HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 31st May, 2017**

Time: **9.00 a.m.**

A G E N D A

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

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

3. Apologies for absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Communications/Updates

7. Minutes of the previous meeting (Pages 1 - 14)
   Minutes of meeting held on 8th March, 2017

For Discussion

8. Health and Wellbeing Strategy Action Plan and Progress Update (Pages 15 - 30)
   Terri Roche to present along with Board sponsors:-

   Mel Meggs
   Richard Cullen
   Kathryn Singh

9. Accountable Care System
   Verbal update by Chris Edwards

10. Social Care Grant
    Verbal update by AnneMarie Lubanski

11. Director of Public Health Annual Report (Pages 31 - 117)
Terri Roche to present

12. Rotherham Health Protection Annual Report 2016 (Pages 118 - 153)
Terri Roche and Giles Ratcliffe to present

For Information

13. Health and Wellbeing Board/Healthwatch/Health Select Commission - Joint Protocol (Pages 154 - 158)

14. Better Mental Health for All Strategy (Pages 159 - 187)

15. Date, Time and Venue of the Future Meeting
Meetings to commence at 9.00 a.m. on:-

5th July
20th September
15th November
10th January, 2018
14th March

Venue to be confirmed

Sharon Kemp.

SHARON KEMP,
Chief Executive.

HEALTH AND WELLBEING BOARD
8th March, 2017

Present:-

Members:-

Councillor D. Roche	Cabinet Member for Adult Social Care and Health **(in the Chair)**
Terri Roche	Director of Public Health, RMBC
Ian Thomas	Strategic Director, Children and Young Peoples' Services
Anne-Marie Lubanski	Strategic Director, Adult Social Care
Tony Clabby	Healthwatch Rotherham
Dr. Richard Cullen	Governance Lead, Rotherham CCG
Chris Edwards	Chief Officer, Rotherham CCG
Dr. Julie Kitlowski	Clinical Chair, RCCG
Carole Lavelle	NHS England
Councillor J. Mallinder	Chair, Improving Places Select Commission, RMBC

Report Presenters:-

Nathan Atkinson	Assistant Director, Adult Social Care, RMBC

Officers:-

Kate Green	Policy Officer, RMBC
Gordon Laidlaw	Communications Lead, Rotherham CCG
Dominic Blaydon	Associate Director of Transformation, Rotherham NHS Foundation Trust

Observers:-

Councillor S. Sansome	Chair, Health Select Commission, RMBC
Shafiq Hussain	Voluntary Action Rotherham
Debbie Smith	Rotherham NHS Foundation Trust
Chris Evans	Rotherham NHS Foundation Trust
J Mortimer	Rotherham NHS Foundation Trust

Apologies for absence were received from Councillor G, Watson, Sharon Kemp (Chief Executive, RMBC), Kathryn Singh (RDaSH), Superintendent Robert Odell (South Yorkshire Police), Louise Barnett (Rotherham NHS Foundation Trust) and Janet Wheatley (Voluntary Action Rotherham).

58. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at this meeting.

59. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

60. COMMUNICATIONS/UPDATES

Discussion took place on the following items:-

(1) Dr. Julie Kitlowski - retirement

Members heard that this would be the last meeting of the Health and Wellbeing Board attended by the Vice-Chair, Dr. Julie Kitlowski, who would shortly be retiring.

Members placed on record their thanks and appreciation of the work of Dr. Kitlowski for the Health and Wellbeing Board and expressed their best wishes for a long and happy retirement. Dr. Kitlowski thanked the members for their kindness and wished the Board well in the future.

It was also noted that Dr. Richard Cullen was due to be appointed to the position of Chair of the Rotherham Clinical Commissioning Group and would consequently also assume the position of Vice-Chair of this Health and Wellbeing Board.

(2) Health and Wellbeing Board – Partnership Working

The Chair reported that both the Rotherham Clinical Commissioning Group and the Borough Council has expressed satisfaction in respect of the strong partnership working being effected by the Health and Wellbeing Board and that these views were supported by the Local Government Association.

(3) Adult Care Development Programme (Better Care Fund)

Reference was made to Minute No. 68 of the meeting of the Borough Council's Health Select Commission held on 19th January, 2017 and it was agreed that the possibility of Continuing Health Care funding being included as part of the Better Care Fund should be considered initially by the Better Care Fund Sub-Group of the Health and Wellbeing Board. The Sub-Group would consider examples and cases of individuals' health care needs not being properly assessed and would report its conclusions to a future meeting of the Health and Wellbeing Board.

(4) Better Care Fund – Draft Plan 2017 to 2019

Although the Better Care Fund Daft Plan 2017 to 2019 would be considered later in the agenda of this meeting (Minute No. 64 below refers), discussion took place on whether the Daft Plan ought to be submitted to the Borough Council's Health Select Commission for consideration. It was agreed that, whilst the Draft Plan could be submitted for discussion by the Health Select Commission, the ultimate responsibility for the sign-off of the Better Care Fund Plan (before its submission to NHS England) remained with the Health and Wellbeing Board.

(5) Scrutiny of the Health and Wellbeing Board - Concordat

Arising from discussion of item 60(4) above, it was agreed that, with regard to the relationship between the Borough Council scrutiny process and this Health and Wellbeing Board, the previously agreed joint protocol between this Health and Wellbeing Board, the Borough Council's Health Select Commission and Healthwatch Rotherham will be included on the agenda for the Board's next meeting, to enable the protocol to be reviewed and clarified.

61. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting of the Health and Wellbeing Board, held on 11th January, 2017, were considered.

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

(a) (Minute 50) – all sponsors and lead officers for the Health and Wellbeing Strategy have been notified of the timetable in respect of the action plans for the five Strategy Aims being presented to the next meeting of this Board, to be held on 17th May, 2017.

(b) (Minute 50) – it was noted that a new protocol had been developed between the two Rotherham Safeguarding Boards (ie: Adults and Children's) and the Health and Wellbeing Board, the Safer Rotherham Partnership and the Children and Young People's Partnership. This protocol was currently being considered by each of the Partnership Boards and would be circulated for comment and feedback after the meeting. Comments were requested to be sent to kate.green@rotherham.gov.uk by 31 March 2017.

(c) (Minute 50) - it was noted that work was underway to identify what was currently being delivered in relation to 'all-age friendly' communities. An update on this matter would be provided at the next meeting of the Health and Wellbeing Board, to be held on 17th May, 2017.

(d) (Minute 52(4)) – Both Tony Clabby and Janet Wheatley had now been advised of the key messages for engagement in respect of the Regional Sustainability and Transformation Plan and the Rotherham Place Plan.

(e) (Minute 55) The Rotherham Carers' Strategy – the requested discussions had now taken place between the Borough Council's Adult Social Care Service and the Rotherham Foundation Trust concerning the procedures for identifying 'hidden' carers upon admission to hospital. There had also been a suggestion that the Carers' Strategy should be officially launched.

(f) (Minute 56) Rotherham Public Mental Health and Wellbeing Strategy 2017-2020 – members of the Board had been asked for nominations to join the multi-agency working group to develop the action plan for this

Strategy. A number of nominations had been received already and any others should be sent to kate.green@rotherham.gov.uk.

Resolved:- That the minutes of the meeting held on 11th January, 2017, be approved as a correct record.

62. HEALTH AND WELLBEING STRATEGY AIM 5 - HEALTHY, SAFE AND SUSTAINABLE COMMUNITIES

The Chair referred to a survey undertaken in 2011 by the former coalition Government about levels of happiness and anxiety within society. According to data held by the National Office for Statistics, Rotherham is placed in the top ten towns in the country which have the widest disparity between happiness and anxiety amongst its residents.

In that context, the Chair welcomed Mrs. Karen Hanson (Assistant Director, Community Safety and Street Scene, RMBC) and Superintendent Sarah Poolman (South Yorkshire Police), who gave the following presentation about the Health and Wellbeing Strategy Aim 5: Rotherham has healthy, safe and sustainable communities as places:-

Safer Rotherham Partnership – "Working together to make Rotherham Safe, to keep Rotherham safe and to ensure the communities of Rotherham feel safe

- Statutory partnership under the Crime and Disorder Act 1998
- Six responsible authorities (Local Authority, Police, Fire and Rescue Service, Probation Service, Community Rehabilitation Company, Clinical Commissioning Group);
- Statutory duty to develop an annual Joint Strategic Intelligence Assessment (JSIA)
- Requirement to develop and implement a partnership plan
- Safeguarding protocol linking Partnership Boards

Safer Rotherham Partnership Priorities

- Reducing the threat of child sexual exploitation and harm to victims and survivors
- Building confident and cohesive communities
- Reducing the threat of domestic abuse and harm to victims and survivors
- Reducing and managing anti-social behaviour and criminal damage
- Reducing the risk of becoming a victim of domestic burglary
- Reducing violent crime and sexual offences

Safer Rotherham Partnership Structure

- Safer Rotherham Partnership Board
- Performance and Delivery Group
- Priority Theme Groups
- Task and Finish Groups

- Other meetings and networks
  Countywide meeting
  CIMs
  Area Assemblies

Reducing Crime and Anti-Social Behaviour
- Prevention
- Early Intervention
- Development of integrated neighbourhood model
- Enforcement
- Communication

Rotherham's Local Plan
- Health is a cross-cutting theme in Rotherham's Local Plan – which guides all future development in our Borough
- The Plan includes "Promoting Healthy Communities – Good Practice Guidance" which seeks to strengthen and integrate provision for health and wellbeing within the design of new development
- It highlights key health impacts and requires the consideration of health and wellbeing in planning applications to promote healthy communities and sustainable development
- Locating shops and services in accessible areas – can promote improved walking and cycling and use of public transport
- Providing and protecting green spaces near to home – enables greater use and enjoyment of the outdoor environment
- The Local Plan also has policies on the Natural and Historic Environment, Air Quality and creating Safe and Sustainable Communities
- Examples of specific policies (development with Public Health partners)
  Promoting hot food takeaways (AP25) to limit their proximity to local schools and colleges, the impact they have on local amenity and their concentration within local areas

Opportunities for people in Rotherham to use outdoor space for improving their health and wellbeing
- Pensioners playgrounds
- New and improved children's play areas
- Allotments
- Improved changing rooms
- Tennis courts
- Footpaths
- Cycling
- Family friendly attractions
- Watersports
- Events and activities:-
  Volunteer ramblers
  Working with students
  Park runs

Walking for Health Scheme
Foot golf

Discussion took place on the multi-agency approach to improving the environment and reducing crime in the Eastwood area of Rotherham. The Board noted that the 'Eastwood Deal' had resulted in some positive changes to the local area and concentrated upon the health and wellbeing of local people as well as focusing on reducing crime. It was suggested that this approach should eventually be used in other areas of the Rotherham Borough (Dinnington was one suggestion). Later this year, in July 2017, there would be a multi-agency review of the work undertaken in Eastwood.

It was also noted that the appropriate Borough Council staff were available to attend a future meeting of the Health and Wellbeing Board for discussion of the detail of the Rotherham Local Plan.

There was also a brief mention of the continuing development of the new Waverley settlement, which will eventually include a local retail centre, a health centre and a primary school.

Other issues raised by members of the Board were:-

- serious crimes (eg: drugs, firearms, organised crime and gangs);
- selective licensing of private sector landlords (whether there was any evidence of landlords aiding and abetting crime);
- use of Police covert tactics to detect and disrupt crime;
- marches and demonstrations in the Rotherham town centre and the use of Public Space Protection Orders;
- displacement of crime from one area to another.

The Board thanked Mrs. Karen Hanson and Superintendent Sarah Poolman for their informative presentation.

It was noted that the action plans in respect of each of the aims of the Health and Wellbeing Strategy would be submitted to the next meeting of the Health and Wellbeing Board, to be held on 17th May, 2017.

63. THE ROTHERHAM PLACE PLAN

Further to Minute No. 52 of the meeting of the Health and Wellbeing Board held on 11th January, 2017, members of the Board heard that progress was being made with engagement and consultation in respect of the Rotherham Place Plan. It was noted that the governance arrangements had still to be finalised and that the aims of the Plan would have to be achieved within existing financial resources.

Resolved:- that the Rotherham Place Plan would be included on the agenda for consideration at the next meeting of the Health and Wellbeing Board, to be held on 17th May, 2017.
ACTION: Chris Edwards

64. BETTER CARE FUND

(a) Draft Plan 2017/19
Nathan Atkinson, Assistant Director of Strategic Commissioning (RMBC Adult Social Care), presented the draft version of the Better Care Fund Plan 2017-19 for information which incorporated feedback from the BCF Executive Group.

NHS England had requested a two year Better Care Fund plan covering the financial years 2017/18 and 2018/19. The intention was to "simplify the guidance and assurance process but plans are expected to be an evolution of the 2016/17 plan and not require significant rework".

The number of National Conditions would be reduced to three from 2017/18:-

- A requirement for a jointly agreed plan, approved by the Health and Wellbeing Board.
  Rotherham - All minimum funding requirements had been achieved

- Real terms maintenance of transfer of funding from Health to support Adult Social Care
  Rotherham's local plan was higher than the contribution required and there were no plans to reduce this. It continued to fund several Social Care Services which were strategically relevant and performing well, including Social Workers supporting A&E, case management and supported discharge

- Requirement to ring-fence a portion of the CCG minimum to invest in Out of Hospital services
  In Rotherham there were three admission, prevention and supported discharge pathways all supported by the Better Care Fund and backed by the wider initiatives within Rotherham's Integrated Health and Social Care Place Plan

Rotherham's BCF plan sets out key schemes, and how each would be measured and managed.

It has been confirmed that when guidance was published, a template would be issued, but that the use of it would not be mandatory. The current version had been adapted to include the recently issued guidance regarding the narrative plan. Once issued, there would be a minimum of six weeks to complete and submit the plan to NHS England.

The key priorities for 2017-19 were:-

- A single point of access into Health and Social Care Services
- Integrated Health and Social Care teams
- Development of preventative services that supported independence
- Reconfiguration of the Home Enabling Service and strengthening the seven day Social Work offer
- Consideration of a specialist reablement centre incorporating Intermediate Care
- A single Health and Social Care Plan for people with long term conditions
- A joint approach to care home support
- A shared approach to delayed transfers of care (DTOC)

Discussion took place on the importance of assisting individuals in the self-management of conditions, without necessarily having recourse to personal budgets.

Members of the Board were asked to contact Nathan Atkinson and Karen Smith (RMBC Adult Social Care) with any further comments they wished to make on the draft Plan.

Resolved:- (1) That the current iteration of the daft Better Care Fund Plan 2017-2019 and the strategic direction be noted.

(2) That the formal approval of the Better Care Fund Plan 2017-2019 shall be delegated to the Better Care Fund Executive Group of this Health and Wellbeing Board.

(b) Better Care Fund Quarter 3 Submission (2016/17)
Nathan Atkinson, Assistant Director of Strategic Commissioning (RMBC Adult Social Care), presented the quarterly report to NHS England regarding the performance of Rotherham's Better Care Fund in 2016/17.

Rotherham was fully meeting seven out of the eight national conditions:-

1. Plans were still jointly agreed between the Local Authority and the Clinical Commissioning Group.

2. Maintaining provision of Social Care Services (not spending).

3. A joint approach to assessments and care planning were taking place and, where funding was being used for integrated packages of care, there was an accountable professional.

4. An agreement on the consequential impact of changes on the providers that were predicted to be substantially affected by the plans.

5. Agreement to invest in NHS commissioned out-of-hospital services.

6. Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan.

7. Seven day Social Care working was now in place and embedded at the hospital with on-site Social Care Assessment available to support patients. This had become “business as usual” from 3rd October, 2016, following the implementation of a Social care restructure. Support over the full seven days was provided by the same core team, ensuring that there was consistency of process over this period. Additional support over and above the dedicated resources identified could be accessed through the out of hours service on an as needed basis.

Rotherham was currently partly meeting one out of the eight national conditions which comprised of two elements as follows:-

a. The first element (which was fully met) included better data sharing between Health and Social Care, based on the NHS Number (NHSN). This was being used as primary identifier for Health and Social Care Services Work was now complete to ensure better sharing between Health and Social Care. There were 5,495 adults who were in the scope of the NHSN matching project and all BCF records now had a NHS number assigned. The new Social Care system would go "live" on 13th December, 2016, and included the facility to integrate with the NHS ‘Patient Demographic Service’ (PDS) – which would deliver the ability to quickly look up NHS numbers on the NHS spine. The NHSN number would be used on correspondence when the new Liquidlogic system was "live".

b. The second element (which was partly met) was around better data sharing including whether we ensure that patients/service users have clarity about how data about them is used, who may have access and how they can exercise their legal rights. This second element of the national condition has recently been introduced since August 2016.

Significant progress was underway with an expected full implementation date of 31st May, 2017, to ensure that it fully met the national condition. The original date for full implementation was 31st January, 2017. The reasons behind the delay were set out in the report submitted.

A series of individual "deep dive" service reviews on BCF schemes was underway which would identify if there were any funding or performance issues or where there were concerns regarding strategic relevance.

Resolved:- (1) That the Better Care Fund Quarter 3 Submission (2016/17), as now submitted, be approved.

(2) That further information be provided for members of the Health and Wellbeing Board about data sharing between health and social care services.

65. ROTHERHAM JOINT COMMISSIONING STRATEGY FOR CHILDREN AND YOUNG PEOPLE WITH SPECIAL EDUCATIONAL NEEDS AND/OR DISABILITIES (SEND)

The Strategic Director for Children and Young People's Services presented the Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND). The Strategy provided an overview of how the joint commissioning of services for children and young people with SEND in Rotherham would be developed and implemented in line with the requirements of the Children's and Families Act 2014 and the associated Code of Practice for SEND.

The Strategy, through a mapping exercise, consultation and a review of transitions with parents/carers and stakeholders, had identified nine priority areas of work that would be implemented over the next three years:-

1. Create a joint SEND Education, Health and Social Care Assessment hub at Kimberworth Place.

2. Review and re-model services that provided support for children and young people with challenging behaviour.

3. Develop a Performance and Outcomes Framework that would be applied across all local authority and CCG SEND provision.

4. Align local authority and CCG Service Specifications for SEND Service provision, to facilitate commonality of practice and a consistent approach (thus reducing duplication, improving efficiencies and develop clearer pathways).

5. Audit the Education, Health and Care Planning (EHCP) process to look at how the assessment process (including the decision making process/panels and allocation of resources) could be streamlined, so as to reduce the multiple assessments that young people and their families had to undertake.

6. Ensure that there was a co-ordinated joint Workforce Development Plan.

7. Develop and implement Personal Budgets.

8. Develop pathways to adulthood.

9. Develop approaches to improving life experiences which were person centred.

The Strategy had been previously approved by the Clinical Commissioning Group's Operational Executive, the Council's Children and Young People's Services leadership team and the Children and Young People's Partnership Board, and endorsed for sharing with the Health and Wellbeing Board.

The full implementation of the Strategy would require a phased approach to move from the current position. Work had already commenced in taking forward a number of the priority areas, namely the creation of a joint SEND Assessment Hub, the re-modelling of services that provided support for children and young people with challenging behaviour, the development of personal budgets, the development of aligned Service Specifications for Education, health and social care services, and the development of pathways to adulthood.

Resolved:- That the refreshed Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND) be noted.

66. SPECIALIST RESIDENTIAL AND NURSING CARE FOR ADULTS IN ROTHERHAM

In accordance with Minute No. 50(3) of the meeting of this Board held on 11th January, 2017, the current position with regard to commissioned Care homes in Rotherham was submitted. The scope of the update included Residential, Nursing, Residential with Dementia Care and Nursing with Dementia Care for Adults i.e. 18-64 and older people.

There was a total of thirty-five independent sector care homes (owned by twenty-three organisations) contracted to support older people in Rotherham. They provided a range of care types categorised as Residential Care, Residential Care for people who were Elderly and Mentally Infirm, Nursing Care and Nursing Care for people who were Elderly and Mentally Infirm.

There was a total of thirty-six Independent sector homes (owned by twenty-four organisations) contracted to support Adults with specialist needs. They provided a range of care for Adults who lived with Learning Disabilities, Physical Disabilities, Mental Health and Sensory conditions (including Acquired Brain Injury).

The independent sector care home market in Rotherham supplied 1,779 beds and accommodated around 1,593 older people. The Council was the dominant purchaser with the majority of the population placed by the Council. There was currently a vacancy factor of 186 beds or 10.5% of the total capacity. It also supplied 397 beds and accommodated around 386 adults with specialist needs. The Council purchased 37% (145 beds) with the remaining 63% (252) beds occupied by residents who were fully funded by Continuing Health Care and Out of Authority places. There was currently a vacancy factor of 31 beds (8%) of the total capacity.

As of February 2016, the total Older People's care home population was made up of:-

- 26% (409 people) private paying clients including from out of Borough.
- 4.5% (72 people) placed and funded by other local authorities.
- 62% (987 people) placed and funded by the Council – this includes
- people who receive Funded Nursing Care.
- 7.5% (125 people) placed and funded by our health partners under
- Continuing Health Care arrangements (fully funded by Rotherham CCG).

As of February 2016, the specialist care home population placed by the Council was made up of:

- 21% (31 people) funded fully by the Council (no client contribution) – this included people who received Funded Nursing Care.
- 7% (10 people) jointly funded by the Council and Continuing Health Care.
- 72% (104 people) funded by the Council and a financial contribution from the service user.

All Council commissioned providers were registered with, monitored and inspected by the Care Quality Commission (CQC) as well as monitored and inspected by a team of Contracting Compliance Officers. Providers were monitored against standards set out in the Council's service specification(s) and the associated contract(s) terms and conditions. Deviation away from the standards resulted in intervention with providers which may include action plans, special measures improvement plans, contract default action and/or embargoes. Action undertaken by the Strategic Commissioning Team may ultimately result in contract termination should providers continue fall below the required standard.

All Older People's care homes were fully aligned to GP practices to provide medical cover for residents in older people's care homes.

A question was asked about the number of out-of-authority residential placements and it was agreed that a response would be provided.

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

67. LONELINESS AND ISOLATION

The Chair opened a discussion about the impact of loneliness and isolation upon the mental and physical health of individuals. Specific reference was made to:-

- the incidence of early deaths amongst sufferers of loneliness and isolation;

- community support projects/schemes (eg: Men-in-Sheds; Home First);

- the suggestion of a survey being undertaken of persons within the Rotherham Borough area who suffer loneliness and isolation;

- identifying the extent of service provision and any gaps in such provision – as well as the possible reluctance of lonely and isolated people to gain access to appropriate advice and assistance.

The Health and Wellbeing Board noted the intention to establish a Working Group to examine this issue further. A number of members of the Board expressed a willingness to contribute to this Working Group. The Chair asked for nominations to be sent by e-mail to kate.green@rotherham.gov.uk

68. ROTHERHAM CAMHS LOCAL TRANSFORMATION PLAN - QUARTER 3 REPORT 2016-17

The Board received the Quarter 3 update for the CAMHS Local Transformation Plan for information.

The Plan continued to be closely monitored and updated on a bi-monthly basis and was now published on the NHS Rotherham Clinical Commissioning Group website alongside the Local Transformation Plan (LTP) itself. It reflected all the proposed developments in the 'Future in Mind' report and went behind the specific priority development areas outlined in the Local Transformation Plan and to which extra funding was attached.

Further detail on each local priority scheme was set out in the report submitted.

All of the priority schemes had started their implementation in 2015/16. There were a number of other identified areas for development, which were included in the CAMHS LTP Action Plan, scheduled to start in 2017/18 or beyond. These included:-

- Undertaking a scoping exercise to understand if the 'Thrive' model or something similar could be developed in Rotherham.
- Undertaking a scoping exercise to understand how 'One-stop-shops' could be developed in Rotherham.
- Implementing a Social Prescribing Service during 2017/18 to support children and young people who transition out of CAMHS services but not into Adult Services. This would involve new funding from the LTP monies.
- A new service to be developed from 2017/18 providing education and prevention around self-harm. This would probably be delivered in school settings by voluntary sector CAMHS providers. Specific details were being developed and new LTP funding would be allocated to this area.

The report also set out the areas of most challenge in implementation, finance and activity review and review of partnerships.

It was also noted that the Clinical Commissioning Group's duty to publish an annual engagement report would be fulfilled by including the necessary information within the standard Annual Report.

Resolved;- That the report be received and its contents noted.

69. DATE, TIME AND VENUE OF THE FUTURE MEETING

Resolved:- (1) That the next meeting of the Health and Wellbeing Board be held on Wednesday, 17th May, 2017, with the venue to be confirmed.

(2) That future meetings of the Board take place on: -

- 5th July, 2017
- 20th September, 2017
- 15th November, 2017
- 10th January, 2018
- 14th March, 2018

All meetings to start at 9.00 a.m. and venues to be confirmed.

REPORT FOR HEALTH AND WELLBEING BOARD

Date of meeting:	**31 May 2017**
Title:	**Health and Wellbeing Strategy – action plan and progress update**
Directorate:	**Assistant Chief Executive's / Public Health**

1. Background

The second health and wellbeing strategy was published in September 2015, having been produced in collaboration with all the Health and Wellbeing Board partners.

The intention of the strategy was to provide a framework to direct the Health and Wellbeing Board (HWbB) activity over the three years between 2015-18; supporting the board's role to provide leadership for health and wellbeing by making the most of collective resources in the borough. The strategy was not intended to, however, reflect everything that the board should consider or that the partners would deliver over the three years.

The strategy includes 5 strategic aims and since the strategy was published the board has received progress reports for each one individually from the identified board sponsor.

This report now provides the board with the full suite of action plans for each aim (appendix A), to consider activity which is taking place or planned, to challenge and influence the plans going forward, and to discuss where the board can add additional value.

As a reminder of the original intention of the strategy and subsequent action plans to deliver the aims, the underpinning principles are set out below:

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

- All services need to be accessible and provide support to the right people, in the right place, at the right time

2. Key Issues

At the time of re-writing the health and wellbeing strategy in 2015, the council and other parters were undergoing a period of significant change, as a result of this the wider strategic partnership and various partnership structures and boards were also refreshed, including the HWbB. The 2015 strategy therefore was the new board's first jointly produced document and although was appropriate at the time, a number of national and local agendas and plans have changed the landscape and there may be a need to refresh the strategy to ensure it remains fit for purpose and relevant in the current context.

Since 2015 the HWbB has been working well; partnerships are considered vastly improved and the partner representatives around the table are working in a cohesive way to improve health and wellbeing outcomes for local people. The board is now in a stronger position to consider what the real challenges are locally, and how they can best work together to add value.

Recently, there have been a number of national strategic drivers influencing the role of local health and wellbeing boards:

Sustainability and Transformation Plans (STPs), bring together the NHS and local councils to develop proposals to make improvements to health and care over a regional footprint (South Yorkskshire and Bassettlaw). Local HWbBs do not have direct responsibility for delivering these plans, but STPs should build on the work of the local HWbBs, Joint Strategic Needs Assessments and health and wellbeing strategies across their region.

Rotherham's Integrated Health and Social Care Place Plan (the Place Plan), was published November 2016, and details the joined up approach to delivering five key initiatives that will help achieve the health and wellbeing strategic aims and contribute towards meeting the region's STP objectives. The HWbB has a key role in the delivery of this plan.

Better Care Fund (BCF) is a government Initiative to create a single joint budget to incentivise the NHS and local government to work more closely together. Although this work has been on-going sincebefore 2015, the plan was refreshed during 2016 to reflect the strategic aims within the health and wellbeing strategy. The HWbB has responsibility for overseeing and signing off this plan locally, which is delegated to the chair of the HWbB via an executive sub-group.

There are also a number of local strategic plans and partnerships which have been refreshed or re-written over the previous two years, which align to the HWbB and strategy, including:

The Rotherham Plan (Rotherham Together Partnership's local plan) was published in March 2017 and includes five 'game changers', which are the most important things local partners – working through the Rotherham Together Partnership (RTP) – will do over the next few years to help improve Rotherham as a place and make life better for local people. Integrated health and social care is one of them, and the HWbB and health and wellbeing strategy has a key role to play in helping to deliver this.

Children and Young people's Strategic Partnership was re-established during 2016 and a new plan was published, demonstrating how they will contribute towards delivering the strategic aims of the health and wellbeing strategy relevant to childen and young people (aims one and two).

The Safer Rotherham Partnership published a new plan during 2016, which includes actions that will contribute towards delivering one of the health and wellbeing strategy's strategic aims in relation to safer communities (aim five).

The Local Safeguarding Partnership Protocol describes the relationships between the two safeguarding boards for adults and children and other key partnership boards, including the HWbB. It sets out how the boards will work together to ensure consistency and mutual challenge and to avoid duplication in local plans. This will help ensure that going forward the HWbB picks up local issues in relation to safeguarding and is able to consider how its strategy can contribute towards achieveing better outcomes.

It is now suggested there is a need to consider all of the above and look to streamline the health and wellbeing strategy, ensuring the HWbBs key roles and functions are delivered in the most appropriate way, including how the board is able to influence other agendas, plans and strategies. There is no suggestion that the current strategy's five aims should be changed; they all remain relevant and a priority for the board, but there may be a need to consider a more strategic approach and a reduced number of actions in its next iteration, which align clearly and appropriately with the HWbBs strategic drivers.

3. Key actions and relevant timelines

3.1 Strategic aims

The strategy includes five strategic aims, all of which have a detailed action plan setting out the activity which will contribute toawards delivering the objectives.

Aim 1. All children get the best start in life

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

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

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

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

To develop these plans, and consider what activity was required across the partnership to achieve the objectives, a number of workshops took place throughout 2016 for aims 1 to 4 (there was no workshop for aim 5, activity for this plan was developed from other exisiting plans, including the Safer Rotherham Partnership Plan).

The outcome of each workshop was a number of key themes for each aim, which the lead officers and board sponsors, working with other relevant stakeholders, worked up into actions.

The action plan included with this report sets out activity for 2017-18, with the strategy initially being published September 2015, it is intended that a new strategy is not required until the end of 2018. However the board may consider an earlier refresh (not full re-write) to take into consideration the context set out above.

The full action plan is included as appendix A.

3.2 Performance reporting

The strategy also includes a suite of indicators aligned to each of the strategic aims and objectives. These are included in the attached appendix B. The board is asked to consider whether this is a useful document to share with the board on a regular baisis (to be agreed).

It is suggested however that to ensure quality focus on performance at board level, the indicators could be reviewed and reduced to a smaller number, aligned to the strategy's priorities and key actions, including those included in other relevant plans such as Place Plan and Better Care Fund Plan.

4. Recommendations to Health and Wellbeing Board

- To review the action plans for each aim, providing challenge where needed and considering how the board can add value going forward.
- To consider the content of this report (under key issues) in relation to the role of the HWbB and how the strategy should be refreshed to best reflect this.
- To agree timescales for bringing a progress report back to the board and refreshing the strategy.
- To consider the role of the board in performance monitoring and how best to share and update on key performance indicators.

5. Name and contact details

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Health and Wellbeing Strategy
Action Plan 2017-18

The health and wellbeing strategy sets the strategic direction of the local Health and Wellbeing Board.

This plan demonstrates the actions which are being delivered to contribute towards each of the five strategy aims for the years 2017 and 2018.

Aim 1	**All children get the best start in life**
Aim 2	**Children and young people achieve their potential and have a healthy adolescence and early adulthood**
Aim 3	**All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life**
Aim 4	**Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing**
Aim 5	**Rotherham has healthy, safe and sustainable communities and places**

RAG rating

GREEN	Complete
AMBER	On track
RED	Not likely to be completed on time/issues or concerns
BLUE	Not yet started

Aim 1: All children get the best start in life

Board sponsor: Ian Thomas, RMBC
Lead Officer: Karla Capstick, RMBC

Health and wellbeing objective	Action/s	Lead/s	Timescale	Progress to date	RAG
1. Improve emotional health and wellbeing for children and young people **2. Improve health outcomes for children and young people through integrated commissioning and service delivery**	Refresh and re-establish a 'Best Start Partnership' to include representatives from Health, Early Help, Early Years, Public Health, CCG, Child Development Centre, Disability Services, Education and the Voluntary Sector	Karla Capstick, CYPS	Jan-17	Workshop took place January 2017 which identified all the key stakeholders/partners and nominated leads from each to form the partnership. Discussions began around shared understanding of 'best start' and how the group could address the 3 objectives in the strategy.	G
	Best Start Partnership to meet for the first time officially in May 2017	Karla Capstick, CYPS	May-17		A
	Best Start Partnership to agree appropriate methodology and then consult with Rotherham parents, children and young people to develop a shared understanding of … What is 'a best start in life'? What do we mean by 'happier'? What is 'emotional health'? What does 'school readiness' look like?	Karla Capstick / BS Partnership (with advice from Emma Hollingworth, Comms.)	May-17		A
	Use and develop the good practice developed by Education and Skills for schools on definition of 'school readiness'	Jane Moore, CYPS	May-17		A
	Launch consultation period June - August 2017 and publish findings.	Karla Capstick, BS Partnership	Sep-17		A
3. Ensure children and young people are healthier and happier	Reduce the number of parents (and significant others) smoking during pregnancy and immediately after birth by having a quit smoking support offer in each childen's centre across the borough, to include:	Sue Smith, Public Health (PH) / Emma Royle, CCG	TBC	Pathway development underway.	A
	a. Working with midwifery and Yorkshire Smoke Free to ensure appropriate pathways are developed and a voucher scheme put in place.				
	b. Training nominated staff from each children's centre (and health practitioners) to offer quit smoking support in the community.	Ann Berridge / Sue Smith, PH	May-17	Training being delivered April/May 2017	A
	c. Offering additional opportunity to pregnant women and their significant others to attempt to quit smoking for those who 'opt-out' of the midwifery pathway or who lapse at any point.	Karla Capstick, CYPS	TBC	Will commence once training is complete.	A
	Work across the partnership and with national children's sleep charity to bid for additional funding from the early Years Social Action Fund - to develop a pool of volunteers to support improved sleep and therefore improved emotional and mental health for parents and children.	Vicky Dawson / Karla Capstick, CYPS	TBC	Pending funding	B

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

Board sponsor: Ian Thomas, RMBC
Lead Officer: Shafiq Hussain, VAR & Teresa Brocklehurst, CYPF Consortium

Health and wellbeing objective	Action/s	Lead/s	Timescale	Progress to date	RAG
1. Reduce the number of young people at risk of child sexual exploitation	HWbB to support the delivery of the CSE sub-group (of the Local Safeguarding Childen Board) plan.	Chair of the CSE sub-group (currently Gary Ridgeway until mid-summer 17)	Mar-18		A
2. Reduce the number of young people experiencing neglect	To improve workforce understanding of the key characteristics of neglect in Rotherham. To provide staff with the tools and skills to intervene effectively, so that less children are placed on CP plans due to neglect	Mel Meggs, Safeguarding Board	Sep-17	Commencing September 2017	B
	To improve our understanding of the characteristics of neglect in Rotherham by completing a multi-agency 'deep dive' into a sample of cases	Mel Meggs, Safeguarding Board			
	To improve our understanding of what works to reduce neglect by testing different interventions such as: - Troubled families - Multi-systemic therapy (can train workforce to deliver interventions)	Mel Meggs, Safeguarding Board			
	To improve joint working between adult / children's workforce. Addressing the 'toxic trio': drugs/alcohol, mental health and domestic abuse.	Mel Meggs, Safeguarding Board			
3. Reduce the number of young people who are overweight and obese	Review of current children's weight management pathway to streamline it and target those children that need help the most. This will be linked in with public health nurses and children's centres/early help, regarding healthy eating and weaning messages using evidence based programmes such as HENRY (health, exercise and nutrition for the really young). This will be ongoing work with the 0-19 service and early help.	Jacqui Wiltschinsky, Public Health	May-17	Following a review of obesity services, consultation on the redesign of the children's obesity pathway is underway with service providers, linking with CCG commissioner. Also look at whether the pathway can incorporate the NCMP in light of the new 0-19 commissioned service.	A
4. Reduce the risk of self-harm and suicide among young people	Continue to implement the Rotherham Suicide Prevention and Self Harm Action Plan 2016- 2018. The HWbB receives annual updates with the next update due in July 2017. The Rotherham Suicide Prevention and Self Harm Group have been working with young people in Rotherham to develop a mental health campaign which will be launched in the summer. Also included under aim 3.	Jo Abbott/ Ruth Fletcher-Brown, Public Health	Mar-18	100 frontline staff attended the Safe Talk suicide prevention course in March 2017. This training targeted people who worked with/cared for young people.	A
5. Increase the number of young people in education, employment or training **6. Reduce risky health behaviours in young people** ***(these objectives were considered as a theme around raising self-esteem)***	All HWb partners to commit to increasing numbers of apprenticeships in their organisations which are available to young people in Rotherham, including care leavers.	Ian Walker, RMBC	Mar-18	HWb partners to consider this action at its May meeting.	B
	Different but Equal' Board (young people's sub group of the Voice and Influence partnership) to plan an event for young people, which will look at being proud of Rotherham/becoming a child friendly borough/heritage bid, and can also include informaton about the strategy's objectives (i.e. risky health behaviour, self-harm, CSE)	Teresa Brocklehurst, CYPF Consortium	Jul-17	The Different but Equal Board (DbEB) meeting regularly to plan the 27/7 young people (YP) event. DbEB acts as a support mechanism for YP & a conduit for consulting & involving a representative group of YP on a range of initiatives.	A
	Produce set of recommendations following the Different but Equal Board's event in July - to address the strategy's objectives.	Teresa Brocklehurst, CYPF Consortium	Sep-17		B

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

Board sponsor: Kathryn Singh, RDaSH
Lead Officer: Ian Atkinson, CCG

Health and wellbeing objective	Action/s	Lead/s	Timescale	Progress to date	RAG
1. Improve support for people with enduring mental health needs, including dementia, to help them live healthier lives	To increase levels of dementia diagnosis within the community setting by introducing primary care diagnosis in every GP practice.	Ian Atkinson, Rotherham CCG	Mar-18	Diagnosis taking place in 21 of 31 practices	A
	Delivery of national targets for Improving Access to Psychological Therapies (IAPT)	Ian Atkinson, Rotherham CCG	Mar-18	6 waiting week and 18 waiting week targets currently being achieved (April 2017)	A
	Delivery of national diagnosis and treatment targets for patients experiencing psychosis (Early intervention Psychosis)	Ian Atkinson, Rotherham CCG	Mar-18		A
	Implementation of the CAMHS Transformational Plan by 2019.	Ian Atkinson, Rotherham CCG	3-year plan (2017/18 year 2)	CAMHS action plan on track at q4 16-17	A
2. Reduce the occurrence of common mental health problems	Roll out Making Every Contact Count model (see aim 4)	Giles Radcliffe, Public Health	See Aim 4 detail	See Aim 4 detail	A
	Continue to deliver the Rotherham Suicide Prevention and Self Harm Strategy. The HWbB receives annual updates with the next update due in July 2017.	Jo Abbott / Ruth Fletcher-Brown, Public Health	Mar-18	Strategy presented to board June16, progress report due July 17. Young people's mental health campaign (May 2017), Safe Talk suicide prevention training (100 frontline workers), Samaritans pilot	A
	Development of 'Better Mental Health for All'; Rotherham's strategy for promoting mental health and wellbeing.	Ruth Fletcher-Brown, Public Health	Sep-17	Strategy presented to HWbB Jan 17 Action plan now in development.	G
3. Reduce social isolation	Continue to roll out Rotherham Social Prescribing for Mental Health - aim to discharge from mainstream services, support individuals in their community and reduce social isolation.	Ruth Nutbrown, RCCG / Janet Wheatley, VAR	March 18 review	Positive evaluation of social prescribing	G

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

Board sponsor: Dr Richard Cullen, CCG
Lead Officer: Giles Ratcliffe, RMBC Public Health

Health and wellbeing objective	Action/s	Lead/s	Timescale	Progress to date	RAG
1. Reduce the number of early deaths from cardiovascular disease and cancer **2. Improve support for people with long term health and disability needs to live healthier lives** **3. Increase the opportunities for participation in physical activity** **4. Reduce levels of alcohol-related harm** **5. Reduce levels of tobacco use**	Roll out Making Every Contact Count (MECC) model in Rotherham, including: - Develop online training tool - Establish steering group with key stakeholders inc. CCG, GPs, RMBC, voluntary and community sector - Develop 'train the trainer' resources and begin roll-out of training	Giles Ratcliffe, Public Health (PH)	Oct 17 Jan 17 Jul 17	Researched training tools from neighbouring authorities and investigating training platform options with IT. 'Virtual' steering group of external partners established January 2017. A further RMBC internal group established May 2017. Resources in development and internal champions being identified through May.	A
	Ensure all statutory and provider organisations are prioritising workplace health and wellbeing and aiming for the Workplace Wellbeing Charter by Jan 18	Jacqui Wiltschinsky, PH	Jan-18	RMBC aiming for December 2017. Rotherham Foundation Trust currently working towards the charter. Further work to engage provider organisations.	A
	Incorporate MECC tools and approach into Workplace Charter	Jacqui Wiltschinsky, PH	Jan 18 onwards	This will follow roll-out of MECC training and resources in July 2017	A
	Develop a network of care 'navigators' within priority communities of Rotherham, including the training and upskilling of relevant staff (action included in the 5yr Forward View).	Richard Cullen, CCG	TBC		B
	Review the existing health trainer offer to ensure increased prioritisation of health behaviour change across the borough, and alignment, where possible, with the neighbourhood working model for Rotherham (currently being developed). (health trainers will become part of the wellness service to be commissioned from April 2018)	Jacqui Wiltschinsky, PH	Apr-18	Further service reorganisation underway to prioritise working in areas of high deprivation. From April 2018, health trainers to be part of Wellness Service, which will have outcomes and KPIs focused on reducing inequalities and prioritising areas of disadvantage.	G
	Undertake equity audit of public health services in relation to identified priority communities	Giles Ratcliffe, PH	Jan-17	Audit and analysis complete - paper being produced for RMBC management and health and wellbeing board	G
	All health and wellbeing (HWb) partner organisations to undertake equity audits of services, ensuring the HWb system is delivering equitable services across the borough.	Each organisation to nominate lead	Mar-18	Findings of PH equity audit to be shared with HWb board by August 2017, with intention to encourage other organisations and RMBC directorates to do the same.	A
	Request the Knowledge Service undertakes a review of the evidence of different measures' effectiveness in addressing health inequalities.	Giles Ratcliffe, PH	Oct-17	Scheduled	A
	Health checks to become part of the Wellness Service which will be commissioned in 2018 in a way that ensures appropriate targeting of health checks to relevant communities.	Anne Charlesworth, PH	Apr-18	Specification in development and on target	A
	Establish a task and finish group to look at self-care and the appropriate actions needed.	BCF/PH/ASC/CCG	TBC		B
	Commission the Wellness Service to support self-care amongst communities and help people make behaviour/lifestyle changes.	Anne Charlesworth, PH	Apr-18	On track	A

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

Board sponsor: Rob Odell, SY Police
Lead Officer: Karen Hanson, RMBC

Health and wellbeing objectives	Action/s	Lead/s	Timescale	Progress to date	RAG
1. Develop high quality and well-connected built and green environments **2. Ensure planning decisions consider the impact on health and wellbeing**	Planning policies in the Local Plan aim to create sustainable quality development and: - Require the creation of safe, accessible and well-managed places, buildings and public spaces - Protect and enhance the borough's green infrastructure and recreation facilities to help improve the health of Rotherham's population - Protect green infrastructure corridors across the borough and ensure green spaces are provided near to new homes	Bronwen Knight, RMBC	Adoption of the Local Plan spring 2018	New policies to be used to guide development following adoption of Local Plan	A
	Health is a cross-cutting theme in Rotherham's Local Plan, which guides all future development. Planners have also developed "Promoting Healthy Communities" good practice guidance, which provides for health and wellbeing in new development through health impact assessments and consideration of health and wellbeing through the planning application process.				
3. Increase opportunities for people in Rotherham to use outdoor space for improving their health and wellbeing	Pursue initiatives to sustain provision of good quality outdoor space close to where people live, in the context of falling local authority budgets. These may include enabling voluntary/community management of sites (e.g. through asset transfers), generation of additional income to support continued service delivery, and application of Community Infrastructure Levy for green space improvements.	Steve Hallsworth, RMBC	2017-2020	Will be looked at as part of a new cultural strategy and subsequent plans for green spaces/leisure.	B
	Seek opportunities to develop and deliver campaigns and activity programmes aimed at promoting people's use and enjoyment of indoor and outdoor space to improve physical and mental health and wellbeing.	Steve Hallsworth, RMBC	2017-2020	During 16/17 appx 26 new walk leaders trained locally and a number of walking groups are set up: Herringthorpe Thomas Rotherham College KImberworth Park Tasibee Asians Women's Group Rotherham Cancer Survivors group Love Later Life Run (Age UK) took place in May inc. 55 people from Active for Health Programme. Promoting One You campaign acros wider partnership.	A
4 Increase the number of residents who feel safe in their community **5. Reduce crime and anti-social behaviour in the borough**	The HWb board to support the delivery of the local Safer Rotherham Partnership (SRP) Plan and its vision to: *Work together to make Rotherham safe, to keep Rotherham safe and to ensure the communities of Rotherham feel safe.* The HWb board to receive annual update reports on the impact of the SRP Plan.	Rob Odell, SY Police	Ongoing		A
	For the SRP to ensure it continues to align its plans with the HWb strategy; ensuring improving the health and wellbeing of local people is a key focus of priority areas.		Current plan 2016-19	This will be done via the lead for this action being a member of the Health and Wellbeing Board, and ensuring the links are made between the SRP and HWb Strategy.	A

Health and Wellbeing Strategy
Performance Monitoring 2017-18

Aim 1	**All children get the best start in life**
Aim 2	**Children and young people achieve their potential and have a healthy adolescence and early adulthood**
Aim 3	**All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life**
Aim 4	**Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing**
Aim 5	**Rotherham has healthy, safe and sustainable communities and places**

Aim 1: All children get the best start in life

Board sponsor: Ian Thomas, RMBC
Lead Officer: Karla Capstick, RMBC

Ref	Indicator	Good performance	Reporting mechanism	Frequency of reporting	Baseline	Previous performance	Current performance	DOT	Notes
1.1	% take up of free school meals for all FSM pupils	High	DfE School Census	Termly	15.3% - Spring 16 Census	15.4% - Autumn 16 Census	15.4% - Spring 17 Census	Increase	
1.2	% of mothers who breastfeed their babies in the first 48 hrs after delivery	High	PHOF 2.02i	quarterly	62.2% (2015/16 Q4)	47.9% (2016/17 Q2)	59.6% (2016/17 Q3)	Data fluctuates but 16/17 down on 15/16	Breastfeeding has expected health benefits for infant and mother and reduced illness in childhood (PHE)
1.3	% of infants due a 6-8 week check that are totally or partially breastfed	High	PHOF 2.02ii	quarterly	29.7% (2012/13)				No published data for Rotherham since 2012/13 due to data quality issues. New methodology from 2015/16.
1.4	Children aged 5 years with at least one decayed, filled or missing tooth	Low	CHIMAT child health profile	survey every 2-3 years	28.9% (2014/15 survey)	40.4% (2011/12 survey)	28.9% (2014/15 survey)		Tooth decay is a predominately preventable disease (PHE) Next data (2016/17 survey) published early 2018.
1.5	% of children achieving a good level of development at the end of reception	High	PHOF 1.02i	annually	70.4% (2015/16)	67.4% (2014/15)	70.4% (2015/16)	Increasing/ improving	Key measure of early years development (PHE)
1.6	% of children achieving the expected level in the phonics screening check	High	PHOF 1.02ii	annually	78.8% (2015/16)	74.4% (2014/15)	78.8% (2015/16)	Increasing/ improving	Key measure of early years development (PHE)
1.7	% of term babies with a low birth weight	Low	PHOF 2.01	annually	3.2% (2015)	3.9% (2014)	3.2% (2015)	Fluctuating	Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life (PHE)

Aim 2: Children & young people achieve their potential & have a healthy adolescence & early adulthood

Board sponsor: Ian Thomas, RMBC
Lead Officer: Shafiq Hussain, VAR & Teresa Brocklehurst, CYPF Consortium

Ref	Indicator	Good performance	Reporting mechanism	Frequency of reporting	Baseline	Previous performance	Current performance	DOT	Notes
2.1	% of 16-18 year olds not in education, employment or training	Low	PHOF 1.05	annually	5.3% (2015)	5.9% (2014)	5.3% (2015)	Decreasing/ improving	Young people who are not in education, employment or training are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood (PHE)
2.2	Percentage of Education Health and Care Plans completed in statutory timescales (based on NEW Plans issued cumulative from September 2014)	High	RMBC Corporate Plan Report	monthly	58.3% (2015/16)	54% (Qtr 3 2016/17)	52% (2016/17)	Decreased	Data relates to completion of EHC plans within the reporting period (based on new plans). Performance is cumulative from September 2014 to March 2017. Target is 90% by April 2018
2.3	Percentage of Education Health and Care Plans completed in statutory timescales (based on Conversions from Statements to EHCP cumulative from September 2014)	High	RMBC Corporate Plan Report	monthly	85.5% (2015/16)	52% (Qtr 3 2016/17	58% (2016/17)	Decreased	Data relates to completion of EHC plans within the reporting period (based on conversions from statement to EHCP). Performance is cumulative from September 2014 to March 2017. Target is 90% by April 2018
2.4	Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31 March	Low	PHOF 2.08	annually	15.5 (2015/16)	15.2 (2014/15)	15.5 (2015/16)	Increasing recently, longer-term little change.	With half of adult mental health problems starting before the age of 14, early intervention to support children and young people with mental health and emotional well-being issues is very important (PHE) Score: 14-16 = borderline cause for concern, 17 and over = cause for concern
2.5	Reduced hospital admissions caused by unintentional or deliberate injuries (0-14 years)	Low	PHOF 2.07i	annually	89.5 per 10,000 (crude rate) (2015/16)	106.5 per 10,000 (crude rate) (2014/15)	89.5 per 10,000 (crude rate) (2015/16)	Decreasing/ improving	Injuries are a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people. They are also a source of long-term health issues, including mental health related to experience (PHE) Data is fluctuating over time.
2.6	Reduced hospital admissions caused by unintentional or deliberate injuries (15-24 years)	Low	PHOF 2.07ii	annually	116.6 per 10,000 (crude rate) (2015/16)	122.6 per 10,000 (crude rate) (2014/15)	116.6 per 10,000 (crude rate) (2015/16)	Decreasing/ improving	See above.
2.7	Reduced hospital admissions for mental health conditions (0-17 years)	Low	CHIMAT child health profile	annually	58.6 per 100,000 (crude rate) (2015/16)	40.8 per 100,000 (crude rate) (2014/15)	58.6 per 100,000 (crude rate) (2015/16)	Fluctuating. Virtually no net change over past 4 years.	One in ten children aged 5-16 years has a clinically diagnosable mental health problem.Failure to treat mental health disorders in children can have a devastating impact on their future, resulting in reduced job and life expectations (PHE)
2.8	Reduced hospital admissions as a result of self-harm (10-24 years)	Low	CHIMAT child health profile	annually	289.5 per 100,000 (standardised rate) (2015/16)	312.1 per 100,000 (standardised rate) (2014/15)	289.5 per 100,000 (standardised rate) (2015/16)	Fluctuating. Small net decrease over past 4 years.	Self-harming and substance abuse are known to be much more common in children and young people with mental health disorders (PHE)
2.9 (a)	Health of Looked After Children - up to date Health Assessments	High	RMBC CYPS Monthly Report	monthly	92.8% (2015/16)	88.4% (Feb 17)	87.1% (2016/17)	Decreased	The overall number of health assessments completed remains at a good level. From our reviews we know that in the main, those not having health or dental checks are the older young people who are recorded as 'refuses'. This is no longer going to be accepted on face value and we will be actively exploring with
2.9 (b)	Health of Looked After Children - up to date Dental Assessments	High	RMBC CYPS Monthly Report	monthly	94.5% (2015/16)	62.3% (Feb 17)	62.7% (2016/17)	Decreased	
2.10	No. of CSE referrals	N/A	RMBC Corporate Plan Report	monthly	200 (2015/16)	26 (Feb 17)	231 (2016/17)	Increased	There is no target for this measure as numbers can fluctuate significantly.
2.11	No. of children and young people presenting with neglect	Low		monthly	492 (2015/16)	22 (Feb 17)	336 (2016/17)	Decreased	There is no target for this measure as numbers can fluctuate significantly.
2.12	% of all pupils achieving the expected standard in reading, writing & mathematics (KS2)	High	DfE	annually	–	–	54.0% (2016)	–	New Measure for 2016 therefore no comparable data is available.
2.13	Average Attainment 8 score per pupil (KS4)	High	DfE	annually	46.10 (2015)	46.10 (2015)	48.80 (2016)	Increased	
2.14	The progress a pupil makes from the end of primary school to the end of secondary school. (Key Stage 4	High	DfE	annually	No previous annual data - New	0.03 (Qtr 3 2016/17)	+0.04 (Final Results)	Increased	This is a new measure for secondary school accountability in 2016. Targets in future years would be set in line with or above

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

Board sponsor: Kathryn Singh, RDaSH
Lead Officer: Ian Atkinson, CCG

Ref	Indicator	Good performance	Reporting mechanism	Frequency of reporting	Baseline	Previous performance	Current performance	DOT	Notes
3.1	% of adult social care users who have as much social contact as they would like	High	PHOF 1.18i / ASCOF 1Ii	annual	45.5% (2015/16)	40.2% (2014/15)	45.5% (2015/16)	Fluctuating. Virtually no net change over past 5 years.	There is clear link between loneliness and poor mental and physical health (PHE)
3.2	% of adult carers who have as much social contact as they would like	High	PHOF 1.18ii / ASCOF 1Iii	biennial	45.5% (2014/15)	53.2% (2012/13)	45.5% (2014/15)	Decreased, but only 2 points of data.	A key element of the Government's vision for social care it to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family (PHE)
3.3	Suicide rate	Low	PHOF 4.10	annual	14.2 per 100,000 (standardised rate) (2013-2015)	10.9 per 100,000 (standardised rate) (2012-2014)	14.2 per 100,000 (standardised rate) (2013-2015)	Increasing/ worsening	Suicide is a significant cause of death in young adults, and is seen as an indicator of underlying rates of mental ill-health (PHE)
3.4	Excess under 75 mortality rate in adults with serious mental illness	Low	PHOF 4.09	annual	411.0 (ratio) (2014/15)	409.3 (ratio) (2012/13)	411.0 (ratio) (2014/15)	Generally increasing	There is extensive published evidence that people with severe mental illness, such as schizophrenia, die between 15 and 25 years earlier than the average for the general population (PHE)
3.5	Rate of domestic abuse incidents recorded by the police per 1,000 population	Low	PHOF 1.11	annual	28.9 per 1,000 (crude rate)(2015/16)		28.9 per 1,000 (crude rate)(2015/16)	n/a	Tackling domestic abuse as a public health issue is vital for ensuring that some of the most vulnerable people in our society receive the support, understanding and treatment they deserve (PHE) Methodology changed for 2015/16 data therefore no comparable historic data.
3.6	Social care-related quality of life for service users	High	ASCOF 1A	annual	18.8 (Score) (2015/16)	18.5 (Score) (2014/15)	18.8 (Score) (2015/16)		Composite measure using responses to survey questions covering the eight domains identified in the ASCOF (control, dignity, personal care, food and nutrition, safety, occupation, social participation and accommodation) Score is out of 24.
3.7	Social care-related quality of life for carers	High	ASCOF 1D	biennial	8.3 (Score) (2014/15)	8.8 (Score) (2012/13)	8.3 (Score) (2014/15)		Composite measure covering six domains (occupation, control, personal care, safety, social participation and encouragement and support). Score is out of 12

Aim 4 Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing
Board sponsor: Richard Cullen, CCG
Lead Officer: Giles Ratcliffe, RMBC PH

Ref	Indicator	Good performance	Reporting mechanism	Frequency of reporting	Baseline	Previous performance	Current performance	DOT	Notes
4.1	Potential years of life lost considered amenable to healthcare	Low	NHSOF 1.1	annually	7,047.7 per 100,000 (DSR) (2014)	6,441.6 per 100,000 (DSR) (2013)	7,047.7 per 100,000 (DSR) (2014)	Fluctuating long-term.	Purpose - To ensure that the NHS is held to account for doing all that it can to prevent amenable deaths. Deaths from causes considered 'amenable' to healthcare are premature deaths that should not occur in the presence of timely and effective healthcare (Notes: NHS Digital)
4.2	Proportion of older people (65+) still at home 91 days after discharge into rehabilitation	High	BCF metric / ASCOF 2Bi	annually	88.5% (2013/14)	84.6% (2012/13)	88.5% (2013/14)	increasing/improving	This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode (PHE)
4.3	Non-elective first finished consultant episodes	High	BCF metric	monthly					
4.4	Delayed transfers of care from hospital per 100,000 population (no. of days delayed)	Low	BCF metric	monthly	11.4 per 100,000 (crude rate)(Oct 2014)	10.4 per 100,000 (crude rate) (Sep 2014)	11.4 per 100,000 (crude rate)(Oct 2014)	increasing/worsening	This indicator measures the impact of hospital services and community based care in facilitating timely and appropriate discharge from all hospitals and is an indicator of the effectiveness of the interface between health and social care services (PHE)
4.5	Emergency readmissions within 30 days of discharge from hospital	Low	BCF metric	monthly					
4.6	Permanent admissions of older people (aged 65+) to residential and nursing care homes per 100,000	Low	BCF metric / ASCOF 2A part 2	monthly					
4.7	% deaths not in hospital	High	End of life care group local metric	quarterly	54.2% (3 years to 2015/16 Q4)	53.9% (3 years to 2016/17 Q1)	53.9% (3 years to 2016/17 Q2)	Fluctuating long-term	Proxy indicator for quality of end of life care (PHE) Data represents rolling 12 quarterly figure.

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

Board sponsor: Rob Odell, SY Police
Lead Officer: Karen Hanson, RMBC

Ref	Indicator	Good performance	Reporting mechanism	Frequency of reporting	Baseline	Previous performance	Current performance	DOT	Notes
5.1	Fuel poverty	Low	PHOF 1.17	annually	10.5% (2014)	9.0% (2013)	10.5% (2014)	Fluctuating	Compelling evidence shows that the drivers of fuel poverty (low income, poor energy efficiency and energy prices) are strongly linked to living at low temperatures (Wilkinson et al 2001) which is strongly linked to a range of negative health outcomes(PHE)
5.2	Fear of crime		SYP "Your Voice Counts" survey Q5						
5.3	Proportion of service users who feel safe	High	ASCOF 4A	annually	65.9% (2015/16)	61.5% (2014/15)	65.9% (2015/16)	Fluctuating	Safety is fundamental to the wellbeing and independence of people using social care (and others) (PHE)
5.4	% of children aged 4-5 classified as overweight or obese	Low	PHOF 2.06i	annually	22.1% (2015/16)	21.7% (2014/15)	22.1% (2015/16)	Recently relatively unchanged.	There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. Childhood obesity has health consequences and is associated with psychological problems (PHE)
5.5	% of children aged 10-11 classified as overweight or obese	Low	PHOF 2.06ii	annually	35.8% (2015/16)	35.3% (2014/15)	35.8% (2015/16)	Recently relatively unchanged.	The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older (PHE)
5.6	% of adults classified as overweight or obese	Low	PHOF 2.12	annually	76.2% (2013-2015)	73.3% (2012-2014)	76.2% (2013-2015)	Increasing but only 2 data points.	Obesity is a priority area for Government. Excess weight in adults is recognised as a major determinant of premature mortality and avoidable ill health (PHE) Figures shown are based on self-reported survey data.
5.7	No. of people in tier 3 alcohol treatment services aged under 18		PHE young people stats						Small numbers potentially confidential.
5.8	Number in treatment in specialist alcohol misuse services (aged 18+)	Low	PHE alcohol stats	annually	490 (2015/16)	570 (2014/15)	490 (2015/16)	Decreasing but only 2 data points.	Mental health problems are common among those needing treatment for alcohol misuse and alcohol misuse is common among those with a mental health problem.
5.9	% of women who smoke at time of time of delivery	Low	PHOF 2.03	annually	18.1% (2015/16)	18.3% (2014/15)	18.1% (2015/16)	Decreasing/improving	Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother (PHE)
5.1	Smoking prevalence at age 15 - current smokers	Low	PHOF 2.09i	2014/15 survey was the first. Hoped to be repeated.	10.0% (2014/15)		10.0% (2014/15)	n/a	Smoking is a major cause of preventable morbidity and premature death. There is a large body of evidence showing that smoking behaviour in early adulthood affects health behaviours later in life (PHE)
5.11	Smoking prevalence at age 15 - regular smokers	Low	PHOF 2.09ii	2014/15 survey was the first. Hoped to be repeated.	7.2% (2014/15)		7.2% (2014/15)	n/a	This indicator will ensure that local authorities will also address the issue of reducing the uptake of smoking among children (PHE)
5.12	Prevalence of smoking among persons aged 18 years and over	Low	PHOF 2.14		18.1% (2015)	19.4% (2014)	18.1% (2015/16)	Decreasing/improving	Smoking is the most important cause of preventable ill health and premature mortality in the UK (PHE)
5.13	% of people using outdoor space for exercise / health reasons	High	PHOF 1.16		13.5% (Mar 2015-Feb 2016)	12.9% (Mar 2014-Feb 2015)	13.5% (Mar 2015-Feb 2016)	Fluctuating	There is strong evidence to suggest that green spaces have a beneficial impact on physical and mental wellbeing and cognitive function through both physical access and usage (PHE)

BRIEFING PAPER FOR H&WBB

1.	**Date of meeting:**	**31st May 2017**
2.	**Title:**	**Director of Public Health Annual Report 2015/16**
3.	**Directorate:**	**Public Health Directorate, RMBC**

4. Introduction

4.1 Every Director of Public Health (DPH) must produce an independent Annual Report on the local population's health. The 2015-2016 annual report was the first in a series of annual reports that planned to work through the life course, focusing on key health issues at different stages of our lives. This year's focus is on healthy ageing. The intention is to use this year's annual report to consider the changes that are developing within our older population in terms of health, but also as an opportunity to shine the light on the rich asset that older people are within Rotherham.

4.2 The report highlights some of the successes in Rotherham, but also gives a frank assessment of some of the challenges we face as a community. According to the Faculty of Public Health guidance DPH reports should:

- Contribute to improving the health and well-being of the Rotherham population.
- Reduce health inequalities.
- Promote action for better health, through measuring progress towards health targets.
- Assist with the planning and monitoring of local programmes and services that impact on health over time.

The annual report is the DPH's professional statement about the health of local communities, based on sound epidemiological evidence, and interpreted objectively. The report should be publicly accessible. The DPH report is not a strategy document, but can make recommendations for system change.

4.3 The report is built on an evidence-based framework for healthy ageing across the life-course - the World Health Organisation's (WHO) Life-Course Approach to Healthy and Active Ageing (Good Health Adds Life to Years (WHO, 2012) – which offers a sustainable framework from which to realise opportunities, and to recognise, embrace and celebrate all the positive aspects of ageing. The framework provides a means of reviewing the Rotherham picture, as well as exploring the untapped potential of over-65's in Rotherham. The framework and report is based around four themes (Healthy Behaviours and Lifestyles; Age friendly environment & community supporting health; Encouraging social inclusion & positive mental health, independence & productivity; and, Quality integrated services and preventative interventions).

5. Key Issues

5.1 In Rotherham the number of people aged 75+ is increasing rapidly, with the numbers aged 85+ rising faster than nationally. Within Rotherham we know that there is a gap between life expectancy and healthy life expectancy and that there are significant numbers of people who will be of ill health before they are 60. As retirement age increases there are additional challenges for older people and the ill health impact will increase as the gap between healthy life expectancy and retirement age increases. The combination of the poor health of those over 75 years and their growing number will place growing pressures on local health and social care services to a greater extent than are experienced nationally.

5.2 For people aged 65 and over, the main difference between Rotherham and the national average concerns health and disability where older people in Rotherham are far more likely to be disabled and in poor health than England, and therefore are living longer in poor health. However, in comparison with close statistical neighbours with similar levels of deprivation, those aged 65 and over with a long-term health problem or disability Rotherham (32.5%) is similar to Doncaster (32.2%) and better than Barnsley (35.2%)

5.3 'Views from the past' are personal reflections of older people within Rotherham that are included throughout this report to shed light on how lifestyles and behaviours have changed over the years. Consultation work undertaken by the Public Health Directorate as part of the development of the Healthy Ageing Framework has guided the content of this report and helps add the local view, feelings and priorities to the document, and the voice of users is paramount in developing a healthy ageing community.

6. Key actions and relevant timelines

6.1 The annual Report highlights Key Messages within each chapter and sub-chapter. These should be digested by all relevant organisations and sectors and considered when planning strategy and service delivery.

6.2 The DPH and colleagues from Public Health will share the report and recommendations individually with each organisation and ask them to consider what actions they will commit to over the next 12 months that address the recommendations This will form the basis of an action plan to be monitored and reported on next year.

6.3 Each chapter contains one or more high-level recommendations for system-wide action. They are:

Healthy behaviours & lifestyle – adding life to years and years to life
All services should prioritise and facilitate healthy behaviours in later life by providing and encouraging behaviour change, particularly in the most disadvantaged communities.

Age friendly environment & community supporting health (physical and mental)

Rotherham Health and Wellbeing board considers implementing the WHO age friendly cities and communities in Rotherham and become the first area in South Yorkshire to achieve the accreditation, learning from other UK cities that have begun this work.

Encouraging social inclusion

The social inclusion of older people in Rotherham needs to be at the heart of policy and delivery across the Rotherham Partnership, addressing issues such as maintaining independence, income and participation, mental health, loneliness & isolation. To achieve this goal older people must experience proactive involvement and participation in life and society as a whole.

Quality integrated services and preventative interventions (incl. screening & immunisation and lifestyle)

All partners to deliver against the aspirations and commitments relating to older people within the Rotherham Integrated Health & Social Care Place Plan, and to continue to strive for the highest quality services for older people. There must be an increased focus on early identification and prevention, with clear pathways for lifestyle behaviour change for older people that support individuals to make changes when the time is right for them.

7. Recommendations to H&WBB

7.1 That H&WBB notes the content and recommendations of the DPH Annual Report 2016/17

7.2 That H&WBB members review the content and recommendations of the Report and consider what actions they will take in contribution to the recommendations. These will be collated by Public Health and reported back to the H&WBB for reporting and governance.

8. Name and contact details

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Healthy Ageing

living well and living longer

Director of Public Health
Annual Report 2016

Contents

Foreword and Introduction from the Director of Public Health

Every Director of Public Health (DPH) must produce an Annual Report on the local populations' health. The Rotherham reports follow the life course approach (health at the key stages of life) and this year's focus is on healthy ageing. This provides the opportunity to shine the light on the rich asset that older people are within our society and also to consider the changes that are developing within our older population.

A life course approach to ageing understands that older people are not a homogeneous group of people. Individual diversity tends to increase with age, meaning that the differences between people in perfect health and people in poor health are greater in old age . Interventions that create supportive environments and foster healthy choices are important at all stages of life, but this is particularly so in the later stages of life. This in turn means that older age is a time when prevention of disease can make an enormous difference to the quality of life of individuals.

Active ageing is the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age.[1]

If ageing is to be a positive and fulfilling experience for individuals and their families, longer life must be accompanied by continuing opportunities for health, participation and security. The World Health Organisation[1] (WHO) has adopted the term "active ageing" to express the process for achieving this vision, and it is a vision this report endorses.

Introduction

Older people can be active citizens, participating fully in society according to their needs, wishes and capacities. The vision is for people to realise their potential for physical, social and mental wellbeing throughout the life course. Active ageing applies equally to individuals and populations. Active ageing also requires the necessary protection, security and care for older people when they require assistance[1].

The WHO and United Nations use a standard age of 60 to describe "older" people. However, it is important to acknowledge that chronological age is not a precise marker for the changes that accompany ageing. There are dramatic variations in health status, participation and levels of independence among older people of the same age around the world[1]. For the UK as a developed nation with a high life expectancy, the age of 60 is still considered quite young when compared to developing nations. Although data sources can define 'old age' using other categorisations (e.g. over 75), the WHO have for some time acknowledged that most developed countries have accepted 65 years or older as a definition of 'elderly'[1]. This definition is the one adopted in this report, and is the benchmark used by the Office of National Statistics for the purposes of the Census .

In Rotherham, the number of people aged 75 and over is increasing rapidly, with the numbers aged 85 and over rising faster than nationally. Within Rotherham we know that there are gaps in life expectancy and healthy life expectancy between the most and least affluent areas of the Borough, and that there are significant numbers of people who will experience ill health before the age of 60. These inequalities are manifestations of the differences in life chances between different parts of the Borough. As retirement age increases there are additional challenges for older people. The impact of ill health will increase as the gap between healthy life expectancy and retirement age increases. The combination of poor health for people over 75 years, and their growing numbers, will place further pressures on local health and social care services. This will be experienced in Rotherham to a greater extent than nationally.

Throughout this document the reader will see 'Views from the past'; these are the personal reflections of some of the older people of Rotherham. These are included in this report to shed light on how lifestyles and behaviours have changed over the years. Consultation work undertaken by the Public Health Directorate as part of the development of the Healthy Ageing Framework has guided the content of this report. It adds the local view, feelings and the voice of users in identifying the public health priorities for a healthy ageing community.

The report is built on an evidence based framework for healthy ageing across the life course: the World Health Organisation's (WHO) Life-Course Approach to Healthy and Active Ageing (Good Health Adds Life to Years)[1]. This provides a sustainable framework from which to realise opportunities, and to recognise, embrace and celebrate all the positive aspects of ageing. The framework provides a means of reviewing the local picture, as well as exploring the untapped potential of the over 65's in Rotherham.

The last DPH annual report[5] (2015) was the first in a series that adopted the life course approach, focusing on the key health issues at different stages of our lives. The report looked at the importance of prenatal, childhood and young people's health issues. The report identified work already underway to tackle some of the key health issues for children and young people and highlighted the areas that required a greater focus to improve their health outcomes. Consequently, eight overarching

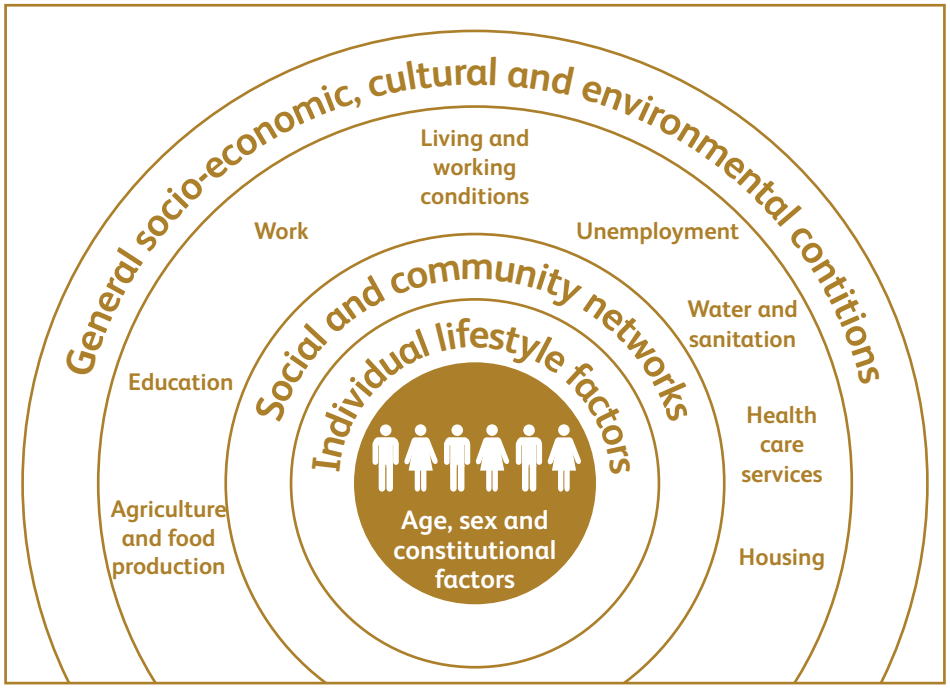
recommendations were made prompting a partnership approach to tackle existing health inequalities and to improve health outcomes for children and young people in Rotherham. These recommendations were incorporated into an action plan summarising 'what we'd like to see' actions (see the appendix of this report for progress update).

'Healthy Ageing – living well and living longer' is a report for all the people and organisations of Rotherham. It is intended to stimulate local interest and be useful in shaping policies, services and approaches, so that in the future, everyone can look forward to a happy, healthier, older age.

Executive summary

An individual can't change the genes they are born with (their biological programming) and these can influence how quickly people age. What people do with their lives and what happens to them during their lives, also influences how quickly they age. These are referred to by Kuh et al (2014) as life exposure modifiers. These modifiers can determine risk of accelerated ageing and ill health which accumulates over a lifetime and whether particular chains of risk are set in motion[6]. Dahlgren and Whitehead explained these modifiers in their 'social' or 'wider determinants' model of health (see Fig. 1)[7].

Fig. 1: Wider Determinants of Health



Source[7]

These layers of influence can affect the health of an individual. The model attempts to map the relationship between the individual, their environment and all the factors that influence their wellbeing. As described by Marmot (2010) in 'Fair Society, Healthy Lives'[8], such factors also contribute to the health inequalities that continue to persist in England, inequalities that are mirrored in Rotherham.

This report utilises an amended version of this framework within the World Health Organisation's (WHO) 'Life-Course Approach to Healthy and Active Ageing'[4]. It provides an evidence based, sustainable and long term strategic approach which underpins this reports review of older people's health and wellbeing, enabling partners to explore opportunities for doing better.

The framework is structured around four key themes that are both interrelated and interdependent, whilst embracing the six Marmot principles aimed at reducing health inequalities[8]. The four which are highlighted directly relate to adults. The Marmot Principles are:

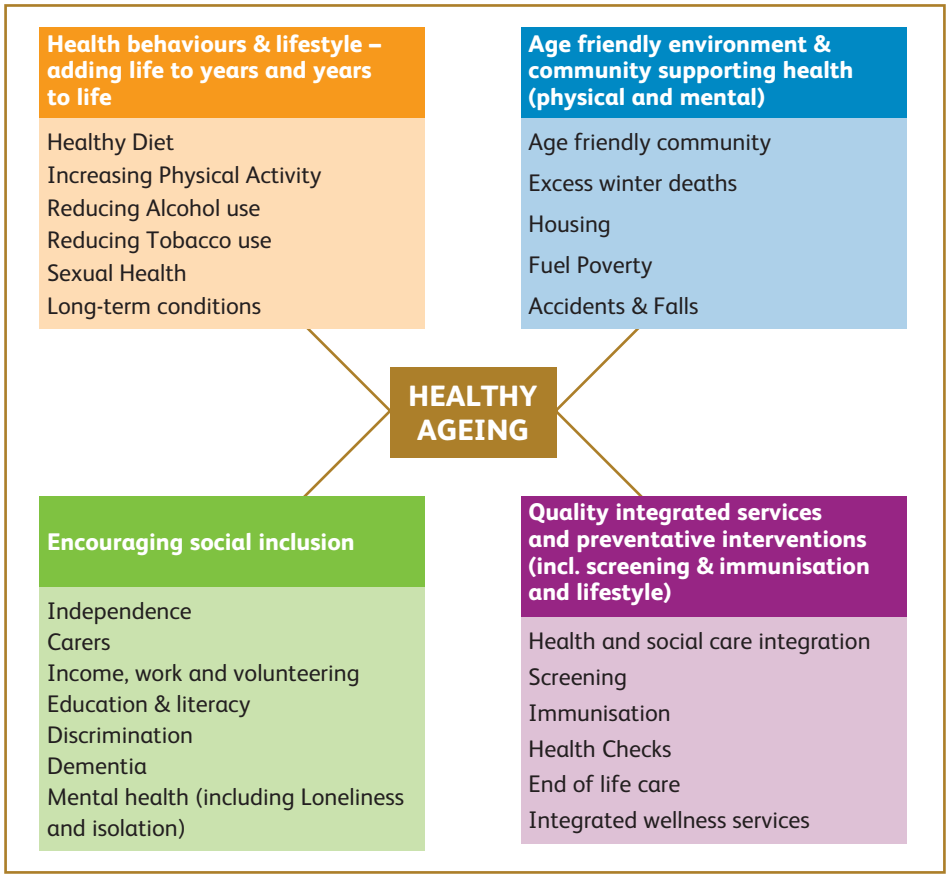
1. To give every child the best start in life
2. To enable all children, young people and adults to maximise their capabilities and have control over their lives
3. To create fair employment and good work for all
4. To ensure healthy standard of living for all
5. To create and develop healthy and sustainable places and communities
6. To strengthen the role and impact of ill-health prevention.

Source[8]

A Framework for Healthy Ageing

The WHO 'Life-Course Approach to Healthy and Active Ageing'[4] provides four themes: Healthy Behaviours and Lifestyles; Age friendly environment & community supporting health; Encouraging social inclusion & positive mental health, independence & productivity; and, Quality integrated services and preventative interventions, all of which cover a broad range of issues. For the purpose of this report, we have focused on some specific and important areas of interest as follows:

Fig. 2: Healthy Ageing Framework



Current picture

In Rotherham the number of people aged 75+ is increasing rapidly, with the numbers aged 85+ rising faster than nationally. Within Rotherham we know that there is a gap between life expectancy and healthy life expectancy and that there are significant numbers of people who will be of ill health before they are 60. As retirement age increases there are additional challenges for older people and the ill health impact will increase as the gap between healthy life expectancy and retirement age increases. The combination of the poor health of those over 75 years and their growing number will place growing pressures on local health and social care services to a greater extent than are experienced nationally.

Healthy behaviours & lifestyle – adding life to years and years to life

The proportion of adults classified as overweight or obese is higher in Rotherham than the regional or England average, and older adults are more likely to be affected by obesity. In Rotherham residents eat fewer fruit and vegetables than the national average. The correct nutrition and balanced diet is particularly important for the over 65 age group as their energy requirements change. Individuals and care givers should ensure hydration is maintained, as older people are more susceptible to dehydration.

Society is 20% less active than it was in the 1960's, and yet being active is one of the most important actions individuals can take to slow the ageing process. Being active impacts on our mental and physical health and enables people to remain independent, connected and reduces isolation. Older age groups should be encouraged to continue undertaking physical activity and exercise to strengthen muscles and maintain aerobic capacity and bone density. All adults, including older adults, should aim to move more and strive to undertake the recommended 150 minutes (2.5 hours) of moderate activity per week (in bouts of 10 minutes or more). The overall amount of activity is more important than the type, intensity or frequency.

Today's over 65 year olds were born at a time of low alcohol consumption in the UK, but have subsequently lived through a rapid rise in the national consumption rate. Increased consumption of alcohol is associated with an increase in alcohol-related disease and mortality. Older people are biologically more susceptible to the effects of alcohol and experience increased risks of adverse interactions with medication. It is important that older people in Rotherham are made aware of the additional health risk of regular and excessive alcohol use, and professionals are aware of

the signs and symptoms and be prepared to have 'healthy conversations' to inform behaviour change, where appropriate.

Despite the proportion of older people who smoke reducing since the 1990's, smoking contributes to many of the preventable diseases in Rotherham, such as heart disease and cancer. Although there is the perception that smoking cessation for older people can be more difficult or less beneficial to health, evidence suggests older people are more successful at quitting and see real and immediate health benefits. Older people who smoke should consider stopping smoking, and should be encouraged to do so by professionals of all statutory services.

The sexual health needs of older people are often forgotten. It's a myth that older people no longer want or need a sex life. Services should ensure they address the sexual health needs and concerns of the over 65 population. Older people should consider the risks of sexually transmitted infections when embarking on new relationships.

As the population lives longer, more people are also living with single and multiple long term conditions (LTCs), many of which are preventable by modification of lifestyle behaviours. LTCs are more prevalent in areas of high deprivation in Rotherham. Nearly 80% of premature heart disease, cancer, stroke and type 2 diabetes can be prevented through lifestyle change.

Making Every Contact Count (MECC) is an opportunity to engage with older people on issues of lifestyle behaviour change via 'healthy conversations' in the community. All Rotherham residents aged 65 and over should consider their own health behaviours and lifestyle choices and aim to make small but sustainable changes that can have a significant impact on the quality of their lives.

Age friendly environment & community supporting health (physical and mental)

The WHO 'Age Friendly Cities and Communities' is a recognised way to focus local action on improving the services and opportunities for older people, via strong partnership, improved area and building design, and consideration of older peoples' needs in planning and strategies. The model places the needs of older people at the heart of any development plans and that older people are an important asset to the community.

Rotherham has begun to develop a Healthy Ageing Framework to ensure that the vision and actions are more joined up and working towards a common goal. There are 3 key high level outcomes:
1) I am emotionally well; 2) I live well; 3) I am physically well.

Excess deaths in winter continue to be an important public health issue in the UK and are potentially preventable through effective interventions. This excess death is greatest in both relative and absolute terms in older people and for certain disease groups. Rotherham rates for the single year August 2014-July 2015 for persons and males 85 and over were the worst in Yorkshire and the Humber Region, and second worst compared to similar local authorities (CIPFA nearest neighbours) .

Professionals, families, neighbours and communities should be aware of vulnerable older people who may be at increased risk from cold weather and take necessary action to enquire, refer and provide support where required.

Poor housing can have a serious impact on the lives of older people. Damp, unfit and cold housing can cause or exacerbate a range of health problems including respiratory conditions, arthritis, heart disease and stroke, as well as mental health problems. Mental health problems are often caused by the added stress and anxiety of poor housing. Hazards

in the home and poor accessibility can also contribute to falls and accidents.

Individuals, housing providers and housing strategy and policy must plan adequately for the rising older population in Rotherham to ensure sufficient and appropriate housing is available to enable older people to stay independent and in their own homes should they wish.

Older people are particularly at risk of health problems relating to living in a cold home. Some may have a cold home due to the costs of heating, but 'fuel poverty' is also related to the energy efficiency of a house and household income. Evidence suggests the key driver of fuel poverty is related to housing conditions. Levels of fuel poverty in Rotherham seem to be improving (10.5% in 2014 reduced from 15.1% in 2012) and Rotherham's Creating Warmer Homes Strategy (Draft) has an aspiration to ensure all Rotherham householders can live in warmer homes. Rotherham policy makers should ensure the Warmer Homes agenda remains a partnership priority.

Falls among older people are a large and increasing cause of injury, treatment costs and death. The falls rate has improved significantly over the last few years in Rotherham. There is an established falls recovery pathway which refers hospital admissions and community rehabilitation to long term postural stability exercise classes. Preventing falls through the early identification, referral and appropriate interventions for older people at risk of falls is essential action if we are to maintain the independence of individuals in our community.

Encouraging social inclusion

It is recognised that later life can provide a series of challenges that can be grouped under the heading social inclusion, including: maintaining independence; carer responsibilities; income, work and volunteering; education & literacy; discrimination; dementia; and, mental health (including loneliness and isolation).

There has been a large amount of literature developed that emphasises the importance of maintaining independence for ageing adults' health and wellbeing. Maintaining the independence of older people in Rotherham in the coming years will require all stakeholders, including communities themselves, to work together to support individuals to be active partners in their own health and care, and full participants in community life. There is an appetite to increase independence as part of a whole system approach to ageing in Rotherham; this will be partly by changing social attitudes to encourage the participation in community activities by older people.

Carers often provide similar support to that which would otherwise be provided by social care; it is recognised that most of this care is provided voluntarily by people of retirement age. This care includes the care of young grandchildren, older disabled adults and vulnerable partners or relatives. Older people play a significant role in society as care givers. In Rotherham older carers must be adequately recognised and supported. The new Rotherham Carers Strategy will drive this commitment.

Past consultation in Rotherham reported that reducing the number of older people on low incomes should be a top priority . However, the opportunities in later life are now more diverse and fluid. The set retirement age no longer exists and the state pension age rises to 66 by 2020, and likely to rise further in the coming decades. This change will rebalance the proportions of workers and retired people in society.

The opportunities for those over the age of 65 to remain in work are much greater than it has ever been and can help support the financial, health and social well-being of individuals into later life. Volunteering in later life is important for positive human development and as a social activity can combat social isolation and loneliness.

Low levels of education and illiteracy are associated with increased risks for disability and death among people as they age, as well as with higher rates of unemployment. Health literacy refers to people having the appropriate skills, knowledge, understanding and confidence to access, understand, evaluate, use and navigate health and social care information and services. Limited health literacy is linked with unhealthy lifestyle behaviours such as poor diet, smoking and a lack of physical activity and is associated with an increased risk of morbidity and premature death. People with limited health literacy are less likely to use preventive services and more likely to use emergency services, are less likely to successfully manage long-term health conditions and, as a result, incur higher healthcare costs. Health literacy needs to be considered as an important factor in supporting older people to self-manage.

Policy development and service delivery of all partners is mindful of the perceived age discrimination experienced by older people. Becoming an Age Friendly Borough is key to ensuring that discrimination on the basis of age is considered routinely by everyone in the Rotherham Community.

With symptoms including memory loss and difficulties with thinking or language, dementia can disrupt not only the lives of people living with the condition, but also friends and family, who often act as carers. There is no cure for dementia, and so taking action to reduce the risk is particularly important. All Rotherham partners and stakeholders should identify ways to become more dementia friendly, and to promote the prevention agenda for dementia across the community.

With respect to mental health and wellbeing measures, Rotherham's scores are significantly higher (worse) than the rest of England for all measures, with the exception of 'level of worthwhileness' where Rotherham is equal to the national average. It appears that more people in Rotherham are reporting poorer emotional well-being and higher anxiety rates. Improving the mental well-being of the ageing population cannot be the responsibility of one organisation. All communities and organisations need to work together to help improve the mental health of our ageing population.

Older people are particularly vulnerable to social isolation and loneliness. This can be due to loss of friends and family, mobility and/or income. Social isolation and loneliness can have a negative impact on an individual's health and wellbeing. Research shows that loneliness and social isolation are harmful to health, comparable to other well known risk factors such as obesity and physical inactivity.

Quality integrated services and preventative interventions
(incl. screening & immunisation and lifestyle)

Healthy lifestyles and appropriate, supportive environments and communities, can reduce the risk of chronic disease and long term conditions. However, people in Rotherham will still inevitably develop health problems in older age. Consequently our services need to be able to detect any health problems early in order to improve outcomes and manage them effectively. For those who can no longer care for themselves, we must also have health and social care services that can work with the individuals and their families/carers to meet their needs.

There are many different models for providing integrated care for an ageing population; our collective task is to ensure Rotherham's model complements and meets its own particular needs and circumstances. Rotherham is well placed to meet the challenges posed, through the Rotherham Integrated Health and Social Care Place Plan (2016) which sits alongside the Rotherham Better Care Fund Plan. Both plans were built on the existing evidence base and good practice. These documents outline the commitment of the whole system approach to the Rotherham vision.

Rotherham must continue the journey towards fully integrated health and social care services built on the assets within the community and providing care that is co-ordinated around the individual's needs and goals; the right care at the right time, and in the right place.

Screening is a way of identifying apparently healthy people who may have an increased risk of a particular condition. Screening programmes are there to identify disease early to give individuals the best chance of recovery. Generally screening uptake in Rotherham is good. Older people in Rotherham should continue to take advantage of all the relevant screening offers available to them.

Immunisations have greatly reduced the incidence and spread of infectious diseases. People aged 65 years and older are more susceptible to suffering from serious health consequences from infectious diseases, which can result in hospitalisation, disability or even death. There are three immunisation programmes for older people available (Influenza, Pneumococcal Polysaccharide Vaccine (PPV) and Shingles). For all three vaccinations, Rotherham ranks in the top two across the Yorkshire and Humber Region. Older people in Rotherham should continue to (and be encouraged to) receive the necessary immunisations to help protect them from these infections.

The NHS Health Check is for adults in England aged 40-74. It is designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. Health checks are a useful way of encouraging middle aged and older people to make lifestyle changes and behaviour modification. In the future, health checks should be targeted at those

communities with the greatest need in order to help address health inequalities across the borough.

Personalised care planning at 'End of Life' will be of increasing importance as the population of older people (many of whom will have multiple long term conditions and complex care needs) grows in Rotherham, and services will need to adapt and plan for this change.

Behaviour change plays an important role in many aspects of improving health such as; weight management, physical activity, and stopping smoking. Historically, lifestyle behaviour change services have been provided separately, so that, for example, people would access 'stop smoking services' or 'weight management services'. An integrated wellness service in Rotherham will help target the communities and individuals with the greatest need, whilst simplifying access to services to assist individuals make the lifestyle changes that can improve their health outcomes. When combined with Making Every Contact Count (MECC), this will provide a comprehensive behaviour change pathway.

Recommendation One

All services should encourage lifestyle behaviour change in older people where appropriate, particularly in the most disadvantaged communities. This could be achieved through taking a systematic approach to MECC.

Recommendation Two

Rotherham Health and Wellbeing board considers implementing the WHO 'Age Friendly Cities and Communities'[11] and become the first area in South Yorkshire to achieve this accreditation, learning from other UK cities that have already begun this work. This would be complementary to the Borough's aspiration to be young people and dementia friendly.

Recommendation Three

The social inclusion of older people in Rotherham needs to be at the heart of policy and delivery across the Rotherham Partnership, addressing issues such as maintaining independence, income and participation, mental health, loneliness & isolation. To achieve this goal, older people must experience proactive involvement and participation in life and society as a whole.

Recommendation Four

All partners to deliver against the aspirations and commitments within the Rotherham Integrated Health & Social Care Place Plan, and to continue to strive for the highest quality services for older people. This is to include an increased focus on prevention, early identification and self-management, with clear pathways for lifestyle behaviour change for older people that support individuals to make changes when the time is right for them.

Acknowledgements

I would like to thank RMBC library services for gaining useful participant insight (views from the past) from the older people of Rotherham and the archive images.

My thanks also go to (in no particular order) The Rotherham NHS Foundation Trust Library & Knowledge Service; Voluntary Action Rotherham; Age UK Rotherham; Healthwatch; RMBC: Communications, Policy & Partnerships, Adult Care and Housing.

I would like to thank my Public Health Directorate for their hard work.

Finally, a big thank you to the older people of Rotherham who have contributed directly and indirectly to the formation of this report.

Chapter 1 Demographic context – The current picture for older people in Rotherham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"Old age is like everything else. To make a success of it, you've got to start young."

(Theodore Roosevelt 1858 – 1919)

Rotherham's population is both growing and ageing, as people live longer. The latest figures show that by mid-2015 the population of Rotherham had reached its highest ever level, at an estimated 260,800[15].

Key Fact

In line with the rest of the country, the most significant change within the age structure of the population is the growing number of older people in Rotherham. 19.0% of the population were aged 65 or over in 2015 and this is projected to rise to 21.7% by 2025[15]. Compare this to 1953, when those currently 65 years of age had only recently been born. Data for the United Kingdom for 1953 showed the percentage of the population aged 65 and over was just 11.1%[16].

Within the population over 65, the oldest age groups are increasing fastest, with the number aged 85 or over rising from 5,770 in 2015 to a projected 8,060 in 2025, a 39.7% increase, and a faster growth than the national average[15].

Rotherham's total population is projected to increase by 3.2% between 2015 and 2025 and although the number aged 65 and over will increase significantly, the number aged 65-74 will increase only slightly (3.7%). The main growth in Rotherham's population over the next 10 years will be in the number aged over 75 which is projected to increase from 21,800 in 2015 to 29,600 in 2025, a 36% rise. The number aged over 85 is projected to increase by 40%, twelve times faster than the borough average for all ages.

Table 1: Projected Population Growth in Rotherham by Age Group

Age Group	2015	2020	2025	% Change 2015-25
0-17 years	56,400	57,400	58,400	+3.7%
18-64 years	154,800	153,900	152,200	-1.7%
65-74 years	27,800	28,600	28,900	+3.7%
75-79 years	9,500	10,800	12,900	+34.8%
80-84 years	6,500	7,600	8,700	+34.6%
85-89 years	3,700	4,300	5,200	+41.4%
90+ years	2,100	2,300	2,800	+36.7%
Total (Including borough average)	260,800	264,900	269,100	+3.2%

Source[15]

Potential Impact on the Health and Social Care System

It is recognised that the population changes described above will have an impact on the demand for health and social care services. People aged over 75 years are those most likely to be in need or receipt of some form of health or social care service. Based on the Council's service user data in 2015, 13.7% of 75-84 year olds in Rotherham received some form of social care service, rising to 42.5% of people aged over 85. If these rates were to remain unchanged, the number of users of social care services aged 75 and over would increase from 4,650 in 2015 to 6,380 in 2025. This trend is broadly replicated nationally.

Table 2: Life Expectancy and Ill Health 2012-2014

	Rotherham Males	England Males	Rotherham Females	England Females
Life Expectancy at Birth	78.1	79.5	81.3	83.2
Healthy Life Expectancy at birth	58.9	63.4	58.7	64.0

Source[17]

Life expectancy is defined as the average number of years a person would expect to live based on contemporary mortality rates[17]. Men in Rotherham can expect to live 1.4 years less than the national average and for women the gap is greater at 1.9 years less. Healthy Life Expectancy is defined as the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health[17]. The gap in healthy life expectancy is much greater than general life expectancy when compared to the national average, at 4.5 years for men and 5.3 years for women. The average Rotherham male can expect to live 19.2 years in ill health (16.1 years nationally) and the average female 22.6 years in ill health (19.2 years nationally). This means that a significantly higher proportion of older people in Rotherham live with poor health compared to the national average[17].

Older People with Bad or Very Bad General Health

The National Census asked people to report their general health as 'very good', 'good', 'fair', 'bad' or 'very bad'. The table below shows the percentages of older age groups who reported their health as 'bad' or 'very bad'.

Table 3: Percentage of older people reporting their health as 'Bad' or 'Very bad' by age group

Age Group	Rotherham	England
65-74 years	16.1 %	11.2 %
75-84 years	23.0 %	16.5 %
85+ years	31.1 %	23.4 %
All aged 65+ years	20.0 %	14.5 %

Source[18]

Census data shows that older people in Rotherham were over 5 percentage points more likely to self-report having 'bad' or 'very bad' health than the national average. This equates to 1 in 5 of the older people in Rotherham reporting their health as 'bad' or 'very bad' compared to 1 in 7 nationally. If the above percentages were to remain constant, the number of people aged 65 and over in 'bad' or 'very bad' health in Rotherham would have increased from 8,694 in 2011 to 9,960 in 2015 and projected forward, would likely reach 12,109 by 2025.

Older People with Limiting Long Term Health Problem or Disability

The table below shows the percentages of older age groups who have self-reported within the Census having a long term health problem or disability which limits their daily activities 'a lot'.

Table 4: Percentage of older people with a long term condition or disability that limits their daily activities 'a lot' by age group

Age Group	Rotherham	England
65-74 years	23.9 %	16.4 %
75-84 years	37.7 %	29.1 %
85+ years	61.3 %	52.3 %
All aged 65+ years	32.5 %	25.0 %

Source[18]

Census data shows that 1 in 3 older people (aged 65+) in Rotherham have a seriously limiting long term condition or disability compared to 1 in 4 nationally. In Rotherham, for those aged 65-74 just under 1 in 4 are affected in Rotherham compared with 1 in 6 nationally. If the above trends in Rotherham were to remain constant, the number of people aged 65 and over described in the Census as 'limited a lot' by a long term health problem or disability would have increased from 14,120 in 2011 to 16,231 in 2015 and projected forward, could reach 19,954 by 2025.

Older People claiming Disability Living Allowance (DLA)

DLA is a benefit (not subject to a means test or tax) claimed by people of any age who are disabled and need help with mobility or care costs. The table below shows the proportion of older people claiming the benefit by the main condition of entitlement.

Table 5: Percentage of people aged 65+ years claiming Disability Living Allowance (DLA)

People Aged 65+ Years		
Disabling Condition	Rotherham	England
Total (all conditions)	14.1 %	7.8 %
Arthritis	5.03 %	2.62 %
Heart disease	1.15 %	0.51 %
Spondylosis (spine)	1.13 %	0.39 %
Disease of muscles, bones or joints	0.81 %	0.49 %
Chest disease	0.75 %	0.36 %
Back pain	0.71 %	0.42 %
Other conditions	4.5 %	3.0 %

Source[19]

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Table 5 shows that 1 in 7 people aged 65 and over in Rotherham claim Disability Living Allowance compared to 1 in 13 nationally. The most common reason for those aged 65+ in Rotherham claiming DLA is arthritis, responsible for over 1 in 3 claims. The proportions of older people claiming DLA for heart disease, spondylosis and chest disease in Rotherham are all over twice the national average. These statistics further illustrate the high level of local demand amongst older people for health and social care.

The proportion of those aged 65+ claiming Attendance Allowance (used to provide help and support in the home) in Rotherham is 14.7 %, also above the national average of 13.6 %. It is likely that this allowance is under-claimed, so the true level of need could be even higher.

Ethnicity and older people

Rotherham's BME population more than doubled between 2001 and 2011, increasing from 10,080 (4.1%) to 20,842 (8.1%). Only 1,215 were aged 65 and over in 2011 (0.5% of Rotherham's population). Around 30% of the BME population aged 65 and over in Rotherham have declared they are from Pakistani heritage[18]. The BME population is projected to increase by about a third over the next twenty years across all ages[15]. Although this change will be particularly evident in younger residents, there will be a significant growth in the BME over 65 population in the years to come.

Challenge

The combination of the poor health of those over 65 years and their growing number will place pressures on local health and social care services in Rotherham to a greater extent than experienced nationally. For people aged 65 and over, the main difference between Rotherham and the national average relates to health and disability where older people in Rotherham are far more likely to be disabled and in poor health than England (25.0%) (living longer in poor health). In comparison to statistical neighbours with similar levels of deprivation, Rotherham (32.5%) is similar to Doncaster (32.2%) and better than Barnsley (35.2%)[18].

Chapter 2 Healthy behaviours & lifestyles – Adding life to years & years to life

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There are steps we can all take towards limiting the physical and mental manifestations of the ageing process.

Being physically active, eating a healthy diet, avoiding harmful use of alcohol and not smoking can all reduce the risk of chronic disease in older age. It is therefore important to recognise that older people have a responsibility to adopt behaviours to protect their own health, in order to live longer in good health and maintain their independence. Services, communities and individuals all have a responsibility to enable people to adopt healthier lifestyles and reduce risky behaviours across the life-course.

Healthy lifestyles are traditionally associated with primary prevention including 'Healthy Chats' or Making Every Contact Count (MECC), and other education and interventions relating to stopping smoking, diet and exercise. Enabling older people to adopt healthier lifestyles also requires targeted secondary prevention interventions. These can empower people to change behaviour and to effectively manage their own health, including the self-care of long term conditions.

As more people are reaching older age, their health, including their emotional and social needs, are increasingly important for society. Appropriate preventative support services will need to be available for older people at key transition or risk points in their life where they are more receptive to behaviour change, such as retirement, having grandchildren, bereavement, becoming a carer, or diagnosis of a long-term condition.

The challenge is to embed a framework and model for Rotherham which ensures adults reach old age well enough to enjoy it and suitably informed and motivated to stay in good health for their older years.

Making Every Contact Count

Making Every Contact Count (MECC) is an approach to behaviour change that utilises the millions of day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations[20].

For organisations in Rotherham MECC means providing their staff with the leadership, environment, training and information they need to deliver the MECC approach. It also means supporting their own staff to adopt healthier lifestyles.

For staff in Rotherham MECC means having the competence and confidence to deliver culturally sensitive healthy lifestyle messages, to encourage people to change their behaviour, and where appropriate to direct them to local services that can support them.

For older people in Rotherham MECC means seeking support and taking action to improve their own lifestyle by eating well, maintaining a healthy weight, drinking alcohol sensibly, exercising regularly, not smoking and looking after their wellbeing and mental health[20].

Healthy Diet

The importance of diet as a major contributor to chronic disease and premature death in England is recognised in the Government White Paper 'Healthy Lives, Healthy People'[21].

Poor diet (food and drink which are low in fibre or high in fat, salt and/or sugar) is a significant public health concern as it increases the risk of some cancers and cardiovascular disease (CVD), both of which are major causes of premature death. These diseases and type II diabetes (which increases CVD risk) are associated with obesity, which has a high prevalence in England. The costs of diet related chronic diseases to society, in particular the NHS and social care are considerable. Poor diet is estimated to account for about one third of all deaths from cancer and CVD[21].

The prevalence of obesity in adults tends to be higher in older age groups for both men and women[22]. Average intakes in the UK of saturated fat, sugar, and salt are above recommended levels while intakes of fruit and vegetables, fibre and some vitamins and minerals are below recommendations[15].

The proportion of adults classified as overweight or obese in Rotherham is 76.2% for the period 2013-2015. This is worse than both Yorkshire & the Humber (67.4%) and England (64.8%) and Rotherham ranks 2nd worst among similar local authorities[17]. As we know that older adults are more likely to be overweight or obese, then we can assume that the proportion of over 65's in Rotherham is even higher than the borough average.

Rotherham residents eat less fruit and vegetables than the regional and England averages, although they are in-line with local authorities with similar levels of deprivation.

A view from the past

Mary 71 yrs (Swinton) "We grew loads of salad stuff in the garden… …we had hens… …we liked to get something out of nothing".

John 84yrs (Aston) "It set us right – we were well fed… …had all the mod cons of the time, nothing like today through".

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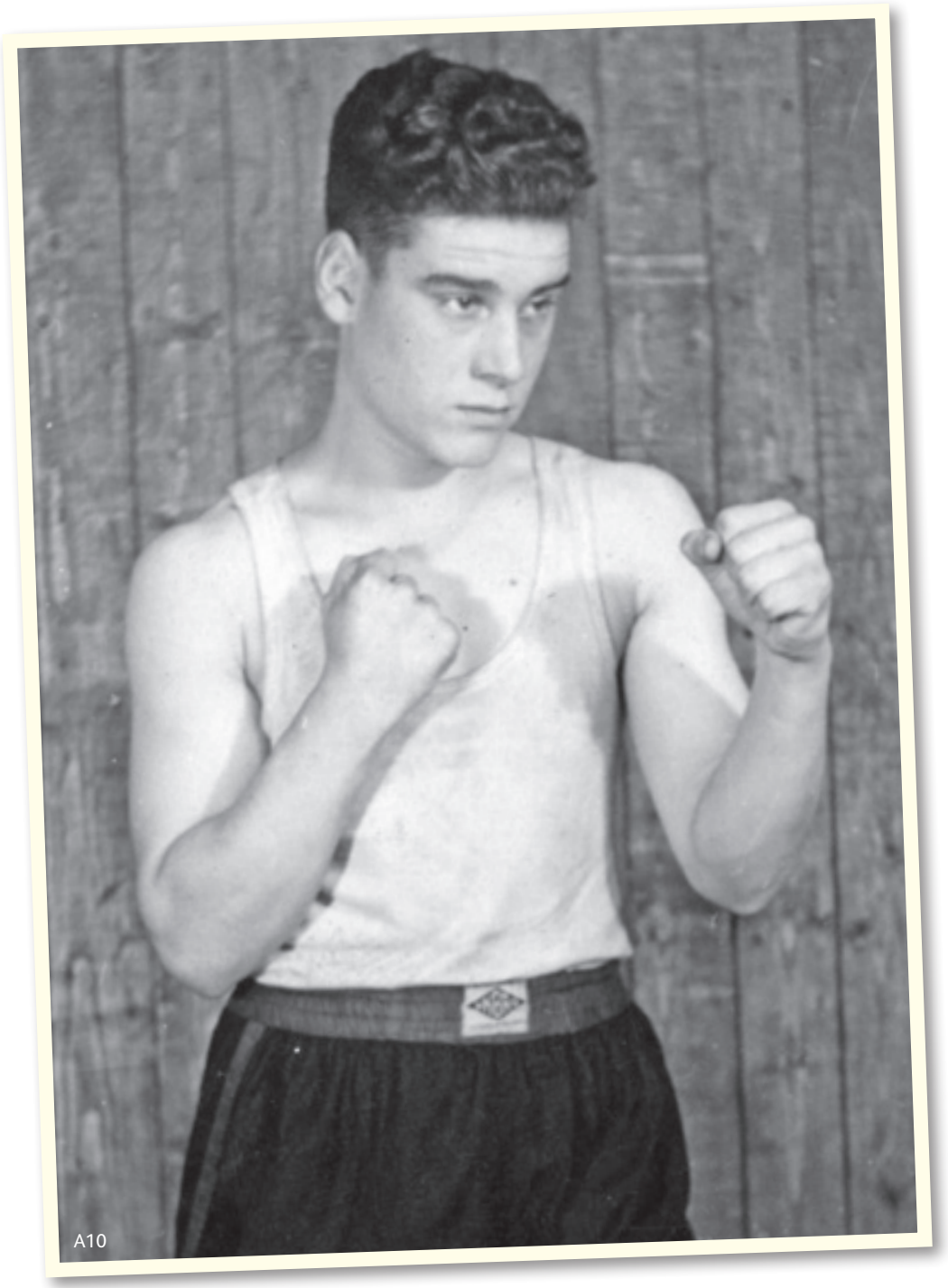
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Nutritional needs of older adults

As people age changes occur in the body that affect dietary requirements. Whilst energy requirements and appetite may change, nutritional requirements do not. If people are eating less into older adulthood (as energy requirements fall with advancing age) it is important that they consume more nutrient rich foods and drinks[17]. Older people are also vulnerable to dehydration due to physiological changes in the ageing process, but this can be complicated by many disease states, and mental and physical frailty that can further increase risk of dehydration.

Some older people in the UK have been found to have low intakes and/or low blood levels of a range of nutrients and micronutrients. For example, evidence indicates an association between low levels of vitamin D and diseases associated with ageing such as cognitive decline, depression, osteoporosis, cardiovascular disease, hypertension, type 2 diabetes, and cancer[23].

Eating a variety of foods from all food groups and keeping hydrated can help supply the nutrients a person needs as they age[23]. As a borough messages around diet, nutrition and hydration are promoted routinely to older people via health, social care and housing providers.

Key Message

Promoting the five-a-day and balanced diet messages and their importance to all groups throughout the life-course is key to improving nutrition and diet. Proper hydration is particularly important for older people and individuals and care givers should ensure hydration is maintained.

Increasing physical activity

How life has changed…

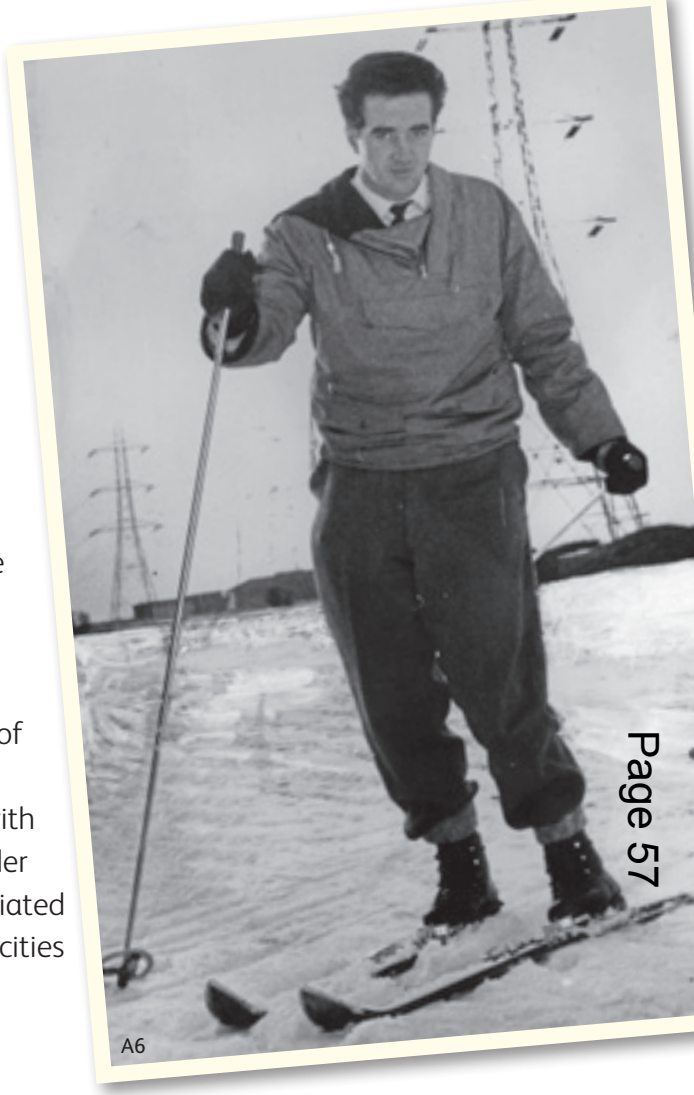
- **People in the UK are around 20% less active now than in the 1960s[9]. Lifestyles of older people have become increasingly inactive, with sedentary behaviours increasing.**
- **Older men are on average more sedentary than women. The time spent sedentary ranges from 5.3 to 9.4 hours per waking day in older adults[24].**

Physical activity is one of the most important actions individuals can take to slow the ageing process[6]. The greatest improvements in health are actually observed when people who are sedentary and least fit become more physically active. Importantly, the beneficial effects of physical activity on survival also extend to older adults who become physically active in later life.[6, 25].

There is a wide ranging and robust body of evidence that demonstrates the benefits of physical activity to physical health, mental health and wellbeing, including the Chief Medical Officer (CMO) for the UK report 2011[26], Start Active, Stay Active[27], Sport England strategy "Towards An Active Nation"[28] and Public Health England's 'Health matters: getting every adult active every day'[29]. Being physically active provides older people with a number of benefits, from improving physical and mental health to enabling people to stay connected to their family, friends and communities.

Many people in later life do not undertake the recommended levels of physical activity: only 17% of men and 13% of women aged 65-74 years[30]. Among some minority communities, and in areas experiencing social and economic deprivation, levels of physical activity are particularly low[31]. This is further compounded by those who are the most vulnerable or living in poverty.

People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health. In older adults physical activity is associated with increased functional capacities e.g. muscular strength and cardiovascular fitness[26].



The Chief Medical Officer[26] recommends that adults (including older adults) undertake 150 minutes (2.5 hours) of moderate activity per week, in bouts of 10 minutes or more. The overall amount of activity is more important than the type, intensity or frequency. In order to monitor the CMO recommendations, the Department of Health (since 2009) has commissioned Sport England to include a number of questions in the Active People Survey around people's wider participation in physical activity.

Key Fact

- **65.6% of baby boomers in the UK* have not engaged in any moderate physical activity lasting 30 minutes or longer in the past month[32].**
- **Only 17% of men and 13% of women aged 65-74 undertake the recommended amount of regular aerobic and muscle-strengthening exercise. This falls to 10% and 2% respectively in men and women aged 75-85[33].**

*** Those born between 1946 and 1964**

Within Rotherham there are a range of physical activity opportunities for people in later life. These opportunities are tailored to the changing needs of older people and suitable to a range of abilities.

Active Always brochure

There are over 50 sessions promoted and delivered across the Borough including gentle to moderate exercise sessions, Zumba, Tai Chi, aqua fit, and walking. These sessions are aimed at keeping older people active in fun and friendly environments that support social engagement and mutual help.

A further example of good practice in Rotherham is the **Mature Millers Association** established in 2013. The group aims to enrich the health and social wellbeing of people over the age of 50 in Rotherham utilising their love of sport, and football in particular.

The Mature Millers Association has been set up independently and is being supported by Rotherham United Community Sports Trust. The group focuses on men, and has specific objectives of finding ways to help and counteract loneliness. The group members participate in walking football, exercise, fitness sessions and table tennis. They have also attended football tournaments and organised trips to the football museum and St. George's Park.

Key Message

All adults including older adults to be more active in daily life, and are recommended to undertake 150 minutes (2.5 hours) of moderate activity per week, in bouts of 10 minutes or more. The overall amount of activity is more important than the type, intensity or frequency.

Reducing Alcohol Use

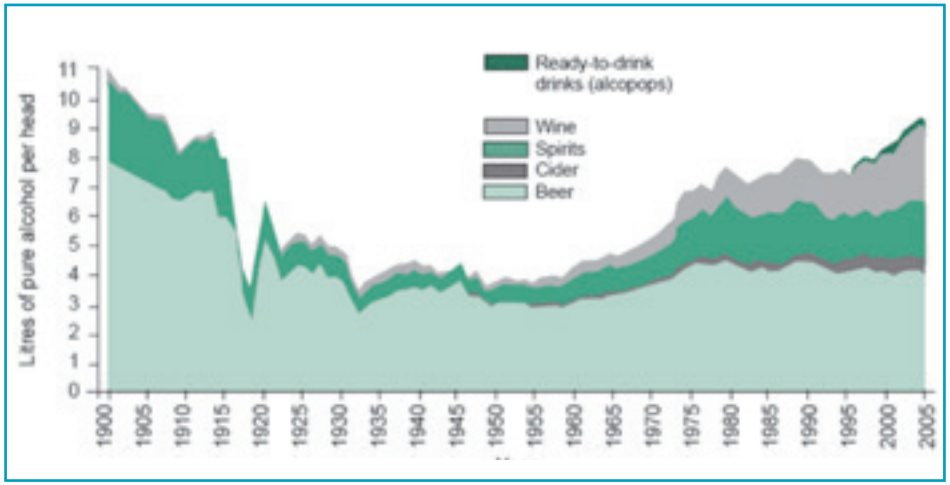
Drinking within the recommended alcohol unit guidelines (of no more than 14 units a week for both men and women) can help keep the health risks from the effects of alcohol low. If individuals do choose to drink, the units should be spread evenly across the week rather than "saving-up" all the drinks for one or two days[34].

There are short and long term effects of regularly drinking more than the recommended guidelines. When drinking is reduced, the short term effects of consuming too much alcohol can improve[34].

The short term effects of alcohol can include anxiety, disturbed sleep, stress, memory loss, stomach problems, and weight gain. Some effects of drinking to excess are not reversible and can cause permanent damage to long term health. The long term effects of alcohol can include brain damage, some cancers, dementia, heart disease, liver disease, osteoporosis, stomach ulcers and stroke[34].

Evidence presented to the House of Commons Health Select Committee (2009) on alcohol shows that in the UK from the mid-20th century onwards there has been an increase in consumption of alcohol from 3.5 litres per head per annum in 1950 to 9.5 in 2004 (with slight falls in the early 1990s and from 2005 onwards). Older people today were born at a time in the post war years when alcohol consumption in the UK was at an all-time low, but as adults they will have observed and participated in a rapid acceleration of alcohol consumption from the 1960's up to the present day.

Fig. 3: Per capita alcohol consumption in the UK (litres of pure alcohol)



Source: Statistical handbook 2007 (British Beer and Pub Association, 2007)

A view from the past

Tom 62yrs (Swinton) "…didn't drink much, only at Christmas time…"

How life has changed…

- **The strength of beer and wine has increased over the years.**
- **Beer in the 1950's had an average alcohol by volume (ABV) of 3.54. Values in 2000 were 4.22 ABV, a 19% increase in the alcohol level.**
- **It wasn't until the 1960s that British drinking culture began to shift in fundamental ways and the volume of alcohol consumed per head started to increase significantly[35].**

Rotherham is significantly worse than the England average for hospital admission episodes for alcohol-related conditions, for those aged 40-64 and 65 plus. Compared to similar authorities Rotherham ranks 6 out of 16 for those aged 40-64 and 10 out of 16 for those aged 65 plus (with 1 being the lowest admissions, and 16 being highest)[33].

Alcohol-specific mortality has decreased by 20% between 2006-08 and 2012-14 and is now lower than the England average. Rotherham ranks as 5th best in Yorkshire & Humber and 2nd best among similar local authorities[36]. However, if all alcohol-related deaths were prevented this would increase life expectancy in Rotherham by 12.7 months in males and 6.7 months in females.

However, the much higher levels of drinking among middle aged people (currently in their 40s and 50s), predicts that future generations of older people may see a disproportionate increase in alcohol-related conditions, that can result in cognitive dysfunction and dementia.

Despite these worrying trends, many older people in our community will drink alcohol socially at low levels without any significant health problems or likelihood of a drinking problem. However, it is important that all over 65's understand the changes to alcohol tolerance levels that can occur in old age resulting in even modest alcohol consumption having a significant impact on their health.

Tolerance to alcohol is significantly lowered in the older person, so it is possible that the same amount of alcohol can have a more detrimental effect than it would on a younger person. Reasons for this physical change include:

- A fall in ratio of body water to fat, meaning there is less water for the alcohol to be diluted in
- Decreased blood flow to the liver, leading to weakening of the liver
- Liver enzyme inefficiency, so alcohol will not be broken down as well as in younger people
- Poorer kidney function
- An altered responsiveness of the brain; alcohol affects older brains more quickly than younger ones[37]

It is therefore possible that the same amount of alcohol may produce a higher Blood Alcohol Concentration (BAC) in older than in younger people. Alcohol depresses the brain function to a greater extent in older people, impairing coordination and memory, and raising the likelihood of incontinence, hypothermia, injury by accident, and self-neglect[37].

Key Fact

"…perhaps up to 60% [of older people] who are admitted to hospital because of confusion, repeated falls at home, recurrent chest infections and heart failure, may have unrecognised alcohol problems. Some… are long-standing drinkers who have become old, others started drinking in old age… elderly widowers are the most vulnerable group." Source[37]

Adverse interactions between alcohol with some prescribed medications can occur, placing older people at increased risk of harm. Around 80% of people aged 65 and over regularly take prescribed medicine, more than half taking at least three prescribed medicines and more than a third of those aged 75 and over taking six or more prescribed medicines a day[38].

Key Message

Older people in Rotherham are made aware of the additional health risk of regular and excessive alcohol use, and professionals are aware of the signs and symptoms and have healthy conversations to inform behaviour change, where appropriate.

Reducing Tobacco Use

A view from the past

Lynn 65yrs (Rawmarsh) "…I spent money going into Sheffield at the weekends, I would give my board over and then spend perhaps too much money on smoking… but everyone did back then. At work the staffroom was one big smoke room – dreadful really… some girls didn't stop smoking even when they were pregnant…"

There is significant evidence demonstrating that stopping smoking can provide health benefits for older adults by adding both 'years to life' and 'life to years'. It is becoming increasingly evident that mortality is reduced among those who stop between 65-75 years and that the benefits of stopping smoking are almost immediate for some health conditions.

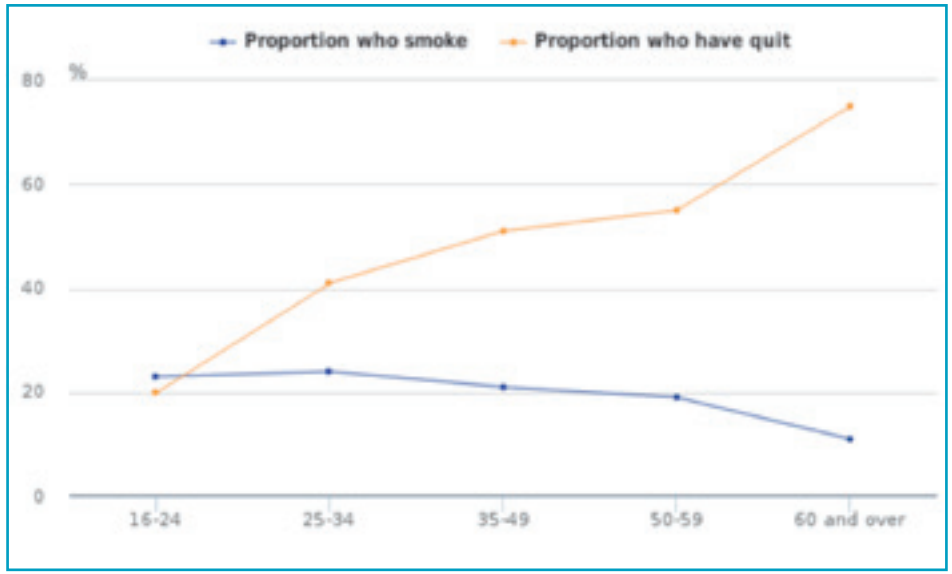
Fewer older people are smoking now than in the past. Nationally, 18% of men and 19% of women aged 65-74 were cigarette smokers in 1998, in 2014 this had reduced to 13% and 12% respectively. For those aged 75 and over there were 9% of men and 10% of women current smokers in 1998, but 5% & 5% respectively in 2014[38].

There is significant risk to the health of older adults from tobacco use and the hazards of smoking. On average, nearly 10 Rotherham residents died every week from smoking related causes (based on 2012-2014 death registrations)[9].

The perception of older smokers is that smoking cessation in later life is more challenging. Smokers of this age often fail to see the point of stopping and have many misconceptions regarding smoking and health. Many smokers in this age group have smoked for many years and are strongly addicted to both nicotine and the habit. They come from

a time where smoking was very much socially acceptable and often encouraged. However, as Fig. 4 below illustrates, it is never too late to stop smoking, with more people quitting over the age of 60 than at any other age, in England. This picture is likely to be similar in Rotherham.

Fig. 4: Proportion of smokers and smokers who have quit smoking by age group in England



Source[15]

This trend is reinforced by local data from Rotherham's Stop Smoking Service (Yorkshire Smokefree) where over 65's are more successful at quitting (67%) than the average (62%). Older people can still make a difference to their health and quality of life, if they quit.

Fig. 5 The health benefits of quitting

Source[39]

It is important to acknowledge that at whatever age, it can be difficult to give up smoking, as nicotine is addictive. Therefore, most people have to attempt to quit more than once. There are a number of different ways to quit, but the stop smoking specialist service still remains the most effective method, as a combination of support and nicotine replacement therapy is offered.

Key Message

Older people who smoke should consider stopping smoking, and should be encouraged to do so by professionals of all statutory services.

Sexual Health

It's a myth that older people no longer want or need a sex life. Sexuality doesn't just disappear as you age and it's perfectly natural to have sexual desires. A recent report by the English Longitudinal Study of Ageing found that two-thirds of men and women aged 50 – 90 years old said that sex was an important part of a relationship. They also found that people are still sexually active into their 80s and 90s.[40]

For all our adults of any age we need them to have access to timely, accessible, high quality sexual health services and information.

Although older people do not generally have to consider their contraceptive needs as part of sexual activity they will still need to take into account the risk of sexually transmitted infections (STIs), particularly when embarking on new relationships. Nationally figures show that 38,000 people over the age of 50 went through a divorce in 1995, compared to 55,000 in 2005[41]. It is in the older population that the divorce rate is increasing the most.

Currently, there is evidence both that older people are less likely to use condoms than any other age group, and that health professionals do not perceive older people to be at risk of STI's[42]. It is therefore important that health professionals take the needs of this age group into account when developing health promotion messages and promoting sexual health information and services.

There may be specific sexual health needs among the often hidden population of older lesbian, gay, bisexual and transgender (LGBT) individuals. Although there is now broad societal and legal support for LGBT individuals, the majority of older people will have lived a large part of their lives in less liberal times, which may have made them cautious of mainstream services. Age UK estimates that one in every fifteen potential users of a service for older people is a lesbian or a gay man[43].

The over 50s are the fastest growing group of people with HIV in the UK and research by the Terrence Higgins Trust and Age UK has shown that this age group has specific needs including reporting poorer general health than their peers, being worse off financially and having specific emotional needs[44]. There is a need for providers of health and social care services to cater specifically for this group.

Key Message

Professionals in Rotherham consider the needs of older people when developing health promotion messages and providing sexual health information and services.

Long Term Conditions

The population is living longer. This is good news in that most people are experiencing more years of life, but it also means that there are more people with single and multiple Long Term Conditions (LTC's). LTC's include illnesses such as heart disease, Chronic Obstructive Pulmonary Disease (COPD), diabetes, dementia, hearing and vision impairment, and cancer.

LTCs are important because there is scope to prevent some of them by modifying lifestyles and behaviours and promoting healthy living. They also contribute to inequalities by affecting an individual's ability to earn.

Key Fact

Nearly 80% of premature heart disease, cancer, stroke and diabetes can be prevented.

Researchers found that by making the correct lifestyle choices by following the four rules below the risk of developing diabetes, heart attack, stroke and cancer is reduced by 78%.

- **Exercising regularly – The Chief Medical Officer recommends 150 minutes (2.5 hours) of moderate activity per week, in bouts of 10 minutes or more[26]**
- **Keeping a healthy weight – (having a BMI lower than 30)**
- **Eating a healthy diet – high in fruit, vegetables & whole grain, and low in red meat**
- **Never smoking – never having taken-up smoking is best, but quitting smoking has a significant effect on health**

Source[10]

Based on the four chronic conditions of diabetes, chronic heart disease, stroke and cancer, for 2015/16 Rotherham has around 38,850 patients on NHS Rotherham GP Practice registers. Applying the fact that 78% of the big four diseases can be prevented to the 2015/16 local GP Practice register statistics above, there are nearly 29,500 people in Rotherham, many of whom are over 65, for whom their condition was likely to have been preventable.

LTCs become more common as people get older and because people in Rotherham are living longer, we can expect more people to be diagnosed with LTCs over time. Chapter 1 highlighted that older people in Rotherham are 30% more likely to have a seriously limiting long term illness (LLLTI) or disability than the national average. If the above percentage were to remain constant, the number of people aged 65 and over 'limited a lot' by a long term health problem or disability in Rotherham would have increased from 14,120 in 2011 to 16,231 in 2015 and projected forward, reach 19,954 by 2025.

People with LTCs tend to need more health and social care, and family members and friends may need to take on a carer role in order to support the person with a LTC. Individuals are more commonly found to have multiple LTCs rather than just one. This is an important issue because the effective management of individuals with multiple co-existing conditions is more complicated.

LTCs have long lasting economic impacts for individuals and appear to be concentrated in areas with higher levels of deprivation. For example, by looking at the percent of people with LLLTI from the 2011 Census, we can see that 3 of the 4 most deprived wards in Rotherham[45] were in the 6 wards with the highest percentage of LLTI.

Social prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with a non-

medical referral option that can operate alongside existing treatments to improve health and well-being[46]. Social prescribing commissions services that will prevent worsening health for people with existing LTCs and reduce costly interventions in specialist care. It links patients in primary care and their carers' with non-medical sources of support within the community.

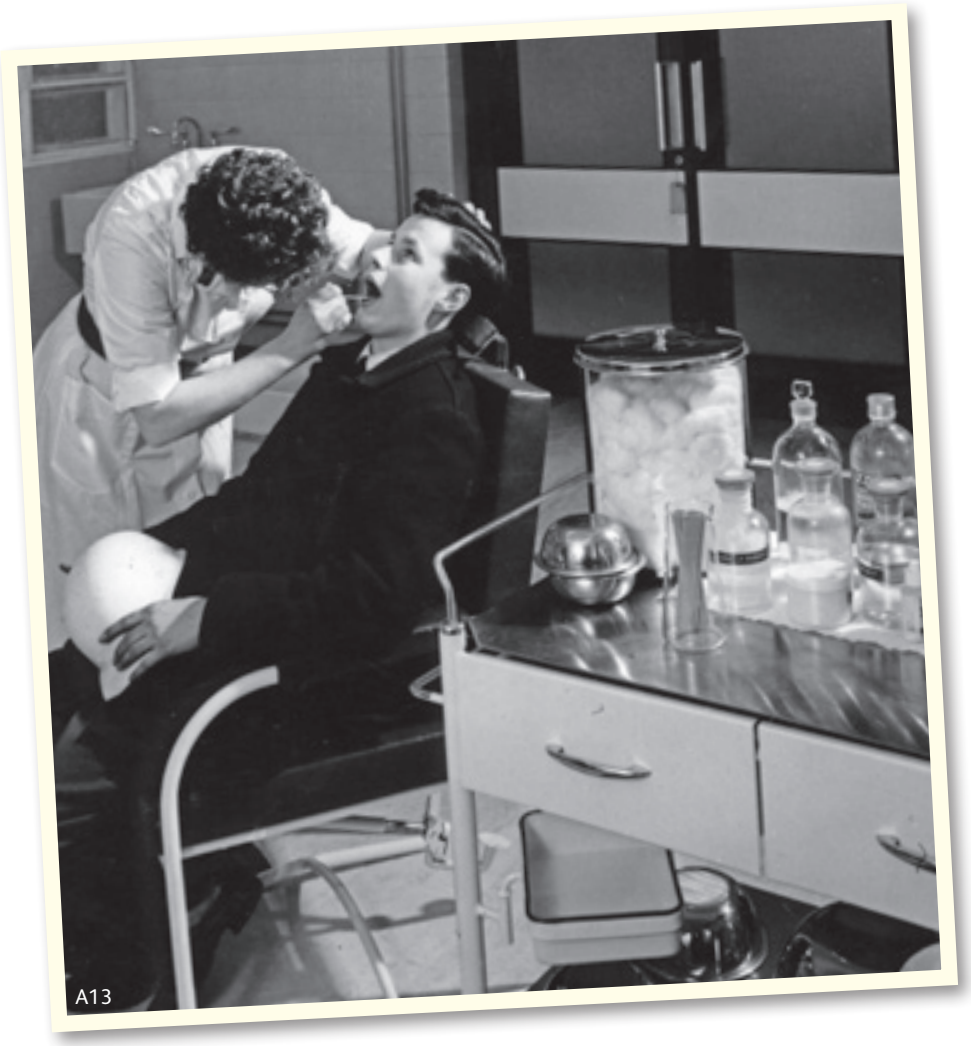
Rotherham Social Prescribing Service is an award winning service delivered by **Voluntary Action Rotherham** (VAR). **The Social Prescribing service helps people with long-term health conditions to access a wide variety of services and activities provided by voluntary organisations and community groups.** Funded by Rotherham Clinical Commissioning Group, the case management scheme brings together health, social care and voluntary sector professionals, who work together in a co-ordinated way to plan care for people with long-term health conditions. The voluntary sector runs more than 20 projects ranging from art, befriending and discussion groups to Tai Chi and the service has now been extended to those discharged from community mental health services. In Rotherham, more than 2,000 patients with long-term health conditions, who are at risk of hospital admission, have been referred for a social prescription.

An evaluation by Sheffield Hallam University's Centre for Regional Economic and Social Research (CRESR)[47] found that as a result of the social prescribing:

- non-elective inpatient episodes reduced by 7%
- non-elective inpatient spells reduced by 11%
- Accident and Emergency attendances reduced by 17%.

82% of service users, regardless of age or gender, also reported a positive change in their well-being within four months of being issued with a social prescription.

The NHS Five Year Forward View[48] quoted the Rotherham Social prescribing service as an "emerging model for the future".



Be Active to Stay Healthy

www.rotherhamgetactive.co.uk/activeforhealth

The Rotherham "Active for Health" Research Project aims to increase patients' with long term conditions participation in physical activity. It is evidence based, driven by local need and incorporates best practice.

"Active for Health" offers specialist physical activity referral pathways that have been developed for patients with the following conditions leaving rehabilitation services or identified by their GP:

- Cardiac and heart failure
- Stroke
- COPD
- Cancer
- Lower back pain
- Falls

Patients benefit from a specifically designed programme of exercise to maintain activity to aid their recovery from a health condition(s). All programmes follow a 3 step process consisting of rehabilitation, moving on and keeping active.

Step 1 Rehabilitation

NHS Rehabilitation services, lead exercise professionals will work directly with patients to motivate referrals into Step 2.

Step 2 Moving on

12 week FREE programme of exercise, tailored to patients' health condition. Group sessions delivered by specialist exercise professionals with individualised programmes to improve patients' recovery.

Step 3 Keeping Active

Patients are offered an opportunity to continue being active. These sessions will be suited to their condition/abilities and aimed at continuing recovery.

The programme also utilises the passion and enthusiasm of patients who complete it by enabling them to continue as community buddies. The social community buddies share their experiences, make new attenders welcome and support with the running of the session, especially the social coffee time. This important asset-based approach recognises their role and gives participants ownership of the project.

What can people do to help themselves?

In Rotherham NHS Health Checks are available from your GP if you're aged 40-74 and you haven't had a stroke, or you don't already have heart disease, diabetes or kidney disease. For those 75 and over, check-ups are available by request from GP's, if the individual hasn't already received one in the last year. The NHS Health Check is a free check-up of your overall health. It can tell you whether you're at higher risk of getting certain health problems, such as heart disease, diabetes, kidney disease and stroke. As well as measuring your risk of developing these health problems, an NHS Health Check gives you personalised behaviour and lifestyle advice on how to prevent them or lower your risk. Examples include: how to improve your diet and the amount of physical activity you do; taking medicines to lower your blood pressure or cholesterol; how to lose weight or stop smoking.

Key Message

- **All services should encourage lifestyle behaviour change in older people where appropriate, particularly in the most disadvantaged communities.**
- **All Rotherham residents aged 65 and over to consider their own health behaviours and lifestyle choices.**

Recommendation One

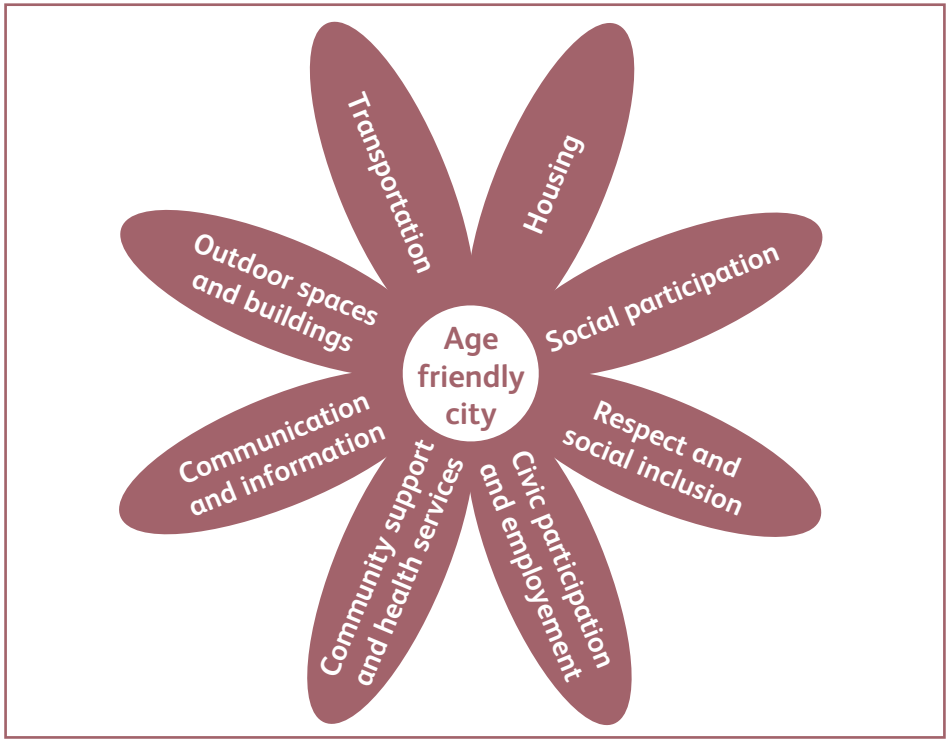
All services should encourage lifestyle behaviour change in older people where appropriate, particularly in the most disadvantaged communities. This could be achieved through taking a systematic approach to MECC.

Chapter 3 Age friendly environment & community, supporting health (physical and mental)

Developing an age friendly community

Developing a community that is age friendly is viewed as complementary to improving independence. The Local Government Association (2012) "Ageing well: a whole system approach" recommends a "place based approach"[49] identifying how the public sector working together with the voluntary and community sector can deliver better value services to citizens through joint working which in turn can reduce waste and duplication. It is recognised that this approach encourages creative solutions, maximises the use of community assets (what the community already has rather than what is doesn't), builds capacity and further develops social capital in local communities.

Figure 6: WHO Age Friendly Cities and Communities[11]



The World Health Organisation (WHO) Age Friendly Cities and Communities[11] is a recognised way to focus local action on improving the services and opportunities for older people. This is achieved through strong partnership, improved area and building design, and consideration of older peoples' needs in planning and strategies. This model places the needs of older people at the heart of any development plans and recognises that older people are an important asset to the community. There is a significant opportunity for all Rotherham policy makers to ensure that policies and plans reference the full breadth of opportunities that are created within our ageing society and does not only focus on the challenges[11].

Rotherham's Healthy Ageing Framework

Rotherham has developed a Healthy Ageing Framework to ensure that the vision and actions are more joined up and working towards a common goal. This is particularly important at a time when public resources are being reduced, to maximise assets to deliver good outcomes for our ageing population. The framework has been shared with Rotherham residents and amended to make the text more relevant to individuals and communities.


A14

There are three key high level outcomes with a series of supporting indicators.

I am emotionally well
- I have choice and control over my decisions
- I feel valued
- I am well connected
- I have hobbies and interests
- I feel safe in my community

I live well
- I am making a positive contribution
- I am safe from abuse
- I live in a suitable home that meets my needs
- I can get out and about
- I can look after my finances
- I have strong social networks

I am physically well
- I can complete my daily tasks
- I lead a healthy lifestyle
- I am working / volunteering
- I can manage my long term condition
- I am being cared for

There is an opportunity for Rotherham to consider the WHO Age Friendly Cities framework alongside the locally developed Healthy Ageing Framework as a way to ensure that Rotherham services and developments are progressively meeting the needs of the ageing Borough. The quality of life of older Rotherham residents will be improved by taking this approach and encouraging residents to continue to be active community residents. This framework complements the current Rotherham aspiration to be a child friendly borough.

Key Fact

As people live longer, communities will need to respond to the changing demographics. Older people are a key asset and resource both physically and economically within local communities. For example, the financial contribution of older people in formal volunteering roles in the UK is estimated to be over £10 billion per year[50].

GOOD PRACTICE *EXAMPLE*

Age Friendly Manchester

Manchester has a strong history in focussing on the needs of older people.

Age friendly is an internationally recognised concept that enables good quality of life for older people, and is supported by a World Health Organisation movement of over 200 Age Friendly Cities and Communities worldwide.

Age Friendly Manchester is a partnership involving organisations, groups and individuals across the city playing their part in making Manchester a great place to grow older.

This is delivered through a multi-agency, city wide approach:

- Age friendly neighbourhoods
- Age friendly services
- Communication and involvement
- Knowledge and innovation
- Influence

Source[51]

A view from the past

Bob 68yrs (Dinnington) "nights used to seem hours as a kid a lot longer than now… we would just play in the streets we didn't really have much to play with, but I remember playing for hours well into the dark ..."

"…the wife picked our house … It was a nice street near to the school… she wanted a mortgage she would never rent….so we lived in a detached house, we are still there …she liked it because it was bright and has loads of windows…"

Key Message

- **Partners across Rotherham use the Healthy Ageing Framework to ensure that the vision and actions for older people are more joined up and working towards a common goal.**

Excess winter deaths

Excess deaths in winter continue to be an important public health issue in the UK and are potentially preventable through effective interventions. Excess deaths is greatest in both relative and absolute terms in older people and for certain disease groups. It also varies from area to area. Excess Winter Deaths (EWD) data is available for the 85 and over age group. Rotherham rates for the single year (August 2014 to July 2015) for persons and males were the worst in Yorkshire and the Humber Region and 2nd worst compared to similar local authorities (CIPFA nearest neighbours). Rotherham female excess winter death rates are average for the region[12].

Although EWD are often associated with cold weather, it has been observed that other countries in Europe especially the colder Scandinavian countries have relatively fewer EWDs in winter compared to the UK. Actions to reduce excess deaths include:

- Tackling certain underlying conditions which cause premature death, such as respiratory disease
- Supporting energy efficient interventions in housing
- Encouraging fuel poverty referral (see fuel poverty section on page 43)

The Cold Weather Plan for England[52] identifies a number of 'at risk' groups who may be more susceptible to harm from cold weather including the following that affect older people:

- Elderly people living alone without additional support from social services
- People aged over 75
- Those with pre-existing chronic medical conditions
- People with ill health affecting their ability to self-care (including dementia)
- Those at risk of recurrent falls
- People with poor mobility or who are housebound
- Those who are fuel poor, live in deprived circumstances or are homeless

Key Fact

Respiratory diseases are often caused or made worse by damp and cold conditions and national research shows that winter deaths increase more in England compared to other European countries with colder climates.

Locally we have a Cold Weather Alert system based on Met Office forecasts providing advanced warning and advice, triggering levels of response from the NHS, local government and the public health system. This includes offering Emergency Accommodation to the homeless.

Preparedness of the health and social care system for cold weather is central to local policy and action which includes emergency planning and business continuity.

Rotherham has prominent winter preparedness media campaigns including communicating risks and actions for the public associated with Keep Well, Keep Warm. This campaign includes supporting provider organisations and their staff to reduce cold related harm, and raising awareness of toolkits, best practice and referral mechanisms for winter warmth initiatives.

Engagement of the community and voluntary sector organisations is key to reaching the most vulnerable in our community. The voluntary and community sector in Rotherham plays a crucial role in identifying and supporting particularly vulnerable or marginalised individuals.

Health partners work collectively to maximise the uptake of pneumococcal (Pneumococcal Conjugate Vaccine) and seasonal flu vaccination. GP's in Rotherham are being supported to improve the uptake within specific populations, such as people living with Long Term Conditions (LTCs) or weakened immune systems.

Existing home, work and community environments should be maintained and improved to ensure that they protect individuals from harm associated with high and low temperatures, damp and other physical hazards.

Key Message

Professionals, families, neighbours and communities are aware of vulnerable older people who may be at increased risk from cold weather and take the necessary action to enquire, refer and provide support where required.

Housing

Key Fact

Households where the oldest person was aged 85 years or over were more likely to live in a non-decent* home than other age groups, according to the English Housing Survey Housing for Older People Report, 2014-15[53] .

***Decent home: A home that meets all of the following four criteria:**

- **it meets the current statutory minimum standard for housing as set out in the Housing Health and Safety Rating System.**
- **it is in a reasonable state of repair (related to the age and condition of a range of building components including walls, roofs, windows, doors, chimneys, electrics and heating systems).**
- **it has reasonably modern facilities and services (related to the age, size and layout/location of the kitchen, bathroom and WC and any common areas for blocks of flats, and to noise insulation).**
- **it provides a reasonable degree of thermal comfort (related to insulation and heating efficiency).**

Many older people live in cold and deteriorating housing. It is often difficult for them to find the resources they need to fix and improve their homes. This has contributed to thousands of older people suffering discomfort and ill health, resulting in increased demand on the NHS and social care[54]. The substandard housing and conditions older people can find themselves living in are exacerbated by the fact that older people spend more time at home.

Poor housing can have a serious impact on the lives of older people. Damp, unfit and cold housing can cause a range of health problems including respiratory conditions, arthritis, heart disease and stroke, as well as mental health problems. Mental health problems are often caused by added stress and anxiety of poor housing. Hazards in the home and poor accessibility contribute to falls and accidents[54, 55].

The Decent Homes Scheme provides for the refurbishment of council owned properties borough wide under the Government's Decent Homes Legislation. To meet the national standard of Decent Homes, all council and housing association properties must:

- Be free from damp
- Have a kitchen less than 20 years old
- Have a bathroom less than 30 years old
- Have an efficient heating system
- Be in a reasonable state of repair
- Have double glazed windows
- Have secure external doors

If a home does not meet this standard, individuals should contact their landlord in the first instance to discuss any issues.

The ageing population of Rotherham need to consider if their housing is suitable for them as they grow older (future proofed for their needs). Most people in Rotherham would like to remain in their own home and there are many adaptations and changes that can be made to enable them to live independently in their own home. However a quarter of older people want or expect to move to specialist housing. The demand for these properties is high and often older people's needs are complex.

It is recognised that:

- Specialist housing for older people, particularly extra care housing, can lead to significant savings to Adult Social Care and Health budgets as it can provide an alternative to residential care.
- Older people will experience improved health and wellbeing if they are able to live in homes that meet their needs, with easier access to services and opportunities to connect with other people.

To help address these issues, Rotherham is developing two further 'elderly people' specialist housing schemes in Thurcroft and the Town Centre.

Shaftesbury House is an ideal location for older people in terms of its proximity to shops, facilities (including the adjacent Rotherham Leisure complex) Rotherham Council is currently exploring options to extend the number of homes, improve the overall quality of the accommodation and provide better communal facilities to enhance residents' health and wellbeing. Six of the flats at Shaftesbury House have recently been fitted with adaptations and assistive technology to meet a variety of complex needs, and designated as short stay accommodation to support people to remain living independently.

As the population ages and their housing requirements change it will be increasingly important to have a full range of housing options for the older population in Rotherham that are fully integrated into the community. From the stock of around 20,000 council properties 23% are now suitable and designated to those over 55 years of age. The environment where older people live has a large impact on their health and wellbeing. Older people are at high risk of any changes in weather conditions and may require additional considerations when allocating housing or within town centre developments to enable them to live as active members of their community.

Key Message

Individuals, housing providers and housing strategy and policy must plan adequately for the rising older population in Rotherham to ensure sufficient and appropriate housing is available to enable older people to stay independent and in their own homes should they wish, whilst taking account of the needs of both tenants and owner occupiers.

Fuel poverty

Older people are particularly at risk of health problems relating to living in a cold home. Some may have a cold home due to the costs of heating, but 'fuel poverty' is also related to the energy efficiency of a house and household income. Evidence suggests, the key driver of fuel poverty is related to housing conditions.

The choice to heat or eat

There is a wealth of knowledge and an evidence base identifying the direct negative impacts of living in a cold home to health[56]. The personal and social costs arising from cold related premature death and a range of cold home related illnesses in Rotherham is estimated to stand at over £10million. It is regularly reported in the media that the cost of heating homes is a particular concern for older people. This can lead older people to making choices over how they spend their money and whether to eat sufficiently or heat their home. The rise in energy bills and the cold weather often result in people reducing the amount of heating they have in their homes. Older people are at the highest risk and are often the hardest hit as they may be on more expensive energy tariffs due to a reluctance to switch suppliers and utilise on-line discounts, whilst also spending more time at home.

GOOD PRACTICE *EXAMPLE*

Warm Homes Healthy People and Fuel Poverty Funding

Since 2011, Rotherham has successfully secured over £600,000 of funding from the Department of Health (DH) and Department of Energy and Climate Change (DECC) for projects to reduce levels of fuel poverty*, excess winter deaths, and suffering of vulnerable people who live in cold homes during the winter months. This has enabled partnership working to provide:

- Home safety checks
- Warm packs for both elderly householders and families
- Supporting householders to sign up to energy efficiency schemes
- Financial support in accessing benefits and changing utility tariffs
- One to one tailored energy saving advice

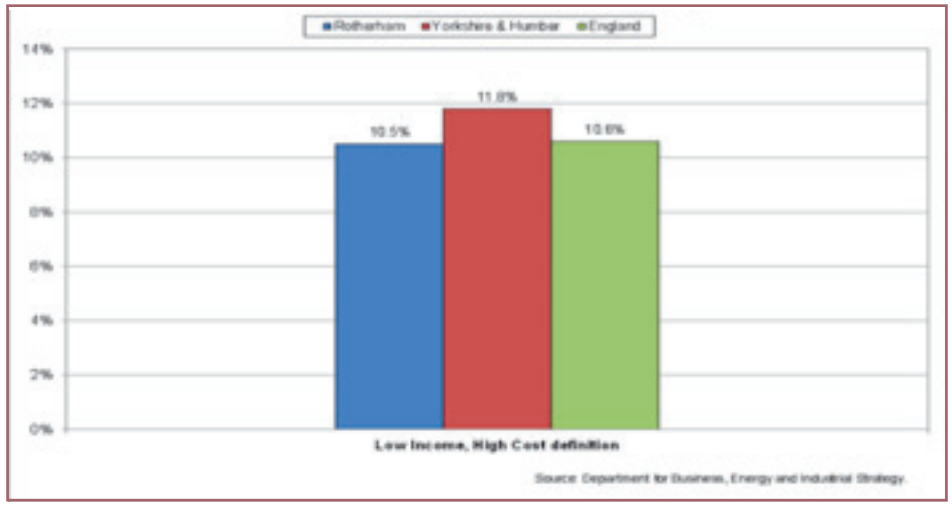
Levels of fuel poverty in Rotherham seem to be improving (10.5% in 2014 reduced from 15.1% in 2012)*.

* A fuel poor household is defined as one which needs to spend more than 10% of its income on all fuel use and to heat its home to an adequate standard of warmth. In England, this is defined as 21°C in the living room and 18°C in other occupied rooms.

The two year delay in reporting fuel poverty figures, the changes to current national energy policy and welfare reform means this index result may not be indicative of current levels of fuel poverty.

Rotherham Council have focussed their private sector related energy efficiency activity in areas where there are high proportions of fuel poor households identified, based on income and the 10% definition.

Fig. 7: Percentage of households in an area defined as being fuel poor. Rotherham compared to Yorkshire & Humber region and England 2014



Source[57]

Rotherham's Creating Warmer Homes Strategy (draft) has an aspiration to ensure all Rotherham householders can live in warmer homes.

This will be achieved through five aims:

- Work in partnership to deliver Rotherham's Warmer Homes Strategy
- Residents are aware of affordable warmth issues and services available
- Improve the energy efficiency of Rotherham's housing stock
- Health and wellbeing is improved through warmer homes
- Maximise income and minimise energy costs for all Rotherham residents

Work to reduce levels of fuel poverty within Rotherham has been taking place for a number of years and is a strategic focus and priority of the Health and Wellbeing Board.

GOOD PRACTICE *EXAMPLE*

Keeping Warm in Later Life Project (KWILLT)

The research study aimed to understand the influences and decisions of vulnerable older people in relation to keeping warm in winter. It generated insight into why vulnerable older people are cold at home and revealed the many complex factors that can combine to prevent some older people keeping warm. It also revealed that it is not only the very old and ill who are vulnerable. Fuel poverty, lack of knowledge about fuel costs and fear of fuel debt were amongst the factors identified. See the project website **http://www.kwillt.org**

Key Message

Rotherham policy makers to ensure the Warmer Homes initiative remains a partnership priority in order to deliver the aspiration of ensuring all Rotherham householders (including older people) can live in warmer homes.

Accidents & Falls

Hazards in the physical environment can lead to debilitating and painful injuries among older people. Injuries from falls, fires and traffic collisions are the most common.

Safe and Well visits

Fire Officers are providing Safe and Well visits across South Yorkshire to older people within their own homes to undertaking a risk assessment for the safety of the home and adaptations and improvements to reduce the risk of falls. These visits are an opportunity for health messages to be shared and allow people to be referred or signposted to support services as appropriate.

This is an example of how services can work together to improve the health and wellbeing of our communities.

South Yorkshire Fire and Rescue are preparing to roll out the Safe and Well visits in Rotherham in 2017.

Falls among older people are a large and increasing cause of injury, death and associated treatment costs. Falls have many causes including medical conditions, side effects of some medications and environmental hazards. Most often, these falls occur in the home environment and are preventable. The consequences of injuries sustained in older age can be more severe than among younger people. For injuries of the same severity, older people experience more disability, longer hospital stays, extended periods of rehabilitation, a higher risk of subsequent dependency and a higher risk of dying[1].

Falls Prevention Pathway: Improvements in falls rate

The falls rate has improved significantly over the last few years in Rotherham. The most recent data shows that 676 Rotherham people over 65 had an injury that was due to a fall in 2014/15[17].

Table 6: Rotherham Falls Rate Trends 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
Falls rate in over 65s population (per 100,000)	2297	1570	1656	1417
Number of people who have fallen (over 65s)	1039	720	752	676
Falls rate in over 80s population (per 100,000)	5847	3953	4189	3545
Number of people who have fallen (over 80s)	686	467	476	426

Rotherham's age-sex standardised rate per 100,000 injuries due to falls for those aged 65 and over and those aged 80 and over have both improved by nearly 40% from being significantly worse than England in 2010/11 to significantly better than England in 2014/15[17].


A18

Action in Rotherham

A falls recovery pathway has been established which links hospital admissions and community rehabilitation to long term postural stability exercise classes. This pathway has been in existence since 2011. The pathway has been refined over time and the communication between the different professional groups has been further developed. In 2015 the pathway was used to develop the "Active for Health" physical activity programme (see Chapter 2).

The cost savings to the Rotherham health and social care system for the falls that have been prevented over the last 3 years (2012-15) are in excess of £11 million (using the mean rate).

This has been calculated using the Kings Fund[58] costings and using the actual number of falls from 2011/12 when the number of falls was at a high point in Rotherham.

Table 7: Annual costs per fall

Number of falls prevented 2012/15 (3 year period)	Low level cost per fall (£6,419)	Medium cost per fall (£11,731)	High level cost per fall (£18,397)
969	£6,220,011	£11,367,339	£17,826,693

Key Message

Preventing falls through the early identification, referral and appropriate interventions for older people at risk, is an important factor in maintaining the independence of individuals in our community.

Recommendation Two

Rotherham Health and Wellbeing board considers implementing the WHO 'Age Friendly Cities and Communities'[11] and become the first area in South Yorkshire to achieve this accreditation, learning from other UK cities that have already begun this work. This would be complementary to the Borough's aspiration to be young people and dementia friendly.

Chapter 4 Encouraging social inclusion

A18

A10

A19

A3

It is recognised that later life can provide a series of challenges that can be grouped under the heading social inclusion, including: maintaining independence, income and participation, mental health, loneliness & isolation.

At the heart of the WHO recommendations[4] for healthy and active ageing is the vital importance of enabling older people's proactive involvement and participation in life and society as a whole. Older people are particularly vulnerable to social exclusion in a number of ways:

- Insufficient income to be able to participate in society.
- Older women living in more remote rural areas experience some of the highest rates of exclusion, as do older people living in disadvantaged urban housing estates.
- Discrimination affects people's access to services and their ability to earn income independently over a longer period of their life. National research reveals 33% of all older people experience perceived age discrimination[59].
- Ill-health and disability is progressive with age, and curtails independence that can be crucial to feeling valued within family, community or society.
- Lack of access to transport can prevent people from getting to and from services and facilities necessary for a decent standard of life.

Independence

There has been a large amount of literature developed that emphasises the importance of maintaining independence for older adults health and wellbeing. Many older people no longer live close to their families so a reduction in their abilities to stay independent can happen without anyone noticing. In order to facilitate independence it requires support from many agencies and a truly joined up approach. A change in approaches has resulted in a move away from "doing to" people and are now looking for our residents to be active partners in their own health and care.

There is an appetite to increase independence as part of a whole system approach to ageing in Rotherham; this will be partly by changing social attitudes to encourage the participation of older people. Independence is highly valued as it brings with it dignity, control, self-esteem, and fulfilment[60]. When independence is removed from a person's life, the individual may feel defeated, depressed, or begin to doubt their own ability to care for themselves. Low expectations lead to reduced capabilities and can be self-fulfilling, causing deterioration in health and cognitive ability. Part of the vision of the Rotherham Metropolitan Borough Council Corporate Plan 2016/17 is that every adult is secure, responsible and empowered.

"We want to help all adults enjoy good health and live independently for as long as possible and to support people to make choices about how best to do this. We want a Rotherham where vulnerable adults, such as those with disabilities and older people and their carers, have the necessary support within their community."

Key Facts

Encouraging people to undertake independent activities (either physical or mental) is good for maintaining independence. These can be varied and include:

- **Light housework or cooking**
- **Travelling on public transport**
- **Attending social events and meeting with friends**
- **Talking on the phone, writing letters or emails**
- **Using the computer**
- **Personal hygiene and dressing**
- **Playing games or solving puzzles**
- **Making tea and refreshments**
- **Going for walks or engaging in gentle to moderate exercise**
- **Volunteering and charity work**

By continuing to do tasks you are maintaining your functional abilities.

Source[61]

How life has changed…

Families lived locally and there were local shops in every group of streets. Community was very local and it was the norm for people to be shopping daily and meeting people regularly.

Source[62]

The change in family structures and geography influences the supply and demand for formal and informal care by older people. Care is now often provided by family members. Adults are now starting families later in life, there are increased levels of marital disruption and more complex family relationships. The greater geographical separation may impact on the families' ability to care, with only 50% of older people in the UK having an adult child living within 15 minutes proximity of their parents, but this does vary with ethnicity. There are increased divorce rates, particularly among the over 60's (by 73% between1991 to 2011), which increases the number of older people living alone[63]. These new complexities make it more likely that care and support may be required from external sources rather than the family.

Communities have an important role in the development of independence and supporting their ageing populations. Social connections can be facilitated through the use of community assets (both people and places) including religious and voluntary groups, craft and social events, libraries, community centres, pubs, shops and cafes. It is really any place where people can meet up with a shared purpose and grow their social connections.

Independence is not delivered by one organisation it is a result of all stakeholders working together to meet the needs of ageing individuals within their communities.

During 2016 Public Health worked with partners to consult with older people on their health and wellbeing needs as part of the co-production of the Healthy Ageing Framework. Rotherham's ageing communities stressed that not being able to do the things they enjoy affected their wellbeing. A common theme is that being connected to their local community and volunteering has a positive impact on ageing well. Loneliness and isolation was an issue of concern. Transport was the biggest challenge to them accessing services across the Borough, and parking issues further hindered their decisions.

Rotherham's Assets: Ted Ring

Ted's volunteering knows no bounds - Churches Together in Rotherham, Community Volunteer Ambassador, Founder Trustee and Company Secretary of Spires Venues, Sheffield Referee Association, fundraiser for Bluebell Wood Children's Hospice to name a few! His wit and wisdom shine through along with his unwavering commitment to keeping people connected, consistently going that extra mile and raising the profile, he is an amazing ambassador for the sector and the town of Rotherham.

It's incredible to think at 80 years young, Ted is in his 62nd year as a volunteer and to quote him .. "I still love doing something to help others, here's looking forward to a good few more years of voluntary work".

The Council has provided free parking in the town centre at certain times in the week and over weekends to help minimise barriers to access for older people. The free parking also corresponds to the time when the free bus pass is active e.g. after 9.30am, to reduce transport barriers preventing access to the town centre.

Older people in Rotherham also perceived the health and social care system to be complicated, and didn't always know where or how to access the support or opportunities that they require. Commissioners and services from across Rotherham have worked together with service users to find a way to enable older people to better navigate the health and care system. These solutions include:

- Rotherham Clinical Commissioning Group and Voluntary Action Rotherham (VAR) – Social Prescribing Advisors
- RMBC Social Care – Link workers
- RMBC Social Care and AgeUK – Community connectors

These services all aim to be care navigators and link people to services and opportunities that will help maintain and increase independence and social connectivity. It is recognised that closer working between health and social care services would ensure timely and more joined-up service provision.

I Age Well – healthy ageing and maintaining independence

Public Health and Adult Social Care are working together to roll out an innovative approach to identifying older people's stage on their ageing journey. A web based resource plots where someone is by considering the activities that they are able to complete to live their daily lives. The tool provides information, guidance and signposting to help people make changes that will improve their functional abilities. The tool will go live during 2017 and be rolled out across the Borough**. www.rotherham.lifecurve.uk/**

Key Message

Maintaining the independence of older people in Rotherham in the coming years will require all stakeholders including communities themselves to work together to support individuals to be active partners in their own health and care, and full participants in community life.

Carers

It is recognised that most of the care that is provided voluntarily is by people of retirement age[64]. This care includes the care of young grandchildren, older disabled adults and vulnerable partners or relatives.

Key Facts

- **3 in 5 people in the UK will be carers at some point in their lives**
- **1 in 5 people aged 50-64 are carers in the UK**
- **1 in 4 carers are caring for someone with a mental health need, up to 1.5 million carers in the UK**
- **1 in 10 carers are caring for someone with dementia – this is 11% of all UK's carers**

Source[64]

Carers often provide similar support that would be otherwise provided by social care e.g. dressing, feeding, and in doing so provide significant support for statutory services in Rotherham. Within Rotherham the new Carers Strategy (Draft) will outline four outcomes that intend to improve the lives of adult carers, the first three (highlighted) directly relevant to older people:

1) Carers in Rotherham are more resilient

2) The caring role is manageable and sustainable

3) Carers in Rotherham have their needs understood and their well-being promoted

4) Families with young carers are consistently identified early to prevent problems from occurring and getting worse and that there is shared responsibility across partners for this early identification

Caring is often rewarding but can also have a significant impact on the carer's health and wellbeing. It is important that carers are supported and given the time to look after their own needs.

Key Message

Older people play a significant role in society as care givers. In Rotherham they must be adequately recognised and supported. The new Rotherham Carers Strategy will drive this commitment.

Income, work & volunteering

11,900 (19%) people over pensionable age in Rotherham are deemed to be living in income deprived households[65]. They may, for example, live on a small fixed pension or have significant assets such as a family home but in practice live on a limited regular income. Consultation with the community in the past has shown that reducing the number of older people on low incomes to be important to the people of Rotherham[14].

However, the opportunities in later life are now more diverse and fluid. The set retirement age no longer exists and the state pension age rises to 66 by 2020, and is likely to rise further in the coming decades. This change will rebalance the proportions of workers and retired people in society.

Retirement needs to be seen as an increasingly active phase of life where people:

- have opportunities to continue contributing to society by working longer or volunteering in their communities
- take personal responsibility for their own wellbeing by working, saving and looking after their health[66]

People aged 65 and over in the UK contributed £61 billion to the economy (in 2014) through employement, informal caring and volunteering. This is equivalent to 4.6% of gross added value, and 6 times more than the money spent on social care by local authorities in England (around£10 billion a year)[67]. It is important to recognise the contribution made by older people in Rotherham to the local economy.

It is recognised that enabling people to stay in work in their 50s and early 60s and, if they wish, after State Pension age can help support the financial, health and social well-being of individuals into later life. It is important for our economy, for employers and for individuals to make sure we can continue to afford pensions. For example it is calculated that:

- Data from the 2015/16 Annual Population Survey[65] suggests that around one in twenty people aged 65 and over in England are in employment, half the England average.
- retiring at 55 instead of 65 could reduce an average earner's pension pot by a third – they would also have to spread this over a much longer retirement
- UK Gross Domestic Product (GDP) could have been £18 billion higher in 2013 if the difference in employment levels between people in their 40s and those aged 50 to State Pension age was halved
- by 2022 there will be 700,000 fewer people aged 16 to 49, but 3.7 million more people aged 50 to State Pension age[66].

Employers can no longer force employees to retire just because they reach the retirement age, therefore this will have an impact in changing the face of workforces in the future[66].

Rotherham has 1,382 voluntary and community sector (VCS) organisations, with 49,000 volunteers and some 12,300 committee / board members. The VCS also directly employs 3,600 full and part-time staff[68]. It is likely that people over 65 form a significant percentage of volunteers in our community.

Rotherham's Assets: Edna Bateman

Think you are too old to volunteer? Think again…Edna Bateman recently celebrated her 100th Birthday which is an achievement in itself but add to this that Edna still volunteers every Wednesday in Rotherham Hospice Charity Shop and that just makes her amazing! She is Rotherham's oldest volunteer. Edna began volunteering 19 years ago at the local Sue Ryder charity shop after her husband passed away and moved to the Rotherham Hospice Charity Shop eight years ago.

Volunteering has been said to provide a meaningful role and sense of purpose in life, it helps to raise confidence and self-esteem, by providing an 'other-centred' focus, associated with personal agency and control. Volunteering in later life is also important for positive human development and as a social activity can combat social isolation and loneliness[69].

Key Message

The opportunities for those over the age of 65 to remain in work are much greater than they have ever been and can help support the financial, health and social well-being of individuals into later life. Volunteering in later life is important for positive human development and as a social activity can combat social isolation and loneliness.

Education & literacy

Key Fact

15% of Rotherham's population live in 5% of most deprived areas nationally in terms of education and skills[45]

Low levels of education and illiteracy are associated with increased risks for disability and death among people as they age, as well as with higher rates of unemployment[1]. The number of years we spend in full time education reduces the risk of mental decline and dementia[6]. Literacy is the ability to read, write, speak and listen to a level that enables a person to communicate effectively, understand written information and therefore to participate fully in society[70].

The education an individual receives in early life, combined with the opportunities that present themselves for lifelong learning, develops the skills and confidence they need to adapt and stay independent in later life. Employment problems of older workers are not necessarily an inevitable part of ageing, but can be an issue for those with low literacy skills. Engaging in continuous training whilst in the workplace and lifelong learning opportunities can help people remain engaged in meaningful and productive activities as they grow older[1].

Like younger people, older citizens need training in new technologies such as means of electronic communications and computing. By using self-directed learning, increased practice and physical adjustments e.g. using large print, older people can reduce the impact of any loss in visual acuity, hearing and short-term memory[1].

Rotherham has 20% more working age adults qualified below NVQ Level 2 than the British average, and 14% more with no qualifications in 2015[19]. As working age adults move into older age this lack of literacy and qualifications is likely to translate into higher levels of unemployment and poorer health literacy.

Health literacy refers to people having the appropriate skills, knowledge, understanding and confidence to access, understand, evaluate, use and navigate health and social care information and services[71]. Limited health literacy is linked with unhealthy lifestyle behaviours such as poor diet, smoking and a lack of physical activity and is associated with an increased risk of morbidity and premature death. People with limited health literacy are less likely to use preventive services and more likely to use emergency services, are less likely to successfully manage long-term health conditions and as a result incur higher healthcare costs.

An individual's health literacy tends to be related to their social circumstances. Educational attainment strongly predicts good health literacy and people with limited financial and social resources are more likely to have limited health literacy. In turn, limited health literacy limits opportunities for vulnerable and disadvantaged groups to be actively involved in decisions about their health and care over the life course. This can undermine people's ability to take control of their health and the conditions that affect their health.

Key Message

Health literacy needs to be considered as an important factor in supporting older people to self-manage.

Discrimination


A15

The English Longitudinal Study of Ageing[59] reveals 33% of all older people experience perceived age discrimination, with poorer, older men being at highest risk. 26.6% of people aged between 52 and 59 reported age discrimination, a figure which rose to 37.2% for adults aged between 70 and 79[72].

The poorest older people are 35% more likely to report age discrimination than the wealthiest. Retired older people are 25% more likely to report age discrimination than those who were still employed[72].

10% of men and 9% of women over the age of 52 felt that they had received poorer service or treatment from doctors or hospitals than younger people because of their age[72].

Older people are of course also susceptible to other forms of discrimination including gender, race, sexuality, and disability, in addition to any discrimination they may face relating specifically to age.

Key Message

Policy development and service delivery of all partners is mindful of the perceived age discrimination experienced by older people. Becoming an Age Friendly Borough is key to ensuring that discrimination on the basis of age is considered routinely by everyone in the Rotherham Community.

Dementia

Dementia is an umbrella term that describes the symptoms that occur when the brain is affected by certain diseases or conditions. Symptoms may include memory loss and difficulties with thinking, problem solving or language. Dementia is not an inevitable part of ageing.

In Rotherham 4.76% of the 65 and over recorded on practice disease register have a diagnosis of dementia. This relates to 2,315 people[73]. This is likely to be an under estimate of the true figure as not all individuals with symptoms of dementia will be registered.

Dementia friendly

The Alzheimer's Society's Dementia Friends programme is the biggest ever initiative to change people's perceptions of dementia. It aims to transform the way the nation thinks, acts and talks about the condition.

Five key messages:

- Dementia is not a natural part of ageing
- Dementia is caused by diseases of the brain
- Dementia is not just about losing your memory
- It is possible to live well with dementia
- There is more to the person than the dementia

There are 5,500 people registered as dementia friends in Rotherham.

Risk reduction/prevention

It may be surprising to hear that the disease most feared by people aged over 55 in the UK is dementia – ahead of cancer, heart attack and stroke[74]. With symptoms including memory loss and difficulties with thinking or language, dementia can disrupt not only the lives of people living with the condition, but also friends and family, who often act as carers. There is no cure for dementia, and so taking action to reduce the risk is particularly important.

Risk factors for developing dementia include: heavy drinking, smoking, high blood pressure, depression and diabetes. There is growing evidence that as much as a third of dementia cases could be a result of modifiable risk factors such as smoking and not getting enough exercise[75].

Taking steps to reduce dementia risk

What's good for the heart is good for the brain and taking steps like giving up smoking, reducing alcohol intake, losing weight and taking regular exercise could reduce the risk of developing dementia in the future.

Fig. 8: Modifiable Risk Factors of Dementia

Source[76]


A18

Protective factors are also important, including keeping the brain stimulated, for example by learning a new language, doing crosswords and playing word games. Activities such as volunteering and meeting friends can also protect against social isolation and loneliness, which are risk factors for dementia.

Rotherham Dementia Action Alliance

Rotherham Dementia Action Alliance is committed to helping raise awareness of dementia and its impact upon those who have the condition or are otherwise affected by it. The Alliance works with statutory and private sector organisations to create dementia friendly communities, where people with dementia and their carers can lead fulfilling lives. Currently there are 145 established members (agencies/ organisations), including RMBC.

Key Message

To identify ways in which all Rotherham partners and stakeholders can become more dementia friendly, and to promote the prevention agenda for dementia across the community.

Mental Health
(including loneliness and isolation)

People often talk about mental health when they are really referring to mental ill health. However mental health is something which all people have, but we often only think about mental health when things go wrong and people become unwell. Mental health influences how people think and feel about themselves and others, the ability to form friendships, learn and cope with life events. A person's mental health is not static and will change like physical health does. Mental health can be adversely affected by a range of factors including bereavement, where we live, poverty, unemployment, retirement, physical illness, loneliness and isolation. For older people mental health and emotional well-being are as important as at any other time of life[77].

Nationally there are four self-reported measures which can help us understand the mental health of Rotherham people[78]:

- low satisfaction
- low worthwhile
- low happiness
- high anxiety scores

Rotherham compares as significantly higher than England for all but the low worthwhile score, which is rated similar to England. It appears that more people in Rotherham are reporting poorer emotional well-being and higher anxiety rates.

Mental health problems are common. One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression[78]. In 2015 4,284 people aged 65 and over were estimated to have depression in Rotherham (4,655 projected by 2020)[79].

Some groups are more at risk of a decline in their mental health and independence, these include: carers, those living alone who have little opportunity to socialise, recently separated or divorced, recently retired (particularly if involuntary), on a low income, have recently experienced or developed a health problem and have an age-related disability[80]. During the period 2010-2014 there were 17 deaths by suicide of people aged 60 and over in Rotherham. Whilst this is not the age group with the highest number of suicide deaths in the Borough, action can be taken to prevent suicides amongst older people. Some of the risk factors noted in Rotherham are individuals with caring responsibilities and those who have recently been bereaved.

Depression and other mental health problems are not an inevitable part of growing older. Promotion of good mental health is important for healthy ageing.

Loneliness & Isolation

Older people are particularly vulnerable to social isolation, and loneliness, this can be due to loss of friends and family, mobility and/or income. Social isolation and loneliness have a negative impact on an individual's health and wellbeing. As well as links to physical and emotional health, loneliness can lead to individuals visiting their GP more frequently and losing their independence at an earlier age than average. Lone pensioners are particularly at risk of loneliness and social isolation[81].

Research shows that loneliness and social isolation are harmful to health. Lacking social connections as a risk factor for early death is comparable to smoking 15 cigarettes a day, sitting alongside other well known risk factors such as obesity and physical inactivity[81].

Loneliness and isolation are not the same thing. Isolation is about the absence of social contact. Loneliness is about how a person feels about their situation. A person can feel lonely with frequent contact with others because it might not be meeting their emotional needs. Equally a person can have less social contact and not feel lonely[81].

Key Facts

In the United Kingdom we know that:

- **An estimated 10% of the general population over the age of 65 are lonely all or most of the time[82].**
- **Figures show that older people are more likely to live alone, with 59% of those aged 85 and over and 38% of those aged 75 to 84 living alone[83].**
- **Nearly half of older people (49% of aged 65 and over) say that television or pets are their main form of company[84].**

Loneliness can be felt by people of all ages, but as we get older, risk factors that might lead to loneliness begin to increase and converge. Such risk factors include (but are not limited to):

Personal	Wider Society
• Poor health	• Lack of public transport
• Sensory loss	• Physical environment (e.g.no public toilets or benches)
• Loss of mobility	• Housing
• Lower income	• Fear of crime
• Bereavement	• High population turnover
• Retirement	• Demographics
• Becoming a carer	• Technological changes
• Other changes(e.g. giving up driving)	

Source[85]

The National Institute for Health and Care Excellence (NICE) recommends that councils, housing organisations and the voluntary sector to work together to identify vulnerable older people and promote opportunities for them to join activities which will help their socialisation[86].

Age Concern (now Age UK) and the Mental Health Foundation (2006) produced a report on promoting mental health in later life; they concluded that five main areas influence mental health and well-being in later life. These are:

- Participation in meaningful activities
- Relationships
- Poverty
- Physical health
- Discrimination


A20

Examples of local practice which address some of these themes

Breaking the silence on suicide

Rotherham's Suicide Prevention and Self Harm Group launched a campaign in July 2016 to break the silence on suicide. The first part of this rolling programme focussed on targeting men, their families and friends.

Rotherham Together Partnership – Let's Get Rotherham Talking

'Let's get Rotherham Talking' is an initiative supported by the Rotherham Together Partnership. The aim is to encourage people to talk and get to know each other, build a sense of community for all, with the outcome of making Rotherham a place where nobody feels lonely or isolated.

What has changed?

Mental health services look very different now to what they looked like in the 1960s. Plans were put in place to close the asylums with large scale closures starting in the 1980s. Prior to this people with mental health problems were treated in asylums in large numbers. There was public and moral pressure to close asylums and psychiatry had moved in its thinking to recognise that these larger asylums were causing more harm than good and people could be treated in the community. Change within mental health services continues today. NHS England is looking to transform mental health services over the next five years which will see further improvements in health care, people with mental health problems having good physical health and more people with mental health problems being supported to work[78].

Rotherham Public Health is leading on the development of a public mental health and wellbeing strategy for the borough. All Partners in the statutory and voluntary and community sector will be encouraged to look at actions they can take to promote good mental health and wellbeing of people living and working in Rotherham. The strategy and action plan will look at approaches to improving public mental health including:

- Take a life course approach to promoting good mental health
- Promote a more holistic approach to physical and mental health
- Integrate mental health into all aspects of our work
- Develop environments that support good mental health and tackle stigma

Key Message

Improving the mental well-being of the ageing population in Rotherham needs to be everybody's responsibility. The areas which affect our mental health cannot be the responsibility of one organisation. Organisations and communities need to work together to help improve the mental health of our ageing population.

Recommendation Three

The social inclusion of older people in Rotherham needs to be at the heart of policy and delivery across the Rotherham Partnership, addressing issues such as maintaining independence, income and participation, mental health, loneliness & isolation. To achieve this goal, older people must experience proactive involvement and participation in life and society as a whole.

Chapter 5 Quality integrated services and preventative interventions (incl. screening & immunisation and lifestyle)


A11


A13


A12

In addition to and in spite of healthy lifestyles interventions and supportive environments and communities, many people in Rotherham will still develop health problems in older age.

Our services need to be able to detect any health problems early to improve outcomes and manage them effectively. For those who have chronic conditions or can no longer care for themselves, health and social care services are required that can meet their needs and ensure everyone receives the appropriate care at the end of life, to die with dignity.

Health & social care integration

In Rotherham, each of the individual professionals, teams and organisations working towards the healthy ageing agenda are striving to improve the quality and continuity of their individual practice and services for older people. However good our existing services are, we can always look to do better.

Rotherham is faced with financial and demographic pressures that suggest small improvements in the years to come may not be sufficient, what we need is a transformation of approaches and systems. National evidence suggests that many of the current services across the UK are not meeting the needs of older people, a group who are most likely to suffer problems related to care co-ordination and transitions between services[87,88] and a transformation is required in the years to come.

What would such a transformation of systems look like for older people? The service users voice[89] tells us it means providing care that is co-ordinated around their individual needs and goals: the right care at the right time, and in the right place. To achieve this vision all aspects of the system must be working together, coordinated around the needs of the individual. It means all aspects of physical and mental health, social care, public health and the wider public, private and voluntary sectors all working together to deliver truly integrated care.

There are many different models for providing integrated care for an ageing population, and our collective task is to ensure Rotherham's model complements and meets its own particular needs and circumstances.

Work underway

Rotherham is well placed to meet the challenges posed by the integration agenda for older people. The Rotherham Integrated Health and Social Care Place Plan (2016) sits alongside the Rotherham Better Care Fund Plan and is based on existing evidence and good practice. These documents outline the commitment of the whole system partnership to the Rotherham vision for integrated care and person centred working to improve the health outcomes for local people.

This vision promotes independent living in the community, with prevention and self-care at the heart of delivery, focusing on information, prevention and enablement to reduce dependence and reliance on health and social care services. The 2016 Rotherham Integrated Health and Social Care Place Plan has the following vision:

"Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery"

The challenge is to continue to develop an asset-based approach to local work with communities, to better understand what matters to them, and where we could better meet their needs, and focus on the strengths and values of their community. This approach should help to embed an owned culture of wellbeing and prevention across communities and within statutory services, creating a demand shift for services whilst improving outcomes for older people. The continued dialogue with communities about individuals and families taking control of their own health and care needs will be a vital part of the sustainability of integrated services now and for the future.

In order to realise the vision of self-care, independent living and reduced dependency on services the health improvement and prevention offer across the health and social care system must be fit for purpose. There needs to be the capacity and ability in all parts of the system to support individuals to make sustained lifestyle changes in order to prevent ill health and extend healthy life expectancy. Embedding Making Every Contact Count (MECC) across the health and social care workforce should be an urgent priority and an essential element of an integrated care pathway.

Key Message

To identify ways in which all Rotherham partners and stakeholders can become more dementia friendly, and to promote the prevention agenda for dementia across the community.

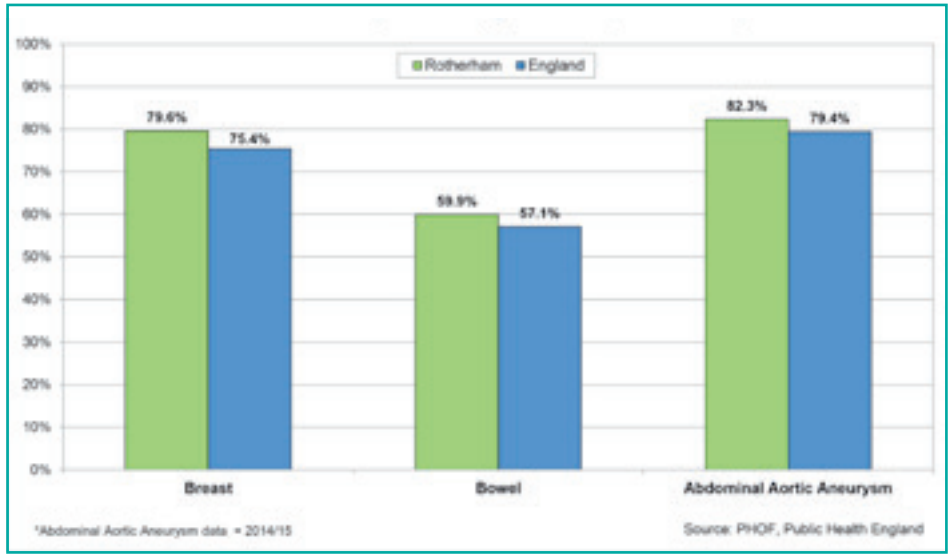
Screening

Screening is a way of identifying apparently healthy people who may have an increased risk of a particular condition. The NHS offers a range of screening tests to different sections of the population. The aim is to offer screening to the people who are most likely to benefit from it. For example, some screening tests are only offered to newborn babies, while others such as breast, bowel and abdominal aortic aneurysm screening are only offered to older people.

Cancer is primarily a disease of older people, with incidence rates increasing with age for most cancers. In the UK in 2012-2014, on average each year half (50%) of cases were diagnosed in people aged 70 and over[90]. Abdominal aortic aneurysm (AAA) screening is a way of detecting a dangerous swelling (aneurysm) of the aorta, the main blood vessel that runs from the heart, down through the abdomen to the rest of the body. This swelling is far more common in men aged over 65 than it is in women and younger men, so men are invited for screening in the year they turn 65.

Figure 9 shows data for three forms of screening coverage: cancer (breast and bowel) screening and abdominal aortic aneurysm (AAA) screening. Rotherham data for 2015 shows coverage is above the England average for all these and above target requirements (green rated). Rotherham ranks above average in the Yorkshire and Humber Region and among the best compared to similar local authorities (4th highest out of 16 authorities for bowel and AAA and second highest for breast screening)[91].

Fig. 9: Screening coverage (%) Rotherham compared to England 2015



Breast Cancer screening

Breast cancer screening uses X-ray mammography to detect changes in breast tissue indicative of breast cancer. Routine screening every three years is designed to increase the chance that breast cancer is found at an early stage, the treatment outcomes of which are much better than with more advance breast cancers.

As the likelihood of getting breast cancer increases with age, all women who are aged 50-70 and registered with a GP are automatically invited for breast cancer screening every three years. If you're over the age of 70, you'll stop receiving screening invitations. However, you're still eligible for screening and can arrange an appointment by contacting your local screening unit.

Key Facts

Breast cancer screening is offered to women aged 50 to 70 to detect early signs of breast cancer. Women aged 70 and over can self-refer for further screening.

Bowel Cancer

Bowel cancer screening can save lives. If bowel cancer is found early, it is easier to treat. Evidence suggests that people in the most deprived areas are accessing screening the least and that bowel screening remains the least attractive screening programme. Some screening centres including Rotherham will be starting to offer a one-off test in the near future, called bowel scope screening, to men and women at the age of 55. This is in addition to the home screening test that starts at the age of 60. It is envisaged that the new easier, single sample test will increase the uptake further.

If you are aged between 60 and 74, you will be invited to take part in bowel cancer screening every two years. If you are aged 75 or over, you can ask for a screening test by calling the bowel cancer screening helpline on 0800 707 60 60.

Key Message

Screening programmes are there to identify disease early to give individuals the best chance of recovery. Older people in Rotherham should take-up all the relevant screening offers available to them.

Immunisations

It is important to promote and implement the interventions that we know work. Vaccinations have greatly reduced the incidence and spread of infectious diseases.

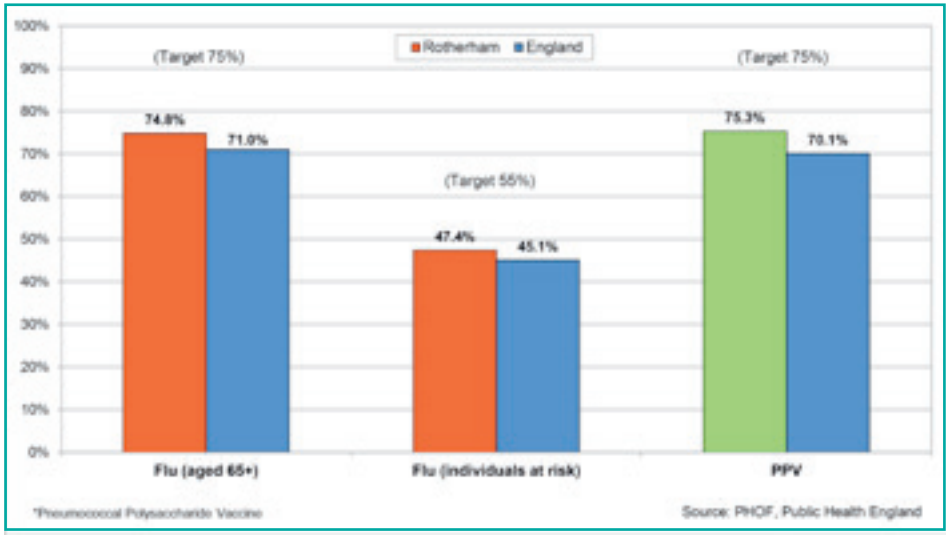
The population is offered routine vaccinations for protection against several infectious diseases over their lifetime, starting in childhood through to adolescence and finally as adults. The aim for most vaccination programmes is to maintain 'herd immunity'. This is a form of indirect protection that occurs when a large percentage of a population has become immune to an infection. Vaccinated individuals are then less likely to be a source of infection to others even those not protected by vaccination.

People aged 65 years and older are more susceptible to suffering from serious health consequences from infectious diseases, which can result in hospitalisation, disability or even death. There are three routine programmes in place for older people:

- Annual flu vaccine which protects against flu for people aged 65 years and over
- Pneumococcal polysaccharide vaccine (PPV) which protects against pneumococcal disease for people aged 65 years and over
- Shingles vaccination for people aged 70

Figure 10 shows population vaccination coverage data for Influenza and PPV immunisations. Rotherham data for 2015/16 shows coverage is above England average for all three measures (Good), above target requirements (green rated) for PPV and very close to target for flu coverage in people aged 65 and over. Rotherham ranks in the top two in the Yorkshire and Humber Region for all three (first best for PPV) and among the best compared to similar local authorities (thrid highest out of 16 authorities) for Ffu and PPV (aged 65+). Rotherham ranks 7th of 16 for Flu coverage for at risk individuals[92].

Fig. 10: Influenza and PPV coverage (%) Rotherham compared to England 2015/16



Seasonal Flu

All people aged 65 or above are offered an annual seasonal influenza vaccination, between September and February, to help protect them against circulating strains of flu. Vaccination needs to be given annually to ensure that older people are protected against newly emerging and circulating strains[93]. The government target is to achieve 75% uptake of influenza vaccination in those aged 65 years and over.

Seasonal flu vaccinations are also offered to at risk people aged between six months and 65 years, for example those with long term conditions or a weakened immune system.

Key Facts

In 2013/14, the introduction of a universal childhood flu vaccination programme was phased in across pilot areas in England, including Rotherham. These changes to the annual influenza programme aim to provide indirect protection (herd immunity) to the whole population, including the elderly and vulnerable populations, by vaccinating individuals who act as the main source of transmission.

Pneumococcal infections can cause a range of diseases, including pneumonia and meningitis. Older people aged 65 and above, and those with long term health conditions, are at particular risk, so these groups are targeted to receive the pneumococcal vaccination (PPV) (usually a one-off injection).

Key Message

Those over 65 are at increased risk of health complications from flu, pneumococcal and shingles (over 70). Older people in Rotherham should ensure (and be encouraged) that they receive the necessary immunisations to help protect them from these infections.

NHS Health Checks

Key Fact

In 2015 – 2016, 6,419 Health Checks were conducted in Rotherham.

The NHS Health Check is a health check-up for adults in England aged 40-74. It is designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes and dementia. As we get older, we have a higher risk of developing one of these conditions. An NHS Health Check helps find ways to lower this risk. If you're aged 40-74 and you haven't had a stroke, or you don't already have heart disease, diabetes or kidney disease, you should have an NHS Health Check every five years.

As well as measuring your risk of developing these health problems, an NHS Health Check gives you advice on how to prevent them. The risk level varies from person to person, but everyone is at risk of developing heart disease, stroke, type 2 diabetes, kidney disease and some types of dementia. Having a NHS Health Check can detect potential health problems before they do real damage.

If you're over 65, you will also be told how to look out for the signs and symptoms of dementia. Last year **458 people in Rotherham** received this information through their Health Check. Maintaining behaviour change through self-management not only benefits health but also quality of life and self-confidence. We know that people in areas of higher deprivation are less likely to take-up the offer of a free health check, and further targeting of Health checks at the areas of greatest need is required in order to reduce health inequalities.

Key Message

Health checks are a useful way of detecting the signs of illness and disease in middle aged and older people and making early lifestyle change and behaviour modification. A further targeting of health checks in Rotherham to areas of greatest need would increase the impact on health inequalities.

End of life Care

Good End of Life Care (EoLC) needs to consider both the social and health needs of a person. This includes:

- The opportunity and support to have honest discussions about needs and preferences for physical, mental and spiritual wellbeing, to enable the ability to live well until death.
- making informed choices about care, supported by clear and accessible information.
- considering the voice of the person as well as their carers and families.

These three points need to feed into the development of personalised care plans, based on the individual's needs and preferences, including any advance decisions of where they want to be cared for and die.

Hospital is generally considered to be the place where people would least like to die, and most would prefer to be at home, in a care home or hospice. Everybody has their own idea of what a 'good death' is, for most people it involves being without pain, in a familiar place with close family or friends and being treated with respect[94].

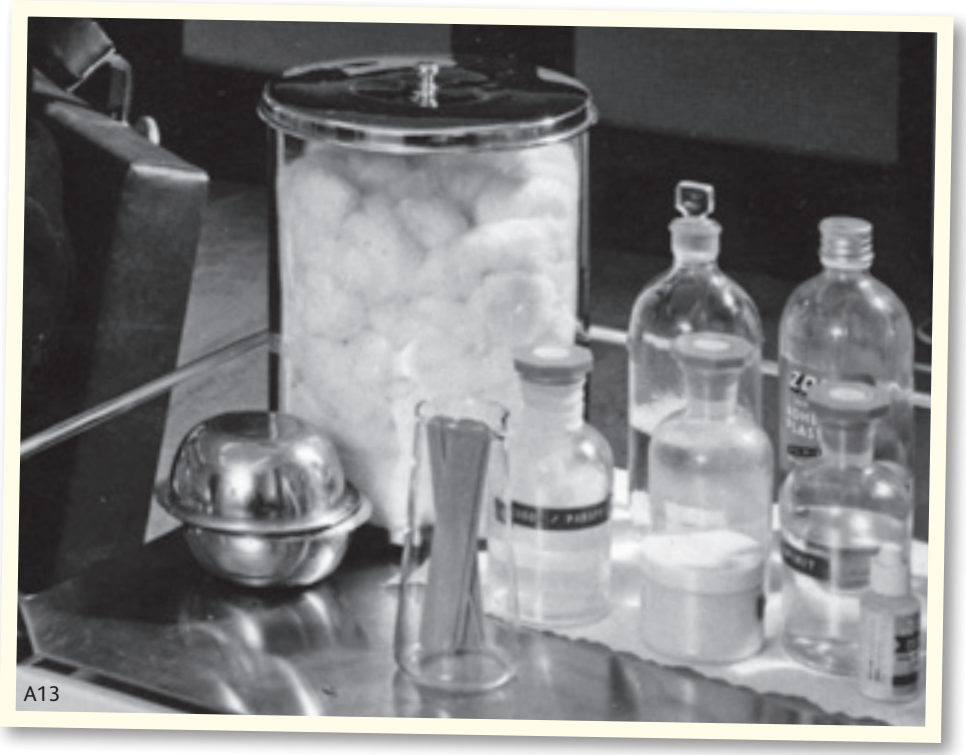
Rotherham statistics reflect the trend above. Deaths in hospital have decreased greatly for all elderly age groups (65-74, 75-84 and 85+) from 62.5%, 66.7% and 59.5% in 2004 to 44.1%, 54.2% and 45.0% in 2015 respectively. Deaths in Usual Place of Residence (home, care home or religious establishment) have increased over the period 2004 to 2015[95].

An example of good practice in EoLC is the Rotherham CCG Case Management project which gives GP practices extra time for EoLC patients and their families so appropriate discussions can help develop a personalised care plan. Appropriate pathways have been developed to help facilitate informed choices about care.

Encouraging both social and health professionals to share relevant information, so that difficult and sensitive conversations only need to be had once, and allowing all partners to consider early planning and develop appropriate personalised plans is key to successful EoLC.

Key Message

Personalised care planning at EoL will be of increasing importance as the population of older people (many of whom will have multiple long-term conditions and complex care needs) grows in Rotherham, and services will need to adapt and plan for this change.


A13

Integrated wellness services

Behaviour change is really important for many of the healthy lifestyle behaviours that have a positive effect on the morbidity (disease) and mortality (death rates) of the population.

Behaviour change plays an important role in many aspects of improving health such as; weight management, physical activity, and stopping smoking. Patterns of behaviour can become a habit, as part of a person's day to day routines and also be influenced by social and economic factors.

In order to have the greatest impact on a person's health, a person-centred approach is essential. It is important that an individual's health needs are taken into account alongside other things such as their social, cultural and economic circumstances.

Potential barriers which may stop or make it harder to change, need to be identified. This could be motivation and a lack of skills or knowledge, in order to make change easier. Individuals from lower socio-economic groups are less likely to perceive that they need lifestyle advice but are more likely to benefit their health by making a change to their behaviour[96].

Historically, lifestyle services have been provided separately, so that people would access a stop smoking service or a weight management service, for example. However, what if people have several lifestyle issues? Traditionally they would be expected to visit several services.

A Wellness Service, however, could be a truly aspirational way to tackle behaviour change. Individuals could be given appropriate advice tailored to their complex needs and behaviours. This could provide a single point of access where people can feel that they are being treated as an individual, changing a range of health behaviours simultaneously, not for example, just focussing on quitting smoking.

A 'wellness' approach for services looks to simplify referral routes for people who need help and provide new and innovative ways of encouraging positive health behaviours. This is the aspiration for the future of the Public Health behaviour change services in Rotherham and will complement the roll out of Making Every Contact Count (MECC), providing a clear and accessible pathway for behaviour change from an initial 'healthy conversation' through to specialised help where appropriate.

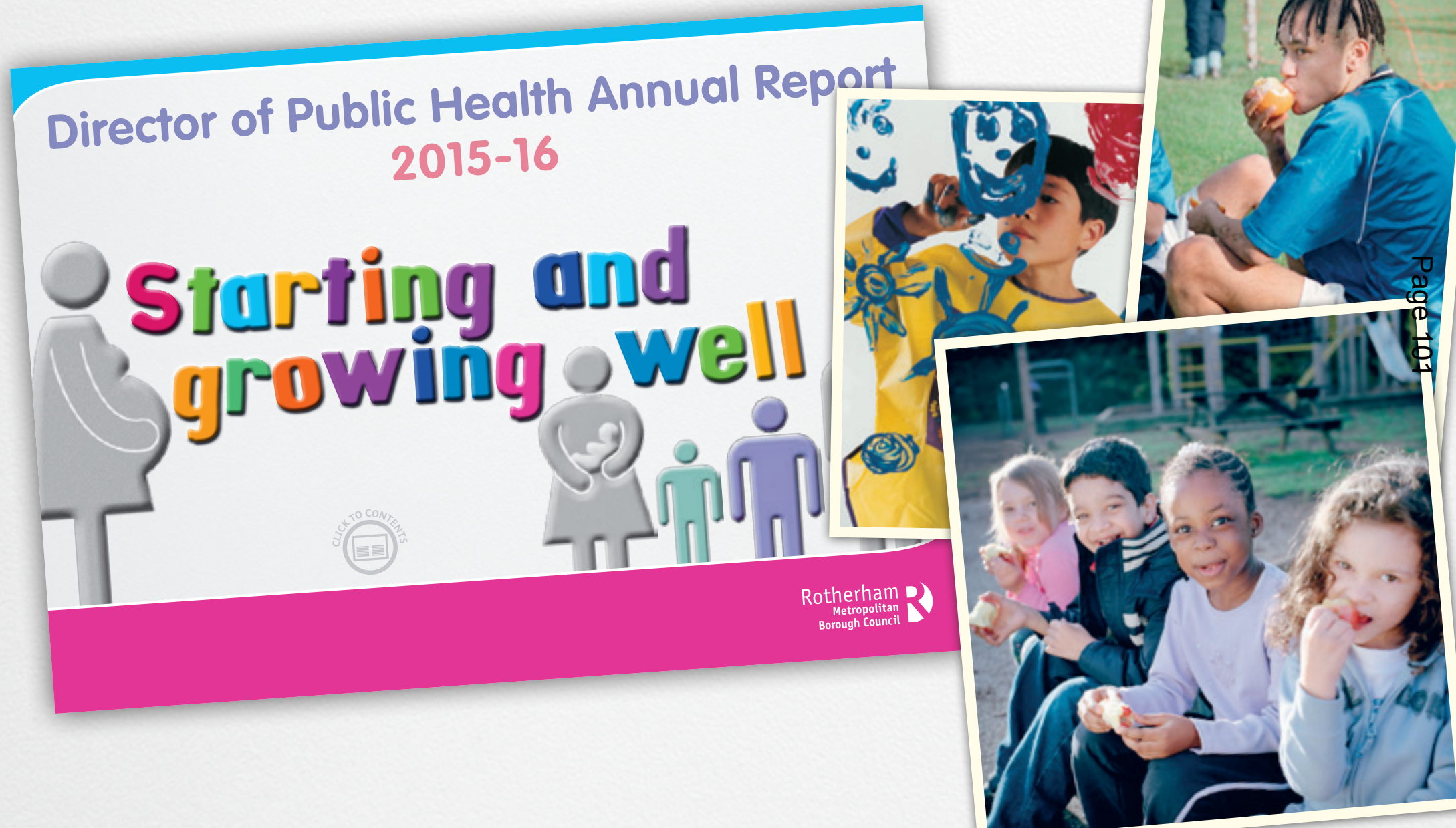
Key Message

An integrated wellness service in Rotherham will help target the communities and individuals of greatest need whilst simplifying access to services to assist individuals to make the lifestyle changes that can improve their health outcomes. Combined with MECC it provides a comprehensive behaviour change pathway.

Recommendation Four

All partners to deliver against the aspirations and commitments within the Rotherham Integrated Health & Social Care Place Plan, and to continue to strive for the highest quality services for older people. This is to include an increased focus on prevention, early identification and self-management, with clear pathways for lifestyle behaviour change for older people that support individuals to make changes when the time is right for them.

Appendix: Update on the 2015-2016 Director of Public Health Annual Report



The following table provides a summary of the 'Rotherham ambitions' that fell under the 8 overarching recommendations highlighted within the 2015-2016 Annual Report.

Overarching Recommendation	Progress in 2016
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).	• 92% of pregnant women at initial booking and throughout pregnancy are Carbon Monoxide (CO) screened in pregnancy in accordance with the Yorkshire and Humber Stillbirth and Bereavement Recommendations (2015). • Foetal Alcohol Syndrome Disorder (FASD) multi-agency training has been delivered to 115 professionals. • Joint Safe Sleeping Guidelines have been developed and agreed by Rotherham Child Death Overview Panel (CDOP) and Local Safeguarding Childrens Board and partner organisations – with the aim of reducing deaths from Sudden Infant Death Syndrome. • The Rotherham Hospital Foundation Trust (TRFT) Maternity Services has achieved the UNICEF Baby Friendly Initiative and are working towards the community standards to achieve Stage 2 for Health Visiting Teams by March 2017. This is evidenced based initiative shown to increase local area breastfeeding rates. • There was a 89.46% uptake of the HPV (Human papilloma virus) two dose vaccination in Rotherham schools – this is an increase from the previous year. • The Rotherham Sexual Health Services have been tendered and the contract awarded to TRFT. The mobilisation plan is now looking at how and where sexual health clinics should operate following consultation with young people – to commence the 1st April 2017.

Overarching Recommendation	Progress in 2016
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	• The Healthy Start Scheme is being rolled out across the Borough and forms part of the 0-19 Integrated Public Health Nursing Service. This is a national initiative to improve the health of new mothers and children under four years. • Children's Centre workers are accessing UNICEF Baby Friendly Initiative Training delivered by TRFT to support breastfeeding in the community to support the improvements in breastfeeding across the Borough. • Domestic Abuse training for front line services, 12 courses for up to 25 delegates provided in 2017. A new Domestic Advice Co-ordinator appointed and is undertaking outreach work with all services ensuring all have pathways training. • All mothers in Rotherham now receive a maternal mood review by eight weeks after birth. This is now a detailed requirement in the TRFT 0-19 Integrated Public Health Nursing Service and aims to identify women at risk of postnatal depression at the earliest opportunity. • The 0-19 Integrated Public Health Nursing service contract requires Nursing Practitioners and Early Years and Childcare Services to work together to ensure the two year progress checks completed by each service are integrated. This will further support the identification of children at risk of developmental delay to enable earlier intervention. • A comprehensive range of oral health preventative initiatives have been rolled out including tooth brushing clubs, with over 925 children participating and over 446 professionals receiving training in oral health awareness/prevention. These interventions have contributed to reduction of tooth decay for children and young people.

Overarching Recommendation	Progress in 2016
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.	• Advice on how to spend the Primary School premiums to maximise their impact on increasing physical activity has been provided by Active Rotherham. • Conference delivered in Rotherham, January 2017 "Active Body, Active Minds" to further promote opportunities to increase physical activity in schools including the "mile a day". • Substance misuse materials have been made available to all schools, Early Help services and Rotherham College's to ensure that young people receive the most current information and resources. • Barnados have been working in partnership with Rotherham schools to ensure that a well evaluated Theatre in Education performance/workshop tackling issues around relationships, sexual health and abuse/exploitation is reaching as many young people as possible. So far it has been delivered in 19 Primary schools, seven secondary schools and five pupil referral units, reaching over 800 young people.
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.	• Six Rotherham schools are now participating in a 'whole school' approach to mental health and emotional well-being with the aim of creating school environments that foster positive mental health and emotional well-being for all. This is based on national guidance and eight key principles. Learning will be shared across the borough to benefit all schools. • Self-Harm Guidance has been distributed to all schools, colleges, GP practices and other venues where staff are working with young people. The aim of the guidance is for frontline staff to be confident in supporting young people, providing consistent information. Guidance has also been promoted at Youth Mental Health First Aid training and will appear on the My Mind Matters website.

Overarching Recommendation	Progress in 2016
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.	• Rotherham has launched a Suicide Prevention and Self Harm action for 2016-2018. • Wentworth Valley Area Assembly has identified Suicide prevention as a priority for their area and is hosting training on mental health and suicide prevention. • RDaSH CAMHS (Child and Adolescent Mental Health Services) has launched locality working across the borough. The aim of Locality Working is to improve partnership working with key workers, Schools, Colleges, Early Help Teams, Social Care Teams, GPs and other partnering agencies who are involved in supporting the needs of children, young people and their families.
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.	• The National Childhood Obesity Strategy was released in August 2016 and a local action plan is being considered to tackle a 'whole systems approach' to Obesity in Rotherham. • Rotherham's Healthy Weight Framework Services are promoting the Weigh-Up service and this has increased the number of children and families accessing weight management services and successfully losing weight.

Overarching Recommendation	Progress in 2016
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.	• There is an ongoing commitment to implementing part time advisory 20 mph speed limits outside six schools in Rotherham. There are also plans for a further 10 schools to be treated this financial year and five of these will be funded by Area Assembly capital budgets. The intention behind these schemes is to reduce the speed of vehicles passing the schools when pupils are arriving and leaving by installing signage that will be more conspicuous to motorists, whilst also raising their awareness of pedestrians in the area. Outside of these periods the speed limit will revert back to that which is currently in place. • The Crucial Crew programme is offered to all Key Stage 2 children in Rotherham. 84 schools in Rotherham were invited to attend the programme 100% attended.
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	• Work with young people Not in Education Employment or Training is ongoing and a range of tailored interventions and support has been developed locally.

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Document Published
MAY 2017

REF: 77680/MAY 2017 – Prospectus produced by RMBC Design Studio Tel:01709 823583

BRIEFING PAPER FOR HEALTH AND WELLBEING BOARD

1.	**Date of meeting:**	**31th May 2017**
2.	**Title:**	**Rotherham Health Protection Annual Report 2016**
3.	**Directorate:**	**Public Health Directorate**

4. Background

4.1 The health protection roles and responsibilities, discharged by the Director of Public Health on behalf of the council, are overseen by the Health Protection Committee. To fulfil this statutory responsibility, there is a line of accountability from the Health Protection Committee to the Health and Wellbeing Board (H&WB).

4.2 This is the second Health Protection Annual Report for Rotherham which summarises the main areas of health protection activity over the period 1st January 2016 to the 31st December 2016. The report highlights the joint successes and challenges over the year, as identified by the Health Protection Committee. The annual report seeks to provide assurance that the public's health is protected.

4.3 The organisations represented on the Health Protection Committee collectively act to prevent or reduce the harm or impact on the health of the local population caused by infectious diseases or environmental hazards, major incidents and other threats.

5. Key Issues

5.1 The Health Protection Committee has made considerable progress over the year, often within the context of further re-structuring and re-alignment of organisations. This has been achieved by maintaining strong working relationships and by clarifying our roles and responsibilities. These underpin the local public health response to threats, outbreaks and major incidents.

5.2 Organisations have maintained effective surveillance, communication and responses to incidents or outbreaks by ensuring that there is;

- continuous monitoring of data and local intelligence to enable early detection of emerging infections or hazards
- timely and accurate information shared with the relevant agencies
- use of local expertise to inform the relevant control measures and a proportionate response implemented
- regular review and testing of local plans for the prevention, planning and response to protect the public's health

6. Key actions and relevant timelines

6.1 The Health Protection Committee, on behalf of the Director of Public Health, will continue to meet on a quarterly basis to oversee and discharge the council's health protection duties.

6.2 Continue to work collectively to bring system wide improvements and improved outcomes for the population. Some examples include;

- Joint work between NHS and council colleagues to implement additional scrutiny and support for Infection Prevention and Control in the community including for Care Homes
- Using the multi-agency Emergency Planning Forum, chaired by RMBC, to develop and test local emergency plans
- Improving air quality in Rotherham using behavioural, structural and strategic changes to ensure we all are working towards meeting the national objectives

6.3 Maintain and update organisational risk registers to inform the Rotherham Health Protection Assurance Framework.

7. Recommendations to H&WB partners

7.1 That the H&WB notes the content and recommendations of the Health Protection Annual Report 2016.

8. Name and contact details

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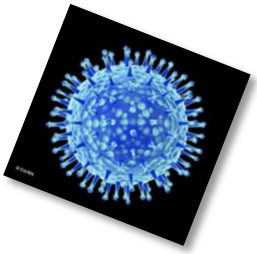
ROTHERHAM HEALTH PROTECTION ANNUAL REPORT 2016



Foreword

Health protection services continue to make improvements and respond to the health needs of the Rotherham population. The services co-ordinate their actions through local and regional networks, the Health Protection Committee and associated working groups or forums.

By doing the basics well, continually seeking feedback from patients or customers and learning from each other, health protection services can find solutions and good practice which can be shared across the system.

Whilst the scope of health protection in Rotherham is extremely wide ranging, some examples are highlighted to illustrate the quality of care delivered by people responsible for health protection on a day-to-day basis.

Thank you to all those people who have contributed to this report and who work behind the scenes to protect the health of the Rotherham population.

Teresa Roche

Director of Public Health

Councillor David Roche

Cabinet Member for Adult Social Care and Health

CONTENTS

GLOSSARY

AMR	Antimicrobial Resistance
BCG	Bacillus Calmette-Guerin
C.difficile	Clostridium difficile
CHRD	Child Health Records Department
CMO	Chief Medical Officer
Defra	Department for Environment, Food and Rural Affairs
DOT	Directly Observed Therapy
DIPC	Director of Infection, Prevention and Control
DPH	Director of Public Health
ECDC	European Centre for Disease, Prevention and Control
EHO	Environmental Health Officers
EPSS	Emergency Planning Shared Services
E.coli	Escherichia coli
ESPAUR	English surveillance programme for antimicrobial utilisation and resistance
FSA	Food Standards Agency
GI	Gastro Intestinal
H&WB	Health and Wellbeing Board
HAIRS	Human Animal Infections and Risk Surveillance
HCAI	Health Care Associated Infections
HCWs	Health Care Workers
HIV	Human Immunodeficiency Virus
HPC	Health Protection Committee
HPV	Human Papilloma Virus
IPC	Infection, Prevention and Control
LHRP	Local Health Resilience Partnership
LTBI	Latent Tuberculosis Infection
MDRTB	Multi Drug Resistant TB
MMR	Measles Mumps and Rubella
MRSA	Meticillin Resistant Staphylococcus Aureus
MSSA	Meticillin Sensitive Staphylococcus Aureus
NHSEY&H	NHS England Yorkshire and Humber
NICE	National Institute of Clinical Excellence
NMRS	National Mycobacterial Reference Service
PPE	Personal Protective Equipment
PHE	Public Health England
PHOF	Public Health Outcome Framework
PM	Particulate Matter
RCCG	Rotherham Clinical Commissioning Group
RDaSH	Rotherham Doncaster and South Humber NHS Foundation Trust
REPF	Rotherham Emergency Planning Forum
RMBC	Rotherham Metropolitan Borough Council
SIOG	Screening and Immunisation Oversight Group
SIT	Screening and Immunisation Team
STI	Sexually Transmitted Infection
SYFR	South Yorkshire Fire and Rescue
SYLRF	South Yorkshire Local Resilience Forum
SYP	South Yorkshire Police
TB	Tuberculosis
TRFT	The Rotherham NHS Foundation Trust
YH&NE	Yorkshire and Humber and North East
UTI	Urinary Tract Infections
VAR	Voluntary Action Rotherham
WGS	Whole Genome Sequencing

BACKGROUND

This is Rotherham's second annual report to the Health and Wellbeing Board (H&WB) highlighting the local health protection work over the year. To improve accessibility for the reader, the report has been written in distinct sections highlighting key successes and challenges over the year. It summarises the main areas of health protection activity over the period 1st January 2016 to the 31st December 2016 and includes a range of priorities identified by the Health Protection Committee and areas where further assurance is required.

The Health Protection Committee reviews and challenges any areas of under-performance associated with the Public Health Outcomes Framework (PHOF) indicators, subsequent risks to the local population and the mitigating actions for partner agencies. The public health indicators linked to health protection include:

- Fraction of mortality attributable to particulate air pollution
- Chlamydia diagnosis (15-24 year olds)
- Routine population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for tuberculosis
- Public sector organisations with board-approved sustainable development management plans
- Comprehensive, agreed interagency plans for responding to health protection and major health related incidents

PURPOSE OF THIS DOCUMENT

The purpose of this document is to provide a clear overview of the current health protection arrangements within Rotherham highlighting our joint successes, challenges and mitigating actions. The document enables the Director of Public Health (DPH) to provide assurance to the Health and Wellbeing Board (H&WB), Chief Executive and Leader of the Council, that the health of the residents of Rotherham is being protected in a proactive and effective way.

SUMMARY

The scope of the health protection work for the population of Rotherham (whether resident, working or visiting) is as follows;

- Vaccine preventable diseases and Immunisation programmes
- National screening programmes
- Infection, Prevention and Control including Health Care Associated Infections (HCAIs)
- Communicable disease control including Tuberculosis (TB), blood borne viruses, gastro-intestinal infections (GI) and seasonal influenza
- Public Health aspects of emergency planning and preparedness (including severe weather, pandemic influenza)

- Environmental hazards and control, biological, chemical, radiological and nuclear, including air and water quality, food safety
- Sexually Transmitted Infections including HIV and Hepatitis
- Substance Misuse and blood borne viruses

The themes in the report are a combination of maintaining good outcomes and addressing any poor performance. Over the year, the Health Protection Committee has discussed emerging priorities raised by partners where additional assurance has been required. Some examples are outlined below;

- Managing and embedding lessons learned on a range of health protection incidents in the community, e.g. Cryptosporidium, Clostridium difficile (C.difficile) and Norovirus
- Linking in with Yorkshire and Humber and North East (YH&NE) TB clinical networks, strengthening local Tuberculosis (TB) specialist services and responding to the latest National Institute for Health and Care Excellence (NICE) guidance for TB
- Pursuing clarity on the roles of the agencies involved in health protection and emergency planning through a number of exercises to test local and regional plans
- Specifically, reviewing, testing and updating the Pandemic Influenza Plans for Rotherham
- Improving joint working between directorates within the council and key external partners, for instance, around infection prevention and control in the community and air quality
- Up-dating the Rotherham multi-agency Assurance Framework identifying the controls, gaps and mitigating actions

WHY IS HEALTH PROTECTION IMPORTANT?

There are many factors which influence a person's health over the course of a lifetime. The objective of health protection is to ensure that the public's health is protected from major incidents and other threats whilst reducing health inequalities. Health protection work aims to prevent or reduce the harm or impact on the health of the local population caused by infectious diseases or environmental hazards. In total there are 27 indicators which the Director of Public Health (on behalf of the council) requires assurance on[1].

The Health Protection Annual Report provides this assurance on behalf of the Health & Wellbeing Board through the Health Protection Committee.

[1] http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000043/pat/6/par/E12000003/ati/102/are/E08000018/iid/30101/age/230/sex/4

RECOMMENDATIONS

1) The Health Protection Committee should continue to meet quarterly to monitor health protection measures, ensure they are aware of any potential risks/scenarios and develop mitigating actions.

2) Health protection partners to continually look for opportunities of inter-disciplinary and multi-agency working which will bring system wide improvements and improved outcomes for the population.

3) Organisations maintain effective surveillance, communication and response to incidents or outbreaks by ensuring that there is;
   - continuous monitoring of data and local intelligence to enable early detection of emerging infections or hazards
   - timely and accurate information shared with the relevant agencies
   - use of local expertise to inform the relevant control measures and a proportionate response implemented
   - regular review and testing of plans

WHO ARE WE?

All the agencies below are represented on the Rotherham Health Protection Committee, chaired by Public Health, RMBC. This committee collectively aims to address a range of health protection issues at a population-level that no single agency can address on its own.

Rotherham Metropolitan Borough Council (RMBC) – delivers a range of the council's health protection functions, including environmental hazards, regulation and enforcement, emergency planning and health and social care (see Appendix 1).

Rotherham Clinical Commissioning Group (RCCG) – commissions acute and community healthcare services, representing 31 GP practices across Rotherham. RCCG hold the acute and community healthcare services to account for reducing their HCAIs.

The Rotherham NHS Foundation Trust (TRFT) – an approximately 500 in-patient bed hospital and community service, providing a full range of local hospital and community services. In particular, TRFT provide microbiological and Infection Prevention and Control specialist services and are required to have robust arrangements in place to meet the Emergency Planning Response and Resilience (EPRR) Core Standards.

NHS England Yorkshire and Humber (NHSEY&H) – oversees Quality and Patient Safety of the RCCG, including HCAIs. Ensuring Emergency Planning arrangements for NHSEY&H, RCCG and NHS providers are in place and can respond to emergencies. Their specialised commissioning role includes HIV treatment services.

Public Health England Yorkshire and Humber (PHEY&H) – aims to protect and improve the nation's health and wellbeing, for example, through vaccination and immunisation, advice on communicable diseases and managing outbreaks.

South Yorkshire Police (SYP) and South Yorkshire Fire and Rescue (SYFR) – work closely with the council on their preparedness and response to any emergencies and major incidents.

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) – provides mental health services in 200 locations across Rotherham, Doncaster, Lincolnshire and Manchester. RDaSH have their own dedicated Infection Prevention & Control team and robust arrangements in place to meet the Emergency Planning Response and Resilience core standards.

WHAT WE SAID WE WOULD DO IN LAST YEAR'S REPORT

Achieving success in health protection relies on strong working relationships at a local level. The Director of Public Health (DPH) helps facilitate these relationships ensuring that clearly defined roles and responsibilities are in place that underpin the local public health response to threats, outbreaks and major incidents.

The Health Protection Committee has continued to oversee Rotherham's health protection arrangements. The Committee has met quarterly to review actions to mitigate identified risks and update the Health Protection Assurance Framework with the control measures and assurances on those controls. Any significant health protection risks are added to the Public Health Risk Register and escalated, as appropriate, to the Council's Corporate Risk Register. Individual organisations represented on the Committee are also responsible for escalating risks through their own governance arrangements.

Below is a brief outline of what *'we said we would'* do and '*what we did'* in last year's annual report.

Environmental Hazards and Control

We said we would: Monitor Particulate Matter (PM) 2.5[2] at different locations across the borough, ensure timely communications on air quality and implement mitigating measures where possible.

What we did: Real time monitoring for PM 2.5 was implemented in the Air Quality Management Areas at St.Anns Primary School, Blackburn Primary School and in Bradgate, close to the M1. Air Quality was reported on the RMBC website and an assessment for the feasibility and practicalities of installing ''Living walls''[3] in the borough was undertaken followed by a bid to Defra for funding.

Communicable Diseases

[2] http://laqm.defra.gov.uk/public-health/pm25.html

[3] A Living Wall is a wall partially or completely covered with greenery that includes a growing medium, such as soil. Most green walls also feature an integrated water delivery system. Green walls are also known as living walls or vertical gardens and help protect against air pollution.

We said we would: strengthen the sustainability and resilience of TB specialist services, improve our links with the YH&NE TB Control Board and review latent screening.

What we did: A Respiratory Consultant has been successfully appointed to lead the specialist TB service within TRFT. The TB Specialist nurse and Lead Consultant represent Rotherham at regional and sub-regional networks of the YH&NE TB Control Board, including contributing to the South Yorkshire TB cohort reviews[4]. A local Multi-Disciplinary Group has now been established to take forward capacity and capability issues and to review latent screening.

We said we would: re-tender the integrated sexual health services, commissioned by RMBC, during 2016/17.

What we did: Following a successful re-tender, the Rotherham integrated sexual health services have been procured from The Rotherham NHS Foundation Trust.

Infection, Prevention, Control and Antimicrobial resistance

We said we would: improve surveillance for community-based transmission of Health Care Associated Infections, identify gaps and further mitigating actions.

What we did: Community cases of C. difficile have been closely monitored and scrutinised over the year. As a result, identified actions and learning have been implemented across the patient pathway. Hospital and community acquired cases of C.diffic ile are currently on target to remain within the annual trajectory set by NHSE/RCCG, a significant improvement on last year.

Emergency Planning

We said we would: ensure emergency plans are kept under review and tested when possible, in particular for Pandemic Flu and incident/outbreak management.

What we did: We have contributed to and led on several local, sub-regional and national exercises held over the year to test pandemic flu plans. Consequently, the Rotherham Public Health Pandemic Flu Response Plan has been updated and linked with the RMBC Corporate Framework for Pandemic Influenza in line with regional and national expectations.

Screening and Immunisation

We said we would: continue to implement the two year screening and immunisation improvement plan (2016/2017 and 2017/2018), with a particular focus on promoting cervical screening and seasonal flu.

What we did: Local multi-agency groups for seasonal flu and vaccination and immunisation have met on a quarterly basis to successfully implement the two year plan. The screening programmes have been extremely well promoted at promotional

[4] Cohort review is a systematic review of the management of all TB patients for treatment completion and contact investigation. The cohort comprises a group of cases counted over a specific time, usually three months (PHE Handbook, June 2015)

events/opportunities over the year showing an increase in service uptake, e.g. through the South Yorkshire and Bassetlaw Fear or Smear website[5].

SUCCESSES AND CHALLENGES IN 2016

The Health Protection Committee has made considerable progress over the year, often within the context of further re-structuring and re-alignment of staff. Even so, this has still provided opportunities to develop joint working within the new council directorates, re-vitalise some of Rotherham's multi-agency emergency planning networks, improve surveillance and scrutinise community infections.

As with last year, health protection activities are reported under the following five, overarching areas;

- Communicable Diseases
- Environmental Hazards and Control
- Screening and Immunisations
- Infection, Prevention, Control and Antimicrobial Resistance
- Emergency Preparedness, Response and Resilience

SUCCESSES AND CHALLENGES IN 2016

COMMUNICABLE DISEASES

Public Health England (PHE) aims to detect possible outbreaks of disease and epidemics as rapidly as possible. To ensure early detection, the accuracy of the diagnosis is secondary, and since 1968 the initial clinical suspicion of a notifiable infection is all that's required (testing follows to confirm diagnosis). Registered medical practitioners in England and Wales have a statutory duty to notify the Local Authority or local PHE Health Protection Team of suspected cases of certain infectious diseases. In addition, all laboratories in England performing a primary diagnostic role must notify Public Health England (PHE) when they confirm a notifiable organism. PHE collects these notifications and publishes analyses of local and national trends every week[6].

New testing methodologies

Whole Genome Sequencing (WGS) reveals the complete DNA make-up of an organism, which allows differentiation between organisms with a precision that other technologies do not. This is likely to bring substantial benefits to the management and control of communicable diseases, nationally and locally.

[5] http://fearorsmear.dbh.nhs.uk/

[6] https://www.gov.uk/guidance/notifiable-diseases-and-causative-organisms-how-to-report

For communicable disease outbreaks, whether through food, water, animal or human transmission, a reliable link can quickly be made between the infection and the source. Its ability to differentiate between even closely related organisms allows outbreaks to be detected with fewer clinical cases and provides the opportunity to stop outbreaks sooner and avoid additional illnesses (Source Food and Drug Administration, USA).

WGS has a wealth of benefits including:

- improving our understanding of the evolution of bacteria and viruses helping us to understand how some strains can cause more serious disease than others (virulence)
- further our understanding of patterns of antibiotic resistance
- gaining insights as to why some people are more susceptible to infections than others (potentially)
- informing improved and targeted infection control measures[7]

With effect from 12th December, 2016, the National Mycobacterial Reference Service (NMRS) will be using WGS to identify Mycobacterium tuberculosis in Yorkshire and Humber, including Rotherham.

EMERGING INFECTIONS

Public Health England (PHE), in association with the Department for Environment, Food and Rural Affairs (Defra) and the Animal and Plant Health Agency, regularly monitor and provide updates on any notable incidents of public health significance[8].

In the November 2016, PHE and the European Centre for Disease Prevention and Control (ECDC) reported an increase in the detection of the highly pathogenic avian influenza A(H5N8) in wild and domestic birds in many European countries. To-date, no human cases have been detected and PHE and ECDC regard the risk to the general public in the UK to be very low. National and local plans are in place to ensure a rapid, effective and co-ordinated response to protect against animal diseases and hazards[9] [10]. Public Health and Environmental Health, in RMBC, work with the Y&H PHE Team and Defra to monitor the situation and advise all partners as appropriate.

INCIDENTS AND OUTBREAKS

PHE, in conjunction with Public Health, Environmental Health and Microbiology, continually monitor incidents of communicable diseases across the borough, neighbouring districts and at regional and national levels. Where community

[7] Source Gov.uk press release 2014

[8] https://www.gov.uk/government/publications/emerging-infections-monthly-summaries

[9] https://www.gov.uk/government/publications/contingency-plan-for-exotic-notifiable-diseases-of-animals-2016

[10] Rotherham Exotic Notifiable Animal Disease Contingency Plan Template, RMBC 2016 (Annex B, Avian Influenza).

outbreaks have been reported to PHE, 'situation reports' based on suspected cases of communicable diseases are produced and then shared with the relevant agencies. In many cases, if appropriate, laboratory confirmation follows.

Over the year there have been various incidents in Rotherham which have required effective inter-agency management to protect the public's health. Managing any outbreak or incident requires identifying the source of infection and implementing control measures to prevent further spread or recurrence. Some examples are outlined below.

Gastro-intestinal Infection

The most common type of infectious disease notified nationally as well as locally, was gastro-intestinal infection. Gastrointestinal (GI) diseases affect the gut and are usually related to food borne or person to person spread. In 2016, over 18 outbreaks or clusters of infectious diseases or suspected food poisoning were managed and over 474 cases of suspected infectious diseases in Rotherham were notified to PHE (RMBC, 2016).

Of these, over 271 were confirmed cases of Campylobacter, 30 cases of Salmonella, 51 cases of Cryptosporidium and a small number of cases of Giardia reported in Rotherham in 2016. The Local Authority investigates all of these cases by writing/telephoning the patients and completing questionnaires which are specific to the particular disease. In certain instances, visits are made to food premises to carry out food hygiene inspections or samples taken to check that the food or water supplied is safe.

Norovirus

Norovirus (winter vomiting virus) is one of the most common gastro-intestinal infections in the UK. It is not always possible to avoid infection as it is highly infectious. As expected in early winter, there was an increase in the number of outbreaks of suspected viral gastroenteritis in Yorkshire and the Humber, reported in schools, hospitals, care homes and by GPs. In Rotherham, this was closely monitored by TRFT, PHE, RCCG and RMBC and all appropriate control measures undertaken, including circulating the following advice and information;

- a PHE Yorkshire and Humber press release to all key stakeholders
- PHE diarrhoea & vomiting/outbreak guidance and a norovirus leaflet (see appendix 2) to Care Homes, schools, RMBC staff and the public
- RCCG information, advice to GPs and clinical support to TRFT
- RDaSH information and advice to services

Tuberculosis

Over the last 12 months, although there may only have been a small number of new cases of TB per month, the cases of TB can be complex, for example, some may require enhanced case management including Directly Observed Therapy (DOT). This can be time consuming as treatment can extend over long periods of time with an on-going case load usually considerably higher than the diagnosis rate. This is

particularly relevant where public health measures, such as contact tracing, screening, treatment and chemoprophylaxis (the use of drugs to prevent disease) have been necessary. When appropriate, an incident team has been convened to ensure an appropriate and co-ordinated multi-agency response to protect the population and reduce the risk of transmission. The latest figures for Rotherham can be seen in the Tuberculosis in Yorkshire and Humber: Annual Review[11]. The increase in drug resistant cases which are observed year on year in the UK remains a big concern and a priority for PHE and local commissioners and providers. MDR-TB continues to disproportionately affect those in hard-to-reach and vulnerable groups and even a single case is associated with significant resource implications. The proportion of MDR-TB cases in Yorkshire and the Humber increased to 2.4% in 2014, above the England average of 1.4%[12].

Successes

RMBC have been instrumental in establishing and chairing a South Yorkshire Health Protection Network which has been established to share good practice and intelligence across the public health directorates in South Yorkshire. This enables public health colleagues to make the best use of resources in order to co-ordinate our responses and communications with the Local Health Resilience Partnership (LHRP).

All incidents/clusters/outbreaks of infections, identified in the Rotherham community and hospital settings, have been managed and controlled effectively.

Challenges and future work

With such a wide range of communicable diseases (world-wide) and the increase in travel and migration, there is the potential for a greater frequency and range of communicable diseases in the UK. This poses a constant risk of incidents or outbreaks of communicable diseases in the Rotherham population. Therefore, the work of the Health Protection Committee and partners will be to remain vigilant, ensuring continuous surveillance and that multi-agency plans are fit for purpose to control any future incidents/outbreaks effectively. In the event of an outbreak, RMBC and partner agencies will continue to work together to investigate the situation and put in place measures to protect the public's health.

In 2017, to reflect regional arrangements, the South Yorkshire Regulatory Services in Environmental Health, in conjunction with PHE, are reviewing their investigative procedures (such as, questionnaires and letters) which are currently being used across the patch to regulate communicable diseases.

SEXUALLY TRANSMITTED INFECTIONS

Under the Health Protection Regulations (2010) of the Public Health Act (1984) (see appendix 1), it is clearly stated that sexual health services have a statutory duty to

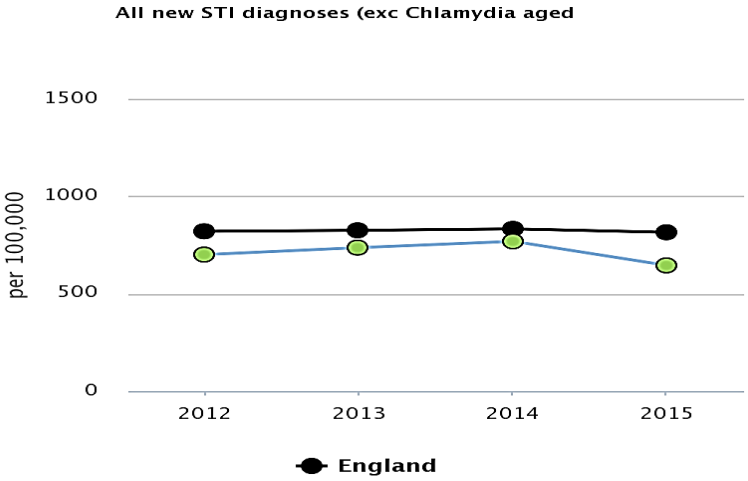
[11] Tuberculosis in Yorkshire and Humber: Annual review (2015 data), PHE, March 2017

[12] Public Health England Yorkshire and Humber Field Epidemiology Service. (2014). Tuberculosis in Yorkshire and the Humber region 2014.

carry out partner notification and contact tracing. As such, they are a vital part of the health protection mechanism for controlling the spread of Sexually Transmitted Infections (STI).

The PHE and Public Health role is to facilitate and co-ordinate responses to the more exceptional (rather than routine) clusters of STIs or incidents that require a multi-agency approach. This is particularly apparent if it is cross-boundary or involves exceptional pathogens (e.g. antibiotic resistant gonorrhoea).

Although the STI rate (excluding chlamydia) in Rotherham in 2015 was slightly higher than the Yorkshire and Humber average rate, it was lower than the national average rate. The chart below shows the rate of all STIs in Rotherham (blue line) is lower than the national rate (black line) and is decreasing.

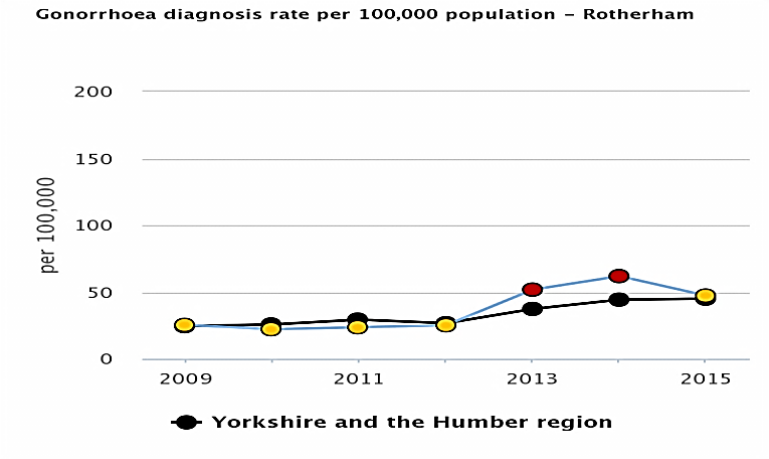


Source PHE fingertips

Successes

PHE have been working with the clinical leads and health advisors from the sexual health services across the region to agree a common approach to handling outbreaks of sexually transmitted infections and have subsequently produced an STI Outbreak Protocol and Flowchart. The aim is that the flowchart and protocol will help services systematically look at data/trends, to identify clusters or outbreaks and more formally and robustly risk-assess each situation and alert the relevant partners (including PHE and Public Health (RMBC). This will strengthen local sexual health protection processes.

Rotherham's diagnosis rates for gonorrhoea, having been the second highest in Yorkshire and Humber, have decreased significantly over the year. The annual rate is now close to the Yorkshire and Humber average and fifth highest in the region (see chart below. The blue line represents Rotherham and the black line is Yorkshire and Humber).



The latest LASER (Local Authority HIV, sexual and reproductive health epidemiology report) for 2015 shows a significant improvement in sexual health in Rotherham since 2013.

- In **2013** Rotherham had the **60th** highest (out of 326 LAs in England) rate of new STIs with a rate of 951.4 per 100,000 residents
- In **2015** Rotherham had the **139th** highest rate of new STIs with a rate of 644.9 per 100,000 residents
- In **2013** Rotherham was the **third** highest in Y&H for the rate of new STIs. This has dropped to **11th** highest out of 21 LAs in **2015**
- In **2013** Rotherham had the **59th** highest rate for gonorrhoea with a rate of 51.9 per 100,000 residents
- In **2015** Rotherham had the **91st** highest rate for gonorrhoea with a rate of 47.3 per 100, 000 residents

This year World AIDS day was commemorated with a gathering outside the Minster for people living with or affected by HIV in Rotherham, Barnsley and Sheffield. The public gathering included stalls, HIV prevention and testing, light refreshments and music. The Leader of the Council, Cllr Chris Read, was tested for HIV, to promote the importance of knowing your HIV status, the local support available and de-stigmatising HIV (see picture below).

Challenges and future work

PHE has identified an increase in cases of syphilis across the Yorkshire and Humber region, which has included an increase in the number of cases in Rotherham.

Actions to address this include:

- Sexual Health providers continuing to carry out robust partner notification and treatment of cases and contacts. This is the key intervention necessary for controlling the spread of sexually transmitted infections
- alerting teams to be vigilant for new cases and notifying PHE if any significant clusters are observed or risk areas emerging
- PHE/Genito-Urinary Medicine (GUM) wrote to all GPs notifying them of an increase in Syphilis infection in the local community

TUBERCULOSIS

There has been a year-on-year decline in the incidence of TB in England over the past four years, down to 10.5 per 100,000 (5,758 cases) in 2015, a reduction of one-third since the peak of 15.6 per 100,000 (8,280 cases) in 2011. Despite this reduction, the number of cases with social risk factors (homelessness, drug or alcohol misuse or imprisonment) has not declined (PHE, Tuberculosis in England 2016 Report).

Yorkshire and Humber has the third highest levels of TB in England and an above average proportion of Multi Drug Resistant Tuberculosis (MDR-TB). Although, to-date, Rotherham has not had any MDRTB cases, they are often associated with complex social circumstances where there may be no recourse to public funds. MDR-TB is much more difficult and expensive to treat than non-MDR TB, and patients may require long hospital stays with several months of intravenous medication. Treatment for MDR-TB can last up to two years, occasionally longer, compared with six months for standard TB[13].

Over the last year, the incidence of TB in Rotherham has reduced even further than the national reduction. However, cases are often complex, requiring longer-term case management and treatment which may involve significant levels of screening to ensure no other cases of TB go undetected.

The association between TB and deprivation is well established. Tackling the needs of the under-served, challenges to our health and social care system and identification of key issues and models of good practice, are key areas of the national and regional strategies. This remains a challenging area for Rotherham which is 6th in the deprivation rank for Yorkshire and Humber.

With the publication of the recent NICE guidance there are several implications for both children and adult TB services. The regional and local discussions, regarding

[13] All Party Parliamentary Group on Global Tuberculosis (2013). Drug Resistant Tuberculosis: Old Disease - New Threat. All Party Parliamentary Group on Global Tuberculosis: London.

their implementation, are mainly focused around the revised NICE recommendations for the diagnosis and treatment of latent TB, namely altering the detection criteria and widening the age range for treatment. This is likely to generate an increase in the number of patients being treated for latent TB infection.

Substantial benefits are expected with the introduction of Whole Genome Sequencing (WGS) laboratory services for TB testing in Rotherham. These high quality diagnostics will bring fast and accurate results (days rather than weeks), reduce the likelihood of drug resistance, improve contact tracing and surveillance and focus resources more efficiently.

Successes

- Administrative support for the TB Specialist Nurse and the appointment of a Lead Respiratory Consultant and Lead Paediatrician. This has enabled additional TB clinics to be held (TRFT) allowing more timely referrals and management of TB patients
- Multi – Disciplinary Team meetings (led by TRFT) have been established to develop local protocols/pathways in response to the latest NICE guidance
- Links have been strengthened with commissioners and the regional TB clinical networks to review Rotherham's TB Specialist Service Specification and to participate in sub groups of the TB Control Board (YH&NE)

Challenges and future work

- Further input into South Yorkshire TB cohort review[14] meetings
- Review the options for latent TB screening and support for affected communities through the Rotherham MDT
- Identify actions to mitigate against the potential capacity and capability issues for the TB Specialist services associated with implementing the new NICE guidance
- On-going challenges associated with global BCG shortage and alternative supply arrangements
- Local arrangements for new entrant screening for people from high incident countries
- Explore regional contingencies to share financial risks associated with the costs of treating MDRTB

SUCCESSES AND CHALLENGES IN 2016

ENVIRONMENTAL HAZARDS AND CONTROL

Environmental Health has a wide remit which educates, regulates and enforces legislation to ensure quality air, safe food and working environments, safe and clean environments and minimising statutory nuisances such as noise and smoke. Pest

[14] https://www2.rcn.org.uk/__data/assets/pdf_file/0010/439129/004204.pdf

control contributes to reducing disease caused by pests whilst Animal Health helps to reduce health risks associated with the transmission of zoonotic disease[15].

The Human Animal Infections and Risk Surveillance (HAIRS) group is a national multi-agency and cross-disciplinary horizon scanning group, chaired by the PHE Emerging Infections and Zoonoses section[16]. HAIRS acts as a forum to identify and discuss infections with potential for interspecies transfer (particularly zoonotic infections).

Food Hygiene and Animal Health

The local council advise and support new businesses to ensure legal compliance and to take enforcement action against traders relating to illicit alcohol, meat substitution and unhygienic premises. In December 2016, Rotherham had 1,880 food premises displayed on the Food Standards Agency (FSA), Hygiene Rating Scheme,[17] of which 1,469 were rated good or very good. Numerous re-assessment visits have been made to check the food business operators have carried out the required works to improve their rating and the majority have showed sustained improvement and gained higher ratings. There have been over 474 suspected cases of food related illness in Rotherham which have been reported between January and December 2016 and there are many more cases that are not reported.

There are currently 147 registered feed premises supplying food to animals. Visits are made to ensure they comply with the feed law and several were made to the open farms in the area to check that they were adhering to the health and safety requirements, focussing upon any potential spread of infection and measures to control organisms such as E. coli 0157 and Salmonella.

EHOs have undertaken a number of sampling initiatives in 2016 looking at a range of issues. All the meat speciation samples were satisfactory this year; although a survey looking at the quality of ice in public houses and restaurants highlighted problems with the hygiene of the ice-making machines and the practices of storing and serving the ice. As a result of the survey a number of businesses changed their cleaning regimes and updated their cleaning procedures. Further sampling was undertaken to ensure standards improved as a result in the changes implemented. Other initiatives in Rotherham have looked for the presence of Southampton colours[18] indicating the presence of some of the artificial food colours and preservatives (which can be linked to increased hyperactivity) and the quality of drinking water at establishments which have private water supplies.

Figure 1: Laboratory confirmed cases of gastrointestinal infections in Yorkshire and the Humber, 2015 (Images from: Hufton R, Utsi L & Coole L. Gastrointestinal Infection in Yorkshire and the Humber, 2015, August 2016)

[15] http://www.who.int/zoonoses/en/

[16] https://www.gov.uk/government/collections/human-animal-infections-and-risk-surveillance-group-hairs

[17] http://ratings.food.gov.uk/

[18] https://www.food.gov.uk/science/additives/foodcolours

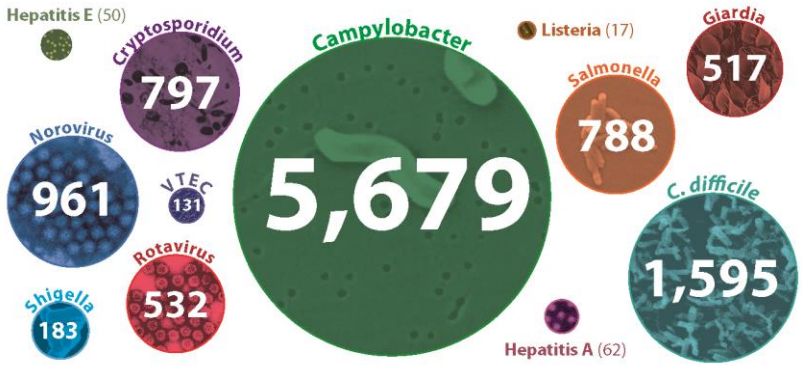
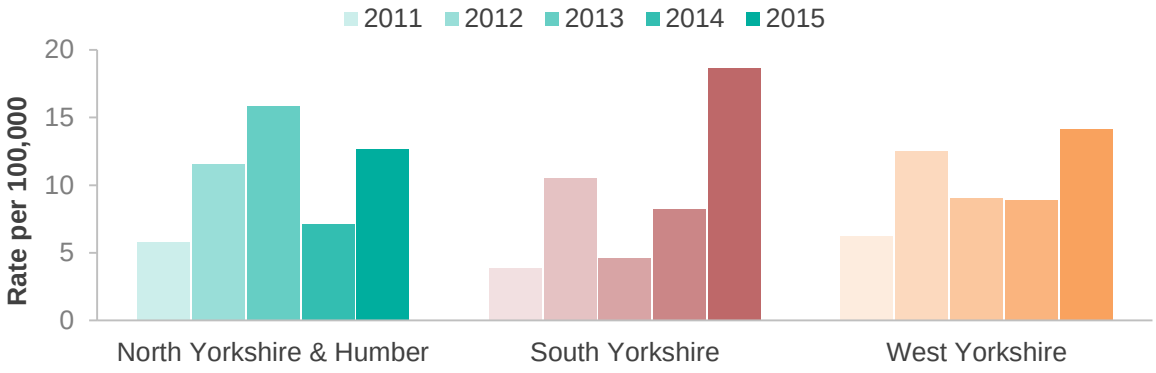


Figure 1 above, shows the burden of gastrointestinal infections across Yorkshire and the Humber reported to PHE over 2015. Campylobacter infection is the most prevalent and is more common in males of all ages, peaking in the young and old. Campylobacter is often found in raw meat, especially poultry although can be found in untreated water.

Water borne infections

In 2015/2016, there were significant increases of cryptosporidiosis[19] reported nationally and locally, 797 cases were reported in Yorkshire and the Humber in 2015 with South Yorkshire being the highest. Following extensive investigations within Yorkshire and the Humber, a common local source was ruled out and the excess in cases was determined to be part of a national exceedance.

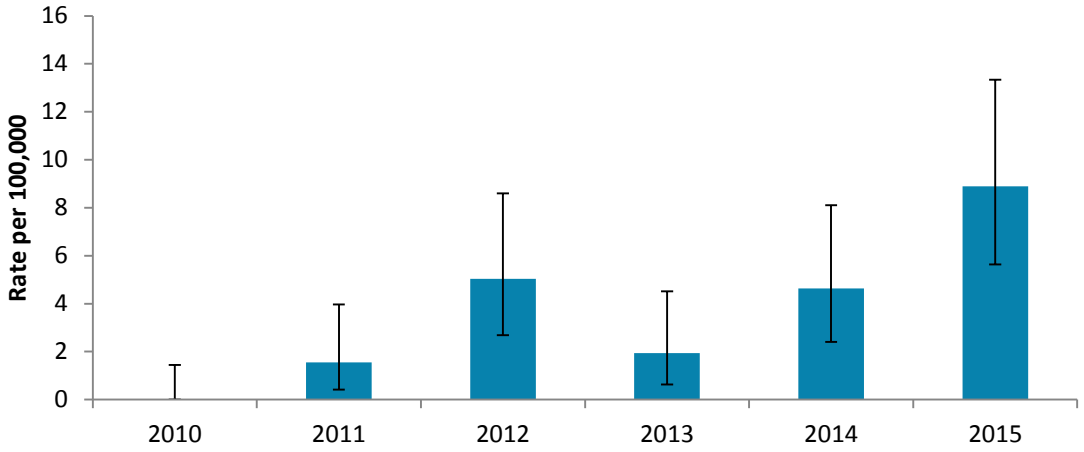
Figure 2: Annual incidence (per 100,000 persons) of laboratory confirmed cases of Cryptosporidium by Health Protection Locality in Yorkshire and the Humber from 2011 to 2015



In 2016, there have been over 51 cases of Cryptosporidiosis[20] reported in Rotherham; a reduction from 59 cases reported in 2015. There were 7 cases of Giardia in 2016.

[19] Cryptosporidium is a parasite that causes the infection cryptosporidiosis. This can affect people, cattle and sheep. Although it is more common in children 1-5 years old, it can affect all ages. People who are immuno-compromised are at risk of developing a more serious and sustained infection, but for most, the illness is self-limiting. Infection is usually acquired by the ingestion of food or water contaminated with animal waste. Person to person secondary spread also occurs.

[20] https://www.gov.uk/government/collections/cryptosporidiosis-guidance-data-and-analysis



The above chart shows the increase in rate per 100,000 of Cryptosporidium cases in Rotherham from 2010 to 2015 (source: SGSS as at 26/03/2015).

Successes

The level of compliance at food premises in Rotherham increased from 86% in January 2016 to 89% in December 2016. Environmental Health Officers (EHO) have made over 867 food hygiene and 688 food standards inspections this year, undertaking further visits to high risk premises not complying with the law and serving notices where necessary.

This year EHOs have focussed on the implementation of the Food Information Regulations which require premises, such as restaurants and pubs, to provide information to consumers about the allergens in their food. Customer Advisory Notices and EHO checks ensure that food business operators are aware of exactly which allergens are present in all the items on their menu and that they have procedures in place to review ingredients and minimise any risk of cross contamination to food.

PHE, Yorkshire Water Authority and Environmental Health worked effectively together to try to identify the cause of the increase in cryptosporidium and to monitor the situation over several months. In these circumstances, EHOs in the local authority provide data to the water authority who undertake to map the incidence of Cryptosporidiosis (also applies for Giardia). In this instance, any common local sources were ruled out and the excess in cases was determined to be part of a national exceedance[21].

Challenges and future work

Surveillance and outbreak investigation are key to rapidly identifying outbreaks and their source. Gastro-intestinal diseases are avoidable through effective preventative measures which include promoting good hand hygiene, correct food storage, preparation and cooking. This includes the prevention of contamination during food production and ensuring visitors and petting farms minimise risks due to animal contact.

[21] Exceeding a limit set by recommended practice, legislation, FSA.

Air Quality and Statutory Noise Nuisance

Excessive noise exposure can cause annoyance and fatigue, reduce efficiency and impact on health. Reducing exposure to pollution for populations is vital as people often have very little control over their individual exposure. In 2016, Community Protection services investigated 2029 complaints about excessive noise from sources including loud music, barking dogs, industrial noise, burglar alarms and domestic noise.

There is substantial evidence to demonstrate the negative effects of poor air quality on morbidity and mortality. Nationally, the most significant cause of air pollution is vehicle emissions. Whilst it is difficult to tackle such a national problem locally, it is important that partners and public are aware of the significance and the local short-term and medium-term measures to mitigate this. Key pollutants that affect human health includes NO2, PM10 (particulates less than 10 microns in size) and fine particulate pollution PM2.5 (particles less than 2.5 microns in size) (PHOF indicator 3.01), which can penetrate deep into the lungs. During 2016, and in addition to PM10 and NO2 monitoring, RMBC continued real time monitoring for PM2.5 at St Ann's School (postcode, S65 1PD), Blackburn Primary School (postcode S61 2BU), close to the M1 motorway, and in Bradgate in the A629 Air Quality Management Area.

Successes

In relation to noise incidents, whilst the vast majority of cases were resolved before going to formal action, some 104 statutory notices were served, of which four resulted in seizures of equipment and prosecution. In total 5,830 actions were carried out by officers, of which 1,325 were out of hours visits.

There has been a year on year improvement of the council's performance against PHOF 1.14i - The percentage of the population affected by noise. The target of 10.60 (2016), adjusted to 10.57 in 2017, has been met with good performance below the threshold at 10.09 in 2014/15 and 8.44. Currently performance stands at 6.33 and it is anticipated that there will be further improvement of performance over 2017. This year on year improvement is achieved through improved case management, faster response, and out of hours work to resolve problems quickly.

The 'Care4Air' initiative[22] continues to deliver vital key messages about air pollution across South Yorkshire through a range of interactive mediums. Partnership working is a critical element of effective work to tackle air pollution. This has long been established at a regional level. Important steps have been taken to develop the profile of air quality at a local level with strengthened partnership working through the co-ordination of the Health Protection Committee, and the adoption of an Air Quality Steering Group. This will link transport, active travel, planning and public health work within RMBC, to drive improvements whilst providing a focused link into regional work.

[22] http://www.care4air.org/

Traffic emissions continue to negatively impact on the quality of air in Rotherham. In certain areas, air quality standards have deteriorated. Therefore the Council has taken appropriate steps to address the exceedance of thresholds (hourly mean levels of NO2), at Wales Road, Wortley Road and Fitzwilliam Road. Rawmarsh has been declared a new Air Quality Management Area (AQMAs).

Challenges and future work

Work to tackle the health effects of noise to deliver against the PHOF indicator is underpinned by out-of-hours work. This targets RMBC's resources at the most important times when it will be more effective in bringing about a rapid solution.

The profile of air quality as a national priority has never been higher. Following successful court action against the UK Government for failures to effectively tackle air quality, the secretary of state has written to all Council leaders, Chief Executives, and Directors to Public Health, making it clear that the Government expects Councils to take air quality seriously. This position is supported by provisions of the Localism Act 2011 which allows Westminster to fine Councils for failures. Subsequently, the Council needs to demonstrate actions and improvements to air quality to mitigate these, not insignificant, risks.

Work continues to secure funding to build a 'Living Wall' [23] at St. Anne's Junior and Infant school to reduce the impact of air pollution within this key Air Quality Management Area. In addition, funding streams are being explored to establish an Electric Vehicle Rapid Charging initiative to encourage the use of alternatives fuels whilst, at the same time, reducing the levels of air pollution from vehicles within the Borough.

SUCCESSES AND CHALLENGES IN 2016

SCREENING AND IMMUNISATION

All the national screening and immunisation programmes are specified by Public Health England (PHE) and commissioned by NHS England, several of which are included in the PHOF indicators. Assurance is received through the South Yorkshire & Bassetlaw Screening and Immunisation Oversight Group (SIOG) to ensure there is a targeted, equitable and successful uptake and delivery of safe, high quality services.

There are a range of multi-agency implementation groups for Measles, Mumps and Rubella (MMR) catch-up, BCG, seasonal flu and other vaccinations. These sub-groups report to the relevant Programme Board who, in turn, report to the SIOG. For each screening and vaccination programme area, specific performance, barriers, achievements, future planning and quality assurance are discussed at individual Programme Boards and operational groups.

[23] Definition: A green (living) wall is a wall partially or completely covered with greenery that includes a growing medium, such as soil. Most green walls also feature an integrated water delivery system. Green walls are also known as living walls or vertical gardens and help protect against air pollution

Screening Programmes

There are a total of 14 screening programmes in England[24], 9 for mothers during pregnancy and newborn babies, and 5 to detect Breast, Bowel and Cervical cancers, and screening for Abdominal Aortic Aneurysm and Diabetic Eye Retinopathy.

The Screening and Immunisation Team (SIT) work closely with primary and secondary care, to advise and review specific uptake data, to encourage the promotion of screening and immunisation within their populations and for quality assurance.

Routine Vaccination and Immunisation

The population is offered routine vaccinations for protection against 14 infectious diseases in childhood, adolescence and as adults, with another four vaccines for eligible at risk groups. Girls are offered Human Papilloma Virus (HPV) vaccinations to protect women later in life against the most common cancer-causing types of HPV[25].

Successes

Overall for Rotherham, population routine vaccination coverage is good. Childhood vaccinations are all above the national average, and all ages are achieving the PHOF targets. The Rotherham practices waiting lists for childhood vaccinations have been significantly reduced following work between primary care, Child Health Records Department (CHRD) and Public Health England. In addition, financial incentives have been included in the primary care quality contract for three years which will include a pneumonia and shingles vaccination offer for all care home residents. There was improved uptake of pertussis (whooping cough) in pregnant women and Hep B vaccine for at risk children following targeted work with maternity services and the SIT.

By December 2016, The Rotherham NHS Foundation Trust had successfully met the national target (75%) for the uptake of the flu vaccine by Health Care Workers (HCWs), achieving over 80%. This was managed by;

- Line of sight, top down, support from Senior Managers through to frontline staff
- Daily communications with HCWs and by operating flexible clinic timetables to cover shifts
- The use of peer vaccinators and outreach to the employees in their place of work

Challenges and future work

- As deliveries of the UK licensed BCG vaccine were delayed due to manufacturing issues (also an international concern) PHE secured an

[24] http://www.nhs.uk/Livewell/Screening/Pages/screening.aspx

[25] http://www.nhs.uk/conditions/vaccinations/pages/vaccination-schedule-age-checklist.aspx

alternative vaccine, which has been issued on a priority basis[26]. With the more recent availability of the BCG vaccine, at risk babies will be immunised with the BCG before discharge and reviewed as part of the maternity audit in 2017

- Increasing the uptake of the MMR dose 2 to 95% WHO target (meeting the PHOF target)
- Strengthening inequalities work with a greater focus on screening and immunising people with mental health issues or learning disabilities
- Enhancing health promotion for screening through the South Yorkshire and Bassetlaw Fear or Smear website[27] and general practice visits to increase cervical screening uptake in the 25-49 age groups (recent downturn in uptake consistent with the national picture)
- Due to relatively poor uptake of seasonal flu vaccine for eligible health and social care staff in RMBC in 2016, delivery for the 2017 programme will be reviewed

SUCCESSES AND CHALLENGES IN 2016

INFECTION, PREVENTION, CONTROL AND ANTIMICROBIAL RESISTANCE

Good infection prevention and control is fundamental in improving the safety and quality of care provided to patients and in managing and controlling the spread of communicable diseases. Healthcare-associated infections (HCAIs) can pose a serious risk to patients, staff and visitors. They may incur significant costs for the NHS and partners and cause significant morbidity to those infected. Infection prevention and control is therefore a key priority for protecting the health of the population in Rotherham.

HEALTH CARE ASSOCIATED INFECTIONS

HCAIs can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. The most well-known include those caused by Meticillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile). Other less well known but significant HCAIs include Meticillin-Sensitive Staphylococcus Aureus (MSSA) and Escherichia coli (E.coli) bacteraemia.

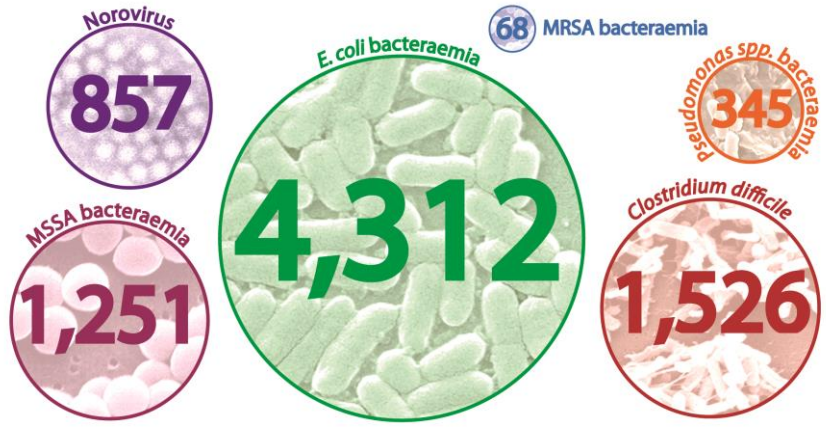
Although to-date, a national target has not been set for E.coli bacteraemia, following national surveillance, there is an awareness that these infections are increasing. In 2015, there were more than 50,000 Gram-negative blood stream infections in

26 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/533925/PHE_247_June_2016_BCG_Special_new.pdf

27 http://fearorsmear.dbh.nhs.uk/

England, 50% of which are HCAI. Gram-negative blood stream infections are increasing by almost 10% each year, 50% of which are caused by Urinary Tract Infections (UTI), most commonly caused by E.coli (Local Health and Care Planning:

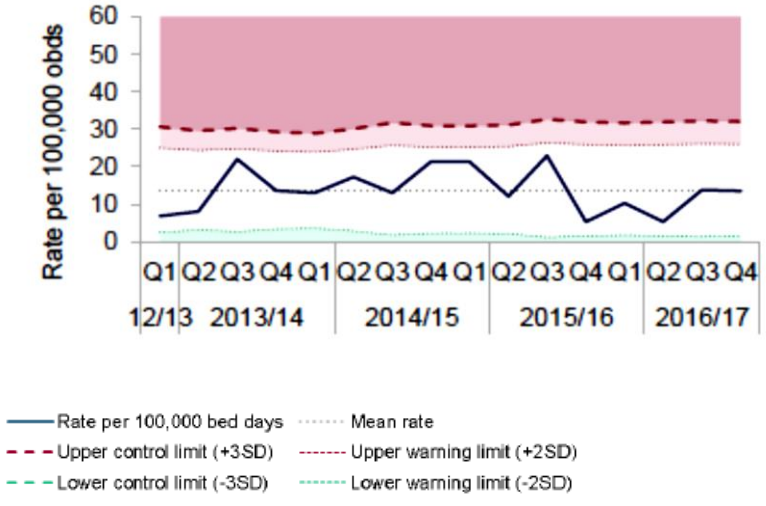
Figure 1: Burden of Healthcare-associated Infections in Yorkshire and the Humber, 2015/16 Menu of interventions PHE, Nov 2016. (Images from: Utsi L, Coole L & Hughes G. Healthcare-associated Infections in Yorkshire and the Humber, 2015/16, October 2016.)



In 2015/16, no cases of MRSA Bacteraemia were attributed TRFT. So far during 2016/17 there has not been a case of MRSA attributed to either RCCG or TRFT. Although no national target has been set and the numbers remain stable, both hospital and community cases of MSSA bacteraemia continue to be monitored by the Director of Infection, Prevention and Control (DIPC) and Infection Prevention and Control Team based at TRFT.

Clostridium Difficile

Below is a chart showing trends in C.difficile infection incidence for TRFT shown as quarterly rates of acute trust apportioned C.Difficile infection per 100,000 bed days from January 2013 to December 2016. These have remained within the 'upper warning limit'. The number of C.Difficile infections, attributed to the Hospital Trust, are within the annual trajectory set by NHSE.



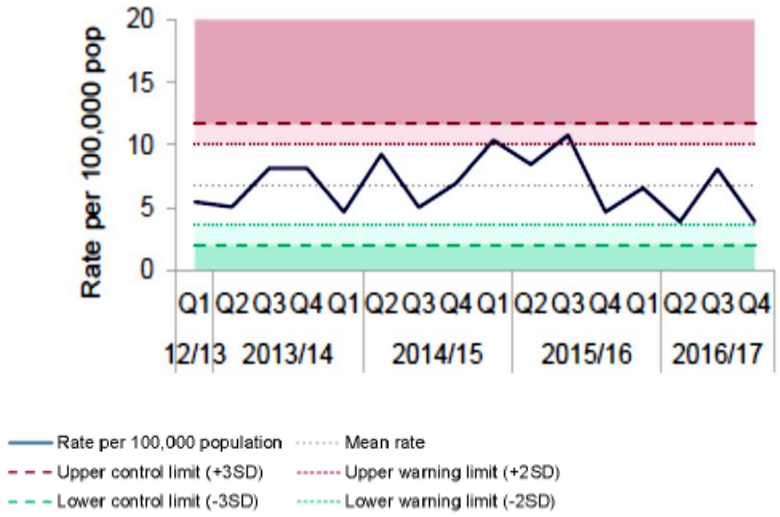
Source: HCAI Quarterly Report, October to December 2016, PHE.

Successes

Due to an increase in community acquired (CCG attributable) C.difficile infections, which resulted in RCCG exceeding the annual trajectory (2015/16).Therefore, since April 2016, a Root Cause Analysis has been undertaken for each community acquired /CCG attributable case (RCAs have always been undertaken for Acute trust cases). Subsequently, this has resulted in an increased focus on community prevention work with GPs, Care Homes, community nursing services and other acute trusts that are attended by Rotherham residents.

The chart below shows the trends for C.difficile Infection for the Rotherham Clinical Commissioning Group. The chart shows the rate of C.difficile Infections per 100,000 population from January 2013 to December 2016.

Below is the rate of C. Difficile infection (per 100,000 population) which is attributed to RCCG for 2016/17. Over the last year, the quarterly rates have reduced within the 'upper warning limit'. The number of C.Difficile infections which are attributed to the Hospital Trust remain within the annual trajectory set by NHSE.



Source: HCAI Quarterly Report, October to December 2016, PHE.

Challenges and future work

Nationally, E. coli infections have increased by a fifth in the last 5 years. Building on the progress made in infection control for MRSA and C.difficile, targeting preventable infections like E. coli will help to make surgeries and care homes safer for patients and reduce the need for antibiotics. National surveillance has indicated that the Department of Health would be announcing some national plans, in the imminent future, to reduce E. coli (bacteraemia) infections[28].

There are many residential homes for older people and people with physical and/or learning disabilities in Rotherham (79 in total). Such groups of people are particularly at risk of outbreaks of infectious diseases. The health impact of an outbreak in a

[28] https://www.gov.uk/government/news/reducing-infections-in-the-nhs

social care setting can be significant to individuals and to the running of the establishment. The following have been identified by NHS and LA partners;

- To maximise uptake of the seasonal 'flu' vaccine amongst health and social care staff
- Continue to scrutinise community acquired health care associated infections acquired in a community setting whilst providing additional support to care home staff.

ANTIMICROBIAL RESISTANCE

The overuse of antimicrobials in clinical and other settings (e.g. in animal health) is leading to increasing resistance to antibiotics that is spreading worldwide. Antimicrobial Resistance (AMR) makes treating infections caused by multi-drug resistant organisms increasingly difficult, which is both costly and a safety risk (source Local Health and Care Planning: Menu of interventions PHE, Nov 2016).

The English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR)[29] was established in 2013 in response to the cross-government UK five-year antimicrobial resistance (AMR) strategy[30]. The Chief Medical Officer's (CMO) five-year strategy highlights the need for action at an international, national and local level; a joint national approach between the Department of Health DH and the Department for Environment, Food and Rural Affairs (Defra) and rapid diagnostics to ensure appropriate treatment and surveillance.

ESPAUR supports the five-year strategy by ensuring better access to and use of data, improved AMR surveillance and improved monitoring of Antimicrobial Use (AMU).

There is also a UK-wide Antibiotic Guardian campaign[31] to raise awareness and to stimulate behaviour change in members of the public, healthcare professionals and other local stakeholders who can sign up to these national aspirations.

Successes

There has been a significant amount of work undertaken, led by the DIPC and the Antimicrobial Pharmacist (TRFT), to reduce inappropriate antibiotic prescribing in order to achieve the local targets (2016/17 AMR Quality Premium and CQUIN). This

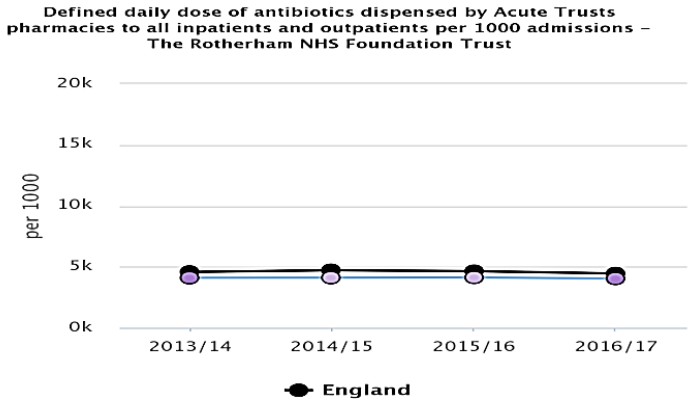
[29] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575626/ESPAUR_Report_2016.pdf

[30] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/244058/20130902_UK_5_year_AMR_strategy.pdf

[31] http://antibioticguardian.com/

includes/ strengthening the scrutiny and accountability role of the Antimicrobial Stewardship Group.

The chart below shows TRFT is below the national England average for the defined daily dose of antibiotics dispensed by acute trusts pharmacies to all inpatients and outpatients per 1000 admissions. This is also the case for antibiotic prescribing performance relating to defined daily doses of piperacillin/tazcobactam and carbapenems.



TRFT have successfully been nominated to be a pilot site for the National Voluntary Point Prevalence Surveillance for HCAIs and antimicrobial stewardship in acute care settings which contributes to the PHE and ECDC surveillance.

Challenges and future work

It will remain important for providers to maintain effective local antimicrobial stewardship (AMS) and optimised infection prevention and control by working closely with the DIPC, the DPH and the Chief Nurse (RCCG) to ensure that;

- there is progress against the CQUIN (Commissioning for Quality and Innovation) and QP (Quality Premium) indicators for antimicrobial stewardship between RCCG, TRFT, RDaSH and primary care
- infection protection and control (IPC) targets in relation to a range of infections caused by Gram-negative organisms including E. coli are achieved
- education and training on antimicrobial resistance and infection protection and control is maintained, alongside routine reports on local antimicrobial resistance and rates of antibiotic prescribing[32]

[32] Local Health and Care Planning: Menu of interventions PHE, Nov 2016.

SUCCESSES AND CHALLENGES IN 2016

EMERGENCY PREPAREDNESS, RESPONSE AND RESILIENCE

This section focuses mainly on the public health role in emergency preparedness planning and response to mitigate the health risks of various threats. Many of the emergency planning arrangements for current and future Rotherham residents are inextricably linked to Climate change and health[33]. Most of the public health activity is in relation to emergency preparedness; which have the potential for a large impact on the public's health. Chemical and radiation incidents requiring public health action are relatively uncommon and are therefore not covered in this year's report.

There were several exercises undertaken over the year, most notable amongst these, were those for pandemic flu which remains high up on the UK's National Risk Register.

Exercises

The SYLRF, (one of the eight local resilience teams), took part in Tier 1 of the national exercise **Cygnus**. This was commissioned by the Cabinet Office and jointly delivered through the Department of Health and PHE and looked at arrangements after 6 weeks into a flu pandemic.

The overarching aim of this exercise was to assess preparedness and response to an influenza pandemic in the United Kingdom. There were also a number of locally agreed objectives which were tested. These included; local resilience plans, assessing the co-ordination of public messages, strategic decision making, managing surges in health and social care activity and the wider consequence management (including dealing with excess deaths). Although the formal debrief is still to be finalised, key learning points were drawn from our internal debrief process, summarised as follows:

- Gathering accurate and up-to-date information from health and social care providers across the borough for sustained periods
- A better and wider understanding of the pressures within the social care setting and how these can be jointly managed
- Ensuring the supply and proper use of PPE
- Jointly reviewing, with partner agencies, the processes for managing excess deaths in a community setting
- Reviewing how we can communicate and engage with people in the community more effectively

Exercise **Swan**, led by PHE (Y&H), explored South Yorkshire's public health response during the initial phases of an influenza pandemic. The exercise considered the first 6 weeks of a flu pandemic using 4 scenarios (from notification to potential impacts on local organisations). It assumed that the bulk of the public

[33] http://fph.org.uk/sustaining_a_healthy%20future

health activity, around ‘Detect’ and ‘Assess’, had already occurred. Key learning points/actions were as follows;

- Communications; ensure consistent messages are agreed and sent out from a single source from the outset. Myth busting and the use of CCG networks as a good route to disseminate information to providers
- Swabbing and Mass vaccination; a Yorkshire and Humber specification needs to be developed detailing training, competencies, equipment, etc. for the mobilisation of teams undertaking swabbing/mass vaccination in the community
- Clarification on how to access the national stockpile and use of Personal Protective Equipment (PPE) for use in social care settings, including the independent care sector
- Making links with Prison Health services through the Prison Accountable Officer

A **local multi-agency pandemic flu exercise** led by PHE and Public Health (RMBC) involving all the key NHS and LA partners was held. The scenarios provided opportunities for partners to collectively assess their pandemic flu preparedness and response, agree partner roles and responsibilities and co-ordinate and dovetail local plans.

Successes

The Rotherham Public Health Pandemic Flu Response plan and Corporate Influenza Plan been updated following the sub regional exercise ‘Swan’ (held on the 10th October), the national exercise ‘Cygnus’ (held between 18th-20th October) and a local Pandemic Flu scenario exercise (held on the 17th June). Pandemic Influenza is on the national risk register and is annually reviewed through the SYLRF to ensure an integrated approach. PH also continually monitors the threat level through PHE regular surveillance updates (see Emerging Infections Section) and works closely with the Emergency Planning Shared Services (EPSS, RMBC) to ensure good links with the RMBC Pandemic Flu and Corporate Contingency Planning.

Challenges and future work

The risk of a new influenza pandemic is recognised by the Government as one of the most severe natural threats facing the UK and is top of the UK National Risk Register. This is included on RMBC’s Strategic Risk Register via Public Health. The effect on local communities / work force will remain unknown but in the worst case scenario could affect up to 50% of population (resulting in up to 3,220 additional deaths in Rotherham throughout the course of the pandemic). This in turn would have a major effect on all services / businesses as well as communities.

LOOKING AHEAD 2017

OUR COMMITMENT TO ROTHERHAM

We acknowledge that there is always room for improvement, recognising the importance of line-of-sight from senior leadership to the frontline staff and seeking innovative ways of working to drive improvement. Our commitment to the people of Rotherham, over 2017, is as follows:

Communicable Diseases

Sharing local intelligence between agencies to ensure that;

- there is effective monitoring and surveillance of emerging Infections and local implications are identified promptly
- communication is effective across organisations and the relevant health information, advice and support is provided in a timely manner
- all incidents/clusters/outbreaks are managed and controlled effectively, the response is proportionate and learning from incidents is shared and reported to the Health Protection Committee

Work with the Sexual Health and TB Multi-Disciplinary Teams/networks to;

- develop clinical TB pathways and protocols
- implement and monitor the Yorkshire and Humber STI outbreak Protocol

Food Safety

- support the legislative changes to bring in the compulsory display of Food Hygiene Ratings by food businesses
- continue to target higher risk premises for inspections and sampling
- support legal action against traders who do not comply with the law
- review procedures across South Yorkshire for managing environmental related outbreaks of communicable diseases and Standard Operating Procedures

Air Quality

- enforce environmental legislation to ensure exposure standards are not breached and maintain the air quality action plan to take account of the latest evidence and most appropriate actions
- establish an Air Quality Steering Group to more effectively co-ordinate Environmental Health, Planning, Transport and Highways and Public Health to ensure pollution exposure on new developments meets standards

Screening and Immunisation

Implement PHE's Rotherham 2 year improvement plan to:

- increase cervical screening uptake in the 25-49 age groups and uptake of MMR (second dose)
- raise the awareness and knowledge of the Diabetic Eye Screening programme to ensure timely and appropriate referrals
- immunise 'at risk' babies with the BCG (Bacillus Calmette-Guerin) vaccine before discharge, and review the BCG maternity audit on using a risk assessment to identify high risk babies
- improve access to screening and immunisation services for individuals with mental health with learning disabilities issues

Infection, Prevention and Control

Maintain effective local antimicrobial stewardship (AMS) and optimised infection protection and control across a wide range of health care settings, including the nationally emerging commitment to halve the number of gram-negative bloodstream infections in the NHS by 2020[34].

Use the learning from the analysis of community-based transmissions of HCAIs to strengthen Infection, Prevention and Control (IPC) measures in the community.

- establishing joint meetings between NHS and LA partners to identify areas to develop across the patient pathway
- introduce/strengthen a range of support initiatives for community-based services, i.e. in GPs, Residential Care Homes, Homes, etc
- improved surveillance and information sharing between partner agencies and Care Homes

Emergency Planning

Learning will be embedded from exercises undertaken in 2016 to review local and sub- regional resilience arrangements. RMBC, Voluntary Action Rotherham (VAR), NHSEY&H, PHE, RCCG, TRFT and RDaSH will continue to work through the, South Yorkshire Local Resilience Forum (SYLRF), Local Health Resilience Partnership (LHRP) and Rotherham Emergency Planning Forum (REPF), exercising and training together and developing and testing contingency plans to mitigate against the risks.

Work within the revised corporate Emergency Planning governance structures (RMBC) to monitor and review RMBC's preparedness arrangements and report on a quarterly basis to the Senior Leadership Team on progress and performance.

[34] https://www.gov.uk/government/news/reducing-infections-in-the-nhs

APPENDIX 1

Strategy Guidance

Local Authorities (Public Health Functions and Entry to Premises by Local Health Watch Representatives) Regulations 2013, made under section C of the National Health Service Act 2006
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199773/Health_Protection_in_Local_Authorities_Final.pdf

Public Health (Control of Disease) Act (1984)
http://www.legislation.gov.uk/ukpga/1984/22

Health and Social Care Act (2008) Code of Practice
https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

Health and Safety at Work Act (1974) http://www.legislation.gov.uk/ukpga/1974/37

Food Safety Act (1990) http://www.legislation.gov.uk/ukpga/1990/16/contents

APPENDIX 2

Public Health England

Stop norovirus spreading this winter

Norovirus, sometimes known as the 'winter vomiting bug', is the **most common stomach bug** in the UK, affecting people of all ages. It is **highly contagious** and is transmitted by contact with contaminated surfaces, an infected person, or consumption of contaminated food or water.

The symptoms of norovirus are very distinctive – people often report a sudden onset of **nausea** followed by **projectile vomiting and watery diarrhoea.**

Good hand hygiene is important to stop the spread of the virus.

People are advised to:

- Wash their hands thoroughly using soap and water and drying them after using the toilet, before preparing food and eating
- Not rely on alcohol gels as these do not kill the virus

An infection with norovirus is self-limiting and most people will make a full recovery in 1-2 days. It is important to keep hydrated – especially children and the elderly.

Do not visit either A&E or GPs with symptoms as this may spread the virus.

Further information and advice is available from NHS 111, including an online symptom checker at nhs.uk.

Gateway Number: 2013189

Joint Protocol Between Rotherham Health and Wellbeing Board, Health Select Commission and Healthwatch Rotherham

This joint protocol ensures that the local Health and Wellbeing Board (HWB), Health Select Commission (HSC) and Healthwatch Rotherham develop a constructive and productive working relationship with one another. Each body has an independent role and a shared aim to reduce health inequalities and improve health and wellbeing outcomes. The roles are distinctive but complementary and must add value to each other's work, and avoid duplication. This joint protocol details the distinctive roles of each body, and presents examples of working together and reporting arrangements.

Rotherham Health and Wellbeing Board

The HWB is a statutory, sub-committee of the council. Locally, it is the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health and other services directly related to health and wellbeing, in order to secure better health and wellbeing outcomes for the whole Rotherham population, better quality of care for all patients and care users and better value for the taxpayer.

The board brings together key decision makers to address issues of local significance and to seek solutions through integrated and collaborative working, whilst being an advocate and ambassador for Rotherham collectively on regional, national and international forums.

Main functions of the board:

- To enable, advise and support organisations that arrange for the provision of health or social care services to work in an integrated way**,** for the purpose of advancing the health and wellbeing of people in Rotherham
- To ensure that public health functions are discharged in a way that help partner agencies to fully contribute to reducing health inequalities
- To assess the needs of the local population and lead the coordination, development and delivery of the local Joint Strategic needs Assessment (JSNA) and Health and Wellbeing Strategy
- To oversee the development of local commissioning plans, ensuring they take account of the Health and Wellbeing Strategy and are aligned to other policies and plans that have an affect on health and wellbeing
- To hold relevant partners to account for the quality and effectiveness of their commissioning plans and request relevant information from any of its members or agencies represented on the board (cross over with scrutiny function)
- To ensure arrangements are in place to provide assurance that the standards of service provided and quality of services are safe, meet national standards and local expectations

Health Select Commission (health overview and scrutiny)

Legislation sets out that health scrutiny can scrutinise any matter in relation to commissioning or providing health and wellbeing services in the local area. This includes holding to account all local commissioners and providers of publically funded health and social care services (including the HWB, Clinical Commissioning Group, NHS organisations) for the quality and outcomes of services; ensuring they reflect the local Health and Wellbeing Strategy, are accessible and equitable, and meet the needs and aspirations of local people.

Scrutiny can request information from the above bodies/organisations, request that they attend meetings, and make recommendations for service improvement.

The terms of reference for the HSC specifically mention scrutinising the following:

- health services commissioned for the people of Rotherham
- partnerships and commissioning arrangements in relation to health and well-being and their governance arrangements
- measures for achieving health improvements and the promotion of wellbeing for Rotherham's adults and children
- measures designed to address health inequalities
- public health arrangements

It is a requirement for the relevant body/organisation/officer to consider and respond to the recommendations in a timely way following a scrutiny review. This will generally require a full response to all recommendations to be made within two months of the review report being presented to cabinet, as set out in the Council Constitution. However NHS commissioners and service providers do have a duty to respond in writing to a report or recommendation within 28 days if so requested. If the recommendations involve both the council and one or more health partners, or only health partners, they should be presented at the next HWB meeting following presentation at cabinet.

NHS bodies and commissioners, including the Clinical Commissioning Group, are required to consult with scrutiny on substantial developments or variations to local health services. If scrutiny has significant concerns with any proposal, it has the power to make referral to the Secretary of State for Health.

Any referral made to scrutiny by Healthwatch Rotherham must be acknowledged and advised of what action will be taken.

Local Authority Health Scrutiny guidance published by the Department of Health in June 2014 sets out duties and responsibilities for local authorities and health partners to ensure effective scrutiny.

Healthwatch Rotherham

Healthwatch is the new independent consumer champion for both health and social care. It is a vital part of the government's health reform plans to give people a stronger voice and drive improvements in services.

Healthwatch Rotherham will represent the views and experiences of the diverse communities in the borough, ensuring the voices of vulnerable people and hidden communities are heard.

The national vision for local Healthwatch is that it will:

- Act as local consumer champion representing the collective voice of patients, service users, carers and the public
- Support individuals to access information about services
- Provide or signpost people to independent advocacy if they need help to complain about NHS services
- Have real influence with commissioners, providers, regulators and Healthwatch England using their knowledge of what matters to local people

The vision for Rotherham's local Healthwatch was created by the Healthwatch Rotherham Board.

Vision: Healthwatch Rotherham will be known by all communities and individuals as delivering on its promises backed up by robust action and supported by improvements in local services.

Mission: To be the first point of contact for all of Rotherham's communities and individuals, to help them to have a means of improving their own and others quality of health, wellbeing and social care.

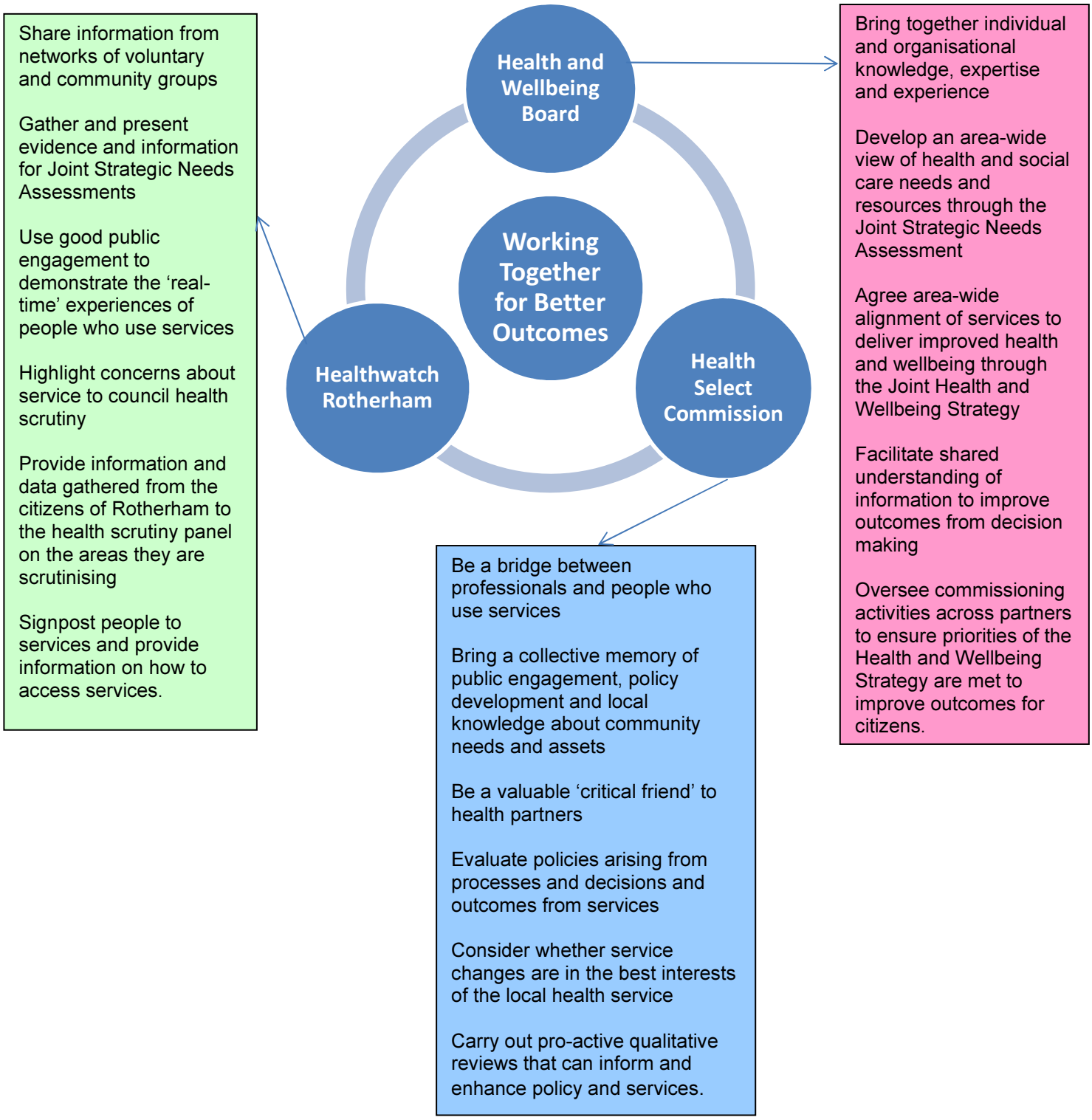
Values: To be an impartial and trusted friend to help communities and individuals to achieve their desired results and be recognised for being a fiercely independent organisation by the citizens of Rotherham.

Healthwatch Rotherham will also influence the development the local JSNA and health and wellbeing priorities, through its seat on the Health and Wellbeing Board.

Working Together

All three bodies recognise they have a role to play in the way that local services are planned and delivered and that how they interact with each other will directly influence and add value to outcomes for local people and communities.

Diagram below adapted from 'Local Healthwatch, health and wellbeing boards and health scrutiny - Roles, relationships and adding value' CfPS http://cfps.org.uk/publications?item=7195



Joint Principles, Actions and Reporting Arrangements

The Rotherham Health and Wellbeing Board, Health Select Commission and Healthwatch Rotherham agree to adhere to the following:

Key Principles:

- To improve health and social care services and reduce health inequalities in Rotherham
- To ensure and enable early and inclusive discussions about key health and wellbeing challenges
- To develop relationships based on openness, honesty and accountability

Actions:

1. To ensure regular and timely sharing of information, including sharing key actions, minutes and work plans as appropriate. As required, update reports to be presented at the respective boards to ensure transparency, provide an early opportunity to comment and to avoid duplication.

2. To coordinate the work plans of each body, ensuring duplication is avoided, cross-cutting issues are managed and clarity is given as to how each body can add value.

3. To ensure the understanding of roles and responsibilities between each body, members of each will have a seat, and/or be invited to attend meetings or joint discussions with regards to work plans and key areas of work:

- Chair of HWB invited to attend HSC and share minutes of meetings
- Open invitation for scrutiny members to attend HWB as observer/s
- Chair of Healthwatch Rotherham to have a formal seat on the HWB and receive minutes of and attend where appropriate the HSC
- Healthwatch items raised at HWB to be noted through the minutes shared at HSC meetings
- HSC has a standard agenda item enabling Healthwatch to bring issues to their attention
- Once per year the three bodies to share their draft work programmes to reduce the possibility of duplication and/or align their plans
- The chair of each body to attend joint briefings or meetings as required

Reporting Arrangements

The agreement between the HWB and HSC states that scrutiny reviews taking place that have implications for health and wellbeing board partners, should be circulated to the board for information at the early scoping stage.

Once a scrutiny review has taken place, the recommendations should be fed back to the HWB following agreement by cabinet (if implications for the council) and/or the appropriate board or committee (if implications for health partners).

Healthwatch Rotherham, as a formal member of the HWB, are able to raise issues with the board and request reports or information to be presented as appropriate.

Reporting from the HWB to HSC on delivery and performance of the health and wellbeing strategy will be undertaken annually.

Formal Agreement

Rotherham Health and Wellbeing Board, Health Select Commission and Healthwatch Rotherham agree to adhere to the principles, actions and reporting arrangements above in order to work effectively together.

Signed on behalf of the three bodies:

Cllr J Doyle	**Cllr G Watson**	**Naveen Judah**
Chair of the Health and Wellbeing Board	Chair of the Health Select Commission	Chair of Healthwatch Rotherham

Date: January 2015

BRIEFING PAPER FOR HEALTH AND WELLBEING BOARD- PUBLIC

1.	**Date of meeting:**	**31st May 2017**
2.	**Title:**	**Better Mental Health for all** **Rotherham's Strategy to promote the mental health and wellbeing of Rotherham people, 2017-2020**
3.	**Directorate:**	**Public Health, RMBC**

1. Background

In any given year, one in four adults experiences at least one diagnosable mental health problem, this represents the largest single cause of disability in the UK. There is a cost to the individual and the cost to the economy is an estimated £105 billion a year, roughly the cost of the entire NHS.

Promoting the mental health of Rotherham people and preventing mental ill health is a collective responsibility. Working with partners across Rotherham this strategy aims to improve the mental health of Rotherham people. The vision of the strategy is:

Partners in Rotherham will work together to help all Rotherham residents to be as happy as they can be, to have good mental health and wellbeing as well as emotional resilience skills.

This strategy addresses mental health promotion and prevention across a three tiered approach:

- Universal interventions - promoting good mental health and emotional resilience for all ages (primary prevention)
- Targeted prevention and early intervention - targeted prevention of mental ill health and early intervention for people at risk of mental health problems (secondary prevention)
- Wider support for those with mental health problems - softening the impact of mental health problems (tertiary prevention)

It draws upon the evidence of what works for the whole population, for individuals who are more at risk of developing mental health problems and for people living with a mental health problem.

2. Key Issues

National research shows that half of all mental health problems have been established by the age of 14 years, rising to 75 per cent by age 24. The prevalence of mental health disorders amongst children and young people in Rotherham is estimated to be 14% above the UK average, this due to higher levels of deprivation in the borough.

In Rotherham in 2014/15, 10.8% of adults over 18 in the borough had depression in, the average for England during this period was 7.3%. For self-reported emotional wellbeing in 2015/16 Rotherham residents reported high levels of; low satisfaction with life, low happiness and high anxiety. These rates were higher than the average for England and for the Yorkshire and Humber region as a whole. In 2013-15 there were 96 suicides in Rotherham (aged 10+). The suicide rate of 14.2 per 100,000 is higher than both the England rate (10.1) and the Yorkshire and Humber regional rate (10.7).

Improved mental wellbeing and reduced mental disorder are associated with; better physical health, longer life expectancy, reduced inequalities, healthier lifestyles, improved social functioning and better quality of life. Improving mental wellbeing is also associated with positive outcomes in relation to education, employment, as well as reduced crime and antisocial behaviour. (Joint Commissioning Panel for Mental Health, 2012).

Promoting the mental health of Rotherham people and preventing mental ill health is not the responsibility of one organisation. The coordination of the strategy will be led by Public Health, RMBC, with input from partners of the Health and Wellbeing Board.

This strategy is not about developing new services but about linking into community assets (strengths) and connecting people within their local community. The strategy recognises the skills, knowledge and expertise of individuals and the assets (strengths) that communities and organisations have to improve mental health and wellbeing.

Indicators from the Public Health Outcomes Framework (PHOF) and Quality Outcomes Framework (QOF) will be used to monitor the overall progress of this strategy. Interim targets to measure progress of specific areas will be in the action plan.

This Strategy does not cover specific actions on suicide prevention these are covered in the Rotherham Suicide Prevention and Self Harm Action Plan 2016-2018. Similarly crisis interventions are addressed in the Rotherham Crisis Care Concordat which can be found at http://www.crisiscareconcordat.org.uk/areas/rotherham/.

Adult Care & Housing, RMBC, produced the Mental Health Commissioning Strategy for Rotherham, 2016-18. This addresses mental health service provision with its focus on effective and evidenced based mental health services across the sectors.

The Local Child and Adolescent Mental Health Services (CAMHS) Transformation Plan for Rotherham which is in response to the National report, 'Future in Mind', published in May 2015, outlines key development areas for future years for children and young people's mental health services. The full plan can be accessed at: http://www.rotherhamccg.nhs.uk/mental-health_2.htm

3. Key actions and relevant timelines

As part of delivering the recommendations in The Five Year Forward View for Mental Health, Public Health England is working with partners to develop a Prevention Concordat Programme for Better Mental Health. One of the aims of this concordat will be to facilitate every local area to put into place effective prevention

planning arrangements led by Health and Wellbeing Boards, CCGs and Local Authorities. The concordat will cover the promotion of good mental health through to living well with mental health problems. The concordat is expected to be published this year.

The Mental Health Foundation (2016) called for local areas to have a focus on preventative approaches building on existing strengths and assets. They recommended that local areas take into account all factors which influence mental health on an individual, family, community and structural level.

The framework for **'Better Mental Health for all - Rotherham's Strategy to promote the mental health and wellbeing of Rotherham people',** has been developed inline with this national focus on prevention and mental health. A stakeholder event in October 2016, with partners from statutory services and the voluntary and community sector helped shaped the development of the Rotherham strategy. The draft strategy was sent to these stakeholders for initial comments in December 2016 and came to the Health and Wellbeing Board in January 2017 for consultation with partners. This final version has incorporated comments and feedback from partner organisations.

Lead Officers from all partner organisations met as a Task and Finish Group on the 12th May to commence work on an action plan which will accompany this strategy. The actions address mental health promotion at a whole population level, targeted approach and wider support for people living with mental health problems. The action plan will take a wholelife course approach from prebirth to ageing well. Partner organsiations have been encouraged to look at opportunities within their current interventions to promote good mental health.

4. Recommendations to Health and Wellbeing Board

4.1 Member organisations of the Health and Wellbeing Board accept and endorse the final version of the strategy content prior to it being sent to the design team.

4.2 Members of the Health and Wellbeing Board continue to support Lead Officers from their organisation to asist with the development of an action plan.

4.3 The detailed action plan to be submitted to the Health and Wellbeing Board for approval by October 2017.

4.4 The Health and Wellbeing Board to receive an annual update on progress made.

5. Name and contact details

Teresa Roche, Director of Public Health (DPH)

Ruth Fletcher-Brown
Public Health Specialist, Rotherham Public Health, Rotherham MBC,
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Better Mental Health for All

Rotherham's Strategy to promote the mental health and wellbeing of Rotherham people

2017-2025

May 2017

Contents

Foreword

It is a privilege to present Rotherham's Strategy to promote the mental health and wellbeing of Rotherham people 2017-2025. The Strategy outlines the Health and Wellbeing Board's plans for improving the mental health and wellbeing of people living in Rotherham. Mental health is something that we all have and the good news is that there is a lot we can do to improve and maintain good mental wellbeing. We know from talking with people in Rotherham that mental health and wellbeing is important to them. Many people are already aware of increasing and maintaining their own good mental health and have a clear understanding of what helps them. However there is more that can be done for many groups and individuals in offering signposting opportunities to take part in activities or events or making lifestyle changes that will improve both their mental health and wellbeing.

Good mental health increases people's capacity to cope with life's ups and downs. Improving mental health at a community level strengthens community resilience and enables individuals to be healthier and active participants in society.

This strategy recommends actions which individuals, communities and organisations can do to prevent mental ill health and promote good mental health and wellbeing.

By improving the mental health and wellbeing of individuals and communities it will help us all to flourish and thrive within the borough.

I hope you join in!

Cllr Roche

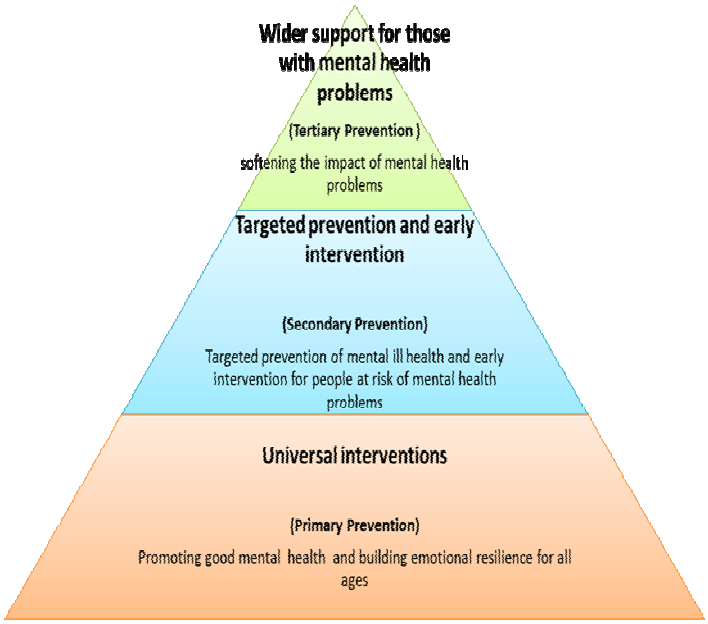
Chair of the Rotherham Health and Wellbeing Board

Introduction

Promoting the mental health and wellbeing of Rotherham people and preventing mental ill health is the responsibility of all.

Mental health is a something which everyone has and is linked to a person's physical health. Good mental health is more than an absence of mental illness. On an individual level it is about ensuring that a person takes the opportunities to look after themselves. However, there are things which impact on a person's mental health which are beyond their control, Dahlgren and Whitehead[1] explained these as 'social' or 'wider determinants'. These could include aspects such as employment, housing and education. Therefore actions to promote good mental health will require the support of a range of partners, individuals and communities. This strategy and the action plan which will accompany it will focus on promoting self-management and prevention whilst making links to wider community assets (strengths) in the borough.

1. Executive Summary – Plan on a Page



We will encourage individuals, communities and organisations in Rotherham to use the Five Ways to Wellbeing:

Be Active
Connect
Give
Keep Learning
Take notice

2. Why is this important?

Mental health is something everybody has. Mental health, as defined by the World Health Organisation[2], is;

'…. *a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community.'*[2]

Good mental health therefore is fundamental to how an individual, community and society functions. However, one in four adults experiences at least one diagnosable mental health problem in any given year. Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year, roughly the cost of the entire NHS.[3]

Poor mental health affects every stage of life. For instance mental ill health of mothers can have longstanding effects on a child's emotional, social and cognitive development. One in five mothers will experience depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death, after cardiovascular disease[3].

Half of all mental health problems have been established by the age of 14, rising to 75% by age 24. In a class size of thirty children, three will have a diagnosable mental health problem[3].

One in five older people living in the community and 40% of older people living in care homes are affected by depression. Suicide is now the leading cause of death for men aged 15 - 49 years[3].

Mental health and physical health are strongly linked. Evidence shows that people with severe mental health problems are at risk of dying, on average, 15 to 20 years earlier than other people. All physical health problems will have a psychological dimension; this is particularly evident when people are learning to live with a long-term condition. For some people this may mean a loss of income and earning potential, loneliness, isolation and functional impairment[4]. For those people living with physical health problems, who then develop mental health problems, it can mean that they experience more complications[3].

People living with mental health problems report that stigma and discrimination has an impact on their wellbeing. It can prevent them from seeking help, delay treatment, impair recovery, make them feel isolated and excluded from activities and can be a barrier to employment[5].

Having good quality and accessible mental health services is important for times when people are experiencing a mental health problem. However, this is only one part of the solution and is intervening when problems have arisen rather than

preventing mental ill health in the first place. Promoting mental wellbeing and resilience results in improvements to a person's physical health, life expectancy, educational outcomes, economic productivity, social functioning and produces healthier lifestyles[6].

3. Our Vision

Promoting the mental health and wellbeing of Rotherham people and preventing mental ill health is the responsibility of all. Working closely with partners across Rotherham this strategy aims to improve the mental health and wellbeing of Rotherham people.

The vision for Rotherham is that:

Partners in Rotherham will work together to help all Rotherham residents to be as happy as they can be, to have good mental health and wellbeing as well as emotional resilience skills.

4. Background - Why have a Mental Health and Wellbeing Strategy?

Improved mental wellbeing and reduced mental disorder are associated with; better physical health, longer life expectancy, reduced inequalities, healthier lifestyles, improved social functioning and a better quality of life. Improving mental wellbeing of people is also associated with positive outcomes in relation to education, employment, as well as reduced crime and antisocial behaviour[6].

In a recent report from the Mental Health Foundation the authors called for local areas to focus on preventative approaches making poor mental health a rarer occurrence. By focusing on prevention, not only will there be savings for services but also for the wider society[7]. The report makes the case for building on existing strengths, assets and resilience, through a 'Whole Community Approach' that recognises that mental health is influenced by many factors from those at an individual and family level to community and structural levels.

In November 2008, Professor Sir Michael Marmot was asked by the Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The review concluded that reducing health inequalities will require action on six policy objectives:-

- Give every child the best start in life.

- Enable all children young people and adults to maximise their capabilities and have control over their lives.
- Create fair employment and good work for all.
- Ensure a healthy standard of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill health prevention.

Marmot stated that to deliver these objectives, action would be required from central and local government, the NHS, the third and private sectors and community groups. Indeed, National policies would not work without effective local delivery systems which focus on health equity in all policies. Effective local delivery would require effective participatory decision-making at local level which can only happen if local people and communities are empowered.

A central theme to the review included the 'life course' perspective. The report argues that disadvantage starts before birth and if disadvantages are to prevented then actions to reduce inequalities must begin before birth and continue throughout the child's life[8].

In 2011, the cross - governmental mental health strategy was published entitled 'No Health without Mental Health'[9]. The aim of this strategy was to mainstream mental health in England, establishing parity of esteem between mental and physical health services. The strategy recognised that mental health was every body's business, not just health services. This includes individuals, families, communities, employers in addition to health and local authority services.

4.1 Economic reasons for investing in public mental health

There are good economic reasons for investing in public mental health. In 2011, the Department of Health published a report which shows the potential savings which can be made for every £1 invested in mental health promotion and mental illness prevention[10]. The examples below show that for every £1 invested the potential net savings are:

- £84 saved through school based social and emotional learning programmes

- £44 saved through suicide prevention training for GPs

- £14 saved through school based interventions to reduce bullying

- £10 saved through work-based mental health promotion (after one year)

- £8 saved through early intervention for parents of children with conduct disorder

-£5 saved through early diagnosis and treatment of depression at work

- £4 saved through debt advice services

5. National Facts

- Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year – approximately the cost of the entire NHS.
- One in five mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth.
- One in ten children (aged 5 – 16) has a diagnosable problem such as conduct disorder (6%), anxiety disorder (3%), attention deficit hyperactivity disorder (ADHD) (2%) or depression (2%).
- Half of all mental health problems have been established by the age of 14, rising to 75% by age 24.
- One in four adults experiences at least one diagnosable mental health problem in any given year.
- Suicide is now the leading cause of death for men aged 15–49.
- People with severe and prolonged mental illness are at risk of dying, on average, 15 to 20 years earlier than other people, one of the greatest health inequalities in England.
- One in five older people living in the community and 40% of older people living in care homes are affected by depression.
- An estimated 10% of the general population over the age of 65 are lonely all or most of the time. [11]

(Above data taken from The Five Year Forward View for Mental Health, The Mental Health Taskforce[3])

6. The Local Picture

The projected population in Rotherham for 2016 is 261,400, with 90% being white British. The largest Black and Minority Ethnic (BME) community group is Pakistani/Kashmiri and Slovak/Czech Roma.

The age profile is:

- 21.6% of the population are aged 0-17 (56,400)
- 53.3% of the population are aged 18-59 (139,400)
- 25.1% of the population are aged 60+ (65,600)

Rotherham's age profile is slightly older than the national average with a lower proportion aged 20-39 and a higher proportion aged 45-79.

6.1 Children and young people

The prevalence of mental health disorders varies significantly according to a range of socio-economic and demographic factors. Prevalence rates of poor mental health have been found to be higher amongst children and young people living in certain family circumstances. These circumstances include living in a lone parent family, living in families where the parents are unemployed and living in families where there is greater poverty[12]. The prevalence of mental health disorders amongst children and young people in Rotherham is estimated to be above the national average due to higher levels of deprivation. Table 1 below uses the national prevalence rates taking into account the higher levels of deprivation in Rotherham, to estimate mental ill health amongst children 5 to 16 years old.

Table 1 Estimates of Mental Health Disorders in Rotherham Based on National Prevalence Rates

	5-10		11-16		All
	Boys	**Girls**	**Boys**	**Girls**	**5-16**
Total Number of Children	10,040	9,480	9,110	8,750	37,380
Emotional Disorders	2.2% 250	2.5% 270	4.0% 420	6.1% 610	3.7% 1,550
Conduct Disorders	6.9% 790	2.8% 300	8.1% 840	5.1% 510	5.8% 2,440
Hyperkinetic Disorders	2.7% 310	0.4% 40	2.4% 250	0.4% 40	1.5% 640
Autistic Spectrum Disorder	1.9% 220	0.1% 10	1.0% 100	0.5% 50	0.9% 380
Rare Disorders	0.3% 30	0.3% 30	0.6% 60	0.6% 60	0.4% 180
All Disorders	**10.2% 1,170**	**5.1% 550**	**12.6% 1,310**	**10.3% 1030**	**9.6% 4,060**

Source[13]

The Rotherham Child Lifestyle Survey[14] is open to all pupils in Year 7 and Year 10 at secondary schools and pupil referral units in the borough. Pupils completing the survey are aged 11/12 years and 14/15 years of age. This survey gives young people an opportunity to have a say about their health, well-being and their future.

The 2016 survey asked young people to describe the things they felt good about and the things that they did not feel so good about. The combined results for girls and boys found that overall **Year 10 pupils** felt most good about friendships and least good about how they looked, as follows:

1. Friendships
2. Home Life
3. Future
4. Myself
5. Schoolwork
6. Relationships
7. How they look

Overall **Year 7 pupils** said they most felt good about home life and least good about how they look:

1. Home Life
2. Friendships
3. Future
4. Myself
5. Schoolwork
6. Relationships
7. How they look

Table 2 compares these themes with the previous year and shows very little change between the views of young people in 2015 compared to 2016:

Table 2 Young People for the 2015 and 2016 survey were asked to put in order the things they feel good about from the following:

	2015 Overall Ranking	**2016 Year 7**	**2016 Year 10**
Friendships	2nd	2nd	1st
Home Life	1st	1st	2nd
School Work	5th	5th	5th
Future	3rd	3rd	3rd
Myself	4th	4th	4th
How I Look	6th	7th	7th
Relationships	7th	6th	6th

Source[13]

The findings show that young people in Rotherham rank friendships, home life and the future as being the things they most feel good about. However, how they look and relationships are the two things they feel least good about.

6.2 Adults and older people

- 10.8% of adults over 18 in Rotherham had depression in 2014/15 (England average 7.3%).
- People with mental health conditions consume 42% of all tobacco in England[15]. It is estimated that tobacco sales in Rotherham were £75.7 million pounds in 2013. 42% equates to nearly £31.8 million pounds spent by people with mental health conditions.
- By 2015 nearly 4,300 (4,284) of people aged 65 and over were projected to have depression in Rotherham (4,655 by 2020)[16].
- In 2013-15 there were 96 suicides in Rotherham (aged 10+). The suicide rate of 14.2 per 100,000 is higher than both the England rate (10.1) and the Yorkshire and Humber regional rate (10.7).
- The percentage of people registered at Rotherham practices with dementia for 2014/15 was 0.85% (England average 0.74%) This relates to 2,206 people (all ages).
- The rate of hospital admissions for alcohol related conditions in Rotherham (broad definition) in 2014/15 was 2,454 per 100,000 (England average 2,139).
- The mortality rate among people with a severe mental illness aged 18-74 is three times higher than that of the general population[17]. For Rotherham there were 123 premature deaths in adults aged 18-74 with a severe mental illness in 2012/13.
- For self-reported emotional wellbeing in 2015/16 Rotherham residents reported high levels of; low satisfaction with life, low happiness and high anxiety. These rates were higher than the average for England and for the Yorkshire and Humber region as a whole.

(Above data for Rotherham is taken from Public Health England Profiles unless otherwise stated[18])

Baseline- Public Health Outcomes Framework (PHOF) and Quality Outcomes Framework (QOF) data for Rotherham

The aim of the Strategy is to see an improvement in mental health and wellbeing. This requires the ability to measure this improvement from a baseline position. To achieve this we are using selected national indicators which can provide robust, consistent data updated at least annually. These are taken from Public Health England Profiles.

The data included measures the levels of mental health problems and wellbeing in the population based on people registered with GP practices (depression prevalence) and national surveys (self-reported wellbeing). It also measures the effect on people living with mental health conditions based on employment levels and levels of premature deaths.

Depression prevalence is included as the most common form of a mental health condition affecting over 24,000 Rotherham residents aged 18 and over in 2015/16. Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for patients, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs[18].

The self-reported wellbeing measures are included because people with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health[18].

The 2006 evidence review, 'Is work good for your health and wellbeing'[19] concluded that work was generally beneficial for both physical and mental health and wellbeing. This indicator provides a good indication of the impact of long term illness on employment[18]. The value shown is the absolute difference (gap) between the employment rate in the general population and people in contact with mental health services. For Rotherham in 2013/14 this was 68.2% minus 4.9% giving 63.2% (to 1 decimal place).

The Disability Rights Commission (2006)[20] reported on the serious inequalities experienced, in terms of reduced life expectancy, by those with living with a severe mental illness. There is extensive published evidence that people with severe mental illness, such as schizophrenia, die between 15 and 25 years earlier than the average for the general population.

To understand this measure a value of 100 means a mortality rate no different to that of the general population and a rate of 200 means twice the mortality rate of the general population. Therefore, Rotherham's value of 411 for 2013/14 shows that adults aged under 75 (18-74) with serious mental illness have a mortality rate over 4 times higher than adults aged under 75 in the general population.

Table 3 Baseline data

Indicator	Period	Rotherham	England	RAG	Rank
Depression prevalence (aged 18+) (QOF)	2015/16	11.8%	8.3%	Higher	2nd highest
Self-reported wellbeing (aged 16+)					
People with a low satisfaction score (PHOF 2.23i)	2015/16	8.5%	4.6%	Red	Highest
People with a low worthwhile score (PHOF 2.23ii)	2015/16	5.1%	3.6%	Amber	3rd highest
People with a low happiness score (PHOF 2.23iii)	2015/16	11.7%	8.8%	Red	2nd highest
People with a high anxiety score (PHOF 2.23iv)	2015/16	27.3%	19.4%	Red	Highest
Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (aged 18-69) (PHOF 1.08iii)	2014/15	63.2	66.1	Not compared	5th lowest

Excess under 75 mortality rate in adults with serious mental illness (ratio) (PHOF 4.09i)	2014/15	411	370	Not compared	9th highest

Notes
PHOF – Measures taken from the Public Health Outcomes Framework (PHOF) published by Public Health England. References shown are the indicator numbers in the PHOF[18].

RAG – Red/Amber/Green rating. This compares the values for Rotherham and England and shows if Rotherham is statistically significantly different (based on 95% confidence intervals)
Red = worse, Amber = similar, Green = better.
Higher/Lower shown when a rating of 'better/worse' is not possible due to how the data is interpreted.

Rank – Rotherham is compared to 15 similar local authorities based on the Chartered Institute of Public Finance and Accountancy (CIPFA) model. Rank shown is out of 16.

QOF – Quality and Outcomes Framework (NHS Digital)

7. What are we doing in Rotherham to promote good mental health and wellbeing?

Across Rotherham there are a wide range of activities, initiatives and services which make a positive contribution to improving the mental health of Rotherham people. A scoping exercise will accompany this strategy to highlight this preventative work and identify any gaps.

Examples include the 'My Mind Matters' website which is a mental health and emotional wellbeing website site for young people, parents, carers and practitioners in Rotherham. The website was developed to be a safe and reliable site for young people and families to obtain information on a variety of mental health issues.

Since 2007, many workers from a range of organisations across the borough have attended Youth or Adult Mental Health First Aid courses. These are international courses with a strong evidence base aimed at helping staff to identify early signs of mental ill health, signpost to appropriate services and encourage self-help. The courses tackle the stigma and discrimination associated with mental ill health. The courses also have had an additional benefit of helping participants understand how to look after their own mental health and wellbeing.

Rotherham has a national award winning Social Prescribing service which has been helping people with long term health conditions including mental health problems. This is a partnership model working between primary care and the voluntary sector[21].

In October 2016, an event was held in Rotherham with attendees from the health sector, the local authority, police and voluntary organisations. At the event,

participants looked at the current activity in the borough that will have a positive impact on mental health and wellbeing. Examples of this activity can be seen in Appendix 1.

Mental health and wellbeing is important to Rotherham people. In 2016, RMBC Public Health consulted partners, stakeholders and the general public, on the priorities for the Public Health Grant. The consultation included a public on-line survey, a members working group, stakeholder events and a survey at the Rotherham Show. The findings from this consultation showed that people living and working in Rotherham felt that children's mental health and the prevention of suicide were amongst the most important areas to support. People attending the Rotherham Show indicated that mental health was important to them by ranking mental health and suicide prevention as their top priority.

For the last 4 years, Rotherham Youth Cabinet has identified mental health as a priority area. In March 2016, Rotherham Youth Cabinet held a conference for young people and professionals who work with families, children and young people. The conference was aimed at young people to help them explore self-help techniques around mental health and manage their own emotional wellbeing, thus preventing escalation to other services. The Youth Cabinet's Manifesto for 2016/2017 has 'body image' as a priority area.

What this strategy does not focus on

This Strategy does not cover specific actions on suicide prevention; these are covered in the Rotherham Suicide Prevention and Self Harm Action Plan 2016-2018. Similarly, crisis interventions are addressed in the Rotherham Crisis Care Concordat at http://www.crisiscareconcordat.org.uk/areas/rotherham/.

The Mental Health Commissioning Strategy for Rotherham, 2016-18, addresses mental health service provision with its focus on effective and evidenced based mental health services across all sectors.

The Local Child and Adolescent Mental Health Services (CAMHS) Transformation Plan for Rotherham outlines key development areas for future for children and young people's mental health services[22].

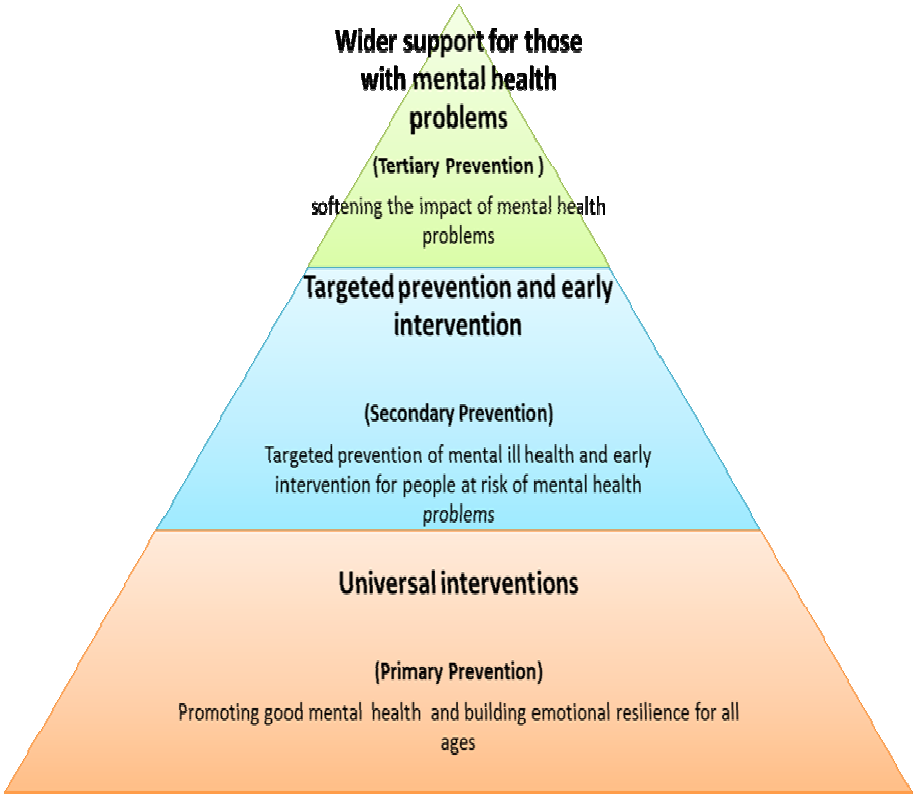
8. What will we do?

8.1 Take a whole population approach

This strategy considers mental health promotion and prevention across a three tiered approach.

It will draw upon the evidence of what works for the whole population's wellbeing, individuals who are more at risk of developing mental health problems and people living with a mental health problem.

Diagram 1 Tiered approach to improving mental health and wellbeing



Source[23]

The strategy uses an asset (strengths) based approach:

'*Every community has a tremendous supply of assets and resources that can be used to build the community and solve problems…*'[24]

This strategy is not about developing new services but about linking into community assets (strengths) and connecting people within their local community. The strategy recognises the skills, knowledge and expertise of individuals and the physical, cultural and economic assets that communities and organisations already to build on to improve mental health and wellbeing. The action plan will reflect this at an individual, community and organisational level which will include working closely with the voluntary sector.

Five Ways to Wellbeing

The Five Ways to Wellbeing provides an alternative way to think about building personal resilience[25].

The ambition is to adopt and embed this approach both strategically and operationally across Rotherham so that it becomes a part of everyone's business and everyone's daily life.

The Five Ways message helps us all to take action to maintain positive mental wellbeing in the same way that we eat well, drink at sensible levels and are active to maintain physical health.

1. ***Be active***

This can be walking, dancing, running, cycling or gardening. Physical activity is not only good for your physical health it is also good for your mental health. It can help reduce anxiety and improve low mood.

2. ***Connect***

Connect with people around you. This might be at work, at home or in your local community. This could be about joining a group, helping a friend, family member or colleague or by volunteering. Having good social support helps people to look after your mental health.

3. ***Give***

This could be as simple as smiling at someone and saying thank you. It could be volunteering within your local community. It could be doing something nice for a colleague or friend.

4. ***Keep Learning***

Trying something new or learning a new skill like cooking, playing an instrument, fixing a bike, photography or painting. Learning a new skill helps improve confidence and is a fun thing to do.

5. ***Take notice***

This is about stopping and observing what is around you. It could be the time you are spending with friends or family or nature around you and the changing seasons. Getting off the bus a stop earlier and walking the last bit is a way of getting more physically active and taking notice of the surroundings.

The plan is to engage wider partners who may not have traditionally been seen as having a role in promoting good mental health in their communities, for example, local workplaces and businesses. The Five Ways to wellbeing will be used as a framework to inform action and engage partners, communities and individuals in a practical way to promote good mental health. The hope is that individuals and communities will be able to identify a range of strategies to improve and maintain good mental health.

8.2 Take a life course approach to promoting good mental health

By taking a life course approach to mental health the action plan, accompanying this strategy, will reflect ways of promoting good mental health and preventing mental ill health across all ages. The action plan will identify groups within the life course who need a more targeted approach.

The life course approach will cover the following:

- **Starting well**
  Giving children the best start in life is the best way of reducing inequalities across the life course[8]. This needs to start pre-birth with good care and support for parents before the child is born and continues post birth.

- **Growing, developing well**
  Partners need to work together to address the social and emotional development of children and young people across all settings. Schools are an important setting to promote mental health, through examples like the whole school approach[26]. Partners can work together to look to build the emotional resilience of young people.

- **Working age**
  Being in good work protects health. Having a job is good for your mental health[8].

- **Ageing well**
  Depression, social isolation and loneliness are not an inevitable part of growing older. Promotion of good mental health is also important for healthy ageing[27].

8.3 Develop environments that support good mental health and tackle stigma

In Rotherham, there are 6,392 people claiming long term sickness benefits as a result of mental health conditions, which is 48.8% of the total claiming long term sickness benefits[28].

Stigma and discrimination has a massive impact on the mental health and wellbeing of someone living with a mental health problem. We know that it can:

- Prevent people accessing help at the earliest opportunity
- Have a negative impact on their recovery
- Prevent people from participation in society thereby making them feel isolated and alone

- Make it difficult to find employment or disclose to their employer that they have a mental health problem for fear that this would be seen as a weakness.

9. Outcomes

The following outcome measures will be used to monitor the impact of the strategy. The baseline data was outlined in section 6.

Public Health Outcomes Framework

Improving the wider determinants of health

1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Persons)

Health Improvement:

2.23 Self-reported wellbeing:

Office of National Statistics (ONS) are currently measuring individual subjective well-being based on four questions included on the Integrated Household Survey:

- Overall, how satisfied are you with your life nowadays?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?
- Overall, to what extent do you feel the things you do in your life are worthwhile?

Healthcare public health and preventing premature mortality:

- 4.09i - Excess under 75 mortality rate in adults with serious mental illness

Quality Outcomes Framework:

- Depression recorded prevalence (QOF): % of practice register aged 18+

10. Governance

The majority of work will be taken forward through existing strategies and their governance structures. These will be outlined in the action plan. The progress of Rotherham's Strategy to promote mental health and wellbeing will be monitored by 'Aim 3' of the Health and Wellbeing Board and progress reported accordingly.

11. Next Steps

An important initial step is to map existing mental health promotion and mental ill health prevention activity in Rotherham in order to understand the gaps and priorities for the borough. From this mapping Public Health will work with champions from organisations represented on the Health and Wellbeing Board to develop a detailed action plan using an Outcomes Based Accountability approach.

Appendices

Appendix 1

The following are examples of activity which were identified by attendees at the stakeholder event in October 2016:

1. Example of current activity in Rotherham

Universal interventions promoting good mental health and emotional resilience for all ages (primary prevention)

- *The Active for Health programme is a specialist physical activity referral programme for patients with long term conditions. Early results are showing the Active for Health programme has had a positive effect on peoples' physical and mental health over the last 12 months, proving to be an effective way in supporting patients to improve their quality of life. The social aspects of this project has been as beneficial as the physical workout, helping to reduce social isolation and loneliness both of which can be a concern for people with long term conditions.*
- *Rotherham's 'My Mind Matters' website: www.mymindmatters.org.uk* is a website for children, young people, parents, carers and practitioners on lots of mental health and emotional wellbeing issues. It has information on how to get help, what help exists and how to look after your mental health.
- *Six pilot schools in Rotherham are adopting a whole school approach to emotional health and wellbeing, in line with national guidance: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414908/Final_EHWB_draft_20_03_15.pdf*
- *Rotherham Healthy Schools.*
- *Organisations and businesses signing up to the Workplace Well-being Charter. The Workplace Wellbeing Charter is a statement of intent, showing organisation's commitment to the health of the people who work for them.*
- *Young people having a voice through Youth Cabinet and Looked After Children's Council and Rotherham's Young Inspectors.*
- *www.talking sense.org is a web based product that people can access for e-learning and Cognitive Behavioural Therapy (CBT) type treatments for mild to moderate depression or anxiety.*

Targeted prevention and early intervention- Targeted prevention of mental ill health and early intervention for people at risk of mental health problems (secondary prevention)

- AGE UK Rotherham Befriending service, 'Two's Company' is a befriending service for Rotherham older people who are living in isolation or feel lonely.

- Carers Resilience Service. This service aims to decrease the pressure on the mental and physical health of carers by providing assessment, information, support, advice, links to other services and respite.
- Memory Cafes run across the borough and are for people living with dementia and their carers. They provide opportunities for people to get support and make new friends.
- Dementia Friends Training.
- Early Help Service providing intense, focused support when problems first emerge. The right Early Help services at the right time can reduce or prevent specific problems from getting worse and becoming deep seated or entrenched.
- Projects in the voluntary sector, for example, Kimberworth Park Community Partnership run Men in sheds and walking groups for isolated people.
- Old Market Gallery (an example of a local arts project).
- Rotherham's armed forces community covenant is a public promise of support to members of the armed forces, past and present.

Wider support for those with mental health problems- Softening the impact of mental health problems (tertiary prevention)

- The Rotherham Social Prescribing Service which helps people with long term health conditions to access a wide variety of services and activities provided by voluntary organisations and community groups in Rotherham.
- *RDaSH – Volunteers.*
- Advocacy services provided by Health Watch and Cloverleaf (Absolute Advocacy).
- Rotherham Parents Forum work with those who provide services for disabled children and their families. The forum shares knowledge, experience and what families tell them to help plan and improve the quality, range and accessibility of services for all disabled children and their families in Rotherham.
- Mental Health First Aid training and suicide prevention training for frontline paid and unpaid staff.

Glossary

Autistic Spectrum Disorder
ASD stands for Autistic Spectrum Disorder a general term for a group of complex disorders of brain development. These disorders are characterized, in varying degrees, by difficulties in social interaction, verbal and nonverbal communication and repetitive behaviours.

Conduct Disorders
Conduct disorders are characterised by aggressive, disruptive or antisocial behaviour. All children and young people can have challenging moments. Occasionally, a child will have a temper tantrum, or an outburst of aggressive or destructive behaviour, but this is often nothing to worry about. When a child or young person is diagnosed with a conduct disorder their behaviour starts to impact on their overall development and ability to function.

Emotional Disorders
These include anxiety disorders, of which there are several, and depression.

Hyperkinetic Disorders
This is characterised by hyperactive, impulsive and inattentive behaviour. This is often referred to as Attention Deficit Hyperactivity Disorder (ADHD).

Mental health
Mental health is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. World Health Organisation, 2014.

Mental health problems
Mental health problems range from the worries we all experience as part of everyday life to serious long-term conditions. The majority of people who experience mental health problems can get over them or learn to live with them, especially if they get help early on.

Parity of esteem
This is about mental health being given equal priority to physical health.

Person with lived experience/experts by experience
People with lived experience/experts by experience are people with experience of mental health problems and care for someone who has. It may also include experience of using mental health services.

Public mental health
Public mental health is about promoting positive mental health across all ages and preventing mental illness. Public mental health strategies focus on what action can be taken to promote mental health, prevent mental illness and improve the lives of people with mental health problems.

Rare Disorders

This includes disorders like selective mutism and eating disorders like bulimia and anorexia.

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