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

Date:-	**Thursday, 14th June, 2018**	**Venue:-**	**Town Hall, Moorgate Street, Rotherham S60 2TH**
Time:-	**10.00 a.m.**		

HEALTH SELECT COMMISSION AGENDA

1. To determine whether the following items should be considered under the categories suggested in accordance with Part 1 of Schedule 12A (as amended March 2006) of the Local Government Act 1972

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

3. Apologies for absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Minutes of the previous meeting (Pages 1 - 11)

7. Director of Public Health Annual Report "The Health and Wellbeing of the Working Age Population" (Pages 12 - 84)
   Terri Roche, Director of Public Health, to present

8. Notes from Health Village Evaluation Workshop (Pages 85 - 96)

9. Ideas for HSC work programme 2018-19 (Pages 97 - 104)
   Janet Spurling, Scrutiny Adviser, to present

For Information

10. Stakeholder Briefing for Hospital Services Review (Pages 105 - 107)

11. Hospital Services Review Q&A sheet (Pages 108 - 118)

12. Rotherham Healthcare Record (Pages 119 - 122)

13. Date and time of next meeting
Thursday, 19th July, 2018, at 10.00 a.m.

Membership 2018/19

Chairman:- Councillor Evans
Vice-Chairman:- Councillor Short

Councillors Albiston, Andrews, Bird, Cooksey, R. W. Elliott, Ellis, Jarvis, Keenan, Marriott, Rushforth, Taylor, Williams and Wilson.

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

Sharon Kemp.

Chief Executive.

HEALTH SELECT COMMISSION
Thursday, 12th April, 2018

Present:- Councillor Evans (in the Chair); Councillors Andrews, Bird, R. Elliott, Ellis, Jarvis, Short, Whysall and Williams.

Councillor Roche, Cabinet Member for Adult Social Care and Health, and Councillor Steele, Chair of the Overview and Scrutiny Management Board, were in attendance at the invitation of the Chair.

Councillor John Turner was in attendance as a member of the public.

Apologies for absence were received from Councillors Allcock, Marriott, Rushforth and Robert Parkin (Rotherham SpeakUp).

The webcast of the Council Meeting can be viewed at:-
https://rotherham.public-i.tv/core/portal/home

80. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

81. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

82. COMMUNICATIONS

The Chair reminded Select Commission Members that the deadline for comments on the Rotherham Clinical Commission's Commissioning Plan was 12th April.

Terri Roche, Director of Public Health, drew attention to an email Members would be receiving regarding a free conference to be held on 24th May, 2018, in Leeds organised through Minding the Gap which would discuss poverty and debt. Places would be limited so if any Members were interested they should respond promptly.

83. MINUTES OF THE PREVIOUS MEETINGS HELD ON 18TH JANUARY 2018 AND ON 1ST MARCH, 2018

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 18th January and the inquorate meeting held on 1st March, 2018. Members noted that:-

Resolved:- (1) That the minutes of the previous meeting, held on 18th January, 2018, be approved as a correct record.

(2) That the recommendations contained within the minutes of the inquorate meeting held on 1st March, 2018, be approved.

Arising from Minute No. 64 (Integrated Locality Evaluation), it was noted that the final report on the evaluation of the Health Village was now available and would be circulated to Members. The working group established to consider the final report would meet on 1st May, 2018.

Arising from Minute No. 65 (Adult Social Care – Outcome Framework), it was noted that future reporting of the Adult Social Care Outcome Framework would be discussed as part of the 2018/19 work programming.

84. URGENT AND EMERGENCY CARE CENTRE UPDATE

George Briggs, The Rotherham Foundation Trust, presented the following powerpoint presentation on the Urgent and Emergency Care Centre (UECC):-

Background

- The new Rotherham UECC opened in July 2017 on the Rotherham Hospital NHS Foundation Trust site
- The new UECC provided an integrated response to urgent care for the Rotherham population – integrating the urgent and emergency care component of what was the Rotherham Walk-in Centre, the GP Out of Hours Service and the Hospital Emergency Department
- The UECC provided one front door for all urgent and emergency care in Rotherham – it opened 24 hours a day, 7 days a week, 365 days a year
- The aim of the UECC was that the local Rotherham population could access the right care, first time
- It was staffed by a mixture of General Practitioners (GP), Emergency Department medical and nursing staff, Advance Nurse Practitioners, Advanced Care Practitioners and other essential non-clinical staff
- It also co-located the Care Co-ordination Centre (CCC) and had work space to facilitate multi-disciplinary working with Mental Health Workers, Social Care Worker and ambulance staff

Initial Challenges

- The original model was based on The Rotherham NHS Foundation Trust as prime provider, but working in partnership with a third party provider – Care UK. This changed when Care UK withdrew from the working arrangements
- Despite doing some organisational development work, merging different cultures into single integrated service provided some initial challenge
- Clinical staffing challenges across both the Primary Care element of the Service and the Emergency Department Service
- Transferring the GP Out of Hours Service
- New ways of working for all teams – embedding change

- Increase in wait times to be sent for patients
- Communication – managing patient and public expectation

Where are we now?

- The original model has been modified as the teams have developed their ways of working
- Teams were starting to work well together – in the intended integrated way
- Recruitment was improving – 2 new Emergency Care Consultants commenced in post in November 2017 and more GPs were joining the team
- More Advanced Nurse Practitioners/Advance Care Practitioners had been appointed
- The Trust had commenced a development programme to train Senior Emergency Department Doctors which would support recruitment
- Rapid Assessment and Triage and See and Treat ways of working were starting to really become embedded
- Quality reviews had been implemented – reviews of the patient experience and outcomes

How are we doing/Performance

- The national 4 Hour Access target was that 95% of patients were seen, treated and admitted or discharged within 4 hours
- This was not being achieved locally or nationally – the national recovery trajectory was to achieve 90% by December 2018 and return to achieving the 95% target in 2018/19. The Trust was aiming to achieve 95% by 31st March 2018 (81% as of 11th April)
- Rotherham was now starting to see a month-on-month improvement in performance
  November 2017 81.36%
  December 2017 85.64%
  January 2018 87.1%
  February 2017 87.25% (as at 25th February 2018)
- This compared to England performance in January 2018 for all attendances – 85.3%
- The Rotherham NHS Foundation Trust currently ranked in the top 40 out of 133 Trusts

Patient Feedback

- Friends & Family response rate required was 15% of attendees – currently average was 5% per month
- Positive score target was 85% - UECC average was 92-99%
- January 2018 there were 320 responses. Of these 267 were extremely likely to recommend the Service; 50 were likely to recommend the Service, 3 were extremely unlikely to recommend the Service

- Positive feedback comments included “great staff attitude”, “staff very professional”, “staff friendly”, “team were very caring”, “excellent facilities”, “reception staff were polite and caring”, “they reassured me when I was ill”
- Negative feedback comments – “wait times – I waited over 5 hours to be seen”, “poor staff attitude”, “the waiting room was cold”

Current Challenges

- The development and opening of the new UECC was (and still was) a significant change management initiative
- Working together across the Primary Care, Emergency Department and GP Out-of-Hours Services needed to continue to develop
- Recruitment was improving but Rotherham would have to continue to be innovative to recruit and retain staff
- Work with patients and the public to manage demand and direct people to the right service, first time – the UECC was for urgent and emergency care
- Continuing to improve and maintain performance against the 4 hour access target was not solely attributable to the UECC

Future Plans

- Continue to develop a truly integrated urgent and emergency care service where teams worked effectively across all the urgent and emergency care pathways
- Further develop partnerships with Social Care, Mental Health Services, Primary Care, Voluntary Sector – project this winter working with Age UK Rotherham and the Red Cross
- More joint working between the Care Co-ordination Centre and the GP Out-of-Hours Service
- Improve the engagement with the public and patients
- Provide a first class service for urgent and emergency care for the population of Rotherham

Discussion ensued with the following issues raised questions/clarified:-

- Disappointment that the presentation did not reflect the integrated work that was already taking place between the Council and the Rotherham Clinical Commissioning Group (RCCG). The UECC came under the remit of the Health and Social Care Place Plan which in turn was under the remit of the Health and Wellbeing Board

- Care UK provided the original Out-of-Hours GP Service. It was a private company who had decided there was insufficient money in the business model so had made a commercial decision to withdraw; the Foundation Trust had stepped in and taken over the contract. Any staff who had wished to transfer to the Trust had transferred across under TUPE regulations to the NHS Terms of Conditions (approximately 30%). Over the past few months the Trust had used its Emergency Centre staff to cover the vacancies. There was the

same number, if not more, of staff than Care UK had been offering. As the RCCG were the commissioners it was not known what financial penalties, if any, there had been but Care UK had given 6 months' notice

- The figures stated in the original presentation had been correct at the time of collation i.e. 2 months ago. However, Winter Pressures had increased. Over the past 6-8 weeks the number of patients through the door and attendance at the Emergency Department had increased. The flow through the Hospital had not improved as one would have predicted and the additional Winter capacity would not close until the end of May. Performance of 87.25% had been very good for February with 84.9% for the year. The national average was 88-89%. The figure in Rotherham for March had been 83% which was a drop from the previous month but this was unsurprising given the snow and the number of respiratory illnesses. Whilst disappointing, nationally the position was the same with Rotherham still in the top 40-50 Trusts in the country but it needed to improve

- The patient feedback data was a national indicator with the associated method of collection that Rotherham was compared against across the NHS. The NHS had a duty to collect that data with an expectation that 85% would fill in the survey to say they were happy with the service. Rotherham scored 92% but it was acknowledged as a very rough measure

- Performance was monitored against a number of factors e.g. how the hospital treated patients, how it discharged patients etc. If the Trust had difficulties due to access to Mental Health/Social Workers, it shared the responsibility

- "Safer" was a national initiative about discharging people earlier in the day, making sure they had the right care at the right time by the right partner earlier in the day. It was about the way Ward rounds were done making sure consultants/junior doctors were appropriate, that TTOs and discharge letters were written in the morning and the plan of discharge done the day before so that patients would be moved out of the organisation in the morning. The national target was 35%; the Trust was at 19% some days and 12% on others. There was a long way to go to get discharges out in the day. An issue that was affecting that performance currently was the 40 extra beds that could not be staffed. It was the plan over the next 3-4 weeks to close as many of those additional beds as possible and get the medical and nurse teams back to their Wards so they could implement "Safer". They could not discharge patients any earlier if they were undertaking what were known as "safari ward rounds".

- There were 3/4 national initiatives:–
  - PJ Paralysis - making sure patients were not left in their nightclothes and in the morning get them up, dressed, talk to them and treat them as if fit to go home.
  - Red-Green – looking at a patient's pathway and journey. A Red Day – a patient has been sat in Hospital waiting for something e.g. CT scan, test result – if they have been waiting 2/3 days the Trust was not doing anything for them but if they got the result early they could be progressed to a Green Day. A Green Day - do something for a patient and move them through the hospital in a safe and appropriate way
  - Safer – see above point

- The partnership worked mainly on the Admissions Medical Unit (AMU) rather than in the UECC. If the UECC Team/GPs/Nurses/Emergency Consultants, decided that a patient required some extra support and was not ready to go home there and then (within 4 hours), they would send the patient through for assessment in the AMU where they would be seen by a Consultant, Junior Doctor, Red Cross, Frailty Team etc. and a view taken as to whether they could get the patient home there and then (within 8-12 hours) or within 12-24 hours. If the person was very frail they would have a comprehensive assessment and if in need of something else they would have an assessment by Occupational Therapist, Physiotherapist, Red Cross, any voluntary organisation the Trust could pull into help, involve family and friends, all within 10-12 hours of coming through the door. If it was clear that it was not going to be suitable to move that day an assessment would take place the following day

- The Trust found that 90% of patients were elderly frail. Recently a Care of the Elderly Consultant has moved into the AMU who would work between the AMU, Emergency Department and UECC to try and see those patients earlier. The Frailty Team would be increased to work alongside the Consultant and it was hoped that in 6 months' time the AMU would become a Frailty Assessment Unit. The emphasis had to change and required Age Concern, Red Cross, Therapists and Frailty Team to work together along with Mental Health Teams and Social Care Teams to ensure Social Services Teams were included within the AMU and Frailty Team in order to turn more people around at the door rather than admit them to hospital.

- There was a National course for Advanced Nurse Practitioners and courses that were funded by Health Education England. The Trust had recently submitted a bid for 6. There were 8 members of staff going through training and 6/7 that were fully trained. It was a problem in that the more trained qualified experienced nurses were pulled out of the Wards the standard of care decreased on the Ward, however, there was an issue around the recruitment of junior doctors; the Trust's vacancy rate around middle grade doctors was

phenomenal and it was trying to balance the act somehow. The Team had been asked to submit a bid for more training places

- It was hoped to develop the Trust's Hospital at Night Service so it would be available 7 days, 24 hours a day and that would be made up of Practitioners who would support and maintain the organisation. In the next 2 years there would be a need for approximately 30+ Advanced Practitioners which would make a big difference

- Typically across England a consultant had 1/2 Junior Doctors on the Ward round and started at one end of the Ward and worked their way through. The full Ward round was taking too long and at the end the Consultant would send the Junior Doctors back to manually write up the medication and letters. There was no electronic prescribing service or system in Rotherham, although one had been discussed. There was a national programme to change Ward rounds and it was planned to get them to visit Rotherham to change the method i.e. the first 6 patients were seen, the Consultant left the Junior Doctor behind to complete the paperwork and moved onto the next 6 taking an Advanced Practitioner/Junior Doctor and then left them to complete the paperwork with the first Junior Doctor rejoining for the next 6 and so on. In theory at the end of the Ward all patients should have their paperwork complete apart from the last 6 patients

- The Trust had space for Mental Health Teams and Mental Health practitioners and had very good facilities for patients with Mental Health needs but what it did not yet have was 24 hours 7 day Mental Health cover. A national project, Core 24, which Rotherham would be part of, would identify, recruit and place a core team of Mental Health practitioners in acute hospitals 24 hours a day so that anyone who needed care, support and treatment from a Mental Health Team could be done. It was Mental Health Commissioner-led with Mental Health, Acute and commissioners working together to provide the service for which there was national funding for it. There may be an issue with regard to the recruitment of nurses and practitioner from a Mental Health point of view because they were scarce

- The Trust had made the decision that if someone arrived at the UECC who had an illness/a need to see someone they would be seen but the message would be reinforced that, if their symptoms could have been treated by their GP, that was where they should have gone

The Chair thanked George for his presentation.

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

(2) That the Scrutiny Officer contact Rotherham Clinical Commissioning Group with regard to further information regarding Care UK's withdrawal from the UECC contract.

85. SCRUTINY REVIEW - DRUG AND ALCOHOL TREATMENT AND RECOVERY SERVICES

The Chair presented the main findings and recommendations from the cross-party spotlight Scrutiny Review of Drug and Alcohol Treatment and Recovery Services for Adults.

A spotlight review had been undertaken to ensure that the Service, which would be operating within a reduced budget, would provide a quality safe service under the new contract from April 2018.

The detailed overview of substance misuse in Rotherham had been received noting that the majority of Service users were male and white British. Although numbers in Service were declining over time, there were a number of older long term drug users many of whom now had associated physical health issues.

The bringing together of various aspects of the Service together under a single contract, including having treatment and recovery services available in one location, may facilitate a more personalised and holistic approach to treatment and recovery.

The members of the Review Group were thanked for their work on the Select Commission's behalf on this issue.

The Review's eight recommendations were as follows:-

1. That Public Health and Change, Grow, Live (CGL) present an overview of how the new service is progressing, including a summary of progress on the key performance indicators, to the Health Select Commission in Autumn 2018.

2. That Public Health ensure robust performance management is in place for the new contract from the outset in 2018, including exception reporting and a mid-contract review (to report back to the Health Select Commission).

3. That the Suicide Prevention and Self-Harm Group revisit the suicide prevention awareness raising work in Wentworth Valley in 2018-19 and roll it out more widely through sharing resources and learning, particularly in hotspot areas identified through the National Drug Treatment Monitoring Service.

4. That Public Health consider strengthening the messages under Making Every Contact Count around safe alcohol consumption and where to go for help, when it is refreshed.

5. That future commissioning of services by RMBC that exceed the Official Journal of the EU threshold, especially Public Health and Social Care Services, includes soft market testing with providers/potential providers in advance of going out to tender to ensure a successful process first time.

6. That drug and alcohol pathways and signposting, including protocols for links to other processes such as the Vulnerable Adults Risk Management process, are reviewed by RMBC and partners in 2018, to minimise any risk of people not being able to access support.

7. That in their initial assessments and reassessments with service users CGL include the additional risk factors identified from the RDaSH analysis into suicides from April 2018.

8. That Public Health and CGL continue to take a proactive approach to safety concerns in the service, including incorporating any lessons learned from elsewhere and the findings of any Serious Case Reviews when published.

Councillor Roche, Cabinet Member for Adult Social Care and Health, expressed concern with regard to recommendation No.3. Wentworth Valley Area Assembly had funded the good work that had been delivered. All Members had been sent a letter regarding rolling out the work to all Wards but they would have to provide funding. However, no Members had responded to the request.

It was suggested that once the geographical data was analysed that might trigger some specific work and lead to discussion on communications and an operational structure.

Resolved:- (1) That the Review findings be endorsed and the recommendations set out in Section 6 of the Review report at Appendix 1 be approved.

(2) That the report be submitted to the Overview and Scrutiny Management Board for consideration prior to submission to the Cabinet/Commissioners' Decision Making Meeting.

(3) That the response from the Cabinet/Commissioners' Decision Making Meeting be reported back to the Select Commission.

86. SOUTH YORKSHIRE, DERBYSHIRE, NOTTINGHAMSHIRE AND WAKEFIELD JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE UPDATE

The Scrutiny Officer reported that the Committee had not met since the last update.

The report on the outcome of the Hospitals Review was due to be finalised towards the end of the month and would be submitted to the Select Commission during the new Municipal Year as well as an update on Stroke Care and Children's Care and Anaesthesia Services.

87. CAMHS UPDATE

The Commission noted a report that had been considered by the Health and Wellbeing Board at its meeting on 14th March, 2018.

88. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised by Healthwatch Rotherham.

89. HEALTH AND WELLBEING BOARD

The minutes of the meeting of the Health and Wellbeing Board held on 10th January, 2018, were noted.

Councillor Roche, Cabinet Member for Adult Social Care and Health, reported that a meeting had been held the previous day of partners to look at the new Strategy for the Place Plan which now came under the remit of the Health and Wellbeing Board.

90. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 14th June, 2017, commencing at 10.00 a.m.

ACTION ON MINUTES

Minute 84 URGENT AND EMERGENCY CARE CENTRE UPDATE

Resolved:- That the Scrutiny Officer contact Rotherham Clinical Commissioning Group with regard to further information regarding Care UK's withdrawal from the UECC contract.

The Chief Officer confirmed that Care UK had had the contract for five years but chose not to renew it as they were looking to refocus their business. There were no financial penalties.

BRIEFING PAPER FOR HEALTH SELECT COMMISSION

1.	**Date of meeting:**	**14th June 2018**
2.	**Title:**	**Director of Public Health Annual Report 2017**
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 and 2016 annual reports were two 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 living and working well. The intention is to use this year's annual report to outline what is working well in Rotherham, what Rotherham is doing as a whole and what is planned for the future, it also is an opportunity to shine the light on the rich asset that the working age population has 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.

5. Key Issues

5.1 Living well is important for individuals and the population as a whole to ensure a good quality of life throughout the life course. Living a healthy life can increase life expectancy and making the right life choices can reduce the likelihood of premature death and suffering certain long term conditions.

5.2 Working adults support the welfare state through income generation and paying taxes as well as contributing to civic society. It is therefore important

to promote and protect both the physical and mental health of this sector of the population.

5.3 There are 161,200 residents in Rotherham of working age (16-64). 22.7% of them are not in work and not looking for work.

5.4 A man in Rotherham can expect to live to 77.9 having spent 18.1 years in poor health. A woman in Rotherham can expect to live to 81.6 having spent 25.9 years in poor health.

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.

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.

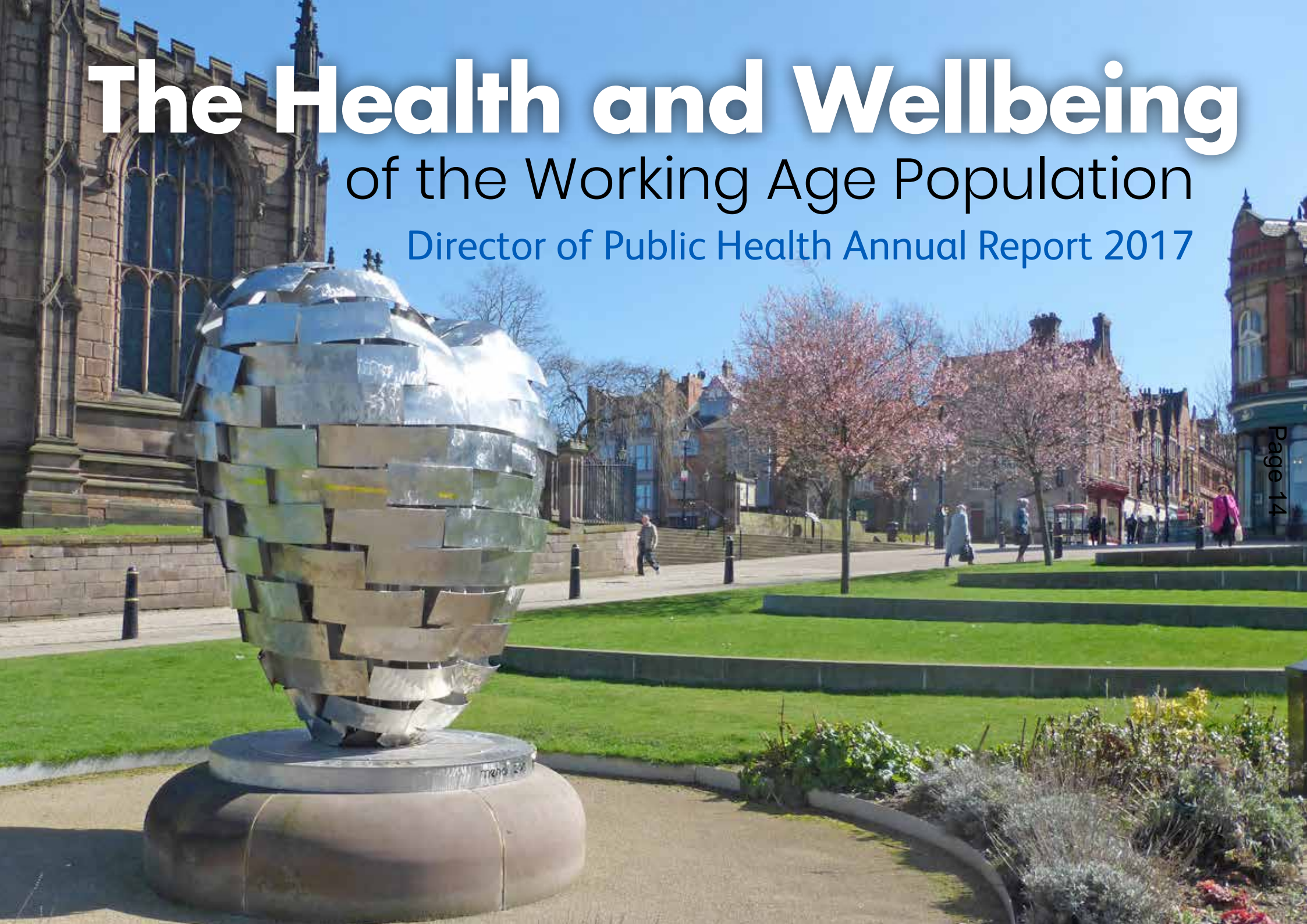
8. Name and contact details

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

Report Author(s)
Jacqui Wiltschinsky, Consultant in Public Health and Gill Harrison Public Health Specialist
Public Health Department

The Health and Wellbeing of the Working Age Population

Director of Public Health Annual Report 2017



Contents

Foreword from the Director of Public Health

The Health and Social Care Act 2012 set out a requirement for all Directors of Public Health to produce an independent annual report on the health of the local population.

This is the final annual report in a series of three which have been planned to work through the life course focusing on key health issues at different stages of our lives; Starting and Growing Well, Living and Working Well and Ageing Well. The vision is for people to realise their potential for physical, social and mental wellbeing throughout the life course.

The first of the three reports highlighted the importance of improving the life chances of our children and young people, especially those who are vulnerable. What happens during the early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing, from obesity, heart disease and mental health, to educational achievement and economic outcomes. Supporting good health and well being for children, young people and families is central to improving health outcomes across our society.

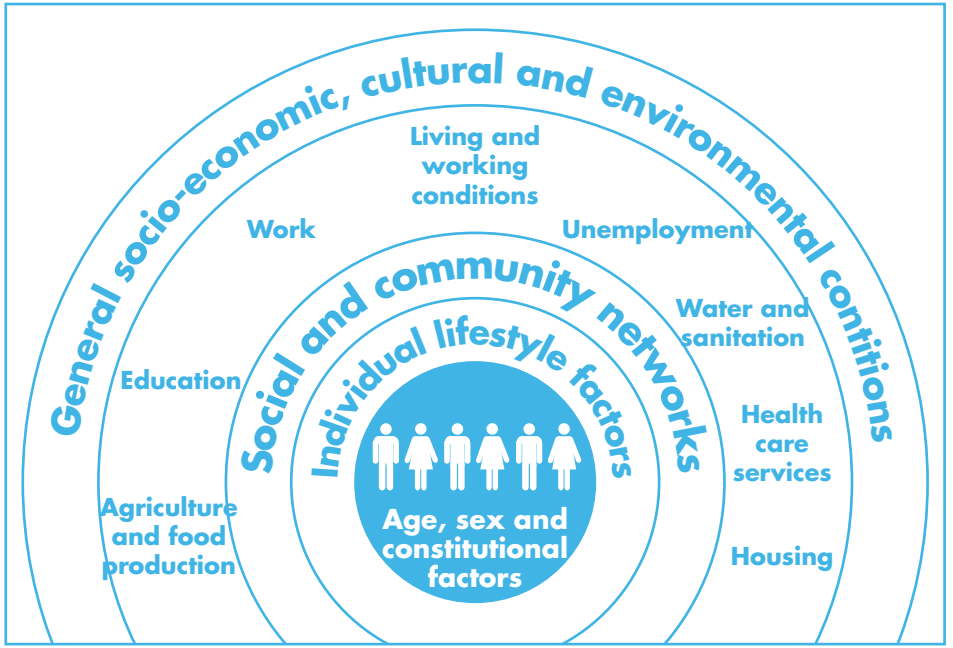
Last year's annual report (the second in the series) focused on a life course approach to ageing which understands that older people are not a homogenous group of people. Individual diversity tends to increase with age, meaning that the differences between people in good health and people in poor health are greater in old age. Older age is a time when prevention of disease can make an enormous difference to the quality of life of individuals. Interventions that create supportive environments and foster healthy choices are therefore particularly important in the later stages of life.

This final report in the life course series explores 'Living and Working Well'. It looks at the health and wellbeing of people from early adulthood where they start to experience financial independence with their first job; establishing families and family units; long term relationships and making life choices; through to mature adulthood where planning for older age and a healthy retirement takes priority.

Introduction

A life course approach to health is based on the understanding that multiple factors, which include biological, social, psychological, geographic, and economic, shape health over the life course. There are various interactions and mechanisms that affect people's lives and the life course approach helps to explain these. The health and wellbeing of individuals and populations across the whole life course is affected by a range of factors both within and outside the individual control. The Dahlgren and Whitehead wider determinants model (fig 1) describes the layers of influence on an individual's potential for health. It describes these factors as those that are fixed core non modifiable factors such as age, sex and genetics and a set of potentially modifiable factors expressed as a series of layers of influence, including personal lifestyle, the physical and social environment and wider socioeconomic, cultural, environmental and global conditions. The model has been useful in providing a framework for raising questions about the size of the contribution for each layer to health, the feasibility of changing specific factors and the complementary action that would be required to influence linked factors in other layers.

Figure 1 Dahlgren and Whitehead Wider Determinants Model.



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

In order to significantly improve the health and wellbeing for Rotherham it requires collective action over a sustained period of time from across the Rotherham Together Partnership(RTP). The RTP meets to co-ordinate priorities across the borough and involves all key partners and partnership board reporting, e.g. Health & Wellbeing Board.

This report outlines the living well and working well life courses as identified by Sir Michael Marmot[1]. Health inequalities are unjust health differences that occur between social groups. They can result in differences in environmental and individual resources (e.g. the quality and availability of employment, housing, transport, access to services, and social and cultural resources). Marmot introduces the concept of universal proportionalism as the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are therefore universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need.

Approaches to addressing health inequalities need to be sustained over a long period of time and in conjunction with partners and the Rotherham population themselves. Rotherham's Accountable Care Partnership (ACP) will enable a joined approach to addressing the boroughs inequalities. The ACP, will deliver the Local Integrated Health and Social Care Place Plan (IHSCPP).[2] The current IHSCPP was agreed in November 2016. Rotherham's IHSCPP details a joined up approach to delivering key initiatives that will achieve the Health and Wellbeing Strategies[3] key aims and meets the South Yorkshire Accountable Care System Plan.

The Accountable Care System within South Yorkshire and Bassetlaw, involves all NHS organisations together with local authorities to take appropriate collective responsibility for resources and population health, to transform the way care is delivered to the benefit of their populations. This will support the Rotherham Together Partnership (RTP) to address health inequalities in a sustained manner.

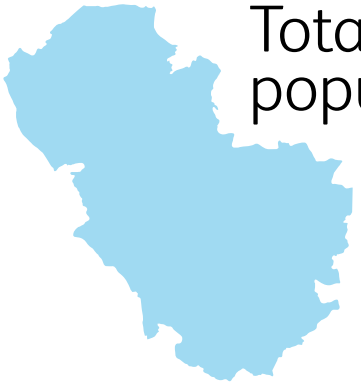
The Rotherham Economic Growth Plan 2015-2025[4] aims to make Rotherham a place where businesses will flourish and grow where the population is highly skilled and enterprising and where there is quality housing provision for all sections of the community. This plan will support the overall health inequalities issue and is part of the RTP whole system approach to sustained development of Rotherham as a successful and vibrant borough.

The plan identifies the need to create more and better quality jobs to increase its contribution to the national economy and provide residents with employment opportunities that enable them to thrive. The plan's themes include "skills for employment and progression" and "inclusion, wellbeing and employment".

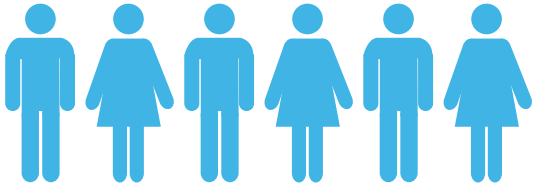
The inclusion, wellbeing and employment theme emphasises that, for the growth plan to be a success, support must be provided to people who are disadvantaged in the jobs market to help them enter and be successful at work. This will involve working with a range of partners, including Jobcentre Plus, to provide tailored support that meets the needs of individuals and businesses, enabling everyone to benefit from economic growth.

Acknowledgements

I would like to thank the Public Health Team, other council contributers and the wider partners who have contributed to this report. Special thanks also go to Gill Harrison and Jacqui Wiltschinsky who put the report together.

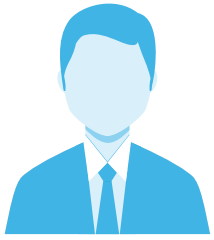


Total population **261,900**



161,200

Number of residents of working age (16-64)



22.7% working age population not in work and not looking for work

77.3%

working age population in work or looking for work

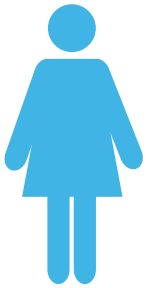
a man in Rotherham can expect to live to

77.9

having spent

18.1

years in poor Health



a woman in Rotherham can expect to live to

81.6

having spent

25.9

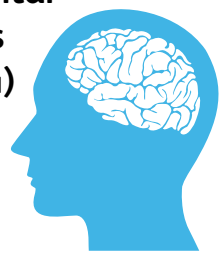
years in poor Health

32.6%

Residents aged over 16 classed as obese

9,445

Adults in contact with secondary mental health services (aged 18 to 74)



37,600

Residents aged over 18 currently smoking

Pregnant women smoking at time of delivery

17.1%

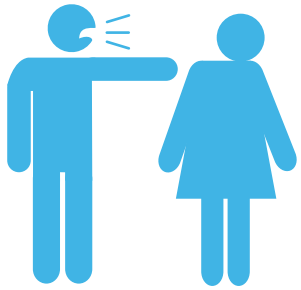
6,284 alcohol related hospital admissions

Annual flu immunisation uptake in at risk groups aged under 65 was

52.7%

725

New cancer cases diagnosed each year aged 25 to 69

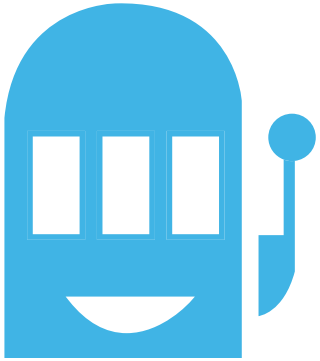


6,100

Domestic abuse incidents

1,196 Adults in contact with substance misuse services

447 Respiratory related deaths



9,610

Residents estimated at risk from their gambling behaviour

1,059 diagnosed

sexually transmitted infections in the 15 to 64 age group

666

CVD related deaths

Only 8.3% residents felt unhappy

Why is The Health and Wellbeing of the Working Age Population Important?

Living well is important for individuals and the population as a whole to ensure a good quality of life throughout the life course. Living a healthy life can increase life expectancy and making the right life choices can reduce the likelihood of premature death and suffering certain long term conditions. Lifestyle risk factors such as smoking and poor diet can lead to poor health and can be linked to deprivation.

Addressing individual lifestyle risk factors is important but so too is the acknowledgement that political, social, economic, environmental and cultural factors will shape the conditions in which people are born, grow, live, work and age. Creating a healthy population requires looking at the bigger picture. The gap in life expectancy and healthy life expectancy between people living in the most and least deprived areas in Rotherham is a concern. The things that make people healthy include; good work, education, housing, resources, physical environment and social connections as well as the absence of ill health or disease.

Working adults support the welfare state through income generation and paying taxes as well as contributing to civic society. It is therefore important to promote and protect both the physical and mental health of this sector of the population.

1 Mental Health, Wellbeing and Loneliness

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What it looks like now

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

> "…a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community."[5]

Good mental health therefore is fundamental to how an individual, communities and society functions. However, one in four adults experiences at least one diagnosable mental health problem in any given year. Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year, roughly the cost of the entire NHS[6].

An adult's mental health is influenced by a variety of protective and risk factors at individual, community and structural levels. For example being in a stable relationship tends to be a protective factor for both physical and mental health. Conversely being in an unhappy relationship can lead to a person having poorer mental health than a person who is not in a relationship at all[7].

Experiencing two or more adverse life events in adulthood is associated with mental health problems. Life events include job loss, illness, bereavement. Many adults may take on more caring responsibilities for a partner or family member who develops long term health problems. This can lead to poor mental wellbeing for the person doing the caring with people feeling unsupported and isolated[7].

Adults in Great Britain who are unemployed are between four and ten times more likely to develop anxiety and depression[8]. However not all work is conducive to good mental health. The workplace needs to be a healthy and supportive environment.

Mental health and physical health are strongly linked. Evidence (Disability Rights Commission, 2006) shows that people with severe mental health problems are at risk of dying, on average, 15 to 20 years earlier than other people[9].

All physical health problems will have a psychological dimension, this is particularly evident when people are learning to live with a long term condition. For some people this may mean a loss of income and earning potential, loneliness, isolation and functional impairment. For those people living with physical health problems, who then develop mental health problems, it can mean that they experience more complications[6].

The mental health of individuals is shaped by social inequalities. People living in more deprived areas tend to experience poorer mental health[1]. This includes an adult's access to community resources, like facilities for children, opportunities for exercise, the quality of the environment, including the quality of housing and any stigma or discrimination they experience. Taking action to improve the mental health of adults must take into consideration the social determinants of health, increasing the protective factors and reducing the risk factors. Taking such action requires a partnership approach.

The public perception of loneliness is often that it is an issue solely experienced by older people and research has tended to focus on this age group. However in a recent report commissioned by British

Red Cross and the Co-op (2016), 'Trapped in a bubble', loneliness is highlighted as an issue of public interest. The report concentrated on six target groups these included; people who had been recently bereaved, adults with no children living at home, individual with mobility limitations and those who have recently been divorced or separated. The survey they conducted found that 73% of those who stated they were always/often lonely fell within one of the six research target groups. The report emphasises that loneliness contributes to poorer physical and mental health, with people experiencing suicidal thoughts when they feel they have nothing to offer society.

The report reflects that some of the features of modern day society, such as work life balance have contributed to people's experience of loneliness. People interviewed for the report felt that working hours were longer and more anti-social which meant that there was less time to socialise with people and make social connections. However good work life balance can help people to feel less lonely with people having those social connections through work. Interviewees also reflected that the rise in digital technology has meant that people are not making social connections in person with more of this happening online.

The report confirms that life events can disrupt a person's social connections which can then lead to loneliness. It makes a strong case for preventative measures to combat loneliness particularly when it is known that people are experiencing these life transitions like children leaving home, bereavement and divorce and separation[10].

People living with mental health problems report that stigma and discrimination has an impact on their wellbeing. It can prevent them from seeking help, delay treatment, impair recovery, make them feel isolated and excluded from activities and can be a barrier to employment.

Across the UK:

- One in four adults experience at least one diagnosable mental health problem in any given year.
- Suicide is now the leading cause of death for men aged 15 – 49.
- People with severe and prolonged mental illness are at risk of dying, on average, 15 to 20 years earlier than other people, one of the greatest health inequalities in England.
- The overall costs to business of mental ill health is £34.9 billion. This is: £10.6 billion in sickness absence; £21.2 billion in reduced productivity when at work (this is often referred to as "presenteeism"); and £3.1 billion in replacing staff who leave their jobs for mental health reasons[11].

Figures for Rotherham show that:

- 10.8% of adults over 18 in Rotherham had depression in 2014/15 (England average 7.3%).
- In 2013 -15 there were 96 suicides in Rotherham (aged 10+). The suicide rate of 14.2 per 100,000 is higher than both the England rate (10.1) and the Yorkshire and Humber regional rate (10.7).
- For self-reported emotional wellbeing in 2015/16 Rotherham residents reported high levels of low satisfaction with life, low happiness and high anxiety. These rates were higher than the average for England and for the Yorkshire and Humber region as a whole.

(Above data for Rotherham is taken from Public Health England Profiles[12])

CASE STUDY

As part of the Early Help strategy's Link to Early help strategy focus on families, there is also a specific commitment to: 'work with our partners at the Department of Work and Pensions to provide employment support as part of a coordinated whole family plan that families are able to engage with.' The case study below demonstrates the effect this support can have on a family.

KC had moved away from the threat of domestic violence in her life but still had a range of problems affecting her life, debt and poor mental health was a continuous problem for her.

After contacting Employment Adviser Support she was shown how much better off financially she could be in work as well as all the other benefits of socialising, raised confidence etc. She was also given advice on job searching and the application process and volunteering was discussed as an option to get some up to date experience and a way of getting a work reference.

After a few months of jobsearch KC had a job interview but she didn't attend as she was feeling anxious and depressed due to escalating debts. Employment Adviser Support arranged for debt support for KC from Citizens Advice so that she could get her debts under control again.

She now works for a local hotel as a cleaner. She had 6 months in-work support to ensure any issues were ironed out.

KC really enjoyed the job although the down side was she never knew how long the working day would be. Sometimes it could be a 2pm finish sometimes it could be 5pm. Luckily she had good family support for her son. If she had to have paid for a childminder her debt may have increased again leading to more anxiety which could have effected her ability to hold down her job.

In this case, debt and poor mental health were the barriers stopping KC getting into work but, if she didn't have good family support the difficulties around child care could have also been a problem. All these things create barriers for families wanting to move into work.

What Rotherham's doing

In July 2016 the Rotherham Suicide Prevention and Self Harm Group launched a social marketing campaign aimed at men, their family and friends called 'Break the Silence'. The campaign encourages men who are thinking about suicide to seek help. The campaign also helps family and friends to spot the signs that the person may be thinking about suicide and get them to appropriate help. The campaign has been promoted at the Rotherham Show, to local workplaces, leisure centres, GP practices, sports clubs and groups. The campaign received further funding from Wickersley, Maltby and Hellaby wards with the message being produced on beermats which were distributed to all pubs and working men's clubs in these wards. In addition the Area Assembly covering these wards funded Mental Health First Aid and suicide prevention training which was accessed by people who lived or worked in the area. Follow up with participants from the suicide prevention courses has shown that over half of the people have already used their newly acquired knowledge and skills to support people in their community who were in distress.

Many frontline workers from Rotherham Council, NHS services, South Yorkshire Police and voluntary and community organisations have attended suicide prevention training in the last few years. Attendees of the courses have reported that they have used the knowledge and skills from the training to help someone who was thinking about suicide.

Mental Health First Aid (MHFA) training is an internationally recognised course. Mental Health First Aid teaches people how to identify, understand and help someone who may be experiencing a mental health issue. The Adult MHFA course has been delivered in Rotherham since 2007.

Between 2008 to 2012 Rotherham had a workplace mental health project, 'Mind your Own Business', which encouraged and supported local employers to look after the mental health of their employees and create mentally healthy workplaces. The Workplace Wellbeing Charter is continuing with this work with mental health being one of the health areas local businesses are encouraged to take action on.

Promoting the mental health and wellbeing of Rotherham people and preventing mental ill health is the responsibility of all. Working closely with partners across Rotherham the Better Mental Health for All strategy (2017-2025) aims to improve the mental health and wellbeing of Rotherham people by encouraging partners across the borough to work together using the strengths (assets) that individuals, communities and organisations have.

Our plans for the future

Delivery of the actions within the Better Mental Health for All Action Plan:

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

2 Dealing with Drug and Alcohol Misuse

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What it looks like now

Drug Abuse

The World Health Organisation defines substance misuse as 'the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs'[13].

The effects of substance abuse, significantly contribute towards poor health, homelessness, family breakdowns and offending. The major cost to society from drug addiction is from drug related crime which is estimated to cost £13.9 billion per year nationally[14].

In 2016/17 there were 1617 adults and 26 young people known to treatment services for drug and/or alcohol misuse in Rotherham.

The young people who are accessing the services are often very vulnerable. In Rotherham 24% of young people in treatment are reported as being a 'child in need'. 26% state that they are affected by domestic abuse compared to 21% in treatment nationally . There are a number of specific issues facing girls, including increased citation of alcohol as a problematic substance, involvement in self-harm, being affected by domestic violence and involvement in sexual exploitation.

Alcohol Abuse

Alcohol abuse is considered the second biggest cause of preventable death in the UK. Routine use of alcohol and drinking above the recommended lower risk guidelines puts people at risk of developing chronic alcohol related diseases such as liver disease, diabetes, cardiovascular disease, and cancers of the breast and gastrointestinal tract. As with drug abuse, excessive alcohol consumption affects all sectors of society and can cause ill health, family breakdown, anti-social behaviour and crime, it is estimated to cost society £21 billion per year nationally (PHE data).

According to the Government Alcohol Strategy 2012: In a community of 100,000: Over 3,000 will be showing some signs of alcohol dependence (3%) and be classed as dependent drinkers. For Rotherham, based on the total population, (all ages) as at mid-2016 (ONS,2017[15]) 3% equates to around 7,850 (ONS,2017).

As quoted by Public Health England (PHE): "Drinking very large amounts of alcohol on a single occasion, increases the likelihood of experiencing acute alcohol related harms." This is classed as hazardous drinking (Home Office, 2012[16]).

For 2011-2014 combined 19.7% of adults in Rotherham (around 40,450 people) were binge-drinking (reported drinking over 6 units for females, over 8 units for males) on the heaviest drinking day in the past week (NHS Digital, 2016[17]).

Additionally, according to Low Risk Drinking guidelines (2016)[18] issued by the UK Chief Medical Officer "To keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis'.

For 2011-2014 combined 30.1% of adults (61,800 people) in Rotherham reported drinking over 14 units of alcohol a week (NHS Digital, 2016)

What Rotherham's doing

Rotherham's Drug and Alcohol Adult Treatment Services provides:

- Single Point of Access
- Assessment of an individual's needs
- Medical treatment if required
- Assessment for rehabilitation placement / direct payments to support social needs
- One-to-one and group therapeutic support
- Relaxation and activity based groups (including auricular acupuncture)
- Signposting to Mutual Aid and other support such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and SMART Recovery
- Signposting and support to access advice around housing, training and employment
- Other health care orientated support around blood borne viruses including Hepatitis vaccination, Hepatitis C screening and referral into treatment for Hepatitis C treatment.

Both treatment and recovery teams are connected closely together enabling service users to access the appropriate treatment for them to meet their needs at any particular point in time and to support them in their journey through recovery.

The young people's substance misuse service works with health, social care, Child and Adolescent Mental Health Services and voluntary sector agencies to provide packages of care and support to young people and their families. This service provides similar treatment interventions as those provided by the adult services.

The team also provides support, advice and educational sessions to a wide range of professionals who are managing young people's substance misuse as part of a wider range of challenging behaviours or circumstances.

Rotherham works to improve the intelligence for young people and front line agencies on emerging drug and alcohol trends. This is done through the Young Persons Substance Misuse Education and Prevention and Intelligence Group, who strive to get key messages and warnings out to young people and adults throughout Rotherham.
A team of substance misuse housing specialists provide support to client's in their own homes for those most at risk of losing their accommodation through substance misuse. This team works closely with treatment and housing services.

Needle exchange schemes and harm minimisation advice is provided from several pharmacists in Rotherham to help reduce infections and the spread of blood borne infections.

Our plans for the future

The Rotherham's Substance Misuse service has been reviewed and re-commissioned under a new structure to start from 1st April 2018.

Part of the new tender requires the provider to produce a campaign to issue and train high risk groups on Naloxone use (emergency treatment for opiate overdoses), to help reduce opiate related Drug Related Deaths in Rotherham.

3 Tackling the issue of Domestic Abuse

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What it looks like now

Domestic abuse is defined as any incident or pattern of controlling, coercive or threatening behaviour or abuse between those aged 16 and over, who are or have been intimate partners or family members, regardless of gender or sexuality. This encompasses, but is not limited to, physical, emotional, psychological, sexual and financial abuse. Domestic Abuse includes forced marriage, "honour" based violence, partner and ex-partner stalking and harassment.

Domestic abuse causes harm not only to the individual but also to other members of the family, community and wider society.
Victims of domestic abuse may suffer long term physical and mental health problems and are more likely to face economic consequences, unemployment and welfare dependency.

The impact of domestic abuse on children includes increased levels of vulnerability and higher risks to their welfare as a result of domestic abuse occurring in their household. 30% of domestic abuse starts in pregnancy.

South Yorkshire Police received 6,500 calls relating to domestic abuse during 2016, a rise of 5.7% in comparison to 2015 (6,152). Recorded domestic-related crime also rose by 28% locally in 15/16 and estimates suggest over 27,000 women and girls in the Rotherham area have suffered abuse in their lifetime.

The number of crimes has risen by 22% from 1,562 in 2014/15 to 1,900 in 2015/16. During 2016/17, there were 3,914 contacts made to the early help service and 'family relationships' are amongst the top three cited needs.
Domestic abuse is a feature for 70% of Rotherham children who are subject to a plan of protection, in line with national trends.

What Rotherham's doing

There are a number of programmes and interventions available across the borough for both victims/survivors and their families.

The most high risk cases of victims/survivors of domestic violence and any children involved are supported by the Independent Domestic Violence Advocate service (IDVA) through a Multi- Agency Risk Assessment Conference (MARAC). This deals with around 500 domestic abuse cases per annum. Public Health fund the current three IDVA workers and the Police and Crime Commissioner is funding two additional staff to bring Rotherham in line with recommendations from Safelives, a national charity dedicated to ending domestic abuse, for good.

Individuals are also offered support through 'Rotherham Rise' (a Rotherham Council Adult Care and Housing commissioned service) and 'Early help' within the Children's services.

Referrals can be made and support obtained from Rotherham Abuse Counselling Service which supports victims of domestic and sexual abuse.

The appointment of a Domestic Abuse Co-ordinator has led to a large increase in training and awareness, along with a new multi-agency Safer Rotherham Partnership 'Domestic Abuse' Strategy.

Our plans for the future

Rotherham has jointly commissioned a perpetrator programme ` with the other areas of South Yorkshire. With the main aims of:

- Reducing the harm caused to families by domestic abuse
- Challenge the acceptance of abusive behaviour, by using a neutral rather than a collusive or persecutory stance
- Change the behaviour of individual perpetrators of domestic abuse
- Prevent abusive behaviour in the future
- Reducing crime and anti-social behaviour.

Rotherham Council RMBC is working towards a one front door approach to Domestic Abuse to ensure continuity of support, avoid duplication and make the victim's referral process simpler.

The additional recruitment of two more IDVA's will increase support to high risk victims.

Wider delivery of Domestic Abuse training and awareness sessions will help promote a 'Make Every Contact Count' (MECC) approach, which is a key aim in the new Domestic Abuse Strategy.

Domestic Abuse awareness and training is also now to be included in the Public Health's 'Workplace, Health and Wellbeing Charter'.

4 Looking after Sexual Health

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What it looks like now

The National Strategy for Sexual Health and HIV (2001) defines sexual health as a key part of our identity as human beings. Good sexual health is an important part of physical and mental health and wellbeing, the consequences of poor sexual health can impact considerably on individuals and communities.

Poor sexual health is disproportionately experienced by some of the most vulnerable members of our local communities, including young people, men who have sex with men (MSM), people from countries of high HIV prevalence, especially Black Africans, those who misuse drugs and/or alcohol and people from our most deprived neighbourhoods. We must, therefore, ensure that measures are put into place to reduce sexual health inequalities and improve the sexual health of all the people of Rotherham.

The rate for new diagnosis of all Sexually Transmitted Infections (STIs), excluding chlamydia diagnosis in 15-24 year olds, is 645 per 100,000 in Rotherham. This is higher than the rate across Yorkshire and Humber (613 per 100,000) but lower than the rate for England (795 per 100,000)[19].

Reinfection with an STI is a marker of persistent risky behaviour. In Rotherham, an estimated 4.2% of women and 4.7% of men presenting with a new STI during the five year period from 2011 to 2015 became reinfected with a new STI within 12 months. Nationally, during the same time period, an estimated 7.1% of women and 9.3% of men presenting with a new STI became reinfected with a new STI within 12 months[19].

Since chlamydia is often asymptomatic, a high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. The chlamydia detection rate per 100,000 young people aged 15-24 years in Rotherham is 2,033. This is slightly lower than the rate across Yorkshire and Humber (2,072 per 100,000) but higher than the rate across England (1,882 per 100,000). Rotherham has also shown an improvement in detection rate as it was as low as 1,738, per 100,000 in 2015.

Rotherham is classed as a low prevalence area for diagnosed HIV. The rate of diagnosis being 1.13 per 1,000 population aged 15-59 years. This compares to 2.26 per 1,000 in England. Early diagnosis of HIV is crucial in the management of the infection and late diagnosis is an important predictor of HIV related morbidity and short term mortality. In Rotherham, between 2013 and 2015 48% of HIV diagnoses were classed as late compared to 68.8% late diagnoses across England[19].

The highest number of unplanned pregnancies occur in the 20 to 34 year age group. Unplanned pregnancy can cause financial, housing and relationship pressures and have impacts on existing children. If a woman choses to have an abortion then the earlier abortions are performed the lower the risk of complications. Prompt access to abortion services, enabling provision earlier in pregnancy, is also an indicator of service quality. Across England 80% of NHS funded abortions occur under 10 weeks. In Rotherham 69.7% of NHS funded abortions occur under 10 weeks[19].

What Rotherham's doing

Local authorities are mandated to provide, or ensure the provision of, open access sexual health services for their populations. This includes testing and treatment for STIs (but not treatment of HIV which is the responsibility of NHS England), partner notification, HIV prevention and contraceptive services.

During 2015 Public Health consulted with a wide range of stakeholders in relation to what would be the best model for delivery of sexual health services in Rotherham. This then informed the procurement process during 2016 and on 1 April 2017 the Integrated Sexual Health Service (ISHS) opened its doors at Rotherham hospital. The new service brought together expertise in STI testing and treatment with a full contraceptive service offering a 'one stop shop' experience for Rotherham residents. The service also offers a range of community outreach initiatives to increase testing and treatment for STIs in partnership with a Yorkshire third sector provider, Mesmac.

Public Health have also commissioned a third sector provider for HIV prevention work in Rotherham. Plusme work with schools and colleges, providing teaching resources and training. They work with communities to raise awareness of HIV and ensure that national campaigns such as 'World AIDS Day' are promoted in Rotherham. Plusme also run a support group for people living with HIV enabling people to access the services they need.

Rotherham has an active Sexual Health Strategy Group which has representatives from a wide range of agencies including Rotherham Council Public Health, Rotherham Clinical Commissioning Group, the ISHS, Local Pharmaceutical Committee, as well as Healthwatch, Barnados, Plusme and Mesmac and new members are added as the work of the group evolves. Chaired by the Cabinet Member for Adult Social Care and Health the group produced a Sexual Health Strategy for Rotherham, 2015 to 2017 with an agreed action plan to improve sexual health in Rotherham. The second year action plan for 2017 highlighted a range of initiatives including the introduction of community testing for STIs and planned promotional activities for 'National Testing Week'.

Our plans for the future

The Rotherham Sexual Health Strategy Group are looking to refresh the strategy and Public Health will be working with a range of services and service users to shape the new strategy and associated action plan. The aim will be on a 'Rotherham Strategy for Rotherham People' with a focus on prevention.

One area which has been highlighted by the Strategy Group for future work is in relation to Rotherham women's prompt access to abortion services. Prompt access is a key indicator of a good quality service. Across England 80% of NHS funded abortions occur under 10 weeks whereas in Rotherham 69.7% of NHS funded abortions occur under 10 weeks. Understanding why women are not accessing the services earlier can inform what can be done differently to allow prompt access

5 Towards a smoke-free generation

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What it looks like now

Smoking prevalence for adult current smokers is 18.3% (Adult Population Survey (APS) 2016[20]) which is the lowest figure since numbers have been recorded. Also this trend is reflected in adults who are classed as working in routine and manual occupations whose rate is 26.5% (APS) 2016. This is the same percentage as the England average, this is to be celebrated given the demographics of Rotherham.

Smoking status at time of delivery rates are 17.1% (2016/17) compared to an England average of 10.7% and the highest rate of over 26%. Rotherham rates remain high but do show a downward trend as in 2009/10 the figure was 26.1%[21].

In addition Smokefree laws have been introduced to protect people from the harms of second-hand smoke. It is illegal for anyone to smoke in:

- an enclosed public place and within the workplace, including public transport and work vehicles (July 2007)
- private vehicles carrying children (from October 2015).

Additional initiatives introduced include all NHS services being Smokefree and the introduction of standardised packaging (2015)[22].

All of these factors have created a very different 'social norm' where now in Rotherham 55% of adults have never smoked and this has reduced the impact of second hand smoke on the general population.

Smoking prevalence is reducing, with the biggest drop amongst adults seen in 2016 in England. Public Health England has reported that the quitting success rate for the first half of 2017 is the highest for at least a decade. Also people are starting to use electronic cigarettes instead of tobacco as a way of helping them to give up.

However, smoking continues to be the leading cause of preventable deaths, in 2015, 16% of all deaths in people aged 35 or over in England (79,100 deaths) were estimated as being attributable to smoking. Smokers are almost twice as likely to have a heart attack as non-smokers. This is due to the narrowing of the arteries, reduced oxygen in the blood and increased likelihood of blood clots caused by cigarette smoke[23].

To stop smoking in pregnancy is the single most important modifiable risk factor to improve the health of a baby; it helps to prevent early births, small babies, stillbirth and Sudden Infant Death Syndrome.

Smoking rates are higher in poorer communities; the Department of Health reports that smoking accounts for almost half the difference in life expectancy between the richest and poorest in society[24]. As well as their health, the cost of smoking further impacts on more deprived areas, as in 2016, tobacco was 27% less affordable than it was in 2006 [25].

What Rotherham's doing

Rotherham's designated quit smoking service offers a universal service and a targeted approach, where the service works pro-actively in areas of greatest need. The majority of its quitters are from the routine and manual occupations. The service helped over a thousand people to quit last year.

Public Health commission a bespoke service which works alongside midwifery to support pregnant women to quit. Working with pregnant women and families creates an opportunity to improve the health of both the family and the baby.

Trading Standards within the Council work to prevent the sale of illicit tobacco, which is unregulated and offers even more health risks. Trading Standards work collaboratively with the police to help identify and convict potential illicit tobacco suppliers.

Public Health also works with key partners to try and reduce the impact of Tobacco on Rotherham residents. The Health and Wellbeing Board have chosen Tobacco as one of their priorities so an action plan will be developed to move this agenda forward.

Our plans for the future

To work towards a 'smokefree generation', eliminating smoking among the under 18s by 2025. Smoking remains an addiction which is largely taken up in childhood, with the majority of smokers starting as teenagers. In general, among current and ex smokers aged 25 and over, men had started at a younger age than women. Around 38 % of men and 33 % of women had started smoking aged 15 or under[26].

One of the most effective ways to reduce the number of young people smoking is to reduce the number of adults who smoke. We know that children are heavily influenced by adult role models who smoke: in 2014, 82 % of pupils who regularly smoked reported having a family member who smoked[27].

Continuing to encourage adult smokers to quit must therefore remain an important part of reducing prevalence amongst the young, and achieving a smokefree generation. As 65 % of smokers say that they want to quit (Department of Health Analysis using Health Survey for England 2014 data) then support for them is essential.

The ethos of Smokefree areas will also be developed further to decrease the impact on smoking for the Rotherham's population and particularly children. Public Health is working with elected members, local schools and Regeneration and Environment, to develop a voluntary code of practise to establish Smokefree playgrounds.

The 'Making Every Contact Count' initiative will also support professionals to have sensitive conversations with their clients to encourage them to quit. The new Integrated Wellness Service (April 2018) will also offer a number of different ways to support people to stop smoking and continue to have a targeted approach.

Public Health will keep up to date with new developments and evidence based practice with the tobacco control agenda, including electronic cigarettes research.

6 Addressing Obesity

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What it looks like now

Adult obesity is classified by working out a person's Body Mass Index (BMI). BMI is a measure of weight relative to height. (This would prob look better in a table)

For most adults, a BMI of:

18.5 to 24.9
means a healthy weight

25 to 29.9
means you're overweight

30 to 39.9
means you're obese

40 or above
means you're severely obese

Living with obesity and overweight presents significant health issues. Adults who carry excess weight are more likely to develop serious physical health problems such as type 2 diabetes, heart disease, stroke and certain cancers therefore potentially reducing their life expectancy.

Psychological problems such as anxiety and depression, low self-confidence and self-esteem are commonly associated with adult obesity. Obese adults are also more likely to have children who are obese.

Obesity has severe cost implications for health and social care and the wider society.

NHS costs attributed to obesity are predicted to be £10 billion per year by 2050 (£352 million for social care). Wider societal costs predicated to be £49.9 billion per year (PHE, 2017[28]).

Nationally two thirds (65%) of adults are overweight or obese, with levels of obesity increasing significantly over the last twenty years (NHS Digital 2016[29]).

Levels amongst Rotherham adults are higher than the national average with 76% (2013-2015) of adults being overweight or obese (PHE 2017[30]) .

All groups in society are not equally affected. National data highlights these disparities with black and minority ethnic groups, those living in deprivation (most deprived decile 65.4%), older adults and people with disabilities (75.7%) are more likely to be obese (PHE 2017[31]).

CASE STUDY

A woman in her 40's who suffers from long term mental and physical health issues was referred to the Rotherham Health Trainer service by her GP as she had asked for support to lose weight.

Due to her mental health she had had a lot of time off work and had been signed off from work. She had lost her confidence and had become more isolated with no friends, problems with her family and was in a lot of pain due to fibromyalgia. She was also very self-conscious about her body image and was an emotional/ comfort eater.

The Health Trainer listened to her, chatted with her and they talked about taking small steps and setting some goals for change including looking for some specialist counselling to help her come to terms with things that had happened in the past.

After three sessions with the Health Trainer she had lost 4kg in weight, had an appointment for counselling and was very pleased with herself and her confidence was growing so much that she was coming up with her own resolutions with support.

The client was happy with health trainer's support and felt for the first time that someone had listened to her and starting putting her on the road to a better life. It was the first time she could see herself achieving her goals and she was starting to feel more positive. She was having more good days in her words.

What Rotherham's doing

Weight management services have been delivered in Rotherham since 2008. The services support obese and overweight adults to lose weight and maintain weight loss.

The weight management services provide assistance and techniques to adults including psychological support, increasing physical activity levels, improving diets and behaviour change.

The services deliver support to adult's dependant on their clinical need. Adults meeting clinical criteria are also supported to access bariatric surgery commissioned separately.

Since 2015 over 2,624 adults have accessed support to lose weight in Rotherham. Of these. 2,369 have lost weight and 832 have sustained their weight loss over a six month period.

Obesity features in a range of initiatives currently being delivered in Rotherham. The Workplace Wellbeing Charter encourages all businesses it engages with to operate minimum standards on healthy eating and physical activity. A role out of MECC aims to empower front line staff to initiate conversations with their clients or customers about changing lifestyle behaviours. NHS Health Checks are offered to all eligible Rotherham residents aged 40-74 BMI is recorded and healthy weight advice is offered.

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Our plans for the future

Weight management services in Rotherham are changing. The Council has commissioned a new integrated wellness service from April 2018 which will provide a person centred approach, via a single point of access that links within a wider wellness network. The individual services to be included are:

- NHS Health Checks Programme
- Alcohol screening
- Smoking Cessation Service
- Single point of access (for weight management)
- Adult Weight Management Service
- Health Trainer Service.

This service will work jointly with the Rotherham Clinical Commissioning Group to provide a seamless pathway to allow adults to continue to access appropriate clinical advice and bariatric surgery.

Whilst weight loss services will continue to be in place in Rotherham, the local authority focus needs to continue and develop three pillars highlighted by Public Health England as key to supporting people to lose weight and maintain weight loss. These pillars are at the population, community and individual level.

Stakeholders and partners need to work together to use opportunities to influence action and encourage a whole systems approach. Examples include working with planners to consider the obesogenic environment in new applications, promotion of green spaces and active transport, continued promotion of physical activity and training frontline staff to have the confidence to talk to clients about their weight as part of the MECC programme.

7 Physical Activity

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What it looks like now

Leading a physically active lifestyle is important for maintaining physical and mental health and it can improve people's quality of life. There is a large amount of evidence to suggest that regular activity reduces incidence of many chronic conditions (PHE, 2016[32]). Physical activity contributes to a wide range of health benefits and regular physical activity can have protective health outcomes irrespective of whether individuals achieve weight loss. Further protective factors for physical activity relate to strength, balance and flexibility, all areas which are important for maintaining our body's health as we age (Taylor, 2014[33]).

Being inactive can have a big impact on health, one in six adults in the UK die as a result of being inactive. The positive is that this is easily fixed with a small amount of regular activity making a big difference and this is particularly the case for those who are least active (Sport England 2016[34]).

Physical activity is about "moving more" and living a more active lifestyle both at home and at work. The focus is to encourage more regular activity and for physical activity to be built into society and our everyday lives. It is recognised that many people live sedentary lifestyles and sit for long periods which has a detrimental impact on their health (PHE, 2014[35]).

Walking is considered an easy and low cost way to be physically active. It is something that can be built into people's everyday life and can help adults meet the daily and weekly targets. Adults are advised that they should walk 10,000 steps a day to stay healthy (NHS Choices, 2017[36]).

The Chief Medical Officer advises that adults aged 19-64 should aim to do at least 150 minutes of moderate aerobic activity such as cycling or brisk walking (100 steps a minute) every week, and strength exercises on two or more days a week that work all the major muscles (legs, hips, back, abdomen, chest, shoulders and arms) to stay healthy (CMO, 2011[37]).

Nationally physical activity is reviewed by the 'Active Lives Survey' which is updated every six months.

The most recent Active Lives survey identifies three groups:

Active (at least 150 minutes a week)

Fairly active (30-149 minutes a week)

Inactive (less than 30 minutes a week)

Locally, we have a less active population when compared to the England average;

	Inactive	Fairly active	Active
England	25.6%	13.8%	60.6%
Rotherham	31.9%	13.6%	54.8%

Ref: Active Lives 2017.

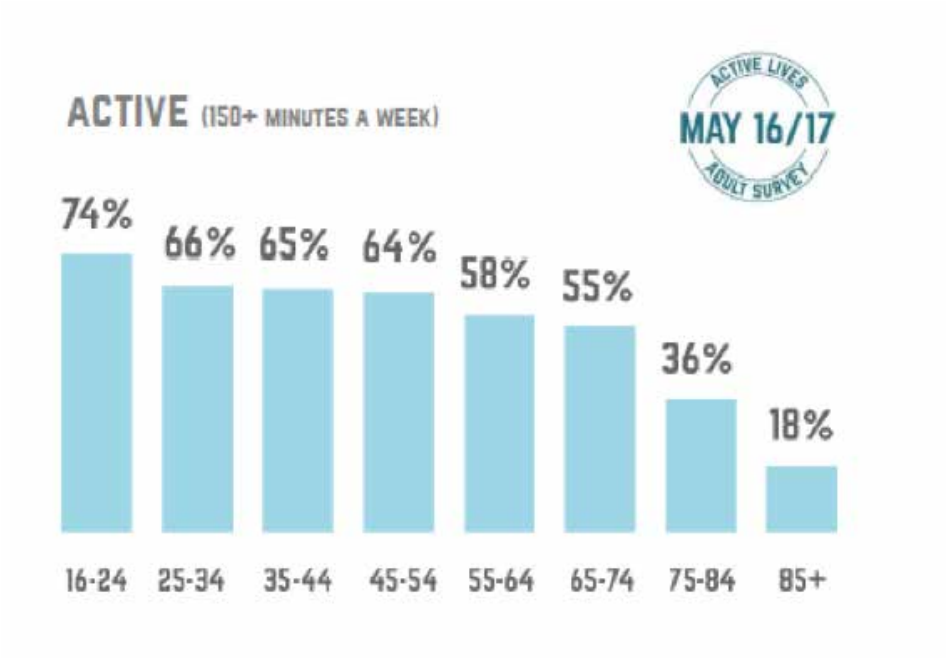
The number of inactive adults in Rotherham derived from the survey is 67,600.

Less than half of Rotherham adults (45.4%) walk for at least 10 minutes, five times per week, which is lower than the England average at 50.6%. Similarly only 74.6% of Rotherham adults walk for at least 10 minutes at least once per week compared to 80.6% in England (PHE, 2017, 2014/15 dataset[38]).

Rotherham is 70% rural and has a good amount of high quality green space identified in the 2017 green space assessment spread across the Borough (Rotherham Council , 2010, 2017[39]). However the utilisation of this space for health reasons is relatively low at 13.5% compared to the England average at 17.9% (PHE, 2017, Mar 2015 – Feb 2016 dataset[38]).

The most recent National data from the Active Lives survey show that there are significant disparities between different socio-economic groups, gender, disability and impairments, and age.

The graph below shows that there are stepped decreases in activity rates during adulthood. The key points are at 25 and 55. These timeframes seem to link to life changes e.g. at 25 these could include; leaving full time education, increased responsibilities through leaving home or becoming a parent. At 55 these could include early retirement, grandparent support or onset of ill health. It is important that we consider these points when developing strategies to target inactive adults.



The active lives survey also identifies the following as more likely to be inactive[40]:

- Disabled people are almost twice as likely to be inactive as non-disabled people
- 27% of women are inactive, compared to only around 24% of men
- 37% of those who are long term unemployed or have never worked are inactive and the most likely group to be inactive.

We also know that people with long term health conditions are much more likely to be inactive than people without a long term health condition.

What Rotherham's doing

Rotherham has focused on inactive groups and communities as well as developing opportunities for people to be active.

Rotherham Council has provided additional funding to increase walking with local communities. The 'Walk 2 Rotherham' project is funded by the Council and delivered by Places for People Leisure. This project began in October 2017 and encourages walking to schools, businesses and within local communities, through delivering a range of led walks, activities and campaigns. There will be a series of challenges and rewards developed and promoted throughout the three year project, to encourage more Rotherham people to walk regularly. Activity can be followed on @walkrotherham

Other local walking groups and places to find walks in Rotherham include:

- Casual ramblers – lists countryside, waterside, woodland and urban walks[41]
- Rotherham Council highlight doorstep walks on the Council pages[42]
- Walking for health[43].

Public Health England has developed tools and national campaigns to help adults assess their physical activity levels and encourage them to be more active.

These include:

One You

The "One You" campaign[44] focuses on several health behaviours and getting adults "moving" encouraging people to be more physically active. The website provides information on why and how adults can be more active. This is being promoted to Rotherham adults across the borough.

Active 10

The Active 10 campaign[45] utilises an app which encourages adults to complete 10 brisk minutes walking everyday to gain maximum health benefits from brisk walking.

A brisk 10 minute walk every day can make a difference to health. Each 10 minute burst of exercise is known as an "Active 10".

Brisk walking is simply walking faster than usual, at a pace. It is suggested that one 10 minute brisk walk a day is done at first then this can be gradually build up to more.

Use of stepometers and devices that measure the number of steps taken help encourage daily activity.

Couch to 5K

Couch to 5K[46] is a specially designed programme which helps build an individual's running ability by building over a period of nine weeks. The nine week plan sets out a three times a week interval training programme (walking and running). Over the weeks your running time increases gradually (and walking decreases) so that by week 9 you will be running (without walking) for half an hour, which equals an approximate distance of 5K. Couch to 5k can be completed independently, with friends or as part of a group. There are many apps available to help people start and complete the programme.

The Rotherham Harriers running group have been supporting people to start running in the 'Couch to 5K' running groups[47]. These groups are aimed at increasing fitness and building a running plan using the NHS Choice Couch to 5k. In 2017 the Harriers supported 72 people in the running groups with 32 people going on to complete the 5K challenge.

Our plans for the future

A new cultural strategy is being developed which will cover culture, sport, physical activity and green spaces. There will be a clear vision and drive to work in partnership to maximise all the opportunities to be physically active in Rotherham.

The One You and Active 10 programmes will be further promoted especially to inactive groups and settings for example, to women within sedentary workplaces. This will be aligned to the Workplace Well Being Charter.

The Rotherham Get Active website, which provides information on physical activity opportunities across Rotherham, will be promoted.

The use of green space for physical activity will be promoted, developing park runs, walking and cycling routes.

A pilot will be introduced using PHE's Physical Activity Clinical Pad to encourage more GPs to prescribe physical activity as part of their primary care consultations.

8 Long Term Conditions

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What it looks like now

Living with one or more diagnosed long term health conditions affects people's lives in a range of ways, resulting in them being more likely to be unemployed, socially isolated and financially challenged[48].

Rotherham has 26,763 people aged 16-64 with a long term health problem or disability, this equates to 16.4% of all working age people in Rotherham, compared with 12.7% of working age people in England, (Rotherham JSNA, 2017[49]).

However the number of people aged 16-64 with a limiting long term illness has reduced by 6.8% from 28,724 in 2001 to 26,763 in 2011.

CASE STUDY

Cancer Pathway

MT was left with only a quarter of his thigh muscle intact following an operation to remove a slow growing cancer. He was told that he might not be able to walk unaided again and he had lost confidence in his ability to get out and about. Being a very active man prior to his operation he was keen to improve and restore his confidence and so his GP referred him into the Active for Health programme.

After ten months MT felt more positive about himself and felt that his wellbeing had improved. He found it easier to walk and had more confidence in his walking ability. He had started gardening again and was enjoying socialising with the Active for Health Group.

What Rotherham's doing

ACTIVE FOR HEALTH

The Active for Health research project uses a partnership approach with Public Health, Rotherham CCG, healthcare services, Sheffield Hallam University and Sports & Leisure providers to test the role that physical activity can play in rehabilitation and recovery. Community based physical activity provision has been integrated into seven healthcare pathways as a rehabilitation exit offer, which enables patients to manage their long term condition(s) (LTCs) by keeping active. The conditions include;

- Cardiac and Heart Failure
- Stroke
- COPD
- Cancer
- Lower back pain
- Falls and fractures.

The Active for Health research programme began in November 2015 and will continue until the end of 2018. Early findings show that participants are seeing improvements in their health condition, quality of life and confidence after completing the 12 week free condition specific physical activity sessions. Over 70% of patients continue to be active after the 12 week programme to continue to improve their health and have fun. Working age patients are also finding that they are able to return to work, which is a real social and financial boost.

CASE STUDY

Lower Back Pathway

SE was referred to the Active for Health programme after suffering from sciatica twice. Before joining the programme he was not daring to exercise too hard in case the sciatica was triggered again.

After eleven months on the programme SE was feeling fitter and more active than he had for years. He was inspired to exercise every day and lead a more healthy lifestyle. He started to take on other personal challenges outside the programme which he accomplished without it resulting in pain and medication.

A strong supporter of the Active for Health programme, SE has now become a 'buddy' and welcomes and encourages new starters. He feels that motivating and reassuring others to attend could make a real difference to their lives.

HEALTHIER YOU
NHS DIABETES PREVENTION PROGRAMME

The Healthier You: NHS Diabetes Prevention Programme (NHS DPP)

This programme started in Rotherham in September 2017. Primary care identify adults who are at risk of becoming diabetic and they are then offered a nine month community based behaviour change programme to help them change their eating and exercise behaviours, to help them lose weight and thus reducing their personal diabetes risk.

NHS HEALTH CHECK
Helping you prevent
diabetes
heart disease
kidney disease
stroke & dementia

Local Authorities are responsible for ensuring that NHS Health Checks are offered to residents. The NHS Health Check is a health check up for adults aged 40-74. It is designed to spot early signs of heart disease, type 2 diabetes, stroke, kidney disease and dementia. As we get older, we have a higher risk of developing one of these conditions. An NHS Health Check can detect potential health problems before they do real damage. The professionals can then provide personised advice to help individuals lower their risk. They can also refer onto behaviour change services as appropriate. Between 2013 and 2017 there have been 28,193 people in Rotherham who have received an NHS Health Check.

Social Prescribing

Rotherham's nationally acclaimed Social Prescribing Scheme provides social activity in partnership with the voluntary sector to patients with a range of health conditions. The original programme addresses social isolation and poverty and sits alongside clinical interventions, helping people add quality time to their lives by maximising community assets.

NHS Rotherham CCG initially focused social prescribing to support people with long term physical health problems at risk of hospital admission and found that it reduced the use of services in this cohort. In 2015 this programme was expanded to mental health patients within Rotherham, many of whom were of working age. The approach to mental health social prescribing is to support and improve the sustainable discharge from secondary care of those who have become dependent on the help they receive from mental health services, long after their mental health illness has stabilised. The scheme focuses on quality of life, and the wide issues with which traditional mental health provision does not focus on but can significantly inhibit a return to normal life. The early findings are showing that the programme is helping patients with mental health problems lead healthier and happier lives.

A living with and beyond cancer

A Living with and beyond cancer project (LWABC) has been developed to deliver a Macmillan's ambition "to ensure that people diagnosed with cancer are living as healthy and active a life as possible during and after treatment". The funding has been used to employ additional Cancer Support Workers to increase the use of Holistic Needs Assessments. In 2018 there will be a new advocacy service to support patients living with and beyond cancer. This will be complemented by education for clinicians and health and wellbeing events for patients. Over the next three years Rotherham will see these services established and there is a long term sustainability plan for supporting continuation beyond the cessation of the Macmillan funding.

Our plans for the future

The development of the Accountable Care Partnership has enabled Rotherham to identify joint commissioning posts for health and social care. The development of these posts will help provide joined up solutions and reduce duplication.

There are external evaluations being completed on Active for Health, Social Prescribing, and Living with and Beyond Cancer. These evaluations will be shared with stakeholders and will help in future commissioning decisions.

9 Environments and Health

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While it is certainly true that the decisions we make as individuals do affect our health, it is also true that environments make a significant contribution. Individual decisions are always made in the context of economic, social and physical environments that can have a far greater impact than medical care on how long and how well people live. These include where people live (living in suitable quality housing), their neighbourhoods (such as access to schools and transport networks) exposure to crime, access to green spaces, air quality and other factors that affect our daily lives, including our health.

As individuals we cannot always control these factors and their influence on the choices we make and the lifestyle we lead. Therefore the consequences of spatial planning, housing, employment, transport, leisure or food systems policies can include lifelong effects on the health of whole communities[50].

Air Quality

What it looks like now

Air pollution presents a serious risk to the public's health. A joined up approach to tackling this threat can have significant benefits, particularly for our most vulnerable residents. It can also reduce the health burden and costs to the NHS[51]. The annual health cost to society of the impacts of particulate matter alone in the UK is estimated to be around £16 billion[52].

Air pollution is a mixture of particles and gases that can have an adverse effect on human health. Although air pollution has improved over recent decades, there are still significant public health challenges mainly related to Particulate Matter (PM2.5 and PM10.0) and nitrogen dioxide (NO2) in ambient air. Air pollution is associated with a number of adverse health impacts and is recognised as a contributing factor in the onset of heart disease and cancer and particularly affects the most vulnerable in society: children and older people, and those with heart and lung conditions[53].

Across much of the borough, air quality is good, but Rotherham, along with most urban areas in England, has areas of elevated air pollution which have been declared as Air Quality Management Areas[54].

There is often a strong correlation with inequalities, because areas with poor air quality are often associated with the less affluent areas[55 56].

What Rotherham's doing

Rotherham Council now has nine designated air quality management areas (AQMAs) in which approximately 30,000 people reside. These are areas which do not meet the European Union limit for Air Quality. The Council has installed a new portable monitoring device for PM2.5 monitoring of fine particulate pollution in two of these areas. Some of the latest low emission buses operate through Rotherham's Air Quality Management Areas.

Within the Sheffield City Region (SCR), the South Yorkshire Air Quality and Climate Group (of which Rotherham has actively contributed) has led on a number of initiatives over the last few years. These include:

- the 'South Yorkshire ECO Stars Scheme' working with HGV fleet operators to reduce emissions. Electric Vehicle Infrastructure rollout (Charging points)
- Hydrogen Fuel Cell vehicles (the first public hydrogen filling station is at the Advanced Manufacturing Park in Rotherham)
- working closely with South Yorkshire Passenger Transport Executive, Sheffield City Region partners and bus companies on a range of other air quality issues.

''Delivering Air Quality Good Practice Planning Guidance'' informs our local initiatives to reduce the impact of emissions by working with developers on air quality measures which can be incorporated into design and planning stages, e.g. electric vehicle charging points.

Our plans for the future

Working collectively through the Rotherham Air Quality Steering Group to improve air quality through behavioural, strategic and infrastructural changes so that the level of pollutants (nitrogen dioxide and fine particulates PM2.5 and PM10) are in line with national air quality objectives and support the principles of sustainable development. This will enable local partners to further integrate programmes of related work, such as active travel, reducing fuel costs, reduction in greenhouse gas emissions, reduction in noise and improving the council's vehicle fleet.

Clean Air Zones (CAZs) are now part of the Government's National Air Quality Plan which aims to reduce the levels of pollutants within specified areas. This is primarily by encouraging fleet and vehicle change to higher emission standards through a number of avenues.

As part of the national extension of Clean Air Zones to around 25 towns and cities, Rotherham Council has agreed to produce a joint Clean Air Zone feasibility study in conjunction with Sheffield City Council to identify the classes of vehicles that might be affected by any future Clean Air Zone.

Housing

What it looks like now

The quality of the built environment, particularly housing, is an important determinant of health and wellbeing.

The supply of housing locally and nationally is not keeping up with demand. This has a direct impact on people's ability to access housing that is affordable and meets their needs, which in turn causes many people to remain in housing impacting on their overall physical and mental health.

Housing conditions (space, location and disrepair), issues affecting affordability (including changes affecting housing benefit) and insecurity of tenure are known to be contributing factors in the development of mental health conditions.

Increasing the supply of good quality housing that meets a range of needs can enable people to live healthy, independent lifestyles for longer and reduce reliance on health care provision over the longer term by providing;

- access to good quality, warm and safe housing
- a better range of housing (size, type, location)
- affordable housing options to meet aspirations or reduce poverty
- flexible and adaptable homes which accommodate different life stages.

Fuel Poverty

In 2014, 10.5% of Rotherham's households were living in fuel poverty with figures being highest within the private rented sector (compared to 9% in 2013, 9.8% in 2012 & 10.1% in 2011) which is slightly above the national average of 10.2%. Area based energy efficiency schemes and improvements to council stock have contributed towards ensuring that fuel poverty levels do not increase further.

Although energy efficiency improvements contribute towards reducing fuel poverty, the cost of energy prices also impacts significantly on fuel poverty levels. Over the year the cost of fixed rate energy tariffs and variable deals has risen, exceeding what had been offered over the previous three years. This is a contributing factor in Rotherham's fuel poverty level increasing and may increase further as a result of recent energy price increases.

Housing in Rotherham is a mixed picture, with 20% living in social housing and around 12% in the private rented sector. The private rented sector has doubled in the last 10 years and continues to increase, while home ownership continued to decrease, particular among younger generations.

Rotherham Council's housing stock receives ongoing investment and meets the Decent Homes Standard but issues around poor quality and condition of housing in the private rented sector have been identified.

What Rotherham's doing

The Council has launched a new tenancy support service to supports tenants struggling to pay their rent. The service offers advice on money management building up the financial capacity of individuals to enable them to make sound financial decisions; and offers access to trusted financial services; which enable people to become more resilient to financial pressures in the future. This includes working with tenants to set up bank accounts or review energy providers and ensure they are getting the best deal.

Pre-tenancy interviews and workshops are now compulsory for any new applicant to the housing register. This is to ensure applicants receive all the support they need in order to secure and sustain a long term tenancy with the Council.

Rotherham Council has an ambitious growth programme in place and is delivering new homes, which will;

- Provide more choice
- Give people access to housing that better suits their needs
- Help people to live independently for longer
- Improve affordability, thermal efficiency through design, and in turn reduce fuel poverty
- New homes will also free up existing stock.

Housing growth also brings economic, environmental and social benefits to communities which in turn make for a healthier Rotherham.

There have already been over 100 strategic new build acquisitions added into Council stock including specialist homes and bungalows, with plans for many more in the pipeline. Substantial financial support is provided via Housing Revenue Account funding but the growth programme has also been successful in accessing external funding through various Government programmes to support the Council ambitions.

In order to deliver these ambitions, Rotherham Council must have a clear understanding of what housing need looks like and what it means to meet need at a local level. Housing need profiles are being developed which will help provide a snapshot of housing, identify what the key issues are and make recommendations on how to address them at a very local level.

There have also been ongoing successes in the private sector, including;

- The private sector loft and cavity wall programme, which was rolled out following funding from the Department of Energy and Climate Change (DECC) Fuel Poverty Fund, enabled 242 private householders to receive improved home insulation totalling 249 individual measures during 2016-27
- The External Wall Insulation programme has assisted Rotherham Council in carrying out insulation improvements on over 700 council owned households to improve thermal efficiency
- Rotherham's Home Improvement Agency (Yorkshire Housing - Stay Put) and Handyperson service assists vulnerable people to remain independent by providing reliable, trustworthy advice and practical assistance with repairs, improvement and adaptations. During 2016/17, the Home Improvement Agency has helped 50 older and vulnerable homeowners beat fuel poverty and stay warm through the provision of a £100,000 grant.

Our plans for the future

The Council will continue to invest in its existing stock to ensure it meets energy efficiency standards and remains affordable. They will also identify opportunities to remodel under utilised housing in order to meet changing needs and will introduce a range of housing products that offer wider choice. The programme will deliver over 30 new specialist homes and increased extra care provision.

The Housing and Neighbourhoods Service is increasing staff resources to ensure tenants receive the right support and that teams can maximise opportunities to access additional funding and increase housing supply.

The production of a new housing strategy will commence in 2018 and will set out the strategic approach to meeting housing need which will include accessible and specialist provision. The Rotherham Partnership structure will deliver benefits through wider partnership arrangements.

The Council will also continue to promote opportunities and share information with private owners in order to improve standards across the private sector:

- Energy Company Obligation (ECO) housing improvement schemes offer opportunities for properties, that meet specific criteria, to access funding to improve thermal efficiency
- Minimum Energy Efficiency Standard (MEES) – particularly focussed in selective licensing designated areas, where the Energy Performance Certificate (EPC) rating is either F or G, to ensure that existing and future tenants are able to only choose private tenancies of a minimum energy efficiency standard
- Through the continuing support for the Home Improvement Agency
- Home Energy Conservation Act – a report is published every two years which shows how the Council considers energy conservation measures that are practicable, cost effective and likely to result in significant improvement in the energy efficiency of the residential accommodation across the borough.

Green Spaces

What it looks like now

'Green spaces' are natural or semi-natural areas partially or completely covered by vegetation that occur in or near urban areas. They include parks, woodlands and allotments, which provide habitat for wildlife and can be used for recreation[57].

Whether green spaces are considered 'good quality', relies on their design and maintenance. Green spaces that are well designed and maintained attract more visitors. Neighbourhoods with attractive green areas or vegetation are viewed as safer, which makes them more 'walkable' and more likely to be used by the community at large[58].

Areas with more accessible green space are associated with better mental and physical health. The risk of mortality caused by cardiovascular disease is lower in residential areas that have higher levels of 'greenness' and there is evidence that exposure to nature could be used as part of the treatment for some conditions[59].

As well as direct health benefits, there can be additional financial savings from green spaces, benefits can include air pollution, noise pollution, flooding mitigation, shaded areas reducing the risk of heat stroke and exhaustion and social cohesion[60].

Rotherham is 70% rural and has a good amount of high quality green space identified in the 2017 green space assessment across the borough.

What Rotherham's doing

Clifton Park in Rotherham has been voted by the public to be one of the best parks in England for the last two years.

In the 2017 public survey, over 90% of people scored Rotherham's green spaces as being good or very good.

Rotherham has invested in a Walk for Health programme which is delivered by Places for People Leisure.

Rotherham Walking Festival in the Dearne Valley was run by the Dearne Valley Ramblers in October 2017. The week-long festival included a series of local walks. It attracted over 500 people and celebrated some of the fantastic walks that are available in the local area.

Park run

Park run[61] organise free, weekly, 5km timed runs around the world. They are inclusive physical activity opportunities that are open to everyone, free, safe and easy to take part in. People register online and then turn up at one of the venues. People are encouraged to run or walk 5km in local parks.

Rotherham has two Park runs that take place every Saturday at 9am. At Clifton Park there are between 61 – 130 runners each week and at Rother Valley Country Park there are between 177 and 365 participants each week.

The Rotherham park runs popularity continue to grow and they are regularly attended by local people, forming part of their weekly exercise routine.

Our plans for the future

There will be further walking developments in 2018 and these will be linked to the workplace wellbeing agenda, encouraging adults to be more active during the workday.

The role of green space for physical activity will be further promoted.

Rotherham Council's Culture, Sport and Leisure team are developing a new Strategy to make the most of the assets within Rotherham. This will include Parks, Green Spaces, theatres and events and it will be completed in 2018. This will be an opportunity to transform the roles of the Parks and Green Spaces alongside Rotherham's other community assets.

Active Travel

What it looks like now

Active Travel is the term used for walking or cycling as a means of transport in order to get to a particular destination such as work, the shops or to visit friends. It does not cover walking and cycling done purely for pleasure, for health reasons, or simply walking the dog. Active travel can be for complete journeys or parts of a journey[62].

However it is recognised that if more people are travelling actively, it has a range of positive outcomes. These include improved health, reduced traffic congestion, reduced air pollution and financial savings[62].

Rotherham Council was part of a South Yorkshire Councils Partnership who submitted a bid for a major investment for a sub-regional sustainable transport programme. The Partnership was awarded £30 million from the Local Sustainable Transport Fund (LSTF) to deliver carbon-friendly economic growth by widening labour markets, increasing business productivity and facilitating sustainable commuting over 15 years (2011 – 2026). Investments include bus priority; "Jobconnector" bus services; cycle routes; upgrade of tram stops; rail-based Park and Ride; promotion of electric vehicle use; infrastructure to unlock urban regeneration; training, marketing and travel planning[63].

What Rotherham's doing

Regeneration and Environment lead and commission a range of Active Travel Projects funded by the LSTF which include the following;

Rotherham Mobile Cycle Hub

The cycle hub visits town centres, businesses and organisations throughout Rotherham and offers; bike hire of pedal and electric bikes for up to three months. They also provide essential accessories such as a helmet, lights and pumps. Dr Bike Check up offer a minor repair service, to keep bikes road ready. Adult and Family Cycle Training in group and one to one sessions are also offered. This project is targeted at adults working at businesses and organisations in Rotherham and students at colleges in Rotherham. All the services are free of charge.

Active Travel in Schools

This project encourages pupils to cycle and walk to school though a range of classroom and outdoor activities. This project is mainly targeted at primary schools though some secondary schools will also participate in activities.

Love to Ride

This project encourages cycling through workplace challenges, friendly competition between workplaces and rewards.

Walk 2 Rotherham

This project encourages walking to schools, businesses and in local communities, through a range of activities and campaigns.

Bikeability

Since the national Bikeability standard replaced cycling proficiency, the Department for Transport has funded training for children in Rotherham schools. This helps children and young people to learn to ride and be safe on the roads, it also includes basic maintenance tasks making sure that bikes continue to be in a useable condition.

Our plans for the future

Rotherham Council is looking to map all the walking and cycling activities and develop a walking and cycling group to support work to improve healthy, sport and transport outcomes.

In March 2018 a free bike hire event is to be held at Rother Valley Country Park and a family cycle event is planned for Rotherham Show in September 2018 with bike try out arenas and a range of other activities.

10 Cancer Screening

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What it looks like now

Reducing the risk of Cancer is important to 'Living Well' for longer. Improving lifestyle behaviours such as stopping smoking, reducing alcohol intake and supporting people to achieve a healthy weight helps to prevent cancer.

Early detection is key to improving health outcomes, minimising complicated treatments and survival rates. National screening programmes aim to either detect cancer before it becomes symptomatic, or identify and treat changes in cells which can develop into cancer. For example, more than 90% of women diagnosed with the earliest stage of breast cancer survive for at least five years. This figure reduces to around 15% for women diagnosed at a late stage. Nationally around 5% of all cancers are detected through screening. There are three national evidence based cancer screening programmes for breast, cervical and bowel cancer (Office for National Statistics (ONS)).

Cancer is the leading cause of all deaths in Rotherham and accounted for almost 27% of deaths locally in 2015 (Office for National Statistics (ONS)). Furthermore, for the 3 years 2013-2015 combined Rotherham experienced a premature mortality rate (deaths under 75 years of age) for cancer of 3.6%, higher than the Yorkshire and Humber Region and 10.7% higher than England (Public Health England (PHE) via data from ONS).

In Rotherham, breast, cervical and bowel cancer account for 44 % of all cancers (20 year prevalence to end of 2010, National Cancer Registration and Analysis System (NCRAS)) and 15% of all cancer deaths (2015, ONS) each year. Bowel cancer is the second largest cause of cancer death after lung cancer (2015, ONS). Numbers of new cases of female bowel cancer have fluctuated over time but are 22% higher in 2014 than in 2001 (PHE Cancer Analysis System).

What Rotherham's doing

NHS England is responsible for commissioning screening programmes and has developed a two year plan with partners to improve uptake. NHS England and the Screening and Immunisation Team (Public Health England) are therefore working closely with partner agencies to increase Rotherham's screening levels and to promote awareness and early detection of cancer to improve the uptake and screening coverage in the borough.

It is very difficult to measure cancer screening uptake in some specific local population groups, such as people with disabilities or mental health problems, but research shows that these groups are less likely to attend for screening.

The Screening and Immunisation Team (SIT) work with Cancer Research UK and the PHE Communications and Engagement team to promote the cervical cancer screening programme in Rotherham. The comms and engagement team continue to target education sessions for people with learning disabilities to encourage them to engage in the screening programme.

Our plans for the future

The National Breast Cancer Screening Programme currently invites all women aged 50 to 70 years for breast screening every three years. The screening programme is in the process of piloting an expansion to include all women aged between 47 to 73 years. Breast cancer screening coverage in Rotherham was 79.5 % in 2016, higher than England (75.5 %) and the Yorkshire and Humber Region (75.7 %).

To reduce the borough's health inequalities gap, all organisations will renew their focus on improving access to the screening programmes for the vulnerable and hard to reach groups within Rotherham. The SIT improvement plan for Rotherham will be updated in March 2018 with input from all local stakeholders. The plan will identify the key priorities and how work can be strengthened to support the vulnerable and hard to reach groups.

11 Immunisation

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What it looks like now

Immunisation is one of the most successful and cost effective health protection interventions and is a cornerstone of public health. High immunisation rates are key to preventing the spread of infectious disease, complications and possible early death among individuals and to protect the population's health through both individual and herd immunity (this means that individuals who cannot be vaccinated will still benefit from the routine vaccination programme).

The majority of the Vaccination and Immunisation Programmes offered and delivered in Rotherham show good overall uptake and Rotherham continues to meet the national Public Health Outcomes Framework (PHOF) targets for all of the national childhood immunisation programmes.

Although performing well for the majority of the flu programme, there was an additional focus in 2017 on all ''at risk'' cohorts, such as, those over the age of 65, those with long term conditions or pregnant women.

What Rotherham's doing

Each year Public Health England and the Department of Health deliver a co-ordinated and evidence based approach to reduce the impact of flu in the population. This includes public communications to promote the uptake of flu vaccination and other aspects of combating flu such as hand hygiene and ensuring that all eligible people are offered vaccination.

In Rotherham, the Screening and Immunisation Team (SIT) work with a wide range of stakeholders to ensure that the delivery mechanisms are in place. In 2016/17, the uptake in at risk groups aged under 65 was 52.7%; this is a good increase when compared with the same period last year 47.4% (although below the goal level of 55%).This is in line with national and local trends, however, Rotherham and South Yorkshire still remain relatively high performers when compared nationally.

Our plans for the future

Future changes to the programme of work include vaccination of the morbidly obese (defined as BMI of 40 and above), and children aged 4-5 years will be offered flu vaccination in reception class, rather than through their general practice. As part of the phased roll out of the children's programme, this year children in school year 4s will also be offered the vaccination. There will be an increased focus on all 'at risk' cohorts, carers and pregnant women.

12 Making Every Contact Count (MECC)

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What it looks like now

Making Every Contact Count (MECC) is an approach to behaviour change that utilises the thousands of day-to-day conversations that take place within organisations such as Rotherham Council or the NHS to support individuals in making positive changes to their physical and mental health and wellbeing. It includes conversations between members of staff, and also with members of the public. MECC enables consistent and concise healthy lifestyle information to be given if and when the opportunity arises, and enables people to engage in conversations about their health on a much larger scale than has been done previously.

MECC is not new to Rotherham, a programme ran in 2013. MECC was re-launched nationally and in Rotherham in 2016 under the banner of 'Healthy Chats'. The Rotherham Health & Wellbeing Board is committed to working with partners to deliver MECC which is a priority within its Health and Wellbeing Strategy. MECC is a key component of the Rotherham Integrated Health & Social Care Place Plan.

What Rotherham's doing

A programme of train-the-trainer MECC trainin has been developed by Public Health Rotherham alongside a digital training package that can be rolled-out to all front line workers. The training will enable workers to have the knowledge, skills and confidence to raise lifestyle issues in a sensitive way, when the opportunity arises.

The roll-out of Healthy Chat training began in September 2017. Initial areas of focus for the Council included Children's Centre Staff and Health Visitors (The Rotherham Foundation Trust), and Culture and Leisure Services including libraries, museums and theatres, and leisure providers.

Our plans for the future

MECC will be embedded within the Rotherham Workplace Charter, encouraging all businesses to consider training both champions for their own organisation and any public facing staff.

The roll-out of Healthy Chat training will continue with key areas of focus including South Yorkshire Fire and Rescue; the Voluntary & Community Sector; TRFT and RDaSH staff.

For MECC to be successful both frontline staff and communities need to take ownership. The vision for Rotherham is that people throughout the borough, on every high street, from hairdressers to those working in the hospitality sector, will use MECC to help enable individuals to make lifestyle and behaviour changes.

13 Work and Health

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What it looks like now

'The relationship between employment and health is close, enduring and multi-dimensional. Being without work is rarely good for one's health, but while 'good work' is linked to positive health outcomes, jobs that are insecure, low-paid and that fail to protect employees from stress and danger make people ill' (Professor Sir Michael Marmot, 2010).

There is increasing evidence to show that businesses/organisations that choose to invest in workplace health and wellbeing will see the following benefits:

- Increased performance and productivity
- Reduction in sickness absence
- Improved staff retention (cost saving in having to recruit and train replacement staff)
- Better employee engagement.

Workforce, skills and employment

A higher proportion of people in Rotherham are employed within lower skilled occupations at 18.3% compared to 17.2% nationally. A lower proportion are employed within the most highly skilled occupations at 34.1% compared to 44.3% nationally.

Of the working age population in Rotherham, 11.7% have no qualifications, well above the national rate of 7.8%. The percentage qualified at the highest levels (NVQ4+ or degree level and above) is just 25.2%, below the regional average and well below the 37.9% national average.

The employment rate of people qualified to NVQ4+ in Rotherham stands at 84% compared to just 27% of those who have no qualifications. The projections are for the majority of new jobs to be created in the coming years to be in sectors requiring higher skill levels[64].

The median average weekly earnings (gross full-time) of Rotherham residents in 2016 was £485, which is well below the national average of £545.

Average full-time earnings for women in Rotherham are 74.4% of men's (compared to 82.5% nationally) and the gap in employment rate between women and men in Rotherham is 12.6% (10.4% nationally)[65].

The Black and Minority Ethnic (BME) employment rate is 54.8%, significantly below the overall rate for the borough of 67.5%, this is almost entirely due to the low rate for BME women of 35.4%, compared to 60.5% for all women.

Around 20,250 people in Rotherham are unemployed or long term sick; one in eight of the working age population[64].

Rotherham has 22,764 people on Disability Living Allowance or Personal Independence Payment (8.7% of the population compared with 5.5% in England) and there are 13,040 people claiming long term sickness benefits (8.1% of all aged 16-64 compared with 5.8% in England.

The number of people claiming Incapacity Benefit or Employment Support Allowance has been falling for some time from 15,400 (9.7%) in 2003 to 13,170 (8.2%) in 2017 and the long term trend is likely to continue, given the emphasis of welfare reform to move long term sick people into work or to seek work[66].

The Need for a Healthy Workforce

Two new reports indicate the need for a healthy workforce.

1. **Thriving at Work: the Stevenson/Farmer review of mental health and employers**
   (Government commissioned review, October 2017)

Thriving at Work sets out what employers can do to better support all employees, including those with mental health problems to remain in and thrive through work.

It includes a detailed analysis that explores the significant cost of poor mental health to UK businesses and the economy as a whole. Poor mental health costs employers between £33 billion and £42 billion a year, with an annual cost to the UK economy of between £74 billion and £99 billion.

The report quantifies how investing in supporting mental health at work is good for business and productivity. The most important recommendation is that all employers, regardless of size or industry, should adopt six 'mental health core standards' that lay basic foundations for an approach to workplace mental health. It also details how large employers and the public sector can develop these standards further through a set of 'mental health enhanced standards'. The report also makes a series of recommendations to government and other bodies.

2. **Good work: the Taylor review of modern working practices**
   (government commissioned review, July 2017)

The Review settled upon the 'QuInnE' model of job quality, developed by the Institute of Employment Research and others as part of a pan-European research programme. This outlines six high level indicators of quality;

- Wages
- Employment quality
- Education and training
- Working conditions
- Work life balance
- Consultative participation & collective representation.

Both reports make clear that in order to achieve positive outcomes from a workplace

health and wellbeing programme, employers need to do more than just meet their legal obligations and develop a culture of partnership working and staff engagement across all departments. There is an increased chance of success in a health and wellbeing programme if it is supported by senior management and has the involvement of all levels throughout the organisation.

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What Rotherham's doing

Workplace Wellbeing Charter

The Workplace Wellbeing Charter is endorsed by Public Health England and delivered locally by Rotherham Council. This is a national framework that provides a clear set of standards for businesses and organisations to work towards achieving. Businesses and organisations who sign up to this charter are encouraged to achieve eight standards which include the following;

- Leadership
- Absence management
- Health and safety
- Healthy eating
- Physical activity
- Mental health
- Smoking and
- Alcohol and substance misuse.

Business and organisations that have achieved or are working toward the charter have benefited from improved productivity, reduced sickness absence, better staff retention as well as contributing to the long term public health aim of reducing premature deaths, particularly those related to lifestyle choices. For instance, in Rotherham many businesses and organisations now have dedicated Health and Wellbeing areas where staff can obtain information or be sign posted to relevant services. Within Rotherham Council there is a team of volunteer health champions which includes volunteers from across the Council. Also, Greencore foods saw a reduction in sickness rate for Musculoskeletal (MSK) conditions and mental ill health of around 24% in the first year after doing the charter. Another local business, Grupobimbo, have introduced free counselling sessions for staff that have mental ill health problems. They have also introduced initiatives around healthy food and free fruit for all staff. They have introduced physical activity challenges that all employees can get involved in at whatever level they choose.

Rotherham Council offer to businesses include;

- All local businesses and organisations are offered support to enable them to meet the standards to achieve the Workplace Wellbeing Charter
- Currently 60 businesses and organisations are registered with the Council to work towards the Charter
- An explanation is offered to businesses and organisations regarding the potential benefits to them about looking after their employees' (both paid and unpaid staff) health and wellbeing
- Training sessions around subjects relevant to the standards in the charter are also offered.

CASE STUDY

Greencore prepared foods was the first business in Rotherham to be accredited with the Wellbeing Charter Award. Based at Kiveton Park they employ in excess of 1200 staff.

They have worked closely with Public Health on all aspects of the Charter. They have mental health awareness training in their mandatory induction training, they have had alcohol awareness briefings in the staff restaurant and organise various social activities that will help to increase physical activity in the workforce including encouraging all employees to walk 'The Greencore Mile' on site. They are also planning a 10,000 steps a day over 100 days initiative with the aim of getting fit for the start of summer.

The company offer a range of healthy meals in the staff canteen and work with Weight Watchers to offer one month free membership for the first 50 employees who lose a minimum of 3.5Kilos in month one. They then offer a free healthy meal from the canteen for each kilo lost until the participants reach their target.Free counselling and Physiotherapy services are now available on site to all staff who may benefit from them.

In the first year Greencore saw a 21% improvement in days lost due to musculoskeletal conditions and a 34.5% improvement in days lost due to mental ill health. Short term sickness has reduced form 4.5% to 3%, along with reductions in long term sickness. They have increased the number of phased returns to work which means that staff are able to return to work quicker. Staff feel that they are well supported at work and that the company genuinely wants to look after their health and wellbeing. One member of staff in particular spoke about being treated as a human being not just a number.

Greencore are committed to continuing their work and will be looking at introducing Workplace Health and Wellbeing Champions in 2018.

Our plans for the future

- To offer businesses and organisations training for Workplace Health and Wellbeing champions.
- To offer basic training around mental health awareness.
- To implement MECC.
- Awareness training around Domestic abuse is going to be offered to businesses.

There are also two new Sheffield City Region (SCR) programmes planned for 2018, these are the Health Led Trial and the Early Intervention Pilot described below.

Health Led Employment Trial

The SCR Health Led Employment trial will introduce a new work health support service consisting of employment specialists (employment advisors) working to Individual Placement Support principles located within local healthcare settings (e.g. GP practices, Improving Access to Psychological Therapies (IAPT) teams, Musculoskeletal (MSK) teams, community hubs). This is only one of two trials in the country, the other being in the West Midlands.

Referrals come primarily from the health system (e.g. GP practices) and individuals can also self-refer. Participation is entirely voluntary and has no implications for an individual's entitlement to benefits. To ensure robust learning, the Individual Placement Support employment trial will be a randomised control trial with 50% of referrals going onto the IPS trial and 50% being supported by existing mainstream employment and health support. This means that all individuals who volunteer for the IPS trial will receive some form of voluntary employment and health support.

The aim is to provide an innovative and evidence based form of voluntary health aligned employment support to individuals with mild to moderate mental health and or musculoskeletal (MSK) conditions who are either unemployed and seeking work or who are in work but are struggling or off sick. The program will offer 12 months personalised support focused on what individuals need to help them find or stay in work.

Early Intervention Pilot

The early intervention pilot will aim to increase access to sustained employment and progression opportunities for people at high risk of long-term unemployment. It will provide early intensive support to key target groups in the borough as identified by local stakeholder data.

The local authority has particular challenges in relation to low skill levels and ill health. These are particular problems for Rotherham and act as barriers to good quality, sustainable employment for many local people. There are key vulnerable groups to prioritise;

- Individuals living in deprived neighbourhoods
- Care leavers
- Adults with Learning Disabilities
- People with "multiple needs" which encompass:
  - Mental health
  - Homelessness and unstable accommodation
  - Substance misuse
  - Domestic violence
  - Anti-Social Behaviour and ex-offenders.

Rotherham Jobcentre Plus (JCP) report the need to address additional groups who, although small in number, require an integrated support package to prevent them becoming long term unemployed. These include;

- Ex-offenders
- People on the autism spectrum
- Refugees
- People with English as a second language
- People with a history of insecure and fragmented employment.

These groups may also be likely to be living in deprived areas, experiencing poor mental health or unstable accommodation. There is acknowledgement that there are overlapping features in all the groups identified.

Rotherham has high numbers of people who are economically inactive or claiming benefits due to ill-health, with a substantial proportion having mental health problems. It is anticipated that the most appropriate provision for people with mild to moderate mental health conditions and musculoskeletal conditions would be the health-led trial. The employment pilot is currently paused nationally but is expected to go live early 2018.

Local Integration Board

The Local Integration Board (LIB) will oversee the long term delivery and performance of the Health Led Trial and Early Intervention Pilot, bringing the relevant partners together to develop a more integrated approach, tackling any barriers to implementation and resolving issues relating to specific cases as required.

14 Recommendations

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Key Recommendations of the Report

Work and health in partnership

To help more people back into work with stronger health and employment connectivity with links to emotional wellbeing. Continue to deliver the Workplace Wellbeing Charter for those in work a systematic approach to MECC.

MECC

MECC – working with partners to deliver MECC (Healthy Chats) which is a key component of the Rotherham Integrated Health and Social Care Strategy.

Mental health

Public Health to lead on the implementation of the Better Mental Health For All Strategy, with a specific focus in year one on Suicide Prevention and Five Ways to Wellbeing.

Physical activity

Public Health will work with the Team Rotherham Partnership to increase physical activity across Rotherham using opportunities such as our award winning parks (green spaces), promoting active travel and working with planning departments to develop obesogenic environments.

Continue to deliver on South Yorkshire and Bassetlaw wider partnership to deliver on the health and social care plan.

APPENDIX: Update from Last Years Annual Report

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

Overarching Recommendation	Progress
1. 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 Making Every Contact Counts (MECC).	Public Health has led a systematic approach to a Making Every Contact Count (MECC). This includes a digital programme of online training, half day train the trainer programme, Public health staff trained to roll out across the Council and wider stakeholders. Roll out has begun focussing on training local authority services including; Libraries, leisure Centres, Housing providers, and Adult Social Care.
2. Rotherham Health and Wellbeing board considers implementing the WHO 'Age Friendly Cities and Communities' 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.	The ambition to be a Healthy Community has been shared with the Older People Network and all stakeholders. There is also an Older People Strategy under development which is considering the role and impact of older people in Rotherham.
3. 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.	A group is looking at what the council and wider partners is currently doing to combat loneliness and isolation. This includes mapping, defining the issue, creating an action plan using an asset based approach and developing tools to evaluate impact. Rotherham also launched the "I age well" website (June 2017) to provide further information to residents and their families so that small changes could be made to increase individuals independence and improve their quality of life.

Overarching Recommendation	Progress
4. 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.	The Rotherham Place Plan has now been finalised and there is an increased focus on prevention, early intervention and self care. The procurement of the Wellness service ensured that there will be an increased level of information on health and wellbeing available to different levels of support to help people make changes at the time that is right for them. This will be going live in April 2018. Joint application to Sport England's Active Ageing fund was unsuccessful.

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[65] Annual Survey of Hours and Earnings, ONS 2016

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Briefing for Health Select Commission **12 June 2018**

Health Village Pilot - Evaluation

Introduction

The Health Village Pilot based at Doncaster Gate is one of the five workstreams in the Rotherham Integrated Health and Social Care Plan (formerly known as the Rotherham Place Plan). As one of the transformational initiatives it has been developed to contribute to closing the gaps – financial and efficiency; care and quality; and health and wellbeing.

Background

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 these into broader multi-disciplinary teams responsible for local populations with an integrated leadership model.

Two GP practices supporting 36,000 residents (Clifton and St. Ann's) have been involved in the pilot, which commenced in July 2016 with a focus on people aged 65+, especially those with long term conditions. A co-located multi-disciplinary team includes community nurses, therapists and a social worker, plus mental health workers and the third sector (social prescribing and links through the Community Link Worker).

Key outcome measures for the pilot are reductions in:

- Hospital Length of Stay
- Non-elective hospital admissions
- Admissions to hospital for assessment
- Cost of social care packages

The seven localities across the borough have subsequently been grouped under three Partnership Areas, North, Central and South; one with three localities and the others each with two. This reflects the fact that adult social care and mental health would not be able to work to seven separate localities, unlike community nursing.

The wider roll out in one of the Partnership Areas is expected to commence towards the end of 2018-19, following consultation with stakeholders/public and the completion of work to separate planned and unplanned care.

Scrutiny

The Health Select Commission considered two interim evaluation updates on the pilot during its work programme in 2017-18, in June 2017 and January 2018. Once the final evaluation report was published in March 2018 this was also circulated to all HSC members.

A sub-group of four members discussed the key findings and challenges from the final evaluation in a workshop session on 1 May 2018. The notes of that meeting are included in Appendix 1. The aim of the session was to feed in to the discussions about the best way

of rolling out the integrated model across the rest of the borough, across localities with differing demographic profiles and health needs.

Recommendations

Members of Health Select Commission are asked to:

- Consider and comment on the information provided in Appendix 1 from the workshop session.

- Consider any outcome measures they would like to see included for the wider roll out to the first Partnership Area.

- Note that the Health Select Commission will continue to monitor progress on developing the Health Village and the roll out to the first Partnership Area during its work programme in 2018-19.

- Indicate if they wish to be part of the field trip visit to include the Health Village, Care Co-ordination Centre and Single Point of Access.

Briefing note: Janet Spurling, Scrutiny Officer janet.spurling@rotherham.gov.uk

Appendix 1 Notes from Health Village Evaluation Sub-group 1/5/2018

Present: Cllrs Evans (Chair), Elliott, Jarvis and Short
Apologies: The Mayor Cllr Keenan
TRFT - Dominic Blaydon, RMBC - Cllr Roche, Nathan Atkinson

Introduction

Cllr Roche introduced the session stating there were many positives from the pilot but greater integration with adult social care was needed and this was seen as the way forward.

Presentation by Dominic Blaydon

Background

- Commenced July 2016
- Based at The Health Village, Doncaster Gate
- 2 GP Practices supporting 36,000 residents (Clifton and St. Ann's)
- Co-located multi-disciplinary team (multi agency)
- Includes community nurses, therapists and social workers
- Also incorporates mental health workers and 3rd sector (social prescribing and links through Community Link Worker)

The pilot focused on vulnerable adults, mainly older people aged 65+ and aimed to develop a clear, consistent health offer.

Aims of Pilot

- Improve communication – between professionals leading to better patient outcomes
- Develop a holistic approach to care – physical health, mental health and adult social care needs in one package
- Reduce hospital admissions – generates efficiencies
- Reduce length of stay in hospital – inreach from locality team to support discharge
- Reduce cost of health and social care
- Reduce duplication

It was a question of transferring care from the hospital to the community safely and maintaining quality. Achieving the aims would be a challenge, with some barriers existing between organisations and professionals, but it was a good opportunity with coterminous boundaries and the drive towards greater integration.

Purpose of Evaluation

- Impact of the pilot service model – in terms of changes in how services were delivered and on patient experience
- Can the service model be replicated?
- Recommendations for future implementation

What's in the Evaluation

- Literature search - locality working in other areas, national documentation
- SWOT Analysis
- Interviews and focus groups carried out – front line staff, senior managers and clinicians
- Dataset analysis – some evidence on the metrics below

- What has worked well
- Key Issues
- Leadership Model – views from Grounded Research who carried out the evaluation

What has worked well

- Development of an MDT approach – effective communications and reduced fragmentation bringing a more, but not fully, holistic approach
- Long term condition meetings – CCG programme that the pilot linked in with
- Separation of planned and unplanned care – reactive, urgent work moved into a centralised team and away from community district nursing
- Benefits of co-location
- Use of Rotherham Health Record – opportunities to integrate more, with the team able to see which of their patients were in A&E or hospital (including the ward) and then inreach
- Interface with primary care – still some work to do
- Identification of high-risk patients
- Culture of service improvement – front line staff given autonomy and authority to make changes in how they work as they are the ones with the specific knowledge
- Simplification of referral pathways – some still needed formalisation so that patients were not handed on to someone else. One process –> triage –> to right people.

Rotherham was in a strong position due to positive relationships between frontline staff and at senior management level. The Rotherham Health Record was unique nationally.

Key Challenges

- Clarity on aims and objectives – lacking originally through trying to give people autonomy but needed to have been more prescriptive
- Development of joint outcomes – what did we want to achieve from adult social care and how this would be measured
- Project management – lack of dedicated resources
- Social care metrics - for example increasing independence, reducing long term care, reducing cost packages
- Silo working - it was still hard to break down some professional barriers, even with different teams employed by the same organisation, such as community nurses and therapy staff
- Common service model – the pilot could not be replicated across all seven localities and there would be some virtual working
- Leadership arrangements – staff were managed in their own professional groups but it was about trying to bring people together in one leadership team with shared responsibility for the same outcomes
- Contractual issues – TRFT are paid on a block contract from the CCG for community services, which could be a potential barrier

Key Metrics

- Non-elective admissions
- Non-elective bed-days
- Length of stay
- Discharge destination
- Elective bed-days

Data for the relevant patient cohort showed progress on the first three metrics compared with other localities and for the pilot locality compared to the previous year. Less evidence

had emerged for the last two metrics. Positively length of stay remained about the same, meaning patients with greater acuity were the ones in hospital.

Next Steps

- Service model approved by Integrated Care Partnership Board
- Roll out into one Partnership area during 18/19
- Also develop the Health Village (Remove pilot status)
- Separation of planned and unplanned care – some work had taken place already and people would be moved from unplanned to planned care once their immediate additional needs had been met and they returned to their standard long term care
- Selection process underway on which Partnership area
- Initially focus will be on alignment of teams

The seven localities across the borough had been grouped under three Partnership Areas, North, Central and South; one with three localities and the others each with two. This was to achieve economies of scale and also reflected the fact that adult social care and mental health would not be able to work to seven, unlike community nursing. Plans were in place to move to area-based working in adult social care and building the relationships.

Discussions were taking place over which Partnership Area would be chosen but even if the Central one was not selected further work to develop the Health Village would continue with an action plan in place.

The points below were raised in discussion after the presentation:

- The governance structure for the Rotherham Integrated Care Partnership with a delivery board and an executive board that reported to the Health and Wellbeing Board. The pilot was one of the workstreams within the Rotherham Integrated Health and Social Care Place Plan, which in turn formed part of the South Yorkshire and Bassetlaw Integrated Care System, but this work would have been undertaken anyway in Rotherham. Concerns about the timescale for the wider rollout being slow had been raised but the present picture around the locality structure was complex with different services and different partners working to a range of locality structures, which needed to be brought together.

- Delayed transfers of care were important for patients but also for the local health and care system as money was lost if these rose above 3.5%. Current performance was good on this measure.

- From an adult social care perspective the evaluation was fair and with only two staff involved, a social worker and a community link worker, it was difficult to draw conclusions. However the value of multi-disciplinary team working and better communications was clear. Developing this new integrated approach was a challenge as nowhere else in the country had fully achieved it yet; even Greater Manchester was still at a formative stage. There had been learning from elsewhere through visits to Northumberland, Lancashire and Morecambe and officers from Knowsley Council had visited Rotherham.

- National evidence did not show any huge savings from the new models, but it was primarily about better patient experience, including not having to tell their story multiple times, and optimal use of resources. Savings might result at a later stage. The adult social care improvement journey was lagging behind the pilot and had had savings requirements to achieve, but it was hoped to move forward more quickly now.

- The development of the adult social care side needed to be seen in the wider context of the service over the last two years when it had possibly been less of a priority than addressing the assessment backlog, developing the learning disability offer and dealing with some staffing issues, but all were progressing. It entailed a change of culture amongst social workers from being service-centred to people-centred. Team managers played a key role in work allocation and setting the tone for their teams.

- Objectives were in place for developing the adult social care side and the social workers were keen to get out into communities and develop that local knowledge and feel as most were currently based at Maltby. Social workers had an office base for administrative work and for management oversight of the team. Having an office base also helped with trying to change the culture through sharing ideas and bringing in best practice as there was a focus on improving the quality of social work. Other benefits resulted from participation in regular MDT meetings to discuss patients and how best to support them. At MDT meetings everyone usually contributed about their patients and most workers could identify those who were most at risk of hospital admission. Technology would also enable more agile working and help to maximise time in the field.

- Previous long waiting times in occupational therapy e.g. for a ferrule had been successfully reduced following a reduction in the number of forms to complete, so it was a case of changing both culture and processes.

- Interface with community groups would also be part of the development of re-ablement, together with bringing in other delivery partners such as care homes and involving them in the process, but at a later stage.

- Different job roles were likely to result, such as a new blended role for home care staff who could take on some tasks previously carried out by other workers after training to build their skills, also helping to reduce duplication. For example, at one time care workers could do bloods and give medication and reinstating this would free up district nurses.

- Maximising the use of assistive technology also helped to keep people at home and the Council was working with the CCG on re-ablement.

- If things went to plan the roll out would continue this year in one of three Partnership Areas covering a third of the borough, then next steps would be determined. TRFT hoped that the full roll out would be within two years but once operational it would take a few years to become optimal. Any redefining or redesigning of job roles would also mean significant training issues.

- With a number of empty buildings in the borough there were questions about whether these should be disposed of or retained and looked at for new purposes. The estate was important and one of the problems with the pilot was that the building did not lend itself to multi-disciplinary working. Configuration of buildings was critical, with open plan being more beneficial than a number of small offices that could perpetuate silos as it also facilitated informal chats.

- Having a preventative element was also important, for example if someone experienced a major life event such as bereavement this might lead to isolation and depression even if the person did not have a long term condition. Appropriate support could be identified through social prescribing or the Community Link Worker.

- The evaluation report mentioned moving to a whole family approach but realistically the borough wide roll out would be incremental. It would commence with the cohort of older and frail people who comprised the majority of those who needed adult social care before including the community overall. Much would depend on which Partnership Area was selected and it was also hoped to incorporate learning disability for the same cohort fairly swiftly. Once the bases were in place links would be developed with Early Help and dialogue around the whole family. Partners were cautious of being overly ambitious, preferring to concentrate on the core group and then fine tune.

- The greater challenge of implementing the model in rural areas was acknowledged, as in the Central area services and the population were more concentrated. Each Partnership Area had different issues to consider, such as greater rurality in the South and a more dispersed, but strong and stable workforce compared with a relative lack of community nurses in the North. Developing a user-focused, tailored offer that reflected the local community was the key.

- Rolling out the locality model was one element of the place plan and wider integration, linking in with other initiatives such as developing a single point of access, reconfiguration of community beds, the integrated discharge team, and the integrated rapid response for unplanned care. The short stay apartments in Shaftesbury House were viewed as a positive step.

- Dedicated resources for project management were highlighted as necessary in the evaluation report and money from the Better Care Fund had funded a joint RMBC/TRFT post, recognising that the Council was a deliverer of services as well as a commissioner.

- Partners would clarify the joint outcomes desired from the roll out and the set of measures in relation to these. The intention was for teams to have autonomy within an overall framework to deliver a set of specific outcomes.

Agreed actions:

1. Health Select Commission to continue to monitor progress on developing the Health Village and the roll out to the first Partnership Area during 2018-19.

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Health Select Commission

Ideas for Work Programme

2018-19

Rotherham Metropolitan Borough Council

Health Select Commission

Recap 2017-18 – "Big Five":

- Rotherham Integrated Health and Social Care Place Plan (IHSCP)
- Adult Social Care (development programme and performance)
- *Learning Disability*
- Mental Health (child & adolescent)

plus

- Joint health scrutiny – NHS reconfiguration

Health Select Commission

Rotherham IHSCP:

- *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*

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Plus:

- Drug and Alcohol Spotlight
- Refresh of Health and Wellbeing Strategy
- CCG Commissioning Plan and IHSCP refreshes
- Carers Strategy
- Access to GPs
- Care Homes
- NHS Trust quality accounts (annual) x 3
- Adult & Older People mental health transformation
- Delayed Transfers of Care

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Continuing from 2017-18:

- "Big Five"
- Director of Public Health – annual report
- Carers – links adult social care programme
- Monitoring reports past reviews
- Social and Emotional Mental Health Strategy
- Child and Adolescent Mental Health
- Joint health scrutiny – new proposals and implementation of service changes

Health Select Commission

Other suggestions:

- Autism Strategy
- Health and Wellbeing Strategy Implementation
- Primary Care and Implementation of GP Forward View
- RDaSH estate – links to locality working
- Breathing Space – respiratory services
- Space for a couple of spotlight reviews on key issues that emerge through the year

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 other suggestions?

Stakeholder Briefing for Hospital Services Review

Tuesday 8th May 2018

Independent report published on Weds 9 May calls on South Yorkshire, Bassetlaw and Chesterfield hospitals to work together even more closely

An Independent Review set up to ensure people across South Yorkshire, Bassetlaw and Chesterfield continue to receive excellent hospital services now and into the future has made a series of recommendations in a report to be published on Wednesday 9 May.

The Hospital Services Review (HSR) Report strongly recommends that to continue to provide high quality services across the region, hospitals must work together even more closely and in ways that connect teams across all sites.

The central theme is for local people to continue to get as much hospital care as possible in their local District General Hospital. This includes a recommendation to keep all seven emergency departments (EDs) in Barnsley, Bassetlaw, Chesterfield, Doncaster, Rotherham, the Major Trauma Centre and ED at the Northern General Hospital in Sheffield and the ED at the Sheffield Children's Hospital.

In new networks of care, it is proposed that different hospitals would take the lead for each of the five clinical services reviewed - urgent and emergency care; maternity services; hospital services for children who are particularly ill; services for stomach and intestines conditions (gastroenterology), including investigations (endoscopy); and stroke (early supported discharge and rehabilitation). The responsibilities of local hospitals could include strengthening the workforce and making sure that all patients get care to the same high standards. The networks would be designed with patients, the public and clinicians with the emphasis on delivering the networked service to a specification agreed across all hospital sites. The aim of care networks would be to ensure the hospitals work together to provide safe, sustainable, high quality care in an even more coordinated way.

Also among the proposals are two new regional centres of excellence to support the networks. A Health and Care Institute would link the region's universities, colleges and schools with the NHS and local authorities to focus on region wide workforce solutions. As well as recruiting and nurturing the workforce of the future, it would include a single joint approach to developing and putting shared ways of working in place.

The creation of an Innovation Hub, which would be in partnership with the Yorkshire and Humber Academic Health Science Network, would spot and quickly roll out innovation schemes across the region, such as new technologies.

The review has identified real challenges in sustaining some services in every DGH, in particular children's and maternity services, and the Report recommends that networks and wider collaboration are the best opportunity to sustain local services at their current levels.

In maternity services, the Report aligns its thinking with the findings from the public consultation that informed the national report, *Better Births*[2], which recommend maternity services support personalisation, safety and choice, with access to specialist care whenever needed. The HSR Report calls for more choice for women and recommends further work is carried out to consider the creation of more care in communities and midwife-led units, and further development of home birth services.

In children's services the Report recommends expanding services for children in the community and in short stay units. This would lead to shorter stays for children and would likely mean there would be less need for longer stay inpatient wards. For those children still needing longer stays in hospital for more complex problems, it may be possible to provide this in fewer units and the Report recommends that further work be carried out to consider a small reduction in the number of inpatient paediatric units.

The Report also recommends that overnight and weekend services for emergency gastrointestinal bleeds are consolidated onto three or four sites. This is intended to increase the safety of services for patients, to make sure that in an emergency, all patients have reliable and rapid access to the care they need.

Work is already happening with local communities and organisations to ensure the right configuration of services are provided locally to support the needs of patients, while addressing the wider challenges, and the Report identifies where more opportunities could be explored.

Should the Report recommendations be accepted, additional work would be undertaken over the next year to further scope the options and the team would continue to hear from patients, public and staff.

The Report also recommends:

- Looking at the sustainability of planned care (eg planned operations and tests) in more depth
- Exploring how to ensure better collaborative decision making between hospitals
- Setting up a Transport Reference Group (TRG) to develop a system-wide transport strategy with representatives from hospitals, commissioners, Yorkshire Ambulance Service and East Midlands Ambulance Service, local transport authorities, patients and the public

The Report will now be received by the South Yorkshire and Bassetlaw Health and Care Working Together Collaborative Partnership Board in June and then the collective committees[3] and individual boards and governing bodies and committees within the partnership throughout June and July. If the partners agree that a further phase of work should take place, to scope out options and to develop business cases for change, this would take another year with continued patient, public and staff involvement and, where appropriate, the relevant Health Scrutiny Committees.

If any major service changes required consultation, this would likely take place in 2019, with another one to two years before changes took effect.

While the Report focuses on hospital-based services, it also recognises that the services cannot exist and operate in isolation and the team also worked with staff in primary care, community care, mental health, social services and wider still to ensure that its recommendations build on related work that is currently under way and recognise system-wide interdependencies.

The review is just one part of the overall approach being taken by the partners in Health and Care Working Together. At the same time, work is underway to develop more and more ways of treating and caring for people in their homes and local clinics, so that they don't need to go to hospital.

The full report will be available from 00.01am Wednesday 9 May here: www.healthandcaretogethersyb.co.uk

Hospital Services Review Report

Question and Answer sheet – May 2018

Please note a Question and Answer sheet has been available on the South Yorkshire and Bassetlaw Health and Care Together website since the launch of the Review in October 2017 (with regular updates).

This Question and Answer sheet relates specifically to the review Report, please see http://www.healthandcaretogethersyb.co.uk/index.php/what-we-do/working-together-future-proof-services/looking-at-hospital-services if you have unanswered questions about the review.

1. **Does this Report mean my local hospital will close?**

No, this Report recommends Barnsley, Bassetlaw, Rotherham, Sheffield, Chesterfield and Doncaster all continue to have district general hospitals delivering high quality care for patients. This includes a recommendation to keep all seven emergency departments (EDs) in Barnsley, Bassetlaw, Chesterfield, Doncaster, Rotherham, the Major Trauma Centre and ED at the Northern General Hospital in Sheffield and the ED at the Sheffield Children's Hospital.

The overarching vision for services put forward by the Report is for all patients to have access to high quality services – with most people, most of the time receiving the vast majority of their hospital-based care in their **local hospital**. It is hoped that some out-patient services that are currently delivered in central hospitals may be possible to be provided in local DGHs in the future.

Although hospitals are under significant pressure, this is not about closing hospitals. There needs to be a hospital in every place, delivering a range of core services.

The Report does however suggest that more work is needed to further understand challenges in some services.

In maternity services, the Report aligns its thinking with the findings from the public consultation that informed the national report, Better Births, which recommended maternity services support care centred around the person, safety and choice, with access to specialist care whenever needed. The HSR Report calls for more choice for women and recommends further work is carried out to consider the creation of more care in communities and midwife-led units, and further development of home birth services.

In children's services the Report recommends expanding services for children in the community and in short stay units. This would lead to shorter stays for children and would likely mean there would be less need for longer stay inpatient wards. For those children still

needing longer stays in hospital for more complex problems, it may be possible to provide this in fewer units and the Report recommends that further work be carried out to consider a small reduction in the number of inpatient paediatric units.

The Report also recommends that overnight and weekend services for emergency gastrointestinal bleeds are consolidated onto three or four sites. This is intended to increase the safety of services for patients, to make sure that in an emergency, all patients have reliable and rapid access to the care they need.

At the moment, not all hospitals in our region provide overnight or out of hours services for urgent GI bleeds and we are not working in the most consistent way to support the staff providing the services for those who need it. The Report therefore recommends making these services safer for patients no matter what time of day, or day of the week they present.

However, even if the Report recommendations are accepted, there would be a further year's work to scope how this would best be adopted. Where any change is significant, there would then be requirements for business cases to be developed and full public consultation to be undertaken in areas where the changes proposed were significant.

2. **Which Trust/hospital will be affected?**

The Report does not make any recommendations about any individual hospitals (Trusts). The recommendations are not site specific but more general and it is now for the partners in the collaboration to consider what happens next. Transformation is the key theme in the Report and as the hospitals continue to transform their services to meet future demand, the Report recommends that they work even more closely together to do so.

3. **Isn't this Report about doing more for less, and so does this not mean that we will see increased waiting times, services that are harder to access and more pressure on ambulance services?**

No. The Report highlights that the current NHS system is the consequence of a system designed to provide treatment in every hospital for every condition that now needs to adapt to much more specialised and advanced treatment which can deliver better outcomes for patients.

The Report takes into account duties that organisations have around meeting waiting time requirements etc and is proposing solutions that are designed to make the system work more efficiently and provide a better service for patients - not one that makes it harder to access services or puts pressure on a different part of the system.

4. **Under the proposed network arrangements who would the staff be managed by? The lead for the network or the hospital they're providing the service in?**

The Report outlines three different approaches to networks. The detail will need to be worked through with staff in each specialty, but on the 'hosted network' which is the basic

model, and the ‘co-ordinated delivery network’ which is the middle model, we expect that staff would continue to be employed and managed by their own trust.

In ‘single service models’ that already exist in some parts of the country, in some places staff continue to be employed and managed through the trust where they are based, while in others they are employed and managed by the trust managing the service. If these recommendations went ahead, we would explore the options and listen to the views of staff before deciding which option would be best.

5. **How do the proposals within the Report fit with current legislation and statutory organisational duties?**

The recommendations have been put together as solutions that enable greater collaboration between organisations and for the benefit of patients. They also would fit within an Integrated Care System working within the current legislative framework. Organisational statutory duties remain and recommendations are designed to support partners to meet these.

6. **Is this the start of merging all of our hospitals?**

This Report is not a merger plan. Hospitals already work closely together across a range of services and it is simply about finding ways for organisations to work together even more to provide better services for patients, where it makes sense to do so.

7. **How long will it take and when will I know?**

Some of the recommendations could get underway quite quickly if the partners agreed with them, such as the networks of care and regional centres of excellence to support them. Further work is recommended to look more in depth at children’s and maternity services and if the Report recommendations are accepted this would likely take a year to scope out even before any options are put forward around changes to the existing units. If it was then decided that changes to existing units were recommended there would be significant further work, including full public consultation, which would likely be in 2019. It would then be likely to take a number of years before any changes would be implemented.

Regular updates on what is happening will be posted on the Health and Care Working Together website.

8. **What are the Health and Care Institute and Innovation Hub going to do?**

Among the proposals are two new regional centres of excellence to support the networks. A Health and Care Institute would link the region’s universities, colleges and schools with the NHS and local authorities to focus on region wide workforce solutions. As well as recruiting and nurturing the workforce of the future, it would include a single joint approach to developing and putting shared ways of working in place.

The creation of an Innovation Hub, in partnership with the Yorkshire and Humber Academic Health Science Network, would develop, spot and quickly roll out innovation schemes across the region, such as new technologies.

9. How much would it cost to make the recommended changes?

The Review was not set up to resolve the financial challenge and it was agreed that any recommendations from it would not make the financial situation worse. Therefore, if any changes took place, they would be within the current budget. The focus of the review was primarily to make services able to sustainably deliver high quality care and not as a means of saving money.

10. What does 'reducing unwarranted variation' mean?

If different organisations treat patients differently from one another without a clear clinical reason or benefit for doing so it can be classed as "unwarranted". By reducing this, we ensure all patients get the right care. By creating one way for all, it would make things fairer for patients, and easier for staff and clinicians who might work across different organisations.

11. What happens next?

The Report will now be received by the South Yorkshire and Bassetlaw Health and Care Working Together Collaborative Partnership Board in June and then the collective committees and individual boards and governing bodies and committees within the partnership throughout June and July. If the partners agree that a further phase of work should take place, to scope out options and to develop business cases for change, this would likely take another year with continued patient, public and staff involvement and, where appropriate, the relevant Health Scrutiny Committees.

If any major service changes required consultation, this would likely take place in 2019, with another one to two years before changes took effect.

12. I am a member of one of the Managed Clinical Networks (MCNs). What does the Hosted Network mean and how will it be different?

The Hosted Networks will build on the work that the MCNs have done. However they will have more 'teeth' than the MCNs can have: they will be backed by formal agreements between the trusts around implementing the elements that the networks agree. They would also be held to account for implementing proposals once they have been agreed, in a way that they are not in most clinical networks at the moment.

13. How will you decide which trust leads each network?

There would be a discussion between trusts and the clinical commissioning groups as commissioners of the services to agree.

We envisage that trusts would choose to lead on a particular service based on having an existing strength or expertise in it, and would need to demonstrate that they are able to consistently meet the standards and provide the support the network needs.

14. Does this mean Sheffield will be running our services?

The Report doesn't recommend this. Each hospital would be responsible for running its own services and lead on one of the proposed networks.

15. What do hosted networks mean for partnership work and staffing?

The networks offer a real opportunity to work even more closely together while supporting and build staffing capacity. They would enable a shared approach to recruitment and increase the attractiveness of SYB for staff to join teams and build their careers.

16. **How will patients, the public and clinicians be engaged in the design of Hosted Networks?**

Should the partners decide to take any of the recommendations forward, full engagement plans will be developed with clinicians, staff, patients and the public given the opportunity to shape future services and ways of working. You can keep up to date by emailing helloworkingtogether@nhs.net with:

Your name

Your email (or postal address)

Your contact telephone number

17. Does the Report make any recommendations that clinicians disagree with?

There are large numbers of clinicians in the region and they have different opinions about how services should develop. The review has consulted extensively with clinicians (and has also collected the views of different members of staff, as well as Medical Directors, patient and public groups, commissioners, and executive teams) and the recommendations reflect the discussions held and best practice elsewhere.

18. What is meant by a DGH's unique service portfolio?

It means that each of the hospitals in the region would provide a core set of services (which would include emergency services) as well as others that are more specialist.

19. **If I am a current patient in one of the five services that the Independent Review is focusing on does that mean I am not getting a quality, safe service now?**

No it does not mean that. Each of the services that were reviewed, provide safe services across all our hospitals. Like many across the country, services are under pressure to meet the rising demands and the Report recommendations suggest how best this can be done so that safe services are sustainable .

20. **How much involvement did patients and the public have in the outcome of the Independent Review?**

There has been extensive patient and public involvement in the Independent Review. The reports which detail the engagement, the feedback and how that feedback has been used to inform the Report are available on the Health and Care Together website: https://www.healthandcaretogethersyb.co.uk/index.php/get-involved

21. How many patients contributed to this review?

Many hundreds of patients and the public have been involved in the review. They have helped to shape the principles for the review and told us what is important to them about hospital services. They also shaped the evaluation criteria, told us what their main concerns were and their ideas on good practice.

All the information gathered was themed and has been used to inform the development of the Review's overall approach, the evaluation criteria, the engagement approach, and to inform the development and modelling of options.

22. **How much say did staff have on the outcome of the Independent Review?**

There have been opportunities for staff to be involved in the Independent Review throughout, as part of the patient and public engagement, in drop-in sessions at a number of hospitals, and also via their colleagues who have attended the regular Clinical Working Groups. The representatives attending the Clinical Working Groups had a commitment to reflect back within their organisations with the staff in the five service areas, and to ensure their input into the Clinical Working Groups represents not only their own views but the views of their colleagues.

23. Will I have to travel for my care?

At the moment nothing will change. If any of the Report recommendations are taken forward and if there were any changes to how people receive their services, business cases would need to be developed, followed by public consultation.

The Report is clear that transforming the way things are done is the preferred way of making improvements and reconfiguring services should only be done where this isn't possible.

The Report also makes the recommendation that a travel and transport group is developed which looks at the impact that changing services could have on travel times and public

transport etc. Patients and the public would be invited to be a part of this group as well as colleagues from the region's ambulance services.

24. Is the Report expecting all staff to work across different sites?

No. The Report recommends that the hosted networks will look at ways in which staff can work more flexibly across sites if they wish, for example through undertaking a secondment to another site to gain experience of working in a different unit, or in different settings such as spending time working in a community setting.

25. Do the unions know you're changing how services are staffed?

As part of the work of Health and Care Working Together, a Staff Partnership Forum has been set up with key union representatives involved. This group meets regularly and is kept up to date with all developments. This group will continue to meet and will be involved in further work should any of the recommendations be taken forward.

26. **Is the Report all about saving money?**

No it is not about saving money. The review is fundamentally about patient safety and sustainability. NHS services constantly change and adapt, and current challenges, such as rising demand, workforce challenges and quality standards mean that to ensure the future of our health services change is necessary. The Independent Review was not set up to resolve the financial challenge although it was agreed that any recommendations from it would not make them worse.

27. **Does the Report make any recommendations that mean staff will lose their jobs?**

No the Report does not. Staff are needed now more than ever and if the recommendations went ahead, they could be certain that the hospitals in the region would be among the most attractive places to work and providing some of the very best care in the world They would have fantastic opportunities to develop and learn and to shape the way they work. There are national workforce shortages, and a key aim of this Report is to recommend ways that the region's services can be even more successful in recruiting, retaining and developing staff.

28. **Why have I only just heard about this?**

The intention to independently review hospital services was first mentioned in the South Yorkshire and Bassetlaw Plan, published in November (2016). After several months of looking at information across many hospital services and talking with the public about how we decide which ones to review, the Independent Review was launched in October 2017. The launch was covered in local media, on social media, and via all of the partners' communications channels. Staff working in the services and patients and the public who use them have had a number of chances to give their views, including public events, online

surveys, focus groups and a telesurvey. Updates on the Review have been discussed at partner boards and governing bodies, which are held in public.

29. **Why are options for stroke not included?**

There is currently a legal challenge being brought against the hyper acute stroke services business case. Until that is complete, we are not considering the configuration of services for other elements of the pathway. However, the Independent Review considers that consultant-led acute stroke services could be managed by partnership working between trusts without the need for reconfiguration.

30. Which sites will be paired together for stroke?

All proposals relating to the reconfiguration of stroke services are provisional and subject to the outcome of the Judicial Review (JR) of the HASU (Hyper Acute Stroke Unit) business case. The proposal is that a pairing approach should be adopted which would see sites with HASUs share consultant rotas with those that have ASU (Acute Stroke Unit) only services. The exact detail of the pairing would need to be worked through, subject to the outcome of the JR and acceptance of the Report recommendations.

31. **I thought there had already been recommendations and a public consultation on stroke services**

The previous consultation looked at hyper acute stroke services only. These are the services where you are looked after for the first 72 hours after having a stroke where you receive critical, specialist care. Hyper acute stroke services are just one part of a patients experience after having a stroke and the hospital services review Report makes recommendations on the wider services within stroke care, subject to the outcome of a Judicial Review of the HASU business case.

32. Which hospitals will no longer provide overnight gastrointestinal (GI) bleed services?

The Report recommends that overnight services for emergency GI bleeds are consolidated onto three or four sites, it does not specify where the consolidation would take place. If the Report recommendations are accepted, there would be further work to scope how this would best be adopted and where changes would need to be made. During this time period we will also be engaging with patients, staff and public.

33. **What if I have a gastrointestinal bleed in the night and my hospital doesn't provide the service?**

In the immediate future there will be no changes to what happens now. Should the Report recommendations be accepted there would be further work to scope how this would best be adopted and where changes would need to be made, which would include ensuring protocols are in place for patients to be taken by ambulance directly to the nearest provider

of this service out of hours. This is common and there are already a number of conditions where the ambulance service will take a patient direct to the hospital where there is specialist care in place and the patient can receive the best possible care.

34. What do you do in the middle of the night if a patient is too ill to move?

At the moment, several of the sites in SYB operate only a partial out of hours rota for GI bleeds. In the interest of patient safety, the Review recommends formalising the overnight and weekend rotas so that all sites have clear protocols about where a patient can receive care out of hours.

In the rare situation where a patient is too ill to be moved, we anticipate that protocols would be in place for a consultant from the site providing the rota to come to the patient.

35. **I thought there had already been recommendations and a public consultation on children's services**

The previous consultation looked at how we could improve the care and experiences of all children needing an emergency operation out of hours in our region. Following a decision on how services are provided, around one or two children per week needing an emergency operation for a small number of conditions, at night or at a weekend, are no longer treated in hospitals in Barnsley, Chesterfield and Rotherham and instead have their surgery at Doncaster Royal Infirmary, Sheffield Children's Hospital or Pinderfield's Hospital. The review took the previous work into account when it made recommendations for services for children who are particularly ill.

36. The Report recommends further work is carried out to consider a reduction in the number of inpatient paediatric units. Does this mean my hospital's unit will close?

Children's services will continue as they are currently, pending any further consideration.

The Report recommends expanding services for children in the community and in short stay units, which would allow for further work to be carried out to consider a reduction in the number of inpatient paediatric units.

If the Report recommendations are accepted this would likely take a year to scope out even before any options are put forward around changes to the existing units. If it was then decided that changes to existing units were recommended there would be significant further work, including full public consultation, which would likely be in 2019. It would then be likely to take a number of years before any changes would be implemented.

The review has identified that there are significant challenges in sustaining certain services in every DGH, in particular paediatrics and maternity services. The Report recommends that networks and wider collaboration will provide the best opportunity to sustain local services at their current levels.

All the Emergency Departments in all of the hospitals which currently accept children (ie not the Northern General ED in Sheffield) will continue to accept children, with facilities to observe and care for them. Where children are particularly ill, they would be transferred to specialist sites. All our data and information tells us is that the majority of children stay in hospital for less than 24 hours and the Report recommendations take this into account.

37. **The Report recommends further work is carried out to consider a reduction in the number of consultant led maternity units. Does this mean my hospital's unit will close?**

The Report highlights transformation and says reconfiguration should only happen where transformation won't be able to solve all the challenges and asks for further work to be done in maternity services.

It aligns its thinking with the findings from the public consultation that informed the national report, Better Births, which recommend maternity services support personalisation, safety and choice, with access to specialist care whenever needed. The HSR Report calls for more choice for women and recommends further work is carried out to consider the creation of more care in communities and midwife-led units, and further development of home birth services.

The review has identified that there are significant challenges in sustaining certain services in every DGH, in particular paediatrics and maternity services. The Report recommends that networks and wider collaboration will provide the best opportunity to sustain local services at their current levels.

If the Report recommendations are accepted this would likely take a year to scope out even before any options are put forward around changes to the existing units. If it was then decided that changes to existing units were recommended there would be significant further work, including full public consultation, which would likely be in 2019. It would then be likely to take a number of years before any changes would be implemented.

38. **Does the recommended 'further work into elective services' mean you are going to stop providing other services in my local hospital?**

No decisions have been made to stop providing services in any hospitals. If the partners take the recommendation around elective services forward, further work would be done to understand the current links between services and hospitals (what we call "interdependencies") as well as whether these services could be delivered in a better way for the patients and people accessing them. Staff, clinicians, patients and the public would all be engaged in the work before any further recommendations are made.

39. **Does the Report make recommendations that mean my A&E is going to close?**

No the Report does not. The review looked at accident and emergency and urgent care services and believes by taking forward the transformation proposals within the Report, and subject to workforce projections being accurate, reconfiguration to A&E services is not necessary

NHS

Rotherham Metropolitan Borough Council

Sharing information to improve care

Patient information

For more information visit:
www.rotherhamhealthrecord.org

About the Rotherham Health Record

The Rotherham Health Record is an electronic system for sharing your health information in a secure way with health and care staff who provide care directly to you. This gives them access to the most up-to-date information so that they can provide better and quicker care.

Health and care professionals, including doctors and nurses, who are directly providing your care, will see a summary of your existing records – such as those held by your GP, hospital or social care provider – to allow them to make the right decisions with you and for you. You will only have to tell your story once.

Your record will contain information from the following organisations, if they have provided care for you at any time:

- Rotherham GP practices
- The Rotherham NHS Foundation Trust (hospital and community)
- Rotherham Doncaster and South Humber NHS Foundation Trust (Mental Health) Available in late 2018.
- Rotherham Metropolitan Borough Council (Adult and Children Social Care Services)
- Rotherham Hospice

The current Summary Care Record only holds information at your GP practice, however, the Rotherham Health Record holds information from all services to deliver better care for you.

What information is shared?

Your Rotherham health record will include information such as:

- Basic personal details including name, address, date of birth, next of kin.
- List of diagnoses – to enable health and care staff to make better decisions and treat your condition better.
- Details of any medications you are taking.
- Details of any allergies.
- Test results – to avoid having to repeat tests and speed up your treatment.
- Letters, referrals and discharge information.

Geoff's story:

"I have a number of health conditions that need treatment. I have some treatments at the hospital from my consultant and some from the practice nurse at my GP surgery. I have to tell each of these teams what the latest is about my health every time I go to an appointment because they aren't able to see each other's notes on the system.

It would be so much more convenient if they were able to show all my referrals and appointments so that everyone could see what tests and treatments I am having. I worry that I'm going to give them the wrong information because it's up to me to explain everything to everyone I see or speak to each time."

Why do you need to share my information?

It is essential that care professionals delivering direct care to individuals have access to up-to-date and accurate information. In the past, when you have received care in a number of places in Rotherham, such as the hospital or GP practice, your information has been stored on different computer systems. Having a more joined-up and co-ordinated record will improve the way information about you is shared in order to deliver better care.

The sharing of this information already occurs in order to deliver care to you, however it is currently done by paper and telephone which can cause delays in your treatment or care.

Who will be able to see my information?

Only Rotherham health or care staff (mentioned on the opposite page) involved in directly providing your care will have access to your information in the Rotherham Health Record system. We will not share your information with any third party who is not providing you with care, treatment or support.

What are the benefits of having a Health Record?

- You won't have to repeat information about your health and social care to different people.
- Professionals providing care to you will be able to find information about you when they need it.
- Your care will be better co-ordinated, with health and care professionals able to make informed decisions about your diagnosis, treatment and care plan.
- You will be able to avoid unnecessary appointments and tests.
- Clinicians and social care workers will have more time to spend looking after you because there will be less paperwork.

How do I know my records are safe and secure?

Legally, everyone working in, or on behalf of the NHS and Rotherham Council social care services, must follow confidentiality rules and keep all information about you in a safe and secure way. Information about you will be viewed through a secure and audited system that meets strict security standards and data protection legislation.

In addition, each organisation's privacy officer will carry out regular checks to make sure that your records are only viewed by authorised health and social care staff, who have a valid reason.

How do I opt out if I don't want my information to be shared?

You can opt out of having your information shared through the Rotherham Health Record at any time. If you would like to opt out please use one of the following options:

- Email: **rotherhamhealthrecord@nhs.net**
- Call: **01709 427299**
- Write to: **Rotherham Health Record Consent**
  Subject access request team
  Rotherham Hospital
  S60 2UD

We ask you to think carefully before opting out as sharing your health and social care records will make it easier to provide the best care and support for you in Rotherham. If you opt out, you may not always receive the best available service that meets your specific needs. For example, the out-of- hours GP service may not be fully aware of which medications you are currently taking and so be unable to advise on the best course of action for you.

You can change your mind at any time.

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