
Doncaster Adult Community Integrated Services
Forensic
Learning Disabilities (community and inpatients)
Drug & Alcohol

**North Lincs**

Adult MH
Older Peoples MH
Learning Disabilities (community)
NE Lincs Drug & Alcohol
Manchester EIP

**Children's**

Doncaster community integrated services
Children & Young Peoples MH in Rotherham, Doncaster and N Lincs
School Nursing in North Lincs

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# Recovery and Wellbeing

Recovery and well being oriented practice:

- emphasises hope, social inclusion, community participation, personal goal setting and self-management
- promotes a coaching or partnership relationship between people accessing health services and health professionals

**"People with lived experience are considered experts on their lives and experiences, while health professionals are considered experts on available treatment services"**

# What does this mean for transformation ?

Rotherham Doncaster and South Humber NHS
NHS Foundation Trust

- Pathways that assist people to build a meaningful and satisfying life, working collaboratively to achieve personal ambitions and goals
- Systems that enable people to take responsibility for decisions about their life, their care and the services they use
- Practice that focuses on strengths, solutions, health and wellness
- Practitioners who inspire hope for the future and hold hope for people when they are unable to hold it for themselves
- Practice that connects and supports people to enable them to take on meaningful, satisfying and valued roles and relationships, and to participate in local communities
- Systems that value and nurture the *expert by experience* role in the organisation
- Valuing and supporting the role of families and supporters; understanding their significant and important role in recovery.
- Health care that seeks to support people with **"what matters to them**" not what **"the matter is**"



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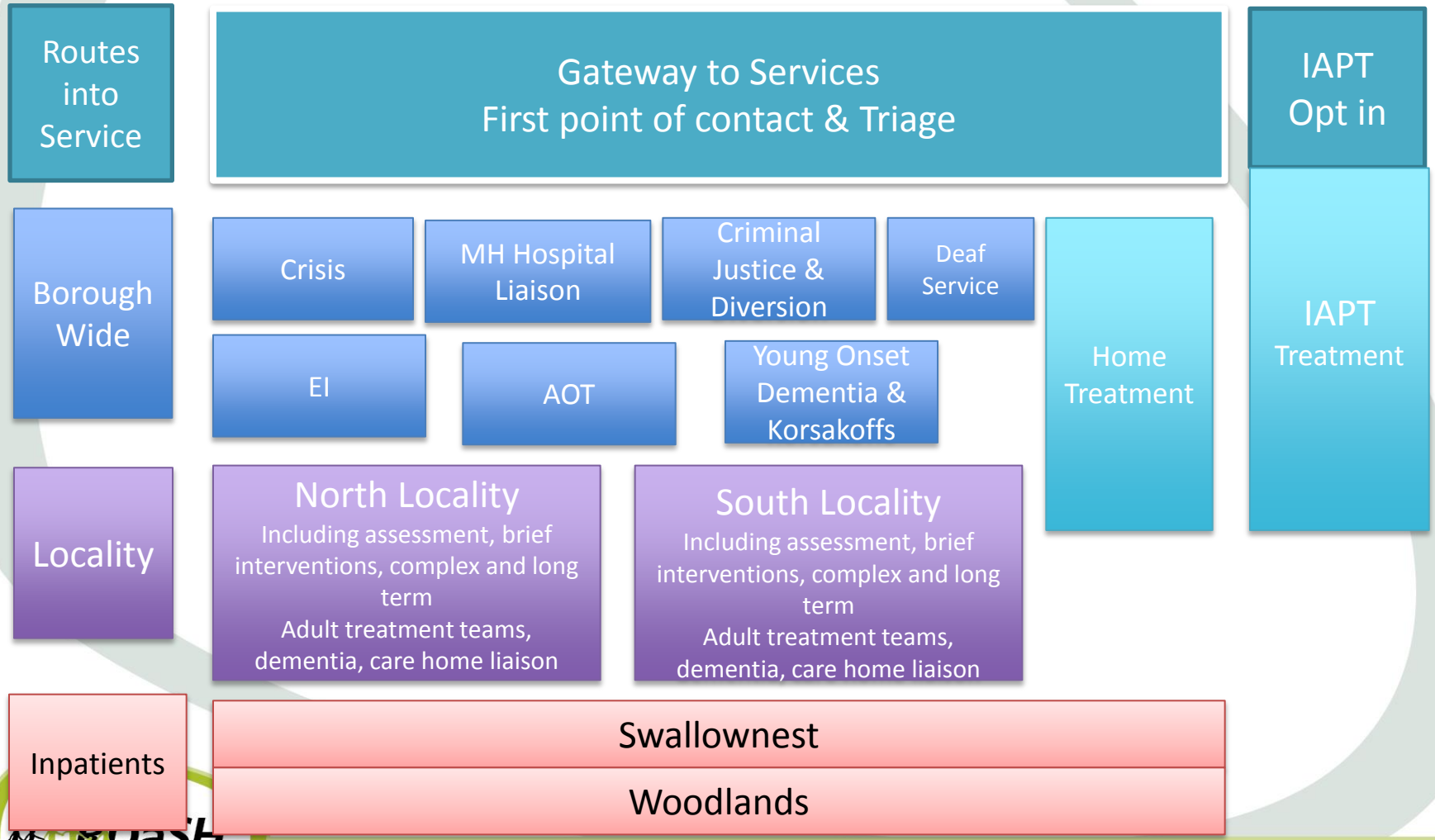
Rotherham Doncaster and South Humber NHS Foundation Trust

# Service Delivery






leading the way with care

# Next Steps

Rotherham Doncaster and South Humber NHS Foundation Trust

- Testing the thinking
- Developing and costing models
- Recommendations through governance process
- HR change process
- Establishment of Care Group
- Phased implementation
- Process and system standardisation (interdependency with Unity programme)



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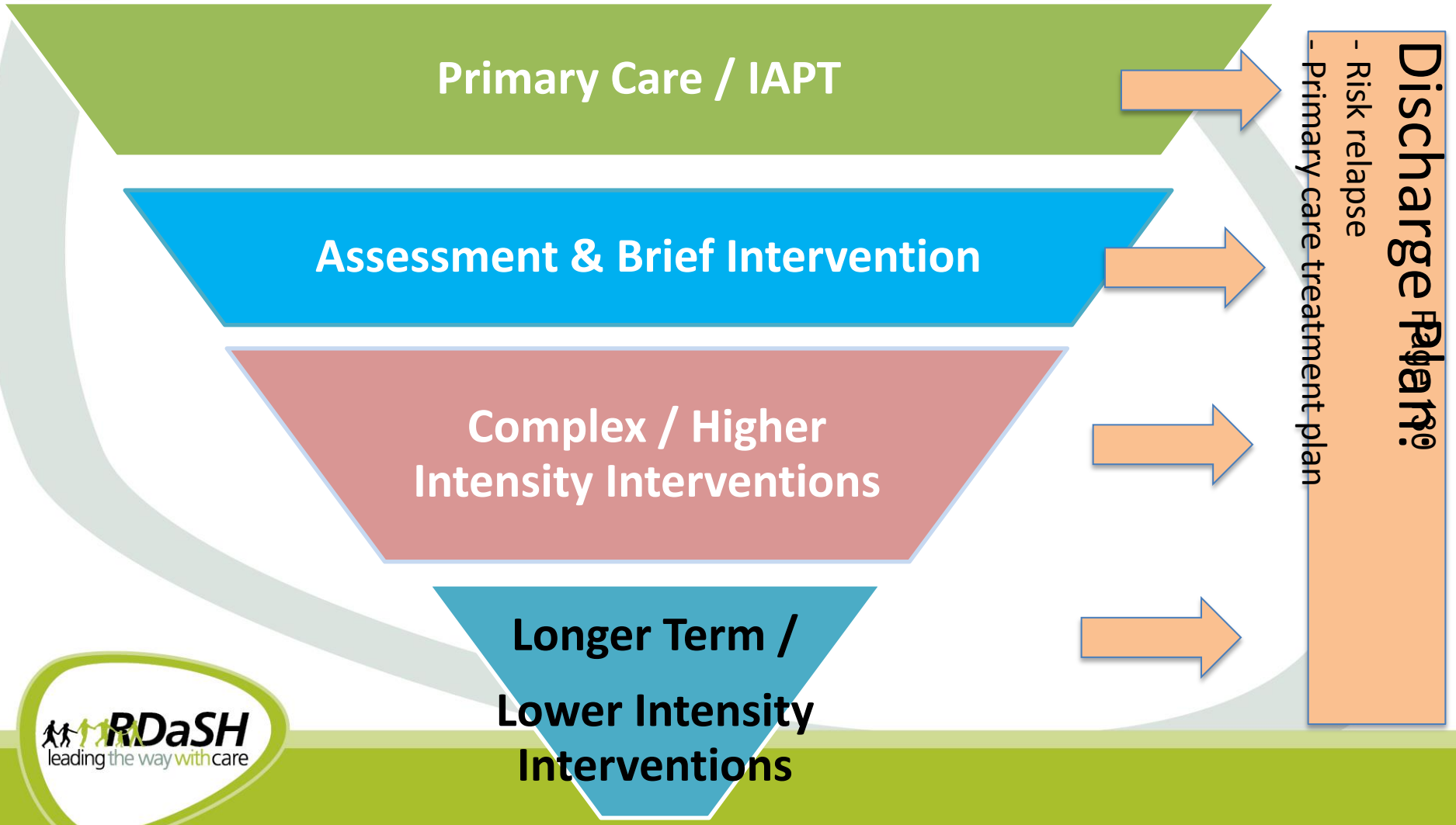
Rotherham Doncaster and South Humber NHS Foundation Trust

# Pathway Framework

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**Discharge Plan: Risk relapse / Primary care treatment plan**

NHS

NHS Foundation Trust

Primary Care IAPT

## Assessment & Brief Interventions

*An effective front end*

Short term interventions
Sessional work
Relapse management
Initial prescribing
Simple meds reviews
Crisis follow up
Groups e.g. mindfulness, steps. WRAP

## Complex Interventions

*Higher Intensity, more MDT*

Formulation driven planning
Complex risk management
Co-morbidities
Targeted therapies e.g. CBT for psychosis
CPA

## Longer Term

*Lower Intensity Interventions*

DEPOT meds
Social care packages
Lithium and clozapine management

Cluster Pathways

Cluster Pathways

Vocational / Occupational Needs — Social Prescribing

Recovery — Well Being

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# Working to our professional specialisms

Rotherham Doncaster and South Humber NHS Foundation Trust

**Function**

- First point of contact
- Triage
- Social Care
- Assessment & Interventions

**Specialism**

- Admin
- Clinical
- Social Workers & AMHPs
- MH practitioners
  - core skills
  - profession specific skills
  - advanced skills



RDaSH leading the way with care

| Rotherham Mental Health Transformation Update May 2016 | Stakeholders said …. |
|---|---|
| **Stakeholder Engagement** | The key themes to address that emerged from stakeholder conversations are:<br>• access to services (closer to home, speed of access and named contacts)<br>• number of assessments<br>• patients being bounced around the system<br>• removal of artificial age barriers<br>A third round of engagement events has been held. We have now held over 20 stake holder events involving 500+ patients, carers, stakeholders and staff to develop and test plans. 90% of respondees in May found the event useful and 96% felt they had had the opportunity to contribute. There was broad support for the direction of travel and outputs have been used to develop and adapt thinking. |
| **Our proposed response ….** | |
| **Placed based Care Groups** | The Trust Board of Directors has approved four new Care Groups. These will replace the existing Business Divisions, providing a greater focus for and understanding of local issues. The Rotherham Care Group will comprise adult (working age and older peoples) Mental Health Services, Learning Disabilities (community) and Drug and Alcohol Services. There will be a Trust wide Children's Care Group. It's anticipated that the Care Groups will be led by a Care Group Director, supported by clinical leads. The aim is to implement these changes by 1 October 2016. |
| **Access to services** | Its proposed to deliver a more efficient and effective gateway into services by reducing the number of entry points. This will provide a robust initial point of contact and triage service underpinned by improved technology. RDaSH are working with RMBC and the CCG regarding a Rotherham wide health and social care hub. In the short term we are working with the Care Co-ordination Centre to discuss the potential for a shared initial point of contact and triage. |
| **Treatment closer to home** | The impact of phase one projects is beginning to come through. IAPT have met their waiting time trajectories with the help of non-recurrent NHSE funding. The patient opt in model contributed to this and the move to Clifton Lane, enabling group work to be offered in a more central location. A new dementia pathway will enable diagnosis in primary care. The draft model for secondary services proposes two localities: north and south. Due to the relatively small numbers of staff in MH services it is not possible to mirror GP localities. Discussions are taking place with RMBC to try and mirror boundaries, co-locating where possible to improve access and reduce cost. Some services will remain borough wide due to size or specialist nature. |
| **All age (18+) Assessment and Treatment** | A new mental health framework of care is emerging to facilitate needs led patient care. The framework aims to remove artificial age barriers whilst not losing specialist expertise. The aim is to have an MDT approach which is less generic than the old CMHT model and less specialist than the current cluster based model in adult services which is too niche and results in patients being moved around the system. The draft framework aims to improve the flow into and through services, underpinned by a recovery and wellbeing ethos. Brief interventions at the front end will provide a more rapid response, with complex care and longer term interventions being managed through MDT locality teams. A mental health and social care task and finish group has been set up to review the respective roles and develop more efficient and effective ways of working together, including opportunities for a shared estate. The MH social prescribing pilot demonstrates how innovative work with the voluntary sector can contribute to improving recovery rates whilst providing good value for money. |
| **Integrated Locality** | RDaSH are proactively involved in the MDT pilot with primary health and social care. Mental health will initially focussing on older peoples MH. |
| **Timeline** | Recommendations for a proposed service model will go t to the Trust Transformation Board in July. Stakeholders will have the opportunity to comment on this, prior to a formal consultation process with the affected staff group planned for September. Implementation will begin before the end of the year. Changes to the estate are likely to be realised in 2017-18. Efficiencies from processes and systems change are interdependent with the Unity programme responsible for the procurement and implementation of a new patient record system. |

Our Ref : RC MH 2016 – 02-06

3 June 2016

North Region Specialised Commissioning Team
6th Floor
Quarry House
Quarry Hill
Leeds
LS2 7UE

Email : m.hardie@nhs.net
Tel : 0113 8255597

**Re: Child and Adolescent Mental Health (CAMHS) Tier 4 services in Yorkshire and Humber**

This communications is to let you know about a nationally coordinated approach to the procurement of CAMHS Tier 4 services. The procurement will be locally directed and driven so that the services meet the needs of local populations. Across Yorkshire and Humber we have agreed to commence the procurement of general adolescent and psychiatric intensive care inpatient services slightly ahead of the national timescales

The way that the procurement is organised will mean that the Yorkshire and Humber area will be divided into three geographical Lots, the first Lot to be procured will be services for Hull, East Riding of Yorkshire, North and North East Lincolnshire. The remaining two Lots are Lot 2; West Yorkshire, North Yorkshire and York, and Lot 3; South Yorkshire. Lot 1 bed requirements are general adolescent beds with co-located psychiatric intensive care beds that will provide for the populations of Hull Clinical Commissioning Group, East Riding of Yorkshire Clinical Commissioning Group, North Lincolnshire Clinical Commissioning Group and North East Lincolnshire Clinical Commissioning Group.

A detailed piece of work has been carried out to assess the numbers of beds required and in which geographical locations

Our timetable and plans mean that NHS England will be engaging with stakeholders for Lot 1 during the months of June and July to ensure that all local and interested parties are fully involved with the process and have the opportunity to inform the future service. We will also in due course notify the market of our intentions for a planned procurement through the issue of a Prior Information Notice via the Official Journal of the European Union. Envisaged timescales mean that invitations to tender will be published later in the summer. This should lead to NHS England awarding a contract to the preferred provider(s) in November, assuming that there are no challenges to the process.

We recognise how important communication and engagement is to this process to ensure it is a success and that the result for everyone is the provision of high quality and effective service provision. This must be located in the most appropriate geographical location to serve this population.

The process and timescales for Lot 2 and Lot 3 will be announced shortly.

Yours faithfully

**Robert Cornall**
Regional Director of Specialised Commissioning (North)

# HEALTH AND WELLBEING BOARD
## 13th January, 2016

**Present:-**

| | |
|---|---|
| Councillor David Roche | Advisory Cabinet Member, (**in the Chair for Minute Nos. 41-45, 49-51)** |
| Dr. Julie Kitlowski | Vice-Chair, Rotherham CCG **(in the Chair for Minute Nos.46-48, 52)** |
| Tony Clabby | Healthwatch Rotherham |
| Miles Crompton | Policy, Improvement and Partnerships, RMBC |
| Dr. Richard Cullen | Governance Lead, Rotherham CCG |
| Chris Edwards | Chief Officer, Rotherham CCG |
| Kate Green | Policy Officer, RMBC |
| Alison Ilif | Public Health Specialist, RMBC |
| Gordon Laidlaw | Communications, Rotherham CCG |
| Carol Levelle | NHS England (representing Zena Robertson) |
| Councillor Jeanette Mallinder | Vice-Chair, Health Select Commission |
| Stella Manzie | Commissioner and Managing Director, RMBC |
| Paul McCurry | South Yorkshire Police (representing Jason Harwin) |
| Teresa Roche | Director of Public Health, RMBC |
| Councillor Stuart Sansome | Chair, Health Select Commission |
| Kathryn Singh | RDaSH |
| Ian Thomas | Strategic Director, Children and Young Peoples Services |
| Jon Tomlinson | Adult Care and Housing, RMBC |
| Janet Wheatley | Voluntary Action Rotherham |

Apologies for absence were received from Jason Harwin, Zena Robertson, Councillors John Turner, Watson and Yasseen.

### 41. ROTHERHAM COUNCIL

The Chairman referred to the recent announcement regarding the potential restoration of some powers to the Council/Elected Members in February, 2016 as well as the appointment of Sharon Kemp as Chief Executive who would commence on 18th January, 2016 and attend future meetings of the Board.

He placed his thanks on record for the work of the Commissioners and in particular Commissioner Manzie for her efforts on behalf of the Health and Wellbeing Board.

### 42. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

## 43. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

## 44. MINUTES OF THE PREVIOUS MEETING

Resolved:- That the minutes of the meetings held on 25th November, 2015, be approved as a correct record.

Arising from Minute No. 34 (Communications), it was noted that an update would be given at the next meeting regarding the refresh of the Board's website.

Arising from Minute No. 37 (Suicide Prevention and Self-Harm), it was noted that meetings had taken place with 2 individual Head Teachers but not at the collective Head Teachers meeting. Commissioner Manzie undertook to raise this issue with the Head of School Effectiveness Service.

It was also noted that 2 training programmes had been publicised. Firstly the Applied Suicide Intervention Skills training to be held on 10th and 11th March, 2016 and secondly the Safe Talk Training to be held on 12th and 26th February, 2015. Both programme were to be held at the Brinsworth Training Centre. They were open to the general public as well as employers.

An All Members seminar was to be held on 5th April, 2016, on this issue.

## 45. FOR INFORMATION

**Physical Activity Event**
The Chairman reported that the event would now take place in May, date to be confirmed, at the New York Stadium.

**Network Event**
An event was to be held in York on 11th March for Health and Wellbeing Board Members and Support Officers. The Chair and Vice would be attending. There were a further two places available. Anyone interested in attending should contact Kate Green.

**Better Care Fund**
A progress report would be submitted to the February meeting. A meeting had taken place between the Council, CCG and Foundation Trust to discuss assurance that there was a shared approach from the Hospital, CCG and Council. A report would be submitted to the March meeting focussing on locality and a named key person to all the services the three organisations offered.

Julie Kitlowski reported that the Trust had developed a ten minute soundbite which talked about what 2016 for Rotherham was going to look like, the transformation plans, getting people out of hospital and looked after closer to home in their home and the locality model. It would need to be shared widely and hopefully would be presented to the next Board meeting. It was hoped to have a version that could be shared with the population of Rotherham.

(Julie Kitlowski assumed the Chair at this point in the meeting.)

## 46. UPDATE ON THE HEALTH AND WELLBEING STRATEGY IMPLEMENTATION

Further to Minute No. 35 of the meeting held on 25th November, 2015, Terri Roche, Director of Public Health, submitted an update on the progress made and the Board sponsors/lead officers as follows:-

| **Aim** | **Proposed Board Sponsor** | **Lead Officer (to be nominated by Board sponsor – from different organisation)** |
|---|---|---|
| 1. All children get the best start in life | Richard Cullen, CCG | Cara Milner, Matron, Children's Services, Rotherham Foundation Trust |
| 2. Children and young people achieve their potential and have a healthy adolescence and early adulthood | Ian Thomas, CYPS | CCG to nominate representative (suggested Safeguarding lead) |
| 3. All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life | Kathryn Singh, RDASH | Ian Atkinson, CCG |
| 4. Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing | Julie Kitlowski, CCG | Giles Ratcliffe, Public Health Consultant |

| | | |
|---|---|---|
| 5. Rotherham has healthy, safe and sustainable communities and places | Jason Harwin, SYP | Assistant Director of Community Safety and Neighbourhoods, RMBC (when appointed) |

A series of development workshops would take place for aims 3, 4 and 5 to help identify where the Board could add value to specific actions and consider what was already in place locally.

Aims 1 and 2 would be led by the Children's Trust Board and was, therefore, suggested that the wider Children's Partnership be used to develop them rather than individual workshops.

Discussion ensued on the nomination of Lead Officers and the need to ensure a balance of organisations.

Resolved:- (1) That the Board sponsors and lead officers for each Strategy aim, as set out above, be approved.

(2) That a review of the nominated officers be reviewed as part of the LGA Peer Review.

(3) That discussions take place with Voluntary Action Rotherham with regard to possible nominated representation.

## 47. NHS PLANNING GUIDANCE 2016/17-20/21

The Chair drew the Board's attention to the recently published NHS Planning Guidance 2016/17-2020/21 which set out the steps to deliver a sustainable, transformed Health Service. It included the key priorities for the system, agreed by all national health and care bodies, plus the business rules and incentives that would support delivery.

The CCG would have to produce two plans as well as consult with the Board on the Rotherham Place Plan which was a five year plan and had to be produced by March, 2016. CCG's were also being instructed to produce a regional Sustainability and Transformation Plan which included sustainability across the hospital sector as well as the CCG. Debate was taking place as to whether this would include South Yorkshire and Bassetlaw or South Yorkshire, Bassetlaw and Derbyshire. Technical guidance was awaited and there would be timescale issues.

Discussion ensued with the following issues raised:-

- Possible alignment with the City Region – Health was not part of the South Yorkshire devolution
- It covered all ages and was all encompassing

Resolved:- That the report be noted and further updates be submitted as and when information becomes available.

## 48. INDICES OF MULTIPLE DEPRIVATION

Miles Crompton, Policy and Partnerships, gave the following presentation:-

Indices of Deprivation 2015

- Government measure produced by Oxford University
- Updates the previous ID2010
- 7 domains (37 Indicators) = Index of Multiple Deprivation (IMD) with 2013/14 baseline
- SOA Geography (167 in Rotherham and 32,844 in England)
- Average of SOA Scores measure – Rotherham increased from 53rd most deprived district in 2010 to 52nd in 2015 (326 districts)
- Minor changes to methodology

Rotherham Deprivation relative to England

| % of Rotherham population within English IMD deciles | IMD 2004 | IMD 2007 | IMD 2010 | IMD 2015 |
|---|---|---|---|---|
| Most deprived 10% | 12% | 12% | 18% | 19.5% |
| Most deprived 20% | 33% | 32% | 33% | 31.5% |
| Most deprived 30% | 49% | 46% | 46% | 45% |
| Less deprived than national average | 29% | 35% | 32% | 37% |

23.1% of children 0-15 live in 10% most deprived areas nationally (15.6% in 2007)

Rotherham's most deprived SOAs
All in top 2% of 32,844 English SOAs

| SOA | Rank in 2010 | Rank in 2015 |
|---|---|---|
| Ferham | 851 | 242 (+609) |
| East Herringthorpe North | 230 | 257 (-27) |
| Eastwood Village | 2,207 | 302 (+1,905) |
| Canklow North | 434 | 315 (+119) |
| Eastwood East | 641 | 323 (+318) |
| East Herringthorpe South | 920 | 480 (+440) |
| Eastwood Central | 1,089 | 500 (+589) |
| Maltby Birks Holt | 1,207 | 597 (+610) |
| East Dene East | 707 | 623 (+84) |
| Masbrough | 847 | 634 (+213) |

Deprivation by Domain

| Domain | Top 10% | Change 2010-15 | Top 20% | Top 50% |
|---|---|---|---|---|
| Education & Skills | 24% | 0 | 39% | 69% |
| Employment | 24% | +2% | 42% | 75% |
| Health & Disability | 21% | -12% | 40% | 85% |
| Income | 17% | +3% | 33% | 64% |
| Crime | 15% | +4% | 25% | 65% |
| Living Environment | 2% | -1% | 4% | 10% |
| "Barriers" | 0% | 0 | 2% | 15% |

40% of Rotherham is in the most deprived 20% nationally but none is in the least deprived 20%

Indices of Deprivation
Change in Health Indicators

| Indicator | ID 2010 | ID 2015 | Change |
|---|---|---|---|
| Years of potential life lost | 74.3 | 64.8 | -9.5 |
| Comparative illness & disability ratio (sickness & disability benefits) | 147.1 | 142.5 | -4.6 |
| Acute morbidity (emergency admissions) 2006-8/2011-13 | 199.5 | 125.8 | -73.7 |
| Mood & anxiety disorders (Mental Health) 2006-8/2012-13 | 0.33 | 0.51 | +0.18 |
| Overall Health & Disability Score | 0.84 | 0.64 | -0.20 |

Average SOA scores (above) show improvement
Mental Health is worse – GP prescribing, hospital episodes, disability benefits and suicides
24.3% of children 0-15 are affected by low income

Income Deprivation affecting Children Index 2015

- Children 0-15 are 19% of population but 25% of those affected by low income
- 35% of children in low income families live in 10% most deprived nationally

Children and Young People's Attainment
Education Sub-Domain 2015

- 27% of children and young people live in 10% most deprived areas nationally
- 16% live in 5% most deprived areas

Comparison of Life Chances: Children

| 20 Contrasting Neighbourhoods | 10 most deprived areas | 10 least deprived areas |
|---|---|---|
| Total population (2013) | 17,486 | 15,822 |
| Children (aged 0-17) | 5,870 (33.6%) | 2,655 (16.8%) |
| Live in a family with 3+ dependent children | 2,975 (50.7%) | 470 (17.7%) |
| Good level of development at Foundation (2013) | 117 (36.7%) | 115 (73.2%) |
| Achieve Level 4 at Key Stage 2 (2011-13) | 143 (56.7%) | 135 (88.0%) |
| Achieve 5+ GSCEs A*-C inc English & maths (2011-13) | 80 (32.7%) | 141 (82.6%) |
| Be a Child in Need (Children Act 1989) (2014) | 236 (4.0%) | 21 (0.8%) |
| Be in contact with or supported by the CSE Team aged 13-16 (2012-14) | 202 (20%) | 31 (4.6%) |

Comparison of Life Chances: Adults & General

| 20 Contrasting Neighbourhoods | 10 most deprived areas | 10 least deprived areas |
|---|---|---|
| Total population (2013) | 17,486 | 15,822 |
| Working Age Adults 18-64 | 9.732 (55.7%) | 9,691 (61.3%) |
| Be unemployed, long term sick or FT carer | 3,226 (33.1%) | 505 (5.2%) |
| Be a disabled adult claiming DLA (2015) | 1,460 (12.6%) | 545 (4.1%) |
| Live in an overcrowded home (all households) | 880 (12.6%) | 114 (1.8%) |
| Recorded violent offences, burglary, theft and criminal damage (per 1,000 pop) | 1,791 (102.4) | 315 (19.9) |
| Older people aged 65+ | 1,884 (10.8%) | 3,476 (22%) |
| Live in poverty as a pensioner | 765 (40.6%) | 222 (6.4%) |
| Male life expectancy | 73.4 | 83 |
| Female life expectancy | 77.4 | 86.9 |

Key Messages

- Deprivation still top 20% nationally
- Employment and education deprivation most severe
- Improvements in health, crime and environment
- Most deprived areas getting worse
- Areas with average or low deprivation doing better
- Mental health getting worse
- Rising barriers to housing – affordability
- Polarisation on all domains except living environment
- 18.7% deprived of income

- 24.3% children v 16.5% working age adults
- Children more likely to be affected by deprivation

Policy Challenges
- Targeting the most deprived areas
  - Are we closing the gap? – no it is getting wider
  - Previous initiatives made little lasting impact
  - Welfare Reform exacerbating deprivation
  - Identify what works: evaluation and best practice
  - Joining-up services and targeting resources
- Improving education and skills in our most deprived areas
  - Raising school attainment and participation post-18
  - Higher adult qualifications and skills
  - Work readiness: basic life skills, welfare to work
  - Cultural shift towards learning and working

Discussion ensued with the following issues raised/highlighted:-

- Should the sub-groups target the top 10 most deprived areas rather trying to affect a change across the whole of the Borough? Or each individual sub-group look at the issues that relate specifically to their area?

- Need for the Local Strategic Partnership to link up activity – role of the Operational Chief Executive to draw up matrices of the different levels as well as the operational day-to-day co-ordination and deployment of resources both in terms of the partnership work and operationally

- Very good work was taking place in driving up the standard of education but what happened when a child left at the end of the school day? There was a whole raft of issues that needed to be picked up given the complexities of neighbourhoods

- A challenge for Health would be do they target more of their budget to localities? Equity v equality

- Consistency was key and not constant time limited initiatives

- "So what Test" - in a year need to be able to see a difference in the deprived areas for the resources that had been deployed

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

(2) That the Health and Wellbeing Strategy workshops give consideration to equity and "closing the gap".

(3) That a discussion take place between the Chair and Vice, the newly appointed Chief Executive and Chris Edwards on the way forward.

(4) That an All Members Seminar be held on this issue.

(Councillor Roche assumed the Chair)

## 49. CHILDREN'S STRATEGIC PARTNERSHIP ARRANGEMENTS

Ian Thomas, Strategic Director, Children and Young People's Services, gave a verbal report on the Children's Strategic Partnership.

The Partnership was strongly related to Aims 1 and 2 of the Health and Wellbeing Strategy. There had been two development days held so far with the first meeting of the refreshed Partnership taking place on 10th February where the Chair and Vice would be agreed as well as the Terms of Reference. The Partnership's key workstreams were:-

Early Help
Workforce Development across the system
Development of a Children and Young People's Plan

with the key headline outcomes of keeping children safe and keeping children and families safe, children ready to learn and children and their families ready for work.

The Partnership would meet bi-monthly and report into the Health and Wellbeing Board.

Resolved:- That the update be noted.

## 50. EARLY HELP PROGRESS REPORT - SEPTEMBER TO DECEMBER, 2015

Ian Thomas, Strategic Director, Children and Young Peoples Services, presented an update on the progress made in developing Rotherham's Early Help Offer.

The report highlighted:-

- Appointment to the posts of Assistant Director for Early Help, Heads of Service, Team Managers and Children Centre Leaders
- Transfer of staff into the new locality team on 5th October, 2015 and major review of all property in the Borough that would provide Early Help office space and Service delivery points
- In excess of 30 different referral routes into Early Help each with its own criteria, assessment and evaluation and recorded across 8 databases
- Review of the Early Help Assessment Team within the MASH and reconfiguration to secure more efficient and effective processes
- 0-19 Pathway almost complete. It would be launched as an interactive online tool for all partners and practitioners as part of the Early Help Offer website

- Progress in developing an online Early Help Offer with over 76 services and agencies having completed a service synopsis of what they offered and how it could be accessed
- Monthly reporting of performance measures. However, until the Case Management System (Liquid Logic) was operational it would continue to be an inefficient process with 7 different databases and systems to interrogate in order to extract the required data
- Finalised Early Help Quality Standards and a new electronic Case Audit tool development and introduced. All Team Managers and Heads of Service were required to undertake 1 Case Audit per month as part of the wider Early Help QA Framework

It was also noted that in October, 2015, the best ever NEET figures had been reported. Rotherham's final (NCCIS validated) figures were:-

Y11 98% offers made (against a national average of 97%)
Y12 97% offers made (against a national average of 91%)
Combined – 97.6% offers made (against a national average of 94.1%)

The Offer would go live on Monday, 18th January, 2016.

Discussion ensued with the following issues raised/clarified:-

- There were six Police Officers within the Integrated Youth Support Service. A Sergeant had also been recruited and a Missing from Home Officer who would sit within the Early Help Office

- The new Barnardos' service, although not live until later in the month, was already taking referrals – there would be fifteen additional bodies out and about raising awareness around CSE working with schools and communities

Resolved:- That the report be noted.

## 51. JOINT COMMISSIONING UPDATE

Ian Thomas, Strategic Director, Children and Young Peoples Services, presented a report outlining the progress that had be made on the Rotherham Joint Commissioning Strategy

The Strategy had been developed in partnership with young people as well as extensive consultation with parents, carers and stakeholders in the development of the 7 priorities i.e. SEND, Child Sexual Exploitation Post-Abuse Support Services, Early Help, Transition, Looked After Children – our Sufficiency Strategy in relation to Residential Care and Fostering Placements, CAMHS and 0-5 Years including Best Start.

Rotherham had suffered in the past as there had been no partnership working to deliver better outcomes for its communities. The Joint Commissioning Strategy aimed to impact positively on children and young

people through enhancement of current Mental Health Service provision. The priorities would bring about a positive contribution to promoting equality through improving access into service provision from disadvantaged and vulnerable groups.

Resolved:- That the report and progress made to date be noted.

(Julie Kitlowski assumed the Chair)

## 52. ROTHERHAM LOCAL SAFEGUARDING CHILDREN ANNUAL REPORT 2014-15

Christine Cassell, Independent Chair of the Rotherham Local Safeguarding Children Board, gave the following powerpoint presentation:-

Role of the Local Safeguarding Children Board

- Section 14 of the Children Act 2004 sets out the objectives of LSCBs which are:-
  - To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area
  - To ensure the effectiveness of what is done by each such person or body for those purposes

Relationship to the Health and Wellbeing Board
LSCBs

- Do not commission or deliver direct frontline services though they may provide training
- Should also work with the Health and Wellbeing Board, informing and drawing on the Joint Strategic Needs Assessment

(Working Together 2015)

LSCB Annual Report

- The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area (Working Together 2015)
- The report should be submitted to the Chair of the Health and Wellbeing Board (Working Together 2015)
- Inspectorates expect to see evidence of LSCB influence on the Health and Wellbeing Board

Rotherham LSCB Report 2014-15
Commentary by previous Chair on priorities

- Importance of Early Help strategy being refreshed
- Neglect and Domestic Abuse – strengthening Families Framework being introduced
- CSE Strategy refresh

Commentary on LSCB Improvements
- Performance, challenge and improvement
- Co-ordination with strategic commissioning activity
- Hearing and acting on the experience of others
- Learning and Development

Priorities for 2015-16
- Effectiveness of Early Help
- Effectiveness of the response to neglect
- Experience of Looked After Children
- Effectiveness of the multi-agency response to child sexual exploitation
- Continuing to improve the effectiveness of the LSCB

Safeguarding is everybody's business
- Council
- Statutory and non-statutory partners
- Voluntary and community organisations
- The wider community

What should the Health and Wellbeing Board do?
- Ensure a safeguarding focus in commissioning decisions
- Support LSCB priorities through the implementation of the Health and Wellbeing Strategy
- Undertake safeguarding impact assessments on major budget and organisational change
- Reports back to the LSCB on the impact of its work in support of LSCB priorities

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

- Further consideration was required to Impact Assessment in terms of the agencies' budgetary and organisational agendas

- To have an impact there had to be a baseline and once that discussion had been hade, how to get a collective view on what the impact was given agencies were driven by their own strategy and all measured outcomes differently; there had to be some commonality

Resolved:- (1) That the Health and Wellbeing Board:-

(a) Ensures a focus on safeguarding children in its commissioning decisions;

(b) Supports LSCB priorities through the implementation of the Health and Wellbeing Strategy

(3) That the issue of Impact Assessments be discussed at the Health and Wellbeing Board's Away Day and reported back to the Local Safeguarding Children Board.

## 53. DATE, TIME AND VENUE OF THE NEXT MEETING

Resolved:- That a further meeting be held on Wednesday, 24th February, 2016, commencing at 9.00 a.m. to be held at the Rotherham Town Hall.

# HEALTH AND WELLBEING BOARD
## 24th February, 2016

**Board Members:-**

| | |
|---|---|
| Councillor David Roche | Cabinet Member for Health and Adult Social Care (**in the Chair)** |
| Dr. Julie Kitlowski | Vice-Chair, Rotherham CCG |
| Tony Clabby | Healthwatch Rotherham |
| Dr. Richard Cullen | Governance Lead, Rotherham CCG |
| Chris Edwards | Chief Officer, Rotherham CCG |
| Teresa Roche | Director of Public Health, RMBC |
| Kathryn Singh | Chief Executive, RDaSH |
| Janet Wheatley | Chief Executive, Voluntary Action Rotherham |
| Sharon Kemp | Chief Executive, Rotherham MBC |
| Louise Barnett | Chief Executive, Rotherham Foundation Trust |
| Councillor Taiba Yasseen | Cabinet Member for Neighbourhood Working and Cultural Services |

**Observers: -**

| | |
|---|---|
| Kate Green | Policy Officer, RMBC |
| Alison Iliff | Public Health Specialist, RMBC |
| J. Hartley | South Yorkshire Police (representing Jason Harwin) |
| Nicole Chavaudra | Representing the Strategic Director, Children and Young Peoples' Services |
| Graeme Betts | Interim Strategic Director, Adult Care and Housing |
| Sandie Keene | Chair of the Rotherham Safeguarding Adults Board |
| Jon Tomlinson | Adult Care and Housing, RMBC |
| Jackie Scantlebury | RMBC, Adult Safeguarding |
| Gemma Parkinson | RMBC, Communications |
| Jackie Tuffnell | Commissioner |
| Kate Tuffnell | Head of Contracts and Service Improvement, CCG |
| Ian Atkinson | Deputy Chief Officer, CCG |

Apologies for absence were received from Ian Thomas and Jason Harwin (both represented).

## 54. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

## 55. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no members of the public or the press in attendance.

## 56. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting of the Health and Wellbeing Board were considered.

Matters arising updates were provided in relation to the following: -

Minute No. 45 (For Information) – Councillor Roche reported that there would be a review/refresh of the content relating to Physical Activity, which would be agreed by the end of March. A meeting for headteachers to discuss the Rotherham Suicide and Self harm Community Response Plan had now been arranged; Councillor Roche had requested that the attendance and format of the meeting be reviewed to ensure that it had good attendance and engagement and alternative meetings be pursued if not.

Rotherham's representatives at the 11th March event in York for Health and Wellbeing Board Members and Support Officers would be Councillors Roche and Sansome, J. Kitlowski, K. Haines, T. Clabby and K. Green.

Under Minute No. 46 (Update on the Health and Wellbeing Strategy Implementation) it was noted that the Children and Young People's Services Directorate had identified a Lead and this would be nominated by the full Council.

Resolved:- That the minutes of the meeting held on 13th January, 2016, be approved as a correct record.

## 57. HEALTH AND WELLBEING STRATEGY IMPLEMENTATION

Further to Minute No. 46 of the meeting held on 13th January, 2016, Terri Roche, Director of Public Health, provided an update on the progress made to date. Terri confirmed that the first of the planned workshops had taken place for aim 3 (mental health) and Kathryn would provide an update on this (see below).

The second workshop would focus on aim 4 (health inequalities) and was taking place on 16 March. An update on this would be provided at the next meeting in April.

Aims 1 and 2 were being delivered by the Children and Young People's Partnership.

It was noted that each of the Strategy aims would be presented to a future Health and Wellbeing Board meeting in detail by the board sponsor and lead officer. The schedule of reporting would be as follows:

- 21st September, 2016 – (aim 1) All children get the best start in life, and (aim 2) Children and Young people achieve their potential and have a healthy adolescence and early adulthood;
- 16th November, 2016 – (aim 3) All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life;
- 11th January, 2017 – (aim 4) Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing;

- 8th March, 2017 – (aim 5) Rotherham has healthy, safe and sustainable communities and places.

Kathryn Singh, RDaSH, provided an update on the workshop which took place for aim 3.

- It had been a fantastic event that was a great credit to the participants and agencies represented;
- Outcomes based accountability principles were used
- All agencies who contributed worked with people with mental health issues;
- 4/5 key bell weather actions were agreed;
- Workplace health and wellbeing was highlighted as something that needed to have a bigger priority, including at the agencies represented;
- Community issues, including the identification of loneliness and the role of the erosion of community spirit in towns and communities;
- The importance of Making Every Contact Count;
- Language used around mental health descriptions tended to be negative and stigmatising;
- Wellness Impact Assessments;
- Communication and training.

Terri wished to place on record her thanks to South Yorkshire Fire Service for the use of their training room within their Fire and Rescue Training Centre.

Governance for the Implementation of the Health and Wellbeing Strategy was considered and regular reports would be provided, in addition to the annual report.

Resolved:- (1) That the update provided be noted.

(2) That further updates on the Health and Wellbeing Strategy Implementation be provided to future meetings.

## 58. WORKING TOWARDS INTEGRATION IN ROTHERHAM

Graeme Betts, Interim Director of Adult Care and Housing, presented a report that covered the process of integration between Health and Social Care Services in Rotherham, including an integrated hub and team approach.

The report outlined the current areas of focus: -

- Development of integrated Health and Social Care Teams;
- Development of a reablement hub incorporating intermediate care beds;

- Community-based multi-professional teams based around practice populations;
- A focus on intermediate care, case management and support to home-based care;
- Joint care planning and co-ordinated assessment of care needs;
- Named care co-ordinators who retain responsibility throughout the patient journey;
- Clinical records shared across the multi-professional team.

Within one locality it was proposed that a fully integrated Health and Social Care Team would be developed. The Team would be co-located and would have a single line-management structure and joint service specification. It was proposed that a combined outcome framework be developed that supported the strategic objectives of both the Local Authority and the CCG.

The integrated approach aimed to: -

- Reduce hospital admissions;
- Help people remain in their own homes for longer;
- Create opportunities for efficiency savings.

Graeme explained that efforts were being made to identify venues to locate to.

Discussion followed, and the following issues were raised: -

- Louise Barnett believed that integration could support and contribute to the Sustainability and Transformation Plan and could attract additional funding;
- Mental Health Teams were being approached to consider how they could also become involved;
- Councillor Roche commended the good news story about integration;
- Julie Kitlowski asked for an update on progress to identifying a location: -
    - Chris Edwards explained that the central area of Rotherham was the focus for the first hub. It was envisaged that there would be seven localities in Rotherham, each serving approximately 30-40,000 people. The central area would be one of the largest localities. Whilst evaluation would be undertaken after the hub's first year of operation, this would be too long to wait to begin the other hubs. Therefore, periodical evaluation would be important.
- Councillor Yasseen asked that this be linked into the Area Assembly Review: -
    - Sharon Kemp wanted to capitalise on the commitment to conduct a piece of work on Early Help.
- Dr. Richard Cullen asked whether there could be any duplication between the emergency hub;

- Louise Barnett referred to the rapid pace of change and the impact that this would have on workforce planning, for example, recruiting a sufficient number of consultants;
- Tony Clabby asked whether the demographic in the central area of the Borough was ideally suited to an initiative that sought to reduce care home admissions. The central locality had higher numbers of younger people than other areas of the Borough: -
    - Terri Roche agreed that there were younger age profile to the Borough average in the central area. However hopefully the hub would also address and improve confidence and aid community cohesion.
- There was likely to be great pressure on the front door;
- Terri Roche asked that consideration be given to the creation of a Steering Group of the provider agencies, staff representatives and the client group. Customer feedback was important to seeing where the added value could be provided;
- There would be a valued role for social prescribing from the voluntary sector;
- Co-production.

Louise Barnett advised they were continuing development of an animation demonstrating transformation and integrated working. It was agreed for this to be presented to the next meeting of the Health and Wellbeing Board.

Resolved:- (1) That the plan to develop integrated Health and Social Care Teams be supported in principle.

(2) That the plan to develop a rehabilitation and reablement hub be supported in principle.

(3) That a detailed action plan on these two initiatives be received at a future meeting of the Health and Wellbeing Board.

## 59. BETTER CARE FUND QUARTER 3 SUBMISSION

Consideration was given to the report that outlined the Quarter Three performance of Rotherham's Better Care Fund. The Q3 submission needed to be submitted to NHS England by 26th February, 2016.

A Section 75 Agreement had been signed between the Local Authority and the Clinical Commissioning Group to pool the Better Together Funds.

In Q2, Rotherham had met four of the six National Conditions. In Q3 Rotherham had met the remaining two: -

- 7 day services to support patients being discharged and prevent unnecessary admissions at weekends in place and delivering – Enabling and Domiciliary Services has been operating as the first phase of our 7 day services plan: -

- Rotherham had now implemented a 7 day working hospital discharge pilot from 1st December, 2015, which will complete the intentions for 7 day working set out in the Rotherham BCF plan.

- NHS number being used as the primary identifier for health and care services: -

  - Work was well underway to ensure better sharing between Health and Social Care. There were 5,495 adults who were in the scope of the NHS number matching project. By the end of February 2016 all in-scope BCF records would have an assigned NHS number. Training materials have been issued which demonstrate to practitioners in adult social care on how to use the NHS number field.

Rotherham's performance on most metrics was on target and commentary was provided about these. Recently introduced integration metrics relating to personal health budgets, use of prevalence of multi-disciplinary and integrated care teams and use of integrated digital care records across health and social care had been included and Rotherham could report favourably on the first two.

Discussion followed the report's presentation and it was requested that future reports include an overview summary. The governance of the Better Care Fund submission was considered and it was suggested that sign-off be delegated to the Health and Wellbeing Board's Executive Group. NHS England had confirmed that this was permissible.

Graeme Betts felt that it was important that the Health and Wellbeing Board continue to consider the reports as all providers were represented and engaged at the meeting. It was agreed that the Health and Wellbeing Board would continue to own the Better Care Fund submission return and consider the quarterly strategic return. The Health and Wellbeing Executive Group would monitor the report on a monthly basis.

Julie Kitlowski thanked all of the staff who had contributed to bringing the report together, and who would continue to do so. This represented a significant level of work and partnership working.

Resolved:- That the Better Care Fund Quarter 3 Submission be approved and be submitted to NHS England.

## 60. CCG COMMISSIONING PLAN

Ian Atkinson, Deputy Chief Officer of the Rotherham CCG, gave a presentation on the annual review of the CCG's four-year Commissioning Plan. The starting point of the review was to consider the Joint Strategic Needs Assessment.

Key themes identified for further/specific discussion relating to the 2016/2017 Commissioning Plan were: -

- Approach to Joint Commissioning with RMBC, including the Better Care Fund;
- Commissioning of Children's Services;
- Response to Child Sexual Exploitation;
- Hospital and Community Services;
- Mental Health Services (including Learning Disability);
- Primary Care.

Ian's presentation included: -

- The key changes;
- The flow of the commissioning plan;
- Delivering the fifteen strategic priorities: -
    - Why is this a strategic priority?;
    - Five-year strategic direction;
    - Progress made in 2015/2016;
    - How will we achieve our intentions;
    - Quality improvements;
    - Innovation;
    - Alignment with the strategic aims of the Health and Wellbeing Strategy;
    - Addressing health inequalities;
    - Previous patient engagement leading to the plan/what patient engagement is planned in the area?.
- The end product: -
    - Succinct executive summary;
    - 50 page strategic plan (part 1);
    - 50-60 page detailed plan (part 2);
    - Easy to read public facing version.
- Drafting and approval would take place between February and March;
- Final version will be submitted to NHS England by 11th April.

Discussion followed Ian's presentation and the following questions and feedback were provided: -

- The 2016/2017 document should reflect the return of certain powers to Rotherham Council;
- The Health and Wellbeing Board did not current receive the SRG reports, although they were publically available;
- The role of social enterprise, development, engaging providers and public services users should be reflected;
- Making Every Contact Count;
- Safeguarding Adults;
- Learning disabilities and their thresholds;
- More explicit reference to Looked after Children would be beneficial.

Resolved: - (1) That the draft plan and feedback provided be noted.

(2) That, following appropriate governance, the plan be submitted to NHS England in April, 2016.

## 61. RDASH INSPECTION REPORT

Kathryn Singh, Chief Executive, RDaSH, gave a presentation to the Health and Wellbeing Board on the recent CQC inspection of her organisation.

The presentation covered: -

- The history of the organisation;
- The services provided to the different localities;
- Facts about RDaSH: -
    - 4, 3000 staff (3,700 whole time equivalent);
    - Around 200 volunteers;
    - £155m annual budget;
    - Commissioned by CCGs, Local Authorities, others such as the Drug Treatment Agency and NHS England.
    - 240 locations across 5 regional areas;
    - 347 beds on 21 wards;
    - 89 community teams across 5 localities;
    - Adult Social Care;
    - In 2014/2015 82,356 people accessed RDaSH services and there had been 912,409 face-to-face interactions. There had been a further 143, 363 non face-to-face patient contacts.

Submitted within the agenda pack, Kathryn explained the individual judgement against each of the RDaSH functions that had been inspected against the six criteria – 'safe', 'effective', 'caring', 'responsive', 'well-led' and 'overall' for each function.

The overall rating was that RDaSH 'Requires Improvement' (dated 19th January, 2016). Thirteen out of seventeen services were rated as good or outstanding. The overall judgement for each criteria was: -

- Safe – requires improvement;
- Effective – requires improvement;
- Caring – good;
- Responsive – good;
- Well-led – good.

The CQC provided information about what RDaSH was doing well.

Kathryn shared the action plan that was implemented following the inspection judgement. There were specific needs around the information technology systems used by RDaSH.

Discussion followed and the following points were raised: -

- Councillor Roche felt that the outstanding judgement in relation to Community Health Services for children, young people and families was excellent;
- He was concerned that the overall requires improvement related to Rotherham and Rotherham's CAMHS;
- Graeme Betts was pleased to note RDaSH's keenness to address the issues identified;
- Dr. Cullen asked that RDaSH's IT issues be addressed to suit what was best for patient care in Rotherham;
- Sharon Kemp asked that a Rotherham multi-agency group address and consider the IT issues. Chris Edwards explained how the Contract Quality Group was tasked with this;
- Tony Clabby pointed out that he had encountered inconsistencies in the recording of complaints and how these had made investigations more difficult.

Resolved: - (1) That the information about RDaSH's inspection outcome of 'Requires Improvement' (19th January, 2016), and the Organisation's action plan in response to this, be noted.

(2) That a progress report relating to Rotherham-specific services be presented to a meeting of the Health and Wellbeing Board in six months' time.

## 62. ADULT SAFEGUARDING STRATEGY

Sandie Keene, the new Chair of the Rotherham Safeguarding Adults Board, was welcomed to the meeting and her new role in the Borough. Sandie had submitted the Rotherham Safeguarding Adults Board's Strategy 2016-2019. She welcomed Rotherham's keen commitment to Safeguarding.

Sandie described her priorities for the coming months: -

- Review and re-energise the Rotherham Safeguarding Adults Board;
- The review had demonstrated some good practice and that services were safe;
- Work to around culture and the governance frameworks that people were operating under;
- Key changes within the Care Act; the Board was now statutory although it had very little sub-structure;
- Getting nominees and finding dates was a challenge;
- Developing the Constitution meant that a budget was required.
- Bringing the public in and hearing their voice: - co-production, how was it for them? What could be done better next time? Public awareness: – do people know what the Board was here for? Differences between Adults and Children's Safeguarding Boards;

- Care Act Policy 'Making Safeguarding Personal' and Deprivation of Liberty Living Standards (DOLLS). Monitoring standards in care homes in a multi-agency way;
- Adult Exploitation relating to learning difficulties and mental health;
- Self-neglect;
- Co-ordination of responses;
- Learn lessons and be transparent;
- Performance framework and management information. South Yorkshire Police had offered to lead;
- Care homes located in Rotherham but did not have Rotherham residents in them.

Discussion followed Sandie's presentation and the following issues were raised: -

- Councillor Roche was witnessing cultural change and could see an impact following recent conversations with whistle blowers;
- Councillor Roche was concerned about the 1,669 reports of abuse within care homes;
- Councillor Roche referred to the early warning system relating to care homes that were becoming a concern. Some related to homes that were not controlled by the Council.
    - Sandie confirmed the monitoring the homes and actions being taken to support improvements in those homes would continue. Commissioning and contracting would be ongoing improvement actions;
    - Graeme Betts knew the Contract Compliance Team to be thorough and robust. They received information from Safeguarding;
    - Julie Kitlowski saw a role for Health in providing early warnings of issues;
    - Chris Edwards explained how there had been changes in the way that the CCG allocated care homes to GPs. One GP Practice was allocated to one care home, meaning there would be consistency in monitoring;
    - Tony Clabby referred to a strong use for soft intelligence and the power of Healthwatch to enter and view homes and escalate if necessary.
- Governance of the report should be undertaken on a multi-agency basis and the report considered and supported by Rotherham's Cabinet to demonstrate the organisation's commitment to safeguarding.

Resolved: - That the information shared be noted.

## 63. TRANSFORMING SERVICES FOR PEOPLE WITH A LEARNING DISABILITY AND/OR AUTISM

Kate Tuffnell, Head of Contracts and Service Improvement, MH, LD and EOLC, presented an update on the NHS England Learning Disability Transforming Care Partnership Programme and the implications for the Rotherham CCG, Council and partner organisations.

Key things to note about the programme included: -

- It was a population based approach which expeceds CCGs, LAs and NHS England specialised hubs to work together to look at what services were needed for the local population with a learning disability and/or autism across a TCP footprint area;
- It was a three year programme that focused on the provision of services to children, young people and adults;
- It was essential that as part of the TCP plans that the CCGs identify how they intend to extend their offer of Personal Health Budgets (PHB) for people with a Learning Disability beyond the current offer within CHC;
- It needed to be about Service transformation and pathway re-design (investing in preventative services/early intervention in the community) – not just 'resettlement' of current inpatients into the community;
- Rotherham was included in the Doncaster, Rotherham, North Lincolnshire and Sheffield TCP footprint in which Chris Stainforth; Doncaster CCG had been identified as the Senior Responsible Officer (SRO) and Phil Homes, Director of Adult Services Communities Portfolio, Sheffield City Council.

The timescale to implementation as currently planned: -

| | |
|---|---|
| 25th January 2016 | Finance & Activity template submission to Doncaster CCG (local milestone) |
| 26th January 2016 | External Consultant Health Needs Assessment Workshops – funded by NHS England |
| 8th February 2016 | First Transforming Care Partnership (TCP) Plan submission |
| 9th February 2016 | NHS England Expert panel reviews against the assessment framework |
| 11th February 2016 | NHS England feedback collated to be shared with local TCPs |
| 15th & 16th February 2016 | NHS England will facilitate a discussion with the local panel for clarification, request further information etc. |
| 22nd February 2016 | Revised TCPs to be resubmitted to the NHS England Regional office |

| | |
|---|---|
| 24th February 2016 | Local TCP Plans to be reviewed for by NHS England Regional panel for sign-off. Potential outcomes – approved, approved with required revisions, not approved (it will then be escalated to the national team ) |
| 24th March 2016 | NHS Contract signature date |
| 11th April 2016 | Implementation to commence (3 year programme from this date) |

Discussion followed on the update: -

- Councillor Roche asked for a language check to be undertaken on the document;
- Would a member/representative of Children's Services be asked to join the Board?;
- There was concern that the Operational Board could be committing the Council to actions;
- Tony Clabby was uncomfortable with the concept of the Partnership working where there were different thresholds in use;
- Tony asked whether the governance structures would include patient or carer voice?
    - Kate explained that this had not been embedded yet; SpeakUp were informing this nationally and the Learning Disability Commissioning Executive would also be involved.

Resolved: - (1) That the work undertaken to date within the timescale be noted.

(2) That the Health and Wellbeing Board delegate the sign-off of the final plan to the Chair and Vice-Chair of the Health and Wellbeing Board.

## 64. ROTHERHAM DEMENTIA ACTION ALLIANCE CO-ORDINATOR

Councillor Roche referred to the Rotherham Dementia Action Alliance and referred to their excellent work. The organisation had submitted a proposal for continued funding.

Councillor Roche noted that this could not be achieved by the Health and Wellbeing Board but asked attendees to take the proposal and consider how the organisations they represented could can help and support it.

## 65. ROTHERHAM GET ACTIVE EVENT

Councillor Roche referred to the draft agenda for the 'Rotherham Get Active' event planned for 11th May, 2016. The event would explore the role that sport and physical activity played in improving the health outcomes and wellbeing of people in Rotherham. Councillor Roche noted

that the keynote speaker, Karen Creavin, had been involved in developing physical activity initiatives in Birmingham and would hopefully be able to share her experiences and inspire the delegates.

**66. DATE, TIME AND VENUE OF THE NEXT MEETING AND FUTURE DATES FOR AGREEMENT**

Resolved: - (1) That a further meeting be held on Wednesday 20th April, 2016, commencing at 9.00 a.m. to be held at Oak House Bramley.

(2) That future meeting dates take place on: -

- 2nd June, 2016;
- 13th July, 2016;
- 21st September, 2016;
- 16th November, 2016;
- 11th January, 2017;
- 8th March, 2017.