HEALTH AND WELLBEING BOARD

Venue: **Town Hall, Moorgate Street, Rotherham. S60 2TH**

Date: **Wednesday, 10th July, 2019**

Time: **9.00 a.m.**

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested in accordance with Part 1 of Schedule 12A to the Local Government Act 1972

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

3. Apologies for absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Minutes of the previous meeting held on 29th May, 2019 (Pages 1 - 8)

Delivery of the Health and Wellbeing Strategy

7. Performance Framework Spotlight: Smoking Status at the time of Delivery
   Presentation by Sue Turner, June Lovett and Wendy Griffiths

8. Developing a Loneliness Plan for Rotherham (Pages 9 - 12)
   Ruth Fletcher-Brown, Public Health Specialist, and Sam Blakeman, Democratic Services, to present

9. Priorities of the Health and Wellbeing Board
   Verbal update by all Board Sponsors

10. Aim 3: All Rotherham People Live Well for Longer
    Presentation by Sharon Kemp, Chief Executive, RMBC, and Louise Barnett, Chief Executive, Rotherham Foundation Trust

Board Assurance

11. Update on the JSNA (Pages 13 - 30)
Gilly Brenner, Consultant in Public Health, to present

Key Developments

12. Primary Care Networks
Verbal update by Chris Edwards, Chief Operating Officer, Rotherham CCG

13. Update from Events and Key Meetings (Pages 31 - 34)
Healthier Rotherham Event and Annual General Meeting – Chair/Chris Edwards, Chief Operating Officer, Rotherham CCG

Rotherham Together Partnership Showcase

Meeting with Andrew Cash – Chris Edwards, Chris Edwards, Chief Operating Officer, Rotherham CCG

Suicide Symposium Feedback – Anne Marie Lubanski, Strategic Director, Adult Social Care and Health

14. Issues escalated from Place Board
Sharon Kemp, Chief Executive, RMBC/Chris Edwards, Chief Operating Officer, Rotherham CCG, to report

15. Upcoming Agenda Items

For Information

16. Health and Wellbeing Strategy Aim 1 Action Plan

17. Rotherham ICP Place Board 1st May 2019 (Pages 35 - 39)

18. Outcomes Framework (Pages 40 - 50)

19. Q4 Place Plan Performance Report (Pages 51 - 76)

20. Date and time of next meeting
Wednesday, 18th September, 2019, at 9.00 a.m. venue to be agreed

HEALTH AND WELLBEING BOARD
29th May, 2019

Present:-

Councillor David Roche	Cabinet Member, Adult Social Care and Health **(in the Chair)**
Steve Chapman	Temporary District Commander, South Yorkshire Police
Tony Clabby	Healthwatch Rotherham
Dr. Richard Cullen	Strategic Clinical Executive, Rotherham CCG
Chris Edwards	Chief Operating Officer, Rotherham CCG
Sharon Kemp	Chief Executive, RMBC
Carol Lavelle	NHS England
Jenny Lingrell	Joint Assistant Director, Commissioning, Performance and Inclusion (representing Jon Stonehouse)
Anne Marie Lubanski	Strategic Director, Adult Care, Housing and Public Health)
Dr. Jason Page	Governance Lead, Rotherham CCG
Terri Roche	Director of Public Health
Angela Wood	Chief Nurse, Rotherham Foundation Trust (representing Louise Barnett)

Also Present:-

Adam Bramall	South Yorkshire Fire and Rescue Service (representing Steve Adams)
Paul Woodcock	Strategic Director, Regeneration and Environment Services
Rebecca Woolley	Policy and Partnerships Officer, RMBC

Report Presenters:-

Sam Barstow	Head of Community Safety and Regulatory Services
Richard Hart	Health Protection Principal
Councillor Emma Hoddinott	Cabinet Member for Waste, Roads and Community Safety
Jill Jones	Homelessness Manager
Sandra Tolley	Head of Housing Options

Apologies for absence were received from Councillors Mallinder and Watson, Louise Barnett (Rotherham Foundation Trust) and Kathryn Singh (RDaSH)

1. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

3. COMMUNICATIONS

The new Local Government Association publication that featured Rotherham's Health and Wellbeing Board was scheduled to be launched in July, 2019.

The Rotherham's Clinical Commissioning Group's Annual General Meeting was to take place on 3rd July, 2019, at the New York Stadium and would include stalls to promote good health and wellbeing and a workshop on loneliness.

4. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting of the Health and Wellbeing Board held on 20th March, 2019, were considered.

Arising from Minute No. 53 (Local Authority Declaration on Healthy Weight), it was noted that the report had been submitted to the Cabinet for information.

Arising from Minute No. 54(2) (Voice of the Child Lifestyle Survey 2019), it was noted that Becky Woolley and the Performance Assurance Manager were drawing up information with regard to long term trends. The information would then be used for Aim 1.

Arising from Minute No. 57(6) (Harmful Gambling), it was noted that the Task and Finish Group had been set up and would meet as soon as the member of staff responsible had returned to work. The first of the training had taken place with more arranged for June.

Resolved:- That the minutes of the previous meeting held on 20th March, 2019, be approved as a correct record.

5. UPDATE FROM SAFER ROTHERHAM PARTNERSHIP

Councillor Hoddinott, Cabinet Member for Waste, Roads and Community Safety and Chair of the Safer Rotherham Partnership Board, together with Sam Barstow, Head of Community Safety and Regulatory Services, gave the following powerpoint presentation on the work of the Partnership:-

Current Priorities (2019/20)

- Protecting vulnerable children
- Protecting vulnerable adults
- Building confident and cohesive communities
- Preventing domestic abuse and other related offences
- Preventing serious and organised crime

Performance Highlights

- First time young offenders down from 229 to 194
- Over 100 engagement sessions regarding countering extremism

Performance Challenges
- Mental Health referrals
- Stalking and harassment
- Substance misuse

Project Highlights
- Hate crime
  101 crimes/incidents reported
  120 drop-in sessions
  45 awareness raising sessions
  6 new panel members
  165 women part of a network
- Kickz
  120 young people engaged
  12 educational workshops for young people
  7 community events and tournaments
  20 young people referred on to education programmes etc.
- Perpetrator Programme
- Engagement activity
  1,224 families receiving leaflet on protecting children from extremism
  3,499 young people participating in the Lifestyle Survey
  7 young people attending a consultant event
  7 domestic abuse victims engaged by a 'DA Car' over the Christmas period
- Training activity
  Hate Crime/Extremism
  Co-abuse training for DA practitioners
  Organised Crime sessions within schools
  Training for responsible authorities under the Licensing Act
  Extreme right wing ideology

Forward Look
- Continuing to develop co-located teams
- Licensing – Gambling, Training and Sex establishments
- Embedding delivery of the Child Criminal Exploitation project
- Tackling Harmful Narratives and Hate Crime
- Focussing on Environmental Crime, Drug Use/Supply and Off-Road Motorcycles
- Exploring and promoting intelligence across agencies
- Community Payback in local communities
- Hate Crime Strategy
- Anti-Social Behaviour Strategy

It was noted that the Cabinet was to shortly consider the Sex Establishment Policy, upon which consultation was currently being undertaken, and a refresh of the Licensing and Gambling Policy.

Discussion ensued with the following issues raised/clarified:-

- Public Health would be contributing to the Licensing and Gambling Policy consultation i.e. the health/alcohol harm evidence
- Anecdotal hotspots were known but supporting data was required for the cumulative impact assessment
- The Partnership had commissioned work later in the year on the vulnerabilities of people that were subject to certain types of crime
- The Board was pressing for a formalised plan around Mate Crime
- The link between anti-social behaviour and isolation/loneliness - would supporting people to address loneliness and isolation have an impact on the frequent reporters of anti-social behaviour

Councillor Hoddinott and Sam were thanked for their presentation.

Resolved:- That the presentation be noted.

6. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

Terri Roche, Director of Public Health, introduced the 2018 independent annual report. For the previous 3 years, the annual reports had focussed on the lifecourse; the 2018 report took a new approach and sought to champion the strengths of Rotherham's local communities and share experiences of what kept its residents healthy, happy and well.

The general public had been asked to submit photographs which showed what kept them healthy, happy and well where they lived. These were then grouped by theme and found that they fell into 2 main themes – community and the environment – as well as capturing all 5 of the 'five ways to wellbeing'.

The 2018 annual report was broken down into chapters on:-

- What does keeping healthy, happy and well in Rotherham mean to you
- Our communities
- Five ways to wellbeing
- What can we do to support health and wellbeing
- Recommendations
- What we will do together
- Progress on last year's recommendations

The key recommendations in the report were:-

- Consider 'health and wellbeing' in the wider context of being influenced by everything around us
- Seek first to understand what is 'strong' in our communities and what assets we can build on together to support the health and wellbeing of our residents

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

- Discussion would take place at the Aim 3 workshop to be held later that day with regard to asset-based training
- Should there be focus on one issue to maximise the impact?

Resolved:- That the report be noted.

7. HEALTH PROTECTION COMMITTEE ANNUAL REPORT

Richard Hart, Health Protection Principal, presented the Health Protection annual report 2018 which highlighted the main areas of health protection activity in Rotherham over the period 1st January to 31st December, 2018.

The organisations represented on the Rotherham Health Protection Committee (RHPC) collectively acted to prevent or reduce the harm or impact on the health of the local population caused by infectious disease or environmental hazards, major incidents and other threats.

The Health Protection Committee, on behalf of the Director of Public Health, would continue to meet on a quarterly basis to oversee and discharge the Council's Health Protection duties.

With the publication of the NHS Long Term Place (7th January 2019), there were opportunities to strengthen actions on health inequalities, antimicrobial resistance, air pollution, supporting people in care homes, national screening programmes and childhood immunisations.

There were 2 risks on the Council's Strategic Risk Register associated with protecting the health of the local health population;-

- To provide an effective co-ordinated multi-agency response in the early stages of any flu pandemic
- To reduce the impact of any communicable disease incident/outbreak in Rotherham

The report set out the areas that RHPC had identified as the focus for actions in the year ahead from which the following key recommendations had been drawn:-

1. Maintain effective monitoring, communication and response to incidents or outbreaks and consolidate multi-agency arrangements which includes an agreed approach to funding.

2. Improve the update of Measles, Mumps and Rubella (MMR) vaccination to achieve minimum herd immunity, routine immunisations for the hard to reach communities and seasonal flu vaccination for staff and the eligible population.

3. Review Borough-wide Infection Prevention and Control Services and make recommendations for improvements to the patient pathway and the sustainability of services (including Tuberculosis Specialist Services).

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

- There was national debate with regard to the take up of vaccinations to children. If there was a national decision with regard to the way forward it would be adopted by Rotherham. Rotherham Public Health worked very closely with partners and the NHSE worked with GPs
- Public Health England was responsible for vaccinations and the CCG for management of local arrangements. There was history of it being unclear who was responsible for what in the event of a pandemic. It was important that PHE representation was in attendance at any workshop to discuss how such an event would be handled
- Whilst awaiting a lead nationally, it was considered prudent to have such conversations with school leaders through the Rotherham Educational Strategic Partnership as to their thoughts on vaccinations
- Consultation was due to start shortly on Clean Air Zones
- Weekly oversight by the CCG on the availability of drugs

Resolved:- (1) That report be noted.

(2) That the Board's commitment for all partners to sustain their contributions to the Borough-wide health protection work and actions of the Rotherham Health Protection Committee be approved.
ACTION:- All Board members

8. UPDATE ON AIM 1 OF THE HEALTH AND WELLBEING STRATEGY

Aim 1: All children get the best start in life and go on to achieve their potential
Dr. Jason Page, Rotherham CCG, presented an update in relation to Aim 1 of the Health and Wellbeing Strategy 2025.

With the aim of a powerpoint presentation, following the principles of Signs of Safety, the Board considered:-

What's working well
What are we worried about
What needs to happen

Discussion ensued with the following issues raised/clarified:-

- 25.5% of children aged 4-5 years old were classed as obese 15% would be the expected at that level

- Places for People, Rotherham's leisure provider, was fully engaged with the Council. For adults there was Slimming World, through Healthy Rotherham, and the Healthy Weight for All Plan which was about listening and endeavouring to get people more active. The Rotherham Active Partnership was hosted at the Rotherham Leisure Centre recently. Their aim was to engage the harder to reach groups
- Ensure food outlets were not next to schools
- Work required on advertising e.g. the display of adverts on public transport for fast food

Resolved:- That the report be noted.

9. OUTCOMES FRAMEWORK - SPOTLIGHT: HOMELESSNESS

Sandra Tolley, Head of Housing Options, and Jill Jones, Homelessness Manager, gave a powerpoint presentation on Homelessness Prevention and Rough Sleeper Strategy 2019-22.

The presentation included:-

- The vision
- National context – The Homelessness Reduction Act
- The local picture – the demand and funding
- The 6 aims of the Strategy:-
  To support people with complex needs
  To prevent homelessness and offer rapid housing solutions to get people in urgent need rehoused quicker
  To increase support for young people to prevent homelessness
  To end rough sleeping and begging
  To improve access to tenancy support, employment and health support services
  To ensure there is sufficient decent emergency accommodation
- Action plan to address the gaps
- Housing First
- Analysis of temporary accommodation
- Performance framework/trends

Discussion ensued with the following issues raised/clarified:-

- Housing had a good relationship with certain parts of the Hospital's Discharge Team. Some people discharged from A&E and/or the Mental Health Unit at Swallownest Court may be in need of temporary accommodation. The Service would be providing an Outreach Service at Swallownest Court
- Rotherham had seen an increase in the number of people with a disability rough sleeping over the past 12 months. That could be someone who was in temporary accommodation because it took longer to provide the appropriate accommodation

- Housing OT was part of the Housing Team so an applicant would have an assessment. However, they may have to spend more time in temporary accommodation until suitable accommodation was found. They may be unable to return to their previous accommodation due to their illness
- They would still be accepted under the Homeless Duty because their home was no longer suitable for them
- Step Up and Step Down was where people discharged from hospital and did not have a suitable home to go to and went into temporary accommodation as an interim measure
- The need to ensure everyone was aware and understood the pathways and a report back to the Board on what/where the challenges were in the system as experienced by different parties

Resolved:- That the report be noted.

10. ISSUES ESCALATED FROM PLACE BOARD

There were no issues to report.

11. Q3 PLACE PLAN PERFORMANCE

It was noted that Place Plan performance would be available at a future meeting.

12. ROTHERHAM ICP PLACE BOARD 6TH MARCH AND 3RD APRIL 2019

The minutes of the Rotherham Integrated Care Partnership Place Board held on 6th March and 3rd April, 2019, were noted.

13. UPCOMING AGENDA ITEMS

Joint Strategic Needs Assessment update - July

Loneliness - November

14. DATE AND TIME OF NEXT MEETING

Resolved:- That a meeting be held on Wednesday, 10th July, 2019, commencing at 9.00 a.m. venue to be agreed.

BRIEFING	**TO:**	**Health and Wellbeing Board**
	DATE:	**10th July 2019**
	LEAD OFFICER	**Sam Blakeman, Democratic Services, Assistant Chief Executives Directorate** **Ruth Fletcher-Brown, Public Health, Adult Care and Public Health Directorate**
	TITLE:	**Loneliness Making Every Contact Count Pilot**

Background

1.

Local Context

A consideration of loneliness became part of Rotherham's refreshed Joint Health and Wellbeing strategy (2018-2025) in March 2018, as it was highlighted by the Chair of the local Health and Wellbeing Board as being a significant issue. While many think of loneliness as a social issue, it also affects people's physical and mental health and wellbeing.

To recognise the importance of this to health outcomes it was included as a strategic priority under 'Aim 4' of the strategy to: '*Mitigate the impact of loneliness and isolation in people of all ages'*.

This was the start of a range of actions to better understand the local, complex, picture of loneliness, and to develop some specific actions that would help address the issue, using a whole-system, partnership approach (key actions are outlined below).

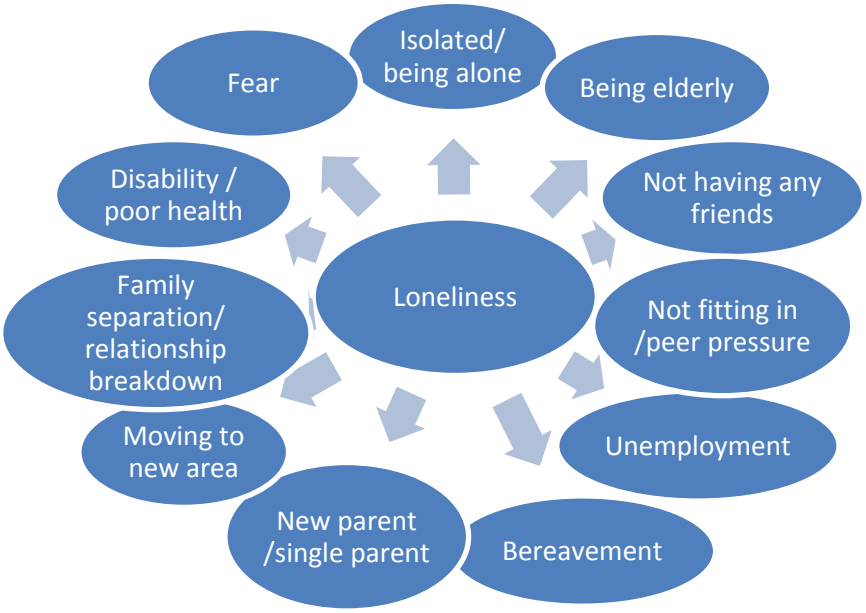
National Context

The Government published their Loneliness Strategy on October 15th 2018 following a call for evidence that had over 400 responses. Following Tracey Crouch's resignation in November 2018, the minister for loneliness is Mims Davies MP.

The content of this strategy provided validation that locally in Rotherham, the approach and actions being explored were going in the right direction. The national, strategic actions that the strategy proposed would also enhance what was being done locally and help drive further change and action across the system.

Key actions in the national strategy include:

- **Plans to mainstream and standardise system of social prescribing with 'link workers' embedded –** national system in place by 2023. Schemes to be mapped. Best practice guide to be published. Online platform to be published. Learning programme to be established.

	• **New money to develop community assets -** £11.5 million 'building connections fund'. The grantees have since been announced. • **'National conversation' to reduce stigma for Loneliness .** • **Focus on whole life course –** understanding that loneliness can strike at any point. Strategy notes that 'vast amount' of research has been done on loneliness for elderly – more needs to be done regarding young people. • **Consideration of Loneliness embedded in national decision making process –** every government department to report back how they have embedded loneliness within their decision making process.
Key Issues	
2.	National research by the Office for National Statistics on loneliness found that several groups of people were more at risk of loneliness and that there were a set of 'triggers' that pushed people into a period of loneliness. These are set out below: 
Key Actions and Relevant Timelines	
3.	**<u>Loneliness Making Every Contact Count Background</u>** One of the key actions within the Health and Wellbeing Strategy under this priority is to roll out a programme of Making Every Contract Count (MECC) training across the borough which focuses on loneliness. The South Multi-Agency Group (MAG) decided that loneliness was to be one of its key priorities. This was due to all partners highlighting their experiences of dealing with local people who they believed to be lonely, but were causing significant 'pressure' on local resources due to front-line

workers not knowing how to help and support them. The loneliness task group therefore approached them to collaborate on developing a pilot project which would test out MECC for loneliness.

The MAG is made up of representatives from the Council, including housing, neighbourhoods, early help and community safety, as well as Fire & Rescue, Health and the Police, to encourage locally informed multi-agency working. In collaboration with public health specialists a pilot was developed to test out and evaluate how front-line workers (in Wickersley, Maltby & Dinnington wards) could identify loneliness, using their knowledge of local people and asking questions based on the MECC 'healthy chat' approach.

MECC has traditionally been used to identify and signpost for smoking, reducing alcohol consumption and weight issues, therefore using it to address loneliness presented something much more complex, as it is much harder to 'see' and there is not one single 'solution' to the problem. Identified front-line workers will be 'up-skilled' to gain a subtle understanding of possible signs of loneliness, a picture of loneliness in Rotherham, suitable methods and ways to talk about these sensitive issues and the appropriate ways to signpost residents to services.

The pilot would also test a new 'community connector' role, which will sit within the Voluntary Action Rotherham (VAR) social prescribing team, and offer a bespoke light-touch connecting service, locating appropriate groups and activities for the identified resident (not a full social prescription). It was decided that many of the people that are lonely may require some appropriate 'hand-holding' to engage them. Research shows that lonely people are more likely to perceive, expect and remember others behaviour to be unfriendly and as such may not be willing to voluntarily attend organised community groups.

The pilot will run for 6 months, and will then be evaluated and inform the roll-out of Loneliness MECC across the borough. The evaluation will attempt to understand how the front-line professionals dealt with asking questions around loneliness and any issues regarding the issue's stigma as well as assessing the signposting and referral pathways.

The pilot project has been designed so that attempts to tackle loneliness are embedded into the everyday activities of the front-line workers and to attempt to reach a demographic who are normally missed by traditional methods to address loneliness and social isolation. The pilot has been designed with a consideration of a whole 'life-course approach' rather than focusing exclusively on elderly people.

MECC Training

All 3 MECC loneliness training sessions have taken place. 32 front-line workers have been trained from across the different public sector organisations who operative in Rotherham. These include:

- Police Community Support Officers
- Fire and Rescue Community Support Officers
- Area Housing Officers

	• Area Housing assistants • Outreach Workers • Neighbourhood co-ordinators • Anti-Social Behaviour officers • Health advocate • Equality and inclusion advisor • Environmental health officer • District Nurses The training sessions took place in Maltby, Dinnington and Wickersley (the same areas where the pilot is taking place). The Community Connector role is in post and awaiting referrals from front-line workers. **<u>Timescales</u>** MECC training – April 2019 Beginning of Pilot – June 2019 End of Pilot – December 2019 Borough-wide launch – Spring 2019 The national campaign 'Five Ways to Wellbeing' will be central to the loneliness action plan. Rather than beginning a new branded campaign, it was decided to maintain and continue to support *Five ways.* We have a large amount of resources and will spread knowledge of the campaign though the Loneliness Make Every Contact Count training. 
Recommendations	
4.	The progress of the Loneliness pilot is noted by the Health and Wellbeing Board.

BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	10th July 2019
	LEAD OFFICER	Gilly Brenner, Consultant in Public Health, Rotherham Metropolitan Borough Council
	TITLE:	Updates: JSNA and key health issues facing Rotherham population

Background

1. The purpose of this report is to update the Health and Wellbeing Board on the relaunch of the Rotherham Joint Strategic Needs Assessment (JSNA) and provide a brief overview of how Rotherham is currently performing against a range of health indicators.

1.1. The aim of a Joint Strategic Needs Assessment (JSNA) is to drive improvement in the health and wellbeing of the local community and reduce inequalities for all ages. It is not a stand-alone product, but a continuous process of strategic assessment. This should support the development of local evidence-based priorities for strategies and commissioning, inform planning, and ultimately help to determine what actions the Council, local NHS organisations and other partners need to take in order to meet Rotherham's health and social care needs and to address the wider determinants that impact on health and wellbeing.

1.2. The Rotherham JSNA was refreshed as an online resource in 2013, replacing the former fixed document format of 2011. Following a period of consultation, the Health and Wellbeing Board signed off the final version of the JSNA in February 2014 and it was subject to further review in 2015/16. In November 2018 a consultation launched at the Health and Wellbeing Board was undertaken to again provide an opportunity to rationalise the content, ensuring it is meaningful and useful to commissioners, service providers, partners, and lay users.

1.3. The November 2018 consultation was launched at Health and Wellbeing Board (21/11/18), and also undertaken with Voluntary Community Sector Representatives (16/01/19), and Health Select Commission (17/01/19), and was additionally available as an online survey promoted through staff bulletins and email cascades.

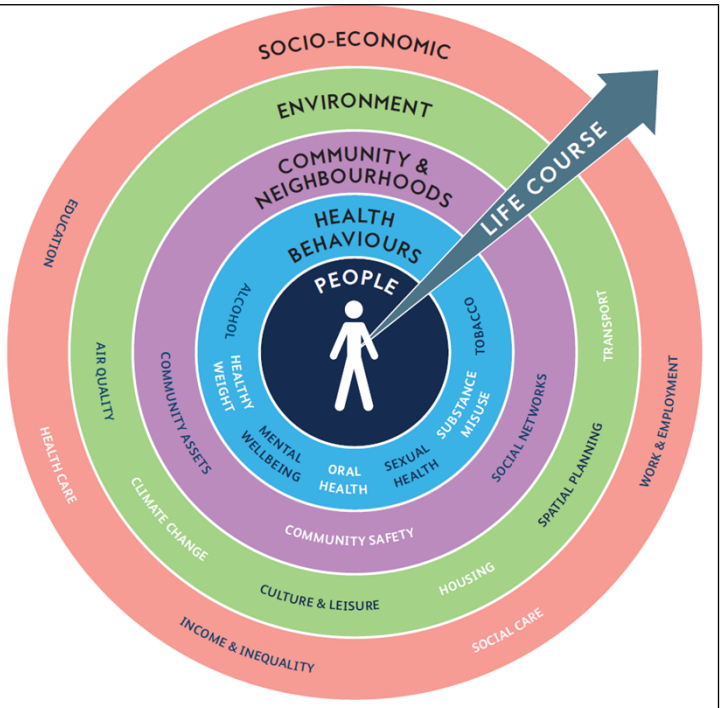
Key Issues

2. <u>JSNA Development</u>

1.4. Analysis of the responses to the consultation concluded that users would prefer a simpler format, making it easier to locate and browse intelligence in an interactive way. It is now more popular to present data and analysis in a more pictorial format, using infographics, maps, graphs and spinecharts rather than

paragraphs of text and tables. This can help make information more accessible to a wider audience, more impactful and quicker to assimilate.

1.5. The new format will be based on an adaptation of the Dahlgren and Whitehead model[1], highlighting how the health of the people of Rotherham is impacted on by a wide range of factors and how these factors impact throughout the life course.



1.6. The Thriving Neighbourhoods strategy[2] sets out a new asset-based way of working which places communities at the heart of everything the Council does. The relaunched JSNA will include a map of all physical community assets (i.e. community-used buildings and grounds, including GP practices, schools, community and faith buildings, parks, allotments, leisure facilities etc.) It will also include a page with a comprehensive list of web links to community-based activity and opportunities for further engagement (such as the Rotherham Gismo directory[3] for signposting to community groups). Where possible, data will be provided for a range of geographies (such as wards and Primary Care Networks), enabling bespoke profiles of interest to be generated by users.

1.7. Previously the JSNA has been primarily owned and maintained by the Council. It is really important that if it is to be meaningful and used by a wider audience, that partners are actively involved in contributing data and contextual analysis. The population health management work and use of the Rotherham Health Record anonymised data sets will enable segmentation and addition of greater context to health data in new ways. Each section of the JSNA will also include 'assets and stakeholder views' which will capture 'softer intelligence,' (such as public consultation, ad hoc gathered views of front line staff or residents, and case studies), which will add contextual information about the data and draw out for example strengths in particular communities.

<u>Key health issues facing Rotherham population</u>

1.1. A comprehensive picture of the health issues facing the Rotherham population will be captured by the new JSNA. New indices of multiple deprivation (IMD) data will also be available nationally in the autumn which will help add refreshed

[1] https://core.ac.uk/download/pdf/6472456.pdf
[2] https://www.rotherham.gov.uk/homepage/466/your_neighbourhood
[3] https://www.rotherhamgismo.org.uk/

context to our local picture.

1.2. Appendix 1 shows an overview of the latest Public Health indicators for Rotherham from the Public Health Outcomes Framework[4]. This gives a snapshot overview of how Rotherham compares to England across a broad range of indicators relevant to health.

1.3. Inequalities persist in Rotherham. Life expectancy in Rotherham not only remains below the England average (0.1ii), but the gap between Rotherham and the England average has been steadily getting wider (0.2iv). Within Rotherham borough itself inequalities are even more striking (0.2iii): a baby boy born in an area with highest deprivation can expect to live on average 10 years less than one born in the least deprived areas.

1.4. As the NHS Long Term Plan[5] describes, people are living longer, but extra years of life are not always spent in good health. People are more likely to live with multiple long-term conditions, frailty or dementia, creating substantial care needs. Boys born now in Rotherham can expect to spend on average 18.5 years in poor health, and girls 24.3 years (the difference between life expectancy at birth (0.1i) and healthy life expectancy at birth (0.1ii)).

1.5. The links between poverty and poor health outcomes are well established. The trend of improving employment (1.08iv) is therefore heartening, but it is not currently seen for vulnerable groups, such as those with learning disabilities (1.08ii) or those in contact with secondary mental health services (1.08iii). The Working Win pilot is an example of how local health providers are supporting people to stay in or get into employment.

1.6. We are aware from local data not yet reflected in national figures, that breastfeeding rates have improved recently, however there is still significant progress to be made to bring Rotherham rates up to the England average (2.02).

1.7. Smoking at time of delivery is subject to focus of the Maternity Transformation Plan, seeing recruitment of an additional stop smoking midwife and other work to support the continued reduction in the proportion of women smoking throughout pregnancy, helping to bring this very high challenging rate down towards the England average (2.03).

1.8. Rates of overweight and obesity in adults has fallen (71.2% in 2016/17 to 62.7% in 2017/18 (2.12)) bringing Rotherham in line with the England average. However, poor diet (2.11) and physical inactivity (2.13) will hinder improvement, and excess weight still begins at an early age (2.06) where it remains above the England average.

1.9. Low rates of successful drug treatment completions and high rates of death in drug users (2.15) are a cause for concern. The substance misuse service

[4] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework
[5] https://www.longtermplan.nhs.uk/

		provider Change Grow Live (CGL) is aware of the challenge and has produced an action plan that targets stratification of opiate users by dose of methadone in order to target the offer of a new detoxification pathway at this group. All staff have had a range of additional training and new clinical approaches are being trialled. 1.10. Health protection indicators generally demonstrate good outcomes in Rotherham, in line with or better than the England average. The Health Protection Annual Report 2018 sets out recommendations to improve 'flu and MMR vaccine uptake in at risk population groups. 1.11. Rates of preventable mortality (4.03) and mortality in under 75 year olds from cardiovascular disease (4.04), cancer (4.05) and respiratory disease (4.07) remain above the England average. Respiratory disease is a particular concern since the rate is increasing faster than the England average. 1.12. Suicide rates in Rotherham remain a significant concern (4.10) and a range of multiagency working is focussed through the Better Mental Health for All strategy, including general wellbeing promotion such as the 'five ways to wellbeing' and also specific additional suicide prevention work. 1.13. Further detail about mortality is available in appendix 2 which highlights some of the key data available in the Global Burden of Disease dataset, recently published at local authority level[6]. In Rotherham, the 5 leading causes of death in 2017 were ischaemic heart disease (IHD), Alzheimer's / dementia, lung cancer, chronic obstructive pulmonary disease (COPD) and lower respiratory disease. The top 5 causes of years lived in disability (YLD) are lower back pain, headache, depression, neck pain and COPD. 1.14. For a disease such as IHD, 93.2% of deaths are considered attributable to risk factors potentially preventable. The risk factors contributing the most to all deaths in Rotherham are smoking, high blood pressure, high blood glucose, high body mass index and high cholesterol. 1.15. Ambitions set out in the NHS Long Term Plan describe the role health providers can play in improving upstream prevention of avoidable illness and its exacerbation. By embracing the South Yorkshire QUIT programme and changing our perception of smoking as a lifestyle choice, to viewing tobacco use as a chronic long-term disease of nicotine addiction, both patients and clinicians will be empowered to treat the single biggest cause of disease.
Key Actions and Relevant Timelines		
3.	1.8.	The JSNA Steering Group has now met twice (14/02/19 and 23/05/19) and will next meet again in June. Terms of Reference have been agreed and lead authors assigned for key sections.

[6] https://vizhub.healthdata.org/gbd-compare/

	1.9. In order to create a more sustainable and efficient process for the generation of intelligence, and to maximise use of new ways of presenting interactive data, it will be necessary to embrace new software technology. This presents a challenge in terms of up-skilling staff, initial capacity to develop content and embedding the new technology into current performance and data analysis work. 1.10. A JSNA update will be taken to the Health and Wellbeing Board in July and the website will be relaunched at Health and Wellbeing Board in November. Training will also be offered to Councillors and wider partners to maximise use of the JSNA, which will also coincide with the publication of new indices of multiple deprivation data.
Recommendations	
4.	1.11. The Health and Wellbeing Board is asked to note the developments of the Rotherham JSNA. 1.12. The Board are asked to note and consider the key health issues facing the Rotherham population.

Appendix 1

Public Health Outcomes Framework Scorecard – Rotherham – May 2019 update

Public Health Outcomes Framework
Update published: 8 May 2019

Significance (RAG) (compared to England)
- Better
- Average
- Worse
- Not compared
- Lower
- Higher

Change (over last period/ since baseline)
- Improving
- Similar
- Worsening
- Increasing
- Decreasing

New, updated or revised indicators shown as shaded. New period shown in red.
Change in RAG status from baseline which is due to latest update is shown in red.

Overarching indicators

Indicator	Latest Period	Rotherham Count	Rotherham Value	Region Value	England Value	Unit	RAG	Last yr	Trend	Since Baseline Overall	Since Baseline RAG-C
0.1i - Healthy life expectancy at birth (Male)	2015-17	n/a	59.3	61.7	63.4	Years					
0.1i - Healthy life expectancy at birth (Female)	2015-17	n/a	57.4	61.5	63.8	Years					
0.1ii - Life Expectancy at birth (Male)	2015-17	n/a	77.8	78.7	79.6	Years					
0.1ii - Life Expectancy at birth (Female)	2015-17	n/a	81.7	82.4	83.1	Years					
0.1ii - Life Expectancy at 65 (Male)	2015-17	n/a	17.9	18.2	18.8	Years					
0.1ii - Life Expectancy at 65 (Female)	2015-17	n/a	20.0	20.6	21.1	Years					
0.2iii - Inequality in life expectancy at birth within English LAs, based on local deprivation deciles within each area (Male)	2015-17	n/a	10.8	10.3	9.4	Years					
0.2iii - Inequality in life expectancy at birth within English LAs, based on local deprivation deciles within each area (Female)	2015-17	n/a	8.4	8.4	7.4	Years					
0.2iii - Inequality in life expectancy at 65 within English LAs, based on local deprivation deciles within each area (Male)	2015-17	n/a	4.9	5.1	4.9	Years					
0.2iii - Inequality in life expectancy at 65 within English LAs, based on local deprivation deciles within each area (Female)	2015-17	n/a	5.1	5.2	4.5	Years					
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Male)	2015-17	n/a	-1.8	-0.9	0.0	Years					
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Fem)	2015-17	n/a	-1.5	-0.7	0.0	Years					

Improving the wider determinants of health

Indicator	Latest Period	Rotherham Count	Rotherham Value	Region Value	England Value	Unit	RAG	Last yr	Trend	Since Baseline Overall	Since Baseline RAG-C
1.01i - Children in low-income families (all dependent children under 20)	2016	12,545	21.5%	19.5%	17.0%	%					
1.01ii - Children in low-income families (under 16s)	2016	10,910	21.8%	19.7%	17.0%	%					
1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception	2017/18	2,416	73.1%	69.5%	71.5%	%					
1.02i - School Readiness: % of children with free school meal status achieving a good level of development at the end of reception	2017/18	272	58.6%	54.1%	56.6%	%					G to A
1.02ii - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2017/18	2,763	80.8%	80.3%	82.5%	%					
1.02ii - School Readiness: Percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2017/18	380	68.3%	66.9%	70.1%	%					R to A
1.03 - Pupil absence (age 5-15)	2016/17	699,057	5.22%	4.86%	4.65%	%					
1.04 - First time entrants to the youth justice system (age 10-17)	2017	53	218.7	319.0	292.5	Crude rate per 100,000					
1.05 - 16-17 year olds not in education employment or training or whose activity is not known (current method)	2017	360	5.9%	5.8%	6.0%	%					
1.05 - 16-18 year olds not in education employment or training (historical method)	2015	510	5.3%	4.8%	4.2%	%					
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (age 18-64)	2017/18	584	80.4%	80.9%	77.2%	%					
1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation (age 18-69)	2017/18	n/a	70.0%	69.0%	57.0%	%					
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate (age 16-64) (S)	2017/18	n/a	10.7	12.0	11.5	Percentage point gap					R to A
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (age 18-64) (Persons)	2017/18	n/a	71.2	66.1	69.2	Percentage point gap					
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (age 18-69)(P)	2017/18	n/a	71.3	64.5	68.2	Percentage point gap					
1.08iv - Percentage of people aged 16-64 in employment (Persons)	2017/18	119,000	75.3%	73.5%	75.2%	%					R to A
1.09i - Sickness absence - The percentage of employees who had at least one day off in the previous week (age 16+)	2015-17	n/a	2.4%	2.3%	2.1%	%					
1.09ii - Sickness absence - The percent of working days lost due to sickness absence (age 16+)	2015-17	n/a	1.5%	1.3%	1.1%	%					R to A

Improving the wider determinants of health (continued)

Indicator	Latest Period	Rotherham Count	Rotherham Value	Region Value	England Value	Unit	RAG	Last yr	Trend	Since Baseline Overall	Since Baseline RAG-C
1.10 - Killed and seriously injured casualties on England's roads (all ages)	2015-17	341	43.4	45.7	40.8	Crude rate per 100,000					G - A
1.11 - Domestic abuse-related incidents and crimes (age 18+) (historic method)	2014/15	n/a	30.0	23.1	20.4	Crude rate per 1,000					
1.11 - Domestic abuse-related incidents and crimes (age 18+) (current method)(CHANGED)	2017/18	n/a	31.1 (P)	28.3	25.0	Crude rate per 1,000					
1.12i - Violent crime (including sexual violence) - hospital admissions for violence (all ages)	2015/16 - 17/18	364	47.6	53.3	43.4	DSR per 100,000					R to A
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population (all ages)	2017/18	7,325	27.9	28.8	23.7	Crude rate per 1,000					
1.12iii- Violent crime (including sexual violence) - Rate of sexual offences per 1,000 pop.n (all ages)	2017/18	979	3.7	2.9	2.4	Crude rate per 1,000					
1.13i - Re-offending levels - percentage of offenders who re-offend (all ages) (current method)	2016/17	487	27.5%	31.4%	29.2%	%		n/a		n/a	
1.13ii - Re-offending levels - average number of re-offences per offender (all ages) (current method)	2016/17	2,018	1.14	1.32	1.17	Crude rate per offender		n/a		n/a	
1.13iii - First time offenders (all ages)	2017	330	125.9	161.2	166.4	Crude rate per 100,000					
1.14i - Percentage of the population affected by noise - No. of complaints about noise (all ages)	2015/16	1,846	7.1 (m)	5.9 (m)	6.3 (m)	Crude rate per 1,000					
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime (all ages)(m)	2016	10,850	4.2%	4.1%	5.5%	%					
1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time (all ages)(m)	2016	20,330	7.8%	6.5%	8.5%	%					
1.15i - Statutory homeless - Eligible homeless people not in priority need	2017/18	32	0.3	1.0	0.8	Crude rate per 1,000					
1.15ii - Statutory homelessness - households in temporary accommodation (all ages)	2016/17 (a)	29	0.3	0.4	3.3	Crude rate per 1,000					
1.16 - Utilisation of outdoor space for exercise/health reasons (age 16+)	Mar 2015 - Feb 2016	n/a	13.5%	17.5%	17.9%	%					
1.17 - Fuel Poverty (all ages)	2016	12,618	11.4%	12.1%	11.1%	%					
who have as much social contact as they would like (18+)	2017/18	n/a	47.5%	47.5%	46.0%	%					
1.18ii - Social Isolation: % of adult carers who have as much social contact as they would like (age 18+)	2016/17	121	37.3%	38.7%	35.5%	%		n/a			G to A

Health improvement

Indicator	Latest Period	Rotherham Count	Rotherham Value	Region Value	England Value	Unit	RAG	Last yr	Trend	Since Baseline Overall	Since Baseline RAG-C
2.01 - Low birth weight of term babies (>= 37 weeks gestational age at birth)	2017	66	2.4%	3.0%	2.8%	%					
2.02i - Breastfeeding - Breastfeeding initiation (Female)	2016/17	1,642	56.0%	69.3%	74.5%	%					
2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth (historical method)	2014/15	553	**	42.2%	43.8%	%	**				
2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth (current method) (S)	2017/18	930	30.4%	**	42.7%	%		n/a	n/a	n/a	
2.03 - Smoking status at time of delivery (Female) (current method)	2017/18	521	19.9%	14.2%	10.8%	%					
2.03 - Smoking status at time of delivery (Female) (historical method)	2016/17	455	17.0%	14.2%	10.5%	%					
2.04 - Under 18 conceptions (Female)	2017	97	22.1	20.6	17.8	Crude rate per 1,000					
2.04 - Under 18 conceptions: conceptions in those aged under 16 (Female)	2017	22	5.1	3.3	2.7	Crude rate per 1,000					A to R
2.05ii - Proportion of children aged 2-2½ years offered ASQ-3 as part of the Healthy Child Programme or integrated review	2017/18	2,431	88.6%	87.6%	90.2%	%					
2.06i - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2017/18	814	25.5%	22.9%	22.4%	%					
2.06ii - Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2017/18	1,114	36.1%	34.7%	34.3%	%					
2.07i - Hospital adms caused by unintentional and deliberate injuries in children (0-14 years)	2017/18	395	82.3	105.0	96.4	Crude rate per 10,000					A to G
2.07i - Hospital adms caused by unintentional and deliberate injuries in children (0-4 years)	2017/18	174	108.9	123.1	121.2	Crude rate per 10,000					
2.07ii - Hospital adms caused by unintentional and deliberate injuries in young people (15-24)	2017/18	365	125.6	145.2	132.7	Crude rate per 10,000					
2.08i - Average difficulties score for all looked after children aged 5-16 in care at least 12 months	2017/18	n/a	14.6	14.9	14.2	Score					
2.08ii - Percentage of children where there is a cause for concern	2017/18	106	44.5%	42.7%	38.6%	%					R to A
2.09i Smoking prevalence age 15 years (WAY survey)	2014/15	n/a	10.0%	8.7%	8.2%	%		n/a		n/a	
2.09ii Smoking prevalence age 15 years - regular smokers (WAY survey)	2014/15	n/a	7.2%	6.2%	5.5%	%		n/a		n/a	
2.09iii Smoking prevalence age 15 years - occasional smokers (WAY survey)	2014/15	n/a	2.9%	2.5%	2.7%	%		n/a		n/a	
2.10ii - Emergency hospital admissions for self harm	2017/18	422	167.3	194.6	185.5	DSR per 100,000					A to G
2.11i - Population meeting the recommended '5-a-day' on a 'usual day' (age 16+) (CHANGED)	2017/18	n/a	54.2%	53.3%	54.8%	%					
2.11ii - Average portions of fruit eaten (age 16+) (CHANGED)	2017/18	n/a	2.58	2.46	2.51	%					
2.11iii - Average portions of vegetables eaten (16+) (CHANGED)	2017/18	n/a	2.50	2.59	2.65	%					A to R
2.11iv - Proportion of the population meeting the 5-day-day recommendations at age 15	2014/15	n/a	47.1	49.6	52.4	%		n/a		n/a	
2.11v -Average portions of fruit consumed daily at age 15	2014/15 (NEW)	3,011	2.12	2.30	2.39	Average daily quantity		n/a		n/a	
2.11vi -Average portions of vegetables consumed daily at age 15	2014/15 (NEW)	2,995	2.13	2.27	2.40	Average daily quantity		n/a		n/a	
2.12 - Excess Weight in Adults (age 18+) (current method)	2017/18	n/a	62.7%	64.1%	62.0%	%					R to A
2.13i - Percentage of physically active adults (age 19+) (CHANGED)	2017/18	n/a	55.8%	64.0%	66.3%	%					A to R
2.13ii - Percentage of physically inactive adults (age 19+) (CHANGED)	2017/18	n/a	30.2%	24.1%	22.2%	%					A to R

Health improvement (continued)

Indicator	Latest Period	Rotherham Count	Rotherham Value	Region Value	England Value	Unit	RAG	Last yr	Trend	Since Baseline Overall	Since Baseline RAG-C
2.14 - Smoking Prevalence (age 18+)	2017	33,397	16.2%	17.0%	14.9%	%					
2.15i - Successful completion of drug treatment - opiate users (age 18-75)	2017	41	4.2%	5.5%	6.5%	%					A to R
2.15ii - Successful completion of drug treatment - non-opiate users (age 18-75)	2017	46	31.5%	37.7%	36.9%	%					
2.15iii - Successful completion of alcohol treatment (age 18-75)	2017	174	43.0%	38.9%	38.9%	%					G to A
2.15iv - Deaths from drugs misuse	2015-17	51	7.1	5.5	4.3	%					A to R
2.16 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison	2017/18	13	16.5%	37.5%	32.1%	%					A to R
2.17 - Estimated diabetes diagnosis rate (age 17+) (CHANGED)	2018	n/a	81.2%	81.9%	78.0%	%					
2.18 - Alcohol related admissions to hospital - narrow definition (Persons)	2017/18	1,818	707	697	632	DSR per 100,000					
2.19 - Cancer diagnosed at early stage (Experimental Statistics) (all ages)	2017	574	47.0%	50.6%	52.2%	%					
2.20i - Cancer screening coverage - breast cancer (Female) (age 53-70)	2018	23,255	77.4%	75.0%	74.9%	%					
2.20ii - Cancer screening coverage - cervical cancer (Female) (age 25-64)	2018	51,069	76.1%	74.2%	71.4%	%					
2.20iii - Cancer screening coverage - bowel cancer (age 60-74)	2018	24,876	60.4%	60.3%	59.0%	%					
2.20iv - Abdominal Aortic Aneurysm screening - coverage (age 65)	2017/18	1,181	81.6%	83.3%	80.8%	%					G to A
2.20xi - Newborn bloodspot screening - coverage (age under 1 year)	2015/16	2,786	94.4%*	94.0%*	95.6%*	%					
2.20xii - Newborn hearing screening - coverage (age under 1 year)	2017/18	2,969	98.9%	99.1%	98.9%	%					
2.22iii - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check (in 5yrs 13/14-17/18)	2013/14 - 2017/18	44,814	57.1%	78.4%	90.9%	%		n/a		n/a	
2.22iv - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received one	2013/14 - 2017/18	34,566	77.1%	49.9%	48.7%	%		n/a		n/a	
2.22v - Cumulative % of the eligible population aged 40-74 who received an NHS Health Check (13/14-17/18)	2013/14 - 2017/18	34,566	44.1%	39.1%	44.3%	%		n/a		n/a	
2.23i - Self-reported well-being - people with a low satisfaction score (age 16+)	2017/18	n/a	7.3%	4.9%	4.4%	%					
2.23ii - Self-reported well-being - people with a low worthwhile score (age 16+)	2017/18	n/a	4.9%	4.0%	3.6%	%					
2.23iii - Self-reported well-being - people with a low happiness score (age 16+)	2017/18	n/a	11.2%	9.1%	8.2%	%					
2.23iv - Self-reported well-being - people with a high anxiety score (age 16+)	2017/18	n/a	26.8%	21.2%	20.0%	%					
2.24i - Injuries due to falls in people aged 65 and over (Persons)	2017/18	1,119	2,285	2,102	2,170	DSR per 100,000					R to A
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 (Persons)	2017/18	370	990	1,004	1,033	DSR per 100,000					R to A
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+ (Persons)	2017/18	749	6,043	5,288	5,469	DSR per 100,000					

Health protection

Indicator	Latest Period	Rotherham Count	Rotherham Value	Region Value	England Value	Unit	RAG	Last yr	Trend	Since Baseline Overall	Since Baseline RAG-C
3.01 - Fraction of mortality attributable to particulate air pollution (age 30+)	2017	n/a	4.1%	4.2%	5.1%	%					
3.02 - Chlamydia detection rate (15-24 year olds) - CTAD (Persons)	2017	596	2,010	2,244	1,882	Crude rate per 1,000					
3.02 - Chlamydia detection rate (15-24 year olds) - CTAD (Male)	2017	188	1,233	1,499	1,264	Crude rate per 1,000					
3.02 - Chlamydia detection rate (15-24 year olds) - CTAD (Female)	2017	404	2,806	3,015	2,502	Crude rate per 1,000					
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2017/18	14	100.0%	**	**	%					
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2017/18	8	80.0%	**	**	%					
3.03iii - Population vaccination coverage - Dtap/ IPV/Hib (1 year old)	2017/18	2,874	96.2%	94.5%	93.1%	%					
3.03iii - Population vaccination coverage - Dtap/ IPV/Hib (2 years old)	2017/18	2,972	97.2%	96.2%	95.1%	%					
3.03iv - Population vaccination coverage - MenC (1 yr)	2015/16	2,784	97.9%*	97.0%	**	%		n/a			
3.03v - Population vaccination coverage - PCV (1 yr)	2017/18	2,875	96.3%	94.7%	93.3%	%					
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	2017/18	2,874	94.0%	93.4%	91.2%	%					G to A
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years)	2017/18	3,003	94.3%	93.8%	92.4%	%					
3.03vii - Population vaccination coverage - PCV booster (2 years old)	2017/18	2,879	94.2%	93.5%	91.0%	%					
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	2017/18	2,864	93.7%	93.3%	91.2%	%					
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	2017/18	3,069	96.4%	95.9%	94.9%	%					A to G
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	2017/18	2,870	90.1%	90.5%	87.2%	%					R to A
3.03xii - Population vaccination coverage - HPV (Female) (12-13 years)	2017/18	1,648	95.3%	91.5%	86.9%	%					
3.03xiii - Population vaccination coverage - PPV (65+)	2017/18	34,452	72.2%	71.3%	69.5%	%					
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2017/18	37,769	76.0%	73.7%	72.6%	%					R to G
3.03xv - Population vaccination coverage - Flu (at risk individuals) (6 months to 64 years)	2017/18	18,242	53.6%	50.3%	48.9%	%					
3.03xvi - Population vaccination coverage - HPV for 2 doses (Female) (13-14 years)	2017/18	1,506	92.3%	89.6%	83.8%	%					A to G
3.03xvii - Shingles vaccination coverage (70 years old)	2017/18	1,517	47.0%	46.8%	44.4%	%		n/a		n/a	
3.03xviii - Population vaccination coverage - Flu (2-4 year olds) (historical method)	2016/17	3,980	42.0%	37.9%	38.1%	%					
3.03xviii - Population vaccination coverage - Flu (2-3 year olds) (current method)	2017/18 (NEW)	2,659	43.8%	42.8%	43.5%	%					
3.04 - People presenting with HIV at a late stage of infection (age 15+)	2015-17	15	48.4%	47.8%	41.1%	%					R to A
3.05i - Treatment completion for TB (all ages)	2016	7	87.5%	86.1%	84.4%	%					
3.05ii - Incidence of TB (all ages)	2015-17	38	4.8	7.4	9.9	Crude rate per 100,000					R to G
3.06 - NHS organisations with a board approved sustainable development management plan	2015/16	2	50.0%	67.1%	66.2%	%					
3.08 Adjusted antibiotic prescribing in primary care by the NHS	2017	177,618	1.20	1.09	1.04	Indirectly std rate					

Healthcare public health and preventing premature mortality

Indicator	Latest Period	Rotherham Count	Rotherham Value	Region Value	England Value	Unit	RAG	Last yr	Trend	Since Baseline Overall	Since Baseline RAG-C
4.01 - Infant mortality (under 1 year)	2015-17	30	3.2	4.1	3.9	Crude rate per 1,000					
4.02 - Proportion of 5 year old children free from dental decay (2016/17 update but no data for Roth)	2014/15	1,284	71.1	71.5	75.2	Mean dmft per child			***		
4.03 - Mortality rate from causes considered preventable (all ages) (Persons)	2015-17	1,632	208.8	197.2	181.5	DSR per 100,000					
4.04i - Under 75 mortality rate from all cardiovascular diseases (Persons)	2015-17	614	85.4	82.6	72.5	DSR per 100,000					
4.04ii - <75 mortality rate from cardiovascular diseases considered preventable (Persons)	2015-17	379	52.6	53.3	45.9	DSR per 100,000					
4.05i - Under 75 mortality rate from cancer (Persons)	2015-17	1,055	146.4	143.5	134.6	DSR per 100,000					
4.05ii - Under 75 mortality rate from cancer considered preventable (Persons)	2015-17	640	88.9	84.7	78.0	DSR per 100,000					
4.06i - Under 75 mortality rate from liver disease (Persons)	2015-17	140	19.7	19.1	18.5	DSR per 100,000					G to A
4.06ii - Under 75 mortality rate from liver disease considered preventable (Persons)	2015-17	116	16.4	16.9	16.3	DSR per 100,000					G to A
4.07i - Under 75 mortality rate from respiratory disease (Persons)	2015-17	341	47.1	39.7	34.3	DSR per 100,000					A to R
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Persons)	2015-17	185	25.4	22.0	18.9	DSR per 100,000					A to R
4.08 - Mortality from a range of communicable diseases, including influenza (Persons)	2015-17	78	10.5	10.6	10.9	DSR per 100,000					G to A
4.09i - Excess under 75 mortality rate in adults with serious mental illness (age 18-74)	2014/15	n/a	411.0	376.9	370.0	Indirectly std. ratio					
4.09ii - Proportion of adults in contact with secondary mental health services (18-74)	2014/15	9,445	5.2%	5.5%	5.4%	%					A to G
4.10 - Suicide rate (all ages) (Persons)	2015-17	107	15.9	10.4	9.6	DSR per 100,000					A to R
4.11 - Emergency readmissions within 30 days of discharge from hospital (all ages) (Persons)	2011/12	4,741	13.4	12.0	11.8	Indirectly std proportion					
4.12i - Preventable sight loss - age related macular degeneration (AMD) (age 65+)	2017/18	62	121.5	127.0	106.7	Crude rate per 100,000					
4.12ii - Preventable sight loss - glaucoma (age 40+)	2017/18	46	33.4	15.0	12.6	Crude rate per 100,000					A to R
4.12iii - Preventable sight loss - diabetic eye disease (age 12+)	2017/18	10	4.5	3.3	2.8	Crude rate per 100,000					
4.12iv - Preventable sight loss - sight loss certifications (all ages)	2017/18	178	67.6	48.2	41.1	Crude rate per 100,000					
4.13 Health-related quality of life for older people (65 and over)	2016/17	n/a	0.714	0.731	0.735	Score					
4.14i - Hip fractures in people aged 65 and over (Persons)	2017/18	290	589	569	578	DSR per 100,000					
4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (Persons)	2017/18	95	255	237	246	DSR per 100,000					
4.14iii - Hip fractures in people aged 65 and over - aged 80+ (Persons)	2017/18	195	1,560	1,533	1,539	DSR per 100,000					
4.15i - Excess Winter Deaths Index (Single year, all ages) (Persons)	Aug 2016 - Jul 2017	237	28.4	24.9	21.6	Ratio					
4.15ii - Excess Winter Deaths Index (single year, age 85+) (Persons)	Aug 2016 - Jul 2017	108	38.6	36.7	30.8	Ratio					
4.15iii - Excess Winter Deaths Index (3 years, all ages) (Persons)	Aug 2014 - Jul 2017	599	23.5	21.8	21.1	Ratio					
4.15iv - Excess Winter Deaths Index (3 years, age 85+) (Persons)	Aug 2014 - Jul 2017	302	34.8	31.0	29.3	Ratio					
4.16 - Estimated dementia diagnosis rate (aged 65+)	2018	2,484	82.9	71.2	67.5	Ratio					

Based on data from May 2019 quarterly update of the Public Health Outcomes Framework (PHOF) (published 08/05/19).
Source - Public Health England.

Notes

RAG = Rotherham compared to England (Red/Amber/Green)
Last yr = change over last year/period.
Trend = all available data from baseline ("n/a" if only 2 points)
Overall = change from baseline to latest.
RAG-C = Change in RAG status baseline to latest.

Value = Rotherham rate.
Region = Yorkshire and the Humber rate.
n/a - not applicable.
* Estimated from former primary care organisations covered by the LA.
** Not published for data quality reasons.
*** Last year/overall based on surveys for 2007/08 and 2011/12.
(S) New data source. (m) modelled data. (a) 2017/18 but data suppressed.
(P) Police force area.

(NEW) New
(CHANGED) Definition changed.
Q - data quality issue.

Indicators with no data at Rotherham level or too few values to calculate a rate:

1.07 - People in prison who have a mental illness or significant MI
2.09iv - Smoking prevalence at age 15 years - regular smokers (SDD survey)
2.09v - Smoking prevalence at age 15 years - occasional smokers (SDD survey)
2.20v – Diabetic eye screening - uptake
2.20vii - Infectious Diseases in Pregnancy Screening – HIV Coverage
2.20viii - Infectious Diseases in Pregnancy Screening – Syphilis Coverage
2.20ix - Infectious Diseases in Pregnancy Screening – Hepatitis B Coverage
2.20x - Sickle Cell and Thalassaemia Screening – Coverage
2.20xi - Newborn Blood Spot Screening - Coverage
2.20xii - Newborn Hearing Screening - Coverage
2.20xiii - Newborn and Infant Physical Examination Screening – Coverage
3.03ii - P.v.c. - Selective neonatal BCG vaccination coverage (< 1yr)

'RAG' column shows how Rotherham is performing compared to the England average:
Green circle = significantly better, Red = significantly worse, Amber = similar.
(R) = Red, (A) = Amber, (G) = Green.

Appendix 2: Global Burden of Disease Study

Background

The Global Burden of Disease Study has been updated to 2017 and now includes data at local authority level. Data is summarised and presented using the online visualisation tool on the Institute for Health Metrics and Evaluation (IHME) website (University of Washington)[7].

The visualisation tool allows users to view data by year from 1990 to 2017 on deaths, years lived with disability (YLD) and disability-adjusted life years (DALYs) by cause and the proportions due to risk factors. Breakdowns are also available by gender and selected age groups.

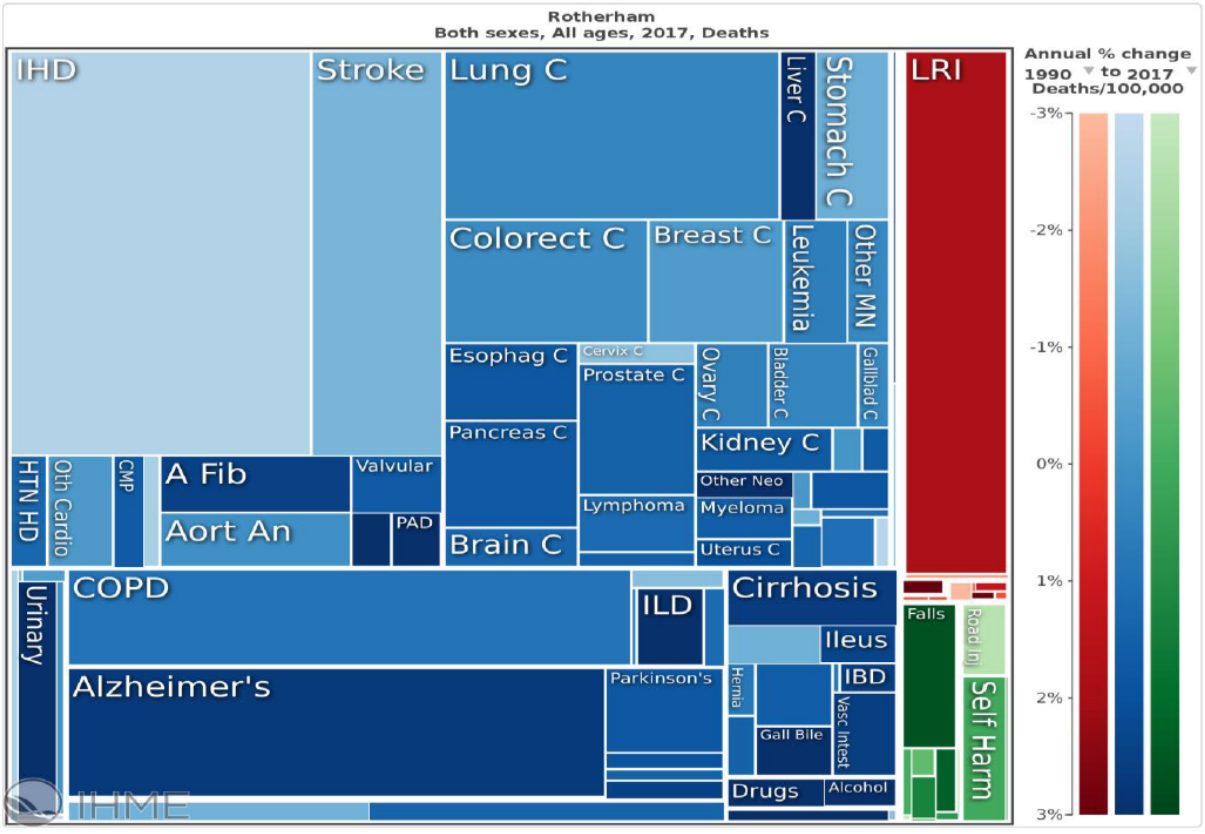
Cause charts are colour-coded into 3 groups (Non-communicable diseases (blue), Communicable diseases, maternal, neonatal and nutritional (red), and Injuries (green)).

Colours are also coded lighter to darker to highlight levels of annual change. Examples of causes showing large average annual increases 1990-2017 for Rotherham are:

- Deaths – liver cancer, urinary diseases, interstitial lung disease (ILD), peripheral arterial disease (PAD), alcohol use disorders.
- YLD – inflammatory bowel disease (IBD), malignant skin melanoma, uterine cancer, diabetes, prostate cancer.
- DALYs – bacterial skin diseases, liver cancer, endocarditis, interstitial lung disease, peripheral arterial disease.

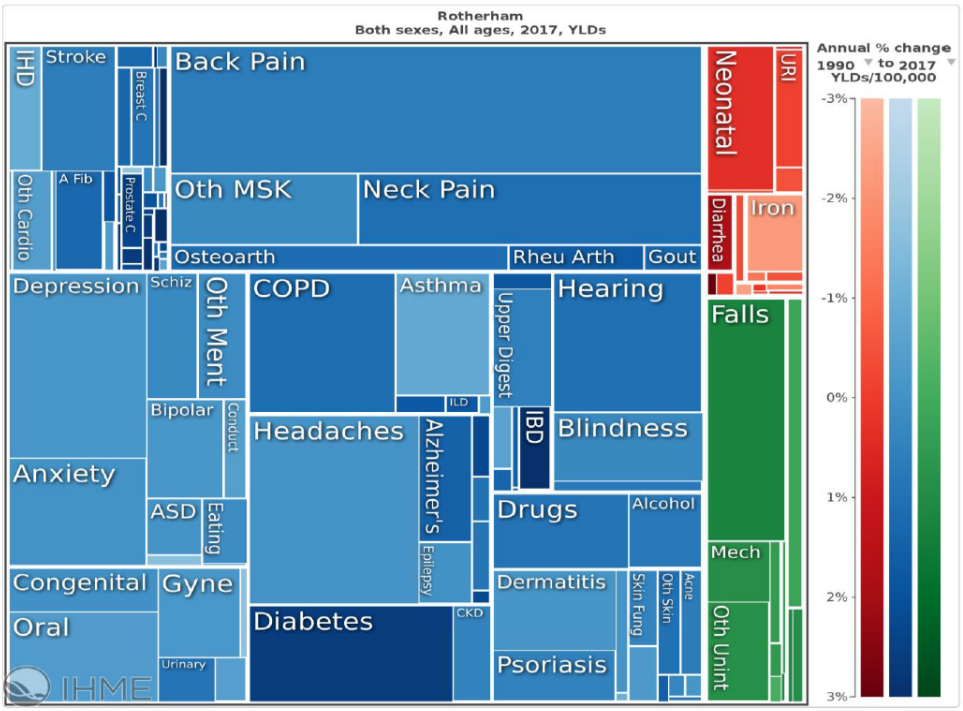
Also see “Treemap” charts below:

Deaths

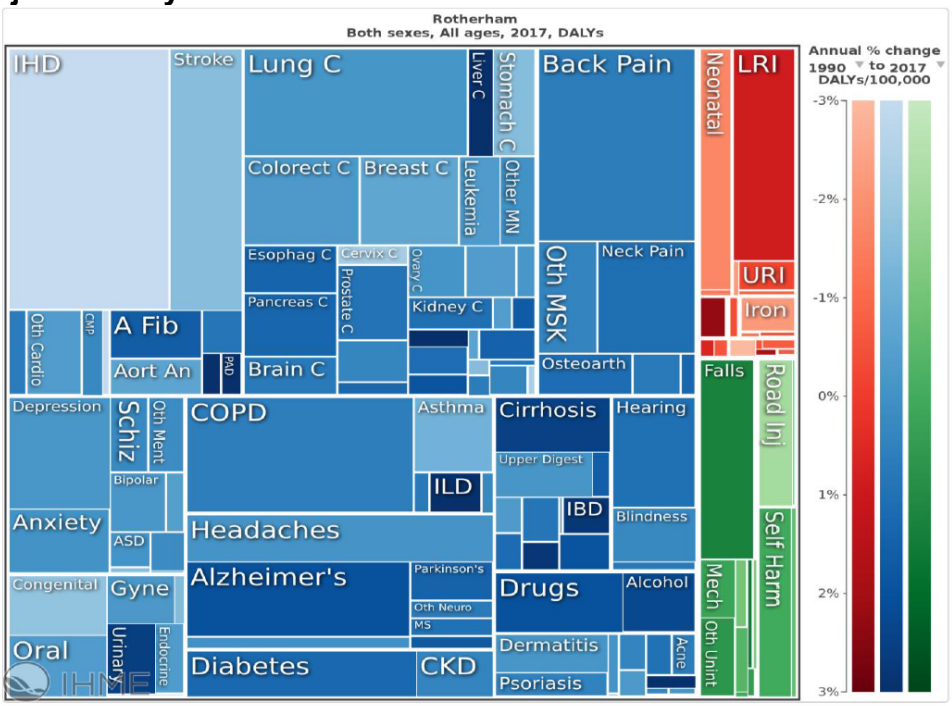


[7] https://vizhub.healthdata.org/gbd-compare/

Years lived with disability



Disability adjusted life years



The Top 5 causes of: death, YLD and DALYs based on the previous treemap charts are shown below. These compare Rotherham over time (1990 and 2017) and Rotherham to England for 2017.

Global Burden of Disease Study 2017
Rotherham 1990 and 2017
Causes of death
(Top 5)

Rank	Cause	1990	Cause	2017
1	Ischaemic heart disease	31.8%	Ischaemic heart disease	16.0%
2	Stroke	9.8%	Alzheimers/dementia	9.2%
3	Lung cancer	6.8%	Lung cancer	7.4%
4	COPD	5.7%	COPD	7.3%
5	Lower respiratory diseases	4.49%	Lower respiratory diseases	7.2%
	Alzheimers/dementia	4.47%		

Global Burden of Disease Study 2017
England 2017
Causes of death
(Top 5)

Rank	Cause	2017
1	Ischaemic heart disease	14.1%
2	Alzheimers/dementia	10.7%
3	Stroke	7.5%
4	COPD	6.5%
5	Lower respiratory diseases	6.2%

Years lived with disability (YLD)
(Top 5)

Rank	Cause	1990	Cause	2017
1	Lower back pain	12.6%	Lower back pain	13.2%
2	Headaches	7.2%	Headaches	6.2%
3	Depression	5.9%	Depression	5.0%
4	Neck pain	4.0%	Neck pain	4.8%
5	Hearing loss	3.47%	COPD	4.05%
	COPD	3.40%	Hearing loss	4.05%

Years lived with disability (YLD)
(Top 5)

Rank	Cause	2017
1	Lower back pain	13.0%
2	Headaches	6.4%
3	Depression	5.1%
4	Neck pain	4.7%
5	Diabetes	4.2%

Disability-adjusted life years (DALYs)
(Top 5)

Rank	Cause	1990	Cause	2017
1	Ischaemic heart disease	18.3%	Ischaemic heart disease	8.3%
2	Stroke	5.4%	Lower back pain	6.0%
3	Lower back pain	4.8%	COPD	5.3%
4	Lung cancer	4.6%	Lung cancer	4.8%
5	COPD	4.2%	Stroke	3.8%

Percentages rounded to one decimal point.

Disability-adjusted life years (DALYs)
(Top 5)

Rank	Cause	2017
1	Lower back pain	6.62%
2	Ischaemic heart disease	6.56%
3	COPD	4.5%
4	Lung cancer	3.7%
5	Stroke	3.6%

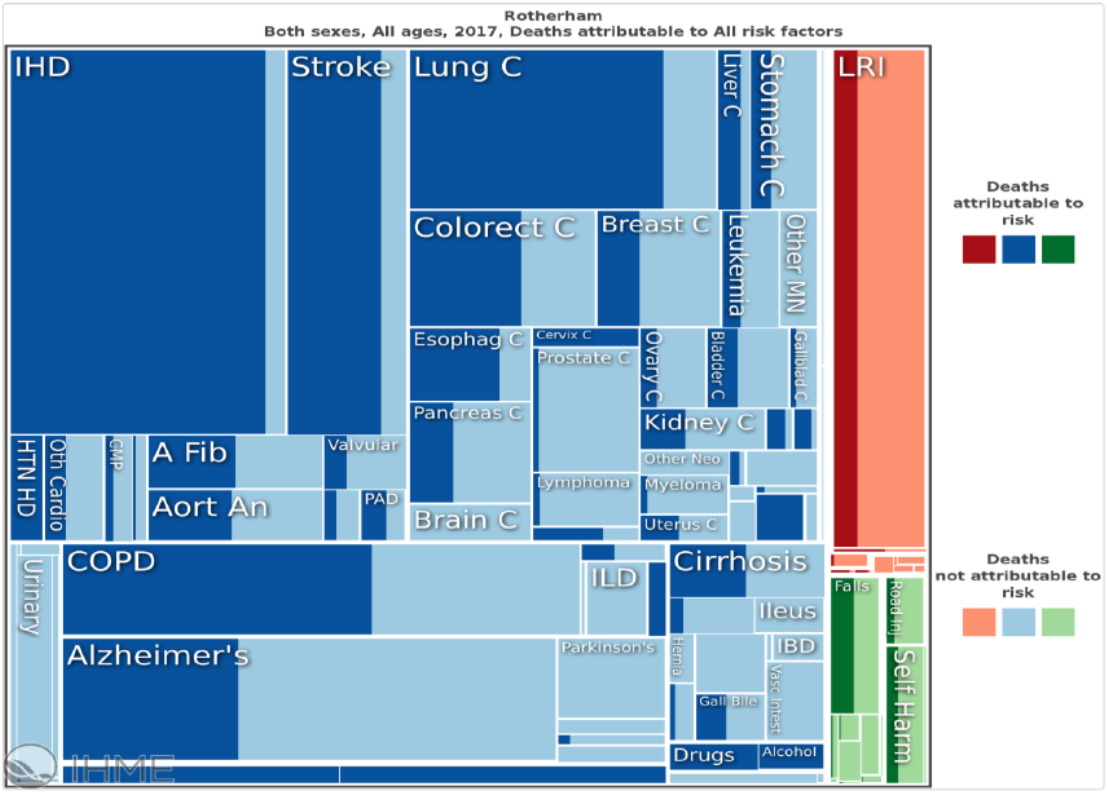
Percentages rounded to one decimal point.

The above tables highlight Ischaemic Heart Disease (IHD) as the greatest burden in terms of deaths and disability-adjusted life years (DALYs) between 1990 and 2017 in Rotherham but the proportion has halved over time. Lower back pain has maintained its position as the greatest burden in terms of years lived with disability (YLD).

Deaths from ‘Alzheimer’s Disease and other dementias’ have doubled their proportion of deaths between 1990 and 2017 and are now the second highest cause of death behind IHD.

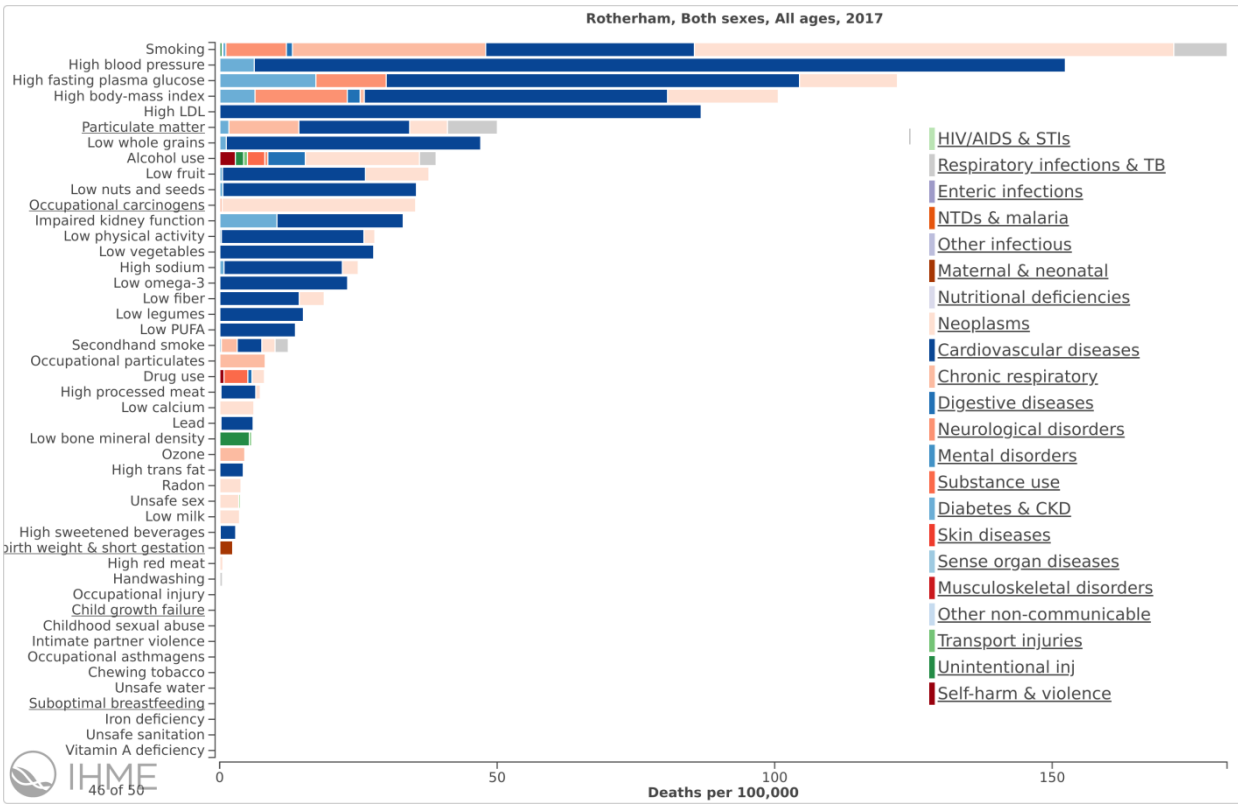
Differences in rank order between Rotherham and England are shown in red. This highlights that lung cancer deaths are a greater burden in Rotherham than nationally (with deaths from stroke a lower priority).

Risk charts are based on the above three groups but also add on the proportion of the deaths, YLDs or DALYs attributable to all risk factors (and therefore potentially preventable)
An example of risks by cause based on the deaths burden treemap is shown below:



This shows that the vast majority of IHD deaths are attributable to risk factors (93.2%). In contrast, 35.5% of Alzheimer's Disease and other dementias deaths, and 5.1% of prostate cancer deaths are attributable to risk factors.

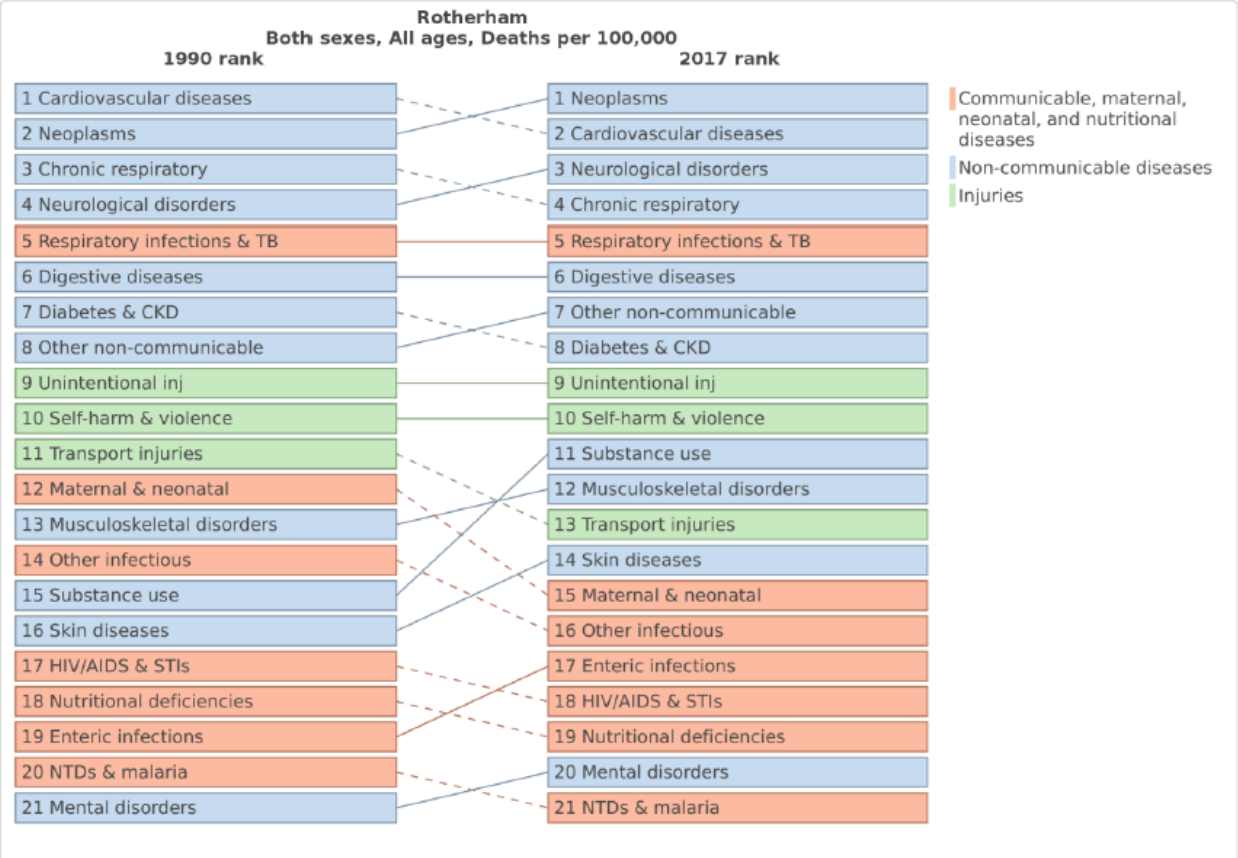
Risk factors



The risk factors contributing the most to deaths in Rotherham are smoking, followed by high blood pressure, high blood glucose, high BMI and high cholesterol.

Arrow diagram charts

Arrow diagram charts show deaths, YLDs and DALYs by broad groups of causes in rank order between 1990 and 2017. This highlights changes over time.
In the example below based on deaths this shows that for Rotherham, deaths from Cardiovascular diseases is no longer the number one cause (deaths per 100,000) with Neoplasms taking over. The largest change in rank order is for deaths from substance use which has moved from 15th to 11th between 1990 and 2017.



Definitions

- Disability-adjusted life years (DALYs): The sum of years lost to premature death (YLL) and years lived with disability (YLD). DALYs are also defined as years of healthy life lost.
- Years lived with disability (YLD): Years of life lived with any short-term or long-term health loss.
- Years of Life Lost (YLL): Years of life lost to premature mortality.
- Risk factors: Potentially modifiable causes of disease and injury.
- Treemap: The treemap chart type is a square pie chart displaying causes (diseases and injures) grouped by hierarchy; the size of the box is proportionate to the burden displayed. Also can display a risk factor and its attribution to the causes





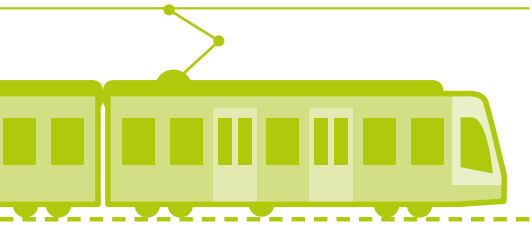
ROTHERHAM
TOGETHER
PARTNERSHIP

The Rotherham Plan
ANNUAL DELIVERY PLAN 2019/20



WHAT WE'VE ACHIEVED...

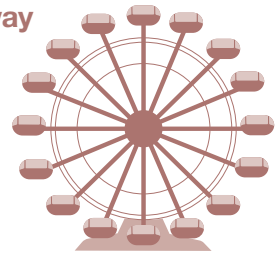
UK's first tram-train service up and running – 100% of survey respondents satisfied with overall journey



20 GP practices now signed up to Rotherham Health Record

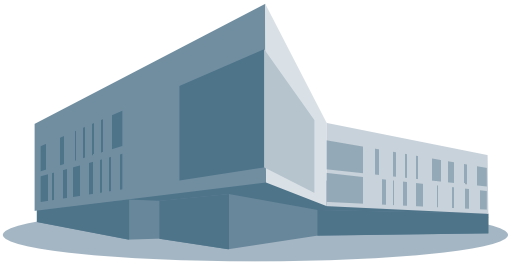
Working Win employment support trial underway – 995 referrals and 100 job outcomes in Rotherham (as at April 2019)

Work underway on Gulliver's Valley theme park



Joint council-police teams established for north, south and central Rotherham

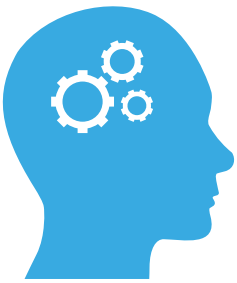
University Centre Rotherham opens, offering 30 higher level courses



Development partner secured for Forge Island regeneration project

Cultural partnership board established and draft cultural strategy developed

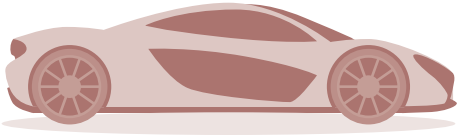
400 young people attended 'harms of hate' event, hearing personal stories of surviving hate, extremism and terror



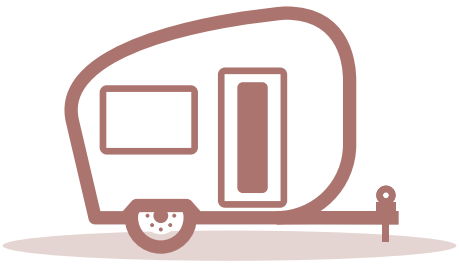
Rotherham's £4.4 billion economy still among the fastest growing in the north

Rotherham United named Yorkshire and north east community club of the year, based on their work on the building stronger communities agenda

Implementation of 24/7 mental health crisis liaison service



Place Plan agreed, paving the way for transformation of the health and social care system



Rother Valley camping and caravan park opens

Official opening of McLaren's £50m composites technology centre at Rotherham's advanced manufacturing park

Further government funding secured to address the impact of migration and promote integration in local neighbourhoods

Refurbished bus station completed

Bringing people and partners together to find solutions to local issues, utilising their collective assets, knowledge and skills.

Building stronger communities

Helping people to gain the skills needed to meet their aspirations and support a growing economy.

Skills and employment

Working in a more joined-up way, acting early to prevent problems worsening, and supporting people to live independently.

Integrated health and social care

Harnessing the energy and creativity of all our stakeholders to raise Rotherham's profile and highlight its many strengths and successes.

A place to be proud of

Transforming the town centre through a range of developments and initiatives focused on culture, leisure and living.

Town centre

2019

MAY

July 2019
Cultural strategy published.

May 2019
Homelessness prevention and rough sleeper strategy approved.

JUNE

June 2019
Launch of council shared ownership homes, aiming to assist young people to remain in Rotherham.

September 2019
Forge Island planning application submitted by Muse Developments.

JULY

July 2019
Updated ward plans agreed, refreshing the priorities for all 21 wards.

September 2019
Produce a video for schools with information on local jobs, educational routes and career progression opportunities.

AUGUST

August 2019
Approval to build housing on 3 key town centre sites.

September 2019
Start of flood mitigation and site preparation works for Forge Island (completion April 2020).

SEPTEMBER

September 2019
Establish a forum for employers, training providers, schools and colleges to discuss recruitment and training needs.

OCTOBER

October 2019
Launch of plan to tackle loneliness in Rotherham.

October 2019
Complete integration of outpatient appointments and the Rotherham Health App.

NOVEMBER

December 2019
Expand the workforce to improve access to psychological therapies, in line with the national target.

DECEMBER

October 2019
Connect the Rotherham Health App with Rotherham Health Record.

2020

JANUARY

March 2020
Develop a set of cross-organisational principles based on the Place Plan.

March 2020
Start on site for town centre housing build.

March 2020
Construct phase 1 of Gulliver's Valley theme park, including 30 resort accommodation units.

FEBRUARY

March 2020
Provide workshop sessions and staff training to 10 schools to help them challenge extremism.

MARCH

March 2020
Approve integrated pathways across intermediate care services.

April 2020
Implement the mental health trailblazer pilot in schools.

March 2020
Submit planning application for Rotherham markets redevelopment.

APRIL

Our ambition: active citizens living and working in harmony, with a shared sense of community spirit.

Our ambition: a borough with highly skilled people who have access to good quality work.

Our ambition: people enjoy the best possible mental and physical health, enabling them to live happy and fulfilling lives.

Our ambition: Rotherham is known as a welcoming place with a rich culture – somewhere people want to be.

Our ambition: a vibrant town centre where people feel safe and there is lots to do and see.

FOR MORE INFORMATION ON PARTNERSHIP EVENTS AND ACTIVITIES:

www.rotherhamtogetherpartnership.org.uk

@RT_Partnership

REF: 83434/JUNE 2019 – Prospectus produced by RMBC Design Studio Tel 01709 823583

Rotherham Integrated Care Partnership

Minutes	
Title of Meeting:	**PUBLIC Rotherham ICP Place Board**
Time of Meeting:	9:00am – 10:00am
Date of Meeting:	Wednesday 1 May 2019
Venue:	Elm Room (G.04), Oak House
Chair:	Chris Edwards
Contact for Meeting:	Lydia George 01709 302116 or Lydia.george@nhs.net

Apologies:	Sharon Kemp, Chief Executive, Rotherham MBC Louise Barnett, Chief Executive, The Rotherham Foundation Trust
Conflicts of Interest:	General declarations were acknowledged for Members as providers/commissioners of services. However, no specific direct conflicts/declarations were made relating to any items on today's agenda.

Members Present:
Chris Edwards (**CE**), (Chairing), Chief Officer, Rotherham CCG
Chris Holt (**CH**), (deputising), Deputy Chief Executive, TRFT
Anne Marie Lubanski (**AML)**, (deputising) Strategic Director for Adult Care & Housing, RMBC
Dr Gok Muthoo (**GK**), Medical Director, Connect Healthcare Rotherham CIC
Kathryn Singh, (**KS**) Chief Executive, RDaSH
Janet Wheatley, (**JW**) Chief Executive, Voluntary Action Rotherham

Participating Observers
Cllr David Roche (**DR**), Joint Chair, Heath & Wellbeing Board, RMBC
Dr Richard Cullen (**RCu**), Chair, Rotherham CCG

In Attendance:
Ian Atkinson (**IA**), Chair, Rotherham ICP Delivery Team
Lydia George (**LG**), Strategy & Development Lead, Rotherham CCG
Gordon Laidlaw (**GL**), Head of Communications, Rotherham CCG
Jon Stonehouse (**JS**), Director of Children's Services, RMBC
Wendy Commons (**WC**), Support to Rotherham ICP

There were 2 members of the public present

Louise Lowry, Head of Financial Services, TRFT
Dr Julie Eversden, LMC Representative & Rotherham GP

Item Number	Discussion Items
1	**Public & Patient Questions**

There were no questions raised.

2	**Transformation Group Updates**

The Place Board received progress updates on the transformation areas below:

Children & Young People's Transformation Group
Subject – Special Educational Needs & Disability (SEND)
Presented by Jon Stonehouse

Jon Stonehouse brought members up to date on a number of SEND developments:

- the SEND Health Sufficiency Plan has been approved and a SEND Education Sufficiency Strategy completed. The latter recognised the need to work differently with schools. Schools have been very supportive and positive relationships established.
- A sensory model has also been developed which is now moving into the implementation phase.
- The Department for Education (DfE) has approved a Sheffield led proposal to create a free school focused on special educational mental health needs which will provide opportunities to benefit Rotherham children. The DfE has also approved the increase of funding in the high needs block to expand capacity.
- A self-evaluation framework to support the inspection planning has been updated and shared across the partnership.
- The new health equipment provider is focussing on prompt supply of wheelchairs to children and young people who need them.

Members noted that the cost of implementing SEND reforms and providing an education package up to the age of 25 has resulted in an overspend in the 'High Needs' budget. Other concerns include over 5's waiting too long for ASD/ADHD diagnosis, education, health and care plans not always being completed within the statutory timescale and an increase in children presenting with complex needs which are overwhelming the system in terms of capacity and skills to respond.

In response to a query from Dr Gok Muthoo around the long waits for ASD/ADHD diagnoses for children over 5, Ian Atkinson explained that capacity has been challenged.as a result of growth in autism numbers. A review of the pathway was undertaken and partners agreed to commit to focussing on implementing early sensory pathways. This approach has been taken and will require full multi-agency support.

Jon highlighted the work that the Group is undertaking by way of next steps including:

- Implementing the SEND Health and the Education Sufficiency strategies
- Reviewing medical capacity to respond to increased demand
- Consulting on the draft social emotional and mental health (SEMH) strategy
- Completion of a needs analysis to develop the workforce for SEND & SEMH
- Producing a remedial action plan and undertaking transformational work to design alternative pathways for an improved system wide to ASD and ADHD assessments.

Jon Stonehouse assured Cllr David Roche that work is being undertaken with colleagues to ensure the special free school in Sheffield will be able to deliver the required standards. The new schools created through the free school route are in response to need. Locally further sub-regional discussions are required to ensure it's the right thing for this area but there are no concerns about viability.

Place Board thanked the Children & Young People's Transformation Group for the update.

Urgent & Community Care Transformation Group
Subject – Primary Care Networks Development
Presented by Ian Atkinson

It was recognised that the introduction of Primary Care Networks (PCN's) will impact upon the current locality working model. Place Board received a brief verbal update about the timescales and progress made with Rotherham primary care network development. Place Board will be working towards establishing close working relationships with PCNs. The strategy for integrated community working

remains and will be supported by the establishment of the networks.

Place Board noted the timelines documented and agreed to change future terminology from integrated localities to primary care networks and therefore Place Board will receive spotlight updates on PCNs going forward.

Chris Edwards advised that Rotherham is required to declare its model for PCNs by 15 May 2019. Discussion with the GP community and the LMC has been positive and work is continuing. The local GP Federation model fits with others nationally.

Chris Edwards and Dr Gok Muthoo will give a progress report back to June Place Board which will allow for a fuller, more detailed discussion around working with partners.

Action: CE/GM

Place Board thanked Ian Atkinson for the update.

Mental Health & Learning Disability Transformation Group
Subject – Learning Disability, Transforming Care, My Front Door & Autism
Presented by Ian Atkinson

Ian Atkinson highlighted that:

- Two people have now been discharged from specialist hospital provision into appropriate community provision within the agreed targets set by NHS England. Work continues to with the remaining cohort and opportunities are being developed to secure additional funding through NHS England's transformational fund for a further 12 months.
- A co-produced draft autism strategy has been developed and is currently being refined following feedback from Rotherham Autism Partnership Board. Rotherham CCG has approved an all age neurological diagnosis pathway plan.
- In relation to the My Front Door Strategy transformation, the offer to people with learning difficulties continues with the initial focus on the Council's in house offer and expanding day opportunities.

Concerns were noted around transforming care where extensive work has been undertaken to map the potential cost pressure as people move from NHS funded provision into the community. There is still a risk to budgetary projections with additional demand and cost pressure for both the NHS and RMBC.

Kathryn Singh advised that RDaSH welcomes the work being undertaken in the autism strategy and is looking forward to the consultation. RDaSH is assured that it has become a priority for Rotherham.

Mr Atkinson confirmed that the transformation group will continue to recognise the challenges of young people on the pathway and to hold itself to account for the position.

Annemarie Lubanski informed Place Board Members that she will be taking over the role of Sub-regional Director of Adult Social Services.

Place Board members noted the progress being made towards the milestones for transforming care, autism and the My Front Door strategy and thanked Ian and the MH & LD transformation group for the updates.

3	**Rotherham Provider Alliance Update**

In order to progress further faster towards developing a local alliance, Place Board members agreed to use one of the informal Place discussion meetings on a Wednesday morning session will be used to determine how to progress.

Action: CE/LG

4	**Rotherham ICP Place Board Terms of Reference Review**

Place Board terms of reference required review in May 2019. Lydia George presented an updated version. The changes included an additional responsibility to reflect how risks identified that may impact on the delivery of the priorities within the Place Plan will be managed, as recommended

following a recent audit, and added Transformation Group Leads who attend to present spotlight updates to the membership under 'in attendance'.

Following discussion, Place Board members ***APPROVED*** the revised version subject to taking off member names in favour of job titles. However, a list of the names of the current membership will be added as a distribution list.

Action: LG

5	**SYB ICS Interim Governance Arrangements – Letter from Sir Andrew Cash**

Chris Edwards referred to a letter from Sir Andrew Cash which detailed the interim governance arrangements for the SYB Integrated Care System to reflect the further responsibilities in working together as partners, with regulators at Place and system level from April 2019.

Members noted that four key meetings that will be led by the Integrated Care System, namely System Health Oversight Board, System Health Executive Group, Integrated Assurance Committee and Collaborative Partnership Board (a forum for wider system partners). These are interim arrangements for 19/20 period only.

Cllr David Roche advised that the Chairs of Health & Wellbeing Board in SY will be taking part in the Collaborative Partnership Boards going forward. Members agreed that Place will continue to have a place view however should any issues arise an agreed shared view will be sought from Place Board Members.

Place Board will review the arrangements when more detailed proposals are received from SYB ICS towards the end of these interim arrangements.

In order to have an overview of the SYB ICS work and developments, it was agreed that the June Confidential Place Board will receive minutes from the SYB ICS System Health Oversight Board and the System Health Executive Group so that Members can consider if these are useful and determine the most appropriate way to be kept updated in future.

Action: CE

6	**Impact of Brexit**

Chris Edwards confirmed that the daily reporting has now ceased and the CCG is awaiting a brief in relation to next steps.

EU Exit Update letter from the Secretary of State for Health & Social Care

Place Board noted the contents of a letter from the Rt Hon Matt Hancock to all health and care staff giving information about the Government's on-going preparations for leaving the European Union. The updates included protecting the rights of EU health and social care staff, EU settlement scheme, recognition of professional qualifications and medicines and prescribing discouraging local stock piling but assuring that this is being carried out by pharmaceutical companies. It was noted however that Rotherham GPs are still experiencing on-going issues with the availability of some medicines.

Place Board noted the update.

7	**ICP Risk Management Process**

Lydia George presented a paper outlining a proposal to strengthen governance and risk management arrangements for Rotherham ICP as recommended following a recent audit.

Members agreed the implementation of:

- a risk statement being included in the terms of reference for all ICP Groups as a responsibility and the terms of reference for all Place groups to be updated and approved by Place Board by July 2019
- the recording of any risks or documenting 'no risks raised' in the minutes of all ICP groups and where a risk is identified this will be escalated as per the flow diagram
- A risk log is to be implemented which will be monitored by the Delivery Team and received at each confidential ICP Place Board.

Enclosure 1 of the proposal outlined a flow chart of the risk management process within the Place structure. It was agreed that the flowchart would be amended to better clarify that the escalation of the risks is via partner organisation and/or Health & Wellbeing Board, subject to this amendment Place

Board **AGREED** the process for implementation. ***Action: LG***	
8	**Draft Minutes from Public ICP Place Board – 3 April 2019**
The minutes from the April meeting were **APPROVED** as a true and accurate record. There were no matters arising.	
9	**Communications to Partners**
None.	
10	**Risk/Items for Escalation**
There were **NO** new risks identified for escalation.	
11	**Future Agenda Items**
	Future Agenda Items • Social Prescribing – Aug/Sept • Estates Update – tbd • OD & Workforce Update – Workforce Maturity Index • Primary Care Network Progress Update – Public & Confi (Jun) • Digital Update (Jun) – o Rotherham Health Record Roadmap o Population Health Management Plan o Rotherham ICP Digital Strategy • Terms of Reference Reviews – All ICP Groups (Jul) Place Board requested that Delivery Team schedule timeframes for updates from Enabling Workstreams in a similar way to those from Transformation Groups. ***Action: IA/LG*** Standard Agenda Items • Delivery Dashboard/Performance Framework (quarterly) • Transformation Groups Spotlight Updates (monthly) • Rotherham Provider Alliance Update (monthly) • Impact of Brexit Updates (as required)
12	**Date of Next Meeting**
Wednesday 5 June 2019, *at 9am at Elm Room, Oak House, Bramley S66 1YY*	

Membership

NHS Rotherham CCG (RCCG) - Chief Officer - Chris Edwards (Joint Chair)
Rotherham Metropolitan Borough Council (RMBC) - Chief Executive – Sharon Kemp (Joint Chair)
The Rotherham Foundation Trust (TRFT) - Chief Executive – Louise Barnett
Voluntary Action Rotherham (VAR) - Chief Executive – Janet Wheatley
Rotherham Doncaster and South Humber NHS Trust (RDaSH) - Chief Executive – Kathryn Singh
Connect Healthcare Rotherham Ltd (Rotherham GP Federation) – Dr Gok Muthoo

Participating Observers:
Joint Chair, Health and Wellbeing Board, RMBC - Cllr David Roche
Joint Chair, Health and Wellbeing Board, RCCG - Dr Richard Cullen

In Attendance:
Deputy Chief Officer, RCCG – Ian Atkinson (as Delivery Team Place Joint Chair)
Director of Legal Services, RMBC – Dermot Pearson
Head of Communications, RCCG – Gordon Laidlaw
Strategy & Development Lead, RCCG – Lydia George

Health and Wellbeing Strategy, 2018-2025 - Performance Framework

↑	Performance has improved
→	Performance is stable
↓	Performance has got worse

Aim	Strategic Priorities	Ref	Measure	Source	Frequency of reporting	Good performance	Baseline	Previous performance	Current performance	Direction of Travel	Data Notes
Aim 1: All children get the best start in life and go on to achieve their potential.	Ensuring every child gets the best start in life (pre-conception to age 3)	1.1	Smoking status at the time of delivery	Rotherham Metropolitan Borough Council	Quarterly	Low	19.9% (Q4, 2017/18)	18.1% (Q2, 2018/19)	**17.6% (Q3, 2018/19)**	↑	Quarter 4 data is due at the end of June 2019.
		1.2	School readiness: the percentage of children achieving a good level of development at the end of reception	Public Health Outcomes Framework	Annually	High	72.1% (2016/17)	72.1% (2016/17)	**73.1% (2017/18)**	↑	A higher percentage of Rotherham children achieve a good level of development at the end of reception compared with both the national average (71.5%) and the Yorkshire and the Humber regional average (69.5%.)
	Improving health and wellbeing outcomes for children and young people through	1.3	Reception: prevalence of overweight (including obesity)	Public Health Outcomes Framework	Annually	Low	23.9% (2016/17)	23.9% (2016/17)	**25.5% (2017/18)**	↓	There is a higher prevalence of overweight children (including obesity) at reception age than the national

	integrated commissioning and service delivery										average (22.4%) and the Yorkshire and the Humber reginoal average (22.9%..)
	Reducing the number of children who experience neglect or abuse	1.4	The number of children subject to a CP plan (rate per 10K population under 18)	Rotherham Metropolitan Borough Council	Quarterly	Low	114.5 (Q4, 2017/18)	99.4 (Q3, 2018/19)	**88.9 (Q4, 2018/19)**	↑	The trend for the number of children per 10K population with a Child Protection Plan (CPP) remains significantly higher (88.9) than that of statistical neighbours (54.5) and the national average (45.3). The numbers of children becoming subject to a plan each month has steadily reduced since June 2018 as expected.
	Ensuring all young people are ready for the world of work	1.5	Average attainment 8 score	Department for Education	Annually	Low	45% (2016/17)	45% (2016/17)	**43.6% (2017/18)**	↓	The average attainment 8 score is lower than both the national average (46.6%) and the Yorkshire and the Humber average (45.1%.)
Aim 2: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life	Improving mental health and wellbeing of all Rotherham people	2.1	Self-reported wellbeing – the proportion of people with a high happiness score	Annual Population Survey, Office for National Statistics	Annually	High	72.63% (2016/17)	72.63% (2016/17)	**70.72% (2017/18)**	↓	This data is based on the Annual Population Survey and the percentage of respondents who selected 'high' or 'very high' in terms of their own happiness. A lower percentage of Rotherham people selected 'high' or 'very high' compared with the national average (75.41%) and the

											Yorkshire and the Humber average (74.63%.)
	Reducing the occurrence of common mental health problems	2.2	A reduction in the number of referrals to Child and Adolescent Mental Health Services	RDaSH CAMHS	Annually	Low	2704 (2018/19)	2135 (2017/18)	**2704 (2018/19)**		It should be noted that this is a "system" measure of effective early intervention and not a performance measure for RDaSH CAMHS and that the drive from health is to increase (not decrease) access to treatment which is reflected in targets set out in Mental Health Five Year Forward View . Data from 2017/18 was prior to the implementation of SystmOne in RDaSH and therefore the comparison between 2017/18 and 2018/19 is not very robust. For this reason, 2018/19 has been set as the baseline year.

		2.3	Depression recorded prevalence (% of practice register aged 18+)	Quality and Outcomes Framework (QoF)	Annually	Low	12.57% (2016/17)	12.57% (2016/17)	**13.37% (2017/18)**	🡻	Depression recorded prevalence was higher in Rotherham in 2017/18 compared with the national average (9.88%) and the North of England (11.08%).
		2.4	Suicide: age-standardised rate per 100,000 population (3 year average)	Public Health Outcomes Framework	Annually	Low	13.9 (2014/16)	13.9 (2014/16)	**15.9 (2015/17)**	🡻	Based on data aggregated from a three year period. The ONS definition of suicide includes deaths given an underlying cause of intentional self harm or an injury/poisoning of undetermined intent. In England and Wales, it has been customary to assume that most injuries and poisonings of undetermined intent are cases where the harm was self-inflicted but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves. However, it cannot be applied to children due to the possibility that these deaths were caused by unverifiable accidents, neglect or abuse. Therefore, only deaths of undetermined

											intent in adults aged 15 years and over are included.
	Improving support for enduring mental health needs (including dementia)	2.5	The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	Quality and Outcomes Framework (QoF)	Annually	High	78.88% (2016/17)	78.88% (2016/17)	**76.48% (2017/18)**		The percentage of patients diagnosed with dementia whose care paln has been reviewed in a face-to face review in the preceding 12 months in 2017/18 was lower than the national average (77.5%) and the North of England (78.52%.)
	Improve the health and wellbeing of people with learning disabilities and autism	2.6	Proportion of supported working age adults with learning disabilities in paid employment	Adult Social Care Outcomes Framework	Annually	High	4.4% (2016/17)	4.4% (2016/17)	**4.1% (2017/18)**		A lower proportion of supporting working age adults with learning disabilities were in paid employment in 2017/18 compared with the national average (6%) and the Yorkshire and the Humber average (7.4%.)

Aim 3: All Rotherham people live well for longer	Preventing and reducing early deaths from the key health issues for Rotherham people, such as cardiovascular disease, cancer and respiratory disease	3.1	Life expectancy at birth (male)	Public Health Outcomes Framework	Annually	High	77.9 (2014/16)	77.9 (2014/16)	**77.8 (2015/17)**	➔	Based on data aggregated from a three year period. Life expectancy at birth (male) is lower than the England average (79.6) and the Yorkshire and the Humber average (78.7).
		3.2	Life expectancy at birth (female)	Public Health Outcomes Framework	Annually	High	81.6 (2014/16)	81.6 (2014/16)	**81.7 (2015/17)**	➔	Based on data aggregated from a three year period. Life expectancy at birth (female) is lower than the England average (83.1) and the Yorkshire and the Humber average (82.4).
		3.3	Healthy life expectancy at birth (male)	Public Health Outcomes Framework	Annually	High	59.8 (2014/16)	59.8 (2014/16)	**59.3 (2015/17)**	➔	Based on data aggregated from a three year period. Healthy life expectancy at birth (male) is lower than the England average (63.4) and the Yorkshire and the Humber average (61.7). According to this data, Rotherham men are expected to live an estimate 18.5 years in poor health.

		3.4	Healthy life expectancy at birth (female)	Public Health Outcomes Framework	Annually	High	55.6 (2014/16)	55.6 (2014/16)	**57.4 (2015/17)**	↑	Based on data aggregated from a three year period. Healthy life expectancy is lower than the England average (63.8) and the Yorkshire and the Humber average (61.5). According to this data, Rotherham women are expected to live an estimate 24.3 years in poor health.
	Promoting independence and self-management and increasing independence of care for all people	3.5	Proportion of people who use services who have control over their daily life	Adult Social Care Outcomes Framework	Annually	High	77.3% (2016/17)	77.3% (2016/17)	**77.2% (2017/18)**	↓	The relevant question drawn from the Adult Social Care Survey is Question 3a: 'Which of the following statements best describes how much control you have over your daily life?' The measure is defined by determining the percentage of all those responding who identify no needs in this area or no needs with help – i.e. by choosing the answer 'I have as much control over my daily life as I want' or "I have adequate control over my daily life". A lower proportion of Rotherham people chose these

											answers than the national average (77.7%) and the Yorkshire and the Humber average (78.2%.)
	Improving health and wellbeing outcomes for adults and older people through integrated commissioning and service delivery; ensuring the right support at the right time	3.6	Health-related quality of life for older people	Public Health Outcomes Framework	Annually	High	0.697 (2015/16)	0.697 (2015/16)	**0.714 (2016/17)**	↑	The health status score is derived from responses to Q34 on the GP Patient's Survey, which asks respondents to describe their health status using the five dimensions of the EuroQuol 5D (EQ-5D) survey instrument: • Mobility • Self-care • Usual activities • Pain / discomfort • Anxiety / depression The average score in Rotherham was lower than the national

											average score (0.735) and the Yorkshire and the Humber average score (0.731.)
	Ensuring every carer in Rotherham is supported to maintain their health, wellbeing and personal outcomes, so they are able to continue their vital role and live a fulfilling life.	3.7	Percentage of carers reporting that their health has not been affected by their caring role	Survey of Adult Carers in England	Bi-annually	High	7.7% (2016/17)	7.7% (2016/17)	**7.3% (2018/19)**	➔	This data is taken from the question within the Survey of Adult Carers in England which asks 'In the last 12 months, has your health been affected by your caring role in any of the ways listed below?' The options listed are feeling tired, feeling depressed, loss of appetite, disturbed sleep, general feeling of stress, physical strain (e.g. back), short-tempered/irritable, had to see own GP, developed my own health conditions, made an existing condition worse, other and no, none of these. The data

											is based on the percentage of respondents who selected 'no, none of these.' A lower percentage of carers in Rotherham selected this answer compared with the England average (8.6%) and the Yorkshire and the Humber average (8.4%.)
Aim 4: All Rotherham people live in healthy, safe and resilient communities	Increasing opportunities for healthy, sustainable employment for all local people.	4.1	Narrow the gap to the UK average on the rate of the working age population economically active in the borough	Rotherham Metropolitan Borough Council	Quarterly	Low	3.23% (Q4 2017/18)	-0.70%	**-0.70%**	↑	Rotherham is now above the national average. Current data is from Quarter 3 2018/19 and previous data is taken from Quarter 2 2018/19. Next available data is due at the end of June for the end of March figures.
	Ensuring everyone is able to live in safe and healthy environments.	4.2	Number of repeat victims of anti-social behaviour	Rotherham Metropolitan Borough Council	Quarterly	Low	63 (Q4, 2017/18)	26 (Q3, 2018/19)	**28 (Q4, 2018/19)**	↑	There has been a continued decline in repeat victims of anti-social behaviour. However, the public perception of ASB does not reflect the downward trend in reported ASB incidents with 44% of people stating that they think ASB is a big or fairly big problem in their

											area in Quarter 4, 2018/19 (compared with 33% in Quarter 4, 2017/18.)
		4.3	Number of households in temporary accommodation	Rotherham Metropolitan Borough Council	Quarterly	Low	38 (Q4, 2017/18)	42 (Q3, 2018/19)	**45 (Q4, 2018/19)**	⬇	This is based on local data rather than that within the Public Health Outcomes Framework which noted a lower count.
	Ensuring planning decisions consider the impact on people's health and wellbeing.										This measure outlines an estimate of the proportion of residents in each area taking a visit to the natural environment for health or exercise purposes. Visits to the natural environment are defined as time spent "out of doors" e.g. in open spaces in and around towns and cities, including parks, canals and nature areas; the coast and beaches; and the countryside including farmland, woodland, hills and rivers.
	Increasing opportunities for people of all ages to participate in culture, leisure, sport and green space activity in order to improve their health and wellbeing	4.4	Utilisation of outdoor space for exercise/health reasons	Natural England: Monitor of Engagement with the Natural Environment Survey	Annually	High	12.9% (2014/15)	12.9% (2014/15)	**13.5% (2015/16)**	⬆	
	Mitigating the impact of loneliness and isolation in people of all ages	4.5	*Loneliness indicator TBC following development of loneliness plan*	TBC	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Rotherham Integrated Care Partnership

Rotherham IH&SC Place Board – 3 July 2019 (public)

Quarter 4 Performance Report for ICP Place Plan

Lead Executive	**Ian Atkinson - Deputy Chief Officer, NHS Rotherham CCG**
Lead Officer	**Lydia George - Strategy and Delivery Lead, NHS Rotherham CCG / Rotherham ICP**

Purpose

For members to note the progress with delivery of the ICP Place Plan as at the end of Quarter 4 2018-19.

Background

A performance report for the ICP Place Plan has been developed so that ICP Place Board members can assess its progress against key priorities and on its implementation of the plan. The performance report includes a small set of milestones and key performance indicators (KPIs) for each of the priorities beneath the three transformational areas.

The performance report will be reported 4 times a year and received at ICP Place Board in September, December, March and June/July.

The performance report will also be received at the Health and Wellbeing Board.

Analysis of key issues and of risks

The following narrative summarises the highlights within the report in comparison to the quarter 3 position, further detail can be found within the report itself.

Children and Young People

Milestones

- In Q4 67% of milestones are on track or complete compared to 63% in Q3
- In Q4 no milestones are of concern compared to 4% in Q3
- 2 have deteriorated, 5 have improved and 1 is still to be confirmed

KPIs

- In Q4 53% of KPIs are on track compared to 47% in Q3
- In Q4 10% of KPIs are of concern compared to 16% in Q3
- The 2 red indicators are: 11.1 Reduction in the number of young people 16/17 year old who have SEND who are NEET or Not Known, and Reduction in the number of exclusions

Mental Health and Learning Disabilities

Milestones

- In Q4 65% of milestones are on track or complete compared to 57% in Q3
- In Q4 no milestones are of concern, the same as in Q3
- 1 has deteriorated and 4 have improved

KPIs

- In Q4 69% of KPIs are on track compared to 63% in Q3
- In Q4 12% of KPIs are of concern the same as Q3
- 1 has deteriorated and 2 have improved
- The 2 red indicators are: Average length of stay (Ferns) and Proportion of adults with a learning disability in paid employment

Urgent and Community

Milestones

- In Q4 50% of milestones are on track or complete, compared to 54% in Q3 – this is due to Integrated Localities and Intermediate Care / Reablement to be determined
- In Q4 no milestones are of concern, which is the same as Q3
- None have deteriorated and 4 have improved
- It should be noted that there are 2 milestones in relation to Integrated Localities and 1 in relation to Intermediate Care /Reablement where the RAG rate is to be determined, this in light of new guidance / outcome of business case

KPIs

- In Q4 70% of KPIs are on track, compared to 75% in Q3
- In Q4 6% of KPIs are of concern, compared to none in Q3
- 1 has deteriorated, this is red and is: New permanent admissions to residential nursing care for adults – 65+ *BCF/ASCOF 2a (2)/ BCF (per100,000)*

Approval history

ICP Delivery Team – =15/05/2019

ICP Place Board (confidential) – 05/06/2019

ICP Place Board (public) – 03/07/2019

Recommendations

Members are asked to:

- Note the performance for Q4, and that overall it is a very similar position to the Q3 position, although overall the shift to milestones that are complete is positive over the year.
- Note that a new performance framework will be developed for 2019/20, this will incorporate the learning from this first year.

Rotherham Integrated Care Partnership

Performance Report: Quarter 4

The **performance framework** will report against the agreed Milestones and Key Performance Indicators on a quarterly basis as follows:

	Delivery Team	Place Board
~~Q1~~	~~22 August 2018~~	~~5 September 2018~~
~~Q2~~	~~28 November 2018~~	~~12 December 2018~~
~~Q3~~	~~20 February 2019~~	~~6 March 2019~~
~~Q4~~	~~15 May 2019~~	~~3 July 2019~~

Key to ratings:

Brown	Milestone	Not due to start
Red	KPI Milestones	Not achieving target *(Tolerance = more than 2%)* Significant issues
Amber	KPI Milestones	Almost achieving target *(Tolerance = within 2%)* Started but not on track
Green	KPI Milestones	Achieving Target On track
Blue	Milestones	Complete

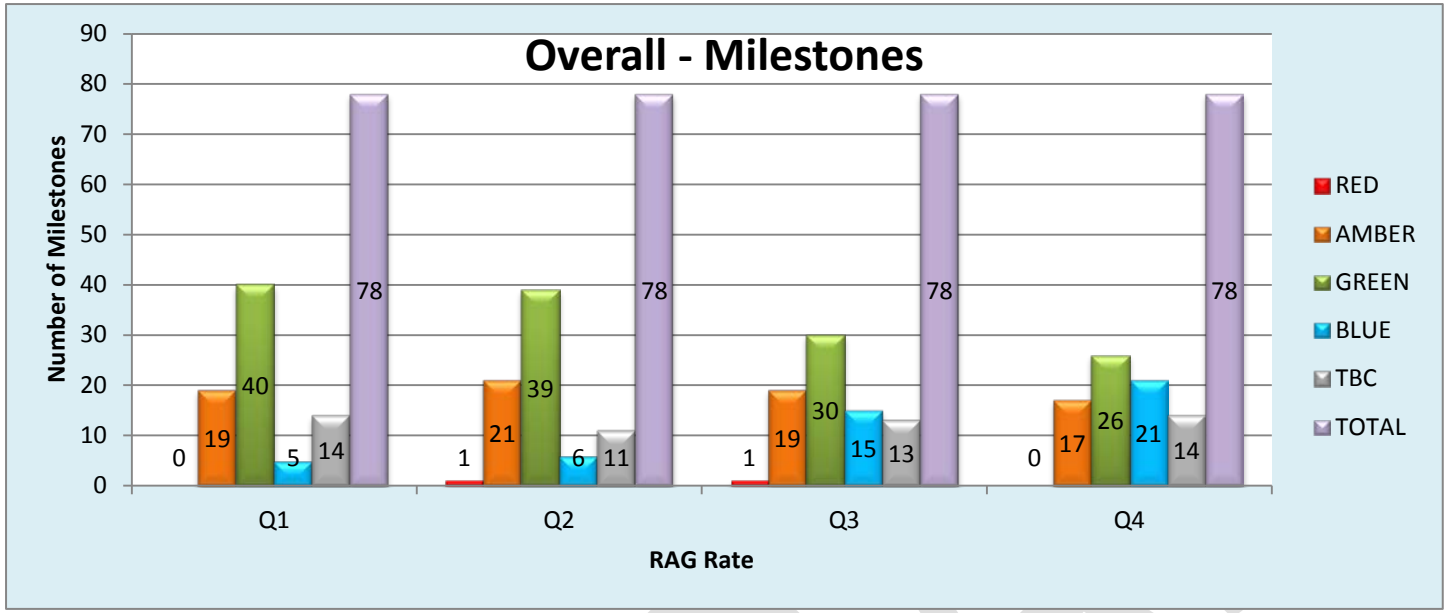
There are five transformational workstreams, led by three Transformational Groups. All workstreams have key priorities as shown below:

Children and Young People	
C&YP 1	Implementation of Children and Young People Mental Health Services (CAMHS) Transformation Plan
C&YP 2	Maternity and Better Births
C&YP 3	Oversee delivery of the 0-19 healthy child pathway services
C&YP 4	Children's Acute and Community Integration
C&YP 5	Special Educational Needs and Disability (SEND) – Journey to Excellence
C&YP 6	Implement 'Signs of Safety' for Children and Young People across partner organisations.
C&YP 7	Transitions

Mental Health and Learning Disability	
LD&MH 1	Deliver improved outcomes and performance in the Improving Access to Psychological Therapies service
LD&MH 2	Improve dementia diagnosis and support
LD&MH 3	Deliver CORE 24 mental health liaison services
LD&MH 4	Transform the Woodlands 'Fern' ward
LD&MH 5	Improve community crisis response and intervention for mental health.
LD&MH 6	Implement Public Health 'Better Mental Health for All' Strategy
LD&MH 7	Oversee delivery of Learning Disability Transforming Care
LD&MH 8	Support the implementation of the 'my front door' Learning Disability Strategy
LD&MH 9	Support the development of the Autism Strategy

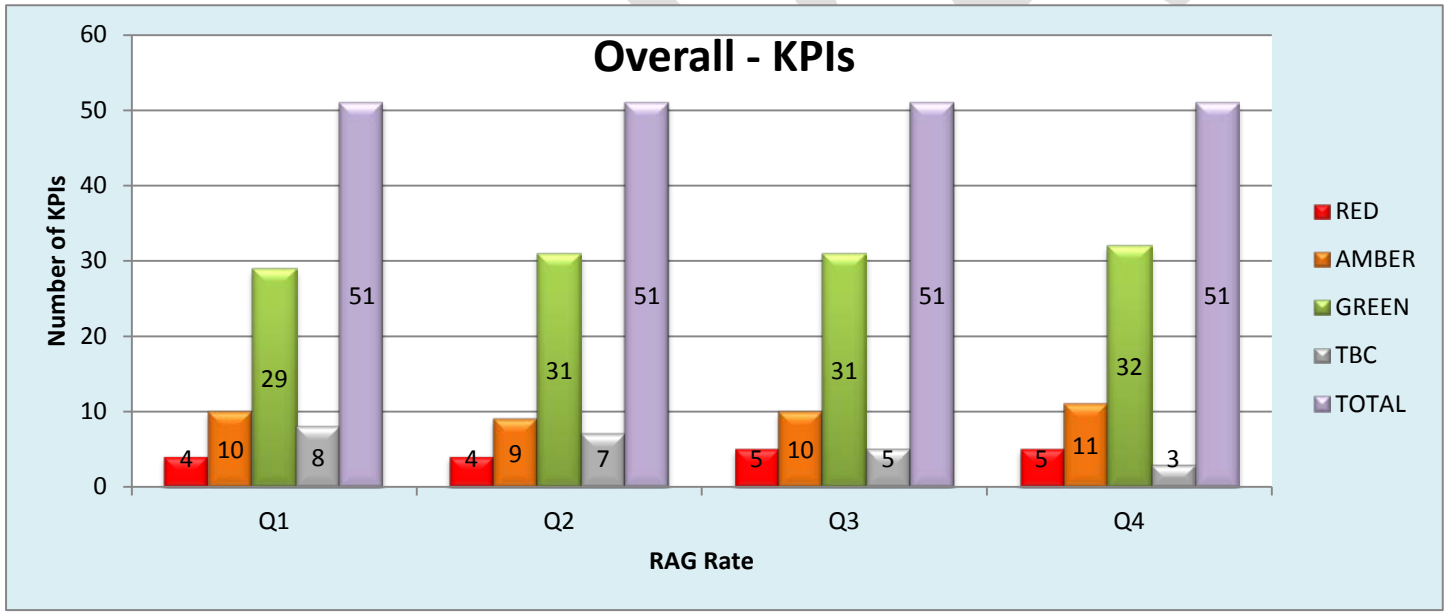
Acute and Community	
UC&C 1	Creation of an integrated point of contact for care needs in Rotherham
UC&C 2	Expansion of the Integrated Rapid Response Service
UC&C 3	Development of an integrated health and social care team to support the discharge of people out of hospital
UC&C 4	Implementation of integrated locality working across Rotherham
UC&C 5	Development of the re-ablement and intermediate care offer
UC&C 6	Development of a coordinated approach to care home support.

Summary of Performance Quarter 1 - 4



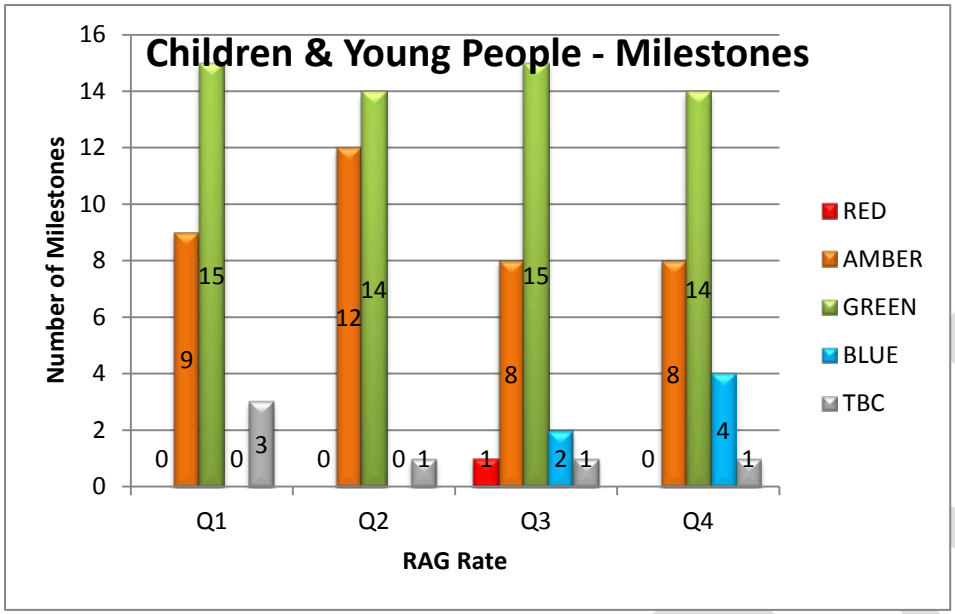
Of note:
The number of milestones either **TBC or Amber** (started but not on track) has remained very similar for Quarters 1 – 4.

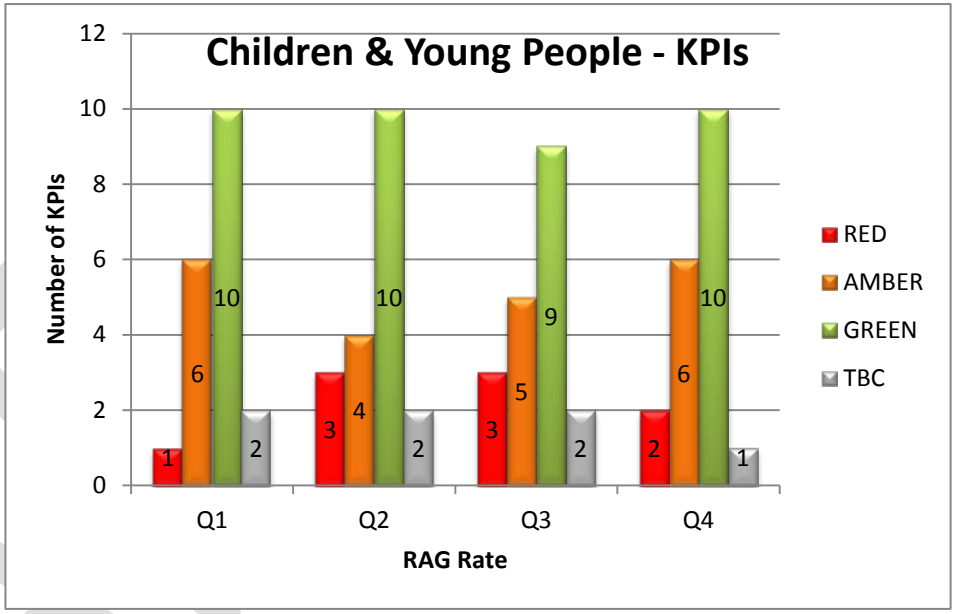
The combined number of milestones either **green or blue** (on track or complete) has remained the same through Quarters 1 – 4, although there has been a significant shift to the number complete.



Of note:
The overall figures show that there has been little fluctuation in performance over Quarters 1 – 4 for **any** of the RAG ratings.

Overview of Children and Young People Performance





The RAG rate of milestones and KPIs by priority are shown in the table below:

	Priority	Number of milestones	BR	Blue	Green	Amber	Red	TBC
Children and Young People	1	5	0	0	2	3	0	0
	2	3	0	0	0	3	0	0
	3	4	0	0	2	2	1	0
	4	3	0	0	3	0	0	0
	5	4	0	2	2	0	0	0
	6	4	1	0	3	0	0	0
	7	4	0	2	2	0	0	0
	No. of milestones	**27**	**1**	**4**	**14**	**8**	**0**	**0**
		% against total	**3%**	**15%**	**52%**	**30%**	**0%**	**0%**
	No. of KPIs	**19**	**0**	**0**	**10**	**6**	**2**	**1**
		% against total	**0%**	**0%**	**53%**	**32%**	**10%**	**5%**

In Q4 67% of **milestones** are on track or complete compared to 63% in Q3
In Q4no **milestones** are of concern compared to 4% in Q3

In Q4 53% of **KPIs** are on track compared to 47% in Q3
In Q4 10% of **KPIs** are of concern compared to 16% in Q3

MILESTONES

CHILDREN AND YOUNG PEOPLE TRANSFORMATION GROUP

Chairs: Councillor Gordon Watson, RMBC/ Vice Chair, Dr Jason Page, CCG

Priority 1 C&YP – CAMHS Transformation Plan

No.	Description	Target	Progress					Comments
			Q4 1718	Q1 1819	Q2 1819	Q3 1819	Q4 1819	
CH1.1	Work with all stakeholders to review the RDaSH CAMHS ASD/ADHD diagnosis pathway.	Q4 18/19	G	G	G	A	G	Commenced in April 2018. Work is ongoing in light of concerns about waiting times for diagnosis. A new model for sensory support has been developed with SEND Strategy Board for approval. This is a long term area of work and will continue into 2019/20 further understanding is required of the waiting list profile in order to identify appropriate commissioning options.
CH1.2	Integration of the CAMHS Single Point of Access (SPA) and RMBC Early Help access point.	Q4 18/19	G	A	A	A	A	The CAMHS locality model is now embedded. Early Help and CAMHS work together. CAMHS is co-located within the Special Educational Needs and Disabilities (SEND) hub at Kimberworth Place. Partners will adopt the principle of "no wrong door" rather than the physical integration of the two services points of access – which could potentially de-stabilise the strong links already working with SEND services. Trailblazer work will strengthen links between CAMHS and schools.
CH1.3	Improved CAMHS Crisis service out of hours.	Q4 18/19	G	A	A	A	A	This is a long term are of work. Recent Changes in the guidance relating to adult mental health crisis service will have implications for developing an all-age crisis service.
CH1.4	Clarification of the pathways between the CAMHS service and Youth Offending Team (YOT) and 'Liaison & Diversion' service.	Q3 18/19	G	G	G	G	A	The bid for a dedicated CAMHS worker was not progressed due to capacity and staff changes, however this will be revisited in 19/20 to identify if establishing this pathway remains a priority. Current data identifies that no children and young people who are open to the Youth Offending Team have a CAMHS involvement
CH1.5	Scoping out of a Schools 'CAMHS' service in line with the government 'Green Paper' recommendations	Q4 18/19	G	G	G	G	G	The trailblazer bid was successful and is at implementation phase.

Priority 2 C&YP – Maternity and Better births								
No.	**Description**	**Target**	**Progress**					**Comments**
			Q4 1718	**Q1 1819**	**Q2 1819**	**Q3 1819**	**Q4 1819**	
CH2.1	*Transformational Funding Plan finalised and agreed at LMS Board and through partners governance arrangements as appropriate	*Q3*	A	A	A	G	G	The Rotherham Transformation Funding Plan has been through The Rotherham Clinical Commissioning Group and TRFT Maternity Better Births Governance Group and is now being monitored via the Better Births Group which is monthly.
CH2.2	Local leadership and governance in place to deliver on the strategy (Better Births Group)	**Q3*	A	A	A	G	G	The Rotherham Maternity Better Births Group is now established and commenced from December 2018 and is a monthly Group. There are a number of Sub Groups that report into the Better Births Group that are progressing the actions required for each of the Key Lines of Enquiry.
CH2.3	Formalised community maternity hubs in north, central and south areas of the borough.	**Q4 (2 of the 3)*	A	A	A	A	G	Discussions taking place to identify community maternity hub venues in the central and north areas of the borough. We are aiming utilise the contact centres and develop them into community Midwifery Hubs **South**- Aston & Maltby contact centre both have suites of rooms which are booked to community midwifery for antenatal care. The Maltby Hub has antenatal, GTT testing, birth workshops and postnatal clinics, Aston Hub has antenatal care with rooms available for postnatal care and birth workshop once the CoC team is in place. **North**- Rawmarsh Contact Centre is the 3rd hub. **Central** - looking at an option and exploring the use of RCHC.

**the target date is dependent upon achieving the target date for milestone 1*

Priority 3 C&YP – 0-19 Healthy Child Pathway								
No.	**Description**	**Target**	**Progress**					**Comments**
			Q4 1718	**Q1 1819**	**Q2 1819**	**Q3 1819**	**Q4 1819**	
CH3.1	To map the 0-19 / RMBC pathways to identify opportunities for efficiencies and highlight any gaps.	Q4 18/19	BR	G	G	G	G	This is a two year project which aims to have an 'AS IS' position by Q4 2018/19. Pathways mapping has begun and on track.
CH3.2	To address the barriers to 0-19 IPHN EHAs and increase the numbers submitted by the service.	Q4 18/19	G	A	A	R	A	There has been a slight improvement in completion of EHA's (8). This is likely to continue and currently there are 36 EHA's in the process of being completed
CH3.3	All 0-19 Practitioners will have completed Signs of Safety training by the end of 2018/19.	Q4 18/19	G	G	G	G	A	Health practitioners accessed the ½ day SoS training. Total number for health 156; number of 0 -19 practitioners is: 58 out of 97 = 60%
CH3.4	We will work with partners to develop a tool and resources in order to capture the voice of the child Q4 18/19	Q4 18/19	G	G	G	G	G	90 % of 0 -19 service clinical records evidence the capture voice of the child

Priority 4 C&YP – Acute and Community Integration								
No.	**Description**	**Target**	**Progress**					**Comments**
			Q4 1718	**Q1 1819**	**Q2 1819**	**Q3 1819**	**Q4 1819**	
CH4.1	Embed the work of the rapid response team with referral routes established across the system Work with GPs and test direct referrals from General Practice to the Rapid Response Team	Q4 18/19	G	G	G	G	G	No change due to capacity within the team due to sickness/absence/vacancy
CH4.2	Establish links between Rapid Response Team & Early Help	Q3 18/19	G	G	G	G	G	No further update
CH4.3	Pilot a direct link between Children's Ward and Children's Service to support timely discharge plans	Q3 18/19	G	G	G	A	G	No further update

Priority 5 C&YP – SEND								
No.	**Description**	**Target**	**Progress**					**Comments**
			Q4 1718	**Q1 1819**	**Q2 1819**	**Q3 1819**	**Q4 1819**	
CH5.1	Develop **Voices Action Plan**	Q2 18/19	G	G	G	B	B	Voices Action Plan is in place and overseen by SEND Strategic Board.
CH5.2	Undertake the following in respect of **Joint Commissioning:** • Implement the **joint financial protocol** and service specifications • Implement the **Special School Funding Model** • Review of **SEMH Support Centres (PRUs)** • Review of **Traded Models** • Review of service provision within the **High Needs Budget**	Q4 18/19	G	G	G	G	G	Multiple workstreams are in place and on track to support joint commissioning arrangements and reduce budget pressures.
CH5.3	Create a plan to reduce placements outside Rotherham (including **residential provision** offer, Reduce **OOA provision** arrangements	Q2 18/19	G	G	A	A	G	Send Sufficiency Strategy has gone to Cabinet. Commissioning places on track and on target..
CH5.4	Implement Phase 1 of the **SEND Sufficiency** Plan Complete **building work** resulting in additional provision at the following locations: • **SEND Hub** (co-location of services) **- Complete** • **Cherry Tree / Kelford Schools** (Open as SLD provision) • **Abbey School** (20 additional places) • **19-25 Provision** (15 new college places) • **Rowan Centre** (15 additional places)	Q3 18/19	G	G	G	B	B	The SEND Hub is open with services in place and co-located. New provisions as identified in SEN Sufficiency phase 1 are complete and educating children.

Priority 6 C&YP – Implementation of 'Signs of Safety'								
No.	**Description**	**Target**	**Progress**					**Comments**
			Q4 1718	**Q1 1819**	**Q2 1819**	**Q3 1819**	**Q4 1819**	
CH6.1	The RLSCB will be sighted on the roll out to partners and this will include training to all levels of practitioner	Q2 18/19	A	A	A	G	G	The planned session with partners took place on 11/7/2018, and looked at the wider and different implementation options for agencies. The wider training plan has been developed and will be shared at the L&I sub group of the LSCB on the 11/3/19. Partners have continued to attend SoS half day partner briefings. The future training plan includes expansion of the current CYPS practice lead sessions to support a partnership approach to embedding SoS at the heart of our Safeguarding practice.
CH6.2	Phase 1 of roll out of training	Q3 18/19	G	G	G	G	G	All of current SC and EH practitioners have attended 2 day training. Over 90 Practice leads within CYPS. We had 6 in house trainers a number of whom have supported phase 1 of the half day briefing sessions for partners. Dates are now set for the rest of the 2018-2019. This is therefore converted to complete as it is business as usual
CH6.3	Phase 2 of roll out of training	Q4 18/19	BR	A	A	G	G	All training for 2018-19 for multi-agency partners is booked, 500 staff have attended so far with further sessions booked until March 2019. The wider training plan has been developed and shared at the L&I sub group of the LSCB.
CH6.4	Evaluation and next steps	Q4 18/19	BR	BR	BR	BR	BR	Task and finish to be agreed from L and Improvement Subgroup to support oversight and evaluation. Alignment of inter-agency forms and documentation underway with conference reports developed and EMARF under development.

Priority 7 C&YP – Transitions								
No.	**Description**	**Target**	**Progress**					**Comments**
			Q4 1718	**Q1 1819**	**Q2 1819**	**Q3 1819**	**Q4 1819**	
CH7.1	The Transitions team to work jointly with Children Young People Services (CYPS), health and education for all new referrals for young people aged 14 to 18 with an Education, Health and Care Plan (EHCP) / Care Needs Assessment (CAN) who may be in need of a social care assessment using the Preparing for Adulthood model.	Q3 18/19	BR	G	G	G	G	New Governance structure is in place Rotherham is adopting Preparing for Adulthood (PfA) model to ensure smooth transition to adulthood
CH7.2	Develop a transition pathway based on Preparing for Adulthood model	Q3 18/19	G	A	A	A	A	A draft pathway has been developed for young people with high support needs (green). Further consideration is required to ensure inclusion of universal and targeted help groups. This is being developed and so will retain amber. Nominated individuals from Education will be engaged to actively support the development of this element.
CH7.3	Create a data matrix of the full cohort and risk register	Q2 18/19	*TBC*	*TBC*	A	G	G	The data matrix has now been completed and is operationally supporting strategic decision making.
CH7.4	Publish transition pathway on the Council website including Local Offer	Q3 18/19	*TBC*	*TBC*	A	A	A	Link to CH7.2 – pathway in development. It is proposed that the high level needs pathway is published on completion of the full activity.

KEY PERFORMANCE INDICATORS

CHILDREN AND YOUNG PEOPLE TRANSFORMATION GROUP

Chairs: Councillor Gordon Watson, RMBC/ Vice Chair, Dr Jason Page, CCG

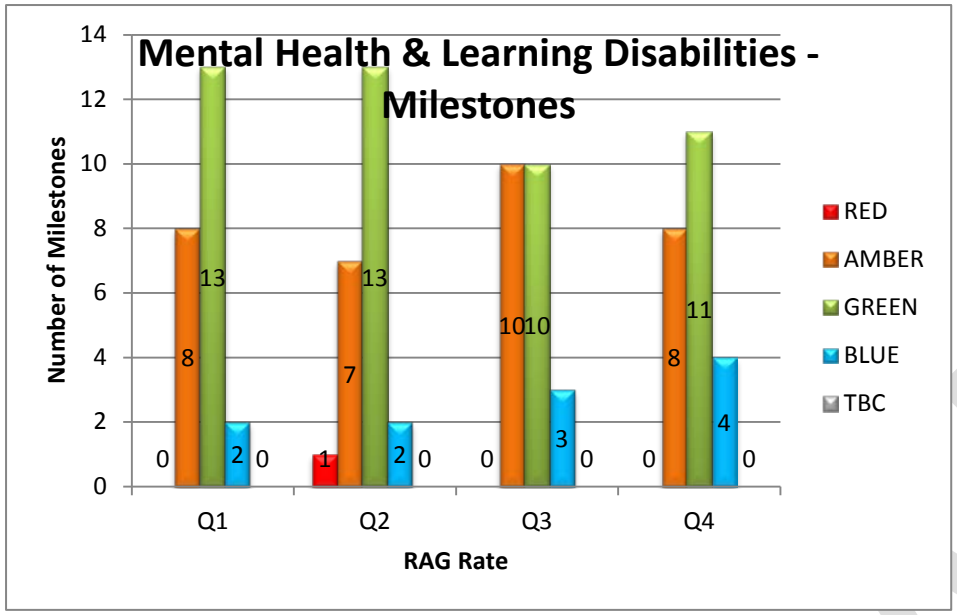
					Performance				
No.	**Description**	**Trajectory**	**Target**	**Priority**	**Q1 1819**	**Q2 1819**	**Q3 1819**	**Q4 1819**	**Comments**
CH/ KPI 1	Percentage of referrals assessed within 6 weeks	Increase	95%	CH1 - CAMHS	G 99%	G 97.2%	G 100%	A 84%	As at 31 March 2019 excluding ASD/ADHD (in line with the Contract Reporting). The dip in performance was caused by short-term staffing issues that have now been addressed.
CH/ KPI2	Percentage of referrals receiving treatment within 18 weeks	Increase	95%	CH1 - CAMHS	G 98%	G 100%	G 100%	A 87%	As at 31 March 2019 excluding ASD/ADHD (in line with the Contract Reporting)The dip in performance was caused by short-term staffing issues that have now been addressed.
CH/ KPI3	Percentage of referrals triaged for urgency within 24 hours of receipt of referral	Increase	100%	CH1 - CAMHS	G 100%	G 100%	G 100%	G 100%	As at 31 March 2019 excluding ASD/ADHD (in line with the Contract Reporting)
CH/ KPI4	Percentage of all appropriate urgent referrals assessed within 24 hours of receipt of referral	Increase	100%	CH1 - CAMHS	G 100%	G 100%	G 100%	G 100%	As at 31 March 2019 excluding ASD/ADHD (in line with the Contract Reporting)
CH / KPI 5	Reduce stillbirths and neonatal deaths	Reduction	10% reduction over the 2015-20 period	CH2 - Maternity	G 2.32	G 3.86	G 3.04	G 1.61	Q4 17/18 = 3.86. SYB reported a rate of 4.7 stillborn babies per thousand 2013-15. This was the higher combined Stillbirth & Neonatal rate taken from 2013-15 Maternity Health Needs Data pack. There is a lag on data received. 2017/18 year end position was 3.99. 2018/19 year end SY&B aspiration is 3.95 Q4 2018/2019 is 1.61.
CH / KPI 6	All women to have Personalised Care Plans	Increase	40% by March 2019	CH2 - Maternity	A 0%	A 0%	A 0%	G 100%	All women should have Personalised Care Plans (PCPs) therefore the aspiration is 100% by March 2021. March 2019 40% across SY&B and March 2020 70% - this is an LMS target and not just for TRFT. The aim is to develop an LMS PCP and work and planning is in progress. Currently the plan is to develop a Rotherham and Barnsley PCP Plan with aim to commence the integrated plan at the end of March 2019. In the interim as of the beginning of March TRFT will be utilising an updated version of the Perinatal Institute Record that has a new section included regarding PCP. Work is in progress to achieve the target by the end of March. All women are now provided with a personalised Care Plan and work is on-going in relation to review to ensure the plan meets the needs of the women.

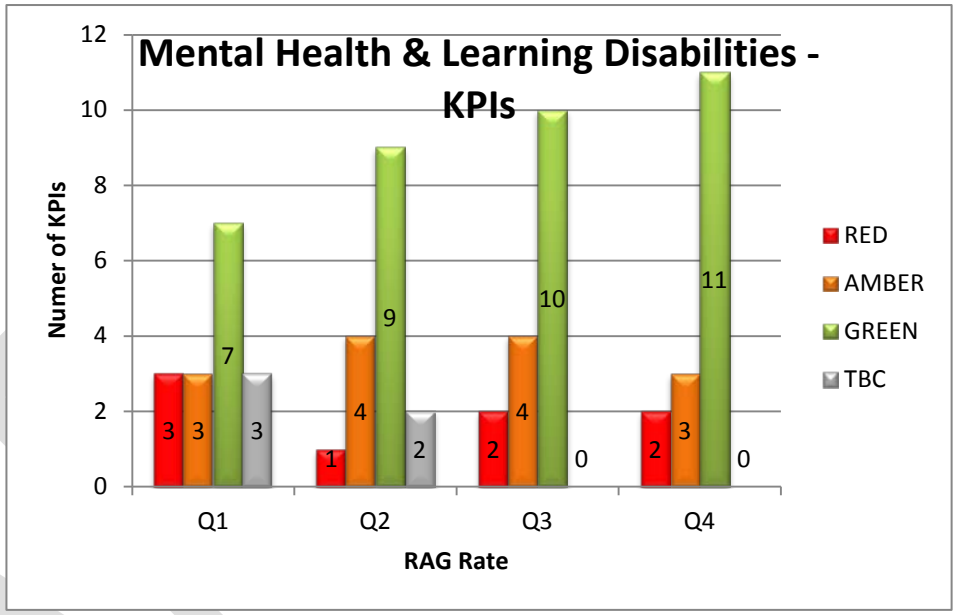
CH / KPI7	Reduce percentage of women smoking at time of delivery	Reduction	10% by end of 2022	CH2 - Maternity	A 16.4%	A 18.1%	A 17.6%	TBA	Q4 17/18 = 17.2% Nationally the aim, by end of 2022, is to reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less. SY&B aim set at 5% reduction.Q2 position was 18.1%, Q4 data available in June/July 2019.
CH/ KPI 8	Increased Early Help Assessments completed by 0-19 practitioners to a minimum of 10 per month	Increase	10 per month	CH 3 - 0-19	A 3	R 1	R 4	A 8	There has been an increase this quarter to quarter 4 but the service is not on course to achieve the target by end of Q4. Steps have been taken to address barriers but there is still no resolution to streamlining case conference work to free up capacity for EHA's. There have been 8 completed but 36 in the process of being completed.
CH/ KPI 9	Evidence of voice of the child being considered in care planning through audit of individual records	Increase	25% sample	CH 3 - 0-19	To be reported in Q3	To be reported in Q3	A Audit to be completed from 1/10/18	90% of records show evidence of capturing the voice of the child	On course programme of work underway to ask C&YP views on healthcare. Some audit results are now available and will be reporting fully on this when greater results available in Q4/ Q1 19/20
CH/ KPI 10	Increase the number of referrals to Early Help from Acute Clinical Services* **Hospital A&E, hospital Children's Ward, maternity ward and other department / ward*	Increase	TBA – Need baseline data before we can set a realistic target	CH 4 - C&A	A 29 referrals	G 55 referrals	A 43 referrals	A 43 Referrals	CYPS report the numbers of referrals from the Acute services. A validation process will need to be agreed. The consistent level of referrals indicates that there is awareness of the Early Help Pathway in the acute workforce which is positive. The focus of this priority for 2019/20 will be refreshed and this measure will be reviewed as part of the wider work for the 19/20 performance reporting.
CH/ KPI 11.1 to 11.3	11.1 Reduction in the number of young people 16/17 year old who have SEND who are NEET or Not Known	Reduce	In line with Council Plan target Combined - 5.8% NEET – 3.3% Not Known – 2.5%	CH 5 - SEND	R 8.5% Combined NEET- 6.5% Not Known – 2.0%	R 22% Combined NEET- 2.0% Not Known – 20.0%	R 7.5% Combined NEET- 5.5% Not Known – 2.0%	R 12.1% Combined NEET- 8.6% Not Known – 3.5%	**At the end of Q4** we have achieved an average of 12.1%. The annual target of 5.8% is measured as an average across the Nov, Dec and Jan returns and the verified outturn was recorded at 7.8%. **Next Steps** Focused work continues on follow up and engagement of the cohort. Work is also ongoing ensuring that the EHCPs are reviewed in a timely manner – this will strengthen the position when reporting against the SEND (EHCP) cohort. It will be an ongoing priority in 19/20. **NOTE: The target has been amended to be in line with the Council Plan target and RAG rating applied retrospectively back to Q1**

	11.2 Reduction in the number of young people 18/19 year old who have SEND who are NEET or Not Known	Reduce	Measured against Statistical Neighbours as at Q4 – 17/18 Combined – 46.9% NEET – 9.5% Not Known – 37.4%	CH 5 - SEND	G 13.7% Combined NEET-3.0 % Not Known – 10.7%	R 52.1% Combined NEET-4.6 % Not Known – 47.5%	G 24.7% Combined NEET- 4.7% Not Known – 20.0%	G 24.4% Combined NEET- 5.7% Not Known – 18.7%	At the end of Q4 we have achieved a combined figure of 24.4%. Performance success is measured by NCCIS comparison data. Performance is strong when compared with all comparison groups for the same period as below: National): Combined 37.8% (NEET 9.0%, NK 37.8%) Regional : Combined 39.0% (NEET 8.6%, NK 30.4%) Stat Neighbours: Combined 38.4% (NEET 9.3%, NK 31.2%). **NOTE: There is no internal target for the 18/19 cohort so the Statistical Neighbour figure for Q4 17/18 and RAG rating applied retrospectively back to Q1**
	11.3 Reduction in the number of young people 20-24 year old who are NEET or Not Known	Reduce	Measured against Statistical Neighbours as at Q4 – 17/18 Combined - 69.4% NEET –16.6% Not Known – 52.8%	CH 5 - SEND	G 13.6% Combined NEET- 1.6% Not Known – 12.0%	G 45.4% combined NEET- 2.8 % Not Known – 42.6%	G 26.4% Combined NEET- 3.1% Not Known – 23.3%	G 21.0% Combined NEET- 2.5% Not Known – 18.5%	At the end of Q4 we have achieved a combined figure of 23.5%. Performance success is measured by NCCIS comparison data. Performance is strong when compared with all comparison groups for the same period as below: National): Combined 78.7% (NEET 12.7%, NK 66.0%) Regional : Combined 68.0% (NEET 10.2%, NK 57.8%) Stat Neighbours: Combined 48.7% (NEET 9.0%, NK 39.7%). **NOTE: There is no internal target for the 20 to 24 cohort so the Statistical Neighbour figure for Q4 17/18 and RAG rating applied retrospectively back to Q1**
CH/ KPI 12	Reduction in the number of exclusions	Reduce	Reduction on previous year	CH 5 - SEND	G 7	G 4	R 15	R 19	13 registered with SEN Support and 6 registered with no specialist provision. This measure is a subset of the Council Plan measure and is now monitored as part of the Inclusion Scorecard and Performance meetings This measure will be reviewed as part of the wider work for the 19/20 performance reporting.
CH/ KPI 13	Increased number of Children in Local Provision (reduced OOA)	Increase	17/18 – 93.5%	CH 5 - SEND	A 90.2%	A 88.4%	A 86.3%	A 88.9%	End of Q4 (Mar 19) there were 235 CYP in an OOA provision out of 2121 CYP who have a EHCP in place (This is 115 Post - 16 CYP and 120 statutory school age CYP). Whilst more provision is being developed this is not currently keeping pace with demand. It is a priority to develop more post 16 provision in the borough.
CH/ KPI 14	Number of practitioners from across the Multi-agency partnership who have accessed the Rotherham Family Approach and Signs of safety Training (½ days and extended 2 day for safeguarding leads).	Increase	TBA 17/18 baseline = 0	CH 6 - 'Signs of Safety'	G 345	G 500	G 600	G 600	To date 600 attended the half day sessions . Half day developed will be incorporated into the safeguarding induction – the core offer of the LSCB across the partnership A 2 day advanced training offer will commence for the key roles in the partnership in July with ongoing support via Multi-agency Practice leads

CH/ KPI 15	An increase in the conversion rate from contacts to referrals from Partnership agencies highlighting a better shared understanding & assessment of risk and threshold - Evidence of embedding the change & maximising impact.	Increase	50% by Q4	CH 6 - 'Signs of Safety'	A 28.9%	A 23%	A 23.6%	A 29.5%	In April 25.9 % of contacts from partner agencies in Q4 went on to a referral i.e. police, schools and health. This is currently amber and increasing – because we have commenced multiagency training regarding signs of safety and we are offering coaching discussion at the front door when we receive contacts that do not convert. We continue to broaden the signs of safety offer and work towards a more unified Early Help and CYPS front door. This work has been raised as a priority by the MASH steering group. Work is also continuing across the partnership to strengthen multiagency practice around the role of the EH Assessment and the role this plays in the continuum of need. There will be a revised 0-19 pathway with a focus on EH assessment and an LSCB multi -agency audit is supporting better understanding around contact to referral conversion
CH/ KPI 16	Ofsted CQC ratings for services used for transitions	Increase	*TBA*	CH 7 - Transitions	G 100%	G 100%	G 100%	G 100%	On track
CH/ KPI 17	Numbers of SEND Tier 1 tribunal applications	Reduce	Baseline now agreed 8 plus 1 in court (Q3)	CH 7 - Transitions	TBC	TBC	TBC	G 3 cases pending	To the end of Qtr 3, 8 cases had been lodged with 1 going to Court which upheld the LA view. 3 cases are pending with dates asked to be rescheduled from December 2018 to early 2019. Whilst there is a need to monitor this increase, the number of Tribunals in Rotherham is still significantly lower than those in neighbouring local authorities and the increase is not out of proportion with the overall increase in the number of children and young people with an Education, Health & Care Plan. This information is being reviewed as part of the development of the new Inclusion scorecard and performance meetings and will be reviewed for 19/20 performance report.

Overview of Mental Health and Learning Disabilities





The

RAG rate of milestones and KPIs by priority are shown in the table below:

	Priority	Number of milestones	BR	Blue	Green	Amber	Red	TBC
Mental Health and Learning Disability	1	4	0	1	2	1	0	0
	2	2	0	0	1	1	0	0
	3	3	0	1	2	0	0	0
	4	2	0	0	2	0	0	0
	5	3	0	0	1	2	0	0
	6	3	0	2	0	1	0	0
	7	3	0	0	2	1	0	0
	8	1	0	0	0	1	0	0
	9	2	0	0	1	1	0	0
	No. of milestones	23	0	4	11	8	0	0
		% against total	0%	17%	48%	35%	0%	0%
	No. of KPIs	16	0	0	11	3	2	0
		% against total	0%	0%	69%	19%	12%	0%

In Q4 65% of **milestones** are on track or complete compared to 57% in Q3
In Q4 no **milestones** are of concern the same as in Q3

In Q4 69% of **KPIs** are on track compared to 63% in Q3
In Q4 12% of **KPIs** are of concern the same as Q3

MILESTONES

MENTAL HEALTH AND LEARNING DISABILITY TRANSFORMATION GROUP

Chair: Ian Atkinson, RCCG

Priority 1 MH - IAPT

No.	Description	Target	Progress					Comments
			Q4 1718	Q1 1819	Q2 1819	Q3 1819	Q4 1819	
MH1.1	Identify and agree workforce development and training requirements (LTC & Core) – IAPT	Q1 18/19	G	G	G	G	G	CBT staff interviewed for three posts. Awaiting final decisions but at least one suitable candidate. One PWP given notice. Two current PWP vacancies to be advertised. PWP interviewed in January started started in post on 6 May. Four CBT trainee places requested and three PWP trainee places requested in this year.
MH1.2	Apply for NHS England LTC training (training commences October-18 & March-19) – IAPT	Q1 18/19	G	B	B	B	B	NHS E funding received, staff scheduled for training as planned
MH1.3	All GP practice review support visits completed – IAPT	Q4 18/19	G	G	G	G	A	Challenges with lack of response from some GP Practices. Aim was to complete by end of Q4. There was further focus on this from Jan to Mar to ensure all complete where possible. Unable to arrange support visits due to lack of response from practices.
MH1.4	Delivery of 5 year forward IAPT 18/19 plan – IAPT	Q4 18/19	A	A	A	G	G	Q4 access target achieved. Recovery rates and waiting times remain above target.

Priority 2 MH - Dementia Diagnosis and Support

No.	Description	Target	Progress					Comments
			Q4 1718	Q1 1819	Q2 1819	Q3 1819	Q4 1819	
MH2.1	Review dementia diagnosis pathway	Q4 17/18	G	G	G	A	A	An interim measure has been agreed with LMC and in place. A revised model is being worked up.
MH2.2	Develop new dementia pathway for post diagnostic care	Q4 18/19	BR	G	G	G	G	Work undertaken. Implementation delayed due to interdependency with diagnostic pathway

Priority 3 MH - Delivery CORE 24 MH Liaison Services

No.	Description	Target	Progress					Comments
			Q4 1718	Q1 1819	Q2 1819	Q3 1819	Q4 1819	
MH3.1	Funding received to support expansion of service to CORE 24 compliance	Q2 18/19	G	G	G	B	B	Funding received.
MH3.2	CORE 24 standards delivered in Rotherham.	Q2 18/19	G	G	R	A	G	Core 24 standard service established
MH3.3	Core 24 Service self-sustaining. – 19/20 onwards	Q1 19/20	G	G	G	G	G	Funding agreed for 2019/20 contract

Priority 4 MH - Transform Ferns Ward								
No.	Description	Target	Progress					Comments
			Q4 1718	Q1 1819	Q2 1819	Q3 1819	Q4 1819	
MH4.1	Implementation of agreed model of provision at Ferns and continuous evaluation	Q3 18/19	G	G	G	G	G	On track – clinically developed model in place, continuous review and refinement of model
MH4.2	Agree long-term model and funding source for Ferns.	Q3 18/19	G	G	G	G	G	Clinical and Senior Management discussions continued throughout Q4 evaluating the pilot and assessing value for money. Decision regarding future of the pilot expected in Q1 19-20.

Priority 5 MH - Improve Community Crisis Response (including Core Fidelity, suicide-prevention)								
No.	Description	Target	Progress					Comments
			Q4 1718	Q1 1819	Q2 1819	Q3 1819	Q4 1819	
MH5.1	Complete CORE Fidelity review, recommendations and action plan for improvement (including investment requirements)	Q4 18/19	G	G	A	A	A	Core 24 review completed with initial recommendations. Discussions ongoing across partners with regard to the new model including social care/health delivery model alignment
MH5.2	SY&B ICS NHS England Suicide-prevention – delivery of Rotherham element of the plan	Q4 18/19	BR	G	G	G	G	Activity delivered by March 2019 included delivery of SafeTalk and PABBS training to frontline staff, allocation of small grants funding to 13 groups to target men in relation to suicide prevention and targeted work in areas with higher suicide rates.
MH5.3	Refresh of the Rotherham suicide prevention and self-harm action plan	Q3 18/19	A	A	G	A	A	Action plan has been refreshed. A Rotherham Suicide Prevention Symposium to be held on 6 June with CEX, Directors and Lead Officers which will contribute to the ongoing development of this.

Priority 6 MH – Public Health: Better Mental Health for All Strategy								
No.	Description	Target	Progress					Comments
			Q4 1718	Q1 1819	Q2 1819	Q3 1819	Q4 1819	
MH6.1	Launch of Five Ways to Wellbeing campaign	Q1 18/19	G	B	B	B	B	Launch complete
MH6.2	Five Ways communication and marketing plan for 2018/19 - agreed and delivered by partners	Q1 18/19	G	G	G	G	B	The communications plan developed to follow the launch has been delivered. Work is ongoing with Comms Leads to look at opportunities to promote the campaign, for example linking in with national campaigns
MH6.3	Evidence of integration of Five Ways messages within provider and commissioned services	Q4 18/19	A	G	G	A	A	Collecting evidence of where the campaign is embedded into provider and commissioned services. Recent examples include: all suicide prevention small grants recipients having received materials and being encouraged to promote this within their activities. Groups/organisations receiving CAMHS LTP monies to promote the campaign as part of the grant agreement.

Priority 7 LD – Oversee Delivery of Transforming Care								
No.	Description	Target	Progress					Comments
			Q4 1718	Q1 1819	Q2 1819	Q3 1819	Q4 1819	
LD7.1	RMBC and CCG to agree process for funding learning disability joint placements	Q2 18/19	NEW	A	A	A	A	The policy text has been agreed. Work is ongoing to agree appendences
LD7.2	Identify Indicative costs for transforming care cohort (including those on the risk register)	Q2 18/19	NEW	A	G	G	G	Implementation of joint review of Transforming Care caseload completed by RMBC and RCCG Finance.
LD7.3	Commissioning solutions to be in place to meet individual trajectories	Q4 18/19	NEW	A	A	A	G	Close partnership working across the system has taken place to identify possible placement opportunities for identified transforming care caseload.

Priority 8 LD – Support the Implementation of the My Front Door – Learning Disability Strategy								
No.	Description	Target	Progress					Comments
			Q4 1718	Q1 1819	Q2 1819	Q3 1819	Q4 1819	
LD8.1	Delivery of joint Learning Disability transformation strategy	Q4 19/20	NEW	A	A	A	A	The policy is being redrafted to ensure that MFD is the delivery vehicle for transformation

Priority 9 LD – Support the development of an Autism Strategy								
No.	Description	Target	Progress					Comments
			Q4 1718	Q1 1819	Q2 1819	Q3 1819	Q4 1819	
LD9.1	Complete the development of the Autism Strategy (including Action Plan)	Q3 18/19	NEW	A	A	A	A	The draft strategy was discussed at the Rotherham Partnership Board and SEND Board. Additional work was identified. This is being completed to circulate the strategy as a draft for discussion.
LD9.2	Development of Rotherham based Autism and ADHD diagnostic pathway	Q4 18/19	NEW	A	A	A	G	Initial clinically led dialogue undertaken to scope opportunities for development of pathway. Looking at options. This is on track.

KEY PERFORMANCE INDICATORS

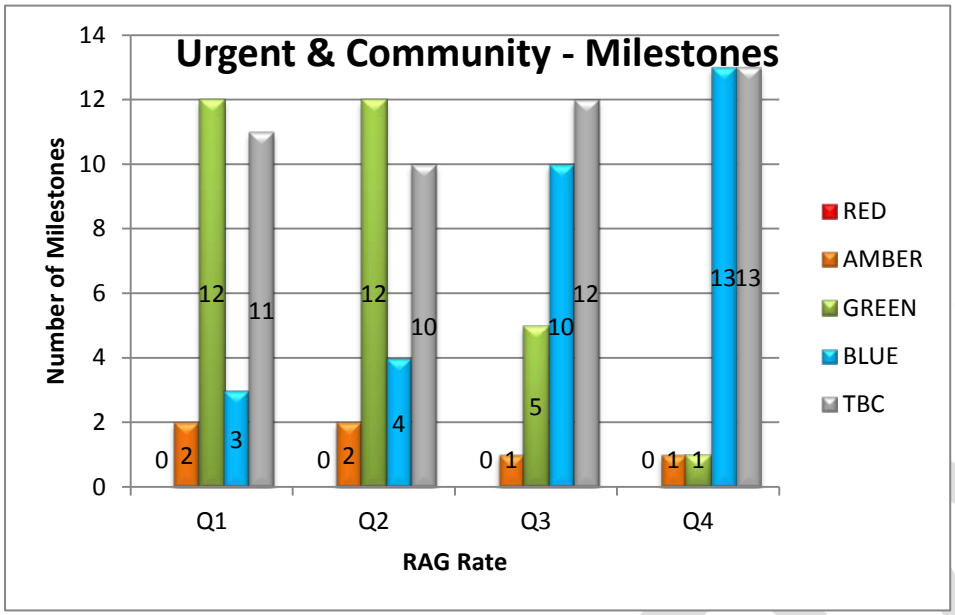
LEARNING DISABILITY AND MENTAL HEALTH TRANSFORMATION GROUP

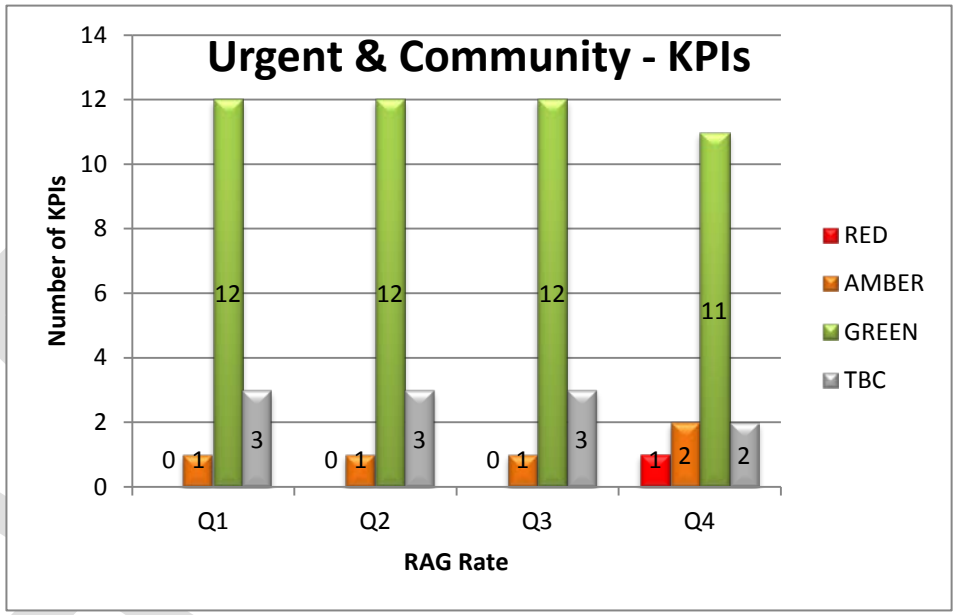
Chair: Ian Atkinson, RCCG

No.	Description	Trajectory	Target	Priority	Performance Q1 1819	Q2 1819	Q3 1819	Q4 1819	Comments
MH/KPI 1	Percentage of people referred to IAPT commencing treatment within 6 weeks of referral.	Maintain	75%	MH 1 - IAPT	G 83.8%	G 87.4%	G 75%	G 91.8%	On track.
MH/KPI 2	% Compliance of those who have entered (i.e. received) treatment as a proportion of people entering treatment with anxiety or depression Qtrly target % Qtr1 = 4.34%; Qtr 2 = 4.48%; Qtr 3 = 4.61%; Qtr 4 = 4.75%	Increase	19% Accumulative total of population with depression - reported to NHSE	MH 1 - IAPT	R 3.84%	A 4.35%	G 4.81%	G 4.77%	On track.
MH/KPI 3	% of people who have completed treatment having attended at least 2 treatment contacts and are moving to recovery	Increase	≥ 50%	MH 1 - IAPT	G 56.5%	G 59.9%	G 63%	G 55.6%	March compliance is 55.6% against the 50% target. The service continues to achieve against the KPI
MH/KPI 4	Dementia diagnosis rates (%)	Maintain	National = 67% Local = ≥80%	MH 2 - Dementia	G 83.5%	G 84.3%	G 85.8%	G 86.4%	National target is 67%. Local target set to maintain or improve on 80%. February performance was 86.4%
MH/KPI 5	50% of GP practices achieving 62% of Post diagnostic support plan recorded in last 12 months	Increase	50% of practices achieving 62 % (in year 1)	MH 2 - Dementia	TBC in Q2	G 43%	A 37%	G 97%	Baseline is 62% based on Rotherham GP practices current average / at Q4 97% currently equal to or above. 62% Performance to be reported on a 6 monthly basis.
MH/KPI 6	Urgent and emergency MH response within 1 hour of receiving an urgent referral (Core 24 liaison)	Increase	95%	MH 3 – Core 24	R 58%	A 90%	G 94.3%	A 84%	Referrals 371. Within 1 hour 253 24/7 service commenced January 2019. During March multiple referrals were received in a short time while staff were still in previous assessments. Two patients were too intoxicated to be assessed. This brought the overall performance down.
MH/KPI 7	Average length of stay (Ferns)	Decrease	28 days	MH 4 - Ferns	R 47	R 50	R 84	R 67	Q4 average LOS = 67 days. January 46 days, February 57 days, March 100 days. The Ferns Pilot ended May 2019. The indicator is no longer relevant.
MH/KPI 8	To reduce the suicide rate by 10% from the 2013-15 baseline (14.2 per 100,000)	Decrease	10% reduction against the 2013-2015 baseline by 2019-2021	MH 5 - Crisis	TBC in Q3	TBC in Q3	A 13.9	A	The metric is reported over a rolling 3 year period due to the small numbers involved. After a small decrease between 2013-15 and 2014-16, the 3-year combined rate increased from 13.9 to 15.9 per 100,000 DSR between 2014-16 and 2015-17
MH/KPI 9	Referrals who require a Face to Face assessment who were seen within 4 Hours % Compliance (crisis)	Increase	≥95%	MH 5 - Crisis	G 97.6%	G 100%	G 97.9%	G 97.6%	March compliance is 97.6% against the 95% target.

LD/KPI 10	Ensure that patients receive a CTR prior to a planned admission to an Assessment and Treatment Unit or mental health inpatients: adults.	Increase	95%	LD 7 - Transforming Care	G 100%	G 97%	G 100%	G 100%	On track.
LD/KPI 11	Ensure that patients receive a CETR prior to a planned admission to an Assessment and Treatment Unit or mental health inpatients: children.	Increase	95%	LD 7 - Transforming Care	G 97%	G 97%	G 100%	G 100%	On track
LD/KPI 12	Ensure that patients in an Assessment and Treatment Unit receive a Care and Treatment Review (CTR) every 6 months.	Increase	100%	LD 7 - Transforming Care	A 92%	G 100%	G 100%	G 100%	On track
LD/KPI 13	Reduce the number of people admitted in line with the South Yorkshire and North Lincolnshire LD TCP trajectory – *Local Reporting*	Reduce	Target = 3 – CCG funded LD beds /5 – NHSE funded secure LD beds	LD 7 - Transforming Care	A 5 =CCG 4 =NHSE	A 5 =CCG 4=NHSE	A 5 = CCG 4=NHSE	G 3 = CCG 4=NHSE	Two people have been discharged. Agreed NHSE targets have been achieved. Plans to discharge.
LD/KPI 14	Proportion of eligible adults with a learning disability having a GP health check	Increase	1058	LD 8 - LD Strategy	A 124	A 111	A 89	A	CCG I&AF, requirement to agree a trajectory as part of 18/19 planning –reported quarterly. Trajectory is: Q1 159, Q2 159, Q3 318, Q4 423. Achieved 89 against target of 318 in Q3, however only 21 practices submitted their figures so we may have achieved the target. Awaiting final outturn figures.
LD/KPI 15	Proportion of adults with a learning disability in paid employment	Increase	5% increase on 17/18 outturn = 9.2% or 46 individuals in paid employment	LD 8 - LD Strategy	TBC	TBC	R 3.7%	R 3.7%	Year end 17/18 position of 4.2% (31 out of 726 eligible long term service users) (*published data 4.1% due to rounding of submitted data) Current Score = 3.7% (25 out of 681 eligible long term service users) Target is to achieve a 5% percentage increase (9.2% based on 17/18 outturn) – an additional 46 individuals would need to be in paid employment. Work is being done with Speak Up and Community Catalysts to support this increase
LD KPI/16	The numbers of people receiving a diagnosis of autism within 18 weeks 55 assessments completed in 2017/18	Increase	5% increase on 2017/18 performance = 58	LD9 – Autism	G 15	G 15	G 15	G 15	No breaches of 18 week waiting time, 15 assessments completed in Q4

Overview of Urgent and Community Performance





The RAG rate of milestones and KPIs by priority are shown in the table below:

	Priority	Number of milestones	BR	Blue	Green	Amber	Red	TBC
Urgent and Community	1	6	2	4	0	0	0	0
	2	3	0	2	0	0	0	1
	3	4	0	2	0	0	0	2
	4	7	4	1	0	0	0	2
	5	4	0	2	0	0	0	2
	6	4	0	2	1	1	0	0
	No. of milestones	28	6	13	1	1	0	7
		% against total	21%	46%	4%	4%	0%	25%
	No. of KPIs	16	0	0	11	2	1	2
		% against total	0%	0%	70%	12%	6%	12%

In Q4 50% of **milestones** are on track or complete, compared to 54% in Q3 – this is due to Integrated Localities and Intermediate Care / Reablement to be determined
In Q4 no **milestones** are of concern, which is the same as Q3

In Q4 70% of **KPIs** are on track, compared to 75% in Q3
In Q4 6% of **KPIs** are of concern, compared to none in Q3

MILESTONES

URGENT CARE AND COMMUNITY TRANSFORMATION GROUP

Chairs: Chris Holt, TRFT and Anne Marie Lubanski RMBC

Priority 1 UC&C - Integrated Point of Contract

No.	Description	Target	Progress					Comments
			Q4 1718	Q1 1819	Q2 1819	Q3 1819	Q4 1819	
UC 1.1	Transfer mental health referrals to the Care Co-ordination Centre	Q2 18/19	A	A	A	B	B	
UC 1.2	Agree joint working arrangements between Integrated Rapid Response/Care Co-ordination Centre /Single Point of Access to test the models.	Q2 18/19	G	G	A	B	B	
UC 1.3	Co-locate Care Co-ordination Centre with Integrated Rapid Response	Q3 18/19	G	G	G	B	B	
UC 1.4	Evaluate joint working arrangements between health and RMBC Single Point of Access	Q3 18/19	BR	BR	G	B	B	
UC 1.5	Partners agree integrated service model for Single Point of Access and Care Co-ordination Centre	Q4 18/19	BR	BR	BR	BR	BR	Development of the model has been re-aligned with the Intermediate Care and Re-ablement project. It has been agreed to move this milestone into 2019-20
UC 1.6	New service model in place	Q2 19/20	BR	BR	BR	BR	BR	To be informed by 1.5

Priority 2 UC&C - Integrated Rapid Response (Phase 1)

No.	Description	Target	Progress					Comments
			Q4 1718	Q1 1819	Q2 1819	Q3 1819	Q4 1819	
UC 2.1	Complete separation of planned/unplanned activity within District Nursing	Q2 18/19	G	G	B	B	B	
UC 2.2	Co-locate the unplanned and Integrated Rapid Response teams	Q3 18/19	G	G	G	B	B	
UC 2.3	Incorporate unplanned specialist community nursing work into the Integrated Rapid Response team	Q1 19/20	G	BR	BR	G	B	The IRR priority has been split into the integrated point of contact and intermediate care and reablement project.

Priority 3 UC&C - Integrated Discharge (Phase 2)								
No.	Description	Target	Progress					Comments
			Q4 1718	Q1 1819	Q2 1819	Q3 1819	Q4 1819	
UC 3.1	Appointment of Integrated Service Manager	Q2 18/19	G	B	B	B	B	Complete
UC 3.2	Appointment of Ward Co-ordinator Roles	Q2 18/19	G	B	B	B	B	Complete
UC 3.3	Partners approve Service Model (incl. team structure and 7/7 working and front door interface)	Q4 18/19	G	G	G	G	TBC	The IDT activity has benchmarked well with DTOCs falling to one of lowest levels of 1.8% Feb 2019 against a national standard of 3.5%. Community nursing and therapies are now working into the team. The future model / resourcing will be impacted by the Intermediate Care and Reablement project. It is recommended that this milestone is changed to Service Evaluation June 2019 with model and structure aligned to IC&R milestones
UC 3.4	Implement new model	Q2 19/20	BR	BR	BR	BR	TBC	To be agreed according to 3.3

Priority 4 UC&C - Integrated Locality Pilot (Phase 2)								
No.	Description	Target	Progress					Comments
			Q4 1718	Q1 1819	Q2 1819	Q3 1819	Q4 1819	
UC 4.1	Map of current resources in each Partnership area for all organisations complete	Q3 18/19	G	G	G	B	B	Completed in January 2019
UC 4.2	Agree outcome framework with partners - identify joint outcomes, agree governance and identify accountable officers for delivery within provider organisations	Q3 18/19	G	G	G	TBC	TBC	The Localities work stream will be re-aligned to maximise opportunities from Primary Care Networks and the Intermediate Care and Reablement model.
UC 4.3	Hold launch workshops (to agree work plans and targets and working principles)	Q3 18/19	G	G	G	TBC	TBC	Resource secured and the physical review of 50 double-handling cases is now underway following a 30 case desk top review suggesting that 40% do not require double handling. Results expected to free up resource to assign elsewhere in the system. Following the inaugural meet and greet organised at Maltby Service Centre, representatives from social care, health and VAR have formed an action group that are meeting regularly. Currently led by a Community Consultant, the PCN Clinical lead for the area has also indicated a desire to be involved.
UC 4.4	Partnership leadership teams agreed by partners	Q3 18/19	BR	BR	BR	BR	BR	As above
UC 4.5	Team configuration agreed by partners	Q4 18/19	BR	BR	BR	BR	BR	As above
UC 4.6	Implementation plan for full roll out agreed by partners	Q4 18/19	BR	BR	BR	BR	BR	As above
UC 4.7	Agree Long Term Conditions LES to ensure that it links with the localities	Q1 19/20	BR	BR	BR	BR	BR	As above

Priority 5 UC&C – Reablement and Intermediate Care								
No.	**Description**	**Target**	**Progress**					**Comments**
			Q4 1718	**Q1 1819**	**Q2 1819**	**Q3 1819**	**Q4 1819**	
UC 5.1	Carry out financial modelling of current pathways	Q2 18/19	G	G	G	G	B	Initial original costings completed in Q2. More detailed costings have been developed as part of the outline business case, subject to approval.
UC 5.2	Programme lead to develop a comprehensive milestone and action plan for delivery of this priority	Q2 18/19	New	A	G	TBC	B	
UC 5.3	Develop draft service model and service specifications for reablement, intermediate Care and Home First	Q4 18/19	New	BR	BR	BR	TBC	The Place Outline Business Case is progressing through partner organisations governance frameworks. Detailed planning has begun including stakeholder communication and engagement plans.
UC 5.4	Phase 1 of new service model implemented	Q4 18/19	BR	BR	BR	BR	TBC	

Priority 6 UC&C - Care Home Support								
No.	**Description**	**Target**	**Progress**					**Comments**
			Q4 1718	**Q1 1819**	**Q2 1819**	**Q3 1819**	**Q4 1819**	
UC 6.1	Local implementation of Red Bag Scheme	Q1 18/19	G	B	B	B	B	Implementation complete
UC 6.2	Implement and evaluate care home pilots: Trusted Assessor, Telehealth and End of Life	Q1-Q3 18/19	G	G	G	A	A	The Trusted Assessor pilot was extended for winter 2018-19. A review has been completed The End of Life project has been extended as a result of a successful evaluation An update on Telehealth is required
UC 6.3	Review training requirements for Care Home staff to enable effective delivery of service	Q4 18/19	G	G	G	G	G	The Care Home task and finish group are auditing training across services. This milestone will be taken forward through the T&F action plan
UC 6.4	Continue to ensure the Care Home LES is fit for purpose	Q4 18/19	G	G	G	G	B	The Care Home LES continues to be reviewed to ensure it is fit for purpose. Monitoring will be taken forward as part of BAU.

KEY PERFORMANCE INDICATORS

No.	Description	Trajectory	1819 Target	Priority)	Performance Q1 1819	Q2 1819	Q3 1819	Q4 1819	Comments
UC/ KPI 1	SPA - Number of people provided with information and advice at first point of contact (to prevent service need) SPA *LOCAL PI (based on ASCOF 2B3)*	Increase	2750	UC 1 - IPC	G 926 (37.9% of contacts)	G 839 (38.8% of all contacts)	G 838 (40.3% of all contacts)	G 889 (37.8% of all contacts)	Council Plan Measure. There has been an increase in the numbers of individuals not known to the service and provided with information and advice in Q4. However, this data when represented as a proportion of the total contacts demonstrates a decline on the previous quarter percentage score. In quarter 4 performance has now been updated to include the proportion of contacts signposted/provided info and advice to more clearly show the direction of travel against total contact volumes.
UC / KPI 2	CCC – Number of GP urgent admissions to AMU (including those referred through CCC)	Reduction	3150 threshold	UC 1 – IPC UC 5 – IC /Reab	G 516	G 461	G 424	G 319	On track.
UC/ KPI 3	Of the new clients who have had a formal social care assessment completed this year, what percentage went on to receive long term social care support? LOCAL PI (based on ASCOF)	Reduction	2018/19 will be the baseline year	UC 1 – IPC UC 2 - IRR UC 4 – Int Locality	55% RAG TBC	60.9% RAG TBC	60% RAG TBC	61% RAG TBC	Regional data/ benchmarking is being monitored to inform targets moving forward, 18/19 will be a baseline year. Adult Care are strengthening and embedding a strength based approach to social care which will improve performance over time
UC / KPI 4	Proportion of new clients who receive short term (enablement) service in year with an outcome of no further requests made for support - *ASCOF 2d 2B7*	Increase	83%	UC 1 – IPC UC 2 – IRR UC4 – Int Loc UC 5 – IC /Reab	G 89%	G 91%	G 90.4%	G 93.5%	Data is provisional pending submission and verification of statutory returns to NHS Digital. This indicator demonstrates continuous improvement from 2016-17 score of 81.9%. Investigation of the cohort is planned to assess measures optimum range along with benchmarking data when available.
UC/ KPI 5	New permanent admissions to residential nursing care for adults – 65+ *BCF/ASCOF 2a (2)/ BCF (per100,000)*	Decrease	140.69	UC 1 – IPC UC 2 – IRR UC 4 – Int Loc UC 5 – IC /Reab	G 124.83 (63 adm)	G 262.6 (132 adm)	G 386.4 (195 adm)	R 574.25 (293 adm)	BCF Indicator, also contributes to Council Plan measure "All Age Admissions". Data is provisional pending submission / verification of statutory returns to NHS Digital. The 2018-19 out turn although narrowly missed target of 287 admissions does represent a continued improvement in direction of travel with 17 fewer admissions than 2017-18.
UC/ KPI 6	Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement / rehabilitation services – *BCF/ ASCOF 2B (1)*	Increase	89%	UC 1 – IPC UC 2 – IRR UC 4 – Int Loc UC 5 – IC /Reab	N/K until Q4	N/K until Q4	N/K until Q4	A 85.6%	An improved performance has been achieved during 2018/19 with the proportion of people remaining at home after 91 days rising to 85.6% from last year's 82.8% outturn. This one year upturn whilst falling short of the stretch target of 89% has stemmed the recent 2 year declining direction of travel and represents the mid performance point across the last five year performance period

UC/ KPI 7	Number of emergency admissions for people over 65 Out of Hours	Reduction	8760 (2190 per qtr)	UC 1 – IPC UC 2 - IRR UC 4 – Int Locality	G 1724	G 1712	G 1656	G 1915	Target = 2190 per quarter. Q1 – 564+598+562 = 1724. Q2 – 571+521+620 = 1712 Q3 = 546+529+646 = 1656 Q4 = 699+581+635 = 1915
UC/ KPI 8	Number of emergency re-admissions within 28 days of hospital discharge (all age - same day readmissions excluded)	Reduction	13.3%	UC 1 – IPC UC 2 - IRR UC 4 – Int Locality	11.4%	11.6%	10% (November figure)	11.2% (Feb figure)	This data used to be available nationally, there is no national target. TRFT local target for 28 days is 13.3%, figure shown for September. **awaiting March figure**
UC/ KPI 9	Length of stay in hospital (over 64's)	Reduction	2017/18 baseline: All = 6.9, NE = 7.5	UC 2 - IRR UC 4 – Int Locality	All = 6.92 NE = 7.33	All = 6.61 NE = 7.05	All = 6.45 NE = 6.89	All - 6.62 NE - 6.96	Using TRFT reporting: 2017/18 baseline: All = 6.9, NE = 7.5
UC/KPI 10	Reducing long lengths of stay (super stranded patients – over 21 days)	Reduction	39 = 10% reduction on 17/18 (43)	UC 2 - IRR UC 4 – Int Locality	G 43.3	G 40.0	TBC	TBC	As per national guidance and as in the Winter Plan. Baseline = Beds occupied with long stay patients 2017/18. Note – work needed to confirm the national data.
UC/KPI 11	Number of patients discharged to their usual place of residence (over 64's) – does not include 0 and 1 day stays	Increase	2017/18 baseline All = 45% NE = 41%	UC 2 - IRR UC 3 - IDisc UC 5 – Int Locality	All = 45% NE = 42%	All = 44.93% NE = 42%	All = 46.69 NE =43.86	All = 45.26% NE=42.93%	Using TRFT reporting, 2017/18 baseline: All = 45%, NE = 41%
UC/KPI 12	Average length of stay to below national intermediate care target (general rehabilitation) (beds only)	Reduce	Less than 21	UC 2 - IRR UC 3 - IDisc UC 5 – Int Locality	G 19	G 18.3	G 20	G Year end = 20.25 average	Q1 = 18, 22, 17 = average of 19 Q2 = 18, 19, 19 = average of 18.3 Q3 = 20,20,20 = average of 20 Q4 = 28,21,21 = 23.3 YTD = 243 = average of 20.25 over year
UC/KPI 13	Average length of stay to below national intermediate care target (specialist rehabilitation) (beds only)	Reduce	Less than 42	UC 2 - IRR UC 3 - IDisc UC 5 – Int Locality	A 53	A 44.3	A 44.6	A Year end = 47.0 average	Q1 = 43, 56,60 = average of 53 Q2 = 52, 46, 35 = average of 44.3 Q3 = 42,48,44 = average of 44.6 Q4 = 50,44,45 = 46.3 YTD = 565 = average of 47.0 over year
UC/ KPI 14	Delayed transfer of care from hospital (I&AF 127e).	Reduction	3.5%	UC 3 – IDis	G 2.1%	G 2.5%	G 2.3%	G 1.5%	Following the on-going implementation of an action plan across partners, performance has significantly improved.
UC/ KPI 15	Number of A&E attendances from care home residents (local)	Reduction	3400 (850 per qtr)	UC 6 – Care Homes	G 400	G 399	G 389	G 477	Q1 RAG rate based on April 145, May 133, June 122 = 400. Qtr average = 375 Q2 RAG rate based on July 144, August 117, September 138 = 399 Q3 = 132+108+149 = 389 Q4 – 166+141+170 = 477
UC/ KPI 16	Number of unscheduled hospital admissions Care Homes	Reduction	1950 (490 per qtr)	UC 6 – Care Homes	G 289	G 301	G 283	G 311	On track Q1 – 100+101+88 = 289 Q2 – 105 + 91 + 105 = 301 Q3 = 107+59+117 = 283 Q4 – 127+90+94 = 311

**KPI 6 is collected annually and will be available Q4*