HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 14th March, 2018**

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 Part 1 of Schedule 12A to the Local Government Act 1972

2. To determine any item(s) which the Chairman is of the opinion should be considered later in the agenda as a matter of urgency.

3. Apologies for absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Minutes of the previous meeting (Pages 1 - 8)

7. Communications

For Discussion

8. Formal Sign-off of the Health and Wellbeing Strategy 2018-2025 (Pages 9 - 51)
   Terri Roche, Director of Public Health, to report

9. Integrated Care Partnership Place Plan Refresh
   Verbal update by Chris Edwards, Chief Operating Officer, Rotherham CCG

10. Health and Wellbeing Strategy - Update from Aim 2 (Mental Health and Wellbeing (Pages 52 - 65)
    Kathryn Singh, RDaSH, to report

11. Winter Plan - Update
Verbal update by Chris Edwards, Chief Operating Officer, Rotherham

12. Pharmaceutical Needs Assessment (Pages 66 - 129)
Steve Turner, Public Health, to present

13. Meeting Dates for 2018/19
Wednesday, 16th May, 2018
11th July
19th September
21st November
23rd January, 2019
20th March
29th May

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

14. Date and time of next meeting
Wednesday, 16th May, 2018, commencing at 9.00 a.m. venue to be confirmed

HEALTH AND WELLBEING BOARD
10th January, 2018

Present:-

Councillor D. Roche	Cabinet Member, Adult Social Care and Health **(in the Chair)**
Nathan Atkinson	Assistant Director Strategic Commissioning, RMBC (representing Anne Marie Lubanski)
Dominic Blaydon	Associate Director of Transformation, TRFT (representing Louise Barnett)
Tony Clabby	Healthwatch Rotherham
Dr. Richard Cullen	Strategic Clinical Executive Rotherham CCG
Chris Edwards	Chief Operating Officer, Rotherham CCG
Carole Lavelle	NHS England
Rob Odell	District Commander, South Yorkshire Police
Terri Roche	Director of Public Health
Kathryn Singh	Chief Executive, RDaSH
Ian Thomas	Strategic Director, Children and Young People's Services
Janet Wheatley	Chief Executive, Voluntary Action Rotherham

Report Presenters:-

Sandi Keene	Independent Chair, Rotherham Safeguarding Adults Board

Also Present:-

Sam Barstow	Head of Service, Community Safety, Resilience and Emergency Planning, RMBC
Ruth Fletcher-Brown	Public Health, RMBC
Lydia George	Rotherham RCCG
Kate Green	Policy and Partnership Officer, RMBC
Bronwen Knight	Planning, Regeneration and Transport, RMBC
Gordon Laidlaw	Communications Lead, RCCG
Councillor P. Short	Vice-Chairman, Health Select Commission
Chris Siddall	Culture, Sport and Tourism, RMBC
Janet Spurling	Scrutiny Officer, RMBC
Sarah Watts	Strategic Housing, RMBC

Apologies for absence were received from Councillors Evans, Mallinder and Watson, Anne Marie Lubanski and Dr. Jason Page (RCCG).

52. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

53. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

54. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting of the Health and Wellbeing Board held on 15th November, 2017, were considered.

Resolved:- That the minutes of the previous meeting held on 15th November, 2017, be approved as a correct record.

Further to Minute No. 41(1) the visit of the Shadow Secretary of State for Health, Jon Ashworth, had taken place on 1st December, 2017 and had shown a genuine interest in the Social Prescribing taking place in Rotherham.

Further to Minute No. 43(3) (Local Safeguarding Children Board Annual Report), it was reported that a response had been submitted on behalf of the Health and Wellbeing Board with regard to the proposed abolition of LSCBs.

It had also been clarified that the comments made at the last meeting with regard to a joint Partnership response had been included in the LSCB consultation response (Minute No. 43(5) refers).

Further to Minute No. 45 (Delayed Transfer of Care), it was noted that Rotherham's recent performance on Delayed Transfers of Care had been 1.5% - good practice was 3%. It was also noted that Winter Pressures was not having an effect at the present time.

55. COMMUNICATIONS

The Chairman reported receipt of an email from the Local Government Association stating that Rotherham's Health and Wellbeing Board was regarded as a leader nationally.

They had asked the Chair to give a presentation at a meeting in York about the journey, where the Board had come from, the barriers it had faced and how it was moving forward.

56. HEALTH AND WELLBEING STRATEGY REFRESH

Further to Minute No. 42 of the previous meeting, Terri Roche, Director of Public Health, presented an update on the progress being made in relation to the refresh of the Health and Wellbeing Strategy together with the full draft of the new 2018-2025 Strategy.

The 4 aims had been agreed at the November Board meeting with a number of minor suggestions made in terms of language and focus. It had also been agreed that the new Strategy became a longer term document, in line with the Rotherham Together Partnership Plan, and set the strategic vision and direction for the Board over the next 7 years. The Strategy's main purpose was to strengthen the Board's role in relation to

high level assurance and holding partners to account as well as influencing commissioning across the health and social care system and wider determinants of health.

The aims contained within the Strategy were ambitious and would require a continued and dedicated focus on improving health and wellbeing outcomes across the Partnership. Results would not be seen overnight but would ensure work at Board level could be focussed on the activity required to deliver the aims in an appropriate timescale.

It was the intention to develop an annual plan demonstrating what activity would be undertaken during that year, what success would look like and, following the first year, also include a progress report in relation to the activity undertaken in the previous year.

It was noted that the Strategy had been discussed at VCS 'An Audience With' session the previous day, copies of the questions/points raised were circulated for consideration.

To ensure proper alignment with the Strategy, it was noted that the refreshed Integrated Health and Social Care Place Plan would now be submitted to the Place Plan Board in April and the Health and Wellbeing Board in May.

Discussion ensued with the following issues raised/clarified:-

Aim 1

- Raised at the Health Select Commission and VCS that loneliness could affect all age groups and not just the elderly - should loneliness be in Aim 3 with a reference in Aim 1?
- Focus on transition – make sure that transition from childhood to adulthood was referenced
- Consideration to be given to loneliness and isolation with regard to children and internet/cyber bullying
- Development work taking place on a Journey to Excellence Strategy for SEND children in Rotherham. Clarity was still required as to what would sit within the HWB Strategy and the discreet Strategy for SEND children
- Did the Aim focus too much on the child and not enough on the family?
- What actions would be available to strengthen perinatal health and supporting young people into work?
  - Perinatal – multi-agency response required with effective anti-natal pathways, peer buddying. Discuss at 0-19 Healthy Children Commissioning
  - Supporting young people into work – Bids within the Troubled Families Programme, NEETS in line with national average but need to increase the number of apprenticeships. The Skills and Employment Sub-Group was working with the University looking at skills and employment strategies

- The Strategy had been updated to emphasis the Voice of the Child as expressed by the Health Select Commission
- Not enough work done to prepare those who were reaching the age of retirement for their journey out of work

Aim 2

- Need to be more explicit with regard to suicide prevention?
- Recognising the numbers of new mothers potentially at risk of perinatal mental health issues?
- The number of young men who committed suicide who had not had any contact with any health services/GP
- Change of language particularly with regard to Learning Disabled
- Need for an explicit link with Primary Care with regard to physical care needs of people with several and enduring mental illness
- Recently issued Prevention Concordat for Mental Health. It was thought that there would be a direction from Public Health England that would look to Health and Wellbeing Boards to state how it was delivering on the Concordat
- Inclusion of alcohol intake during pregnancy and links to Foetal Alcohol Spectrum Disorders

Aim 3

- Need to include Safeguarding
- Promote independence
- Very medically focussed
- People needed to live in high quality housing accommodation (Aim 4)
- Relating to both Aims 3 and 4, frontline staff needed to know what they could do to influence people's housing – holistic assessments with housing considered as part of them and the housing duty captured within
- Preparation for giving up work and living as well as you can
- How to manage life transition points
- End of life care – how to manage death in the most holistic way
- Ageing well and what could be done to improve and influence the services available that could be accessed both short and long term
- Ageing Well should be a separate Priority within the Aim

Aim 4

- That Loneliness be included in Aim 4
- No Theme leader as yet nor as detailed as the others due to the focus of the Aim having changed
- This Aim cut across a number of strategies including the soon to be refreshed Housing Strategy and links to the Local Plan
- Was this Aim just assurance that the strategies were maximising the work of the Health and Wellbeing Board?
- Risk of duplication
- Neighbourhood and building stronger communities was missing
- Loneliness and isolation should be kept separate

- Importance of physical activity
- Inclusion of discrimination in the introduction?
- Resilience should be addressed within the Priorities

Resolved:- (1) That the consultation responses and revised document be noted.

(2) That with regard to Aim 2, the language in relation to "Learning Disabled" be updated to "people with learning disabilities".

(3) That with regard to Aim 3, Ageing Well become a focus across the Priority.

(4) That with regard to Aim 4, Loneliness be included as a Priority within the Aim.

(5) That Board Members receive a copy of the final report as soon as possible for consideration and endorsement by their respective organisations.

(6) That Sara Watts, Bronwen Knight, Chris Siddall and Sam Barstow ensure that the priorities in Aim 4 were correct and the activity required picked up by the relevant strategies and plans identified.

57. ROTHERHAM SAFEGUARDING ADULTS BOARD ANNUAL REPORT

Sandi Keene, Independent Chair of Rotherham Safeguard Adults Board, presented the Rotherham Safeguarding Adults Board 2016/17 Annual Report.

During 2016/17 all the agencies in Rotherham had continued their commitment to improve Adult Safeguarding in the Borough and to build on previous progress. It was still the Board's aim to engage better with the public and make it easy to report concerns about safeguarding and ensure that where there where safeguarding concerns were identified, that a personal response was provided.

Sandie highlighted:-

Achievements

- The Board had developed its Constitution with all partner agreement
- More public awareness, a website, leaflets and posters
- Partner self-assessment and challenge with key partner buy-in
- Performance framework with partner contribution
- Revise and refresh RSAB training plan and strategy
- Increased Board membership

Common Themes

- Mental Health – RDaSH Board and Sub-Group members
- Self-Neglect – regional and local work planned
- Domestic Abuse
- CSE – close partnership working and monitoring
- Users and carers – Board priority to increase customer involvement
- Learning Disability – working to embed the Making Safeguarding Principle in all Learning Disability Service

Future

- Case file audits/quality assurance
- Multi-agency training approaches
- Practice issues (self-neglect, trafficking/modern day slavery, Deprivation of Liberty Safeguards (DoLs – all ages, MCA consistency)
- Assurance (Safeguarding and Learning Disability, Safeguarding Adult Reviews action plans and dissemination, advocacy take-up)
- Campaigns (Safeguarding is everyone's business, Legal Power of Attorney)
- Development (joint work with Community Safety and Children's Boards)

Sandi also drew attention to the following:-

- Due to the profile and complexity of cases it was important that a refresh of the Health and Wellbeing Strategy included a focus on Safeguarding for Adults as well as Children

- An independent person was undertaking the first independent case file audit

- There was to be a Safeguarding Week in Rotherham 9-13th July in collaboration with Children's Services and other South Yorkshire authorities

- Work was taking place with the RSAB's Legal Team updating the literature regarding Lasting Power of Attorney. It was the aim to have a publicity campaign around the issue which would hopefully have a positive impact on the number of DoLS

- Trafficking and modern slavery was seen as a potential growing need and the Board's expertise needed to be built on the issue

- There was a gap in written policy, practice and procedures between all agencies ensuring there was a "golden thread" from a referral to an outcome, the ability to identify the appropriate practice/procedure that delivered the outcome. Sandie suggested the Safeguarding Adults board did not have the capacity to do it

With regard to the last bullet point, Kathryn Singh reported that it had been a common theme for all the Chairs at the Safeguarding Partnership Protocol Joint Chairs meeting that the capacity to ensure an effective safeguarding board was really important. However, it applied to all the organisations as well as the Adults and Children's Boards. If workforces were expected to be consistent with policy and procedures but were not clear of the strategic level there was a disconnection. It was important for Chief Officers to ensure they were supportive of the approach.

It was proposed that practitioners across all agencies be brought together to look at Safeguarding and discuss the same family approach to safeguarding the most vulnerable people. The involvement of Elected Members would also be useful for identifying of those at risk in their Wards. Such an event could be held during the July Safeguarding Week.

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

(2) That consideration be given to an event being held during Safeguarding Week of all practitioners across the agencies, Elected Members and the voluntary sector, to discuss policy, practice and procedures with regard to Safeguarding.

(3) That an agenda item be included at the next meeting of the Chief Executives Group of the Rotherham Together Partnership with regard to policy and procedures for Safeguarding.

58. ENGAGING THE PUBLIC IN THE WORK OF THE HEALTH AND WELLBEING BOARD

The Chairman presented a report on how Durham had successfully engaged with the public through a range of events and public attendance at their Health and Wellbeing Board meetings. Durham annually had over 200 members of the public asking questions at their Board events.

Discussion ensued on the issue of public engagement. It was felt that there were other ways that the Board could engage with the public including the use of social media. However, the Board was more than likely engaging with the public in a number of areas that was not currently being captured.

It was felt that the refreshed Health and Wellbeing Strategy would be engaging communities in developing the various actions. However, there was a need to capture the work that was taking place.

Resolved:- That the report be noted.

59. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting of the Board be held on Wednesday, 14th March, 2018, commencing at 9.00 a.m. to be held at Oak House, Bramley.

REPORT FOR ROTHERHAM HEALTH AND WELLBEING BOARD

Date of meeting:	**14th March 2018**
Title:	**Refreshed Health and Wellbeing Strategy 2018 – 2025**
Directorate:	**Assistant Chief Executive's / Public Health**

1. Summary

Rotherham's Health and Wellbeing Strategy, which has been produced in collaboration with all health and wellbeing partners, has been refreshed for 2018 to 2025. This is the third Strategy produced by the local Health and Wellbeing Board since it was established in 2011.

Health and Wellbeing Boards have a duty to publish a local Health and Wellbeing Strategy, fulfilling the duty set out in the Health and Social Care Act (2012) to set the overarching framework for health, wellbeing and care commissioning plans locally.

This report presents the refreshed Strategy for the Health and Wellbeing Board to formally sign-off.

Recommendations

That the Health and Wellbeing Board:

1. Notes the stakeholder consultation that has taken place and how comments have been incorporated into the strategy where appropriate

2. Notes that the refreshed Health and Wellbeing Strategy for 2018 – 2025 has been endorsed by the Council's Cabinet and Clinical Commissioning Group Governing Body

3. Formally signs-off the refreshed Health and Wellbeing Strategy for 2018 – 2025.

2. Background

Health and Wellbeing Boards (HWbBs) have a duty to publish a local Health and Wellbeing Strategy (Strategy), fulfilling the duty set out in the Health and Social Care Act (2012) to set the overarching framework for health, wellbeing and care commissioning plans locally.

Rotherham's Strategy, which has been produced in collaboration with all health and wellbeing partners including the Council, the Clinical Commissioning Group (CCG), Rotherham NHS Foundation Trust, Rotherham, Doncaster and South Humber NHS Mental Health Trust (RdaSH), Voluntary Action Rotherham (VAR), Healthwatch, NHS England and South Yorkshire Police, has been refreshed for 2018 to 2025. This is the third Strategy produced by the local HWbB since it was established in 2011.

The existing Strategy (2015-2018) runs until the end of 2018, however the local HWbB agreed that due to a number of strategic drivers influencing the role of the HWbBs, such as the local Integrated Health and Social Care Place Plan, an early refresh was appropriate. Refreshing the Strategy for 2018 ensures it remains fit for purpose and strengthens the HWbBs role in relation to partnership working, high level assurance and holding partners to account, as well as influencing commissioning and provision of services across the health and social care system and wider determinants of health.

3. Key Issues

3.1 Integrated Health and Social Care Place Plan

The Rotherham Integrated Care Partnership (ICP) is the local delivery arm of the wider South Yorkshire and Bassetlaw Integrated Care System (ICS), previously known as the Sustainability and Transformation Plan. The local ICP is about health and care partner organisations in Rotherham sharing responsibility for the planning and delivery of improved and sustainable health and social care for local people. The local ICP have previously published the Rotherham Integrated Health and Social Care Place Plan (Place Plan), which will deliver a set of 'place' priorities under five workstreams.

A key factor influencing the refresh of the local Strategy was to align the Place Plan to it. This means that the Place Plan will also be refreshed and its associated workstreams will become the delivery mechanism for the elements in the Strategy relating to health and social care integration.

The diagram in Appendix B demonstrates how these documents will be aligned.

3.2 Principles of the Strategy

The principles of the strategy have not changed from the current version (2015-2018). The HWbB agreed these were still relevant and should continue to be the foundation for the refreshed Strategy, and be embedded in everything that all partners do, both individually as organisations, and jointly as a partnership:

- Reduce health inequalities by ensuring 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
- Prevent physical and mental ill-health as a primary aim, but where there is already an issue, services intervene early to maximise impact
- Promote resilience and independence for all individuals and communities
- Integrate commissioning of services to maximise resources and outcomes
- Ensure pathways are robust, particularly at transition points, so that no one is left behind
- Provide accessible services to the right people, in the right place, at the right time.

The strategy continues to be a high-level document which includes the most important things that the HWbB have agreed to focus on to improve the health and wellbeing of local people. The refreshed version has strengthened this; it is not intended to include everything that all partners do, but what they can do better together. The four aims in the Strategy each has a set of priorities attached, which have been reduced from the current version, ensuring they are properly high-level and in line with the principles.

The refreshed Strategy is also now presented over a longer-term: 2018 – 2025, which puts it into line with the Rotherham Together Partnership Plan and sets the strategic vision and direction for the HWbB over the next seven years.

The four aims in the Strategy are purposely ambitious. They will require a continued and dedicated focus on improving health and wellbeing outcomes across the whole partnership. Results will not be seen overnight, but publishing this strategy until 2025 ensures work at HWbB level can be focused on the activity required to deliver the aims in an appropriate timescale.

4. Consultation

Because the Strategy is a refresh of the current version, and not a complete re-write, broad public consultation has not been undertaken.

The reason for refreshing the Strategy has been to ensure it remains fit for purpose in relation to the HWbBs strategic oversight role, and focuses on the most important areas that the partnership is able to do better by working together. The health and wellbeing issues which the strategy will focus on have been informed by local intelligence in the Joint Strategic Needs Assessment and previous iterations of the strategy have been consulted on publically.

Stakeholders across all partner organisations, including the voluntary and community sector, have been consulted with. The refreshed Strategy has also been shared via public meetings of the CCG and HWbB.

An overview of the consultation undertaken and comments received is included in appendix C.

5. Timetable for approval of the refreshed strategy

The Strategy has been taken through the following process for endorsement and formal approval:

- 19 January 2018 draft strategy circulated to HWbB, Health Select Commission and wider stakeholders to share with their respective boards and networks
- 6 February 2018 Consultation with the Council's Strategic Leadership Team
- 7 February 2018 Consultation with the Integrated Care Partnership Place Board
- 7 February 2018 Taken for comments and endorsement at the CCG Governing Body
- 12 March 2018 Taken for endorsement at the Council's Cabinet
- 14 March 2018 Formal approval to take place at HWbB.

6. List of appendices included and background papers

Appendix A Draft Health and Wellbeing Strategy 2018 – 2025.

Appendix B Health and Wellbeing Strategy and Integrated Health and Social Care Place Plan governance diagram.

Appendix C Overview of consultation comments and responses

Background Papers

Health and Wellbeing Strategy 2015-2018 available at:
http://rotherhamhealthandwellbeing.org.uk/hwp/downloads/download/1/health_and_wellbeing_documents

7. Contacts

Terri Roche, Director of Public Health
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DRAFT

Rotherham Joint Health and Wellbeing Strategy

A healthier Rotherham by 2025

Foreword

Health and wellbeing is important to everybody in Rotherham, enabling people to live fulfilling lives and to be actively engaged in their community. The way individuals achieve good health will differ according to their experiences, life chances, abilities and resources. Unfortunately, we know too many people in Rotherham are not in good health and that significant differences exist between our most and least deprived communities.

As our population grows, health and wellbeing needs change. We need to ensure we are responsive to these changes by continuing to support people to live healthy lives and remain independent as long as possible.

Public sector finances are becoming increasingly stretched, which means that all partners on the Health and Wellbeing Board and local communities will need to be working together to explore new ways of delivering services and meeting needs. We hope that this strategy will help to meet these challenges through a shared vision for health and wellbeing in Rotherham.

The Health and Wellbeing Strategy provides a high level framework which will direct the Health and Wellbeing Board's activity over the next seven years; it will support the board's role to provide leadership for health and wellbeing by making the most of our collective resources within Rotherham. It doesn't, however, reflect everything we will consider as a board or that the partners will deliver, but focuses on what we can do better together and provides strategic direction for each organisation as they deliver services.

The Health and Wellbeing Board is about working together and we believe it is clear that the board is now a real and strong partnership. The strategy contains some ambitious aims, but by working creatively and in partnership, we feel that they are achievable and that we can make long-lasting changes that will improve the health and wellbeing of all Rotherham people.

Cllr David Roche
Cabinet Member for Adult Social Care and Health
Chair of Rotherham Health and Wellbeing Board

Dr Richard Cullen
Chair of Rotherham Clinical Commissioning Group
Vice-chair of Rotherham Health and Wellbeing Board

1. Introduction and context

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

The high-level strategy involves the implementation of a number of workstreams, organisational strategies and action plans. The role of the Health and Wellbeing Board is to support and encourage effective partnership working, share good practice, understand and build on local assets, as well as taking action where needed to remove blockages, identify gaps and to hold organisations, workstream and strategy leads to account for delivery. All of this is about ensuring the board maximises opportunities for improving health and wellbeing in everything it does, across all agendas, policies and strategies.

For the strategy to be effective, it is important that it has a clear focus, and includes only the most important things that the partners on the board can do together. It does not include everything that all partners do, but considers strategically where the most difference can be made by the board working in partnership.

1.1 The Rotherham Together Partnership

The Rotherham Together Partnership plan - 'The Rotherham Plan 2025'- provides a framework for partners' collective efforts to create a borough that is better for everyone who wants to live, work, invest or visit.

The Health and Wellbeing Board and strategy contribute to achieving the vision of the Rotherham Plan, particularly in relation to integrating health and social care and improving health and wellbeing outcomes for local people.

The wider partnership also provides an opportunity to explore where better outcomes could be achieved in relation to the wider determinants of health, for example: the environment people live in, education, employment, financial inclusion and transport; all of which contribute to the aims and priorities within this strategy.

1.2 Accountable Care Partnership and Integrated Health and Social Care Place Plan

The Rotherham Integrated Care Partnership (ICP) is the local delivery arm of the wider South Yorkshire and Bassetlaw Integrated Care System (ICS), previously known as the Sustainability and Transformation Plan. The local ICP is about health and care partner organisations in Rotherham sharing responsibility for the planning and delivery of improved and sustainable health and social care for local people. The ICP have published the Rotherham Integrated Care Partnership: Health and Social Care Place Plan (Place Plan), which will deliver a set of 'place' priorities under five workstreams, which are aligned to the Health and Wellbeing Strategy aims:

- Transforming services for children and young people
- Transforming mental health services
- Transforming learning disability services
- Transforming urgent care services
- Transforming community care services

The Health and Wellbeing Strategy sets the strategic vision for improving health and wellbeing for all Rotherham people, the Rotherham Place Plan is the delivery mechanism for the health and social care integration elements of the strategy.

Rotherham's health and social care community, including the council, clinical commissioning group and providers of health and care services, has been working in a collaborative way for several years to transform the way it cares for its population, and is passionate about providing the best possible services and outcomes. It is recognised that only through working together in a strong partnership, and with local communities, can sustainable services be provided over the long term.

Prevention, early intervention and the integration of health and social care services are the focus of the Place Plan; to transform the way services are delivered.

National and local commissioning has supported increased community care over recent years to improve patient outcomes, improve flow through the system and reduce inefficiencies. Health and social care transformation programmes include developing alternatives to entering services or hospital admission and facilitating discharge. The Place Plan provides an opportunity to build on this to take a more holistic and integrated approach across physical and mental health, social care and the voluntary and community sector in order to develop and embed an integrated model of care which supports individuals and their carers and focuses much more on prevention.

Narrowing inequalities and targeting resources towards areas of greatest need is a principle of the Health and Wellbeing Strategy. The Place Plan will contribute towards achieving this by applying an approach referred to as 'proportionate universalism': services must be universal, but with a scale and intensity that is proportionate to the level of need.

Appendix A demonstrates how the Place Plan aligns to and contributes to achieving the overarching aims of the Health and Wellbeing Strategy

2. What is meant by 'health and wellbeing'

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

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

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

The aims in this strategy, whilst setting the vision for how health and care services will be delivered to those who need it, will also have a strong focus on the role of the individual and the wider community in improving health and wellbeing. Evidence shows that people who are connected to others, not feeling socially isolated or lonely, who are learning, staying active and contributing to their community, are much happier and healthier[1].

2.1 A life course approach

A life course approach to health is based on the understanding that multiple factors, which include biological, social, psychological, geographic, and economic, shape health over the life course. This approach aims to increase the effectiveness of interventions throughout a person's life, focusing on a healthy start to life then targeting the needs of people at critical periods throughout their lifetime such as adolescence, moving into work, pregnancy, retirement, bereavement and end of life.

The health and wellbeing of individuals and populations across the whole life course is affected by a range of factors both within and outside the individual control. The wider determinants model below describes the layers of influence on an individual's potential for health; those that are fixed such as age, sex and genetics and those which are not such as personal lifestyle, the physical and social environment and wider socioeconomic, cultural, environmental and global conditions.

[1] (Government , 2008)

Figure 1 Dahlgren and Whitehead Wider Determinants Model[2].

This model also demonstrates the complex influences on health and identifies that no one individual or organisation can improve the health of the Rotherham population on their own: improving health and wellbeing is a shared responsibility between all organisations and the people of Rotherham. People need to take some responsibility for their own health and wellbeing, whilst local partners and organisations contribute by developing services and environments that support and enable them to do this.

2.2 What causes poor health and wellbeing?

People's experience of health and wellbeing is influenced by more than health and care services, and there are stark differences in the life expectancy of people living in the best and worst off parts of the borough. People living in Wickersley, for example, can expect to live on average 8 years longer than those living in the town centre.

The single biggest cause of ill health and health inequalities are socio-economic factors such as education, employment and income, as well as family and social support networks available to people and the physical environment in which people live – including the quality of our built environment, housing, transport and access to green spaces.

The following diagram demonstrates the things that can impact people's ability to live a healthy life and the strength of association between these health factors and health outcomes. It suggests that the greatest improvements in population health will require addressing the social and economic determinants of health.

[2] (Kings Fund , 2018)

Diagram available here - http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank
[to include this diagram in designed version to be produced once the strategy content is signed-of]

3. Strategic aims

The strategy includes four aims which the Health and Wellbeing Board have agreed are the most important things to focus on to improve health and wellbeing outcomes for all Rotherham people, but can best be tackled by a 'whole system' approach where the involvement of the whole range of partners at the Health and Wellbeing Board is needed to achieve improvement.

Aim 1: All children get the best start in life and go on to achieve their potential.

Aim 2: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life.

Aim 3: All Rotherham people live well for longer.

Aim 4: All Rotherham people live in healthy, safe and resilient communities.

Each aim includes a small set of high-level priorities, which demonstrate the particular areas of interest that will contribute to achieving the aim. These are described in section 5.

3.1 Strategy principles

Underpinning these aims is a set of principles that all Health and Wellbeing Board partners have committed to embedding in everything that they do, both individually as organisations, and jointly as a partnership:

- **Reduce health inequalities** by ensuring 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
- **Prevent physical and mental ill-health as a primary aim**, but where there is already an issue, services intervene early to maximise impact
- **Promote resilience and independence** for all individuals and communities
- **Integrate commissioning of services** to maximise resources and outcomes
- **Ensure pathways are robust**, particularly at transition points, so that no one is left behind
- **Provide accessible services** to the right people, in the right place, at the right time.

3.2 How the strategy has been developed

In developing the Health and Wellbeing Strategy the aim was to identify priorities based on strong evidence, an understanding of what would work locally, stakeholder feedback and specific areas where the Health and Wellbeing Board could have the biggest impact.

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

4. Joint Strategic Needs Assessment – what the data tells us

Table 1: Rotherham – at a glance *[to be presented as an infographic in the designed version to be produced once the strategy content is signed-off]*

- The health of people in Rotherham is generally poorer than the England average
- Life expectancy for men and women is lower than the England average and is nearly 10 years lower for men and 7 and a half years lower for women in the most deprived areas of Rotherham compared to the most affluent areas (2013-2015)
- Rotherham's population is changing:
  - the number of older people is increasing, especially in the oldest age groups, and people will live longer with poorer health
  - our Black and Minority Ethnic communities are growing and changing, most evident amongst children and young people and a growing Roma community
- Deprivation in Rotherham is amongst the highest 20% in England, with 14,000 children (24%) living in poverty
- 11,200 people in Rotherham are economically inactive (neither working nor seeking work) due to long-term sickness (July 2016 – June 2017)
- 9.4% of working age people in Rotherham are claiming long term sickness or disability-related benefits
- People in Rotherham are 24% more likely to have a long term health problem or disability than the English average
- 8,214 people in Rotherham are entitled to Carers Allowance with 5,627 receiving the payment due to their role as a carer
- Household incomes in Rotherham are lower than the Yorkshire and Humber and UK average and women earn only 86% of the average for women in England (2017 provisional)
- 11,670 homes (10.6%) are in fuel poverty with localised rates up to 32%
- Rotherham's breastfeeding initiation rate is amongst the lowest in the region at 62.5%, contributing to levels of childhood obesity and paediatric hospital admissions
- 17.1% of mothers were smokers during pregnancy in 2016/17. Smoking in pregnancy contributes to increased risk of stillbirth, low birthweight and neonatal deaths.
- 22.2% of children leaving primary school are obese, above the national average (2016/17)

- 5.3% of 16-18 year olds in Rotherham are not in employment, education or training, higher than the 4.2% nationally (2015)
- 1,059 people aged 15-64 in Rotherham were newly diagnosed with a sexually transmitted infection (excluding chlamydia in under 25s) in 2016, the rate being below the national average.
- 71.4% of adults in Rotherham were overweight or obese in 2015/16, worse than the 61.3% average for England
- 1,847 hospital admissions in Rotherham during 2015/16 could be attributed to alcohol and 2,038 years of life were lost due to alcohol related conditions in 2016.
- 30% of the Rotherham population are estimated to drink at a level that puts their health at risk (over 14 units per week)
- An estimated 18.3% of adults in Rotherham smoke, above the national average of 15.5%
- There are nearly 500 smoking related deaths each year in Rotherham – 22% higher than the England average
- On average, mental health problems affect one in four people at some point each year, most commonly depression or anxiety but can be more complex disorders
- Half of people aged 75 years and over live alone and most experience loneliness, especially those who are widowed
- Welfare reform has been adversely affecting people claiming benefits and tax credits in Rotherham since 2010, with an annual loss estimated at £66 million in 2015/16, rising to £94 million in 2017/18. Those most affected have been families with children, disabled people and the long term sick.

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

- School readiness (children achieving a good level of development at the end of reception year) and GCSE achievement are slightly better than national averages.
- Sickness absence of all Rotherham working adults has been reducing and is now close to the England average.
- The rate of under-18 conceptions in the borough has more than halved in the last 10 years but is still above the England average.
- The percentage of alcohol users who successfully complete treatment has increased and is now higher than England average.
- More people are having routine vaccinations and cancer screening in Rotherham than the national average. Incidence of tuberculosis is less than half the England average.
- Hospital admissions for injuries in children and young people have reduced and are now below England average.
- The rate of emergency hospital admissions due to injuries from falls in the elderly has decreased by a third in the past 5 years and is among the lowest in England.
- Mortality rates have reduced, in particular infant mortality and premature deaths from cancer.

5. Strategic priorities: the areas the Health and Wellbeing Board will focus on to achieve the aims

Under each of the four aims is a small set of **strategic priorities**. These are the 'high-level' things that the board has agreed will contribute best to achieving the overall aims. They are **not** intended to include everything that the Health and Wellbeing Board partners will deliver, but what they can deliver **better together**.

Five questions have been used in selecting these priorities:

1. Can **more be done** to tackle this issue?
2. Is it an issue that is **amenable to intervention**?
3. Is the delivery of this issue **important to all partners** on the Health and Wellbeing Board?
4. Is it of **strategic importance**?
5. Would this issue lead to **considerable impact** across the borough, or to one of our vulnerable target groups?

Each of the priorities under the four aims cannot be delivered in isolation. The board acknowledges that to really make a difference to the health and wellbeing of local people, it must ensure that those coordinating and delivering the activities, workstreams, strategies and plans mentioned in this document are aware of and understand the contribution they will make to all four aims.

Aim 1: All children get the best start in life and go on to achieve their potential

There are 56,600 children and young people (up to the age of 18) in Rotherham, making 21.6% of population.

All aspects of our development – physical, emotional and intellectual – are established in early childhood. Development in the early years (including in the womb) can have a lifelong impact on health and wellbeing, educational achievement and economic status. A strong focus on health and wellbeing in those early years will ensure all Rotherham children can fulfil their potential in later life.

Rotherham has committed to being a child friendly borough which means…
'Rotherham will be a great place to grow up in; where children, young people and their families have fun and enjoy living, learning and working'

This commitment is about helping all our children and young people to have a voice and be able to influence everything we do, to have high aspirations and self-esteem and feel able to actively participate in their communities, and to grow into healthy and resilient adults. This strategy will contribute towards achieving that vision for children and young people.

What the focus will be

Strategic Priority 1. Ensuring every child gets the best start in life (pre-conception to age 3)

On average, there are around 3,100 births in Rotherham each year and around 16,000 children aged 0-4 years. Too many of these children are not currently getting the best start in life due to differing life chances.

The first 1001 days (from conception to age 2) is widely recognised as a crucial period; evidence shows that this will have impact and influence on the rest of the life course. A healthy pregnancy is important to the health of the baby and the transition to parenthood; providing a nurturing environment, positive attachment and relationships which are vital to build good health, emotional self-regulation and resilience through childhood and into adult life[3].

The percentage of children living in poverty in Rotherham is higher than regional and England averages, with 12,340 children and young people aged 0-16 living in families whose income is less than 60% of median income (2014). Child poverty influences educational achievement (by the age of three, poorer children are estimated to be nine months behind children from more wealthy backgrounds – and this gap continues throughout the educational stages) and health, with children in poverty almost twice as likely to live in poor housing and be affected by fuel poverty.

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

[3] (Parent Infant Partnership UK, 2016)

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

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

Strategic Priority 2. Improving health and wellbeing outcomes for children and young people through integrated commissioning and service delivery

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

During adolescence young people become more independent. But with this increasing autonomy they may experiment with risk-taking behaviours. They may try alcohol, tobacco and other substances, and may become sexually active.

Childhood is also an important time in the development of behaviours that will have a lifelong influence on health and wellbeing, including healthy eating. In Rotherham obesity levels double between reception (aged 4-5 years – 11.5% obese, higher than the England average) and Year 6 (aged 10-11 years – 22.2% obese, again higher than the England average). There will be many contributing factors to this increase: lifestyle and diet choices of the children, their parents, their school, and the local environment.

The most effective interventions will ensure that there is consistent practice across the whole children's workforce and that pathways for support are integrated and efficient. To understand and respond to need effectively requires a holistic understanding of need and a shared view of outcomes.

Strategic Priority 3. Reducing the number of children who experience neglect or abuse

Child neglect is the most prevalent form of child maltreatment in the UK, with an estimated one in 10 young adults having been severely neglected by parents or guardians during childhood[4]. The human and economic costs are vast, far-reaching and long-lasting. Neglect is often responded to too late, focusing limited resources on 'late intervention', which responds to a child and family's needs once harm has been done. Stopping child neglect in its tracks would not only protect this generation of children but also, in turn, help them to become the best possible parents for the generation to come.

[4] (Lorraine Radford, 2011)

The evidence tells us that preventative services will do more to reduce abuse and neglect than reactive services. Coordination of services is important to maximise efficiency and there need to be good mechanisms for identifying those children and young people who are suffering or likely to suffer harm from abuse and neglect and who need referral to children's social care. It is also important that professionals work together effectively to ensure that families experience smooth transition between services and that all services supporting the family remain focused on the needs of the child.

Strategic Priority 4. Ensuring all young people are ready for the world of work

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

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

Those young people who become NEET or are at risk of becoming NEET are more likely to experience low self-esteem and poor mental health and are more likely to become teenage parents. They are more likely to live in poverty and to have low paid work or claim benefits. This group are also more likely to suffer from poor physical health with an increased likelihood of alcohol and substance misuse.

Activities that will deliver the priorities…

The Health and Wellbeing Board will:

Ensure the priorities of the 'children and young people's transformation' workstream of the Integrated Health and Social Care Place Plan that contribute towards this aim are delivered effectively. These include:

- Working together to implement the Child and Adolescent Mental Health Service (CAMHS) Transformation Plan, including formal joint commissioning arrangement
- Working together to deliver the 0-19 healthy child pathway services
- Taking action to improve perinatal mental health
- Ensuring that children and young people are included in the Shared Rotherham Healthcare Record
- Working together to ensure a best start in life, including reducing smoking at time of delivery, breastfeeding and a stronger focus on pre-natal mental health

Work across the partnership to look at ways to improve and enhance the use of evidence-based programmes to reduce health and wellbeing inequalities, including: parenting programmes, sleep programmes, weaning, oral health programmes and smoking cessation projects.

Work with the local children and young people's partnership to consider the best approaches to raise aspirations, narrow the attainment gap and reduce the number of young people becoming NEET.

Ensure the effective implementation of the 'Signs of Safety' model in Rotherham:

- Ensuring that the workforce is trained to spot the signs of neglect and respond appropriately (Rotherham uses the Graded Care Profile)
- Ensuring that the Signs of Safety operating model is understood across the workforce and is used to work with families to identify and respond to risk

Work as a partnership to ensure that pathways into preventative and statutory services are well defined and understood across the borough and that robust arrangements are in place to step up and step down families in response to their needs.

Aim 2: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life

Mental health is something everybody has. Mental health, as defined by the World Health Organisation, 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.'

Good mental health therefore is fundamental to how an individual, community and society functions. 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 people's mental wellbeing is also associated with positive outcomes in relation to education and employment, as well as reduced crime and antisocial behaviour[5].

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. Mental health problems can affect anybody at any age. It is estimated that one in four of us will suffer from mental health problems at some point in our lives. Half of those with lifetime mental illness (excluding dementia) first experience symptoms by the age of 14, and three-quarters by their mid-20s[6]. It is vital that positive mental and emotional wellbeing is a priority at every age. Therefore the priorities identified within this aim apply across the life course.

What the focus will be

Strategic Priority 1. Improving mental health and wellbeing of all Rotherham people

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[7]. People with higher wellbeing have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.

Suicide prevention is a focus within this aim because deaths by suicides are not inevitable. Every death by suicide is a tragedy having a devastating impact on family, friends, work colleagues and the wider community. When a person dies by suicide it is often the end point of a complex history of risk factors and distressing events. The majority of people who die by suicide are not in contact with mental health services. It is important, therefore, that other organisations and local communities can provide environments where suicide can be talked about and trained people can spot the signs and offer initial support and signposting.

[5] (Department of Health, 2011)
[6] (independent Mental Health Taskforce to the NHS in England, 2016)
[7] (Office for National Statistics, 2012)

Rotherham's suicide rate increased sharply between the periods 2012-2014 and 2013-2015, from 10.9 to 14.2. The latest rate for 2014-2016 has seen a slight decrease in this figure to 13.9, but this is still significantly worse than the England rate of 9.9.

Strategic Priority 2. Reducing the occurrence of common mental health problems

Depression prevalence is the most common form of a mental health condition, affecting over 25,900 Rotherham residents aged 18 and over in 2016/17. 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[8].

The prevalence of mental health disorders amongst children and young people varies significantly according to a range of socio-economic and demographic factors. Based on the socio-demographic profile of Rotherham (summarised in 5 ACORN Categories[9]), the prevalence of mental health disorders in Rotherham is estimated to be 14% above the UK average. This is a result of the higher levels of deprivation in Rotherham which is reflected in the higher proportion of children in the ACORN Category "hard-pressed" families.

Strategic Priority 3. Improving support for enduring mental health needs (including dementia)

Less common mental health problems (enduring mental health problems) include those with 'psychotic' symptoms. These symptoms can interfere with a person's perception of reality and may include hallucinations such as seeing, hearing, smelling or feeling things that no one else can. Anxiety and depression can be also be severe and long-lasting and have a big impact on a person's ability to participate in day to day life[10].

The mortality rate among people with a severe mental illness aged 18-74 is four times higher than that of the general population. For Rotherham there were 144 premature deaths in adults aged 18-74 with a severe mental illness in 2014/15.

People with mental health conditions consume 42% of all tobacco in England. 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.

A consequence of our ageing population is the increasing number of people living with dementia. By the age of 90, around 30% of people will be living with dementia. On average, people live for around seven years after the onset of symptoms and two years after diagnosis. Most people with dementia live at home, supported by family, neighbours, mainstream health services and the community. The impact of dementia on carers' physical and mental health must also be taken into account. The percentage of people registered at Rotherham practices with dementia for 2016/17 was 0.9% (England average 0.76%). This equates to 2,401 people (all ages).

[8] (Public Health England , 2017)
[9] (CACI, 2013)
[10] (Mental Health Foundation , 2018)

Strategic Priority 4. Improve the health and wellbeing of people with learning disabilities and autism

The needs of people with learning disabilities and autism cut across all the strategic aims of this strategy. To prevent dilution of the focus on these communities, delivery will be placed under the mental health and learning disability transformation workstreams of the Place Plan, and therefore aligns best to the mental health aim in this strategy.

Why people with learning disabilities are a key focus:

All children, young people and adults with a learning disability have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with the same dignity and respect. They should have a home within their community, be able to develop and maintain relationships, and get the support they need to live a healthy, safe and fulfilling life.

Rotherham's learning disability population (18-64) is estimated to be 3,754 people[11], and it is estimated that this number will reduce by 3% by 2035. This reduction needs to be compared with other demographic changes and will have significant implications for planning, service development and market shaping.

- The numbers of people with **severe** learning disabilities will remain static until 2035
- Rotherham's **older** (65 plus) learning disability population **will increase by 36% by 2035**[12].

This is a good news story: people with learning disabilities in Rotherham are living longer. The challenge is that people with learning disabilities are more likely to experience chronic health conditions (e.g. obesity, diabetes) much earlier than the general population. Work will need to be undertaken to prepare services, the third sector and health promotion projects to support people with learning disabilities.

Why people with autism are a key focus:

All children, young people and adults with autism in Rotherham should be able to live fulfilling and rewarding lives within a community that accepts and understands them. People with autism need a diagnosis and should be able to access support if they need it, and depend on mainstream public and third sector services to treat them fairly as individuals to get the right information and help them make the most of their talents.

It is estimated that Rotherham has around 789 children and young people and 2,328 adults (16+) who have autism. The number of over 18s in Rotherham with autism is predicted to increase by 3% by 2025 (and 7% by 2035). For over 65 year olds the predicted increase is over 15% by 2025 (and nearly 40% by 2035)[13].

[11] (Institute of Public Care)
[12] (Institute of Public Care)
[13] (Institute of Public Care)

Many people with autism also have common mental disorders, including depression and anxiety. People with autism are seven times more likely to die by suicide than the general population. Those with high-functioning autism are at greater risk than the general population and women are more at risk than men (in contrast to suicide rates more generally, where men are three times more likely than women to die by suicide)[14].

Activities that will deliver the priorities…

The Health and Wellbeing Board will:

Ensure the priorities agreed in the 'mental health and learning disability transformation' workstream of the Integrated Health and Social Care Place Plan that contribute towards this aim are delivered effectively.

Continue to oversee and monitor the delivery of the actions within the Better Mental Health for All Action Plan, including:

- Encouraging individuals, communities and organisations in Rotherham to use the Five Ways to Wellbeing to improve and maintain good mental health: Be Active, Connect, Give, Keep Learning and Take Notice
- Helping local employers to see the value of promoting good mental health within the workplace and then make changes to create mentally healthy working environments
- Develop environments that support good mental health and look for opportunities to work with partners in Rotherham to tackle mental health stigma.

Continue to oversee and monitor the delivery of the Suicide Prevention Action Plan priorities, including:

- Reduce suicides amongst high risk groups
- Provide better information and support to those bereaved by suicide
- Increase the knowledge and skills of staff and communities to spot the signs of suicide and signpost to professional help.

Support the Council and partners, including the Clinical Commissioning Group and the Alzheimer's Society, to populate the 'Prime Minister's Challenge 2020' Association of Directors of Adult Social Services (ADASS) Commitments Progress Tracker[15], which evidences the work taking place in relation to dementia.

[14] (Hirvikoski, 2016)
[15] (Department of Health , 2015)

Aim 3: All Rotherham people live well for longer

Life expectancy and healthy life expectancy in Rotherham are lower than average for both men and women. Within Rotherham, life expectancy is 10 years lower for men and 7 and a half years lower for women in the most deprived areas of the borough compared to the most affluent areas.

2014-2016	Life expectancy at birth	Healthy life expectancy at birth
Rotherham men	77.9 years	59.8 years
England average	79.5 years	63.3 years
Rotherham women	81.6 years	55.7 years
England average	83.1 years	63.9 years

[this table will be displayed as a graph in the designed version to be produced once the strategy content is signed-off, to demonstrate the gap in a visual manner]

This inequality in health leads to around 6,560 years of life being lost each year in Rotherham (2012-2014 average) through causes considered amenable to healthcare. This is almost 1,400 years more than might be expected based on the England average.

This aim is about all Rotherham adults, with a particular focus on ageing well: acknowledging that 'healthy ageing' starts early in life and that we want to ensure all local people live their life as well as they can for as long as possible.

Some people may not have 'good' health due to long-term health conditions or disabilities, but they should still be able to live well by getting the right support they need and keeping mentally, physically and socially active. Ensuring the right care is provided when people need it is important, but this aim is not simply about health care, but about ensuring that what matters most to people is considered, not just looking at what is the matter with them.

What the focus will be

Strategic Priority 1. Preventing and reducing early deaths from the key health issues for Rotherham people, such as cardiovascular disease, cancer and respiratory disease

The main drivers of the excess years of life lost in Rotherham are cardiovascular disease, respiratory disease and cancer. Tackling premature mortality will require a coordinated approach from all members of the Health and Wellbeing Board.

Our concern should not, however, be just about extending life, it should also cover the factors that contribute to healthy life expectancy. The difference in healthy life expectancy means that people in Rotherham develop poor health nearly 6 years earlier than the average for England. This disability burden has significant implications for public services locally, on the need for health and social care and for employment opportunities. This is because, on average, people in Rotherham will develop long term conditions around 9 years before the current state pension age of 67. This means more working age people living with long term conditions such as heart disease, diabetes, dementia, chronic mental health disability and cancer.

The priorities in aim 1 for early years, childhood and adolescence will all contribute to increasing life expectancy and healthy life expectancy, but we also need to focus on those who are already in adulthood, or who may have already developed long-term conditions.

The risk of early death and disability from the three main contributors to the years of life lost in Rotherham can be effectively reduced by reducing levels of overweight and obesity, not smoking, limiting alcohol consumption and increasing levels of physical activity. Increasing physical activity alone can vastly improve health and reduce risk of major illnesses, such as heart disease, stroke, type 2 diabetes and cancer by up to 50%[16].

It must be recognised, however, that individual behaviour change is difficult and needs support. A multifactorial approach that addresses all risk factors yields most benefit. This is because tackling multiple risk factors in individuals has a cumulative effect in reducing the chance of death.

[the following will be displayed as an infographic in the designed version to be produced once the strategy content is signed-off]
The following demonstrates the potential of what could be achieved if we focus on prevention[17]:
95% of liver disease is attributable to 3 preventable causes – alcohol, obesity and viral hepatitis
90% of 1st heart attacks related to 1 of 9 modifiable factors
80% of diabetes spend is treating avoidable illness and complications
Two thirds of premature deaths could be avoided through improved prevention, early detection and better treatment
42% of cancers in the UK are preventable
17% of deaths in adults over 35 are attributable to smoking

Strategic Priority 2. Promoting independence and self-management and increasing independence of care for all people

The health of the Rotherham population is generally poorer than the English average, with significant numbers of people with a long-term health condition or disability[18]. Rotherham has a growing population and will see a significant increase in the 85-plus population. This leads to growing pressures on our health services, social care, informal care, supported housing and other services. The average time spent in ill-health has also been increasing as people are living longer in poor health, resulting in a growing number of people with high levels of need.

In Rotherham, health and care should be managed long before someone needs to have hospital treatment or experiences problems in their life. This needs to be done in a way that is right for them, whether this is through providing information and advice, or through more active management. Having a 'life course' approach, starting by giving every child the best start in life and continuing throughout their life journey, will ensure this happens effectively.

[16] (Department of Health , 2015)
[17] (Alisha Davies, 2016)
[18] (Data, 2011)

Targeting individuals that can gain the most benefit, including people from specific populations, disabilities or at a vulnerable time in their life, will allow us to support positive, sustained lifestyle changes, which will significantly improve their health and wellbeing whilst increasing capacity across the health and social care system.

All health and wellbeing partners, including commissioners and providers, need to work with our communities to have a different conversation, understanding what matters to them and what their strengths and weaknesses are; helping to understand their needs outside of traditional service models. Focusing on assets and strength-based approaches; what people and places have to offer and the strengths of individuals, families and organisations, values the capacity, skills, knowledge, connection and potential in a community. Helping local people feel like active agents in their own and their families' lives, which in turn promotes independence and empowerment.

Independence of care is also about ensuring people are cared for and supported at the end of their life. All Rotherham people should live as well as possible until they die, they should be able to die with dignity, with all family members and carers supported and cared for where needed.

Strategic Priority 3. Improving health and wellbeing outcomes for adults and older people through integrated commissioning and service delivery; ensuring the right support at the right time

Within Rotherham, public services need to commission for excellence, focusing on better outcomes for individuals and bringing the concepts of people and place together to take a whole system view, based on the Marmot principles for reducing health inequalities[19]. Integrating commissioning and provision of health and care services, pooling resources and using collective experience and knowledge, should result in efficiencies for all partners, whilst also focusing on what the most important things are for local people, helping them to live healthier lives for as long as possible.

When services are commissioned a life course approach will be taken, ensuring unintentional silos are not created, especially with regard to the transition from children and young people's services to adult care and taking account of key life events throughout later life. This priority also has an important link back to aim 1 for children and young people.

Too many people are admitted to hospital unnecessarily and are kept in hospital for too long as the services to support them on discharge are taking too much time to put in place. To ensure that people who have a long-term condition or disability and those with mental health problems receive the right care in the right place at the right time, access to health services in the community needs to be increased, and the proportion of care that occurs in hospital reduced. Work to support the most vulnerable to remain independent for as long as possible is required across health and social care, as is high quality support for their friends and family who provide unpaid care.
People approaching the end of their life are entitled to high quality care, wherever that care is delivered. Good end of life care should be planned with the individual and the people close to them to ensure it is tailored to their needs and wishes and includes management of symptoms, as well as provision of psychological, social, spiritual and practical support. More people in Rotherham should be able to exercise choice over their end of life care and the place of their death.

[19] (The Marmot Review , 2010)

Strategic Priority 4. Ensuring every carer in Rotherham is supported to maintain their health, wellbeing and personal outcomes, so they are able to continue their vital role and live a fulfilling life

It is recognised that informal carers are the backbone of the health and social care economy, and that enabling them to continue this role is vital. It is important that all carers, including young and hidden carers, are identified and supported.

In Rotherham there are around 31,000 unpaid carers. Caring can have an impact on the physical health and mental wellbeing of carers; they can often feel physically and emotionally exhausted, stressed or depressed, which can affect relationships and often leads to isolation and financial difficulties.

Carers need to be able to balance their caring roles with other parts of their lives – such as jobs and educational opportunities. They need time to keep up relationships and pursue their own hobbies and interests. Young carers can find it difficult to manage other aspects of their life and are therefore more likely to not be in education, employment or training.

Activities that will deliver the priorities…

The Health and Wellbeing Board will:

Ensure the priorities agreed in the 'urgent and community care transformation' workstreams of the Integrated Health and Social Care Place Plan that contribute towards this aim are delivered effectively.

Work in partnership to continue to roll out Making Every Contact Count across Rotherham: an approach to behaviour change that utilises all of the day to day interactions that organisations and people have with other people, to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations.

Continue as partners of the Health and Wellbeing Board with the ambition to integrate commissioning of services as much as possible.

Continue to oversee and monitor the priorities in the Rotherham Carers' Strategy.

Use the partnership to influence and contribute towards developing a local strategic approach to 'healthy ageing' and Rotherham being a great place to grow older and live in later life.

Aim 4: All Rotherham people live in healthy, safe and resilient communities

Health is influenced by more than just the healthcare we receive. The physical environment in which people live, work and spend their leisure time, how active people are (both physically and how they contribute to their community) and how safe people feel also impacts on health outcomes. The quality of housing, the condition of streets and public places, noise, access to green space, opportunities to be physically active and levels of antisocial behaviour and crime all contribute to inequalities in health.

These wider determinants will all impact on the other three aims in this strategy. It is important, therefore, that all partners of the Health and Wellbeing Board contribute to and support work in these areas. One of the ways in which the board will do this through the strategy will be to influence all other policies and strategies, across all the partner organisations, considering what their impact is on people's health and wellbeing and what more could be done to promote it.

What the focus will be

Strategic Priority 1. Increasing opportunities for healthy, sustainable employment for all local people.

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

The link between good work and health is particularly important here: being in work is, in itself, good for physical and mental health, but for those people of working age who may have a long term condition, we need to ensure employers continue to support them to have a fulfilling working life. Economic growth within Rotherham will play its part in reducing health inequalities.

Strategic Priority 2. Ensuring everyone is able to live in safe and healthy environments.

Alongside the physical impacts caused by some crimes there is also an impact on people's wellbeing and, at times, their mental health. Crimes such as domestic abuse, sexual and violent offences can have a traumatic effect on victims, survivors and their families. With estimates suggesting 27,000 women and girls in Rotherham have suffered abuse in their lifetime and over one million reports to police of domestic abuse nationally, it is clear we must continue to do more. There is a need to promote a culture of healthy relationships, continuing to develop and invest in education and early intervention alongside developing effective partnerships to enhance community safety.

Poor housing costs the NHS at least £2.5 billion a year in treating people with illnesses directly linked to living in cold, damp and dangerous homes[20]. Cold homes and poor housing can have a negative impact on physical and mental health and wellbeing and may ultimately result in excess winter deaths. Associated health inequalities can occur across the life course, from early years through to the frail elderly population.

An increasingly older population, living longer with long term conditions and disability, will require more homes with adaptations to enable them to continue with a good quality of life and to maximise their independence. Older people are also especially vulnerable to feelings of isolation as a result of the loss of friends and family, limited mobility or reduced income that comes with age.

Good housing is much more than providing a roof over people's heads which is safe and warm; it's about the wider communities' people live in and helping people to be active participants in them, which promotes positive health and wellbeing.

Ensuring everyone is able to live in a safe environment is not only about people in their own home or community, but when people need to move into a care home setting. Protecting people's rights to live in safety, free from abuse and neglect in care homes is an important part of the work of the local Safeguarding Adults Board, and the Health and Wellbeing Board will support that by working in partnership to deliver this Strategy.

Strategic Priority 3. Ensuring planning decisions consider the impact on people's health and wellbeing.

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

Rotherham's Local Plan provides a long-term development strategy, setting out policies and proposals for new housing, shopping and employment, and how people travel in the area. The Core Strategy, which is part of the Local Plan, includes the vision: 'Rotherham will provide a high quality of life and aspire to minimise inequalities through the creation of strong, cohesive and sustainable communities…and communities enjoy good access to green spaces and the wider open countryside'.

This is a key document setting out planning policies and guidelines, including: accessibility to community services and facilities, promoting green infrastructure, ensuring developments protect, promote or contribute to securing a healthy and safe environment and minimise health inequalities, and policies dealing with contamination, pollution and waste recycling which all impact on the local health of our communities. The Health and Wellbeing Board will therefore continue to influence this area of work, ensuring health continues to be an important and cross-cutting theme in the Local Plan and Core Strategy.

[20] (Simon Nicol, 2015)

Strategic Priority 4. Increasing opportunities for people of all ages to use green spaces for the benefit of their health and wellbeing.

Physical and mental illnesses associated with mostly sedentary lifestyles are an increasing economic and social cost. Accessing and using green spaces can have huge health and wellbeing benefits for people of all ages. The risk of mortality caused by cardiovascular disease is lower in residential areas that have higher levels of 'greenness' and there is evidence that exposure to nature could be used as part of the treatment for some conditions.

As well as direct health benefits, there can be additional financial savings from green spaces, including improving air and noise pollution, flood mitigation, and promoting social cohesion[21].

Rotherham has a wealth of green space provided for the benefit of local people, including: urban parks and play areas, recreation grounds, and a number of larger country parks. Local people need to be encouraged to use and enjoy them for the benefit of their health and wellbeing. However, to do this there is a need to work in partnership across the whole borough with a range of organisations, voluntary and community groups and local people, to look after, promote and encourage use of all local green spaces.

Green spaces also provide opportunities for people to be more physically active; this priority therefore links directly to aim 3 and the activities that will be delivered in relation to increasing levels of physical activity for all.

Strategic Priority 5. Mitigating the impact of loneliness and isolation in people of all ages

Loneliness is a bigger problem than simply an emotional experience. Research shows that loneliness and social isolation are harmful to our health: lacking social connections is a comparable risk factor for early death as smoking 15 cigarettes a day, and is worse for us than well-known risk factors such as obesity and physical inactivity. Loneliness increases the likelihood of mortality by 26%[22].

Loneliness and social isolation, in people of all ages, can result in increased use of emergency healthcare and earlier admission to residential care for older people. There is a need to ensure our communities are resilient, with the right services and support to enable people to confront and cope with life's challenges.

[21] (Public Health England , 2014)
[22] (Campaign to End Loneliness , 2018)

Activities that will deliver the priorities…

There are a number of initiatives, plans and strategies which will contribute to achieving this aim. The Health and Wellbeing Board will continue to use its influence to ensure the health and wellbeing of local people is a key focus of these, and where appropriate, have some oversight of delivery.

Rotherham has an ambition for every neighbourhood to be thriving and to improve outcomes for residents across the borough, which will involve a neighbourhood-level working approach focused on community development: supporting residents to do more for themselves, listening to each other and working together to make a difference, supporting people from different backgrounds to get on well together, and ultimately helping to make people healthier, happier, safer and proud. This is underpinned by the need to become more efficient and to find new and more cost effective ways to achieve the desired outcomes, and will require the contribution of all partners to achieve success.

The Health and Wellbeing Board will…

Ensure that the 'Neighbourhood Strategy' translates some of the priorities of the Health and Wellbeing Strategy into action at a neighbourhood level.

Oversee a number of other key agendas which will contribute to achieving this aim, including:

- The Workplace Wellbeing Charter
- Employment and health projects
- The 'Loneliness Task Group' which will develop a strategic approach to addressing loneliness and isolation in all ages, and ensure this translates into action across the whole of the partnership.

Continue to influence other plans and strategies, ensuring they consider their impact on the health and wellbeing of local people, including:

- Housing Strategy
- Local Plan and Core Strategy
- NHS planning – 'one public estate'
- Domestic Abuse Strategy
- Cultural Strategy, including leisure and green spaces
- Local Growth Plan.

Work as a partnership to develop opportunities to increase volunteering in Rotherham across the life-course.

Work together with other key stakeholders to develop a strategic approach to increasing the physical activity levels of all people across Rotherham; acknowledging that increasing physical activity will impact on all of the other aims in this strategy. This will also include ensuring the Rotherham Active Partnership is working effectively with a particular emphasis on increasing physical activity levels of those who are inactive.

6. How the strategy will be used

The Health and Wellbeing Strategy places particular emphasis on a shared vision and leadership for improving health and wellbeing services. The strategy will ensure resources are used collectively and partners are held to account to deliver the best outcomes for Rotherham people.

Health and Wellbeing Board members are responsible for a wide range of services that impact on health and wellbeing, but this strategy is not intended to be a final list of everything that the board and partners will do, but a set of the most important health and wellbeing priorities for Rotherham that need to be addressed in partnership. The strategy will therefore be used to ensure that organisations work together and not in isolation.

The Health and Wellbeing Strategy provides a framework for commissioning plans for the council and clinical commissioning group and specifically for the development of the Better Care Fund, the Integrated Health and Social Care Place Plan and for joint commissioning of services to ensure seamless, effective and efficient service delivery.

The board, through the strategy, will also influence the direction of other plans and strategies, including planning and development, transport and economic growth.

6.1 The board's role in safeguarding

The Health and Wellbeing Board acknowledges the contribution it makes to safeguarding all local people. A number of our health and wellbeing priorities will help deliver the priorities set out by the two safeguarding boards for adults and children.

There will be continued engagement with the local safeguarding boards as agreed through the local 'Safeguarding Partnership Protocol', ensuring a shared focus on positive outcomes for children, young people, adults and their families, with appropriate arrangements in place between strategic leaders, elected members and chairs of the boards (including HWbB, Children and Young People's Partnership Board, Safer Rotherham Partnership Board and safeguarding boards for adults and children) to ensure strategic priorities in relation to safeguarding are translated into effective action.

7. Managing and monitoring the strategy

The Health and Wellbeing Board will monitor progress on the strategy by focusing on the impact it will have on people's lives and will identify a number of indicators and data sources for each aim that will help to measure this. One of the main functions of the Health and Wellbeing Board is to have an oversight role and to hold the council and partners to account for delivering improved health and wellbeing outcomes for local people, and it will do this by using the strategy to influence commissioning of services and challenging when improvements are not made.

The strategy's aims are ambitious and will require a continued and dedicated focus on improving health and wellbeing outcomes across the partnership. Results will not be seen overnight, which is why this is a longer-term strategy - until 2025 –ensuring the work of the board remains focused on the activity required to deliver the aims.

To ensure this happens the board will publish an annual plan each year, demonstrating what has been achieved, what further activity will be undertaken during that year, and what success will look like. This will provide the board with a clear work programme and identify risks and opportunities that may impact on achieving the aims.

The board will use its strategic influence within the wider Rotherham Together Partnership to ensure that all partners are contributing to delivering the strategy through:

- Providing regular update reports to the Rotherham Together Partnership Board
- Regular meetings between the chair of the Health and Wellbeing Board and other partnership board chairs (including the Safer Rotherham Partnership, the Children and Young people's Partnership and the adults and children's safeguarding boards)

8. Communication and engagement

As a board there is a need to ensure continued engagement with the people that this strategy is for – the people of Rotherham. This will be done in a number of ways:

Health and Wellbeing Board meetings are open to the public and minutes of meetings are available to view - http://moderngov.rotherham.gov.uk/ieListMeetings.aspx?CId=916&Year=0

Joint events with the clinical commissioning group which are open to the public to come and hear about what is happening in relation to health and wellbeing locally.

Engaging with local people about specific areas of interest through local consultation and engagement activities.

Developing communication plans for each of the Integrated Health and Social Care Place Plan workstreams, which will be shared with the Health and Wellbeing Board.

The strategy's annual plans will include any communication and engagement activity that is due to take place during the year.

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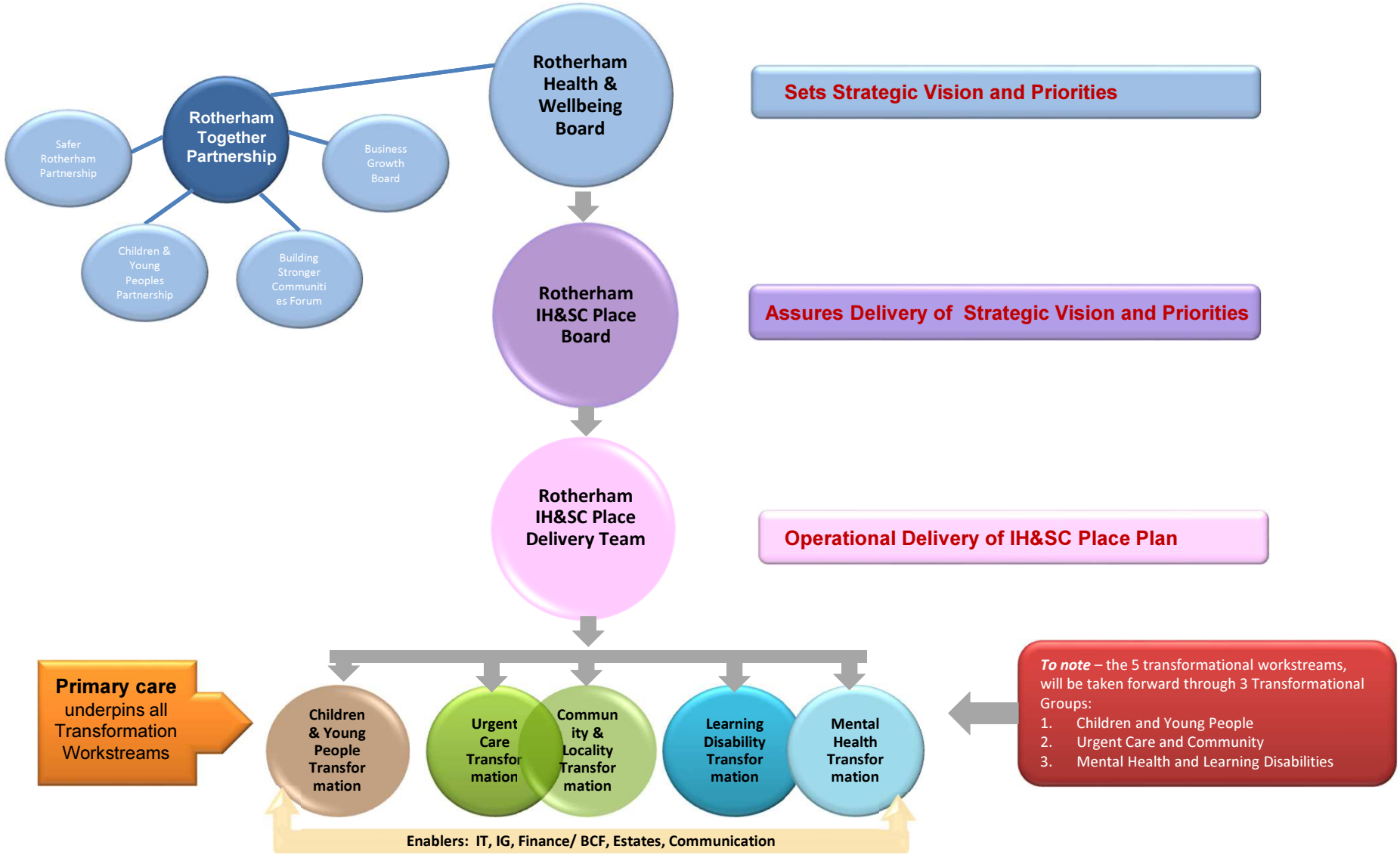
How the Rotherham Health and Wellbeing (H&WB) Strategy and Integrated Health and Social Care (IH&SC) Place Plan will align



Appendix C Overview of Health and Wellbeing Strategy consultation

November 2017 – February 2018

Comments/Feedback	**Response/action taken**
Discussion at Health and Wellbeing Board – 15 November 2017	
Comments on aim 1.	
To include 'abuse' and neglect in priority 3.	Strategic Priority 3 updated to include 'abuse'.
Ensure this aim has a focus on raising self-esteem /aspirations.	Aim 1 includes raising aspirations/self-esteem as an underpinning theme, and will therefore need to be part of the plan developed by the children and young people's transformation work stream of the Place Plan.
Agreed to include an additional priority under this aim: 'children and young people ready for the world of work'.	Strategic Priority 4 has been added.
Voice of the child important to run throughout this aim.	Voice of the child will be a key principle of the Place Plan work stream and the HWbB will continue to identify ways of ensuring public engagement in the work of the Board.
Comments on aim 2.	
Ensure the focus of this aim is about prevention and good mental health for all, not just at the acute end of need.	The description of this aim has been strengthened to ensure the focus is on good mental health for all and not just those with mental health problems.
Agreed that learning disabilities and autism should sit within aim 2 – although it is cross-cutting it needs to sit within an aim to ensure delivery and it does not get diluted – it also aligns to the Place Plan learning disability and mental health transformation work stream.	Aim 2 now includes a strategic priority for learning disabilities and autism, whilst noting that this does not mean it is only about the mental health of these groups.

Comments on aim 3. Suggestion to change the wording of the aim from “people live well and live longer” to ensure more of a focus on quality of life and improving healthy life expectancy.	This aim has been re-worded.
Comments on aim 4. Considered whether loneliness should sit within this aim, as it fits within the work in relation to developing thriving, resilient communities.	Following discussion, a new strategic priority has been added to aim 4.
Recommendations from Health Select Commission - 14th December 2017	
1. To share the full strategy with Health Select Commission in February as part of further consideration and endorsement. 2. Strengthen and embed ‘age friendly’ in aim 4. 3. Strengthen links to the carers’ strategy in aim 3. 4. Consider parish council’s and their work in relation to loneliness in aim 4.	Strategy was circulated to Health Select Commission but no further comments received. Following further discussion at the HWbB and with the Chief executive of Age UK (see comment below) ‘healthy ageing’ was included under the activities to deliver aim 3. An additional strategic priority has been added to aim 3. This has been noted and the loneliness task group will pick this up.
Discussion at the VCS ‘an audience with’ session – 9th January 2018	
• How much is focused on improving quality of life for people and how much on reducing demand / financial constraints • Good to see focus on prevention, but how do we ensure resources are moved to the right place to deliver this? • How do we ensure money ‘flows’ properly through the system – and focuses more up stream	The principles of the strategy include a focus on prevention, and using resources for the best possible outcomes for local people. All partners of the HWbB have committed to these. The HWbB has a role in influencing commissioning. The Place Plan also reflects the importance of prevention and

	early intervention.
• How do we ensure 'older people' as a group don't get lost in the strategy and are not a 'cross-cutting' theme? • Need to ensure that we focus on transition points for all people: children to adults, then specific triggers experienced by adults and older people (unemployment, bereavement etc).	The strategy uses a life-course approach and older people are included in aims 2-4 for specific issues (carers, loneliness, social care, independence etc.) but aim 3, strategic priority 3 has been strengthened to include commissioning services across the life-course, which includes key life events in later life (as well as just transition from children's to adult services). End of life is now included in aim 3, strategic priority 2.
• Where is 'end of life' in the strategy – the life course was a clear focus in the first strategy of the board (2012), this seems to have been lost…	Aim 3, strategic priority 2 is about independence, assets and strength-based approaches, and not just traditional care services.
• Need to focus on what matters to people – not just what is the matter with them: what do people want to help them life healthier/independent lives • "living as well as you can" not just medical interventions, but what else do people need/want to support them to live better • Being 'active' – socially, mentally, physically should be a focus for the strategy (possibly to include in aim 4)	Aim 4 refers to the importance of being active, both physically and in communities. Aim 2 includes reference to the 5 steps to wellbeing for improving mental health.
• Rather than asking how the VCS can support health and social care to deliver the strategy, flip this and think about what they are already doing and what they could do, looking at health and social care to fill the gaps	Once the strategy has been signed-off and action plans are in development, it has been agreed to go back to the VCS to understand what is already going on locally to help achieve the strategy aims.
Comments from other stakeholders received January/February 2018	
Comments from The Rotherham Foundation Trust: Within the strategic principles there is nothing on integration of health and social care provision. However it does highlight the integration of the commissioning function.	Principle referred to is: Integrate commissioning of services to maximise resources and outcomes.

	These principles have been developed based on the statutory functions of the HWbB, which relates to commissioning only as providers are not 'statutory' board members, although they are full members of the Rotherham board. Integrating provision of services however is more about delivery and therefore a principle of the Place Plan, rather than the strategy which is about the 'strategic' statutory functions of the board.
Aim 1: There are no specific activities around childhood obesity, which is a concern. Also it would be useful if we could include some of the work TRFT are intending to do around children, specifically working with health partners	The strategy is about setting the strategic direction of the HWbB, it includes only those high-level activities that the board will work together on – more detail about other activities which partners will deliver both individually and in partnership, including childhood obesity, need to be fed through to the children and young people transformation work stream of the Place Plan which is the delivery mechanism of the strategy – and under activities for this aim it mentions delivery of the place plan work stream priorities. As obesity is a complex multi-factorial issue action will link to other aims, in particular aim 4, which can look at the obesogenic environment to ensure more focus on primary prevention.
Aim 2: It's a concern that the priority on mental health includes learning disabilities and autism. It is important that we are able to make a clear distinction between these issues.	It is explained in the strategy that learning disabilities and autism cut across all of the aims, but to avoid dilution of these priorities (which would be the case without having a distinct lead) they have been placed under aim 2. This is also in-line with the Place Plan mental health and learning disability work stream, which will include the specific actions to deliver this aim. This issue was discussed at the board development session where it was agreed that although this could be considered to be cross-cutting, it made it clearer to place under aim 2.
There are no actions relating to dementia or functional mental health issues such as depression. There is no strategy around workplace stress, which is	More specific activities should be included in the action plan for the Place Plan work stream for mental health and learning

a growing issue nationally. Although people with learning disabilities are mentioned in the narrative there are no activities that focus on this community.	disabilities, these comments will be fed back to the lead for that group.
Aim 3: It would be good to see a greater emphasis on the integration on health and social care provision as well as just commissioning, but no mention of any provider services.	Added to the sentence under strategic priority 3 (page 20) to include provision of services as well as commissioning.
There are a number of key enablers underpinning successful delivery that could be mentioned, specifically: -Technology and the need to use and embrace the advantages of having Integrated Health Care Record and interoperability between systems -A workforce strategy to develop roles and skills across providers, due to shortages across key areas as well developing jobs and careers for the young people of Rotherham to work in the health and care sector	These are important enablers and will help deliver the strategy, but they are more operational and therefore should be included in the Place Plan. The next stage of the strategy development is to produce specific plans for each aim and these types of activities will need to be included in there for the board to be aware of and contribute to.
Comments from Informal Cabinet 12 February 2018 Could you strengthen the housing reference more – with a clear link to housing and health. Could the link to working with the Safer Rotherham Partnership be clearer – (possibly mention the joint protocol that is in place).	Housing and health is included in the strategy but acknowledge this could be strengthened (also see comment below also from SYHA) Strengthened section under aim 4, strategic priority 2 considering the links between health and housing, which is not simply about a roof over someone's head. The safeguarding partnership protocol is already mentioned as part of how the strategy will be delivered (6.1). This has been strengthened though with the inclusion of which boards are included in this protocol to make clearer the links between them. Aim 4, strategic priority 2 refers to domestic abuse, and the domestic abuse strategy is included as an area of work the

Could the strategy be more positive in relation to working in partnership and the commitment to joint working (using more asset based language).	HWbB will continue to influence. Strengthened page 2 paragraph 2 to include more positive language about the work of the board.
Comment from Yorkshire Sport Trust It's great to see that physical activity and being active has been mentioned in the Plan. We would like to see this as part of a bolder approach to prevention and early intervention which is not particularly clear. The content alludes to the fact that physical activity impacts across all other aims so it would be good to see this commitment as an overarching theme wider than Culture & Leisure – a whole system approach. There is a huge potential for VCS contribution across the life-course; via clubs and community organisations. The sector has a significant role to play in community development approaches. The social prescribing model in Rotherham has been very good and has shown impact. A physical activity and sport partnership (we call them District Activity Partnerships) reporting to the Board can support this work further.	It has been acknowledged in the strategy about the importance of physical activity cutting across all aims. Aim 4 (page 22 paragraph 1) has been strengthened to include reference to physical activity. Also added a paragraph under aim 4 'activities…' to include a reference to the HWbB ensuring the Rotherham Active Partnership is effective, particularly at targeting those people who are currently inactive.
Comments from South Yorkshire Housing Association Housing is the 3rd leg of the health and social care stool. Unless housing strategy is fully integrated you will not meet your objectives. You said (at the Strategic Housing Forum meeting) that social determinants accounted for round 40% of people's health outcomes. The figures I have seen have been much higher – nearly double. In our experience health and social care professionals talk the language, but, with a few exceptions mainly from Public Health, they are reluctant to take the radical steps necessary to integrate these agendas. Resources need to be switched to social interventions such as social prescribing, investment in affordable warmth anti-poverty measures etc and away from acute health measures. We also need to give far more attention to the impact of place. An asset-based approach is both more likely to really "stick" and be more cost-effective. We	Housing and the links to health and wellbeing has been strengthened in this refreshed version of the strategy and included under one of the strategic priorities. This will ensure a continued engagement with the Strategic Housing Forum to look at the benefits for local people and how the HWb Strategy can continue to influence other key agendas such as this. The comments made are welcomed, because they are mostly about housing 'providers', this is an area which will be useful to feed into the action planning process which is the next stage of the strategy development, rather than the specific

need a radical agenda and without housing at the table it won't happen effectively. Housing providers do far more than provide a roof over our customers' heads. I mentioned two examples of SYHA projects – Age Better (which reduces loneliness and isolation for the over 55s) and our Building Better Opportunities and WorkingWin projects. The eyes of Ministers are firmly on this one with South Yorkshire and the West Midlands the only locations in the country here this Randomised Control Trial has been commissioned. I would be happy to come along to the Health and Wellbeing Board to talk about this type of project if this would be useful. It is not just SYHA – many providers now have a clear strategy to support the whole person and the whole community. The substantive point here is that housing providers engage in all 5 of your aims, and not just the aim 4. We are a great resource – use us please!	detail being included in the strategy. Strengthened section under aim 4, strategic priority 2 (page 23) considering the links between health and housing (also see comment above).
Your approach to co-design could be enhanced. Our Co-Create team has worked with your authority in the past and we would be happy to do so again to ensure the Strategy really engages local people. There will be no charge.	Welcomed the comment and something we may wish to consider at a later stage when we are developing action plans.
You hardly mention welfare cuts and anti-poverty measures. These are key determinants of health and well-being.	Poverty and deprivation is mentioned in the JSNA section and the strategy has a principle about focusing on areas of greatest need to tackle inequalities, but specific welfare cuts/anti-poverty measures are not included in here. An additional statistic has been included regarding welfare reform (page 8) to highlight the importance of this in relation to health and wellbeing. More specific actions in relation to tackling poverty may be included in the action plan developed for this aim, as well as other key areas of work around welfare reform, neighbourhood working, work and health projects and financial inclusion.

Comment from a member of the public. I would like to ask where do adults between 18 - 64 with long term conditions, physical disabilities or sensory impairments get mentioned within the health and wellbeing strategy? It appears people within these categories have not been mentioned. How will the ACP support these groups of people up to 2025?	The strategy is set out so that aim 1 is about children and young people specifically and the other 3 aims include 'all people' across the life-course, which includes people from all communities and those with specific needs. Aim 3 has been strengthened with more explicit reference to people with disabilities as key group, including on pages 19 and 20. Also added statistic under JSNA section (page 8). People with long-term conditions are already referred to specifically in this section. The Integrated Care Partnership (formally referred to as the Accountable Care Partnership) will need to consider adults with long-term conditions and physical disabilities through the Integrated Health and Social Care Place Plan – which is being aligned to this strategy.
Comment from Age UK representative Older people's needs and opportunities are not explicit in the strategy, other than specifically in relation to health and social care. There is no mention of the significant life changes many adults and older people experience, which can affect their health and wellbeing.	The strategy talks about the life-course and therefore older people are included in aims 2-4. Aim 3, under strategic priority 3, has however been strengthened to reflect key life events in later life as well as

Volunteering as a way of improving health and wellbeing, particularly for older people, is not included in the strategy.	transitions from children's to adult services. Amended the sentence under aim 3 'activities…' (Page 22) to align to the vision for older people set out by the Older People's Forum (Rotherham being a great place to grow older…). Added an activity under aim 4 'activities…' (Page 25) in relation to improving volunteering opportunities.
Comments from the Safeguarding Adults Board The strategy needs to be strengthened in relation to links with adult safeguarding. This is also true in relation to safeguarding of people in care homes.	The strategy includes reference to the Safeguarding Partnership Protocol, which is in place to ensure that the safeguarding boards for adults and children, along with theme boards (HWbB, Safer Rotherham Partnership, Children and Young People's Partnership) work together to ensure work plans are aligned, duplication avoided and where specific issues should be addressed in partnership with more than one board (e.g. domestic abuse). Aim 4, strategic priority 2 now includes reference to the importance of safeguarding in care homes.

Rotherham Health and Well Being Board

Aim 2 Update

Adult Mental Health, Learning Disability and CAMHS

Wednesday 14th March 2018

CONNECT HEALTHCARE ROTHERHAM CIC

Rotherham Doncaster and South Humber NHS Foundation Trust

The Rotherham NHS Foundation Trust

NHS Rotherham Metropolitan Borough Council

NHS Rotherham Clinical Commissioning Group

VoluntaryAction Rotherham

Adult Mental Health and Learning Disability Transformation

1) Deliver improved outcomes and performance in the Improving Access to Psychological Therapies service

2) Improve dementia diagnosis and support – continued focus on community

3) Deliver CORE 24 mental health liaison services

4) Transformation of the Woodlands inpatient 'Ferns' ward

5) Improve Community Crisis and Home Treatment response and intervention in mental health

6) Oversee Delivery of Learning Disability Transforming Care

7) Support the Development of Autism Strategy

8) Support work of Public Mental Health Strategy including Suicide Prevention

What is working well?

* Clear priorities for service improvement and delivery in 2017/18 and 2018/19 which are achievable
* Excellent place-working across all the organisations, e.g. Ferns, Core 24, Community Crisis.
* Moving from planning to delivery, CORE 24, IAPT, Ferns (phase 2), LD TCP.
* Planning for Community Crisis and Community Dementia follow up.
* Joining up agendas e.g. CORE fidelity review with social care review of mental health services.
* Clarity on oversight and assurance roles for work delivered through other structures e.g. TCP, Autism Partnership Board.

What are our challenges?

* Ensuring we remain focused on pathways transformation as well as service transformation.
* Supporting the TCP with expected transfer of high-cost LD service users from NHSE commissioning to Rotherham - possible impact on budgets and available services
* Ensuring project interdependencies are managed within the transformation group's remit and within the wider Rotherham place priorities and governance

What needs to happen (and by when)?

* Ensure regional / ICS level funding flows into Rotherham priorities e.g. suicide prevention (Q1 18/19)
* Delivery of a 24/7 CORE 24 liaison service (Q1 18/19)
* Completion of the CORE fidelity review and recommendations (Q4 17/18)
* To work with GPs and providers to raise awareness (and increase uptake) of health checks for learning disabled people. (Q1 2018/19
* Agree the Ferns model and funding for 18/19 (Q4 17/18)
* Agree post-diagnostic follow-up for dementia in primary care through the LES (Q4 17/18)
* Agree IAPT plan and trajectory (Q4 17/18)
* Continue to provide input, oversight and assurance to TCP, Autism and LD strategy development

Focus on CAMHS – Working Well ?

* New ‘Advice & Consultation’ service through the Single Point of Access (SPA) providing quicker & more focussed access to RDaSH CAMHS.
* Prioritisation of LAC referred to the CAMHS service and close working with LAC Therapeutic Team.
* Locality Mental Health workers who link directly with GP practices, schools, Early Help and Social Care teams.
* CCG funding of 2 ‘Children’s Wellbeing Practitioners’ to provide early intervention for lower level issues.

Focus on CAMHS – Working Well cont?

* Nationally recognised Rotherham Parent Carers Forum (RPCF), providing direct support to families and co-production approach.
* Regular inter-agency dialogue between; RDaSH, RPCF and Healthwatch, providing constructive dialogue for service development/improvement.
* Better support for children & young people diagnosed with autism.
* CCG part funding of schools 'CAMHS' worker pilot.
* New initiative to roll out 'whole school' approach to primary schools.
* RCCG – Continues to fund year on year increase in CAMHS provision

Focus on CAMHS – Impact on Performance

* Significantly reduced waiting times for children & young people:-
  * Assessment –
    * Sept 2016 – 182 waiting & 30% seen in 6 weeks
    * Nov 2017 – 14 waiting & 100% seen in 6 weeks (93% in 3 weeks)
  * Treatment –
    * Sept 2016 – 42% waiting less than 8 weeks & 73% less than 18 weeks
    * Nov 2017 – 84% waiting less than 8 weeks & 97% less than 18 weeks
    * Numbers waiting reduced from 376 (Sept 2016) to 38 (Nov 2017)
  * High Proportion of Young People have 'Goal set' on entering service 94% report improving against goal.

Focus on CAMHS – Next steps for improvement.

* Extension of Intensive Community support to 8am to 8pm.
* Integration of Crisis service with Adult Crisis team.
* Closer working between the CAMHS SPA and RMBC Early Help service.
* Reducing waiting times for ASD & ADHD assessments and consultation with Parent Carers Forum/Healthwatch.
* Further development of outcomes monitoring.

Rotherham Health and Well-Being Board

Wednesday 14th March 2018

Aim 2 Update - Child and Adolescent Mental Health Services in Rotherham.

Board Sponsor:	Kathryn Singh – Chief Executive RDASH
Lead Officer:	Ian Atkinson – Deputy Chief Officer NHS Rotherham CCG

Purpose:

This paper provides Health and Well Being Board with an update relating to Rotherham Child and Adolescent Mental Health Service (CAMHS) and specifically:

- The reconfiguration undertaken by RDaSH CAMHS,
- The current performance of the service,
- Key points from the 2017/18 Rotherham CAMHS Local Transformation Plan (LTP) refresh,
- Two recent papers; An NSPCC paper – 'Transforming the mental health service for children who have been abused' and a CQC paper – 'Review of children and young people's mental health services'.

Background:

1. CAMHS reconfiguration

RDaSH CAMHS has successfully completed the reconfiguration that it started in November 2015. The service has transformed from one which was heavily dependent on agency staff, with poor staff morale and retention and high staff sickness rates to one in which staff are much more engaged and there is a real feeling of team working. In total some 15wte posts have been successfully recruited to.

The service has now been reconfigured into a number of distinct pathways with designated pathway leads to provide much improved team working:-

- A Single Point of Access (SPA) - which is linked with the Local Authority Early Help team,
- A Locality Team – with Locality workers who interface with GP practices, schools, Early Help and Social Care teams and provide local appointments for patients, away from Kimberworth Place as required.
- An Intensive Community Support service – which includes a liaison function and works to avoid patients accessing Inpatient services or stepping down sooner to community services.
- A Learning Disability Pathway.
- A Child Sexual Exploitation (CSE) Pathway – which provides direct support to Children & Young People affected by CSE and also support to staff, both within CAMHS and outside.
- A Developmental Disorder pathway – specifically undertaking Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) diagnoses.
- A Psychological Therapies pathway – providing Cognitive Behavioural Therapy (CBT) and other therapies.

Discussions are ongoing between RDaSH and RMBC in respect of the Single Point of Access (SPA) for the service with a view to integration with the Early Help teams. The two organisations work closely together and meet twice a week to discuss referrals, and co-location is a potential, but not definite, possibility.

A pilot was also undertaken, starting in November of 2016 which prioritised the referrals of Looked After Children (LAC) into the CAMHS service. Whilst the pilot concluded that numbers were very low, it has been decided to continue with this prioritisation, bearing in mind that LAC are an 'at risk' group.

The Rotherham CAMHS service has also recently (from June 2017) introduced a new 'Advice & Consultation' service. The 'Advice and Consultation' model aims to ensure that those supporting children and young people, including parents/ carers and the professional network around the child, have quick and easy access to specialist support, where there are concerns regarding the child's mental and emotional health. Prior to a child being referred directly by CAMHS, professionals are encouraged to discuss the young person with a Locality Practitioner in the first instance, with the overriding aim of ensuring that the young person receives appropriate and individual support in a timely manner.

2. CAMHS Performance

Performance has improved significantly over the last year.

As at September 2016, 182 patients were waiting for an assessment and only 30% were seen within 6 weeks. This is compared to only 14 waiting at November 2017 and 100% waiting less than 6 weeks (and 93% waiting less than 3 weeks).

In terms of treatment waits, as at the end of September 2016, 42% of patients had waited less than 8 weeks and 73% had waited less than 18 weeks. This compares to 84% waiting less than 8 weeks and 97% waiting less than 18 weeks as at November, 2017. Perhaps most significantly, the numbers waiting for treatment have reduced from a total of 376 in September 2016 to only 38 in November 2017, through a concerted and sustained initiative to complete treatment pathways and discharge appropriately. RDaSH are consistently exceeding the 95% target of patients being discharged in a care planned way.

Following the 2016/17 CQUIN relating to Outcome measures a high proportion of children and young people continue to have goals set and for the year to date, preliminary figures show that 94% of those children & young people discharged from CAMHS with the same goal scored more than once are showing a positive improvement in their outcomes.

3. Rotherham CAMHS Local Transformation Plan (LTP) Refresh

In October of 2015, the CCG was required to produce a CAMHS LTP, in conjunction key partners, which would outline how the ambitions of the 'Future in Mind' document would be taken forward in Rotherham. This was produced and submitted in October of 2015 and signed off by NHS England.

A CAMHS LTP Action Plan was also produced, reflecting the 'Local Priority Schemes' outlined in the LTP, and detailing how these schemes would be implemented.

The CCG produced a refresh of the original LTP in October 2016 and has just produced a further refresh as at the end of October 2017.

4. NSPCC paper – 'Transforming the mental health service for children who have been abused' and CQC Paper – 'Review of children and young people's mental health services'.

These are both recently published papers, the former outlined the results of a review of CAMHS Local Transformation Plans in respect of their focus on children who have been abused and the latter summarised the current situation regarding the quality and accessibility of mental health services for children and young people.

Analysis of key issues and of risks

1. CAMHS reconfiguration

Key Issues:-

- 7 distinct pathways created with pathway lead recruited to.
- New 'Advice & Consultation' model introduced to focus on initial support for new referrals and reduce inappropriate signposting of referrals.
- Much improved staff morale with good retention and low levels of absence/vacancies.

Measures to Mitigate the risk

- The CCG continues to have regular monthly meetings to discuss the service reconfiguration and development.
- Progress against various areas of the CAMHS LTP relating to RDaSH CAMHS being picked up through the LTP Action Plan.

2. CAMHS Performance

Key Issues:-

- Performance has much improved over the last year, with the most significant improvement being in the numbers of patients waiting for assessment and treatment. There is also very positive feedback from key stakeholders including GP's, Healthwatch and other service providers.
- The introduction of 'Advice and Consultation' has been well received but needs further time to embed and for the impact to be well understood.

Measures to Mitigate the risk

- A GP survey relating to RDaSH CAMHS is being planned along the lines of the 'survey monkeys' done previously.
- Progress continues to be monitored through monthly CAMHS Service Development and Improvement Meetings' (SDIP).

3. Rotherham CAMHS Local Transformation Plan (LTP) Refresh

Key Issues:-

- The original and October 2016 refreshed LTP included information relating to activity, finance and workforce for CAMHS services provided in Rotherham. This was updated for 2017/18,
- The LTP refresh clarifies the 'Local Priority Schemes' which are ongoing from the original LTP and any new schemes which have been identified.
- The refresh outlines that there is a national expectation that the CCG will increase funding of CAMHS in 2018/19 by approximately 21% or £135,000. This has been discussed at the CAMHS Strategy & Partnership Group and it has been made clear that this will be subject to the CCG's financial allocation.
- The document also identifies where it is proposed that extra CAMHS funding for 2018/19 will be targeted. This will specifically be:-
    - £64,000 to RDaSH CAMHS to support the two new Children's Wellbeing Practitioners (CWPs) which are currently in training this year through the CYPIAPT initiative and funded by Health education England.
    - £45,000 which has yet to be allocated, but may be targeted at back-fill for CAMHS Locality Workers on CYPIAPT training and funding for sensory assessments.
    - £7,000 for administrative support for Care Education and Treatment Reviews

(CETRs).

- The LTP Action Plan has been updated to reflect any new development areas and also transferred to an Excel format, which is more user friendly. It will continue to be the main vehicle for taking forward the objectives of the LTP.
- The CCG was also successful in bidding for £50,000 of funding from NHS England relating to 'Mental Health Crisis and Intensive Community Support for Children and Young People'. This is to be shared equally with Doncaster CCG and must be spent in 2017/18. It will be used across the two areas to support the move to an 'all-age' 8pm to 8am Crisis Service.
- Details of the 'Family Support Service', provided by the Rotherham Parent Carer Forum (RPCF) and the 'Autism Family Support Team' provided by RMBC, have been provided to NHS England as children & young people's mental health case studies. NHSE communications have contacted RPCF directly for permission to use anonymised feedback comments from parents on social media.

Key Risks:-

- That the CAMHS LTP actions are not implemented.
- That the CCG is not able to provide the additional CAMHS funding, in line with NHSE expectations, for 2017/18, 2018/19 and future years up to 2021, in line with the aspirations of 'Future in Mind'.

Measures to Mitigate the risk:

- The CAMHS LTP Action Plan is regularly updated (bi-monthly) and all stakeholders are engaged in its delivery.
- The LTP refresh was signed off by David Roche and Richard Cullen in their respective capacities as the Chair and Vice Chair of the Rotherham Health & Wellbeing Board.
- The CCG will work closely with RDaSH to ensure that the extra £50,000 of 'Crisis' funding is spent effectively and before April 2018.

4. NSPCC paper – 'Transforming the mental health service for children who have been abused' and CQC Paper – 'Review of children and young people's mental health services'.

NSPCC Paper:-

Key Issues:-

- The NSPCC wrote to the CCG outlining that in their review of LTPs Rotherham CCG had only been RAG rated as Amber.

Key Risks:-

- That the CCG is not seen as investing sufficiently in the area of children who have been abused.

Measures to Mitigate the risk:

- The CCG has responded to the NSPCC outlining the significant investments made in this area. This is reflected in the LTP refresh.

CQC Paper:-

Key Issues:-

- Through analysis of a sample of 101 CQC inspection reports of CAMHS services, the report looked at the quality and accessibility of mental health services for children and young people and commented on the variability both of the delivery and commissioning of

services.

- The report concluded that the system as a whole is complex and fragmented.
- The report also stated that 'too many children have a poor experience of care and some are simply unable to access timely and appropriate support'.

Key Risks:-

- That local Rotherham CAMHS services are seen to be poor.

Measures to Mitigate the risk:

- Continue to work with CAMHS services to ensure that they are 'fit for purpose'.

Patient, Public and Stakeholder Involvement:

Development and implementation of the CAMHS Transformation Plan

All stakeholders were involved in the development of the Local Transformation Plan (LTP) including; RDaSH, RMBC, TRFT, Schools, Colleges, voluntary sector, patients, parents/carers etc.

Key stakeholders continue to be involved in the implementation of the LTP and its progress is monitored through the quarterly CAMHS Strategy & Partnership Group.

Financial Implications:

In 2017-18 the CCG has continued to prioritise local investment in CAMHS provision and is investing further additional funding in line with NHS England expectations outlined when 'Future In Mind' was published in 2015.

Recommendations:

1) The Health and Well Being Board are asked to note the position with regard to Rotherham CAMHS

REPORT FOR HEALTH AND WELLBEING BOARD

1.	**Date of meeting:**	**14 March 2018**
2.	**Title:**	**Pharmaceutical Needs Assessment**
3.	**Directorate:**	**Adult Care, Housing and Public Health**

4. Purpose of Report

4.1 The purpose of the report is to present the final draft Rotherham Pharmaceutical Needs Assessment (PNA) for approval and publication by 1 April 2018.

5. Recommendations

5.1 Health and Wellbeing Board members are asked to:-

- To approve the publication of the Rotherham PNA 2018-2021.

6. Background

6.1 The Health and Social Care Act 2012 gave Health and Wellbeing Boards the statutory duty to develop and publish PNAs. Legislation requires that Health and Wellbeing Boards publish revised assessments at least every three years. A revised assessment is due to be published by 1 April 2018.

6.2 Requirements for PNAs are set out in the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. The regulations set out what information is to be included,what matters are to be considered and the process to be followed. This includes a formal consultation with specific stakeholders for at least 60 days.

6.3 The PNA is a commissioning tool to make sure that areas have high quality pharmaceutical services that meet local needs. The PNA sets out the community pharmaceutical services that are currently provided and highlights any identified gaps, taking into account future needs. These services include:

- essential services such as dispensing medicines, giving advice on self care and promoting healthy lifestyles
- advanced services such as giving flu vaccinations, reviewing a patient's use of medicines or appliances and additional support for patients with long-term conditions who have been newly prescribed a medicine, and
- locally commissioned services, such as needle exchange schemes, emergency hormonal contraception or help with minor ailments.

6.4 The formal consultation period ran from 15 December 2017 to 16 February 2018. Consultees were sent a copy of the draft PNA by email together with a brief questionnaire.

7. Summary of the Pharmaceutical Needs Assessment

7.1 The conclusion of this PNA is that the population of Rotherham has sufficient service provision to meet their pharmaceutical needs.

- Rotherham is well provided for with respect to pharmaceutical dispensing services having a greater than the national average of pharmacies per 100,000 people.

- 95% of Rotherham residents are within a 1 mile walk of a Community Pharmacy and 100% are within a 10 minute drive of a Community Pharmacy.

- Community Pharmacies in Rotherham are accessible and offer extended opening times, often into the evening and at weekends, to suit patients and consumers including 100-hour pharmacies that give good geographical cover.

- Rotherham has good coverage of advanced services, e.g. Medicine Use Reviews (MURs)

8. Next Steps

8.1 The 2018 PNA was developed in conjunction with colleagues across South Yorkshire and used a new mapping system made available by Public Health England. The learning from this new approach will be written up and shared with the Directors of Public Health for South Yorkshire.

8.2 Following approval the PNA will be uploaded onto the Rotherham Council website and will be circulated to key partners for their use in commissioning pharmaceutical services.

8.3 Supplementary statements to support the PNA will be produced as and when required prior to the next iteration of the PNA in 2021. Supplementary statements can be produced due to a change in the provider landscape (e.g. closures or mergers of Community Pharmacies) or because of a change in population or health need (e.g. population growth due to new housing developments)

9. Name and contact details

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Rotherham Metropolitan Borough Council

Rotherham Pharmaceutical Needs Assessment

Approved: Version V2.0
Issue Date: 01 April 2018
Full Review Required by: 01 April 2021

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1.0 Document Control

Title	Rotherham Pharmaceutical Needs Assessment 2018
Status	Consultation draft
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Author	Stephen Turnbull, Specialty Registrar Public Health
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Stephen Turnbull – Public Health Specialty Registrar, Rotherham Council

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Barbara Coyle – Knowledge and Information Service, Public Health England

Ashley Clough – Parallel (SHAPE)

Nick Hunter – Rotherham Local Pharmaceutical Committee

Victoria Lindon – Senior Primary Care Manager, NHS England

Matt Auckland – Clinical Advisor (Pharmacy), NHS England

3.0 Executive Summary

3.1 What are Pharmaceutical Needs Assessments (PNA)?

Legislation requires that Health and Wellbeing Boards (HWBB) produce an assessment of the need for pharmaceutical services. These assessments (Pharmaceutical Needs Assessments or PNA) are due every three years. The last PNA was due on 1 April 2015 and a refreshed PNA is due on 1 April 2018.

PNAs describe:

- current pharmaceutical services;
- the need for such services;
- potential future need and;
- potential need for new services.

The duty to publish a PNA falls on the HWBB of each local authority. The Director of Public Health (DPH) in the local authority leads on the process and makes sure the PNA meets regulations.

3.2 How was this PNA produced?

The DsPH across South Yorkshire discussed how to approach the 2018 PNAs. This consideration was to make the most of current resources and support South Yorkshire health care strategy. The DsPH agreed to combine resource in the production of the PNA to make the most efficient use of resources.

Local leads gathered data from NHS England, local authorities and clinical commissioning groups. This data was collated into a single master spreadsheet. Public Health England (PHE) manage mapping software known as SHAPE. SHAPE stands for Strategic Health Asset Planning and Evaluation. PHE have provided support to the South Yorkshire PNAs to help use SHAPE to map the provision and access to pharmaceutical services. SHAPE can layer geographical information with other indicators. SHAPE maps pharmacy locations against demographic information and indicators of health status and need.

To identify health and pharmaceutical need the PNA uses a wide variety of data and information. These include the Joint Strategic Needs Assessments and other relevant strategies. The PNA uses these sources of information to assess current and future population size, measures of health and ill-health and other service provision.

The current provision of pharmacy and pharmaceutical services was compared with current and potential future demographic and health needs.

A 60-day consultation on the PNA was conducted. This consultation was sent to the list of stakeholders as defined by the regulations. The feedback from the consultation has been incorporated into the PNA.

3.3 What are the Health and Wellbeing Needs of the Rotherham population?

The PNA for Rotherham is undertaken in the context of the needs of the local population. Rotherham borough covers an area of 110 square miles and has a population of 262,000.

Rotherham is currently the 52nd most deprived borough out of 326 English districts according to the Index of Multiple Deprivation (IMD). Health and Disability is one of the most challenging domains for Rotherham within the IMD.

Compared with the England average, Rotherham has lower life expectancy and higher mortality from circulatory disease and cancer.

There are also inequalities within Rotherham with significant health differences between the most and least deprived parts of the borough.

The main causes of death that contribute to the gap are circulatory disease, cancer and respiratory problems. These three causes are also the main contributors to the slope of inequality that exists between the most and least deprived parts of Rotherham.

Mental Health, quality of life and wellbeing also follow a socio-economic gradient and are an important consideration when addressing heath inequalities.

3.4 What are the findings of the PNA?

There are a total of 71 providers of pharmaceutical services in Rotherham. This includes 64 Community Pharmacies, 6 distance selling pharmacies and one dispensing appliance contractor (Figure 3). There is one more Community Pharmacy than in the previous PNA.

Dispensing Doctors provide services to patients in rural areas and often where there are no Community Pharmacies or where access is restricted. In Rotherham there are 4 Dispensing Doctor practices.

Rotherham is well provided for with respect to pharmaceutical dispensing services having a greater than the national average of pharmacies per 100,000 people. The availability of pharmaceutical services across the borough is adequate and necessary to meet need.

95% of the population is within a 1 mile walk of a provider of pharmaceutical services. More than half of the residents further than 1 mile are from the less deprived communities in Rotherham.

No gaps in the provision of essential services, such as dispensing medicines, signposting and promoting healthy lifestyles, have been identified. This includes access to these services outside of normal working hours.

No gaps in the provision of advanced or locally commissioned services, e.g. Medicine Use Reviews, Minor Ailments service or Palliative Drug provision have been identified.

3.5 Next Steps

The PNA will be published on the Rotherham Council website and copies made available to Rotherham Council, NHS England and to Rotherham Clinical Commissioning Group. The PNA will assist these organisations when considering commissioning services that could be provided by providers of pharmaceutical services. It will also assist NHS England in assessing any requests to open new pharmacies.

A summary of the process of preparing PNAs collaboratively with neighbouring authorities will be produced and discussed with the Directors of Public Health. This will include feedback to Public Health England on potential future improvements to the SHAPE mapping tool.

Supplementary statements will be produced and published in accordance with regulations. These will be needed when there changes in either population or health need or a change in the provision of pharmaceutical services, e.g. merging of Community Pharmacies.

A revised PNA will be produced by 1 April 2021 in accordance with current regulations.

4.0 INTRODUCTION

Legislation requires that Health and Wellbeing Boards (HWBB) produce an assessment of the need for pharmaceutical services. These assessments (Pharmaceutical Needs Assessments or PNA) are due every three years. The last PNA was due on 1 April 2015 and a refreshed PNA is due on 1 April 2018.

PNAs describe:

- current pharmaceutical services;
- the need for such services;
- potential future need and;
- potential need for new services.

Pharmaceutical services are an important part of the health care system. They play a major role in improving health and reducing health inequalities. The main roles of pharmacies include:

- supplying prescribed medicines and appliances; and
- delivering a wide range of advanced and commissioned services. These include treating minor ailments, reviewing medications and helping those with specific needs.

Community Pharmacies provide most of these services. There are other types providers of pharmaceutical services, e.g. dispensing GPs and dispensing appliance contractors, and the PNA describes these where relevant. Assessment of pharmacy services in hospitals or in prisons are considered separately.

A range of organisations use PNAs to guide developments and commissioning intentions. NHS England considers all applications to introduce new pharmacies and uses the PNA to help assess such applications. Local Authorities and Clinical Commissioning Groups use the PNA to guide commissioning of services from pharmacies. The PNA is not a stand-alone document and organisations use other evidence in their planning. Other evidence includes Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

As part of developing PNAs a consultation must be undertaken for a minimum of 60 days. The regulations list those persons and organisations that must be consulted.

The PNA must be approved by the HWBB. The HWBB includes representatives from the local authority, Health Watch and other relevant partners.

This PNA will be valid for three years from 1 April 2018 to 31 March 2021.

There is a range of legislation and regulation that specifies the development of PNAs and the information they must contain. This PNA complies with these regulations.
For more information see: https://goo.gl/RMBTRF

4.1 Pharmacy Contractual Framework

NHS England does not hold contracts with pharmacy contractors, unlike for GPs, dentists and optometrists. Instead they provide services under a contractual framework. In addition to this framework pharmacies can be commissioned by local commissioners to provide services for residents. Some locally commissioned services in Rotherham are subcontracted by a primary provider.

Essential Services

Essential services are those which each Community Pharmacy must provide. All community and distance selling pharmacies provide the full range of Essential services. These are:

- Dispensing medicines and actions associated with dispensing
- Dispensing appliances
- Repeat dispensing
- Disposal of unwanted medicines
- Public Health (promotion of healthy lifestyles)
- Signposting
- Support for self-care
- Clinical governance

Pharmacies are required to deliver up to 6 Public Health campaigns throughout the year to promote healthy lifestyles.

Signposting and referral: is the provision of information on other health and social care providers or support organisations to people visiting the pharmacy, which require further support, advice or treatment that cannot be provided by the pharmacy.

It intends to inform or advise people who require assistance, which cannot be provided by the pharmacy of other appropriate health and social care providers or support organisations and enable people to contact and / or access further care and support appropriate to their needs

Opening hours

Core hours: Each Community Pharmacy is required to be open for 40 hours a week minimum and this is provided as an Essential service. There are also 100-hour pharmacies. These pharmacies are required to be open for at least 100 hours each week.

Supplementary hours: These are provided as a voluntary service and are additional to the core hours provided. Supplementary hours can be changed by giving 90 days' notice to NHS England.

NHS choices advertises opening hours to the public (www.nhs.uk). Community Pharmacies produce their own information leaflets detailing opening hours which are available from individual pharmacies.

Advanced Services

Advanced Services are those which can be provided if the pharmacist of specialist healthcare professional is suitably accredited against a competency framework and the pharmacy premises meets standards that facilitate the provision of these services in a suitable, confidential environment. These services are agreed nationally and monitored by NHS England

Locally commissioned services

Locally commissioned pharmaceutical services can be commissioned by different commissioners, including Rotherham Borough Council, Rotherham Clinical Commissioning Groups (CCG) and the local NHS England teams. These services are responses to the local needs of the population and the opportunities presented by providers of pharmaceutical services. In some cases, locally commissioned services in Rotherham are subcontracted by a primary provider.

5.0 Pharmaceutical Needs Assessment Process

This section outlines the approach that was taken to produce the Pharmaceutical Needs Assessment.

5.1 Combined approach

The duty to publish a PNA falls on the HWBB of each local authority. The Director of Public Health (DPH) in the local authority leads on the process and makes sure the PNA meets regulations. The DsPH across South Yorkshire discussed how to approach the 2018 PNAs. This consideration was to make the most of current resources and support South Yorkshire health care strategy.

The DsPH agreed to combine resource in the production of the PNA to make the most efficient use of resources.

This combined approach would only apply to the production of the 2018 refresh. It does not, at this stage, apply to the production of any supplementary statements. Any future collaboration is dependent on an evaluation of this approach and any changes to PNA regulations.

The DsPH agreed a project governance structure. A Public Health Specialty Registrar led the work on the combined approach supported by a Consultant in Public Health. PNA leads from each local authority agreed to act as a steering group. The South Yorkshire Local Pharmaceutical Network agreed to act as a stakeholder / reference group for the combined approach. Each individual Health and Wellbeing Board would continue to consult and work with their respective Local Pharmaceutical Committee(s).

5.2 Scope

Regulation 3(2) in the 2013 regulations (see https://goo.gl/FgiSRZ) defines the scope of PNAs. These state:

"The pharmaceutical services to which each pharmaceutical needs assessment must relate are all the pharmaceutical services that may be provided under arrangements made by NHS England:

- *The provision of pharmaceutical services (including directed services) by a person on a pharmaceutical list.*
- *The provision of local pharmaceutical services under an LPS (Local Pharmaceutical Service) – not local pharmaceutical services which are not pharmaceutical services.*
- *The dispensing of drugs and appliances by a person on a dispensing doctors list (but not other NHS services that may be provided under arrangements by the NHS Commissioning board with a dispensing doctor)."*

There are 3 main types of pharmaceutical services in relation to PNAs:

- **Essential Services –** services that every community pharmacy providing NHS pharmaceutical services must provide. These include dispensing medicines, promoting healthy lifestyles and supporting self-care.
- **Advanced Services –** Community Pharmacies can provide advanced services subject to accreditation by NHS England. These include Medicine Use Reviews, New Medicines Service and Appliance Use Reviews.
- **Locally Commissioned Services –** Local Authorities and CCGs commission providers of pharmaceutical services to provide local services. Examples include Emergency Hormonal Contraception, Needle Exchange and Palliative Care Drugs Services.

A pharmaceutical list includes the following:

- **Pharmacy contractors** – healthcare professionals working for themselves or as employees who practice in pharmacy.
- **Dispensing appliance contractors** - appliance suppliers supply, on prescription, appliances including stoma and incontinence aids, dressings, bandages etc. They cannot supply medicines.
- **Dispensing doctors** –medical practitioners authorised to provide drugs and appliances in designated rural areas.
- **Local Pharmacy service contractors** – these provide a level of pharmaceutical services in some HWBB areas

Community Pharmacies can provide services to patients that are not commissioned by NHS England, Local Authorities or CCGs. For example, some pharmacies provide a home delivery service as an added value service to patients. Community Pharmacies are free to choose whether to charge for these services as part of their business model.

In line with the 2013 regulations this PNA does not consider pharmacy provision in prisons or hospital settings.

5.3 Process

Mapping

Local leads gathered data from NHS England, local authorities and clinical commissioning groups. This data was collated into a single master spreadsheet detailing the following:

- Name / Contacts: Pharmacy name, lead pharmacist and contact details
- Geographical information: address, postcode
- Opening Times
- Advanced Services
- Commissioned Services

Public Health England (PHE) manage mapping software known as SHAPE. SHAPE stands for Strategic Health Asset Planning and Evaluation. PHE have provided support to the South Yorkshire PNAs to help use SHAPE to map the provision and

access to pharmaceutical services. SHAPE can layer geographical information with other indicators. SHAPE maps pharmacy locations against demographic information and indicators of health status and need. More information on SHAPE is below.

Health Need

To identify health and pharmaceutical need the PNA uses a wide variety of data and information. These include the Joint Strategic Needs Assessments and other relevant strategies. The PNA uses these sources of information to assess current and future population size, measures of health and ill-health and other service provision.

Analysis

The current provision of pharmacy and pharmaceutical services was compared with current and potential future demographic and health needs.

Consultation

A 60-day consultation on the PNA was conducted. This consultation was sent to the list of stakeholders as defined by the regulations.

5.4 Introduction to SHAPE

SHAPE was developed to help the NHS plan its physical estate. Over time it has developed a more sophisticated interface and incorporates many different information sources.

Public Health England have taken over the management of the SHAPE tool and are looking to improve its take up and usefulness for local areas. When the South Yorkshire authorities agreed to work together on the development of their 2018 PNAs there was a need to geographically map the provision of pharmaceutical services. The mapping of services is a core part of the PNA regulations and a map not only has to be produced but the regulations ask that this be maintained.

Each local authority has access to specialist mapping software used to produce the PNA maps. These systems are not always compatible with each other. Furthermore, access to officer time to produce the maps has become limited. The SHAPE tool is detailed and intuitive and can be used by officers without specialist knowledge of mapping software.

SHAPE lends itself to a range of functions including mapping of basic information such as locations of pharmacies but also more complicated analysis such as mapping different services offered by pharmacies and mapping these against various population indicators.

SHAPE incorporates a sophisticated analysis of access. Access to pharmacies can now be analysed by walking distance, walking time, or by access via car, cycle or public transport. Whilst these functions are a genuine step forward in analysing access

to services they are not perfect. Care should be taken with access analysis – and should be cross referenced with local knowledge particularly when examining small areas.

Some of the known issues with SHAPE access mapping are described below. The examples below all assume that we are analysing access to pharmacies by a 1.6km (1 mile) walk.

The SHAPE tool uses Lower Super Output Areas (LSOA) as the unit of analysis for access. LSOAs have an average population of around 1600 people. Each LSOA has an identifier code, e.g. Rotherham 007B. SHAPE identifies a centre point within each LSOA and it is this point that defines whether the whole of the LSOA population is within a 1.6km walk. This can misrepresent access on a local level. For example, the LSOA Rotherham 007B has a central location near Keppel's Column. This location is further than 1.6km walk from the nearest pharmacy and the whole of the LSOA is deemed to be not within 1.6km. This is despite the access map showing that most of the residents are within 1.6km walk.

The SHAPE tool sometimes incorrectly labels areas as outside of the 1.6km walking distance. This can bias the data towards reporting reduced access. There are no specific examples of this in the Rotherham area although there are examples in other areas, e.g. Barnsley.

Guide to interpreting SHAPE maps

SHAPE works best when viewed interactively on screen via a website. Table 1 provides links to the interactive SHAPE maps used in the PNA **for those with SHAPE access only**. Registered SHAPE users will be able to explore the maps provided in the PNA and can zoom into neighbourhood level for a more detailed view. Users can also explore the potential implications of opening or closing pharmacies at a given location. This functionality will be of great use to NHS England commissioning team when considering new applications and for CCG and local authority commissioners if service provision alters at a local level.

Commissioners of pharmaceutical services in the NHS and in local authorities should register for access to SHAPE.

SHAPE is free to NHS professionals and Local Authority professionals with a role in Public Health or Social Care. Access to the application is by formal registration and licence agreement. Applications to use SHAPE can be made by:

Email: shape@phe.gov.uk

Telephone: 0191 374 2219

Table 1: Links to SHAPE maps used in the PNA (Registered users only)

SHAPE map	Link
Figure 3: All pharmacists and ward boundaries	https://goo.gl/Rg7ANv
Figure 7: 100-hour pharmacies and population density	https://goo.gl/uXM9y2
Figure 8: Pharmacies within 1.6km of Rotherham	https://goo.gl/hvWhF8
Figure 9: Population within 1.6km walk of a provider of pharmaceutical services	https://goo.gl/xxmrpn
Figure 11: Needle Exchange scheme and crime deprivation	https://goo.gl/7rLRXy

The maps show the location of specific services and other indicators. The service sites are highlighted by a service marker. Table 2 shows some of the common services used on the maps

Table 2: Guide to basic service icons used in SHAPE

Service type	Icon indicator
Community Pharmacy	
Dispensing practice	
Where more than one service occupies the same location or the level of detail on the map restricts the amount of detail visible then the number of services in that location is indicated, e.g.	
2 Community Pharmacies	
1 Community Pharmacy and 1 Dispensing practice	

Specific services are highlighted by specific letters appended to the location indicator: these are detailed in Table 3 but also highlighted in the specific maps for ease of reference.

Table 3: Guide to specific service icons used in SHAPE

Service provided	Service indicator
Type of pharmacy and essential services	**Purple**
40-hour contract	4
100-hour contract	1
Distance selling pharmacy	D
Services	**Orange**
New Medicine Service	N
Appliance Use Review	A
Medicines Use review	M
Opening Hours	**Green**
Evening opening	E
Saturday morning opening	M
Saturday afternoon opening	A
Sunday opening	S
Commissioned Services	**Blue**
Emergency Hormonal Contraception	H
Flu vaccination	K
Minor Ailments Scheme	O
Needle Exchange Scheme	P
Palliative Care Drugs	T
Smoking cessation	V
Supervised consumption	Z`

This example shows that there is a community pharmacy that opens on Saturday morning and offers Emergency Hormonal Contraception.

Indicators

There are three main types of indicators used in the PNA analysis.

Geography layers

SHAPE can map various geographies. The following are available:

- Postcode Boundaries
- Lower Super Output Area boundaries
- Ward Boundaries

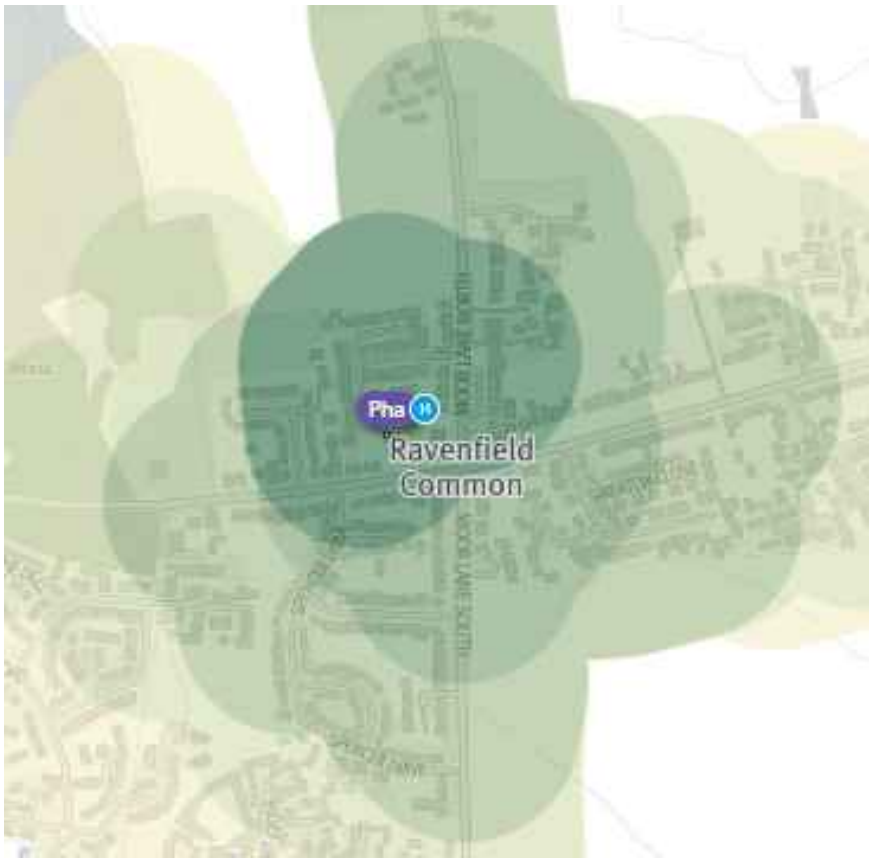
- CCG Boundaries
- Local Authority boundaries

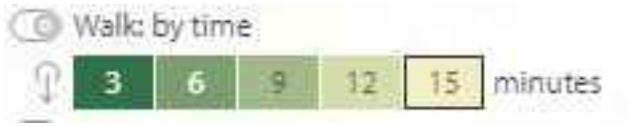
Access indicators

Access to pharmacies is estimated in different ways – SHAPE shades access in green – with darker greens relating to closer measures of access. The following are available on SHAPE:

- Walk: by time (in 3,4 or 5-minute intervals)
- Walk: by distance (different bands are available but the one used in the PNA represents 100m, 400m, 800m (half mile), 1200m and 1600m (mile))
- Cycle (in 3,4, or 5-minute intervals)
- Car (in 4,5 or 10-minute intervals). Rush hour adjustment is enabled on SHAPE but has not been used in this PNA
- Rail, tram & tube. This has not been used in this PNA as this is currently works better in city areas.

Figure 1: Example SHAPE map showing walking times to a pharmacy in 3 minutes bands.





Indicators

SHAPE has access to many different indicators. This will enable registered users to undertake more detailed, bespoke analysis relevant to their interests.

These indicators can be mapped at the geographical level for the data available. The following indicators are some of those of most use

- Population density
- Population estimates
- Population projection
- Ethnicity
- Deprivation: overall index of multiple deprivation and sub-classifications

Interactive mapping can show detail of individual pharmacies – thus for example all the services that the pharmacy offers can be displayed by selecting individual pharmacies. Figure 2 provides an example for a Weldricks pharmacy.

Figure 2: Example Summary information for a pharmacy on SHAPE

5.5 Equality Impact Screening

The RMBC Equality Impact screening pro-forma was completed (Appendix 4). The outcome of which was that a full Equality Impact Assessment was not necessary for the Pharmaceutical Needs Assessment. The process included:

- Sources of information used in the needs assessment
- The consultation process

- The findings of the PNA in particular in relation to communities and individuals with protected characteristics
- The purpose and use of the PNA in supporting commissioning decisions

6.0 Context for the Pharmaceutical Needs Assessment

The PNA for Rotherham is undertaken in the context of the needs of the local population. This section provides an overview of Rotherham and its population.

6.1 Overview of Rotherham

Rotherham borough covers an area of 110 square miles and has a population of 262,000. Around half of the borough's population lives in the Rotherham urban area (including Rawmarsh and Wickersley), in the central part of the borough. Most of the rest live in many outlying small towns, villages and rural areas.

Rotherham is a diverse borough with a mixture of people, cultures and communities. There are densely populated multi-ethnic inner urban areas, large council built housing estates, leafy private residential suburbs, industrial areas, rural villages and farms. About 70% of the borough's land area is rural so the most notable feature of Rotherham is its extensive areas of open countryside, mainly agricultural with some parkland and woodland.

Rotherham is strategically located and well connected to other areas of the region and country via the M1 and M18, both of which run through the borough, and by the rail network which links to Sheffield, Doncaster and Leeds. There are five airports within 55 miles of Rotherham, at Doncaster (Robin Hood), Manchester, Leeds & Bradford, East Midlands and Humberside.

Pre-industrial Rotherham developed as a small market town serving a rural hinterland. It became a major industrial centre during the Nineteenth Century, built around steel making and coal mining. Rotherham attracted workers from other areas, growing rapidly between 1890 and 1910. In 1951, manufacturing industries employed 33,100 people and 27,600 worked in coal mining and quarrying, a total of 65% of all workers. The last coal mine closed in 2013 and the steel industry has declined to employ just 1,600 workers in 2015.

The boundary of Rotherham Metropolitan Borough Council (RMBC) is coterminous with Rotherham Clinical Commissioning Group (CCG). The borough consists of 21 electoral wards, grouped as follows:

North Rotherham and Dearne Valley: Hoober, Rawmarsh, Silverwood, Swinton, Valley, Wath

Central Rotherham: Boston Castle, Keppel, Rotherham East, Rotherham West, Sitwell, Wingfield

South Rotherham and Rother Valley: Anston & Woodsetts, Brinsworth & Catcliffe, Dinnington, Hellaby, Holderness, Maltby, Rother Vale, Wickersley

Rotherham is currently the 52nd most deprived borough out of 326 English districts according to the Index of Multiple Deprivation (IMD). Health and Disability is one of the most challenging domains for Rotherham within the IMD.

Figure 3 identifies the wards and locations of providers of pharmaceutical services including Community Pharmacies, dispensing practices and Dispensing Appliance Contractors within Rotherham and surrounding areas.

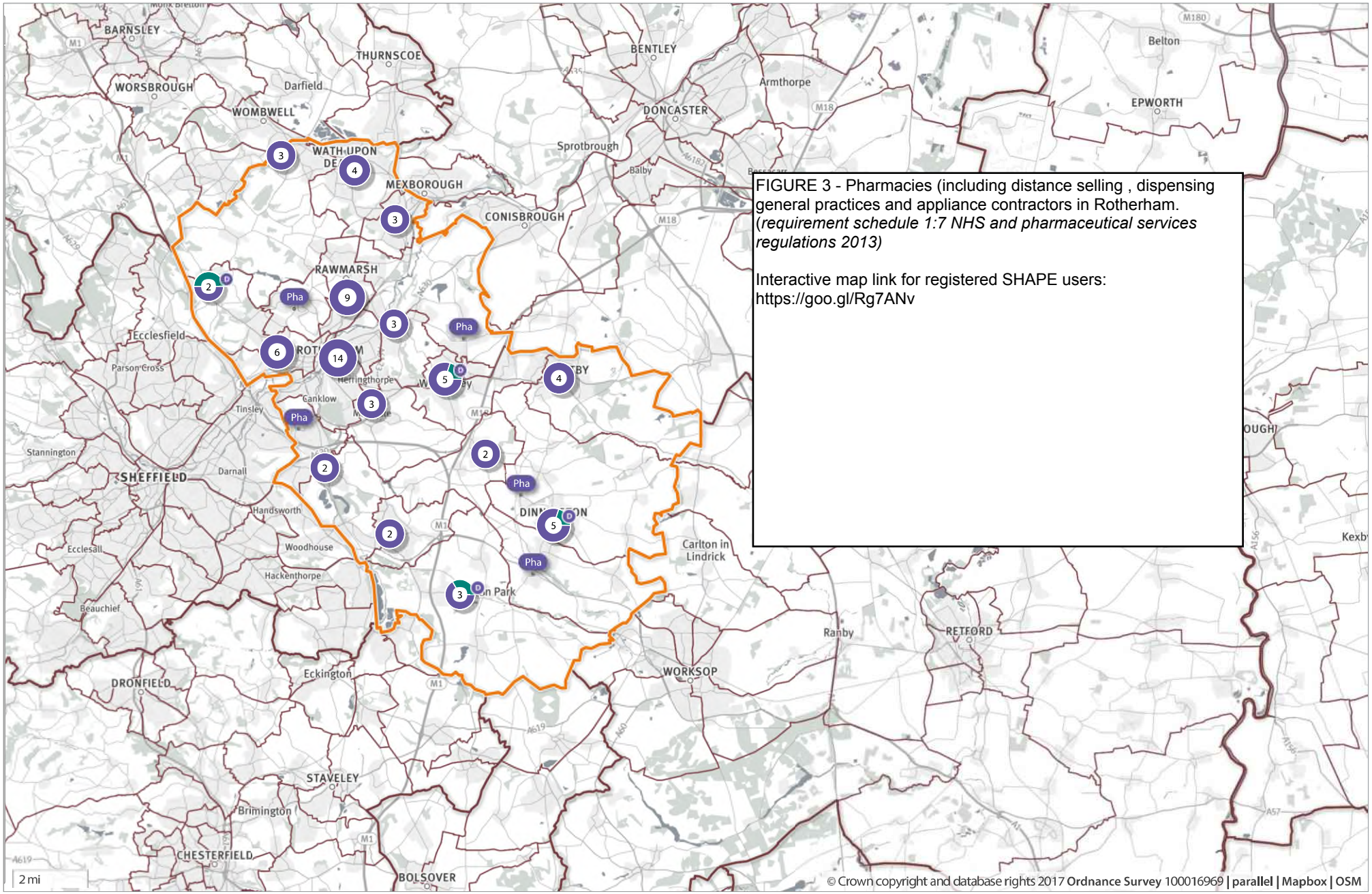


FIGURE 3 - Pharmacies (including distance selling , dispensing general practices and appliance contractors in Rotherham. (*requirement schedule 1:7 NHS and pharmaceutical services regulations 2013)*

Interactive map link for registered SHAPE users: https://goo.gl/Rg7ANv

6.2 Population

Rotherham has an estimated resident population of 261,900 (Office for National Statistics (ONS) Mid-year population estimate, 2016 – see https://goo.gl/N4gAxP). Figure 4 illustrates the resident population age and gender structure.

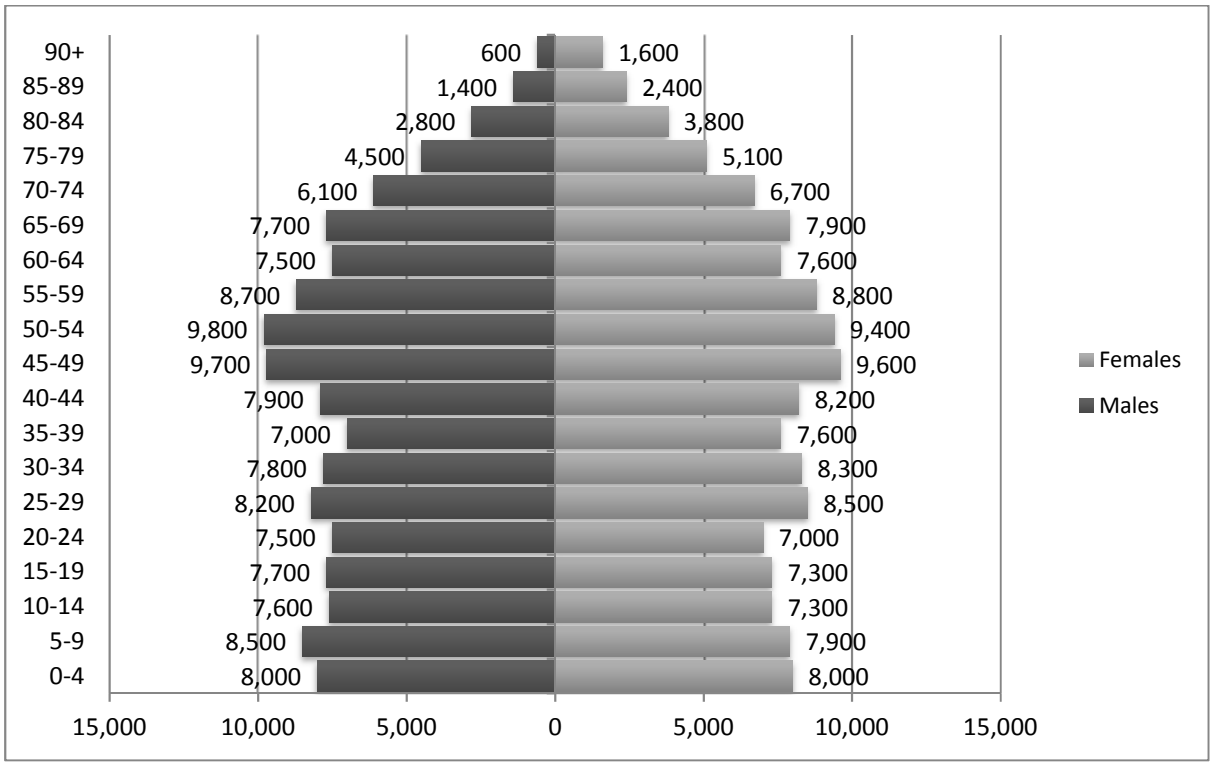
There has been a marked increase in the population aged 65 and over. Rotherham has as many people aged over 63 or over as children under 18. The oldest age groups have increased the most. Those aged over 85 have increased by 44% between 2001 and 2016 - compared to a 5% overall rise.

The population is expected to continue to rise to reach 269,900 by 2026. The projected increase reflects a combination of rising life expectancy, continued natural increase (more births than deaths) and net migration into the borough.

The number of people aged 85+ is projected to increase from 5,900 to 8,300 (40%) between 2016 and 2026. A 41% increase is projected in those aged 90+ who will number 3,000 by 2026.

The number of young people aged 16-24 is projected to reduce by 2,100 (-8%) between 2016 and 2022 but increase again by 1,000 between 2022 and 2026.

Figure 4: Rotherham population by age group and gender



Black and Minority Ethnic (BME) Population profile

Rotherham's Black and Minority Ethnic (BME) population is relatively small but has been growing and becoming more diverse. The BME population more than doubled between 2001 and 2011, increasing from 10,080 to 20,842. 8.1% of the population belonged to ethnic groups other than White British in 2011, well below the English average of 20.2%. 91.9% of Rotherham residents were White British.

The largest BME community is Pakistani & Kashmiri who numbered 7,912 in 2011 - (3.1%) of the population. The second largest group being '*other white'*, mainly Slovak and Czech Roma.

6.3 Life expectancy

Healthy Life Expectancy at Birth is the average number of years a person would expect to live in good health based on existing local mortality rates and prevalence of self-reported good health.

In Rotherham healthy life expectancy, based on 2013-15 data, is 58.7 years for men and 58.0 for women. This is at the lower end of healthy life expectancy in England. The England averages are a healthy life expectancy of 63.4 years for men and 64.1 years for women. (Public Health Outcomes Framework-PHOFwww.phoutcomes.info)

Life expectancy at birth is 78.1 years for Rotherham men; compared to 79.5 years in England. For women life expectancy is 81.3 years compared with 83.1 years in England. (PHOF)

Life expectancy for both men and women living in the most deprived areas is less than for residents living in the least deprived areas (ONS). For men this life expectancy gap is 9.8 years between those living in the most deprived parts of Rotherham and the least deprived part of Rotherham. For women this gap is 7.6 years (Health Profile, 2017)

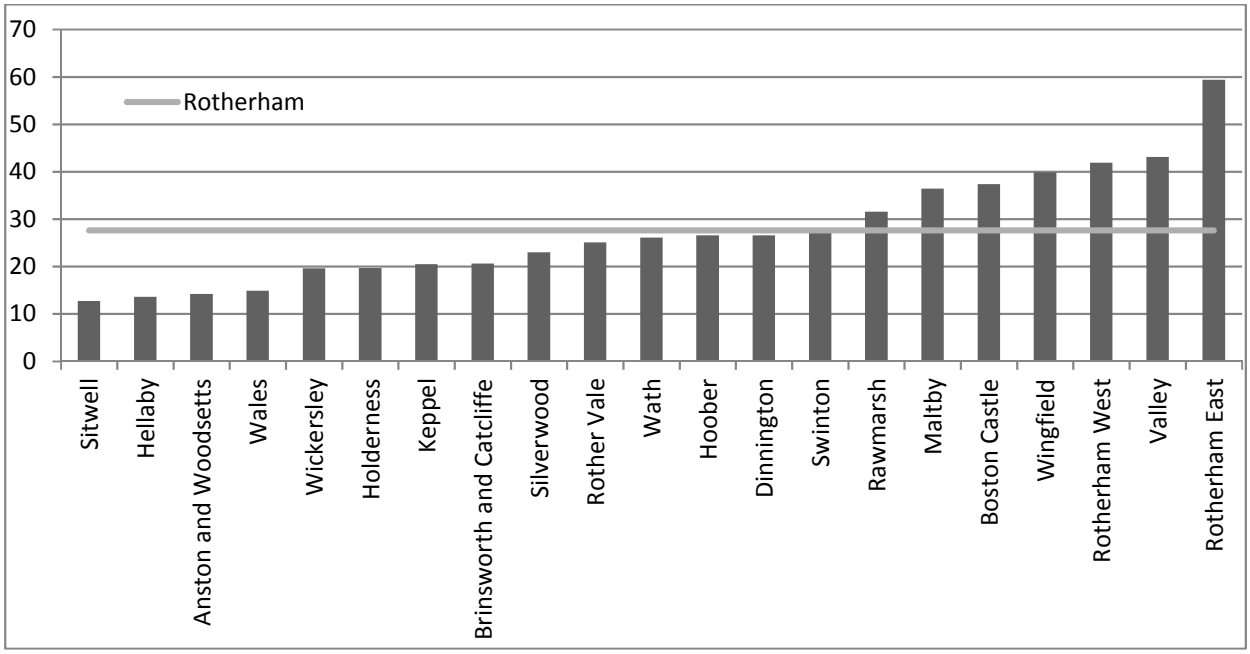
6.4 Deprivation

The Index of Multiple Deprivation (IMD) 2015 measures overall deprivation. It also provides information on specific aspects of deprivation (The English Indices of Deprivation 2015).

There is a wide range of deprivation within Rotherham highlighted by IMD 2015 ward scores ranging from 12.7 to 59.4 – Figure 5.

Rotherham is currently the 52nd most deprived borough out of 326 English districts. In 2010 Rotherham ranked 53rd out of 326.

Figure 5: Index of Multiple Deprivation (2015): Rotherham residents by Ward



6.5 Housing Growth

The Rotherham Local Plan Core Strategy 2013-2028 sets out a spatial strategy for Rotherham. This plan was based on population growth estimates available at this time. The latest population growth estimates show a reduced rate of growth. The general spatial strategy was based on distributing growth across the borough in relation to the size of the current settlements. This strategy considered the provision of local services and facilities, including health, education, sports provision, the retail offer and access to public transport. A new community, such as that at Waverley, would be an exception to this general rule. Most new developments during the period that the strategy covers will therefore take place within Rotherham's urban area and at Principal Settlements for Growth (Table 4).

As such the distribution of providers of pharmaceutical services corresponds to where future new housing is likely to be located. The pace of home building and changes to the spatial strategy should continue to be a factor in examining commissioning or market entry decisions related to providers of pharmaceutical services.

It is anticipated that the Sites and Policies document that details specific housing allocations to meet housing growth targets will be adopted in the summer of 2018 as part of the statutory development of local plan for the borough. More information is available at https://goo.gl/Dd4p6f

Table 4: Local Plan summary of housing developments

Settlement	Approx. number of dwellings	Percentage of borough requirement
Principal settlements for growth		
Rotherham Urban area (including Bassingthorpe Farm strategic allocation)	5471	38%
Wath-upon-Dearne, Brampton Bierlow and West Melton	1300	9%
Dinnington, Anston and Laughton Common (including Dinnington East Broad Location for Growth)	1300	9%
Bramley, Wickersley and Ravenfield Common	800	6%
Principal settlements		
Waverley	2500	17%
Maltby and Hellaby	700	5%
Aston, Aughton and Swallownest	560	4%
Swinton and Kilnhurst	560	4%
Wales and Kiveton Park	370	3%
The remaining housing requirements will be met through smaller developments.		

Source: adapted from Rotherham Local Plan Core Strategy 2013 – 2028 https://goo.gl/BtTdYH

7.0 Health and Wellbeing

The Rotherham Joint Strategic Needs Assessment (JSNA) describes the health and wellbeing needs of the local population.

http://www.rotherham.gov.uk/jsna/

This does not duplicate these detailed descriptions of health needs and should be read in conjunction with the JSNA. This section outlines some of the health and wellbeing priority for Rotherham relevant to access to pharmaceutical services.

A new Health and Wellbeing Strategy for Rotherham will be published by April 2018. The aims of this strategy are:

- All children get the best start in life and go on to achieve their potential.

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

- All Rotherham people live well for longer, and

- All Rotherham people live in healthy, safe and resilient communities.

7.1 Health Inequalities

Inequalities in health outcomes such as life expectancy at birth and preventable years of life lost are unfair.

The weight of scientific evidence supports a socio-economic basis for inequalities. This means that a citizen's risk of ill health is determined to a varying degree by things like where they live, how much they earn, what sort of education they've had as well as their lifestyle choices and constitution.

Inequalities can exist when comparing Rotherham with the England average and within the borough

Compared with the England average, Rotherham has lower life expectancy and higher mortality from circulatory disease and cancer.

There are also inequalities within Rotherham with significant health differences between the most and least deprived parts of the borough.

The main causes of death that contribute to the gap are circulatory disease, cancer and respiratory problems. These three causes are also the main contributors to the slope of inequality that exists between the most and least deprived parts of Rotherham.

Mental Health, quality of life and wellbeing also follow a socio-economic gradient and are an important consideration when addressing heath inequalities.

7.2 Headline health indicators

Table 5: Headline health indicators

Indicator	Rotherham	England
Premature mortality from cancer (directly age standardised rate per 100,000 population under 75)	**153.7**	**138.8**
Premature mortality from Cardiovascular disease (directly age standardised rate per 100,000 population under 75)	**89.2**	**74.6**
Percentage of adults who smoke (modelled data from national survey)	**18.3%**	**15.5%**
Percentage of 10-11-year olds overweight and obese (National Child Weighing and Measuring Programme 2015-16)	**35.8%**	**34.2%**
Alcohol attributable mortality (directly age standardised rate per 100,000 population over 35)	**47.8**	**46.1**
Teenage pregnancy (conception per 1000 11-17-year olds)	**25.5**	**20.8**

Source: Public Health Fingertips tool (www.phoutcomes.info)

7.3 Health and Wellbeing Priorities

The priority areas set out below reflect the importance of the topic to Rotherham and the ability of providers of pharmaceutical services to contribute to local strategy and action to address these priority areas.

Providers of pharmaceutical services have a variety of roles to play in these and other areas. They play a large role in:

- supporting treatment plans by dispensing medicines
- giving help and advice to patients
- signposting onto specialist services
- running public health campaigns
- helping make treatment plans more effective by reviewing medicines usage
- supporting the healthcare system by advising and treating minor ailments
- providing specialist services to support priority areas, e.g. flu vaccinations and emergency hormonal contraception

Tobacco

Smoking remains the main cause of preventable morbidity and premature death in England, leading to 79,100 deaths in 2011 (Statistics on Smoking, England 2013, NHS National Statistics). Tobacco use is a major cause of coronary heart disease, lung and

other cancers and respiratory diseases. Around 510 people in Rotherham die from smoking related illness each year. This is significantly worse than the England average (PHE, Local Tobacco Control Profiles).

Substance Misuse

Substance misuse causes harm not only to the individual but also to other members of the community and wider society. Injecting drug use increases the risk of acquiring blood borne diseases such as viral hepatitis and HIV. The sharing and irresponsible disposal of used needles presents a risk to others.

Substance misuse is not the norm in Rotherham, although opiate use is higher than the national average. Estimates for 2014/15 suggest that the Rotherham rate is 9.82 per 1000 population (aged 15-64) compared to 7.33 per 1000 population (aged 15-64) nationally. These estimates suggest that there are around 1,900 problematic opiate and/or crack users aged 15-64 years.

Alcohol

Alcohol is not only important as a cause of liver cirrhosis; it also contributes to deaths from cancer, heart disease, accidents and mental health.

In 2015/16 there were 2586 hospital admission episodes per 100,000 population that were alcohol-related. The England rate for the same period was 2179 episodes per 100,000 population.

In 2015/16 Rotherham had 490 people in receipt of specialist treatment for alcohol misuse. Only a small number of those believed to have problematic drinking are seeking treatment.

Obesity

Modelled data from the Active People Survey (2013-15) suggests that 76.2 % of Rotherham adults are overweight or obese. This is significantly higher than the England average and is the highest rate in Yorkshire and Humber. This level of obesity will mean that there is an increasing number of health problems associated with this e.g. Type 2 diabetes, heart disease and cancer.

The data for obesity in children is more detailed than that available for adults because of the comprehensive National Child Measurement Programme (NCMP), which weighs and measures all children in Reception and Year 6. We know from this information that childhood is an important time in the development of obesity, as levels more than double between Reception (aged 4-5 years) and Year 6 (aged 10-11 years).

The NCMP data shows that in 2015/16 22.1% of Reception year children had excess weight and 35.8% of Year 6 children had excess weight. Data from 2016/17 shows that these figures continue to rise with 24.1% of Reception year children having excess weight and 36.9% of Year 6 children having excess weight.

Unhealthy diets and sedentary lifestyles play a role in obesity – although there are many complex factors at play, including early life experiences, social norms, the degree of control people have over their life and the built environment.

Physical activity and exercise not only benefit physical health but have also been shown to help people with problems such as anxiety and depression and may even reduce the chances of someone developing such problems in the first place.

The Active Lives Survey is a survey of adults aged 16+ living in England. (http://www.sportengland.org). The latest information shows that 54.8% of adults in Rotherham are active on a weekly basis and 31.9% are inactive. The England averages are 60.6% active and 25.6% inactive.

Sexual Health

Teenage Pregnancy rates for Rotherham have fallen significantly and consistently over the past ten years. The rate of conceptions in under 18s was 54.7 per 1000 in 2008. The rate in 2015 was less than half of the 2008 rate at 25.5 / 1000. The Rotherham rate now approaches the regional rate for Yorkshire and Humber.

In 2016 there were 91 positive diagnosis of Gonorrhoea in Rotherham – representing a rate of 34.9 / 100,000 population. This compares to a national rate of 64.9 / 100,000 and a regional rate of 45.7 / 100,000.

Mental Health

Mental health is a growing public health concern in the UK. Most mental health problems are related to deprivation, poverty and inequality – emphasising the importance of these wider determinants of health.

People with serious mental health problems have their lives shortened by 14-18 years on average. Many mental health problems are often found coexisting with physical health problems such as diabetes.

Depression and anxiety disorders are common. The reported prevalence of depression in Rotherham in 2016/17 was 12.57%. The England prevalence is 8.95%. The Rotherham prevalence is in the upper quartile.

Dementia

Dementia mainly affects people over the age of 65 and the incidence increases with age. People under the age of 65 can develop dementia and this is often referred to as early onset dementia. With more people living longer and the rising numbers in older age groups, more people are likely to develop dementia. This is likely to impact on health and social care and on carers.

Estimates suggest that around 80% of the population with dementia have a diagnosis and are registered with their GP. The proportion is one of the highest in Yorkshire

and the Humber and significantly higher than the national goal of 66.7. Rotherham has seen an increase in the number diagnosed with dementia and this will continue to increase. It is currently estimated that there are around 2,500 people over 65 years diagnosed with dementia in Rotherham.

The Dementia Friends initiative helps to improve understanding of dementia and the small things that could make a difference to people living with dementia. It forms part of the Community Pharmacy Quality Scheme.

Influenza (Flu)

The influenza virus can affect a large proportion of the population annually. The effect of this virus can be more serious for certain groups of people. The influenza (flu) vaccine is recommended on a yearly basis to at-risk groups. Those eligible to receive a free flu jab for the 2017/18 season include:

- People 65 years of age or older
- pregnant women
- those with defined medical conditions, e.g. COPD, asthma or diabetes
- those living in a long stay residential care home of other such facility
- those who receive a carer's allowance or are the main carer for an elderly or disabled person
- paid carers
- children over 6 months with a long-term health condition
- children in reception class and school years 1 to 4
- health and social care workers

8.0 CURRENT PROVISION AND ACCESS

This section outlines the current provision of pharmaceutical services available for Rotherham residents.

8.1 Current provision

There are a total of 71 providers of pharmaceutical services in Rotherham. This includes 64 Community Pharmacies, 6 distance selling pharmacies and one dispensing appliance contractor (Figure 3). There is one more Community Pharmacy than in the previous PNA.

The NHS (Pharmaceutical and Local Pharmaceutical Services) regulations 2013 were amended in December 2016 by the introduction of Section 26A consolidations. Section 26A consolidations is a merger of two pharmacy businesses that does not create a gap in the provision of pharmaceutical services. To date, there have been no Section 26A consolidations in Rotherham.

Assuming a population of 261,000 and 64 Community Pharmacies there is an average of one Community Pharmacy provider per 4078 people. This is more provision that the national average for England of one Community Pharmacy provider per 4647 people.

Another way of expressing this is to say there are 24.5 pharmacies per 100,000 people in Rotherham. This is higher than the national average of 22 pharmacies per 100,000 people.

The number of Community Pharmacies per 100,000 varies across England from 26 community pharmacies per 100,000 population in Lancashire & Greater Manchester and Cheshire & Merseyside to 18 per 100,000 population in South Central region.

Table 6: Community pharmacies and population by NHS region 2015/16

	Number of community pharmacies	ONS population mid-year 2014 (000s)	Pharmacies per 100,000 population
ENGLAND	11688	54317	22
North of England	3723	15259	24
- Yorkshire & Humber	1275	5468	23
- Lancashire & Greater Manchester	1089	4238	26
- Cumbria and North East	727	3123	23
- Cheshire & Merseyside	632	2430	26
Midlands & East	3446	16487	21
- North Midlands	775	3591	22
- West Midlands	980	4123	24
- Central Midlands	890	4518	20
- East	801	4255	19
London	1853	8539	22
South	2666	14032	19
- Wessex	511	2742	19
- South West	637	3171	20
- South East	880	4540	19
- South Central	638	3578	18

Source: NHS Prescription Services, population estimates – Office for National Statistics, NHS Digital http://digital.nhs.uk/pubs/genphasernov16

Dispensing Doctors

Dispensing Doctors provide services to patients in rural areas and often where there are no Community Pharmacies or where access is restricted. In Rotherham there are 4 Dispensing Doctor practices. These practices are located at Thorpe Hesley, Wickersley, Dinnington and Kiveton Park.

Dispensing Appliance Contractors

Dispensing Appliance Contractors dispense specified appliances such as stoma, catheter or incontinence appliances. They provide a home delivery service, a reasonable supply of supplementary items (e.g. disposable wipes) and access to expert clinical advice.

In 2015/16 there were 112 appliance contractors in England. There is one DAC based in Rotherham – South Yorkshire Ostomy Supplies.

Distance Selling Pharmacies

Online pharmacies, internet pharmacies or Mail Order pharmacies are pharmacies that operate over the internet and send order to customers through the mail or shipping companies. Distance Selling pharmacies must provide the full range of essential

services during opening hours to all persons in England presenting prescriptions – but, they cannot provide essential services face to face.

There are 6 distance selling pharmacies in Rotherham.

8.2 Distribution and Access to Pharmaceutical Services

There is a good distribution of providers of pharmaceutical services across Rotherham, including areas of high deprivation and population. Furthermore, there are nine pharmacies located across Rotherham that are contracted to provide 100-hour service. The 100-hour pharmacies are distributed across Rotherham and mirror the areas of highest population (Figure 6). Analysis shows that 36% of residents are within a 20 minute walk of a 100-hour pharmacy. 99% of residents are within a 10 minute drive of a 100-hour pharmacy.

Opening and Closing Hours

Access to Community Pharmacies across Rotherham is well provided for during core and supplementary opening hours. Table 7 summarises opening and closing hours across Rotherham. The numbers relate to the Community Pharmacies open at the given times – the numbers are additional to each other. Thus, there are 13 Community Pharmacies contracted to be open before 09:00 on a normal weekday. The actual number open is more likely to be 26 as the supplementary hours better describes the reality of opening and closing times.

Table 7: Summary of opening and closing hours

Opening Time	Core Hours	Supplementary Hours
Open before 08:00	2	4
Open before 09:00	11	22
Closed after 17:00	31	28
Closed after 18:00	10	24
Open on Saturday morning	36	46
Open on Saturday afternoon	16	27
Open on Sunday	9	16

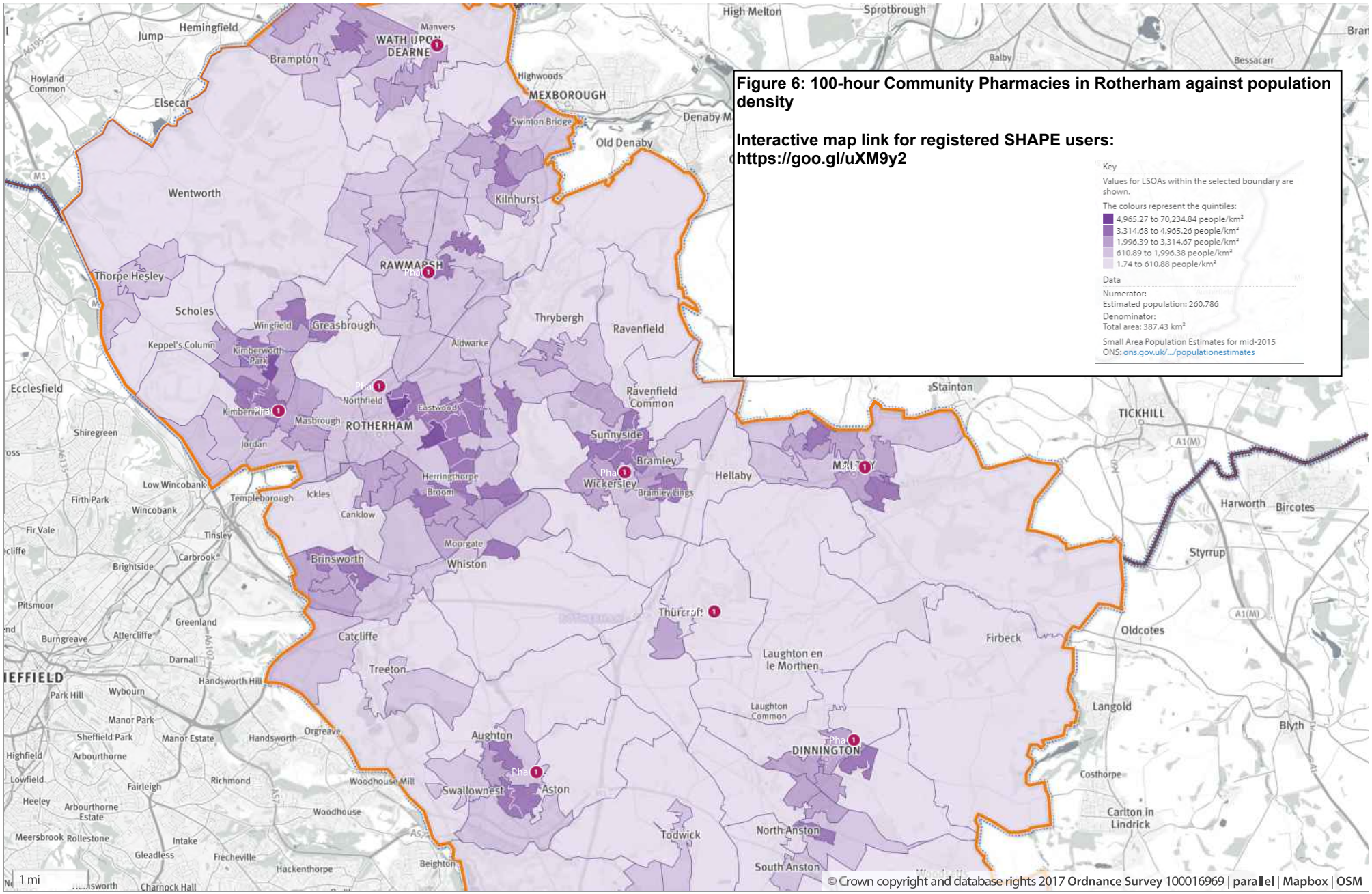


Figure 6: 100-hour Community Pharmacies in Rotherham against population density
Interactive map link for registered SHAPE users: https://goo.gl/uXM9y2
Key
Values for LSOAs within the selected boundary are shown.
The colours represent the quintiles:
4,965.27 to 70,234.84 people/km²
3,314.68 to 4,965.26 people/km²
1,996.39 to 3,314.67 people/km²
610.89 to 1,996.38 people/km²
1.74 to 610.88 people/km²
Data
Numerator:
Estimated population: 260,786
Denominator:
Total area: 387.43 km²
Small Area Population Estimates for mid-2015
ONS: ons.gov.uk/.../populationestimates
ROTHERHAM
MEXBOROUGH
RAWMARSH
DINNINGTON
TICKHILL
Wentworth
Thorpe Hesley
Scholes
Kimberworth
Greasbrough
Kilnhurst
Old Denaby
Thrybergh
Ravenfield
Ravenfield Common
Stainton
Sunnyside
Bramley
Wickersley
Hellaby
Harworth
Bircotes
Styrrup
Oldcotes
Firbeck
Laughton en le Morthen
Thurcroft
Whiston
Brinsworth
Catcliffe
Treeton
Aughton
Swallownest
Aston
Todwick
North Anston
South Anston
Langold
Blyth
Carlton in Lindrick
Costhorpe
Laughton Common
Dalton
Ecclesfield
Shiregreen
Low Wincobank
Firth Park
Wincobank
Fir Vale
Tinsley
Carbrook
Brightside
Pitsmoor
Burngreave
Attercliffe
Greenland
Darnall
Handsworth Hill
Handsworth
Manor Park
Manor Estate
Sheffield Park
Arbourthorne
Highfield
Lowfield
Heeley
Fairleigh
Richmond
Woodhouse Mill
Woodhouse
Meersbrook
Rollestone
Intake
Gleadless
Frecheville
Hackenthorpe
Beighton
Charnock Hall
Park Hill
Wybourn
Orgreave
Templeborough
Ickles
Canklow
Herringthorpe
Broom
Moorgate
Eastwood
Northfield
Masbrough
Jordan
Aldwarke
Keppel's Column
Wingfield
Kimberworth Park
Bramley Lings
Hoyland Common
Elsecar
Jump
Hemingfield
Brampton
Manvers
Highwoods
Swinton Bridge
Denaby M
High Melton
Sprotbrough
Balby
Bessacarr
A1(M)
M1
A57
A631
1 mi
© Crown copyright and database rights 2017 Ordnance Survey 100016969 | parallel | Mapbox | OSM

Geographical Access

An important part of the PNA is to assess how accessible pharmacies are to residents. This is measured by the proportion of residents who are within a 1.6km (1mile) walk of a pharmacy and by the proportion of residents who are within a 10-minute drive of a pharmacy.

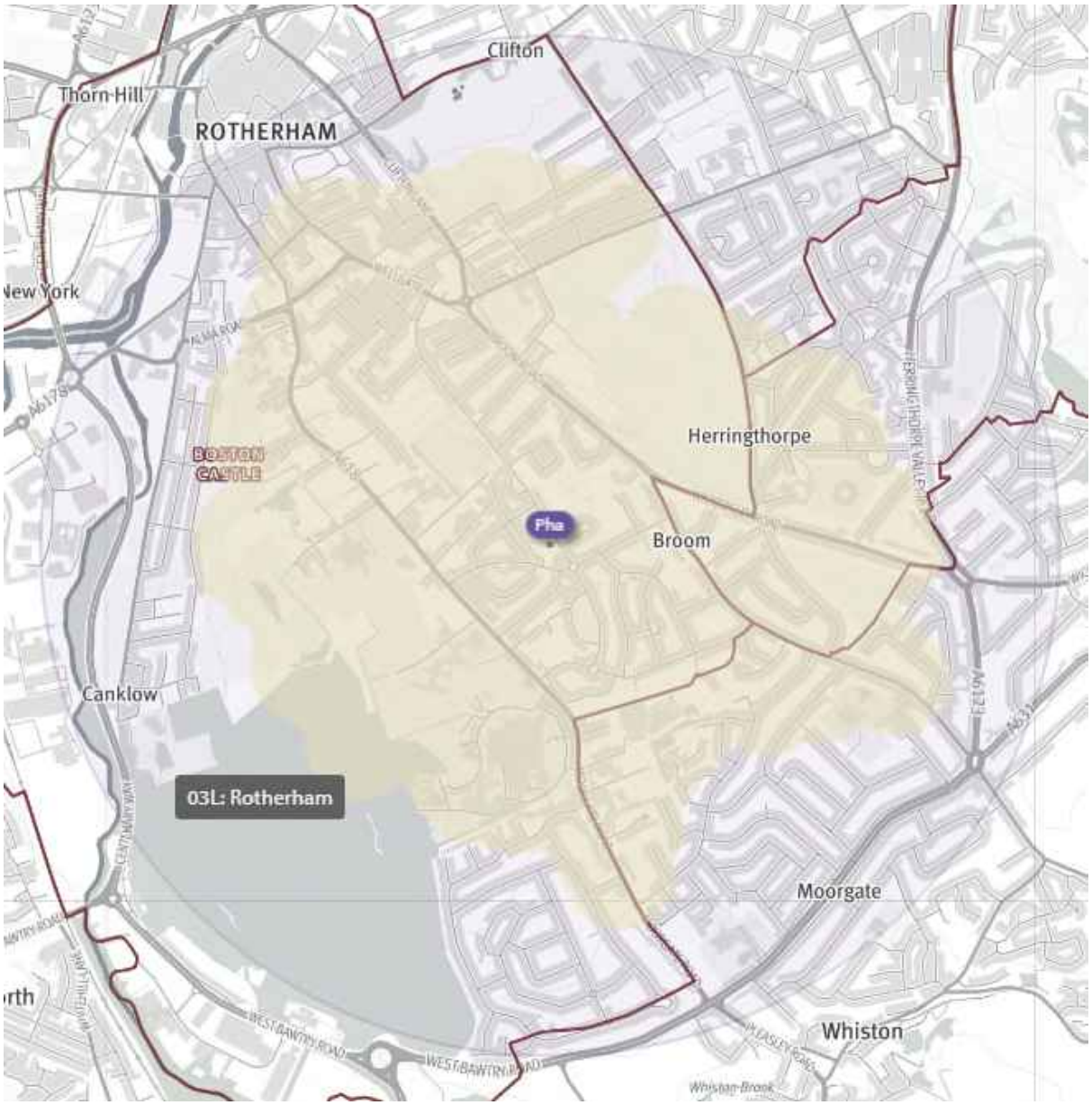
The method of calculating these measures has changed since the last PNA in 2015. The method now uses mapping software to calculate access. This gives a better assessment of access. This can be seen by comparing a walking distance of 1.6km with a 1.6km radius around a Community Pharmacy. Figure 7 illustrates the difference this can make by showing a 1.6km circle around the Whitworth Pharmacy in light purple and a 1.6km walking distance in pale yellow.

Using the SHAPE access tool, the results shown in Table 8 have been calculated. Consideration was also given to the providers of pharmaceutical services outside Rotherham that could be reached by a 1.6km walk. There are 46 providers of pharmaceutical services within 1.6km of the Rotherham boundary (Figure 8). Of these only one (in Mexbrough) was close enough to improve access. Those residents are already within a 1.6km walk of pharmacies in Swinton. The pharmacies outside of Rotherham do not improve access to pharmaceutical services but do improve the choice of pharmacies that are available for Rotherham residents.

Table 8: Population distance and time from a provider of pharmaceutical services - walking

Distance / Time	Number of residents	Percentage of residents
100 metres	35177	13.5
400 metres	91000	34.9
800 metres (half mile)	178745	68.5
1200 metres	224266	86.0
1600 metres (1 mile)	247154	94.8
3 minutes' walk	60204	23.1
6 minutes' walk	104174	40.0
9 minutes' walk	146395	56.1
12 minutes' walk	195402	74.9
15 minutes' walk	222529	85.3

Figure 7: Example showing difference between 1.6km radius and 1.6km walking distance



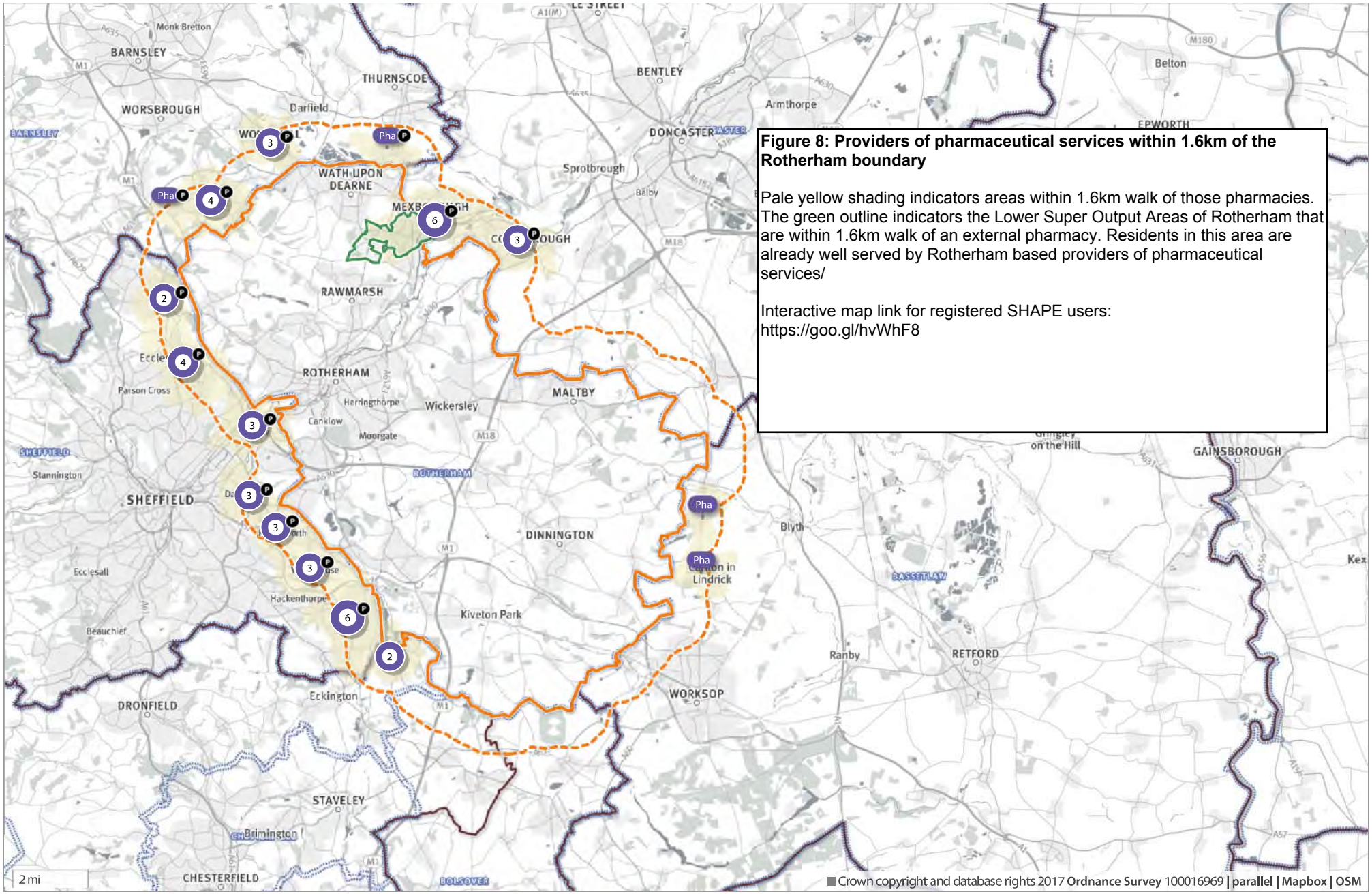


Figure 8: Providers of pharmaceutical services within 1.6km of the Rotherham boundary

Pale yellow shading indicators areas within 1.6km walk of those pharmacies. The green outline indicators the Lower Super Output Areas of Rotherham that are within 1.6km walk of an external pharmacy. Residents in this area are already well served by Rotherham based providers of pharmaceutical services/

Interactive map link for registered SHAPE users:
https://goo.gl/hvWhF8

Proportion of Rotherham residents within 1.6km (1 mile) walk of a provider of pharmaceutical services. **(Figure 9)**

Total population: 260, 786

Number within 1.6km walking distance: 250,609

Number not within 1.6km walking distance: 13,632

Proportion of Rotherham residents within 1.6km (1 mile) walk of a pharmacy is thus 94.8%

More than half of the residents further than 1.6km from a provider of pharmaceutical services are from deprivation deciles 6,7 and 8 – meaning they are less deprived than the average Rotherham population. They also show an older age profile than the Rotherham population (Figure 10)

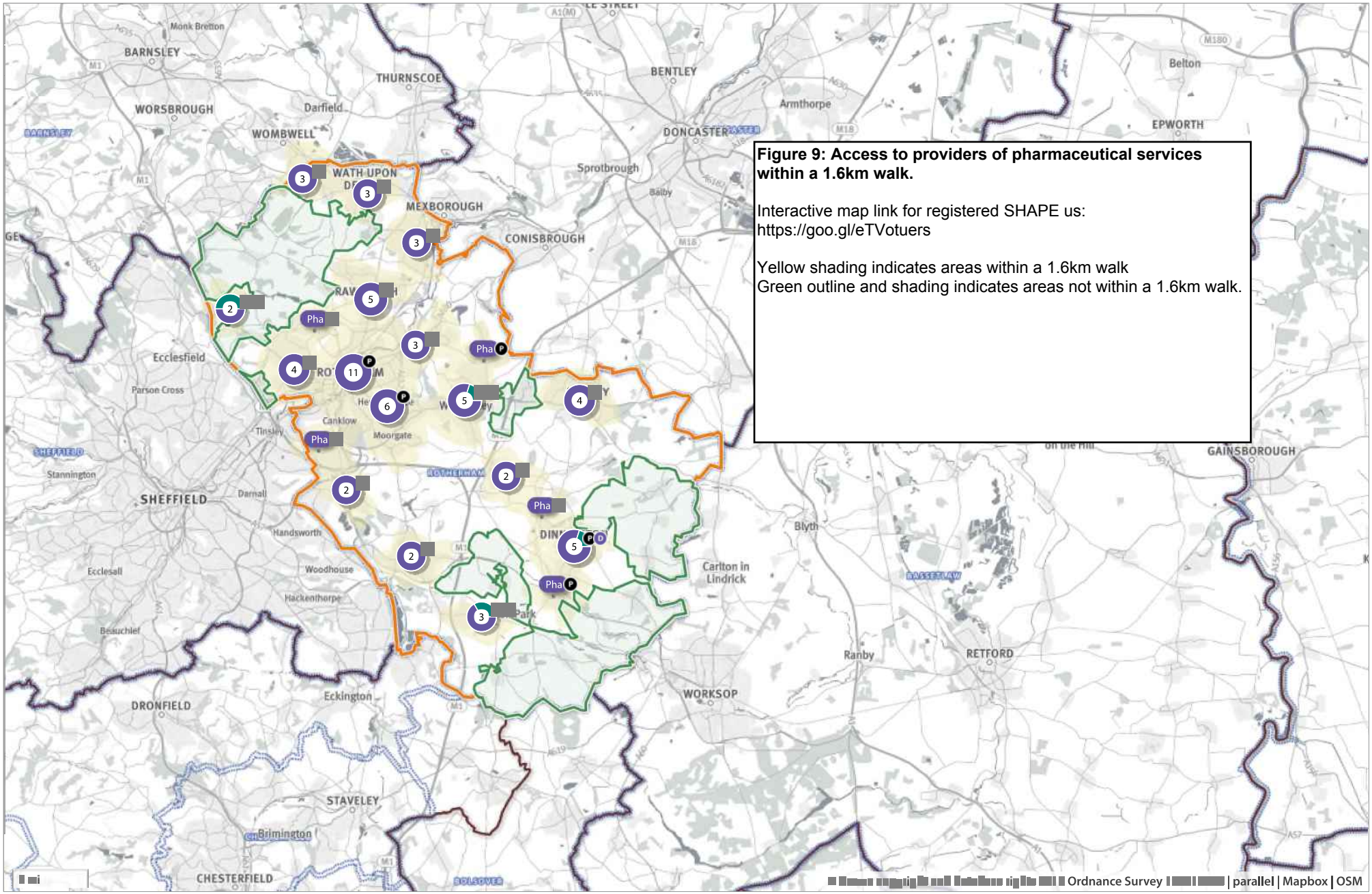
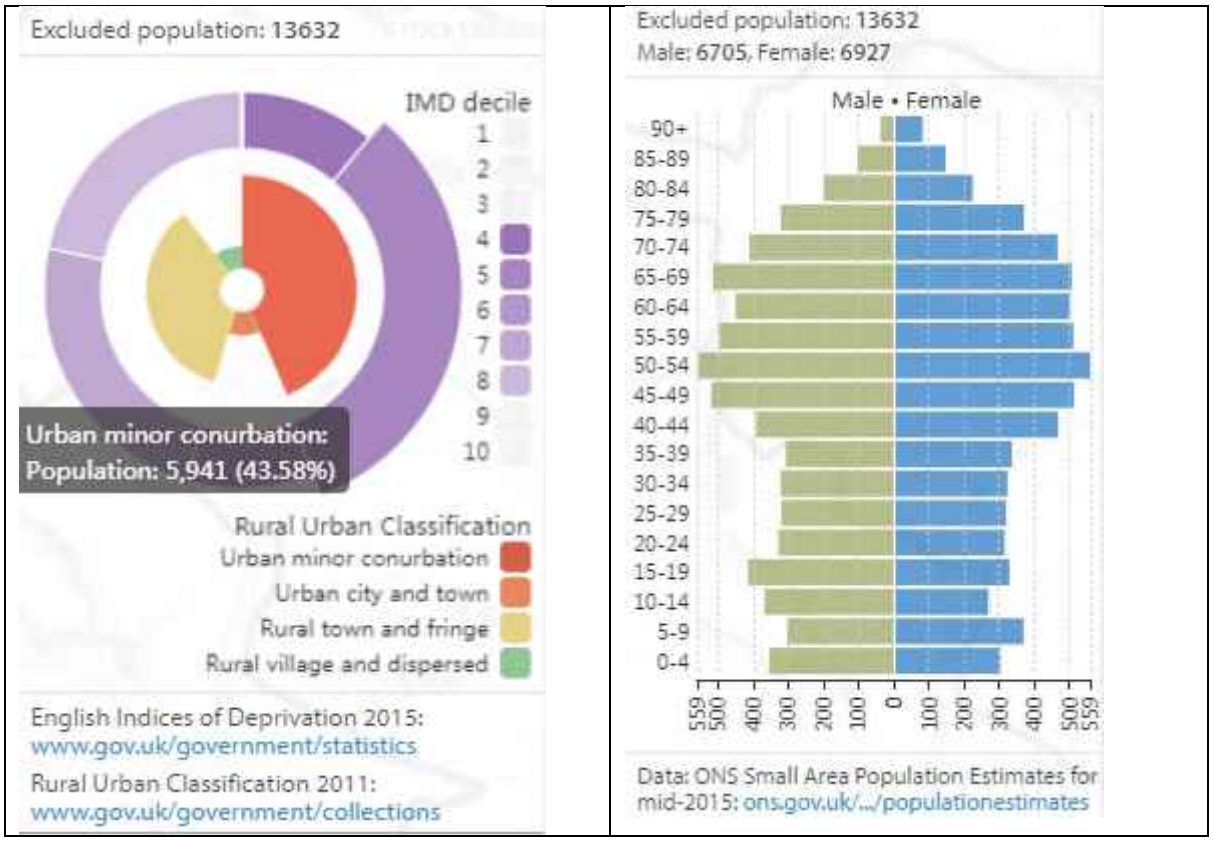


Figure 9: Access to providers of pharmaceutical services within a 1.6km walk.

Interactive map link for registered SHAPE us:
https://goo.gl/eTVotuers

Yellow shading indicates areas within a 1.6km walk
Green outline and shading indicates areas not within a 1.6km walk.

Figure 10: Deprivation status and rural / urban classification of residents further than a 1.6km walk from a provider of pharmaceutical services.



Proportion of Rotherham residents within 10-minute drive of a pharmacy.

Total population: 260,786

Number within 10 minute drive of a pharmacy: 260,786

Number not within 10 minute drive of a pharmacy: 0

Proportion of Rotherham residents within 10-minute drive of a pharmacy is thus 100%

The walking access measure used here is an improved method of analysing access to pharmaceutical services. This new method of analysing access does still have some weaknesses which could bias the results on a very local level. We will work with Public Health England to continue to improve the analysis within the SHAPE tool as we believe that over time this will give a more accurate measure of access.

8.3 Provision of services

Medicines Use Review (MUR)

Accredited pharmacists undertake a structured review with patients on multiple medicines, particularly those receiving medicines for long term conditions, such as diabetes, CHD and COPD. The MUR process attempts to establish a picture of the

patient's use of their medicines – both prescribed and non-prescribed. The review helps a patient understand their therapy and can identify any problems they are experiencing along with possible solutions. A report of the review is provided to the patient and to their GP when there is an issue for them to consider.

Rotherham has 56 (88%) of Community Pharmacies that offer the MUR service. During the consultation, the Local Pharmaceutical Committee noted that all bar two Community Pharmacies are offering MURs. There is therefore a discrepancy between the information provided by NHS England and local knowledge. We will work to reconcile the information to provide an accurate picture of provision – but acknowledge that there is good coverage of the service throughout Rotherham.

Appliance Use Review (AUR)

Pharmacists or specialist nurses, working for either a Community Pharmacy or a Dispensing Appliance Contractor, carry out AURs in the pharmacy or at the patient's home. AURs can improve the patient's knowledge and use of their appliance(s) by:

- Establishing the way the patient uses the appliance and the patients experience of such use
- Identifying discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient
- Advising the patient on the safe and appropriate storage of the appliance
- Advising the patient of the safe and proper disposal of the appliances that are used or unwanted

Rotherham has 7 (11%) of providers of pharmaceutical services that provide this service. An appliance contractor based in Rotherham also offers this service.

New Medicines Service (NMS)

The New Medicines Service is designed to provide early support to patients to maximise the benefits of the medication they have been prescribed.

The purpose of the NMS is to promote the health and wellbeing of patients who are prescribed new medicines for long-term conditions (LTC) to:

- Help reduce the symptoms and long-term complications of the LTC
- Identify problems with the management of the condition and the need for further information or support

Additionally, the service will help patients

- Make informed choices about their care,
- self-manage their LTC, and
- adhere to the agreed lifestyle changes

Rotherham has 53 (83%) Community pharmacies that provide this service. During the consultation, the Local Pharmaceutical Committee noted that all bar one Community Pharmacies have provided this service in the past 12 months. There is therefore a discrepancy between the information provided by NHS England and local knowledge. We will work to reconcile the information to provide an accurate picture of provision – but acknowledge that there is good coverage of the service throughout Rotherham.

NHS Urgent Medicines Supply (NUMSAS) and Pharmacy Urgent Repeat Medicines service (PURM)

The NHS Urgent Medicines Supply service is a new advanced service commissioned by NHS England with the aim of referring people directly from NHS 111 to Community Pharmacy for urgent repeat prescriptions. To date, there are 12 (19%) of Community Pharmacies in Rotherham offering this service. This service complements the Pharmacy Urgent Repeat Medicines service. This service can be accessed directly from participating Community Pharmacies. Four Community Pharmacies offer this service in Rotherham.

Minor Ailments Service (Pharmacy First)

The aim of the minor ailments service is to improve access and choice for patients wishing to consult a healthcare professional in relation to a range of minor conditions. The service provides improved access to both advice and treatment for minor conditions and ensures a consistent, evidence based message is delivered to patients

Patients that don’t pay NHS prescription charges received medicine supplied under the minor ailments scheme free of charge

There are 54 (84%) pharmacies providing a minor ailments services in Rotherham.

Substance Misuse

Supervised consumption services support clients by ensuring compliance with agreed treatment plans.

Both methadone and buprenorphine can be dispensed in specified instalments where each dose is supervised to ensure that the dose is correctly consumed by the service user for whom it was intended.

Supervised consumption aims to reduce the risk to local communities of:

- Over or under usage of medicines
- Diversion of prescribed medicines onto the illicit drugs market
- Protect vulnerable individuals from pressure to relinquish their medication
- Accidental exposure to the prescribed medicines

There are 56 (88%) Community Pharmacies providing supervised consumption services in Rotherham.

There are 16 (25%) of Community Pharmacies providing needle exchange services. All pharmacies providing needle exchange services also provide the supervised consumption service

Clients use multiple outlets and can exercise choice in the services they access.

The map shown in Figure 11 shows the distribution of Community Pharmacies that provide needle exchange services. Supervised consumption was not mapped as the coverage is extensive. The background map shows crime deprivation figures from the 2015 Indicators of Multiple Deprivation. Substance misuse issues have a strong relationship with areas of high crime. Analysis shows that over 25% of residents living within 400 metres walk of Community Pharmacies offering needle exchange services are in the most deprived decile.

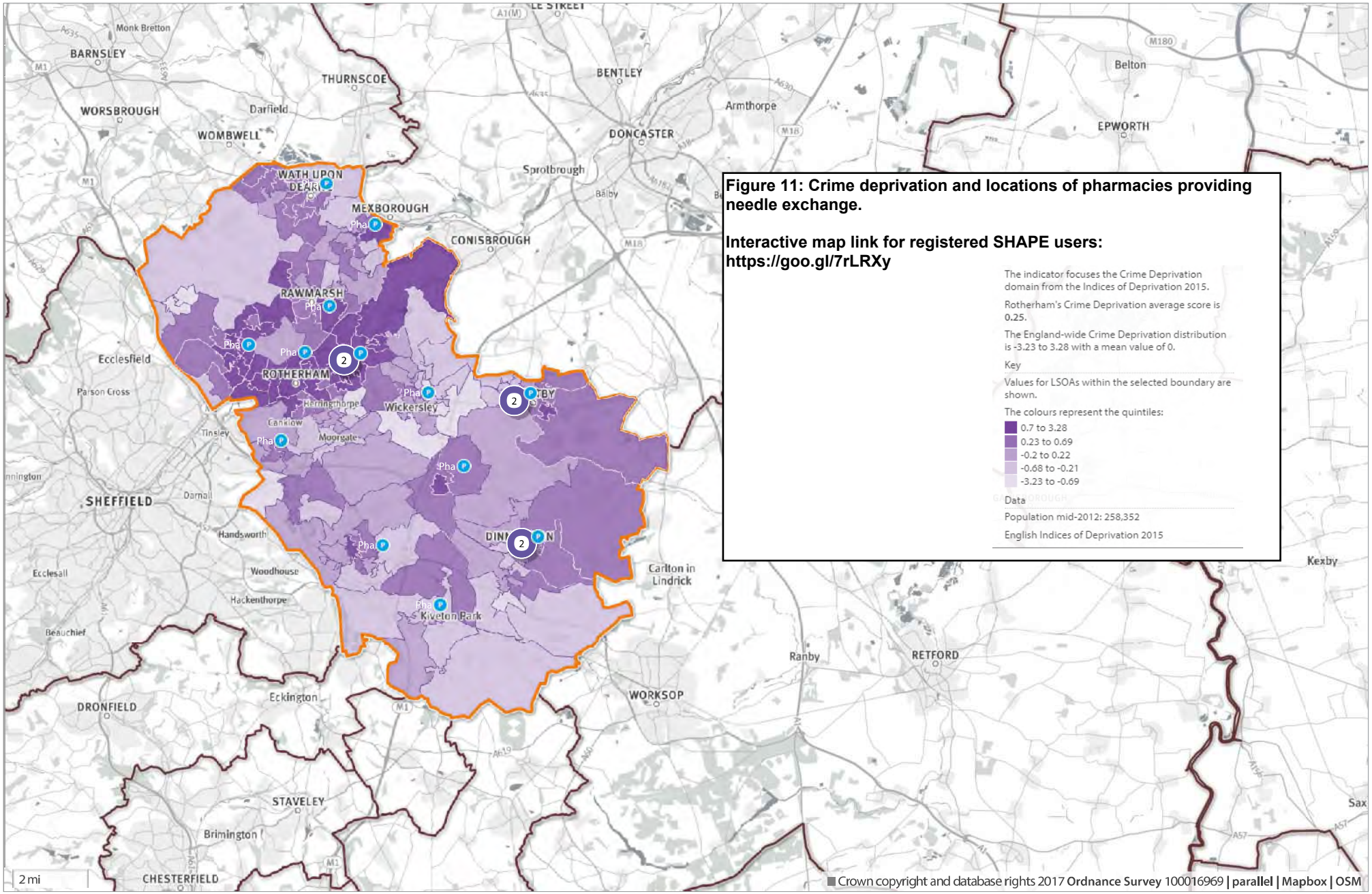


Figure 11: Crime deprivation and locations of pharmacies providing needle exchange.

Interactive map link for registered SHAPE users: https://goo.gl/7rLRXy

Emergency Hormonal Contraception (EHC)

Community Pharmacy is an important provider of sexual health services in Rotherham. The EHC service is currently open to all ages and incorporates:

- Emergency hormonal contraception and related advice
- Information and signposting

There are currently 34 (53%) Community Pharmacists that provide the EHC service.

Palliative care drug provision

Palliative care drugs are specialist medicines that are not available in all Community Pharmacies. The aim of the palliative care drug provision service is to ensure the availability of palliative care drugs across Rotherham. The service improves access to palliative care medicines for patients, carers and healthcare professional when they are required to ensure that there are no delays to treatment whilst also providing access and choice. Improved clinical management of end of life care and anticipatory prescribing reduces the need to access palliative care medication out of hours.

There are 46 (72%) Community Pharmacies that provide the palliative care service.

Flu vaccination

The yearly flu vaccination is free of charge for various groups, e.g. over 65s or people with some chronic long-term conditions. Community Pharmacies sign up to deliver the vaccination on a yearly basis.

At the time of writing 52 (81%) of Community Pharmacies in Rotherham had signed up to deliver the flu vaccination for the 2017 winter season.

8.4 Patient Satisfaction

The NHS Choices website provides patients with the opportunity to comment and rate NHS services. As at 5th November 2017 there were 14 Rotherham Community Pharmacies for which a rating had been submitted. In total 27 reviews had been submitted. Of these most were positive reviews and related to the care, professionalism and attitude of staff. The remaining reviews related to problems with new staff, opening times and delays in receiving medicines.

The Quality Payments scheme – a new part of the Community Pharmacy Contractual framework announced by the Department of Health in October 2016 rewards pharmacies for delivering quality criteria in three dimensions; clinical effectiveness, patient safety and patient experience. It encourages a range of activities designed to widen the pharmacy role beyond dispensing, to improve the quality of health care and to ease demand on the health care system. Such activities could include:

- Supporting the development of Healthy Living Pharmacies and ensuring each pharmacy achieves Healthy Living Pharmacy level 1 status
- Encouraging patient facing staff take part in the Alzheimer’s society dementia friends training.

9.0 Conclusions

This section provides analysis of the current provision of pharmaceutical services and considers whether there are any gaps in provision currently. It also looks forward to assess whether there may be issues to address in the future. There is also a consideration of the issues highlighted in the previous PNA to reflect on progress.

9.1 General access to pharmaceutical services

Rotherham is well provided for with respect to pharmaceutical dispensing services having a greater than the national average of pharmacies per 100,000 people. The availability of pharmaceutical services across the borough is adequate and necessary to meet need.

Rotherham residents can access supplies of appliances from a range of appliance contractors nationally, one who is based in Rotherham. Community Pharmacies within Rotherham also supply appliances.

Patients choose where they have their prescriptions dispensed. This includes any available registered distance selling pharmacy. Rotherham has 6 distance selling pharmacies. There are other distance selling pharmacies outside the boundaries of Rotherham which are used by Rotherham residents.

Rotherham residents currently exercise their choice of where to access pharmaceutical services to a considerable degree.

This PNA has not analysed whether there are any areas where a Section 26A consolidation would create a gap in the provision of pharmaceutical services. Any such applications would need to be considered on a case by case basis. The SHAPE tool could be used to assess such applications.

Based on the information available at the time of developing this PNA no current gaps in the provision of Essential Services have been identified.

9.2 Weekend and Extended hours

Community Pharmacies in Rotherham are accessible and offer extended opening times – often into the evening and at weekends – to suit patients and consumers including 100-hour pharmacies that give good geographical cover.

Based on the information available at the time of developing this PNA no current gaps in the provision of essential services outside normal working hours have been identified.

9.3 Access to advanced and locally commissioned services

Rotherham has good coverage of many of the advanced services.

Rotherham Public Health team are in the process of reshaping their approach to the commissioning of lifestyle services. The commissioning intention is to move away from single lifestyle issues to a holistic approach based on the needs of the individual.

Based on the information available at the time of developing this PNA no current gaps in the provision of advanced or locally commissioned services have been identified.

9.4 Update on previous findings

The previous PNA identified that the areas of Thorpe Hesley and Thrybergh are being less well served than other localities with reduced local access to essential and advanced services, particularly at weekends.

Thorpe Hesley

The village of Thorpe Hesley is currently served by one Community Pharmacy. Over 4100 people are estimated to be within a 1.6km walk of this pharmacy. The GP practice serving the area is also a dispensing practice. Access to pharmaceutical services within the village is therefore good.

The Community Pharmacy offers NMS, MUR and flu vaccination advanced services as well as palliative care drugs and the minor ailments service, Pharmacy First.

The Community Pharmacy is not open beyond 18:00 and is closed at weekends. Patients requiring pharmacy services beyond normal working hours will need to be able to access private or public transport.

In October 2016 as part of a funding review of Community Pharmacies the Department of Health introduced the Pharmacy Access Scheme with the aim of ensuring a baseline level of patient access to Community Pharmacy services. The scheme is designed to make sure that no area will be left without access to NHS Community Pharmacies services. Qualifying pharmacies will receive an additional payment to protect them from the full effect of the reduction in funding. The pharmacy in Thorpe Hesley has been eligible for the Pharmacy Access scheme. This scheme, however, has only been confirmed to March 2018.

Thrybergh

Thrybergh is also served by a single Community Pharmacy. Over 5700 people are estimated to be within a 1.6km walk of this pharmacy – so there is currently good access to the Community Pharmacies services for residents of Thrybergh.

The pharmacy offers NMS, MUR and flu vaccination advanced services as well as EHC, supervised consumption and the minor ailments service, Pharmacy First.

The pharmacy closes at 6pm but is open on Saturday morning. Patients requiring pharmacy services beyond these times will need to be able to access private or public transport.

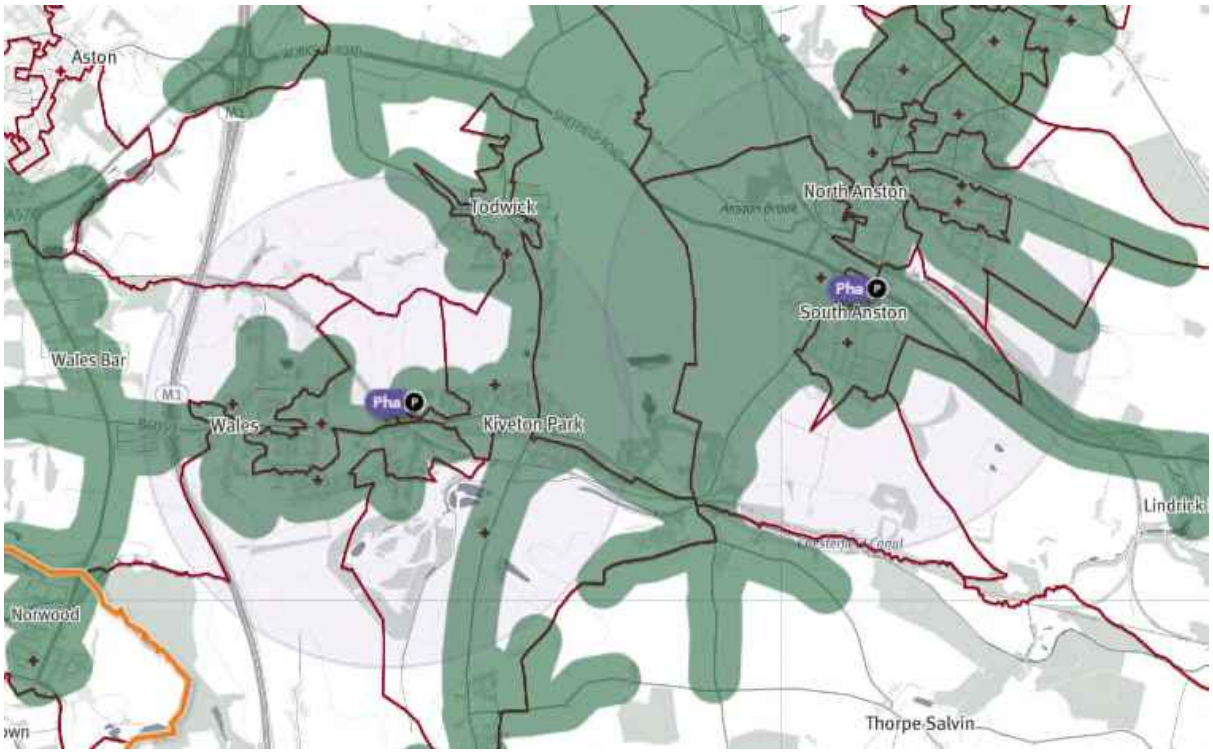
This pharmacy is not included in the Pharmacy access scheme.

Todwick

The previous PNA identified that Todwick sits outside a 1 mile radius of any pharmacy but does have good access to private and public transport.

Figure 12 confirms that only part of Todwick is outside of a 1 mile radius of the pharmacies in Kiveton Park. The analysis also confirms that two pharmacies in Kiveton Park and two in North and South Anston are within a 5 minute drive.

Figure 12: Access to pharmacy services in Todwick – n.b. two pharmacies and the dispensing GP practice at Kiveton Park have been removed from the map for clarity. The green shading indicates 5 minute drive time; the light purple circles are 1.6km radius from the pharmacies



Kilnhurst: Minor Ailments

The previous PNA highlighted that whilst there was wide spread coverage of the Pharmacy First minor ailments scheme this service was absent in Kilnhurst.

This pharmacy now provides the Pharmacy First scheme.

Greasborough: Substance misuse

The previous PNA highlighted that Greasborough may benefit from the provision of a needle exchange service. The pharmacy in Greasborough does not currently offer this service.

Of the 16 Community Pharmacies offering needle exchange in Rotherham 3 of them are within 1.5 miles (2.4km) of Greasborough.

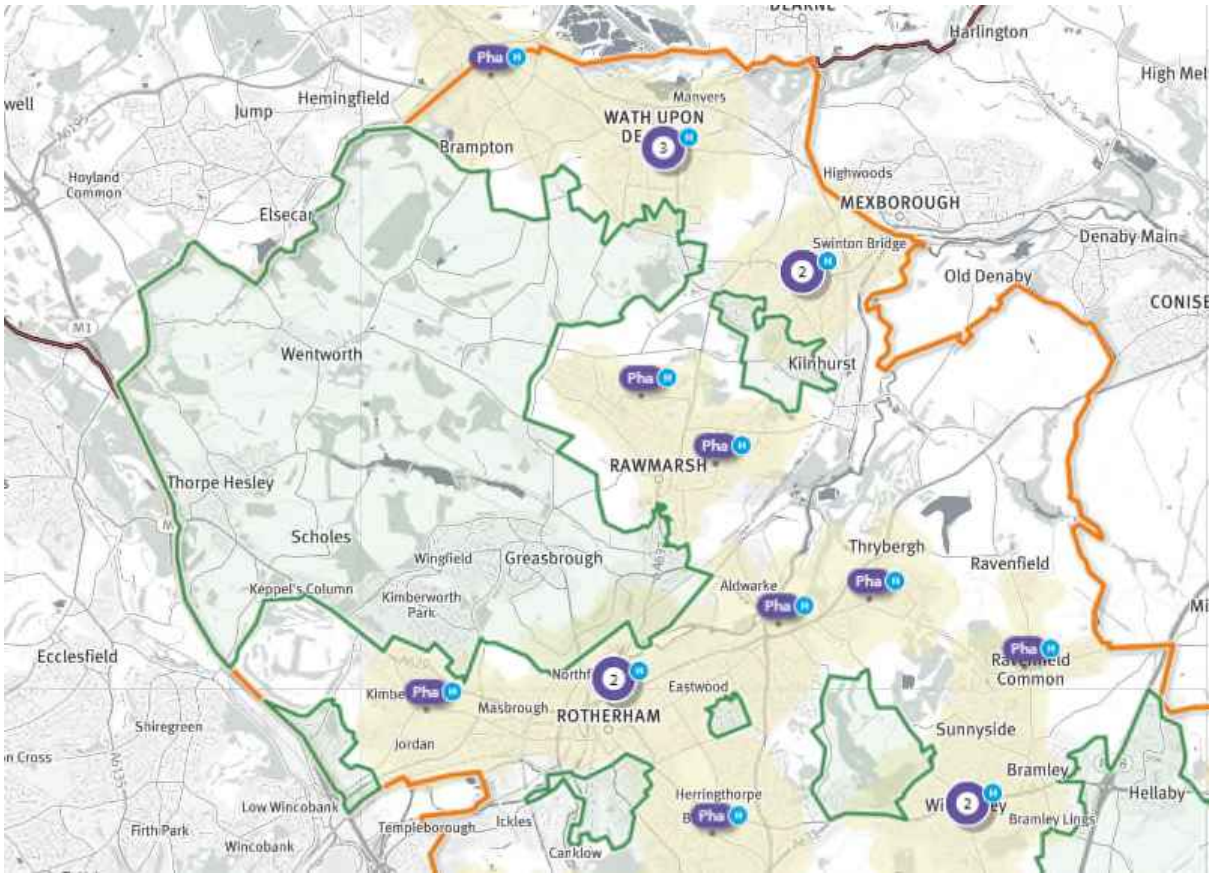
EHC: Various locations

The previous PNA reported poor access to EHC in Canklow, Thorpe Hesley, Brampton and Kilnhurst, through East Rawmarsh to Parkgate.

Figure 13 shows current access to EHC based on a 1.6km walk. This shows continuing gaps in Thorpe Hesley, Canklow and Kilnhurst but improved access in Brampton, Rawmarsh and Parkgate.

Sexual Health Services for Rotherham will move to a new provider from 1 April 2018. The new provider will be responsible for ensuring sexual health services are carried out in primary care settings, including pharmacies.

Figure 13: Access to EHC: Northern and Central Rotherham



9.5 Future health needs

The key population changes anticipated in Rotherham are the aging population. The growth in the number of over 85s will be associated with an increase in people with dementia and other conditions.

In addition, the local plan for Rotherham will begin to shape the spatial pattern in Rotherham with new communities emerging at Waverley and at Bassingthorpe Farm.

These two drivers of future need should be kept in mind when considering applications for market entry and when commissioning services from providers of pharmaceutical services.

9.6 Community Pharmacy: Forward View

The Community Pharmacy Forward View sets out the sector's ambitions to radically enhance and expand the personalised care, support and wellbeing services that Community Pharmacies provide. The document outlines how pharmacy teams could integrate with other services to improve quality and access for patients, increase efficiency and produce better outcomes.

It focuses on three roles for the Community Pharmacies of the future:

- The facilitator of personalised care for people with LTC
- The trusted, convenient first port of call for episodic healthcare advice and treatment
- The neighbourhood health and wellbeing hub

As South Yorkshire develops its Sustainable Transformation plans it will be important to integrate the role of providers of pharmaceutical services into the primary care element of the Accountable Care System.

Appendix 1: Glossary

Community Pharmacy	Community pharmacies are situated in a variety of community locations such as high streets, community centres and in supermarkets. There are several different types and sizes of community pharmacies, ranging from the large chains to small individually owned pharmacies in small communities, in the suburbs and often in deprived areas or rural settings. The provide a range of services and over 1.6 million people visit a Community Pharmacy every week in England.
Dispensing Appliance Contractors	Dispensing appliance contractors (DACs) supply, on prescription, appliances including stoma and incontinence aids, dressings, bandages etc. They cannot supply medicines.
Dispensing GP	Dispensing doctors are general practitioners (GPs) who provide primary healthcare to UK rural patients many of whom live more than a mile from a Community Pharmacy. Dispensing doctors can dispense the medicines they prescribe for these patients.
Distance Selling Pharmacies	Distance Selling Pharmacies receive prescriptions from patients who choose to use their service and dispense the medicines to the patients via a courier or postal service. There are regulations that specific how Distance Selling Pharmacies must operate.
Equality Impact Assessment	A process to assess whether a policy, proposal or scheme would disadvantage groups or communities of people with protected characteristics.
Health and Wellbeing Board (HWBB)	Established and hosted by local authorities, health and wellbeing boards bring together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health. They have the responsibility of publishing the Pharmaceutical Needs Assessment.
Index of Multiple Deprivation	The Index of Multiple Deprivation provides comprehensive statistics on relative deprivation across several specific domains, e.g. health and crime across England.
JSNA	A Joint Strategic Needs Assessment looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, well-being and social care services within a local authority area.
Local Plan	A local plan sets out local planning policies and identifies how land is used, determining what will be built where
SHAPE: Strategic Health Asset Planning and Evaluation	SHAPE is a piece of software, managed by Public Health England and is used for mapping the locations of services and analysing how services are accessed by local populations.

Appendix 2: References

1. Pharmaceutical Needs Assessments: Information pack

https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

2. The NHS (Pharmaceutical and Local Pharmaceutical Services) regulations 2013

http://www.legislation.gov.uk/uksi/2013/349/contents/made

3. Office for National Statistics (ONS) Mid-year population estimate, 2016

https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest

4. Public Health Outcomes Framework

http://www.phoutcomes.info

5. Rotherham Local Plan Core Strategy

http://www.rotherham.gov.uk/downloads/file/1571/adopted_rotherham_core_strategy

5a. Rotherham Local Plan: Sites and policies

http://www.rotherham.gov.uk/info/2000074/planning_and_regeneration/806/a_guide_to_the_sites_and_policies_document4

6. Rotherham Joint Strategic Needs Assessment

http://www.rotherham.gov.uk/jsna/

7. Active Lives Survey

http://www.sportengland.org

8. NHS Prescription Services, population estimates – Office for National Statistics, NHS Digital

http://digital.nhs.uk/pubs/genphasernov16

Appendix 3: Consultation Report

Introduction

As part of the PNA process there is a statutory provision that requires consultation of at least 60 days to take place to establish if the pharmaceutical providers and services supporting the population in the Health and Wellbeing Board area are accurately reflected in the final PNA document. This report outlines the considerations and responses to the consultation and describes the overall process of how the consultation was undertaken.

Consultation process

In order to complete this process those parties identified under Regulation 8 of the NHS (Pharmaceutical and Local Pharmaceutical Services regulations) 2013 , were consulted to establish if the draft PNA addresses issues that they considered relevant to the provision of pharmaceutical services.

Examples of statutory consulted parties included:

- Rotherham LPC
- Rotherham LMC
- Neighbouring HWB areas such as Sheffield, Doncaster and Barnsley
- Those on the pharmaceutical lists

Each consultee was contacted via email explaining the purpose of the PNA and that as a statutory consultee their opinion on whether they agreed with the content of the proposed draft would be welcome. A copy of the draft PNA was attached to each consultation email.

Also attached to the consultation email was a word document outlining a set of questions. The questions were derived to assess the current provision of pharmaceutical services, have regard to any specified future circumstance where the current position may materially change and identify any current and future gaps in pharmaceutical services.

The consultation ran from 15 December 2017 to 16 February 2018.

Results

The consultation received a total of 8 responses.

Summary of responses and considerations

Was the purpose and background of the draft PNA clearly explained?

Of the 5 respondents who answered this question all of them answered positive. There was one additional comment on the wording of one section. The wording on this section has been reviewed and amended.

The Health and Wellbeing Board was pleased to note the high positive response to this question.

Was the information in the draft PNA clear and understandable?

Of the 5 respondents who answered this question all of them answered positive. There were no additional comments.

The Health and Wellbeing Board was pleased to note the high positive response to this question.

Do you agree that the process that was followed was appropriate?

Of the 5 respondents who answered this question all of them answered positive. There were three additional comments highlighting minor issues in the text. The relevant sections have been reviewed and amended.

The Health and Wellbeing Board was pleased to note the high positive response to this question.

Do you feel that the draft PNA accurately describes pharmaceutical service provision in the borough?

Of the 6 respondents who answered this question 5 of them answered positive. The one negative response referred to discrepancies in the number of Community Pharmacies providing advanced services. The text of the PNA has been reviewed and amended to reflect this comment. Further work will be undertaken to reconcile the discrepancies in the information.

The Health and Wellbeing Board was pleased to note the high positive response to this question.

Do you feel the draft PNA accurately describes the pharmaceutical needs of the Rotherham population?

Of the 6 respondents who answered this question all of them answered positive. There were no additional comments.

The Health and Wellbeing Board was pleased to note the high positive response to this question.

Do you feel that there are any unidentified gaps in service provision?

Of the 6 respondents who answered this question all of them answered negative – indicating that there were no unidentified gaps in service provision.There were no additional comments.

The Health and Wellbeing Board was pleased to note the responses to this question.

Any other comments on the draft PNA

Four additional comments were received. These are detailed below alongside the responses.

Comment	Response
A comment noting the high quality and comprehensiveness of the PNA.	The Health and Wellbeing Board were pleased to note this comment.
A comment drawing attention to the overall health priorities being tobacco, substance misuse, alcohol, obesity, sexual health, mental health, dementia and flu and noted that the locally commissioned pharmacy services do not address obesity, sexual health and mental health	The local authority and CCG meet regularly with the Local Pharmaceutical Committee to explore how pharmacies can support health and wellbeing priorities.
A comment regarding the accuracy of information used in an example.	The information illustrated was drawn from the NHS Pharmaceutical list. A different example has been used and the information passed to NHS England.
A comment drawing attention to a typing mistake	Now corrected

Conclusions

The Health and Wellbeing Board would like to thank those who participated in the consultation process. The information provided was helpful and constructive. The consultation did not result in any major changes to the document or any of its determinations.

Appendix 4: Equality Impact Assessment

Under the Equality Act 2010 Protected characteristics are age, disability, gender, gender identity, race, religion or belief, sexuality, civil partnerships and marriage, pregnancy and maternity. Page 6 of guidance. Other areas to note see guidance appendix 1	
Name of policy, service or function. If a policy, list any associated policies:	Pharmaceutical Needs Assessment 2018-2021
Name of service and Directorate	Public Health
Lead manager	Jo Abbott, Assistant Director of Public Health
Date of Equality Analysis (EA)	16/10/17
Names of those involved in the EA (Should include at least two other people)	Stephen Turnbull, Specialty Registrar Sally Jenks, Public Health Specialist
Aim/Scope (who the Policy /Service affects and intended outcomes if known) See page 7 of guidance step 1 Local authorities have the responsibility for the production and maintenance of the PNA. A revised PNA is due to be published by 1 April 2018. PNAs are used to guide commissioning of health care and public health services by CCGs and local authorities and are used by NHS England to help determine market entry applications.	
What equality information is available? Include any engagement undertaken and identify any information gaps you are aware of. What monitoring arrangements have you made to monitor the impact of the policy or service on communities/groups according to their protected characteristics? See page 7 of guidance step 2 Information used to inform the PNA has been sourced from - The JSNA - NHS pharmaceutical list	

- CCG
- Public Health
- Census and other national datasets

Any substantial changes to pharmacy provision have to be considered and supplementary statements issued

Engagement undertaken with customers. (date and group(s) consulted and key findings) See page 7 of guidance step 3	The PNA is subject to a statutory 60 day consultation with a defined list of stakeholders. • Healthwatch • Health and Wellbeing Board • VAR • LPC • LMC • RFT • RDaSH • Rotherham CCG • NHS England • Neighbouring HWB • All pharmacy providers on the NHS pharmaceutical list
Engagement undertaken with staff about the implications on service users (date and group(s)consulted and key findings) See page 7 of guidance step 3	None to date. The PNA and findings will be widely circulated.

The Analysis

How do you think the Policy/Service meets the needs of different communities and groups? Protected characteristics of age, disability, gender, gender identity, race, religion or belief, sexuality, Civil Partnerships and Marriage, Pregnancy and Maternity. Rotherham also includes Carers as a specific group. Other areas to note are Financial Inclusion, Fuel Poverty, and other social economic factors. This list is not exhaustive - see guidance appendix 1 **and** page 8 of guidance step 4

The PNA is an assessment of whether current pharmaceutical services meet the current and future needs of the Rotherham population. The analysis specifically assesses access to pharmaceutical services and to locally commissioned services, such as Emergency Hormonal Contraception and substance misuse services. The analysis within the PNA

found no service gaps, either in the provision of universal services or to specific services that may be of more relevance to different communities and groups.

Analysis of the actual or likely effect of the Policy or Service:

See page 8 of guidance step 4 and 5

Does your Policy/Service present any problems or barriers to communities or Group? Identify by protected characteristics **Does the Service/Policy provide any improvements/remove barriers?** Identify by protected characteristics

The PNA does not directly change the provision of services but commissioners of pharmaceutical services do need to take the findings into account in their future commissioning intentions. Commissioners include the local authority, the CCG and NHS England. As such, the PNA is an important document that would help remove barriers to accessing pharmaceutical services.

What affect will the Policy/Service have on community relations? Identify by protected characteristics

The PNA is publicly available although its main use is as a technical document to be used by the commissioners of pharmaceutical services.