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

Date:- **Thursday, 15 June 2017** **Venue:-** **Town Hall, Moorgate Street, Rotherham S60 2TH**

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

HEALTH SELECT COMMISSION AGENDA

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

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

3. Apologies for Absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Communications

7. Minutes of the Previous Meeting held on 13th April, 2017 (Pages 1 - 8)

For Discussion

8. Evaluation of the Integrated Locality Pilot (Pages 9 - 32)
   Dominic Blaydon, Associate Director of Transformation, TRFT, to present

9. Director of Public Health Annual Report 2015-16 (Pages 33 - 119)
   Terri Roche, Director of Public Health, to present

10. HSC Work Programme 2017-18 (Pages 120 - 127)
    Janet Spurling, Scrutiny Adviser, to present

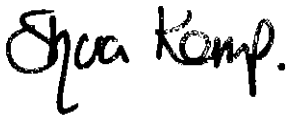
For Information

11. Joint Health Overview and Scrutiny Committee for the Commissioners Working Together Programme

12. Healthwatch Rotherham - Issues

13. Health and Wellbeing Board (Pages 128 - 141)
Minutes of meeting held on 8th March, 2017

14. Date of Next Meeting
Thursday, 20th July at 9.30 a.m.



SHARON KEMP,
Chief Executive.

Membership:

Chairman:- Councillor Evans
Vice-Chairman:- Councillor Short
The Mayor (Councillor Rose Keenan), Councillors Allcock, Andrews, Bird, R. Elliott, Ellis, Ireland, Jarvis, Marriott, Rushforth, Tweed, Whysall, Williams and Wilson.

Co-opted Members:
Vicky Farnsworth and Robert Parkin (Rotherham Speak Up) and Peter Scholey.

HEALTH SELECT COMMISSION
13th April, 2017

Present:- Councillor Sansome (in the Chair); Councillors Bird, Albiston, Andrews, Cusworth, Elliot, Elliott, Ellis, Fenwick-Green, Marriott, John Turner, Williams, Wilson and Short.

Also in attendance:- Councillor Simpson.

Apologies for absence were received from Councillors Brookes, Ireland and Marles.

88. DECLARATIONS OF INTEREST

Councillor J. Elliot declared a personal interest in Minute No. 92 below (RDaSH Quality Account), because of her role as a public member of the RDaSH NHS Foundation Trust. Having declared her personal interest, Councillor J. Elliot spoke in respect of that item and voted.

89. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

90. COMMUNICATIONS

Members were reminded of the discussions about the Health Select Commission's work plan for the 2017/18 Municipal year, which would commence at the rising of this meeting.

91. MINUTES OF THE PREVIOUS MEETINGS HELD ON 2ND MARCH, 2017

Consideration was given to the minutes of the previous meetings of the Health Select Commission held on 2nd March, 2017. Members noted that:-

(a) (Minute No. 81) Adult Care – Local Measures Performance Report – 2016/17 Quarter 3 – the demonstration of Liquidlogic and the cohort data dashboard, to Members of this Select Commission, was scheduled to take place on Thursday, 8th June, 2017; and

(b) (Minute No. 82) Response to Scrutiny Review – Child and Adolescent Mental Health Services (CAMHS) - performance data has been requested from RDaSH CAMHS and will be distributed to Members of this Select Commission in due course.

Resolved:- That the minutes of the previous meeting, held on 2nd March, 2017, be approved as a correct record.

92. RDASH QUALITY ACCOUNT

Consideration was given to a briefing paper submitted by the Scrutiny Officer concerning the "Quality Dashboard" of the Rotherham Doncaster and South Humber (RDaSH) NHS Foundation Trust. The report stated that reconfiguration had involved the creation of place-based care groups across the Trust. Services in the Rotherham Care Group were:-

- Adult and Older People's Mental Health Services;
- Learning Disability Services;
- Drug and Alcohol Services.

Members were informed that, each year in June, all NHS Trusts were required to publish a Quality Account as part of their annual report and accounts. These Quality Accounts are written to a given overall format with mandatory information, including performance on targets. The Quality Account includes progress on the quality priorities and actions agreed in the previous year and an outline of the priorities for the coming year.

Members received a presentation from Dianne Graham (Care Group Director, RDaSH) and Gavin Portier (Head of Quality, RDasH) about the Rotherham Quality Dashboard (a document containing information about health services' performance). The presentation highlighted the following matters:-

- The Care Quality Commission Well-Led Inspection and "What Next" including (the connection between management and staff);

- Since 2015, the Rotherham Doncaster and South Humber (RDaSH) NHS Foundation Trust has moved from a "requires improvement" rating to a "good" rating, as a consequence of Care Quality Commission assessments;

- Launch of the Sustainable Improvement Plan for the Trust – the objective of "outstanding status" after Care Quality Commission assessment;

- Patient Care Experience – emphasis on improvement of communication with patients; especially improving the provision of information to patients prior to them receiving health care and treatment;

- The emphasis which the Care Quality Commission has placed upon improvements to the Pharmacy Service;

- Progress with the Medication Management Initiative;

- Specific actions required in respect of the "Sign Up to Safety" campaign, to reduce avoidable pressure ulcers;

- Quality Improvement Strategy (including addressing specific matters raised by patients using the Child and Adolescent Mental Health Services);

- The Rotherham Vocational Service worked with the Inpatient Occupational Therapists at Swallownest Court, to consider providing a therapeutic space for community patients to engage in 'job skills' prior to returning to work;

- The three Quality priorities for 2016/17, to be in accordance with national priorities : (i) Mental Health Five Year Forward View; (ii) People with learning disabilities; (iii) Future In Mind.

Members of the Health Select Commission raised the following salient issues:-

- Time frames for implementation of the quality improvement proposals (and the emphasis upon continuous improvement);

- RDaSH new ways of reporting; the use of comparative material from previous years;

- Use of locality-based management structures;

- Use of "happy or not" consoles and the limitations of the computer licensing; the implications for customer feedback (eg: "your opinion counts" and score cards); collation and analysis of all customer feedback information;

- Reviews of cases of suicide; ensuring that services are able to learn from all cases of suicide; the community awareness work (eg: in relation to loneliness and isolation); campaign targeting men; review of patients' discharge from hospital who may pose a risk of suicide, including seven day follow up;

- Access to community based services and the development of a single point of access for patients with mental health issues and other vulnerabilities;

- Safeguarding of adults and children – importance of training for staff at all levels; effective processes and recording of training undertaken and staff competences;

- Triggers in respect of the "duty of candour;"

- Reporting of medicine-related errors; the use of the "ten-point checklist" in order to assess whether an error could have been avoided; presence of "speak-up guardians" enabling staff to discuss issues of concern;

- Cases where patient restraint has to be undertaken; training and refresher training for staff in the use of restraint procedures; information provided to families in cases where a patient has had to be restrained; suggestion made to review cases of restraint by an independent person;

- Concerns regarding reference in the dashboard to access to training for staff in dealing with domestic abuse/violence issues;

- Analysis of complaints and whether outcomes lead to service improvement;

- Development of an Autism Strategy for Rotherham;

- Work with the Care Co-ordination Centre to integrate mental health and learning disability:

Members asked to be provided with copies of the RDaSH complaints procedure.

The Select Commission thanked the representatives of RDaSH for the informative presentation.

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

(2) That this Select Commission suggests that RDaSH, in association with its partner agencies, should provide domestic abuse training for staff.

(Councillor J. Elliot declared a personal interest in the above item because of her role as a public member of the RDaSH NHS Foundation Trust. Having declared her personal interest, Councillor J. Elliot spoke in respect of this item and voted.)

Following the meeting additional information was requested and obtained with regard to the issue of access to domestic abuse training:

Domestic violence and abuse training is incorporated in the Local Safeguarding Children Board (LSCB)Toxic Trio training, which is ongoing and delivered by RDaSH and RMBC.

There is also domestic abuse training run by Adult Services, through a training pool who are delivering their own domestic abuse training, which also covers the DASH (Domestic Abuse, Stalking and Honour Based Violence) risk assessment tool and MARAC (Multi Agency Risk Assessment Conference).

The LSCB is currently in negotiation with the Domestic Abuse Co-ordinator to provide some extra sessions later in the year around teenage relationship abuse and other associated issues which are not covered in great depth at present due to time constraints on the workshops.

There is a DA e-learning module available to all staff and partners on the RMBC Directions website as well.

It was confirmed that the reference to training being suspended related to a period when the Council's previous Domestic Abuse Co-ordinator had left the Authority and there had been a gap before the new Co-ordinator was appointed, which had had an impact on overall training capacity.

93. WHOLE SCHOOL APPROACH TO PREVENTION AND EARLY INTERVENTION

Further to Minute No. 70 of the meeting of the Health Select Commission held on 19th January, 2017, consideration was given to a report of the Scrutiny Officer concerning the recommendation of the scrutiny review of the Child and Adolescent Mental Health Services that in its leadership role with schools, the Borough Council should ensure schools link in with partner agencies to discharge their wider duties and responsibilities towards children and young people's emotional wellbeing and mental health.

Individual Members reported on their visits to specific schools (eg: progress at the Maltby Academy and at Wales High School). The Select Commission requested information about the progress at a wide range of schools and it was agreed that such information would be included within a further progress report to be submitted to a meeting of this Select Commission during September, 2017.

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

(2) That the progress by schools piloting a whole-school approach to promoting mental health and wellbeing, as now reported, be noted.

94. IMPROVING LIVES SELECT COMMISSION UPDATE

Councillor V. Cusworth provided an update in respect of issues considered at the Improving Lives Select Commission meetings:-

- Overview of the Provision and Services for Children and Young People with Special Educational Needs and Disability (SEND) in Rotherham;
- SEND Information Advice and Support Service (SENDIASS) Annual Report April 2015/ March 2016.
- Rotherham Children and Young People's Plan 2016 to 2019;
- Children's and Young People's Services Performance Report - January 2016/17;
- Looked After Children – health outcomes;
- Early Help and Family Engagement Monthly Performance Report, as at Month End: January 2017.

Councillor Cusworth was thanked for providing her report.

95. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR THE COMMISSIONERS WORKING TOGETHER PROGRAMME

The Health Select Commission received an update report from the Scrutiny Officer concerning the Joint Health Overview and Scrutiny Committee (JHOSC) for the Commissioners Working Together Programme. The issues highlighted from the recent meeting were:-

- Recap of the cases for change by clinicians – an anaesthetist and a stroke consultant and a run-through the consultation findings report.

- Three members of the public representing local campaigning groups in Barnsley, Doncaster and Sheffield all made a short presentation, raising some concerns but also making links more widely into Sustainability and Transformation Plans (STPs) and future scrutiny of these.

- Discussion of submissions from hospitals and the issues they had raised which will also feed into the business case and be responded to, including hospitals' potential loss of income from changes to services. Reiteration that both proposals are not about saving money in the NHS and there may be a short term increase in costs for Hyper Acute Stroke services.

Hyper Acute Stroke

- Investment in the ambulance services to meet increased demand for transfers – Joint Clinical Commissioning Groups will consider resources as part of the business case if the proposals go forward.

- The longer term intention to move stroke care in Sheffield from the Royal Hallamshire Hospital to the Northern General Hospital (Sheffield), which the majority of people at the meeting had not been aware of in advance of the submission from the Sheffield Teaching Hospitals NHS Foundation Trust

- The increased volume of stroke patients cared for at Rotherham Hospital was noted and the improved performance by the Trust on stroke care was welcomed. With regard to the *Sentinel Stroke National Audit Programme* (*SSNAP*) indicators, this mainly related to the acute phase rather than the hyper-acute phase.

- Rotherham was still not providing a seven days' service, only Sheffield and Doncaster were. Two consultants are unable to cover a full seven days' service, so there is the issue of workforce resilience and needing to future-proof.

- Recruitment and need for a regional workforce strategy – possibly some future joint appointments across hospitals and a meeting is due between NHS England and Health Education England about the medical and wider workforce across senior and junior staff.

- For each additional patient having thrombolysis it has been calculated that this leads to a saving of £11,000 across Health and Social Care services, as well as a better outcome for the individual.

Children's Surgery and Anaesthesia

- 18-24 months' work to develop the options through a series of workshops;

- Reiterated that this would affect small numbers of patients; therefore, only a small number of ambulance transfers and if the care pathway was correct, patients would be taken directly to the correct hospital;

- Issues about staff undertaking procedures through the day but not then doing them in the evenings or at weekends (in relation to anaesthetists) – good attendance by anaesthetists at events and key criteria was firstly the age of child (under or over 3 years), then complexity and type of surgery required.

- Template being developed to ensure all hospitals met the required standards for care on the relevant tiers of paediatric care.

Consultation

- High volume of web hits and use of social media not then converted into formal responses.

- The telephone survey response was less negative than the people who had self-selected to respond.

- Introduction of the telephone survey in the consultation process, following the mid-point review was undertaken by an independent company who undertook the sampling.

- Public meetings and meetings with community groups raised the same themes as the surveys/telephone survey for both proposals.

- The on-line poll was suggested by the Consultation Institute at mid-point review and questions were checked with a market research agency (in response to some concerns that they were leading questions).

- For future consultations it was suggested to avoid the Christmas period and to keep the JHOSC fully informed about any changes to the consultation process, once it has begun.

- The Joint Committee of Clinical Commissioning Groups will have a meeting on 24th May 2017 (in public with web-casting) to make the final decision regarding the proposals and the consultation report will be one of the pieces of work that inform the business case and the final decision on future service reconfiguration.

- A number of JHOSC members wished to see the business case in advance of that meeting, but this will not happen other than being able to access the papers the week before the meeting, on publication. There will be another meeting of the JHOSC in June or July 2017, which will be an opportunity to discuss the final decision and to discuss future scrutiny following any changes.

During discussion, Members of the Health Select Commission expressed concern about the apparent intention to move hyper acute stroke care from the Rotherham Hospital to Sheffield and Doncaster. Members asked to be informed of further details of this proposal, as well as information about the thrombectomy procedure.

Resolved:- That the information be noted.

96. HEALTHWATCH ROTHERHAM - ISSUES

The representative of Healthwatch Rotherham, Mr. Tony Clabby, reported that the following documents are available to view on the Healthwatch Rotherham Internet web site:-

- guide to mental health and wellbeing services in Rotherham;

- Health and social care signposting directory.

97. HEALTH AND WELLBEING BOARD

The minutes of the meeting of the Health and Wellbeing Board held on 11th January, 2017, were noted. Reference was made to Minute No. 54 (Voice of the Child Lifestyle Survey 2016) which has been considered in detail by the Improving Lives Select Commission, at its meeting held on 1st February, 2017.

98. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 15th June, 2017, commencing at 9.30 a.m.

The Rotherham NHS
NHS Foundation Trust

BRIEFING PAPER FOR HEALTH SELECT COMMISSION

1.	**Date of meeting:**	**15th June 2017**
2.	**Title:**	**Evaluation of the Integrated Locality Pilot**
3.	**Directorate:**	**Strategy & Transformation, TRFT**
4.	**Authors:**	**Dominic Blaydon, Associate Director of Transformation** **Mel Simmonds, Strategy & Transformation Manager**

5. Introduction

5.1 Ambitions for the future of health and care in South Yorkshire and Bassetlaw have been published in the region's Sustainability and Transformation Plan (STP). This plan sets out the future vision for health and social care services across all partner organisations. The STP is underpinned by The Rotherham Place Plan, which provides a local perspective on how the Rotherham MBC, Rotherham CCG and The Rotherham Foundation Trust will work together in the future.

5.2 This document provides an evaluation of one of the exciting transformational initiatives that is already underway; The Health Village Integrated Locality Pilot. The Pilot is an illustration of the strong partnership arrangements that already exist and being strengthened in Rotherham, and provides insight into how local health and social care communities can improve the quality of care to vulnerable people.

6. Context

6.1 In line with the rest of the country, the most significant demographic change occurring in Rotherham is the growth in the number of older people. The number of older people (65+) is projected to rise by 8,800 (18%) between 2015 and 2025 and the number aged 85+ is projected to rise by 2,300 (40%) by 2025. This will mean an increase in the number of people with long term conditions such as heart disease, diabetes, dementia and cancer. As at 2014/15 there were almost 13,900 people in Rotherham with diabetes, and nearly 5,400 on GP stroke registers. By 2025 we project that there will be nearly 4,500 people in Rotherham living with dementia.[1]

6.2 The health of the Rotherham population is generally poorer than the English average. We have a growing population, but notably, we will see a significant increase in the 85+ population. This leads to growing pressures on our health services, social care, informal care, supported housing and other services. Life expectancy, although lower than average, has been increasing. However, the average time spent in ill-health has also been increasing as people are living longer in poor health, resulting in a growing number of people with high levels of need.

Our key challenges are described in the diagram below.

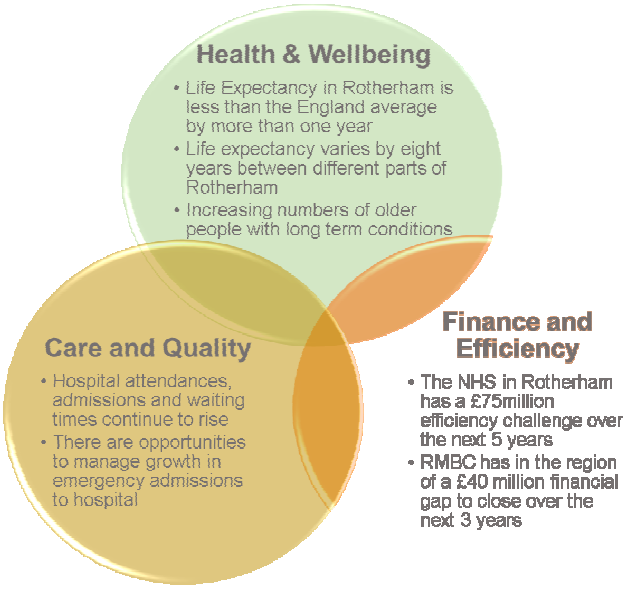


Figure 1. Rotherham's three gaps

The Health Village is one of the transformational initiatives developed to contribute to closing the gaps.

7. Background

7.1 In 2014, The Rotherham NHS Foundation Trust, with support from the local clinical commissioning group, began to undertake a significant piece of work on establishing seven community locality teams. In the first phase, the locality teams were centred around district nursing teams and GP practices, with the plan to develop into broader multidisciplinary teams responsible for local populations.

7.2 The first full multidisciplinary locality team was launched in summer 2016 as a pilot. The team consists of GPs, a community matron, district nurses, community therapists, social workers, a community physician, social prescribing brokers and community link workers. There is also dedicated mental health support. The team proactively manages the care of their locality population (approximately 35,000 people), providing care close to home and where possible helping to avoid hospital admission.

7.3 New technology solutions that have been developed mean that members of the locality team are able to see, for the first time, if and when a patient has attended A&E, been admitted to hospital, or been receiving care in an intermediate care setting. The locality team can also see whether these patients are on the current case load. The locality team has full visibility of patients from the care home sector enabling the delivery of appropriate support. The team can intervene and start to put plans in place to get patients home, or at least back to their local community where they can help them recover and avoid further hospital readmissions. Through the use of the NHS number as a unique identifier, the locality teams are able to share case load information across health and social care. They are able to allocate a lead case worker who is responsible for streamlining interventions, reducing duplication and making things far simpler for the patient.

8. The Approach

There are a number of key features that have developed during the pilot which define the delivery model and differentiate Rotherham from other areas that have adopted integrated ways of working.

8.1 Community Rehabilitation

Therapists lead on case-finding and developing tailored rehabilitation programmes. Social workers identify people on high-cost social care packages with potential, through community rehabilitation, to reduce the cost of or need for formal care, for example, where multiple carers are required. There are plans for reablement support workers to join the team and work with therapists, enabling them to optimise physical function and daily living. Reablement workers will support people through the therapeutic programmes. The aim of this approach is to drive down social care dependency and costs. Figure 2 provides an example of a case study from the community rehabilitation service.

On 30th May 2017 a letter was sent to the Integrated Locality Team, from a couple, thanking the therapists for the time and effort put in to enabling Mr John to get up and walk again, unaided. Mr John was referred in to the Integrated Team after deterioration following a Stroke. He had been isolated to one room in his house due to his inability to move. It required three people to stand Mr John at this point.

His deterioration resulted in him being placed in intermediate care, who referred him to the Community Occupational Therapist (COT) attached to the Integrated team, for a hoist to lift him.

A multi-disciplinary review took place to assess Mr John's needs and the case was to be managed by the Physiotherapy and Occupational therapists with input from the team social worker in relation to the care he would require. The team rehabilitated Mr John from December 2016 and as a result he is now able to function without aids and reports being so much happier. He is spending time in the garden and has three outings planned for the summer, including to London and Llandudno. The team has reduced Mr John's social isolation, enhanced his mental well-being and overall quality of life.

He is now able to attend medical appointments instead of requiring domiciliary visits, the risk of developing sores and District Nursing input has reduced dramatically and his social care package will be reviewed as a result.

Figure 2. Case Study describing the impact of the integrated model (patient name amended to retain anonymity)

8.2 *Community Development*

Our approach is significantly different to other care models. Rotherham has an award winning social prescribing service which supports GPs on the case management of people with long term conditions. We intend to extend the service so that it supports care planning within the localities. Also, the community link worker is responsible for engaging with the local population and developing the 3rd sector and local communities so that it has capacity and capability to support vulnerable adults. As part of this approach we are developing a bespoke carer service within integrated teams aimed at improving the resilience and mental health of local carers.

8.3 *Parity of Esteem*

The integrated team includes a mental health specialist, targeting people who are socially isolated, those with anxiety, depression or dementia and people who have recently experienced a significant life event. The capacity within primary care means this cohort is poorly served, despite evidence showing there is significant risk of spiralling into formal care services.

8.4 Case Management and Integrated Care Planning

The Integrated team works proactively with GPs to manage people who are considered at high risk of poor health or social circumstances, specifically targeting those with long term conditions. Multi-Disciplinary Team (MDT) meetings discuss patients who require integrated care and offer joint ward rounds with GPs for high risk residents within care homes. The MDTs develop integrated care plans for high risk residents or those approaching end of life. The locality teams operate a Virtual Ward for people who are at high risk of hospital admission, overseen by the Community Physician, ensuring that they are regularly reviewed and supported.

8.5 Impact of New Model

Our new approach delivers significant benefits to patients, creating an efficient and holistic offer with less duplication, improved patient experience and outcomes. The model does not only generate efficiencies within community services but also positively impacts upon the cost of acute and urgent care.

9. Challenges and Learning

9.1 The locality pilot has presented a number of challenges, which are being used to aid learning in preparation for the roll out across the Borough.

9.2 Organisational, legal or professional boundaries need to be broken down, to enable teams to operate as distinct units. This has been a key challenge. Workers still operate in professional or organisational silos within some integrated care models, which cannot afford to happen upon roll out. Breaking through this in the pilot has required strong leadership that is fully engaging to create a high-trust environment that empowers the team and develops a shared vision. The success of the roll out is highly dependent upon the will and determination of the teams on the ground, making early engagement imperative.

9.3 Our innovative skill mix model aims to address the challenges associated with the recruitment and retention of healthcare staff that is being experienced nationally. By pioneering the transformation of health and social care provision, TRFT is aspiring to differentiate itself, and hopes to attract the health and social care professionals needed to transform and sustain new ways of working.

9.4 Technology is a key enabler but presents challenges, especially in relation to information sharing. This challenge is amplified once other organisations become involved. Significant work is underway to resolve the complex challenges of information governance in preparation for the roll out as well as seeking practical solutions to integrated record keeping.

9.5 Contextual barriers include:

- Adult social care funding pressures
- The potential impact of Brexit upon the workforce
- The abolishment of NHS Bursaries

9.6 There are potential unintended consequences that may occur as part of the roll out process which may include a lack of clarity over who is accountable for statutory health and social care services. There is concern amongst partners that an integrated model could focus on delivering outcomes for specific parts of the health and social care system. For example, the focus on supporting discharge from hospital could place additional burden on primary and social care. Project sponsors are aware of such issues and committed to an outcome framework which supports the strategic objectives and financial viability of all partners.

10. Impact Assessment

10.1 The outcome measures for the pilot are reductions in;

- Hospital Length of Stay
- Non-elective Admissions
- Cost of social care packages

10.2 The pilot's performance indicates early impact. Metrics for the pilot were agreed with partners at commencement of the project, which measure against historical and aggregated data from comparator localities.

10.3 Length of Stay

The working protocols to address hospital length of stay have not yet been fully implemented and therefore baseline data is being captured to measure impact once implemented.

10.4 Unscheduled Hospital Admissions

Whilst the Borough as a whole has seen an increase in unscheduled hospital admissions the Health Village integrated locality pilot has seen a smaller increase. Since the introduction of the Pilot, the Health Village locality has seen a much steeper declining trend in the number of non-elective hospital admissions for its practice populations in comparison to the previous year.

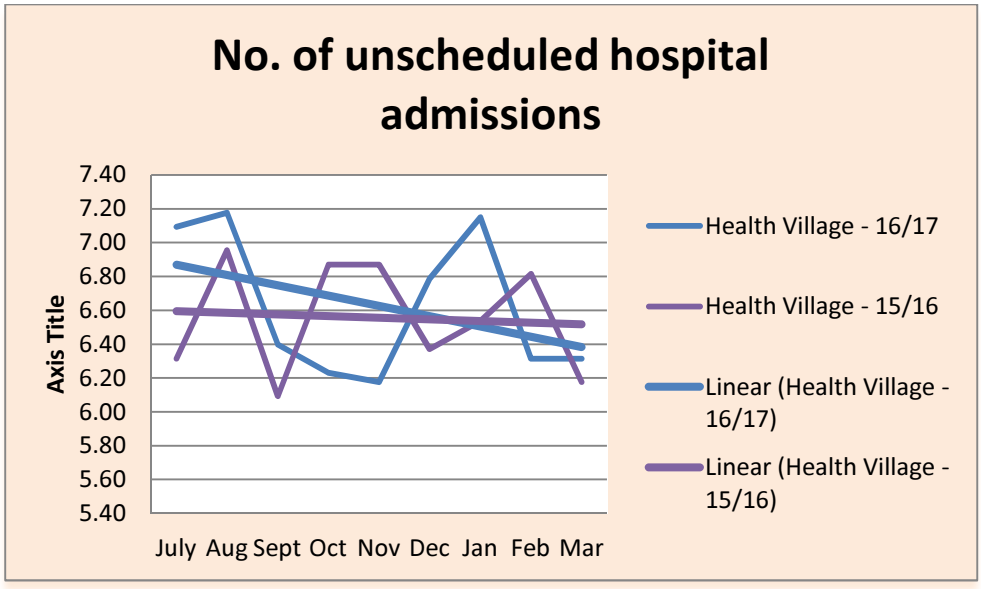


Figure 3: Number of unscheduled hospital admissions for the Health Village: comparing 2015/16 to 2016/17

10.5 Unscheduled Hospital Admissions for Care Home Residents

The Pilot area is engaging proactively with Care Homes to prevent unnecessary admissions, which has resulted in the pilot area having a 35% reduction in comparison to the same period in 2015/16. The Borough has a reduction of 18% overall when comparing the same periods.

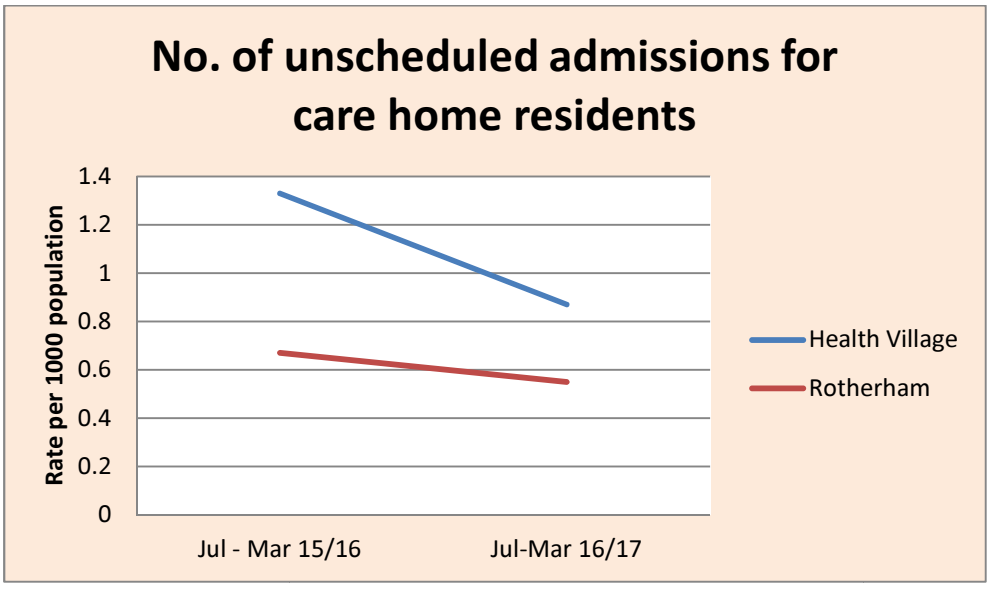


Figure 4. Number of unscheduled hospital admissions for Care Home residents comparing the Health Village Pilot locality to the Borough wide performance.

In 2015/16 the Health Village locality saw a rising trend for Care Home Resident admissions, yet the trend has been bucked since the introduction of the pilot.

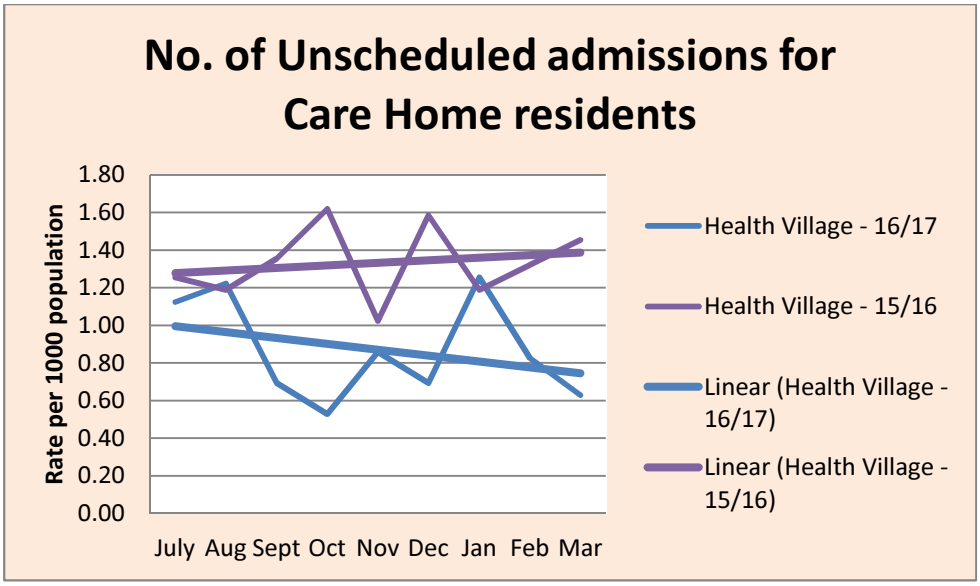


Figure 5. Number of unscheduled hospital admissions for Care Home Residents comparing the Health Village performance since the commencement of the pilot with the same period during the previous year.

10.6 *Unscheduled Admissions to the Acute Medical Assessment Unit (MAU)*
When comparing July to March 2015/16 to July to March 2016/17, the Health Village pilot locality outperformed the Borough 5% in the reduction of unscheduled admissions to the acute MAU.

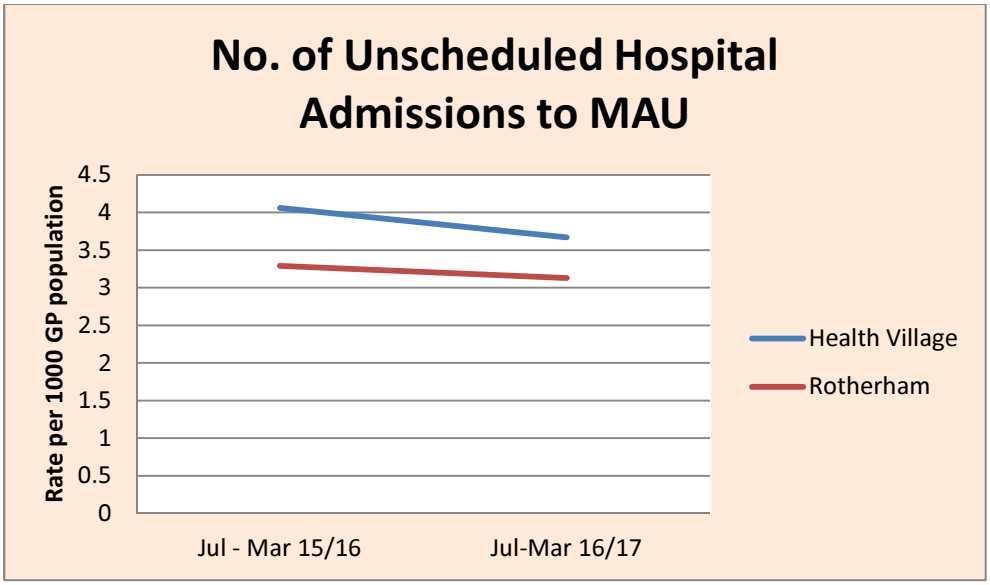


Figure 6. Number of unscheduled admissions to the Medical Assessment Unit, comparing the period before the pilot and the impact since implementation.

Additionally, since implementation of the integrated team the upward trend in admissions to MAU has ceased and, instead, has begun to decline.

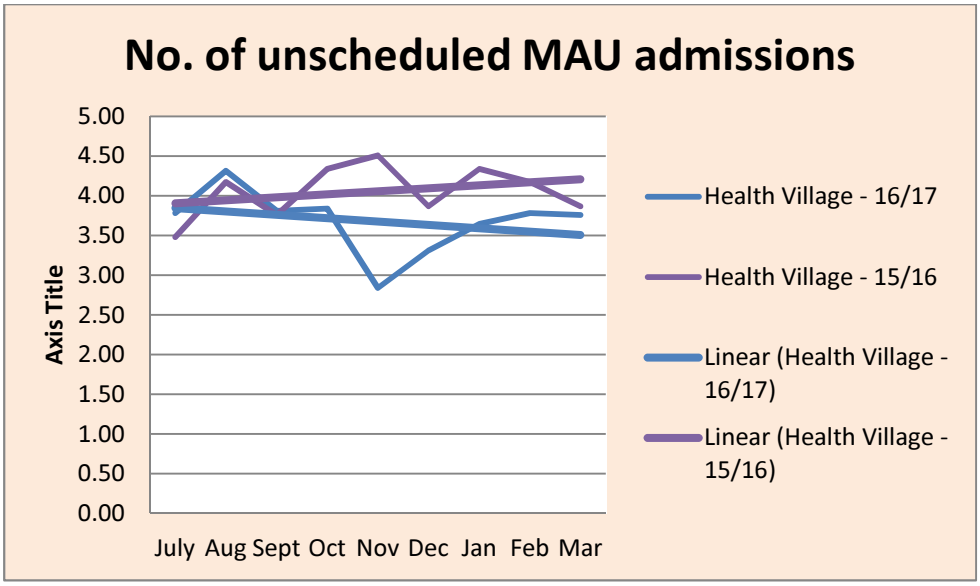


Figure 7. Number of unscheduled admissions to the MAU for the Health Village locality pre- and post- pilot implementation.

10.7 Cost of Social Care Packages

The element of social care resource within the locality pilot is fairly small meaning that it is difficult to accurately compare performance and impact against established ways of working. Consequently, the social care metrics to measure activity are currently under development. Impact is currently being captured using qualitative mechanisms (see figure 2 as an example). More accurate measures will be in place as the scale and volume of the team ramps up in line with wider ambitions for adult care transformation. .

11. Next Steps

11.1 A bid has been submitted to the Health Foundation 'Scaling up for Improvement' funding stream which, if successful, will fund the project management of the roll out and an external evaluation that will coincide with the implementation and conclude with a Lessons Learned Conference 6 months after. Successful applicants will be notified by 30th October 2017 following a stringent selection process.

11.2 Scoping and engagement work has begun in preparation for the model to be rolled out across the Borough. In addition, delivery templates and working protocols are being formulated to assist with adoption in other localities.

11.3 The roll out will be managed utilizing a project plan which includes the following headline milestones;

- Governance and Contracting November 2017-2020
- A contracting model will be designed and agreed with partners by March 2018.
- Scoping and Design November 2017 – March 2018
- Focus will be on developing a shared vision and service, co-produced with patients, carers and stakeholders with a supporting communication and engagement plan.

- Phased Implementation April 2018 – 2020
- Roll out of the project will be phased by locality: south, north and finally, the most complex and largest locality, central. This will manage risk and enable lessons learned to be acted on.
- Evaluation Conclusion & Conference October 2020

12. Enablers

12.1 There are a number of key enablers that will be critical to the success of the roll out. This includes;

- Robust Project Governance and Leadership
- Workforce planning
- Estates
- IT and Information Governance
- Ongoing evaluation

13. Recommendations to HSC

That the Health Select Commission receives and notes the report.

14 Name and contact details

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Health Select Commission

Evaluation of the Integrated Locality Pilot

Dominic Blaydon Associate Director – Transformation

Purpose of Paper

- Context and background of The Integrated Locality Pilot
- Share the Challenges and Learning
- Explore the impact to date
- Provide an overview of the planned roll out

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Key Challenges

- Funding challenges in health and social care
- Increase in older population
- Difference between actual and healthy life expectancy
- Development of new care models
- Early intervention and prevention
- Self management
- Public expectation
- Fragmentation of services
- Strengthening leadership at all levels

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NHS Foundation Trust

Key Elements of New Service Model

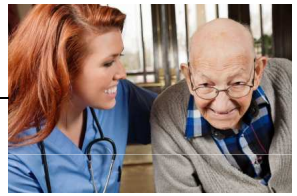
- Multi-disciplinary Team
- Breaks down professional and organisational boundaries
- Team supports GP practice populations
- Designated care homes
- New technology supports interface between locality and acute care
- All workers are co-located
- New leadership model evolving
- Operates a Virtual Ward
- Referral management service

Team Composition

• Community Nurses	Rotherham FT
• Physiotherapists	Rotherham FT
• Occupational Therapists	Rotherham FT
• Social Workers	Rotherham MBC
• Mental Health Workers	RDASH
• Social Prescribing	VAR
• Community Link Workers	Rotherham MBC

A New Approach

- Community Reablement
- Management of Long Term Conditions
- Community Nursing
- Parity of Esteem
- Assessment and Care Management
- Community Development



Outcomes

- Reduction in unscheduled hospital admissions
- Reduction in admissions to hospital for assessment
- Non-elective bed days
- Average length of stay in hospital

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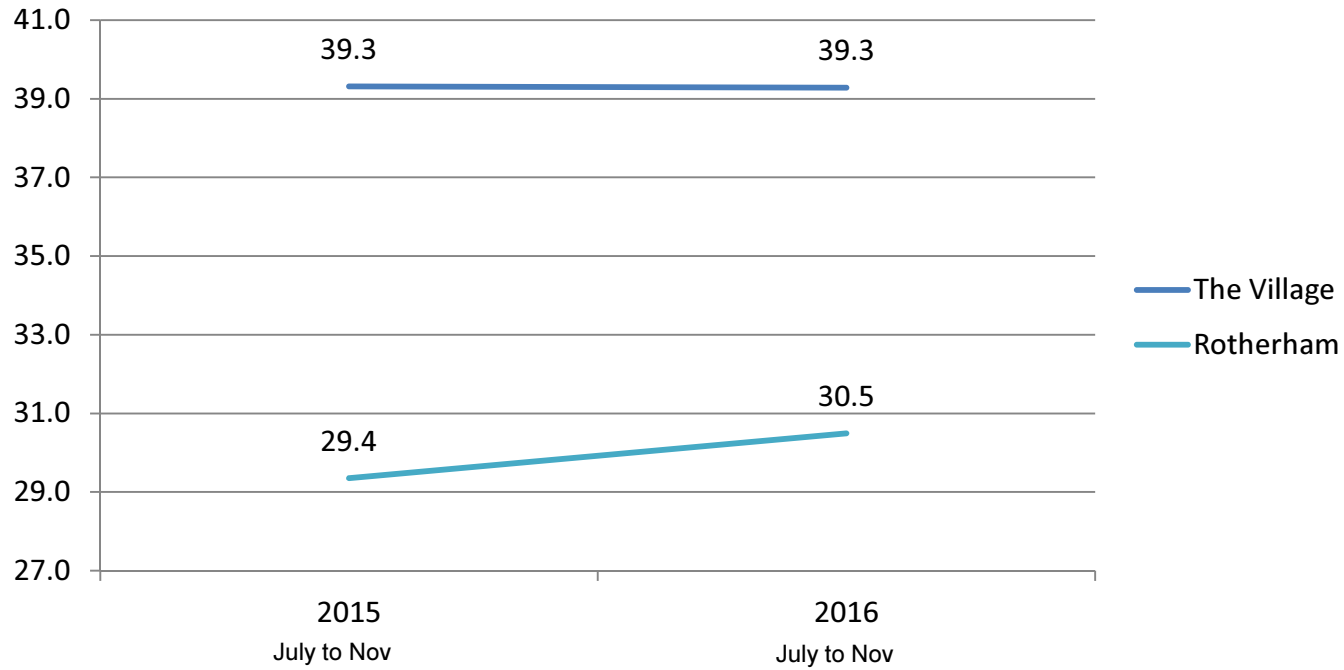
Unscheduled Admissions (Per 1000 Population)



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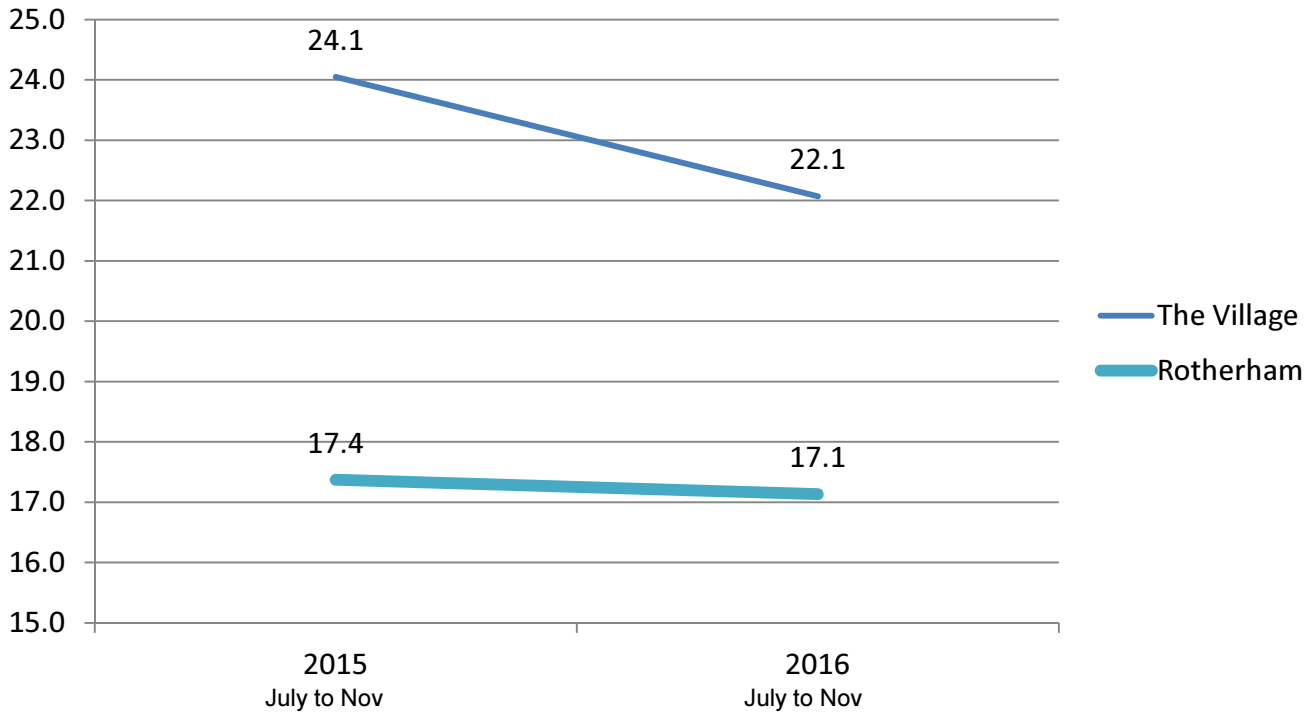
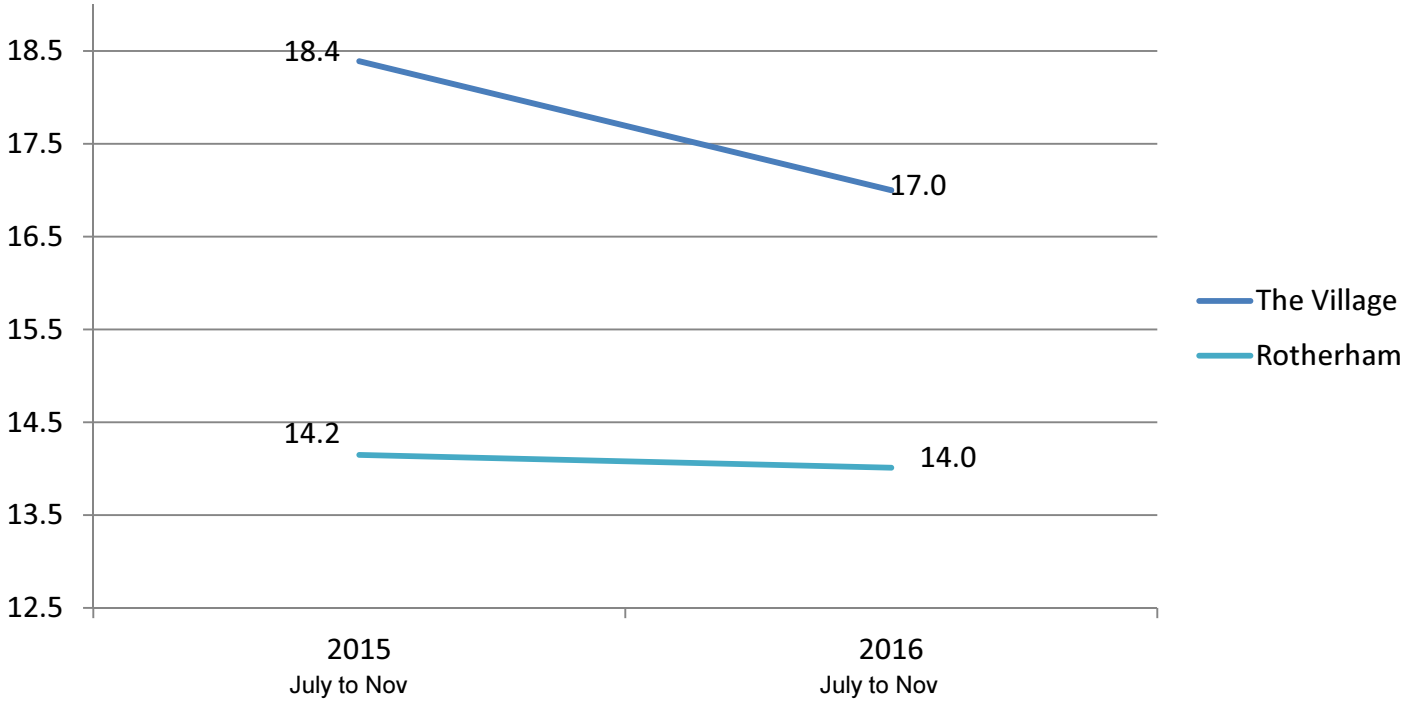
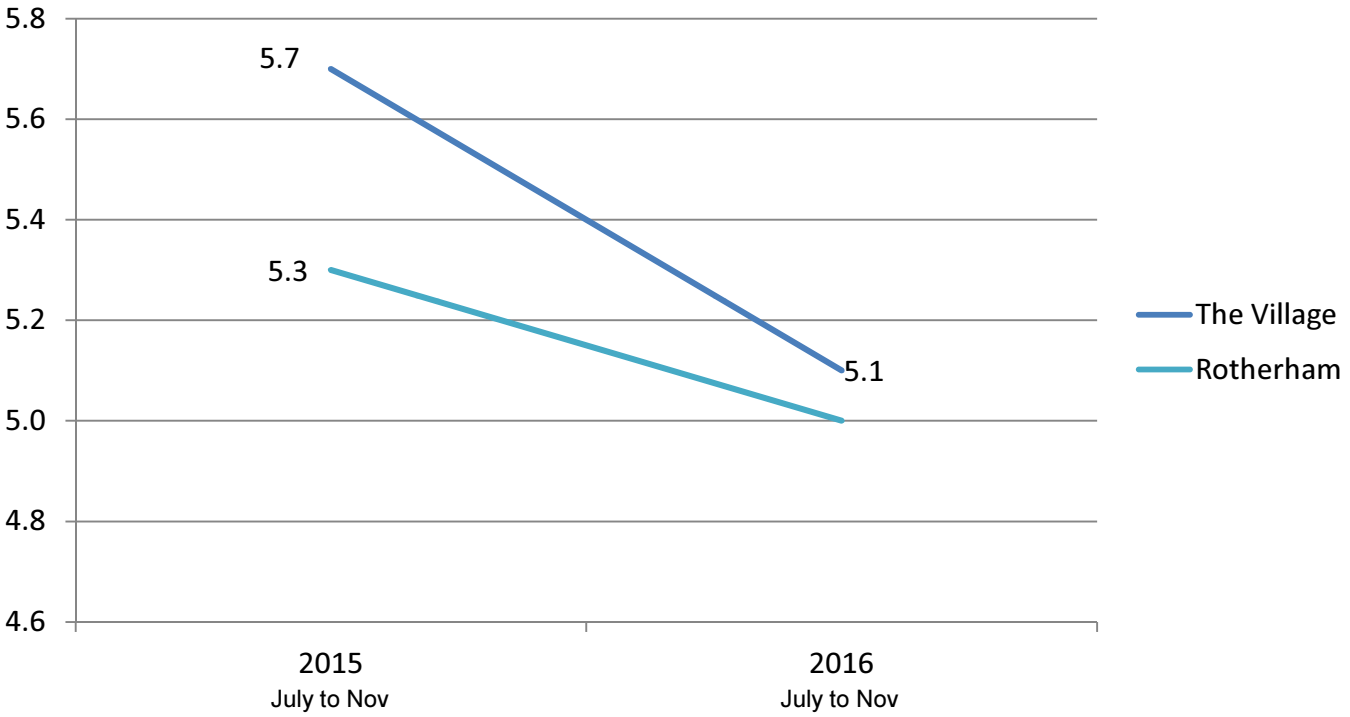
Unscheduled AMU Admissions (Per 1000 Population)



Non-Elective Bed days (Per 100 Population)



Average Length of Stay in an Acute Bed (Days)



Overall Performance Ranking

		Central North		The Village		Central 2		Maltby / Wick	
Positions	Weighted Score	Position Freq	Weighted Score	Position Freq	Weighted Score	Position Freq	Weighted Score	Position Freq	Weighted Score
1st	6	1	6	2	12		0	1	6
2nd	5	2	10	2	10		0		0
3rd	4		0	1	4	1	4	2	8
4th	3		0	1	3	1	3	2	6
5th	2	2	4		0	2	4	1	2
6th	1	1	1		0	2	2		0
Overall Score		21		29		13		22	

Roll out

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Timeframe	Headline Milestones
Nov 17 – Mar 18	Scoping and Design
March 2018	A contracting model will be designed and agreed
April 18 – 2020	Phased Implementation
October 2020	Evaluation Conclusion & Conference

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Any questions?

BRIEFING PAPER FOR HEALTH SELECT COMMISSION

1.	**Date of meeting:**	**15th June 2017**
2.	**Title:**	**Director of Public Health Annual Report 2015/16**
3.	**Directorate:**	**Public Health Directorate, RMBC**

4. Introduction

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

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

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

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

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

5. Key Issues

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

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

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

6. Key actions and relevant timelines

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

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

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

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

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

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

Encouraging social inclusion

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

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

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

7. Recommendations to HSC

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

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

8. Name and contact details

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Healthy Ageing

living well and living longer

Director of Public Health
Annual Report 2016

Contents

Foreword and Introduction from the Director of Public Health

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

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

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

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

Introduction

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

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

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

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

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

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

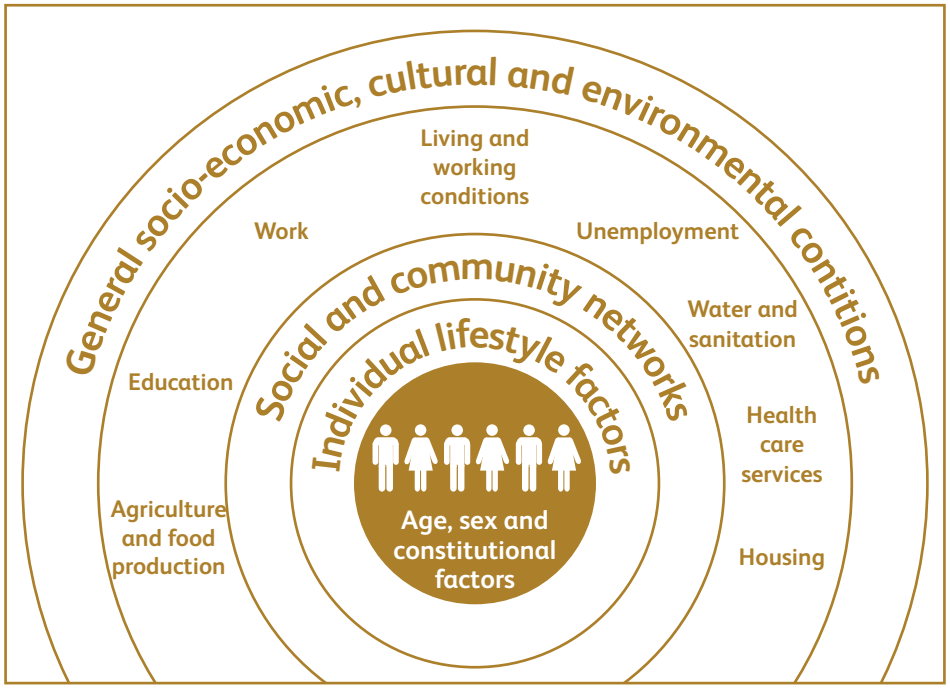
recommendations were made prompting a partnership approach to tackle existing health inequalities and to improve health outcomes for children and young people in Rotherham. These recommendations were incorporated into an action plan summarising 'what we'd like to see' actions (see the appendix of this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

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

Executive summary

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

Fig. 1: Wider Determinants of Health



Source[7]

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

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

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

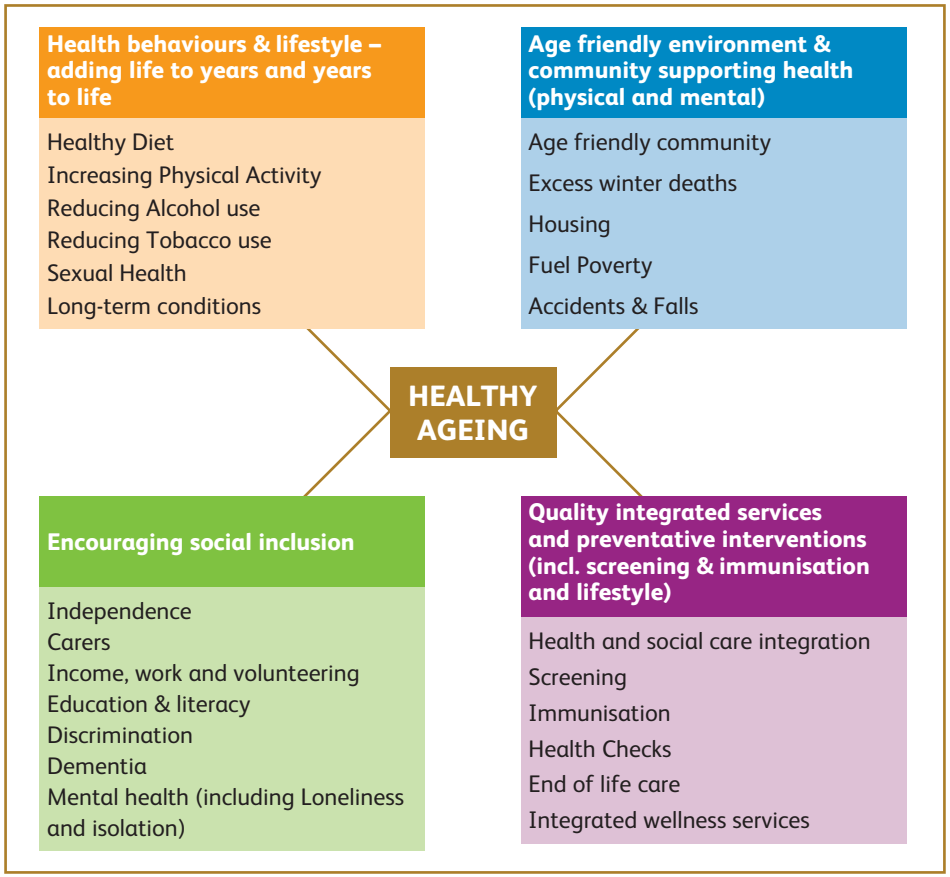
1. To give every child the best start in life
2. To enable all children, young people and adults to maximise their capabilities and have control over their lives
3. To create fair employment and good work for all
4. To ensure healthy standard of living for all
5. To create and develop healthy and sustainable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

Source[8]

A Framework for Healthy Ageing

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

Fig. 2: Healthy Ageing Framework



Current picture

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Encouraging social inclusion

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

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

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

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

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

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

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

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

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

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

Quality integrated services and preventative interventions

(incl. screening & immunisation and lifestyle)

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

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

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

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

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

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

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

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

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

Recommendation One

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

Recommendation Two

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

Recommendation Three

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

Recommendation Four

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

Acknowledgements

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

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

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

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

Chapter 1 Demographic context – The current picture for older people in Rotherham

"Old age is like everything else. To make a success of it, you've got to start young."

(Theodore Roosevelt 1858 – 1919)

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

Key Fact

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

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

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

Table 1: Projected Population Growth in Rotherham by Age Group

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

Source[15]

Potential Impact on the Health and Social Care System

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

Table 2: Life Expectancy and Ill Health 2012-2014

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

Source[17]

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

Older People with Bad or Very Bad General Health

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

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

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

Source[18]

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

Older People with Limiting Long Term Health Problem or Disability

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

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

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

Source[18]

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

Older People claiming Disability Living Allowance (DLA)

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

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

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

Source[19]

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

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

Ethnicity and older people

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

Challenge

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

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

A5

A7

A8

A6

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

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

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

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

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

Making Every Contact Count

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

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

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

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

Healthy Diet

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

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

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

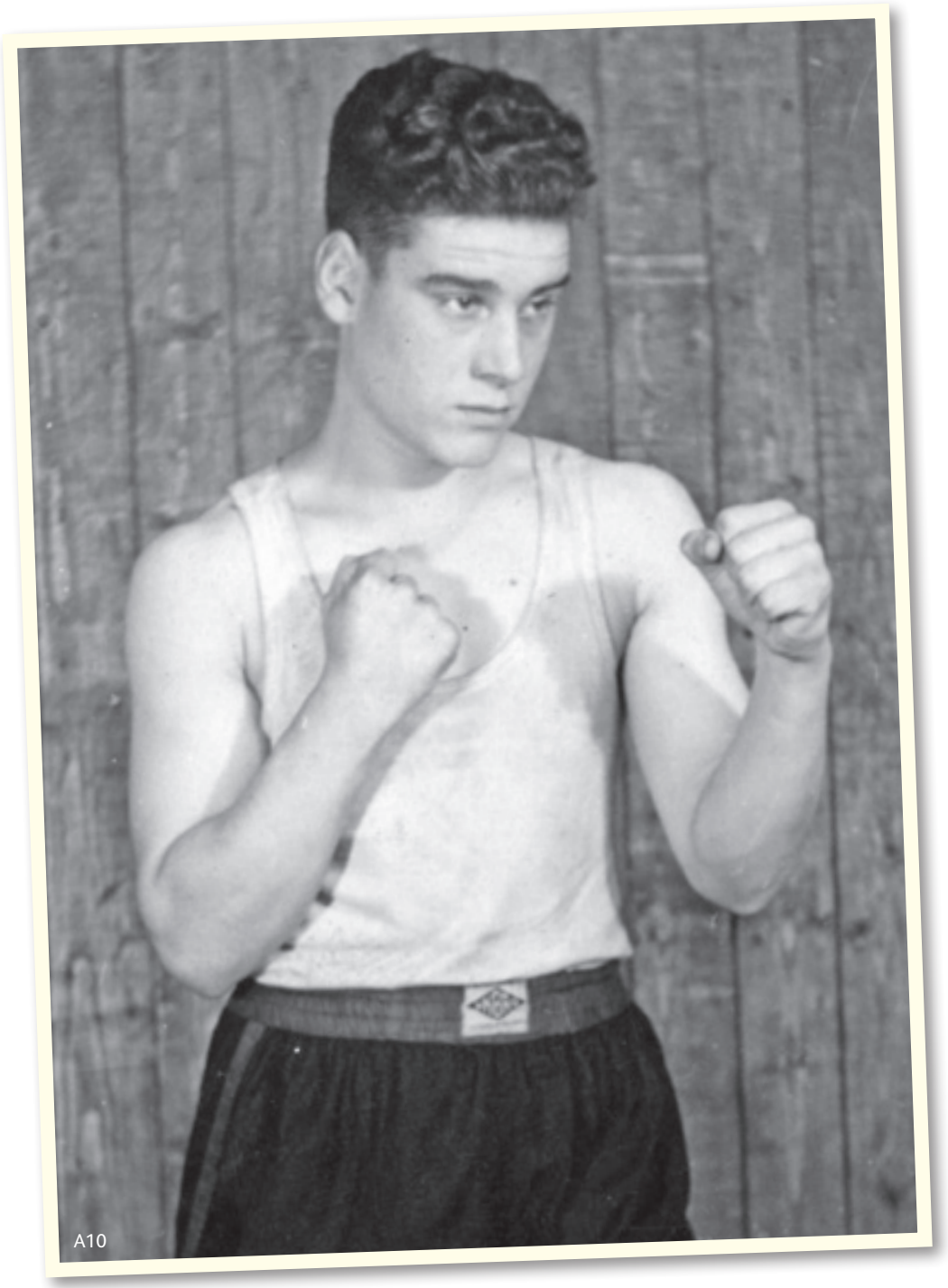
The proportion of adults classified as overweight or obese in Rotherham is 76.2% for the period 2013-2015. This is worse than both Yorkshire & the Humber (67.4%) and England (64.8%) and Rotherham ranks 2nd worst among similar local authorities[17]. As we know that older adults are more likely to be overweight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

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

A view from the past

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

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

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

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

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

Key Message

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

Increasing physical activity

How life has changed…

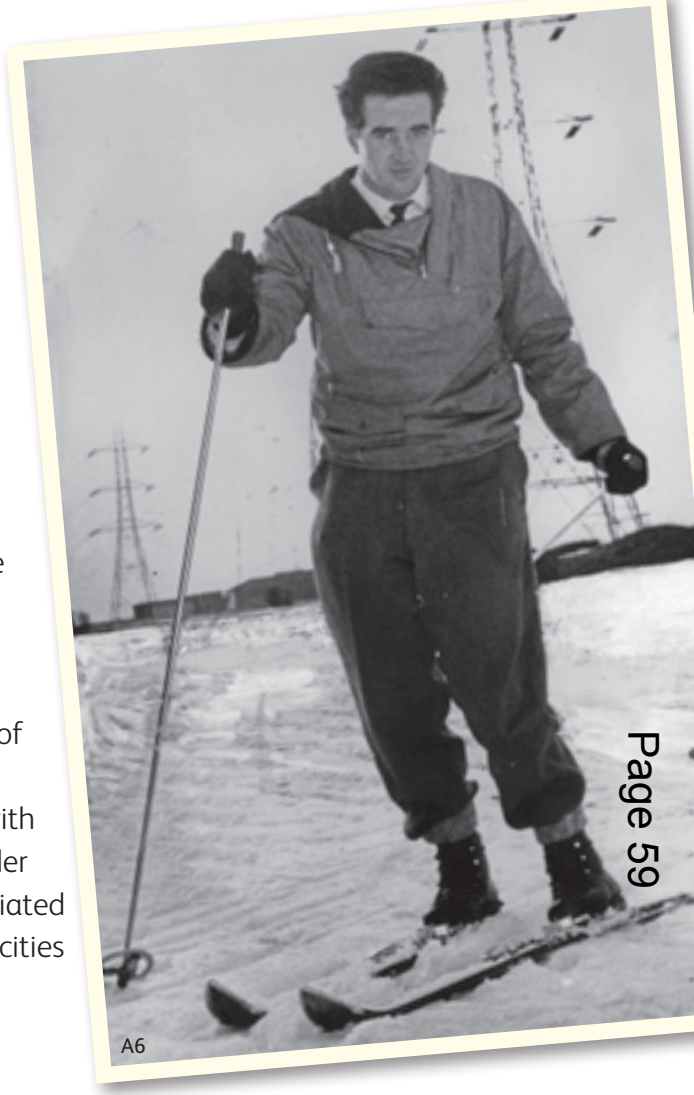
- **People in the UK are around 20% less active now than in the 1960s[9]. Lifestyles of older people have become increasingly inactive, with sedentary behaviours increasing.**
- **Older men are on average more sedentary than women. The time spent sedentary ranges from 5.3 to 9.4 hours per waking day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

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

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

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

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



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

Key Fact

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

*** Those born between 1946 and 1964**

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

Active Always brochure

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

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

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

Key Message

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

Reducing Alcohol Use

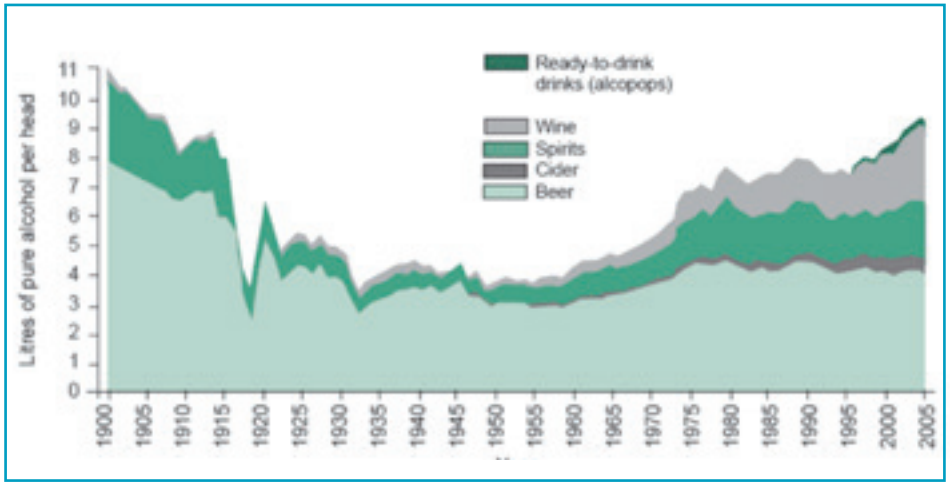
Drinking within the recommended alcohol unit guidelines (of no more than 14 units a week for both men and women) can help keep the health risks from the effects of alcohol low. If individuals do choose to drink, the units should be spread evenly across the week rather than "saving-up" all the drinks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

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

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

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

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



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

A view from the past

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

How life has changed…

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

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

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

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

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

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

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

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

Key Fact

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

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

Key Message

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

Reducing Tobacco Use

A view from the past

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

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

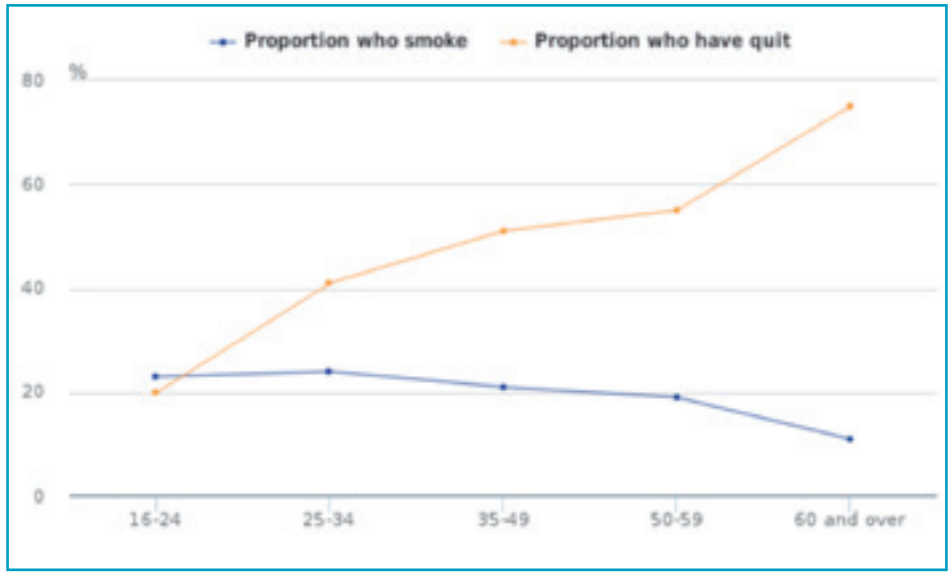
Fewer older people are smoking now than in the past. Nationally, 18% of men and 19% of women aged 65-74 were cigarette smokers in 1998, in 2014 this had reduced to 13% and 12% respectively. For those aged 75 and over there were 9% of men and 10% of women current smokers in 1998, but 5% & 5% respectively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

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

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

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

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



Source[15]

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

Fig. 5 The health benefits of quitting

Source[39]

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

Key Message

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

Sexual Health

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

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

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

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

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

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

Key Message

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

Long Term Conditions

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

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

Key Fact

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

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

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

Source[10]

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

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

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

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

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

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

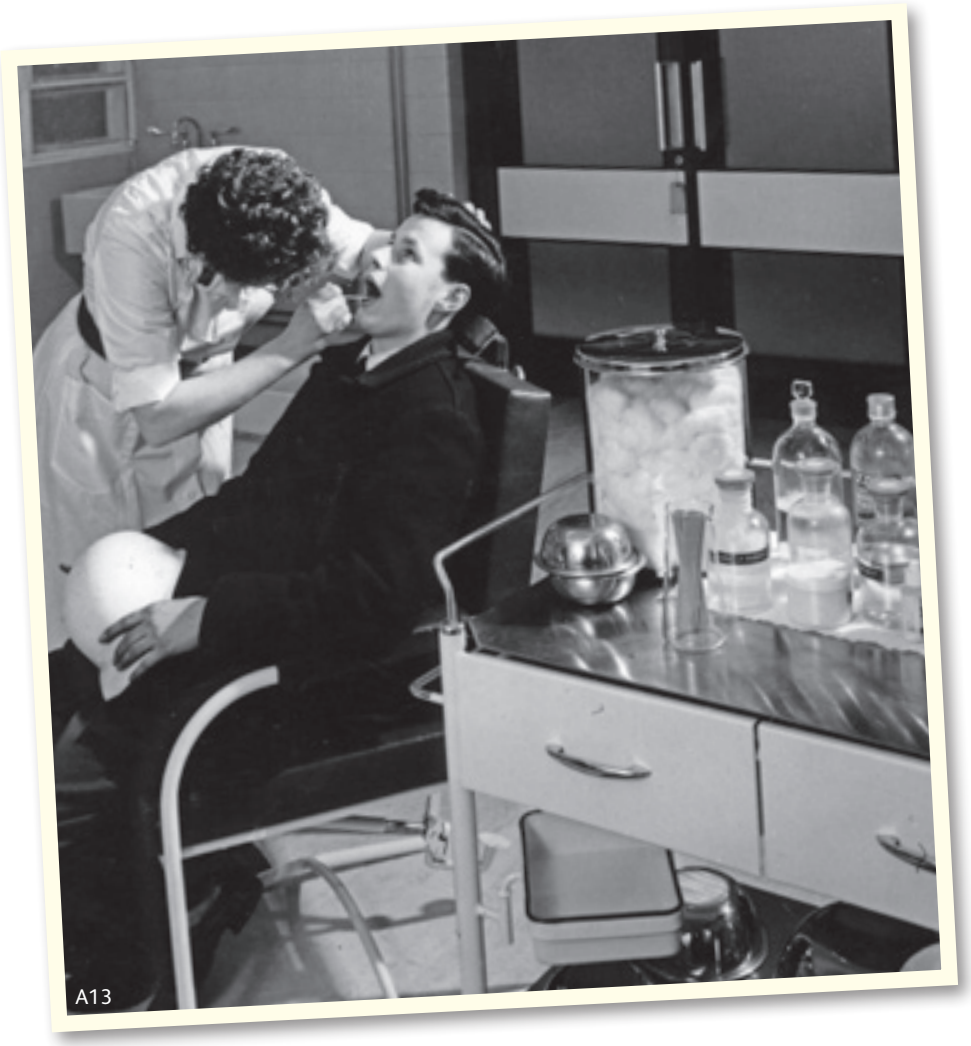
Rotherham Social Prescribing Service is an award winning service delivered by **Voluntary Action Rotherham** (VAR). **The Social Prescribing service helps people with long-term health conditions to access a wide variety of services and activities provided by voluntary organisations and community groups.**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

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

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

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

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



Be Active to Stay Healthy

www.rotherhamgetactive.co.uk/activeforhealth

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

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

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

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

Step 1 Rehabilitation

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

Step 2 Moving on

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

Step 3 Keeping Active

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

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

What can people do to help themselves?

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

Key Message

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

Recommendation One

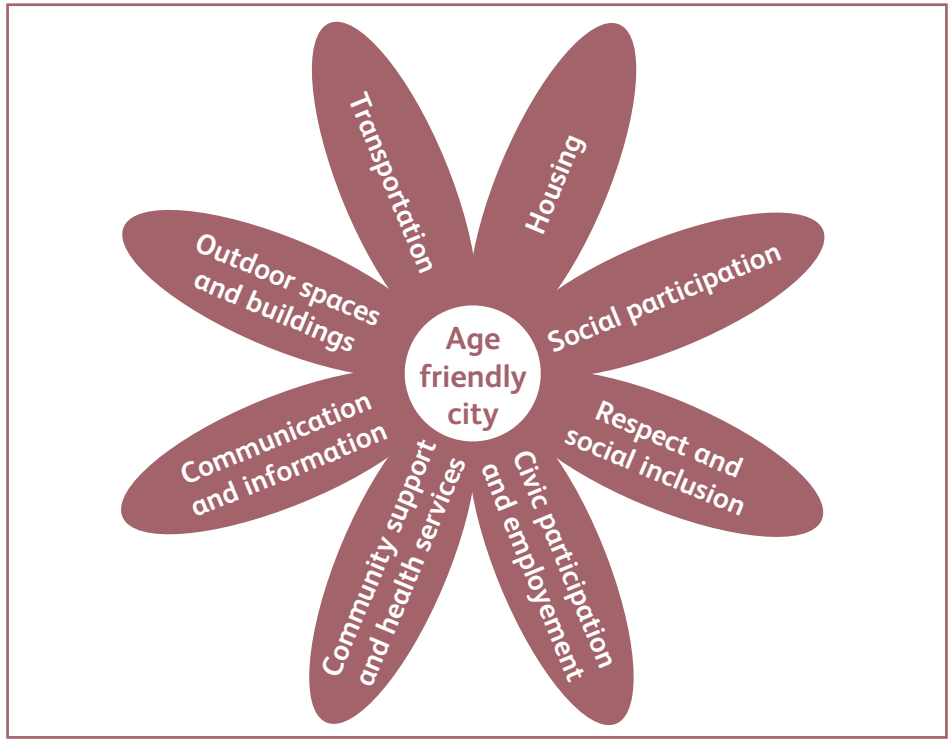
All services should encourage lifestyle behaviour change in older people where appropriate, particularly in the most disadvantaged communities. This could be achieved through taking a systematic approach to MECC.

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

Developing an age friendly community

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

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



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

Rotherham's Healthy Ageing Framework

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


A14

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

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

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

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

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

Key Fact

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

GOOD PRACTICE *EXAMPLE*

Age Friendly Manchester

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

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

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

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

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

Source[51]

A view from the past

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

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

Key Message

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

Excess winter deaths

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

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

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

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

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

Key Fact

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

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

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

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

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

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

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

Key Message

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

Housing

Key Fact

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

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

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

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

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

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

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

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

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

It is recognised that:

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

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

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

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

Key Message

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

Fuel poverty

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

The choice to heat or eat

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

GOOD PRACTICE *EXAMPLE*

Warm Homes Healthy People and Fuel Poverty Funding

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

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

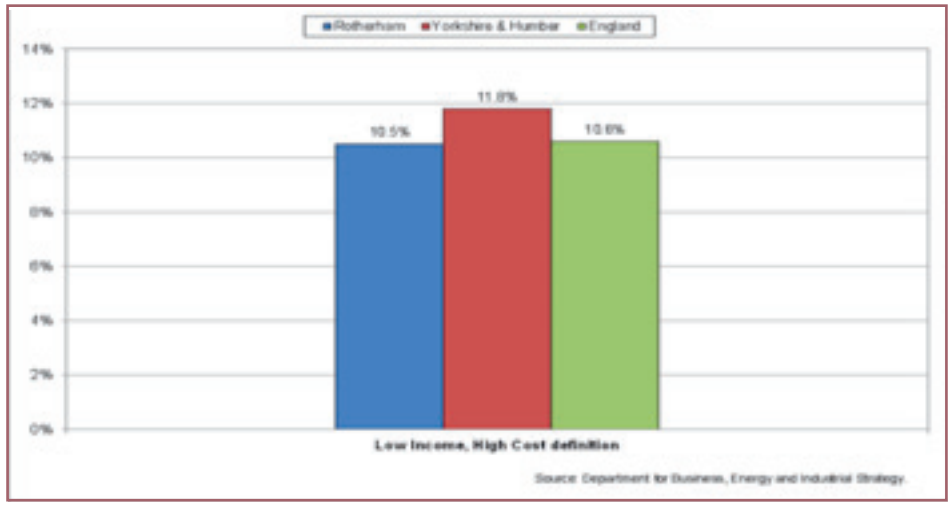
Levels of fuel poverty in Rotherham seem to be improving (10.5% in 2014 reduced from 15.1% in 2012)*.

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

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

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

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



Source[57]

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

This will be achieved through five aims:

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

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

GOOD PRACTICE *EXAMPLE*

Keeping Warm in Later Life Project (KWILLT)

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

Key Message

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

Accidents & Falls

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

Safe and Well visits

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

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

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

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

Falls Prevention Pathway: Improvements in falls rate

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

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

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

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

Action in Rotherham

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

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

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

Table 7: Annual costs per fall

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

Key Message

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

Recommendation Two

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

Chapter 4 Encouraging social inclusion


A18


A10


A19


A3

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

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

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

Independence

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

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

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

Key Facts

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

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

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

Source[61]

How life has changed…

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

Source[62]

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

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

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

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

Rotherham's Assets: Ted Ring

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

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

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

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

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

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

AgeWell Rotherham

I Age Well – healthy ageing and maintaining independence

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

Key Message

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

Carers

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

Key Facts

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

Source[64]

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

1) Carers in Rotherham are more resilient

2) The caring role is manageable and sustainable

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

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

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

Key Message

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

Income, work & volunteering

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

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

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

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

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

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

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

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

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

Rotherham's Assets: Edna Bateman

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

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

Key Message

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

Education & literacy

Key Fact

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

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

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

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

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

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

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

Key Message

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

Discrimination


A15

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

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

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

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

Key Message

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

Dementia

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

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

Dementia friendly

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

Five key messages:

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

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

Risk reduction/prevention

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

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

Taking steps to reduce dementia risk

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

Fig. 8: Modifiable Risk Factors of Dementia

Source[76]


A18

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

Rotherham Dementia Action Alliance

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

Key Message

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

Mental Health
(including loneliness and isolation)

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

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

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

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

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

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

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

Loneliness & Isolation

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

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

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

Key Facts

In the United Kingdom we know that:

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

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

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

Source[85]

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

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

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


A20

Examples of local practice which address some of these themes

Breaking the silence on suicide

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

Rotherham Together Partnership – Let's Get Rotherham Talking

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

What has changed?

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

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

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

Key Message

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

Recommendation Three

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

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


A11


A13


A12

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

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

Health & social care integration

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

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

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

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

Work underway

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

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

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

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

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

Key Message

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

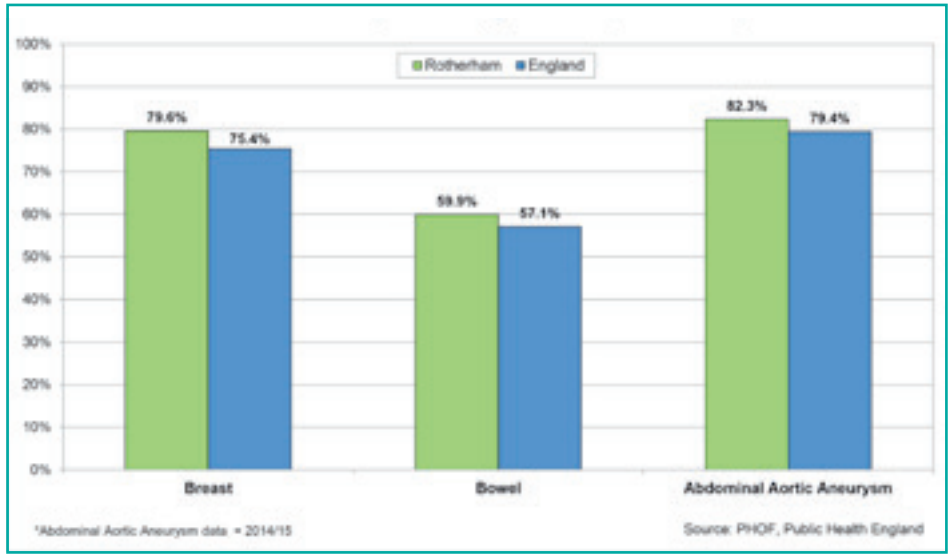
Screening

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

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

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

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



Breast Cancer screening

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

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

Key Facts

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

Bowel Cancer

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

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

Key Message

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

Immunisations

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

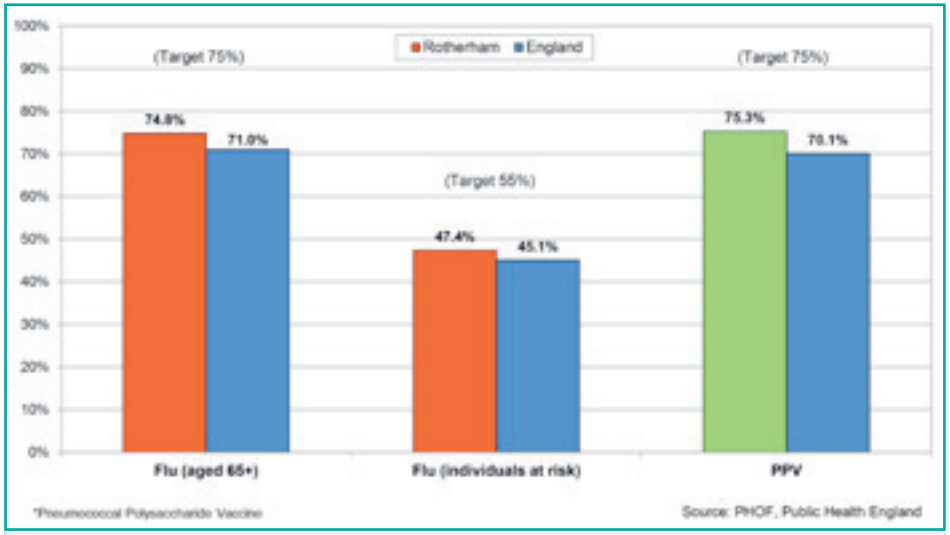
The population is offered routine vaccinations for protection against several infectious diseases over their lifetime, starting in childhood through to adolescence and finally as adults. The aim for most vaccination programmes is to maintain 'herd immunity'. This is a form of indirect protection that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

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

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

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

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



Seasonal Flu

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

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

Key Facts

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

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

Key Message

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

NHS Health Checks

Key Fact

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

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

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

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

Key Message

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

End of life Care

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

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

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

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

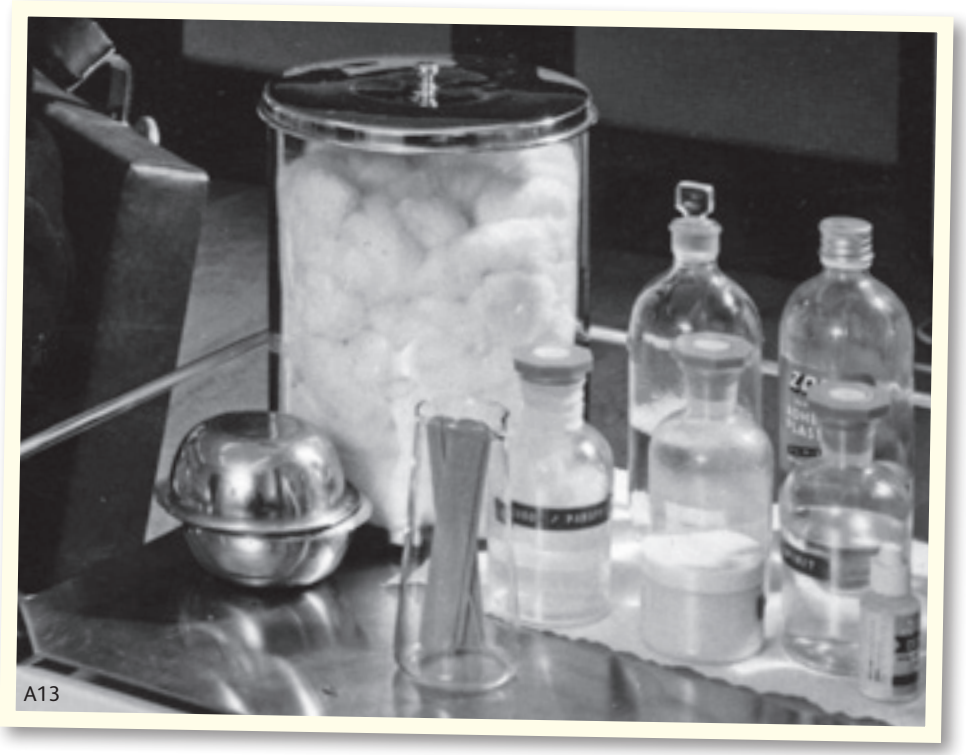
Rotherham statistics reflect the trend above. Deaths in hospital have decreased greatly for all elderly age groups (65-74, 75-84 and 85+) from 62.5%, 66.7% and 59.5% in 2004 to 44.1%, 54.2% and 45.0% in 2015 respectively. Deaths in Usual Place of Residence (home, care home or religious establishment)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

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

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

Key Message

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


A13

Integrated wellness services

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

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

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

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

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

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

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

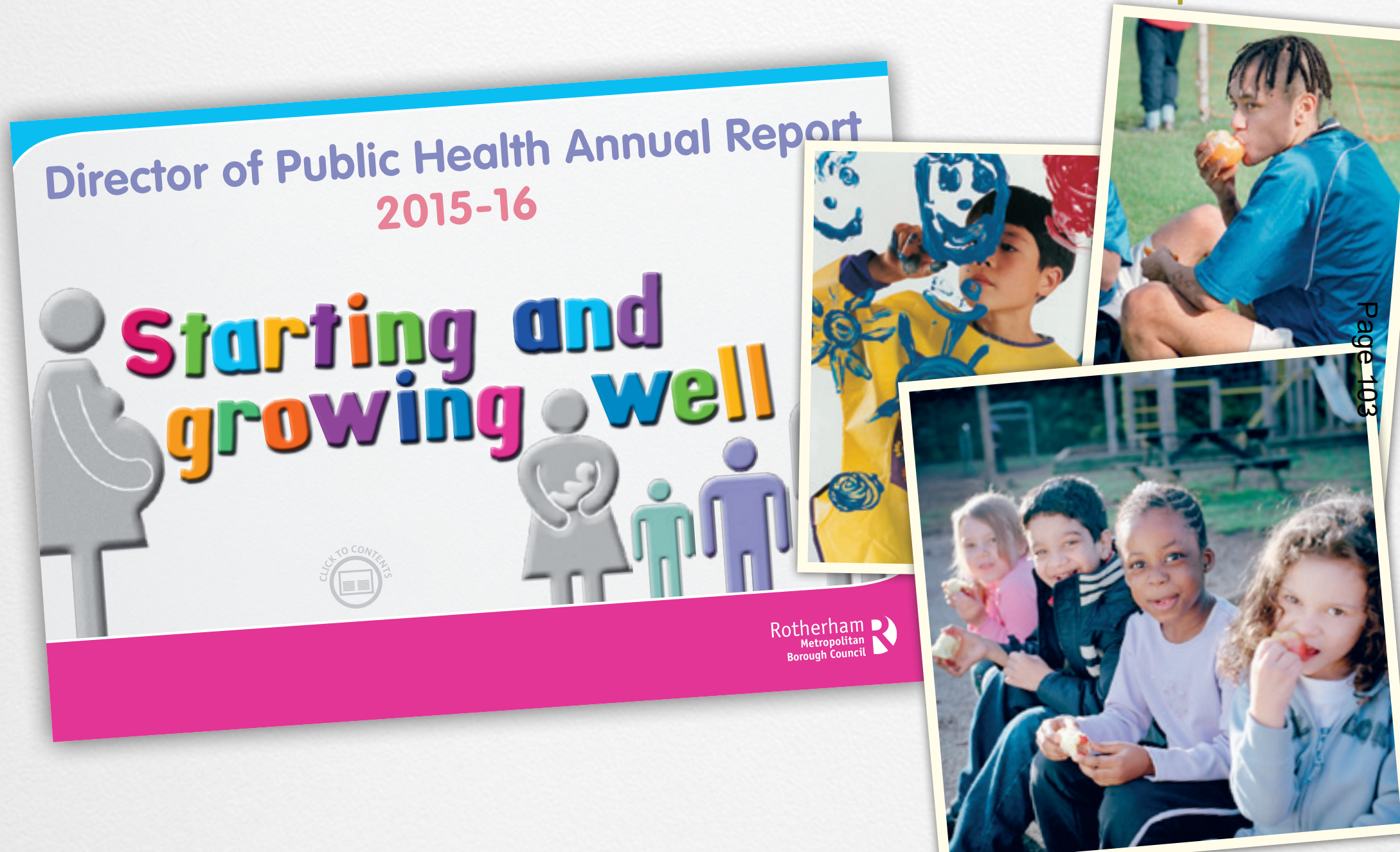
Key Message

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

Recommendation Four

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

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



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

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

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

Overarching Recommendation	Progress in 2016
3. Partners to work together to maximise opportunities for training to improve health outcomes – for example by adopting Making Every Contact Count (MECC) principles and undertaking joint training on the effects of poor health behaviour on children and families.	• Advice on how to spend the Primary School premiums to maximise their impact on increasing physical activity has been provided by Active Rotherham. • Conference delivered in Rotherham, January 2017 "Active Body, Active Minds" to further promote opportunities to increase physical activity in schools including the "mile a day". • Substance misuse materials have been made available to all schools, Early Help services and Rotherham College's to ensure that young people receive the most current information and resources. • Barnados have been working in partnership with Rotherham schools to ensure that a well evaluated Theatre in Education performance/workshop tackling issues around relationships, sexual health and abuse/exploitation is reaching as many young people as possible. So far it has been delivered in 19 Primary schools, seven secondary schools and five pupil referral units, reaching over 800 young people.
4. Schools and colleges should do more work to ensure that all children and young people are supported to improve their mental health and wellbeing – identifying clear pathways of support when children and young people experience mental health problems and raising awareness of self-harm and suicide prevention strategies.	• Six Rotherham schools are now participating in a 'whole school' approach to mental health and emotional well-being with the aim of creating school environments that foster positive mental health and emotional well-being for all. This is based on national guidance and eight key principles. Learning will be shared across the borough to benefit all schools. • Self-Harm Guidance has been distributed to all schools, colleges, GP practices and other venues where staff are working with young people. The aim of the guidance is for frontline staff to be confident in supporting young people, providing consistent information. Guidance has also been promoted at Youth Mental Health First Aid training and will appear on the My Mind Matters website.

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

Overarching Recommendation	Progress in 2016
7. The work programmes of the Health and Wellbeing Board and the Children, Young People and Families Partnership Board should be integrated and add value to the work of all partners.	• There is an ongoing commitment to implementing part time advisory 20 mph speed limits outside six schools in Rotherham. There are also plans for a further 10 schools to be treated this financial year and five of these will be funded by Area Assembly capital budgets. The intention behind these schemes is to reduce the speed of vehicles passing the schools when pupils are arriving and leaving by installing signage that will be more conspicuous to motorists, whilst also raising their awareness of pedestrians in the area. Outside of these periods the speed limit will revert back to that which is currently in place. • The Crucial Crew programme is offered to all Key Stage 2 children in Rotherham. 84 schools in Rotherham were invited to attend the programme 100% attended.
8. RMBC and partners review the need for a poverty strategy which seeks to address the economic wellbeing of families in order to reduce child poverty	• Work with young people Not in Education Employment or Training is ongoing and a range of tailored interventions and support has been developed locally.

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Archive images


A1


A5


A7


A6


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A12

Rotherham archive images

Reference	Image description	Pages
A1	Mothers group Cranworth Clinic 1946	14, 15, 51
A2	Imperial Buildings 1971	14, 16, 74
A3	Rotherham Market, Howard Street 1972-73	14, 18, 47
A4	Doncaster Road 1953	14, 16, 39
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A6	Philip Caroline, Skiing on Brinsworth Golf Course 1964 (Steel, Peech & Tozer)	20, 24
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All the images were sourced from the Archive department based at Clifton Park Museum, Rotherham.

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Health Select Commission

Ideas for Work Programme

2017-18

Rotherham Metropolitan Borough Council

Health Select Commission

Big Five:

- Rotherham Place Plan
  (health and social care integration)
- Adult social care
  (development programme and performance)
- Learning disability
- Mental health (child and adolescent)

plus

- Regional scrutiny – NHS reconfiguration

Health Select Commission

Rotherham Place Plan:

- Prevention, self-management, education and early intervention
- Rolling out integrated locality working model – 'The Village' pilot
- New Integrated Urgent and Emergency Care Centre (July 2017)
- Further development 24/7 Care Co-ordination Centre
- Building a Specialist Re-ablement Centre

Health Select Commission

Continuing from 2016-17:

- Big Five
- Public health – annual report
- Carers – links adult social care programme
- Access to GPs
- Autism

Health Select Commission

Each year:

- NHS Trust quality accounts and provider performance, including
- Progress on Care Quality Commission (CQC) action plans following inspections
  - The Rotherham NHS Foundation Trust (hospital)
  - Rotherham, Doncaster and South Yorkshire NHS Foundation Trust (RDaSH)
  - Yorkshire Ambulance Service

Health Select Commission

Other suggestions:

- Dementia (from discussions in April)
- Suicide Prevention Plans – Parliamentary Select Committee
- Health and Wellbeing Strategy Implementation

Health Select Commission

Methods – for example:

- Reports
  - initial and HSC to decide if more work needed
  - information/progress/monitoring
- Presentations
- Reviews – spotlight or full
- Sub-groups
- Visits
- Service user/patient experience - case study or direct

Health Select Commission

Any questions or suggestions?

HEALTH AND WELLBEING BOARD
8th March, 2017

Present:-

Members:-

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

Report Presenters:-

Nathan Atkinson	Assistant Director, Adult Social Care, RMBC

Officers:-

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

Observers:-

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

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

58. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at this meeting.

59. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

60. COMMUNICATIONS/UPDATES

Discussion took place on the following items:-

(1) Dr. Julie Kitlowski - retirement

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

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

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

(2) Health and Wellbeing Board – Partnership Working

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

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

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

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

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

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

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

61. MINUTES OF THE PREVIOUS MEETING

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Safer Rotherham Partnership Priorities

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

Safer Rotherham Partnership Structure

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

- Other meetings and networks
  Countywide meeting
  CIMs
  Area Assemblies

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

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

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

Walking for Health Scheme
Foot golf

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

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

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

Other issues raised by members of the Board were:-

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

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

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

63. THE ROTHERHAM PLACE PLAN

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

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

64. BETTER CARE FUND

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

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

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

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

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

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

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

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

The key priorities for 2017-19 were:-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Develop and implement Personal Budgets.

8. Develop pathways to adulthood.

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

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

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

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

66. SPECIALIST RESIDENTIAL AND NURSING CARE FOR ADULTS IN ROTHERHAM

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

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

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

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

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

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

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

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

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

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

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

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

67. LONELINESS AND ISOLATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

69. DATE, TIME AND VENUE OF THE FUTURE MEETING

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

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

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

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