HEALTH AND WELLBEING BOARD

Venue: **Garden Room, Clifton Park Museum, Rotherham. S65 2AA**

Date: **Wednesday, 18th September, 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 (Pages 1 - 8)

7. Communications

Key Developments

8. Improving Air Quality in Rotherham (Pages 9 - 26)
   Tom Smith, Assistant Director, Community Safety & Street Scene

9. Advancing our Health: Prevention in the 2020s (Pages 27 - 39)
   Councillor Roche, Chair

Delivery of the Health and Wellbeing Strategy

10. Performance Framework Spotlight: Suicide Prevention (Pages 40 - 45)
    Ruth Fletcher-Brown, Public Health Specialist

11. Refresh of the Sexual Health Strategy (Pages 46 - 81)
Gill Harrison, Public Health Specialist

12. Health and Wellbeing Board Annual Report (Pages 82 - 98)
Councillor Roche, Chair

Board Development

13. Updates to the Health and Wellbeing Board
Councillor Roche, Chair

14. Issues escalated from Place Board

For Information

15. Better Care Fund Planning Template (Pages 99 - 154)

16. Health and Wellbeing Strategy Performance Framework (Pages 155 - 163)

17. Active for Health - Evaluation Report (Pages 164 - 208)

18. ICP Performance Report (Pages 209 - 225)

19. Rotherham Integrated Care Partnership Place Board (Pages 226 - 239)
Minutes of meetings held on 5th June, 3rd July and 7th August, 2019

20. Date and time of next meeting
Wednesday, 20th November, 2019, commencing at 9.00 a.m. to be held at Voluntary Action Rotherham, The Spectrum, Coke Hill, Rotherham

HEALTH AND WELLBEING BOARD
10th July, 2019

Present:-

Councillor David Roche	Cabinet Member, Adult Social Care and Health **(in the Chair)**
Stephen Chapman	Temporary District Commander, South Yorkshire Police
Dr. Richard Cullen	Strategic Clinical Executive, Rotherham CCG
Helen Dobson	Deputy Chief Nurse, Rotherham Foundation Trust (representing Louise Barnett)
Chris Edwards	Chief Operating Officer, Rotherham CCG
Sharon Kemp	Chief Executive, RMBC
Carol Lavelle	NHS England
Dr. Jason Page	Governance Lead, Rotherham CCG
Terri Roche	Director of Public Health
Jon Stonehouse	Strategic Director, Children and Young People's Services, RMBC
Janet Wheatley	Chief Executive, Voluntary Action Rotherham

Report Presenters:-

Sam Blakeman	Democratic Services, Rotherham MBC
Gilly Brenner	Consultant in Public Health
Ruth Fletcher-Brown	Public Health Specialist, Rotherham MBC
Wendy Griffin	Smoking Cessation Midwife
Jane Lovett	Associate Chief Nurse
Sue Turner	Public Health Specialist

Also Present (observers):-

James Kinder	RDaSH
Gordon Laidlaw	Communications Lead, Rotherham CCG
Alison Martindale	Rotherham Foundation Trust
Lesley White	NHS England
Rebecca Woolley	Policy and Partnerships Officer, RMBC

Apologies for absence were received from Councillor Watson, Steve Adams (South Yorkshire Fire and Rescue Service), Louise Barnett (Rotherham Foundation Trust), Tony Clabby (Healthwatch Rotherham), Anne-Marie Lubanski (Rotherham MBC) and Kathryn Singh (RDaSH)

15. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at this meeting.

16. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

17. MINUTES OF THE PREVIOUS MEETING HELD ON 29TH MAY, 2019

The minutes of the previous meeting of the Health and Wellbeing Board were considered.

With regards to Minute No. 3 (Communications) it was noted that the Local Government Association feature on the Health and Wellbeing Board had now been published.

Reference was made to Minute No. 7 (Health Protection Committee Annual Report) where it was noted the report had been more people friendly. However, it was suggested for future reports the use of infographics would be helpful.

Resolved:- That the minutes of the previous meeting held on 29th May, 2019 be approved as a correct record subject to the inclusion of Janet Wheatley to the list of attendees.

18. PERFORMANCE FRAMEWORK SPOTLIGHT: SMOKING STATUS AT THE TIME OF DELIVERY

June Lovett - Associate Chief Nurse, Head of Midwifery Nursing and Professions, Sue Turner - Public Health Specialist and Wendy Griffin – Smoking Cessation Midwife - together gave a powerpoint presentation on smoking status at the time of delivery.

The presentation highlighted:-

- Smoking during pregnancy.
- Background and risks.
- Governance and delivery groups.
- Position up to March, 2019.
- Smoking at the time of delivery statistics.
- Key performance indicators.
- Analysis and implications.
- Plans and actions so far.
- Future Developments.
- Recommendations.

A discussion and answer session ensued and the following issues were raised and subsequently clarified:-

- Degree of impact.
- Reliability of data for CO^2 measurements and whether there was any correlation between areas for air pollution.
- Rotherham's Beacon Service on less staffing resources than South Yorkshire colleagues.

- Need for more publicity and promotion of the service.
- Quit smoking rates and encouragement for life changing events.
- How to stop people smoking and real life supportive campaigns.

Resolved:- (1) That June Lovett, Sue Turner and Wendy Griffin be thanked for their informative presentation.

(2) That the content of the presentation be noted.

19. DEVELOPING A LONELINESS PLAN FOR ROTHERHAM

Ruth Fletcher-Brown, Public Health Specialist, and Sam Blakeman, Democratic Services, together gave a powerpoint presentation on development of a partnership approach to tackling loneliness and social isolation in Rotherham.

The presentation highlighted:-

- What was working well.
- Partnership approach.
- Whole Life Course approach.
- Building on Five Ways to Wellbeing Campaign.
- What was worrying.
- Time pressure for frontline workers.
- Capacity in the Voluntary and Community Sector.
- Funding of Borough-wide roll out.
- What was needed to happen.
- Complete and evaluate 6 month pilot.
- Health and Wellbeing board to use *5 Ways* branding.
- Loneliness Event in September.
- Launch 'Action Plan'.
- Roll out Loneliness MECC from the new year following pilot evaluation.
- Continued buy-in from partners.

The Board noted the joint work taking place across all areas and the social connectedness/social prescribing which would bring together the work done on the I.C.S. proposal with relevant funding.

A discussion and answer session ensued and the following issues were raised and subsequently clarified:-

- Challenges and inclusion of loneliness in social care packages.
- Capacity in the voluntary and community sector.
- Social isolation through loneliness and the pilots being promoted through libraries, leisure centres etc.
- Launch of the Action Plan.

Resolved:- (1) That Ruth Fletcher-Brown and Sam Blakeman be thanked for their informative presentation.

(2) That the content of the presentation be noted.

(3) That a further report be provided to the Health and Wellbeing Board later in the year.

20. PRIORITIES OF THE HEALTH AND WELLBEING BOARD

The Chair invited the Board Sponsors to give a verbal update on the priorities of the Health and Wellbeing Board.

Aim 1

Jon Stonehouse and Jason Page updated on the links with the Children and Young People's Partnership and Transformation Board, its partner strengths, attendance, frequency and voice of young people.

Going forward there would be sharper focus on Early Years and be demand- led to ensure the priorities were right, valuated and measured. There would be further discussion about young people's vulnerability and loneliness and links to other groups looking at areas such as knife crime.

There had been some improvements with childhood obesity and the links to adult obesity. There was emphasis for doing more.

Aim 2

Ian Atkinson on behalf of Kathryn Singh reported on the Mental Health and Learning Disability Group who met on a monthly basis looking at its six themed areas, with its key theme being around self-harm. Consideration was also given to the wider crisis involving mental health responses, delivery, access and the challenges with cognitive behaviour therapy.

There were some challenges on Autism with the development of an All Age new Pathway.

Aim 3

Rebecca Woolley reported on the links to health through the Employment and Skills Strategy and the Cultural Strategy, both of which would have shared action plans.

Aim 4

Stephen Chapman reported on the Town Centre priorities and the issues around safety in Clifton Park, anti-social behaviour figures reducing yet perception rates were increasing. This was having a significant impact on trust and confidence at a local level.

Janet Wheatley confirmed that as part of the Cultural Strategy a significant bid had been submitted to the Arts Council. Those successful at Stage 1 would be informed this week and if successful confirmation should be received in August.

Richard Cullen reported on the elements of digital health, inclusion, education, social media and employment and movement on the Government agenda for digital primary care.

Resolved:- That Board Sponsors be thanked for their updates and feedback.

21. AIM 3: ALL ROTHERHAM PEOPLE LIVE WELL FOR LONGER

Sharon Kemp, Chief Executive, gave a powerpoint presentation on Rotherham people living well for longer.

The presentation highlighted:-

- The challenges.
- Strategic priorities.
- Key themes from the workshop.
- Vision for Rotherham.
- Building on this social movement.
- Building on assets to tackle wider determinants.
- Proposed actions.
- Relationship with other aims.
- Questions to the Health and Wellbeing Board.

A discussion and answer session ensued and the following issues were raised and subsequently clarified:-

- Social movement and the different delivery of health messages.
- Utilisation of the population.
- Implications for services with increased take-up.
- Targeting communities/specific areas.
- Understanding roles.
- Links with digital health and the potential to increase inequalities.
- Engagement with the Target Operating Model.
- New offer for carers.

Resolved:- (1) That Sharon Kemp be thanked for her informative presentation.

(2) That the content of the presentation be noted.

22. UPDATE ON THE JSNA

Gilly Brenner, Consultant in Public Health, provided an update on the relaunch of the Rotherham Joint Strategic Needs Assessment (JSNA) and a brief overview of how Rotherham was currently performing against a range of health indicators.

A comprehensive picture of the health issues facing the Rotherham population would be captured by the new JSNA. New indices of multiple deprivation (IMD) data would also be available nationally in the autumn which would help add refreshed context to our local picture and triangulate intelligence.

The JSNA Steering Group had now met twice and was due to meet again shortly. Terms of Reference have been agreed and lead authors assigned for key sections, which would have a more enhanced view with real headlines and five highlights on each key topic, each driving forward the vision.

Consideration was being given to the name and feedback of examples was welcomed.

Resolved:- (1) That the developments of the Rotherham JSNA be noted.

(2) That the key health issues facing the Rotherham population be noted.

23. PRIMARY CARE NETWORKS

Updates were provided on the Primary Care Networks and the Chair reported on the visits to other Boards and sharing of ideas. The aim was to identify key areas for the operation boards and the route of consideration to avoid any duplication, which would then be overseen by the strategic body, the Health and Wellbeing Board.

Chris Edwards, Chief Operating Officer, provided feedback on the Healthy Rotherham event, which had met its objectives. Whilst well attended and well received from a political/public perspective, it was not as popular as it had been in previous years. Further work would take place in the new year on the event for 2020.

Details of delivery milestones and development of other integral plans were provided and would be shared more widely.

The Board noted the event around suicide prevention on the 6th July, 2019.

The Board noted the four themes coming forward and were in agreement with further details being circulated about the networks in due course.

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

(2) That details on the network developments be circulated to the Health and Wellbeing Board Members.

24. UPDATE FROM EVENTS AND KEY MEETINGS

Chris Edwards, Chief Operating Officer, reported on the Suicide Symposium and how this topic was featuring on many agendas.

An item would also be included on the September agenda for this Board.

Resolved:- That the information be noted.

25. ISSUES ESCALATED FROM PLACE BOARD

There were no issues to report.

26. UPCOMING AGENDA ITEMS

The Board noted:-

- Suicide Prevention – September.
- Loneliness – November.
- Sexual Health Strategy
- Suicide Prevention Strategy
- ICS Plan
- Response to Long Term Care and Clear Air

Resolved:- That the information be noted.

27. HEALTH AND WELLBEING STRATEGY AIM 1 ACTION PLAN

The Health and Wellbeing Strategy Aim 1 Action Plan was noted.

28. ROTHERHAM ICP PLACE BOARD 1ST MAY 2019

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

29. OUTCOMES FRAMEWORK

The Outcomes Framework was noted.

30. Q4 PLACE PLAN PERFORMANCE REPORT

The Quarter 4 Place Plan Performance Report was noted.

31. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting be held on Wednesday, 18th September, 2019, commencing at 9.00 a.m. at a venue yet to be agreed.

Improving Air Quality in Rotherham

Background

- 7m deaths globally are caused by air pollution.
- Estimated up to 36,000 deaths a year in the UK.
- Contributes to over 100 deaths per year in Rotherham.
- Worsens chronic illnesses, shortens life expectancy and damages lung development in children.
- Causes asthma, increases the chances of hospital admissions and respiratory and cardiovascular disease.
- Poorer communities are most exposed to, and suffer the consequences of, polluted air
- UK has been in breach of legal limits since 2010.

Rotherham Air Quality Plan 2016-20

- Mitigation of air quality impacts though the planning process (Development Control);
- Promoting low emission transport, in particular cleaner buses; taxi licensing; the installation of Electric Vehicle recharging infrastructure;
- Promoting travel alternatives to the private car, raising public awareness especially of the impact of diesel vehicles on air quality in our towns and cities;
- Improving the efficiency of the Rotherham MBC Vehicle Fleet.

Work to Date – Sustainable Transport

- Care4Air Campaign
- Promote uptake of electric vehicles – 25 charging points
- Promote alternative transport
  - Cycleboost
  - Sustainable and Active Travel support for schools
  - Independent Travel Training
  - Walk Rotherham" project.
  - Busboost
  - EcoStars

Work to Date - Infrastructure

- National Productivity Investment Fund
- Tram Train Pilot
- Rotherham Interchange
- A630 Parkway Widening

Improving Air Quality in Rotherham

- Rotherham and Sheffield required to work together to:
  - Analyse local air quality
  - Achieve Statutory compliance with Air Quality legislation
  - Proposed scheme(s) are deliverable in the shortest possible time and by no later than 2021
- Submit Final Business Case to Government by December 2019

What is causing the problem?

- Road traffic
- Particular types of vehicles
  - Diesel vehicles and older petrol vehicles are the most polluting.
  - Older non-retrofitted buses
  - Private Hire taxis
  - HGVs and LGVs
- Focused in particular locations across the Borough


Rawmarsh Hill
Wortley Road
Fitzwilliam Road
Parkway
Rotherham
Rawmarsh
Liberty Steels
Rotherham Golf Club
Thrybergh
Parkgate
Aldwarke
Dalton
Dalton Magna
Clifton Park Museum
Herringthorpe Playing Fields
Carlton Park Hotel
Sitwell Park Golf Club
Phoenix Sports & Social Club
Brinsworth
Holiday Inn Rotherham-Sheffield M1,...
TINSLEY
Morthen
A630
A631
M1
Google

Sheffield Parkway in Rotherham (A630)

- Sheffield propose to introduce a Category C (CAZ C) charging zone area bounded by the inner ring-road.
- Would bring both the Sheffield and Rotherham sections of Sheffield Parkway into compliance by 2021.
- Assumes that the proposed 50mph speed limit, associated with the widening of the Parkway in Rotherham is introduced.

Rawmarsh Hill (A633), Rawmarsh

- Upgrade or replace all buses operating on Rawmarsh Hill are to the Euro VI standard as a minimum.
- A Euro VI bus delivers an almost 95% reduction in emissions against earlier Euro standards.
- Divert around 25-30% of the scheduled buses from Rawmarsh Hill onto Barbers Avenue
- Improve the junctions at Dale Road and undertake minor works to Barbers Avenue itself, to support this measure.

Fitzwilliam Road (A630), Eastwood

- Minor engineering and traffic flow works

Wortley Road and Upper Wortley Road (A629), Kimberworth and Thorpe Hesley

Wortley Road and Upper Wortley Road (A629), Kimberworth and Thorpe Hesley

Wortley Road and Upper Wortley Road (A629), Kimberworth and Thorpe Hesley

Wortley Road and Upper Wortley Road (A629), Kimberworth and Thorpe Hesley

- HGV ban – northbound towards M1

Other Measures

Financial Support to Upgrade:

- Taxis and Private Hire Vehicles (PHV)
- Buses
- Heavy Goods Vehicles (HGVs) and Light Goods Vehicles (LGVs)

Campaigns and behavioural change

Outcomes

Rotherham Sites	2017 Baseline	2021	
		Projected without measures	Projected with measures
A630 Parkway Rotherham	48	44	39.5
A633 Rawmarsh Hill Rotherham	49	42	38.4
A629 Wortley Road Rotherham	45	41	31.3
A630 Fitzwilliam Road Rotherham	45	44	37.6

Next Steps

- Public Consultation on proposals – summer 2019
- Submit Final Business Case to Government – December 2019
- Implement proposals – from June/July 2020

BRIEFING	**TO:**	Rotherham Health and Wellbeing Board
	DATE:	18th September 2019
	LEAD OFFICER	Becky Woolley, Policy and Partnerships Officer
	TITLE:	'Advancing our Health: Prevention in the 2020s' consultation

1. Background

1.1 On 22nd July, a consultation on the prevention green paper was launched, following from the prevention vision, which was published in November 2018. At the heart of both of these documents is the ambition that people enjoy at least five extra healthy, independent years of life by 2035, whilst narrowing the gap between the experience of the richest and the poorest.

1.2 Additionally, this paper outlines the vision that in the 2020s, people will not be passive recipients of care, but will be equipped with the knowledge and confidence they need to help themselves. Key to this will be embedding an asset-based approach across health and social care systems, with people viewing their health as an asset to invest in throughout their lives and not just a problem to fix when it goes wrong.

1.3 **Opportunities**
The paper places a significant focus on the role of the latest technology in delivering on the vision, including enhanced use of data, digital innovations and genomics. There is also a shift away from universalist interventions and towards greater personalisation with interventions stratified by risk.

1.4 Key commitments to make best use of these opportunities include:

- A greater focus on predictive prevention. This includes work to support the evaluation and modelling of predictive prevention at scale and exploring ways to support the West Midlands Combined Authority Radical Prevention Fund.
- Transformation of two of the largest existing programmes – screening and NHS Health Checks, with an emphasis on more targeted intervention and improving uptake.
- Publishing a National Genomics Strategy in Autumn 2019 with the ambition that the UK becomes the home to the 'genomic revolution.'
- Tackling current and future threats, including anti-microbial resistance and the gradual decline in vaccination uptake.

1.5 **Challenges**
Three key areas are identified as our biggest challenges nationally: being smoke-free, eating a healthy diet/staying active and taking care of our mental health. The paper also acknowledges wider factors such as alcohol, drug use and sleep.

1.6 Key commitments to address these challenges include:

- Announcing a smoke-free 2030 ambition. Delivering on this vision may include, introducing a levy on the tobacco industry, based on the principle of the 'polluter pays' and including inserts in tobacco products giving quitting advice and calling

	for independent evidence on the effectiveness of heated tobacco products in helping people to quit smoking and reducing health harms from smoking. • Publishing Chapter 3 of the Childhood Obesity Strategy, including bold action on: infant feeding, clear labelling, food reformulation and support for individuals to achieve and maintain a healthier weight. It will also be explored whether the sugar tax should be extended to include milk-based drinks. • Driving forward policies in Chapter 2, including ending the sale of energy drinks to children. • Launching a mental health prevention package, including the national launch of Every Mind Matters. A key ambition of this is to achieve parity of esteem for mental and physical health. • Increasing the availability of alcohol-free and low-alcohol products by 2025. • Furthering policy development in relation to prescribed and illicit opioid use. • Reviewing the evidence of sleep and health and determining what can be done to ensure that those in care settings get the amount of rest they need.
1.7	**Strong foundations** The paper emphasises that everybody in this country should have a solid foundation on which to build their health. Key to this is early years and ensuring that all children get the best start in life. Actions to push for a stronger focus on prevention at both a national and local level are also outlined in this section.
1.8	Key commitments to build strong foundations for health include: • Launching a new health index to help track the health of the nation, which will be used to influence and evaluate the impact of government policies alongside other indicators like GDP. • Modernising the Healthy Child Programme, including making better linkages to other health records, adding components including a digital support tool and new pathways for speech and language development and pre-conception and pregnancy advice. • Developing a consensus statement on Healthy Ageing. • Taking action on children's oral health, including consulting as a new school tooth brushing scheme and supporting water fluoridation.
2. Key Issues	
2.1	**Reception** A number of the commitments within the consultation paper have been widely commended, such as the ambition to develop a national health index and to become a smoke-free nation by 2030. However, the paper has also attracted some criticism.
2.2	The Kings Fund described the paper as a 'missed opportunity to build on the success of the sugar tax by taking a bolder approach to using tax and regulation to improve public health.' The response also included a call for the Prime Minister to 'move quickly to restore confidence that the population's health will be a key priority for the new government.' This response was likely shaped by the fact that shortly before the publication of the consultation paper, Boris Johnson pledged to review "sin taxes" on sugary, salty and fatty foods.[1]
2.3	The paper is also unlikely to include proposals to reverse cuts to Public Health budgets,

[1] The Kings Fund, 'The prevention Green Paper: the right time to put it in its place?' https://www.kingsfund.org.uk/blog/2019/05/prevention-green-paper

	with Ian Hudspeth, chairman of the Local Government Association's Community Wellbeing Board calling for government to 'prioritise preventative services by using the upcoming Spending Review to reverse the £700m of public health funding cuts over the last five years.'[2] This has been echoed by a number of other commentators, including Paul Najsarek, Solace spokesperson for Community Wellbeing and Jo Bibby, the director of health at the Health Foundation thinktank.
2.4	It has also been observed that whilst 'there's a nod to the importance of issues such as housing, planning, and transport in the paper, it fails to provide a coherent approach to tackling these root causes.'[3]
3. Key Actions and Relevant Timelines	
3.1	The consultation on the proposals within the green paper will close on 14th October 2019.
3.2	It is proposed that the Health and Wellbeing Board reviews the paper, and contributes towards a Rotherham Health and Wellbeing Board response to the consultation. The full report can be found via the following link (https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s) and consultation questions are appended to this cover report.
3.3	In order to develop this response, a discussion will take place at the Health and Wellbeing Board on 18th September 2019. Following this discussion, members will be invited to send any further comments to the policy support officer to the Health and Wellbeing Board by 30th September 2019.
4. Recommendations	
4.1	That Health and Wellbeing Board members to contribute towards a Rotherham response to the 'Advancing our Health: Prevention in the 2020s' consultation.

[2] William Eichler, 'Prevention green paper blasted as 'shopping list of half-complete ideas' https://www.localgov.co.uk/Prevention-green-paper-blasted-as-shopping-list-of-half-complete-ideas/47848

[3] Adam Briggs and Tim Elwell-Sutton, 'The prevention green paper – blink and you'll miss it' https://blogs.bmj.com/bmj/2019/07/24/adam-briggs-and-tim-elwell-sutton-the-prevention-green-paper-blink-and-youll-miss-it/

Appendix One: 'Advancing our Health: Prevention in the 2020s' consultation questions

- Which health and social care policies should be reviewed to improve the health of people living in poorer communities, or excluded groups?
- Do you have any ideas for how the NHS Health Checks programme could be improved?
- What ideas should the government consider to raise funds for helping people stop smoking?
- How can we do more to support mothers to breastfeed?
- How can we support families with children aged 0 to 5 years to eat well?
- How else can we help people reach and stay at a healthier weight?
- Have you got any examples or ideas of what would help people to do more strength and balance exercises?
- Can you give any examples of local schemes that help people to do more strength and balance exercises?
- There are many factors affecting people's mental health. How can we support the things that are good for mental health and prevent the things that are bad for mental health, in addition to the mental health actions in the green paper?
- Have you got examples or ideas about using technology to prevent mental ill-health, and promote good mental health and wellbeing?
- We recognise that sleep deprivation (not getting enough sleep) is bad for your health in several ways. What would help people get 7 to 9 hours of sleep a night?
- Have you got examples or ideas for services and or advice that could be delivered by community pharmacies to promote health?
- What should the role of water companies be in fluoridation schemes?
- What would you like to see in a call for evidence on musculoskeletal (MSK) health?
- What could the government do to help people live more healthily: in homes and neighbourhoods; when going somewhere; in workplaces; in communities?
- What is your priority for making England the best country in the world to grow old in, alongside the work of Public Health England and national partner organisations?
    - Support people with staying in work
    - Support people with training to change careers in later life
    - Support people with caring for a loved one
    - Improve homes to meet the needs of older people
    - Improve neighbourhoods to meet the needs of older people
    - Other _____
- What government policies (outside of health and social care) do you think have the biggest impact on people's mental and physical health?
- How can we make better use of existing assets – across both the public and private sectors – to promote the prevention agenda?
- What more can we do to help local authorities and NHS bodies work well together?

- What are the top three things you'd like to see covered in a future strategy on sexual and reproductive health?
- What other areas (in addition to those set out in this green paper) would you like future government policy on prevention to cover?

‘Advancing our Health: Prevention in the 2020s’ consultation

Developing our response as Rotherham Health and Wellbeing Board

Background

- On 22nd July, a consultation on the prevention green paper was launched. The consultation period runs until 14th October.
- This paper builds on previous policy developments, including NHS long term plan and the national prevention vision.

- Board members are asked to:
  1. Contribute towards a Rotherham Health and Wellbeing Board response to the 'Advancing our Health: Prevention in the 2020s' consultation.

Cross-cutting themes of the paper

- **Emphasis on technology, digital and innovation** over other factors such as the wider determinants of health.
- **Focus on greater personalisation and a targeted approach,** with a shift away from universalist interventions and towards interventions stratified by risk.
- **Increasingly important role for regulation and taxation** including exploring the introduction of a levy on the tobacco industry, based on the principle of the 'polluter pays' and exploring how the sugar tax should be extended to include milk-based drinks.

Cross-cutting themes of the paper

- **Focussing on the early years** including modernising the Healthy Child programme and taking action on children's oral health.
- **Closing the 'prevention gap'** and achieving parity of esteem not just for how mental health conditions are treated, but also for how they are prevented.
- **Seeing health as an asset** to invest in throughout life, and not just a problem to fix when it goes wrong.

Key themes of the paper

- **Some of the key areas of focus include:**
  - Delivering on the ambition to be smoke-free by 2030
  - Healthy weight and physical activity, including publishing Chapter 3 of the Childhood Obesity Strategy
  - Launching a mental health prevention package
  - Alcohol, drug-use and sleep
  - Developing a national genomics strategy and leading the 'genomics revolution'
  - Transforming screening and NHS Health Checks
  - Launching a new health index to help track the health of the nation, which will be used to influence and evaluate the impact of government policies alongside other indicators like GDP

Where are the gaps?

- **Partnership working and taking an integrated approach to prevention** does not come through as a strong focus of the paper.
- **Very little focus on the wider determinants of health** and no coherent strategy as to how these will be addressed.
- The Kings Fund stated that the paper could have taken a **bolder approach to using tax and regulation** to improve public health.
- **Overall, there are a number of unanswered questions** particularly around funding for Public Health and social care.

Questions to the Health and Wellbeing Board

- What comments and feedback would board members like to be included in a response?
- What does this paper mean for Rotherham?
- What do board members think of the paper from the perspective of reducing health inequalities?
- Do board members feel that there are any gaps that need resolving?

Next steps

- A response will be developed based on the feedback from the board.
- A draft will be shared with the board via email by **4th October.**
- If there are any additional comments, please contact: rebecca.woolley@rotherham.gov.uk

HEALTH AND WELLBEING STRATEGY: PERFORMANCE SPOTLIGHT	AIM:	Aim 2: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life.
	MEASURE:	Suicide rate (Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population).
	REPORT AUTHOR(S):	Ruth Fletcher-Brown, Public Health Specialist, RMBC

1. Background

1.1 Information taken from the Public Health England Suicide Prevention Profiles and Office of National Statistics (ONS) data.

Suicides are not inevitable. They are often the end point of a complex history of risk factors and distressing events, the prevention of suicide has to address this complexity. This can only be done by working collaboratively across all sectors within Rotherham.

1.2 In England, responsibility for the suicide prevention action plan and strategy usually lies with local government through health and wellbeing boards. Suicide prevention requires a partnership response.

1.3 Rotherham has had an active suicide prevention group which has met since 2013, with action plans to address suicide prevention. Rotherham has developed some excellent joint working between statutory partners and the voluntary sector.

1.4 Suicide Prevention is a high priority in the borough with support from the Chair of the Health and Wellbeing Board. There are strong governance arrangements with links to the Health and Wellbeing Board and the Place Plan Board.

1.5 Rotherham held a symposium in June 2019 as an opportunity for partners working across Rotherham to hear about national research and best practice in relation to suicide prevention. The symposium acted as a self-assessment of the Rotherham Suicide Prevention and Self Harm Action Plan. Following the symposium the action plan was refreshed and will come to the Health and Wellbeing Board for sign off.

Professor Nav Kapur, Head of Research at the Centre for Suicide Prevention at Manchester University and lead for the suicide work programme of the National Confidential Inquiry into Suicide and Safety in Mental Health Services gave the national context/picture for suicide prevention on the themes below:

- People under the care of mental health services.
- Better information/support to those children, young people and adults bereaved or affected by suicide.
- People who self-harm.
- Men and primary care.

1.6 Professor Nav Kapur and colleagues will review Rotherham's action plan to provide assurance and challenge where necessary.

2. Performance

2.1 Information taken from the Public Health England Suicide Prevention Profiles (Rotherham data updated to 2016–2018) and Office of National Statistics (ONS) data.

Suicide rate (Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population).

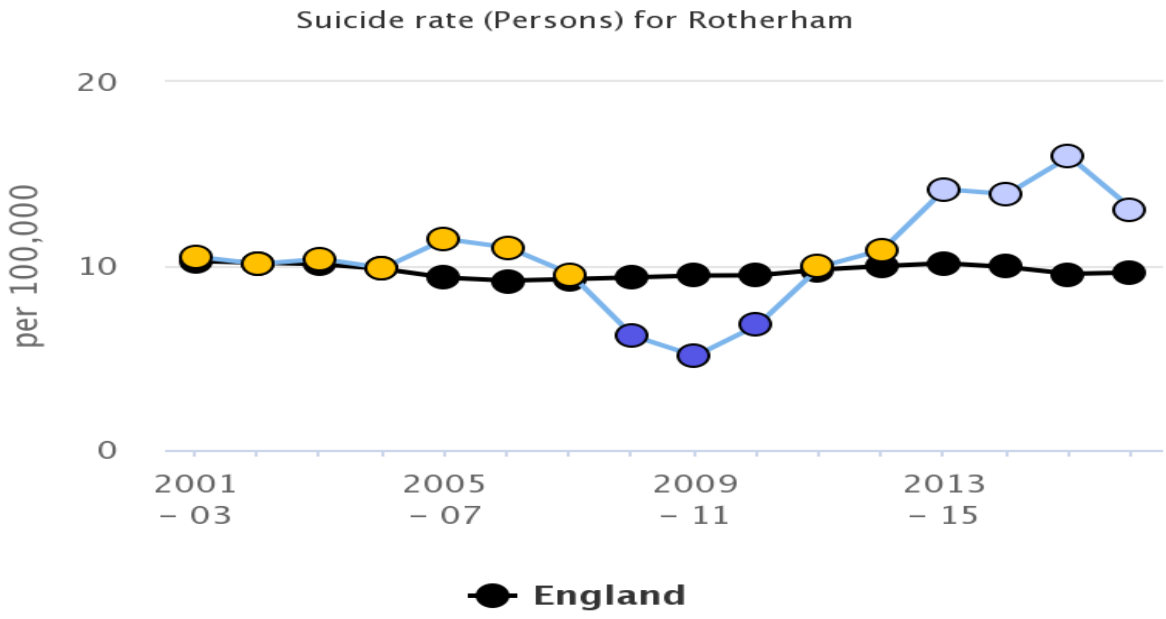
2.2 **OVERALL - ALL PERSONS**

On the 3rd September 2019 the Office of National Statistics published:

1. Suicides in the UK: 2018 registrations
Registered deaths in the UK from suicide analysed by sex, age, area of usual residence of the deceased and suicide method.

2. Quarterly suicide death registrations in England: 2001 to 2018 registrations and 2019 provisional data
Provisional rate and number of suicide deaths registered in England per quarter. Includes 2001 to 2018 registrations and provisional data for 2019 Quarters 1 and 2 (Jan-Mar, April-June).

2.3 ***Rotherham***
After a small decrease between 2013-15 and 2014-16, the 3-year directly age-standardised rate (DSR) increased from 13.9 to 15.9 deaths per 100,000 between 2014-16 and 2015-17. The latest data for 2016 – 2018 shows that this has now dropped to 13.1 deaths per 100,000 a decrease of nearly 18%.



Recent trend:

Period		Rotherham				Yorkshire and the Humber region	England
		Count	Value	Lower CI	Upper CI		
2001 - 03		69	10.5	8.2	13.3	10.0	10.3
2002 - 04		67	10.1	7.8	12.9	10.2	10.2
2003 - 05		69	10.4	8.1	13.2	10.4	10.1
2004 - 06		65	9.9	7.6	12.6	10.2	9.8
2005 - 07		76	11.5	9.0	14.4	9.7	9.4
2006 - 08		74	11.0	8.6	13.8	9.4	9.2
2007 - 09		65	9.6	7.4	12.2	9.4	9.3
2008 - 10		42	6.2	4.5	8.4	9.0	9.4
2009 - 11		34	5.1	3.5	7.1	9.0	9.5
2010 - 12		46	6.8	5.0	9.1	9.6	9.5
2011 - 13		68	10.0	7.7	12.6	10.4	9.8
2012 - 14		74	10.9	8.5	13.7	10.3	10.0
2013 - 15		96	14.2	11.5	17.3	10.7	10.1
2014 - 16		94	13.9	11.2	17.0	10.4	9.9
2015 - 17		107	15.9	13.1	19.3	10.4	9.6
2016 - 18		87	13.1	10.5	16.2	10.7	9.6

Source: Public Health England (based on ONS source data)

Yorkshire and Humber Region

2.4 Yorkshire and the Humber had a statistically higher suicide rate for males in 2018 compared to the overall rate for males in England & Wales – 19.0 deaths per 100,000 males compared to 16.2 (ONS, 2019).
The suicide rate increased from 15.3 in 2017 to 19.0 deaths per 100,000 in 2018 for males in Yorkshire and Humber.
For females, the highest suicide rate in 2018 in England was seen in Yorkshire and the Humber – 5.7 deaths per 100,000 women.

England - All persons suicides

2.5 5,021 suicides were registered in 2018, 570 more than in 2017 when there were 4,451 deaths (12.8% increase). This equates to a statistically significant increase in the suicide rate, with 10.3 deaths per 100,000 persons in 2018 compared to 9.2 deaths per 100,000 in 2017 (ONS, 2019).

The latest England rate represents the first increase since 2014, however, the rate still remains lower than at the beginning of the time series (1981) when there were 14.6 deaths per 100,000 persons.

BY SEX

Rotherham

2.6 The directly age-standardised rate for males in 2016-2018 dropped to 20.3 deaths per 100,000 from 24.0 in 2015-2017.
For females in 2016–2018 the rate has dropped to 6.4 deaths per 100,000 from 8.4 in 2015-2017.

England

2.7	Since the early 1990s males have accounted for around three-quarters of suicide deaths nationally, 76% of the registered deaths in 2018 were among men (3,800 male deaths compared with 1,221 female deaths). The number of male death registrations in 2018 was 14.2% higher than the total in 2017 (3,328 deaths). This equates to a statistically significant increase in the England male suicide rate, with 15.9 deaths per 100,000 males in 2018, compared with 14.0 deaths per 100,000 males in 2017. However, the latest rate remains statistically lower than that observed in 1981 when there were 19.3 deaths per 100,000 males in England.
3. Analysis and implications	
3.1	Suicide rates tend to fluctuate on a year-to-year basis. It is therefore too early to say whether the latest increase nationally represents a change in the recent trend. The factors behind any increase in suicide rates are complex.
3.2	In England and Wales, all deaths caused by suicide are certified by a coroner. In July 2018, the standard of proof used by coroners to determine whether a death was caused by suicide was lowered to the "civil standard" (balance of probabilities) where previously a "criminal standard" was applied (beyond all reasonable doubt).
3.3	It is likely that lowering the standard of proof will result in an increased number of deaths recorded as suicide. The Office for National Statistics will monitor and report the effect of this change when more evidence is available.
3.4	**What's working well** o Joint working between the CCG, RMBC and men's groups to develop the concepts for the suicide prevention campaign, 'Be the One'. Rotherham has secured NHSE Year 2 Suicide Prevention Funding. This will be used to fund: o Promotion of a second round of small grants awards to men's groups who are tackling the risk factors relating to suicide. Current work is taking place to evaluate the impact and outcomes from the first round. o Implementation of the Train the Trainer Self Harm project. The training programme commences at the end of September. o Provision of a listening service for those people bereaved and affected by suicide. o Suicide prevention training for frontline staff and targeted work in areas of higher rates. Rotherham Public Health and Rotherham CCG are working with colleagues across the ICS to look at: o Working with the media in relation to suicide prevention. o Establishing, implementing and evaluating one real time surveillance data system across South Yorkshire. Rotherham Safer Neighbourhood Service (SYP) have been doing this work for years and have been key in sharing good practice across the region. o Supporting those people bereaved and affected by suicide. o Working with Sheffield University to conduct an audit of coroners records to build up a richer narrative about the wider personal, economic and societal factors that contributed to the suicide that could be used to inform the development of future local and ICS level suicide prevention work.

3.5	**What are we worried about?** o Number of women in Rotherham and in the region who take their own lives. Rotherham Public Health has commenced initial conversations with a local university about some research into this area. o Suicide rates whilst dropping in this three year period are still above the national average.
3.6	**What needs to happen next?** o Launch of the 'Be the One' campaign and monitoring of impact. o Health and Wellbeing Board to sign off the Rotherham Suicide Prevention and Self Harm Action Plan. o Implementation, evaluation of NHSE Year 2 funded work. o Discussions with ICS colleagues in relation to any joint commissioning opportunities, for example support for those people bereaved and affected by suicide. o Working with a local university to understand the why women take their own lives and look at what actions can be taken by all partners.
4. Recommendations	
4.1	The Health and Wellbeing Board to receive the refreshed Rotherham Suicide Prevention and Self Harm Action Plan 2019-2021.
4.2	The Health and Wellbeing Board to receive six monthly updates on progress against the action plan and updates on the work funded through the NHS England suicide prevention funds.

Update on the Suicide Prevention and Self Harm action plan

https://www.be-the-one.co.uk/

BRIEFING	**TO:**	Rotherham Health and Wellbeing Board
	DATE:	18th September 2019
	LEAD OFFICER:	Gill Harrison, Public Health Specialist, Adult Social Care, Housing and Public Health
	TITLE:	Sexual Health Strategy for Rotherham (Refresh 2019 – 2021)

1. Background

1.1 The Rotherham Sexual Health Strategy Group is a multi-agency group that promotes good sexual health for all Rotherham residents. The group is made up of representatives from all agencies involved in the delivery of sexual health. It is chaired by the Cabinet Member for Adult Social Care and Health, with coordination and support from the Council's Public Health team.

The Terms of Reference for the group state that representatives should include (but are not limited to):

- Consultant in Public Health
- The Integrated Sexual Health Services, at The Rotherham NHS Foundation Trust (TRFT)
- Rotherham Clinical Commissioning Group (RCCG)
- The Council's Early Help service
- The Council's School Effectiveness Service
- Yorkshire MESMAC
- Rotherham Local Pharmaceutical Committee (LPC)
- Rotherham Local Medical Committee (LMC)
- The Gate Surgery
- Rotherham Children, Young People & Families Consortium
- TRFT Named Nurse (looked after children & care leavers)
- Barnardos
- Healthwatch

1.2 The Sexual Health Strategy for Rotherham was first developed in 2015 with an action plan running through until 2018 when the strategy was due to be refreshed. The strategy was agreed by all parties and endorsed, on behalf of all agencies, by the Health and Wellbeing Board. The group recently refreshed the strategy and agreed an action plan for the first calendar year. An Equality Analysis has been carried out.

1.3 The strategy sets out the priorities for the next three years for improving sexual health outcomes for the local population. This document provides a framework for planning and delivering commissioned services and interventions (within existing resources) aimed at improving sexual health outcomes across the life course.

1.4 The strategy has been scrutinised by Rotherham Health Select Commission (June 2019) and comments relating to suggested actions will be taken to the strategy group.

1.5 The group is always open to comments and suggestions that help progress its actions in the most effective way.

2. Key Issues

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

2.2 Poor sexual health is disproportionately experienced by some of the most vulnerable members of our local communities, including young people, men who have sex with men (MSM), people from countries of high HIV prevalence, especially Black Africans, those who misuse drugs and/or alcohol and people from our most deprived neighbourhoods (Public Health England). For this reason measures should be put in place to reduce sexual health inequalities whilst improving the sexual health of all the people of Rotherham.

2.3 Good sexual health includes having the skills and expectations to enjoy loving and age appropriate relationships. Child sexual exploitation (CSE) and abuse impedes the development of such skills and distorts such expectations, and leads to increased risk of sexually transmitted infections (STIs), unwanted pregnancy, and domestic abuse. The negative impacts upon educational attainment, health behaviours and mental health are also well evidenced (Public Health England).

2.4 The strategy aims to address the sexual health needs reflected by the Public Health England (PHE) sexual and reproductive health epidemiology report, 2017 which highlights areas of concern. The following are identified as concerns to identify actions for 2019 – 2021:

- Sexually Transmitted Infection (STI) diagnosis in young people
- Sexual health within vulnerable groups
- Under 18 conception rate
- Pelvic inflammatory disease (PID) admission rate
- Abortions under 10 weeks

2.5 The refreshed strategy also reflects concerns expressed in the Rotherham Voice of the Child Lifestyle Survey 2018. According to the survey the numbers of those sexually active young people (aged 14/15 years) who said that they did not use any contraception has increased from 27.5% in 2017 to 29.1% in 2018. Furthermore the numbers of young people (aged 14/15 years) reporting that they had had sex after drinking alcohol and/or taking drugs showed a significant increase since the 2017 survey.

3. Key Actions and Timelines

3.1 The Strategy Group has produced a refreshed Sexual Health Strategy for Rotherham, 2019 – 2021.

3.2 The Strategy Group has developed an action plan for 2019 which will be updated on a regular basis. The Group will develop further action plans for 2020 and 2021.

4. Recommendations

4.1 That the Health and Wellbeing Board note and endorse the refreshed Sexual Health Strategy and the associated action plan.

Sexual Health Strategy for Rotherham

(Refresh 2019 – 2021)

The Rotherham Sexual Health Strategy Group (a multi-agency group aiming to promote good sexual health for all Rotherham residents.)

The Sexual Health Strategy Group

The Rotherham Sexual Health Strategy Group is made up of representatives from all agencies involved in the delivery of sexual health work plus supporting officers from Public Health and chaired by the Cabinet Member for Adult Social Care and Health.

The Terms of Reference for the group state that representatives should include (but are not limited to):

- Consultant in Public Health
- The Integrated Sexual Health Services (TRFT)
- RCCG
- RMBC Early Help
- RMBC School Effectiveness Service
- Mesmac
- Rotherham LPC
- Rotherham LMC
- The Gate Surgery
- Rotherham Children, Young People & Families Consortium
- TRFT Named Nurse (looked after children & care leavers)
- Barnardos
- Healthwatch

Contents:

Sexual Health Strategy for Rotherham 2019 – 2021

Purpose and key aims

This strategy gives an overview of the Sexual Health Strategy Group's priorities for supporting improved sexual health outcomes for the local population's health and wellbeing over the next three years.

A challenging public funding landscape means it is vital to identify clear priorities that focus on reducing sexual health inequalities and provide an accessible service to all who need it.

The ambition of the strategy is to:

- Improve sexual health
- Improve reproductive health
- Focus on vulnerable groups
- Build on successful service planning and commissioning

To achieve this, this document provides a framework to guide the planning and delivery of commissioned services and public health interventions aimed at improving sexual health outcomes across the life course.

Introduction

Sexual health as part of wellbeing

The World Health Organisation (2004) defines Sexual Health as: 'a state of physical, mental and social wellbeing in relation to sexuality: it is not merely the absence of disease, dysfunction or infirmity'. The National Strategy for Sexual Health and HIV (2001) regards sexual health as a key part of our identity as human beings. Good sexual health is an important part of physical and mental health and wellbeing; the consequences of poor sexual health can impact considerably on individuals and communities.

Inequalities in sexual health

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

Relationships and education
Good sexual health includes developing skills and expectations to enjoy loving and age appropriate relationships. Child sexual exploitation (CSE) and abuse damages this development, and leads to increased risk of sexually transmitted infections (STIs), unwanted pregnancy, and of domestic violence and abuse in the future. The negative impacts upon educational attainment, health risk behaviours and mental health problems are also well evidenced.

CSE is everyone's responsibility
The Health Working Group Report on Child Sexual Exploitation, January 2014, states that all those concerned with improving the health and welfare of their local population have a responsibility to tackle child sexual abuse.

A duty to protect public health
The Health and Social Care Act (2012) places the overall responsibility for Infection Prevention and Control with the Director Public Health. The legislation enables and requires the Local Authority to intervene and take action to protect the health of the population. Protecting the public from infection relies on maintaining rates of testing and early treatment to prevent spread.

The responsibility of the Local Authority includes prevention, surveillance, planning and response to local incidents and outbreaks.

The Director of Public Health is responsible for ensuring that there are effective arrangements in place for preparing, planning and responding to health protection concerns, including those in relation to the sexual health of the local population.

Effective, relevant and responsive services
It is important that emerging needs and changes in populations and lifestyles are assessed and responded to in a timely and relevant way, to protect population health. It is also important that service models deliver the best outcomes for individuals and the wider population. This involves challenging ourselves to ensure that delivery is the most effective, relevant and responsive to challenging contexts.

The principles align with the government's criteria for improved sexual health in 'A Framework for Sexual Health Improvement in England' (2013):

- Prevention is prioritised: evidence-based interventions that motivate people to alter their behaviour are commissioned.
- Leadership and joined up working: commissioners and key local partners work closely together to ensure that sexual health services are of a high quality and are not fragmented.
- Focus on outcomes: challenging outcome measures are produced, used to develop plans and monitored over time.

- Wider determinants of sexual health are addressed: links are made with other key determinants of health (e.g. alcohol and drug misuse, mental health) in order to tackle them in a joined up way.
- Commissioning of high-quality services: services are commissioned from high quality providers with appropriately trained staff and are offered in a range of settings, with robust care pathways to ensure a seamless service. Patient feedback is used to ensure that service meets needs.
- The needs of more vulnerable groups are met: services are able to meet the needs of groups who may be vulnerable and at risk from poor sexual health.

Measuring sexual and reproductive health
The importance of improving sexual health is acknowledged by the inclusion of three key indicators in the Public Health Outcomes Framework (PHOF):

- under 18 conceptions;
- chlamydia detection (15-24 year olds);
- presentation with HIV at a late stage of infection.

The outcome indicators have been included to give an overall picture of the level of sexually transmitted infection (STI), unprotected sexual activity and general sexual health within a population. The Framework for Sexual Health Improvement in England (2013) acknowledges that effective collaborative commissioning of interventions and services is key to improving outcomes.

A system approach
The lead responsibility for the commissioning of sexual health services and interventions rests with the Local Authority (since 2013). In addition, Rotherham Clinical Commissioning Group (CCG) and NHS England commission certain sexual health services. It is vital that all commissioning organisations work closely together to ensure that services and interventions are comprehensive, high quality, seamless and offer value for money.

Under these commissioning arrangements Rotherham Metropolitan Borough Council (RMBC) has been mandated to ensure that their local populations receive effective provision of contraception and open access to sexual health services. Furthermore, they are also mandated to ensure that there are plans in place to protect the health of the population, for example, in relation to STI outbreaks.

Sexual health needs analysis

Sexually transmitted infections

In the 2017 Local Authority Sexual Health epidemiology report produced by Public Health England (PHE), Rotherham was ranked 179th out of 326 local authorities in England (first in the rank has highest rates) for rates of new STIs. A total of 1524 new STIs were diagnosed in residents of Rotherham, a rate of 581.4 per 100,000 residents (compared to 743 per 100,000 in England). 58% of diagnoses of new STIs in Rotherham were in young people aged 15-24 years (compared to 50% on average nationally).

Rotherham has significantly improved in relation to STI diagnosis since 2013 when we were the 60th highest local authority in England with a rate of 951.4 per 100,000 residents.

Rotherham has also shown significant improvement in the rates of gonorrhea, which is a marker of high levels of risky sexual activity, with rates falling from 51.9 per 100,000 in 2013 to 33.6 per 100,000 in 2017.

The rate of chlamydia detection per 100,000 young people aged 15-24 years in Rotherham was 2,010 (compared to 1,882 per 100,000 in England).

The high rates for chlamydia detection indicates *good* performance, as it means the services are strong on finding and treating chlamydial infection; and this will, in time, lead to lower levels of infection circulating in the population. There are relatively low rates of syphilis and gonorrhea in Rotherham. These two are seen as markers of more ‘severe’ infection and give us a good indication of the overall health protection risk in the population. The rate of HIV is relatively low in Rotherham; which is not a “high incidence area” for HIV. The pattern seen in Rotherham is more of a young, sexually active population and a relatively controlled level of more serious infection, but there is a need to ensure that this control is maintained.

STI reinfection rates

Reinfection with an STI is a marker of persistent risky behaviour. In Rotherham, an estimated 5.3% of women and 5.3% of men presenting with a new STI at a Genitourinary medicine (GUM) clinic during the five year period from 2013 to 2017 became reinfected with a new STI within twelve months. This is significantly lower than national reinfection rates. Nationally, during the same period, an estimated 7.0% of women and 9.4% of men presenting with a new STI at a GUM clinic became reinfected with a new STI within twelve months.

Reinfection specifically with gonorrhea is also comparatively low. Locally and nationally, men are twice as likely to be reinfected compared to women. In Rotherham, an estimated 1.7% of women and 4.6% of men diagnosed with gonorrhoea at a GUM clinic between 2013 and 2017 became reinfected with

gonorrhoea within twelve months. Nationally, an estimated 3.7% of women and 11.1% of men became reinfected with gonorrhoea within twelve months.

Chlamydia

Chlamydia is an important cause of infertility, pelvic infection in women and testicular inflammation in men, and increases the risk of acquiring other sexually transmitted infections.

Chlamydia is the most common STI among Rotherham residents in 2017. The measure that is currently used to assess chlamydia is the rate of detection of disease. It may seem counterintuitive, but there is a need to keep the detection rate of chlamydia in Rotherham high. This is because there is a high background rate in the community, and having a high detection rate suggests it is being identified effectively and treated. Since chlamydia is most often asymptomatic, a high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. The detection rate in Rotherham indicates that there is an effective detection programme in place, but that there is a considerable level of unprotected sexual activity and, thus, high levels of the infection circulating, within the targeted population of young people aged between 15 and 24 years of age.

The initial target, for effective detection, is 2,400 positive tests per 100,000 eligible population. The 2017 detection rate for chlamydia in Rotherham is 2,010 cases per 100,000, which is below the Public Health Outcomes Framework recommendation but higher than the rate in England (1,882 per 100,000). The relatively high percentage of positive tests shows that testing in Rotherham is being effectively targeted towards the populations most at risk. However, as testing is currently predominantly from the core Integrated Sexual Health Services and Primary Care, There is a need to continue to ensure that access to testing is adequate for *all* young people, especially the more vulnerable, who may be less likely to access such services.

Distribution of new STIs and deprivation

Socio-economic deprivation is a known determinant of poor health outcomes; data from Genito Urinary Medicine (GUM) services show a strong positive correlation between rates of new STIs and the Index of Multiple Deprivation across England. The relationship between STIs and socio-economic deprivation is probably influenced by a range of factors such as the provision of and access to sexual health services, education, health awareness and sexual behaviour.

HIV

HIV is now considered to be a chronic disease which can be effectively managed. Crucially the earlier the diagnosis is made the more effective the treatment regime, and the more likely transmission to an uninfected person is prevented. Overall

numbers of those living with HIV is low in Rotherham (the diagnosed HIV prevalence being 1.2 per 1,000 population aged 15-59 years compared to 2.3 per 1,000 in England). There has also been an improvement in the number who present late with the infection. Between 2015 and 2017, 48.4% of HIV diagnoses in Rotherham were made at a late stage of infection (defined as CD4 count <350 cells/mm³ within 3 months of diagnosis) which is classified as 'amber' by PHE. Late diagnosis has implications for success and cost of treatment and onward transmission of the disease and is a critical component of the Public Health Outcomes Framework.

Abortion

The total abortion rate, access to NHS funded abortions at less than 10 weeks gestation, and under and over 25 years repeat abortion rates are indicators of lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method and, potentially, poor access to termination services. Unplanned pregnancies can end in abortion or a maternity. Many unplanned pregnancies that continue will become wanted. However, unplanned pregnancy can cause financial, housing and relationship pressures and have impacts on existing children.

In 2017, in Rotherham the total abortion rate per 1,000 female population aged 15-44 years was 13.4, while in England the rate was 17.2. This metric gives an indication of accessibility to services.

Among NHS funded abortions in Rotherham, the proportion of those under 10 weeks gestation was 71.5%, while in England the proportion was 76.6%. The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality and increases choices around procedure. There is considerable room for improvement in earlier access to terminations.

Rotherham does perform relatively well in terms of repeat termination rates. In 2017, among women under 25 years who had an abortion in Rotherham, the proportion of those who had had a previous abortion was 21.2%, while in England the proportion was 26.7%. It is recognized, however, that there are a group of women who have experienced, or are at risk of, repeated pregnancies that result in children needing to be removed from their care.

The Rotherham Pause project, working through an intense, relationship-based programme, aims to give women the chance to pause and take control of their lives. It seeks to work with women in a way which addresses everybody in their lives including service providers to work towards a more positive future.

Teenage pregnancy

Continuing to reduce under 18 pregnancies is a priority as highlighted by the inclusion of this as an indicator in the Public Outcomes Framework.

Teenage pregnancy in Rotherham has fallen over the past few years due, in part, to increasing take up of Long Acting Reversible Contraception (LARC) and a range of community interventions. Rotherham's under 18 conception rate in 2017 fell to 22.1 per 1,000 females aged 15 -17 years. Between 1998 and 2017 Rotherham has achieved a 60.0% reduction in the under 18 conception rate. However, while there has been an impressive reduction in rates Rotherham still has rates higher than Yorkshire and Humber (20.6 per 1,000) and England (17.8 per 1,000). There is a good uptake of LARC in Rotherham and although there is a higher percentage of under 25 year olds choosing LARC (29.9%) than England (20.6%) there is room for improvement.

In Rotherham (as with the rest of the country) there is a clear relationship between conception rate and deprivation and interventions have been targeted to work with deprived young people to address risk taking behaviour and to raise self-esteem and aspiration.

A life course approach

In order for people to stay healthy, know how to protect their sexual health and how to access appropriate services and interventions when they need them, everyone needs age appropriate education, information and support.

For all young people it is important that they receive high quality education about sex and relationships. Focusing especially on our young people is crucial, as early established behaviour patterns can affect health throughout life. There is a need to prioritise prevention for our young people aged 16 to 19 years, who tend to have significantly higher rates of poor sexual health than older people, it is important that all young people:

- know how to ask for help and are able to access confidential advice and support about wellbeing, relationships and sexual health;
- have the confidence and emotional resilience to understand the benefits of loving, healthy relationships and delaying sex;
- understand consent and issues around abusive relationships;
- make informed and responsible decisions, understand issues around consent and the benefits of stable relationships and are aware of the risks of unprotected sex;

- have rapid and easy access to appropriate services
- whatever their sexuality, have their sexual health needs met.

For all adults there is a need to have access to high quality services and information. Older residents need to remain healthy as they age. It is important that:

- all Rotherham residents understand the range of choices of contraception and where to obtain them;
- people with additional needs are identified and appropriately supported;
- all Rotherham residents have information and support to access testing and early diagnosis to prevent the transmission of HIV and STIs;
- people of all ages understand the risks of unprotected sex and how they can protect themselves;
- older people with diagnosed HIV are able to access any health and social care services they need;
- people with other physical problems that may affect their sexual health are able to access the support they need.

For all residents, regardless of age, there is a need for the services provided to meet their needs and take their views into account.

Safeguarding

It is important that all service providers are aware of child protection and safeguarding issues and the possibility of abuse and/or exploitation and work collaboratively to protect all children under 18 years of age. Sexual health services have a particular role to play in identifying risk and managing the impact of sexual abuse and or exploitation and, by working together with others and sharing intelligence, contributing to the protection of vulnerable young people and the pursuit and prosecution of perpetrators.

The Sexual Offences Act 2003 provides that the age of consent is 16 and that sexual activity involving children under 16 is unlawful. The age of consent also reflects the fact that children aged under 16 are particularly vulnerable to exploitation and abuse.

It is known that young people under 16 in Rotherham are sexually active (Rotherham Voice of the Child Lifestyle Survey 2018) and, worryingly, the numbers reporting that they had had sex after drinking alcohol and/or taking drugs has increased significantly from 2017.

It is important, therefore, that any young person under 16 who is sexually active should have confidence to attend sexual health services and have early access to professional advice, support and treatment.

Health improvement

Sexual health promotion and prevention aims to help people to make informed and responsible choices in their lives. Effective sexual health promotion programmes can help to address the prejudice, stigma and discrimination that can be linked to sexual ill health. Such programmes can help to tackle the factors that can influence sexual health outcomes.

Prevention is key to good sexual health and there are some issues where additional focus is needed to improve outcomes.

In the prevention of unwanted teenage pregnancies (under 18 years) there is strong evidence to suggest that high quality education about relationships and sex and access to, and correct use of, effective contraception is key. In Rotherham there is a clear relationship between teenage conception rate and deprivation and interventions have been targeted to work with young people from the most deprived areas to address risk and raise self-esteem and aspiration.

Increased use of the highly effective LARC methods to prevent unwanted pregnancy could potentially lead to a perception that a condom is unnecessary. The best way for sexually active people of any age to avoid an STI is to use a condom when they have sex. Promotion of, and access to, all methods of contraception is important.

The most vulnerable young people often lead chaotic lifestyles, are often found in the care system and/or have special educational needs. Interventions need to be targeted effectively.

Health protection

The Health and Social Care Act (2012) places the overall responsibility for Infection Prevention and Control with the Director Public Health. The legislation enables and requires the Local Authority to intervene and take action to protect the health of the population. Protecting the public from infection relies on maintaining rates of testing and early treatment to prevent spread.

The responsibility of the Local Authority includes prevention, surveillance, planning and response to local incidents and outbreaks.

RMBC and all partners support preventive actions to protect the health of the population and all sexual health incidents and outbreaks are dealt with effectively at the most appropriate level.

There are local plans and capacity to monitor and manage acute incidents to help prevent the transmission of sexually transmitted infections and to foster improvements in sexual health.

Improving outcomes through effective commissioning

Evidence demonstrates that spending on sexual health interventions and services is cost effective and has a marked effect on other healthcare costs. Preventing unwanted pregnancies and reducing levels of sexual ill health in the population also impacts on social care budgets, benefits, housing and the overall economy of Rotherham. Good sexual health has a clear role to play in improving health and reducing health inequalities.

The commissioning arrangements for sexual health services have been in force since 1st April 2013. RMBC is mandated to commission for comprehensive sexual health services which includes contraception, STI testing and treatment, Chlamydia screening as part of the screening programme and HIV testing. Rotherham CCG commissions abortion services, sterilisation, psychosexual counselling and Gynaecology (including any use of contraception for non-contraceptive purposes). The third commissioner of Rotherham's sexual health services is NHS England which is responsible for commissioning HIV treatment and care and the Sexual Assault Referral Centre (SARC). It is vital for commissioners to work closely together to ensure that the care and treatment the people of Rotherham receive is of high quality and is not fragmented.

A key principle of sexual health services is that they are open access, confidential and free of charge for the user. There are strong public health reasons why this should continue.

Priorities 2019 – 2021

This document provides a framework to guide our planning and delivery of commissioned services and public health interventions aimed at improving sexual health outcomes across the life course.

The strategy aims to address the sexual health needs reflected by the PHE sexual and reproductive health epidemiology report, 2017 which highlights areas of concern. Actions should therefore be identified to address the following concerns during 2019-2021:

Abortions under 10 weeks (%)

The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality and increases choices around procedure.

Among NHS funded abortions in Rotherham, the proportion of those under 10 weeks gestation was 71.5%, while in England the proportion was 76.6%. Whilst this shows an improvement from 2016 when the rate was 69.7% there is still room for improvement.

Under 18 conception rate

In March 2017, an amendment via the Children and Social Work Act (2017) is leading to the introduction of compulsory relationships education in primary schools and compulsory relationships and sex education in secondary schools from September 2020. All agencies should now work together to provide support for this initiative which must be high quality, evidence based and best practice.

Although teenage pregnancies have fallen dramatically in Rotherham there is still a relatively high rate of 22.1 per 1,000 females aged 15-17, compared to the rate of 17.8 in England and 20.6 in Yorkshire and Humber. There is a good uptake of LARC across Rotherham but this could be improved in those women under 25.

The percentage of under 18 conceptions leading to abortion is also far lower in Rotherham (35.5%) than in England (51.8%) and in Yorkshire and Humber (44.3%).

According to the Rotherham Voice of the Child Lifestyle Survey 2018, the numbers of those sexually active young people (aged 14/15 years) who said that they did not use any contraception has increased from 27.5% in 2017 to 29.1% in 2018.

Pelvic inflammatory disease (PID) admission rate/100,000

Rotherham has a much higher rate of admission for PID at 542.8 per 100,000 than in England (242.4 per 100,000) and in Yorkshire and Humber (264.7 per 100,000).

PID can be a complication of some STIs, especially chlamydia which is the most common STI among Rotherham residents in 2016. The 2016 detection rate for chlamydia in Rotherham is 2,033 cases per 100,000, which is below the Public Health Outcomes Framework recommendation but our relatively high percentage of positive tests shows that testing in Rotherham is being effectively targeted towards the populations most at risk. However, testing is currently predominantly from the core Integrated Sexual Health Services and may not being access by the more vulnerable residents.

STI diagnoses in young people

58% of diagnoses of new STIs in Rotherham in 2017 were in young people aged 15-24 years compared to 50% in England. It is crucial that services, health promotion and prevention initiatives prioritise young people.

Correct and consistent condom use remains an extremely effective way to prevent STI transmission and schemes to promote distribution and use should be encouraged. According to the Rotherham Voice of the Child Lifestyle Survey 2018, the numbers of young people (aged 14/15 years) reporting that they had had sex after drinking alcohol and/or taking drugs showed a significant increase since the 2017 survey. The implied risk taking behaviour needs to be taken into account when developing schemes to increased use of condoms.

Young people are also more likely to become re-infected with STIs. In Rotherham, more young men (aged 15 -19 years) became re-infected with an STI within 12 months than young women over a five year period but overall, in 2017, more young women than men were diagnosed with a new STI. Teenagers may be at increased risk of re-infection because they lack the skills and confidence to negotiate safer sex.

Sexual health within vulnerable groups

Whilst prevention, diagnosis, treatment and care needs to be delivered to the general population there should also be a focus on groups and individuals with greater sexual health needs such as young people, black ethnic minorities and MSM.

Prevention programmes are also required for populations known to be at risk of exclusion from routine contraception, pregnancy testing and abortion provision. These include teenagers, the homeless, asylum seekers and refugees, those with learning difficulties, those involved in the criminal justice system, victims of sexual violence and those suffering from domestic abuse or from alcohol and drug problems.

Implementation and monitoring

The strategy highlights the vision, ambitions and priorities for sexual and reproductive health for the people of Rotherham.

It will be implemented by an action plan managed via the Rotherham Sexual Health Strategy Group. An annual action plan will be agreed by the group, but will be kept constantly under review. The Group meets on a quarterly basis to review actions and emerging priorities.

Sexual Health Strategy for Rotherham 2019 Action Plan

Priorities	Agreed Actions	Progress – up to December 2019	Lead/responsibilities
STI diagnoses in young people Using the Rotherham Voice of Child Lifestyle Survey 2018 to identify concerns in relation to risk taking behaviours	Presentation / discussion to be brought to the Sexual Health Strategy Group meeting	Presentation/discussion at meeting January 2019 Areas of concern highlighted / discussed: • Young people not using condoms • Rise in risk taking behaviour in general • Young people are more likely to become re-infected within 12 months • Young people getting advice from friends	**RMBC Public Health** All members of Strategy Group
	An operational group to be established to establish: a) what work is going on with young people now b) what the gaps are c) the sharing of good practice		**RMBC Public Health**
Addressing the need to promote	Promote and expand the		**TRFT ISHS**

condom use	Rotherham condom distribution scheme, including assessing the feasibility of the scheme being used by: • pharmacies • Early Help colleagues • College staff Promote condom use by using national campaign materials including those produced for Sexual Health Week (June 2019) and World AIDS Day (December 2019)		RMBC Early Help Pharmacies Barnados Colleges **Yorkshire Mesmac** All
Sexual health within vulnerable groups Addressing the need for MSM to be aware of the benefits of HPV vaccine Ensuring that young people can: a) access services for contraception b) understand how the products worked/what was best for them Ensuring that adults with learning difficulties can: a) access services for contraception b) understand how the products	All Rotherham MSM aged 45 and under to have access to HPV vaccine Carry out consultation with young people across Rotherham Produce recommendations for improving access and communication in product use Carry out consultation with adults with learning difficulties across Rotherham Produce recommendations for	From January 2019 Yorkshire Mesmac are signposting all Rotherham MSM aged 35 and under to the ISHS	**ISHS** Yorkshire Mesmac **RMBC Early Help** TRFT ISHS Barnados RMBC/RDASH

worked/what was best for them	improving access and communication in product use		
Under 18 conception rate Ensuring that young people are supported to make informed choices in relation to their sexual health Ensuring that young people have access to contraception	Support local schools to develop good, evidence based sexual health and relationship education by: • providing resources • training Work with young men to: • encourage healthy relationships • use condoms Review the provision of LARC in both the ISHS and in General Practice (map provision for under 18s) Increase provision of LARC for under 18s		**RMBC School Effectiveness** ISHS Barnados **RMBC Early Help** Barnados **TRFT ISHS** RMBC Public Health

PID admission rate/100,000 Ensuring that chlamydia prevalence / detection and treatment is continued and that reinfection is targeted	Reinfection rate of chlamydia to be investigated The feasibility of chlamydia screening to be expanded to the following to be looked into: • RMBC Early Help • Pharmacies • College staff	Work being carried out April 2019	**TRFT ISHS** **TRFT ISHS** RMBC Early Help Pharmacy College Staff
Abortions under 10 weeks (%) Ensuring that women are able to access services in a timely fashion Understanding the barriers to access	Undertake a mapping exercise in relation to women accessing the services now Carry out consultation in relation to any barriers to women accessing the services and make recommendations		**RMBC Public Health** BPAS TRFT

Sexual Health Strategy
for
Rotherham
(Refresh 2019 – 2021)

The World Health Organisation (2004) defined Sexual Health as: ‘a state of physical, mental and social wellbeing in relation to sexuality: it is not merely the absence of disease, dysfunction or infirmity’.

Sexual health includes access to sexually transmitted infection (STI) testing and treatment, contraception and includes healthy, safe relationships, consent and resilience.

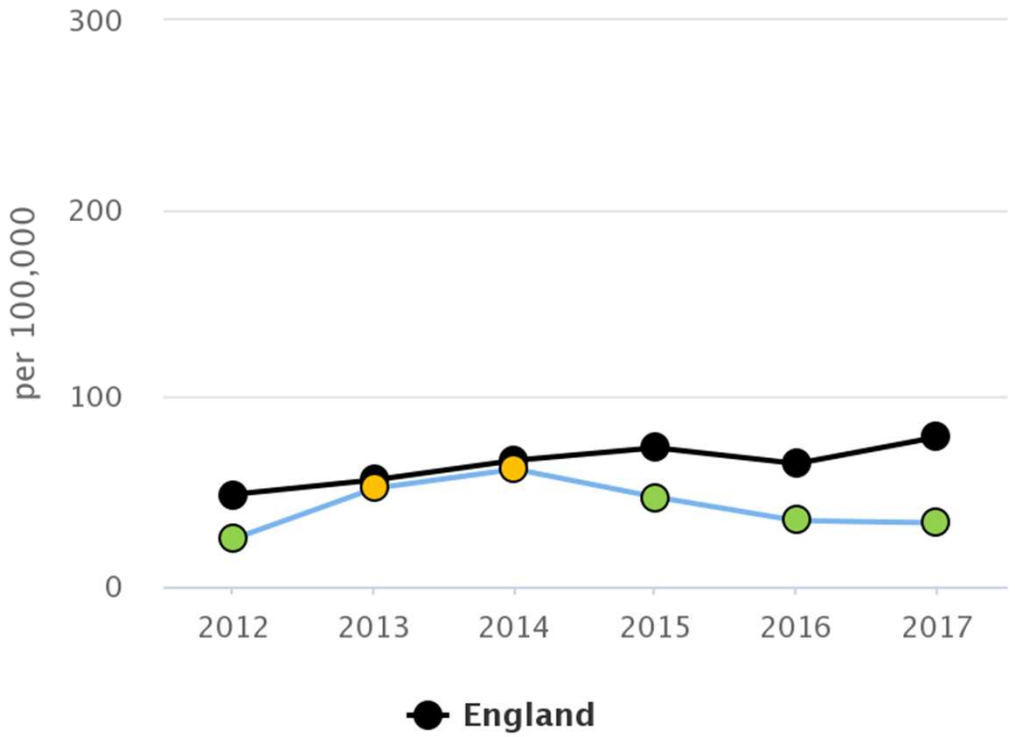
Strategic Ambitions

- Improving sexual health
- Improving reproductive health
- Focusing on vulnerable groups
- Building on successful service planning and commissioning

Improving Sexual Health

- STI diagnosis of 581.4 per 100,000 (compared to 743 per 100,000 in England)
- 58% of diagnoses of new STIs were in young people aged 15-24 (compared to 50% in England)
- Rate of chlamydia detection per 100,000 young people aged 15-24 was 2,010 (compared to 1,882 per 100,000 in England)

Rates of gonorrhea (2013-2017)



Priorities

- STI diagnoses in young people:

  58% of diagnoses in Rotherham in 2017 in young people aged 15-24.

  Young people are also more likely to become re-infected with STIs.

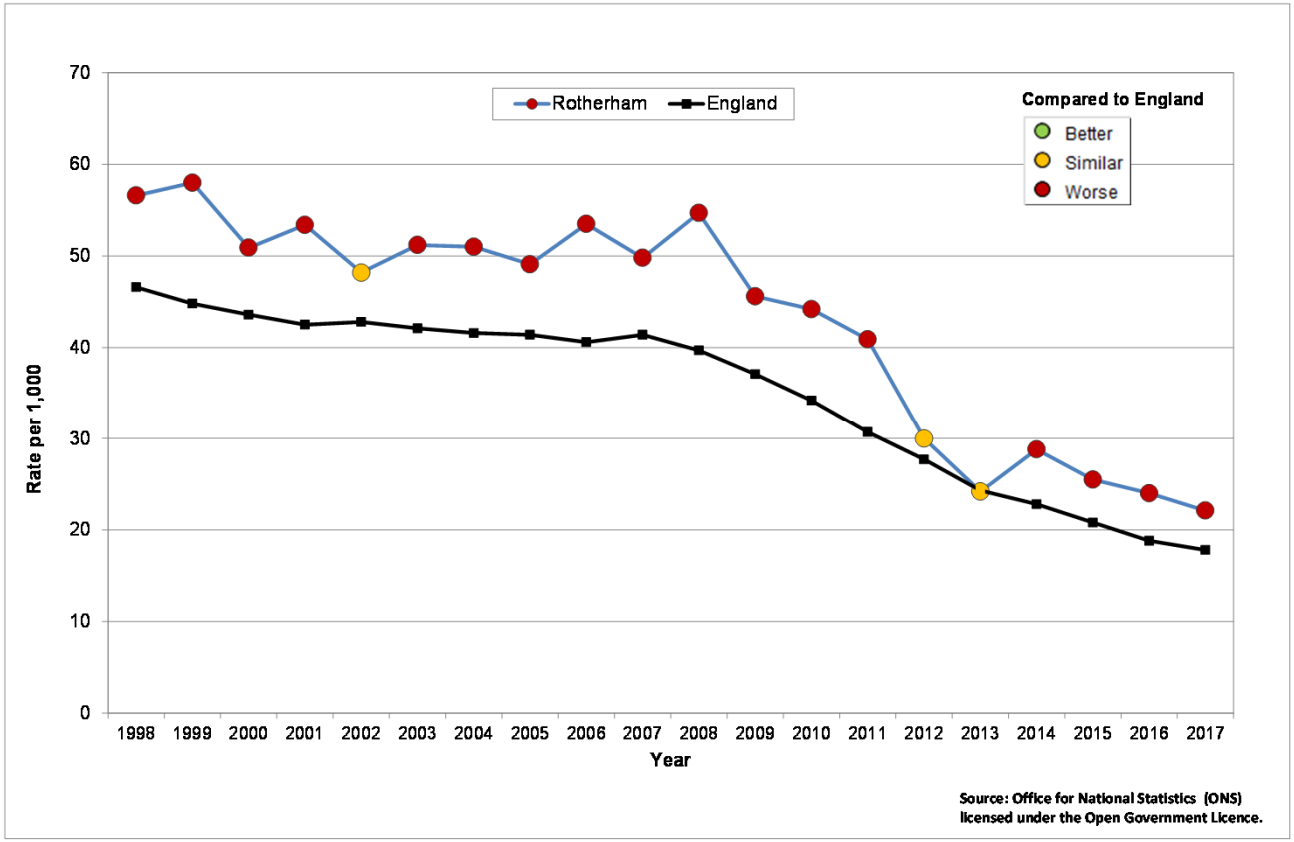
- Pelvic Inflammatory Disease (PID) admissions:

  PID admission rate in Rotherham, at 542.8 per 100,000, is much higher than the rate in England (242.4 per 100,000) and Yorkshire and Humber (264.7 per 100,000).

  PID can be a complication of some STIs especially chlamydia so screening and treatment of this infection is a priority.

Improving Reproductive Health

Under 18 Conceptions by Year (rate per 1,000 females aged 15-17) Rotherham compared to England 1998 – 2017



Priorities

- Under 18 conception rate:

  Rotherham has a relatively high rate of 24.0 per 1,000 females aged 15-17 compared to the rate of 18.8 in England and 22.0 in Yorkshire and Humber.

- Access to contraception:

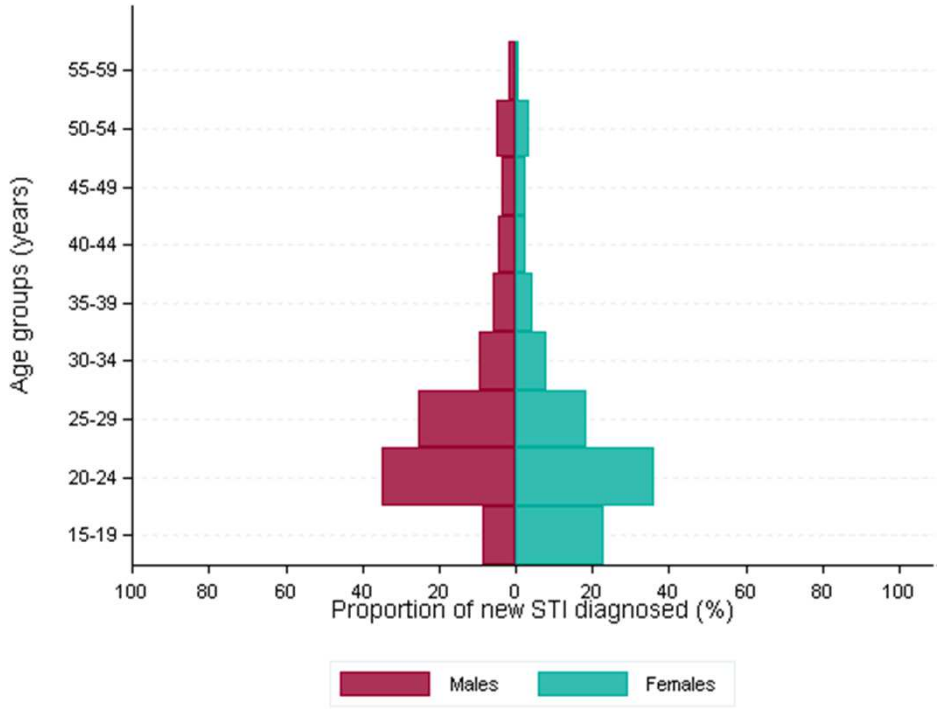
  There is good uptake of LARC in Rotherham but this could be improved in those women under 25

- Timely access to abortion services:

  Among NHS funded abortions in Rotherham, the proportion of those under 10 weeks gestation was 71.5%, while in England the proportion was 76.6%. Whilst this shows an improvement from 2016 when the rate was 69.7% there is still room for improvement.

Focusing on Vulnerable Groups

Certain population groups are more affected by poor sexual health than others, young people, for example:



Priorities

- 58% of diagnoses of new STIs in Rotherham in 2017 were in young people aged 15-24 years compared to 50% in England. Services, health promotion and prevention initiatives to prioritise young people.

- Prevention, diagnosis, treatment and care needs to be delivered to the general population as well as having a focus on groups and individuals with greater sexual health needs such as young people under 25, vulnerable adults such as those with ,learning difficulties, MSM, black and ethnic minority groups and people living in areas of high deprivation

Building on Successful Service Planning and Commissioning

The Rotherham NHS
NHS Foundation Trust

Yorkshire MESMAC

bpas
British Pregnancy Advisory Service

Priorities

- Ensure provision of integrated services that are evidence based, value for money, informed by sexual health needs

- Build on the success of the commissioned services and look to promote access and understand any barriers preventing access

Key Indicators for Success

- Increased chlamydia detection rate
- Reduction in number of people presenting with HIV at a late stage
- Maintenance of continued year on year reduction in teenage unplanned pregnancy rates
- Reduction in levels of STIs
- Reduction in onward transmission of STIs
- Reduction in repeat abortions
- Increased access to contraception

Implementation and Monitoring – the action plan

The strategy highlights the vision, ambitions and priorities for sexual and reproductive health for the people of Rotherham.

It will be implemented by an action plan managed via the multi agency Rotherham Sexual Health Strategy Group.

Health and Wellbeing Board Annual Report, 2018/19

A healthier Rotherham by 2025

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Foreword

Welcome to the first annual report from Rotherham Health and Wellbeing Board. This is an opportunity to showcase some examples of the excellent work that partners have undertaken to deliver on the Joint Health and Wellbeing Strategy, and I am happy to say that this is just a small portion of the progress we have made as a partnership. The report also sets out our challenges and priorities, which will shape the focus of the Health and Wellbeing Board over the next two years. This will include having a much stronger focus on the wider determinants of health and wellbeing, including loneliness, transport, skills and employment, culture, community safety and housing.

I am incredibly proud of the strength of our partnership working and the way that this has progressed in recent years. All partners show total commitment to the delivery of the strategy, and this has led to the board being featured once again as an exemplar on the LGA website and as part of their publication 'What a difference a place makes: the growing impact of health and wellbeing boards.'

As a board, we are committed to the vision of 'A healthier Rotherham by 2025.' Unfortunately, as outlined in the Health and Wellbeing Strategy, we know that too many people in Rotherham live for long periods in ill health and that significant differences persist between our most and least deprived communities. Additionally, all partners continue to face pressures as a result of long-term austerity.

It is therefore vital that we continue to work effectively together as a partnership, making best use of our combined resources to ensure that we make the biggest impact on outcomes. Whilst we face big challenges, I am confident that our strong and constructive partnership approach will enable us to make a meaningful and long-lasting impact on the health and wellbeing of Rotherham people.

Councillor David Roche
Cabinet Member for Adult Social Care and Health
Chair of the Health and Wellbeing Board

The Health and Wellbeing Board

Rotherham Health and Wellbeing Board brings together local leaders and decision-makers to work to improve the health and wellbeing of Rotherham people, reduce health inequalities and promote the integration of services.

Organisations represented on the board include:

- Rotherham Metropolitan Borough Council
- Rotherham Clinical Commissioning Group (CCG)
- The Rotherham NHS Foundation Trust
- Rotherham, Doncaster and South Humber NHS Foundation Trust
- Voluntary Action Rotherham
- Healthwatch Rotherham
- South Yorkshire Police
- South Yorkshire Fire and Rescue
- NHS England

The board has a number of specific responsibilities, including producing a local JSNA, overseeing the delivery of the joint health and wellbeing strategy, and producing an assessment of the need for pharmaceutical services. Further detail around the role of the board, including how the board has met the statutory duties over 2018/19 is outlined below.

Joint Strategic Needs Assessment (JSNA)

One of the board's key responsibilities is to carry out a JSNA for Rotherham. The JSNA is an assessment of the current and future health and social care needs of the local population and the factors affecting their health, wellbeing, and social care needs. It brings together information from different sources and partners to create a shared evidence base, which supports service planning, decision-making, and delivery.

The JSNA presents headlines from the most recent analysis of the data and includes demographics, wider determinants of health (e.g. employment, housing, education, and environment), health conditions, lifestyles and causes of death. This information is supported by ward profiles, providing data, demographics and intelligence on local neighbourhoods. From 2019/20, ward profiles will reflect Rotherham's new ward boundaries.

In order that it can effectively underpin evidence-based commissioning, the JSNA is a continuous process and is updated as additional information becomes available, highlighting gaps and areas for future work. In November 2018, the Health and Wellbeing Board agreed to redesign and revamp the JSNA to better meet the needs of the partnership and to embrace an asset-based approach. Work has been

ongoing to deliver on this and the redesigned JSNA will be launched at the Health and Wellbeing Board in November 2019.

Joint Health and Wellbeing Strategy

Joint Health and Wellbeing Strategies set out how local health needs identified in the JSNA will be addressed. They set out the priorities for local commissioning and must be taken into account by local councils and CCGs.

Rotherham's Health and Wellbeing Strategy for 2018-2025 was agreed in March 2018 and further detail on the delivery of the strategy is outlined as part of this report.

Pharmaceutical Needs Assessment (PNA)

The board has a statutory responsibility to undertake a PNA every three years. The PNA reviews the current pharmaceutical services in Rotherham and identifies any gaps in provision through assessment, consultation and analysis of current and future local need.

The current PNA for Rotherham runs from April 2018 to March 2021. The mapping of services is a core part of the PNA regulations and a map not only has to be produced, but the regulations ask that this be maintained. For the first time, this assessment utilised the Strategic Health Asset Planning and Evaluation (SHAPE) tool to map the provision and access to pharmaceutical services. This tool has played a key role in continuing to map pharmaceutical services in Rotherham.

Principles

As well as meeting the duties outlined above, partners of the Health and Wellbeing Board have also committed to embedding the following principles in everything they do, both individually as organisations and in partnership:

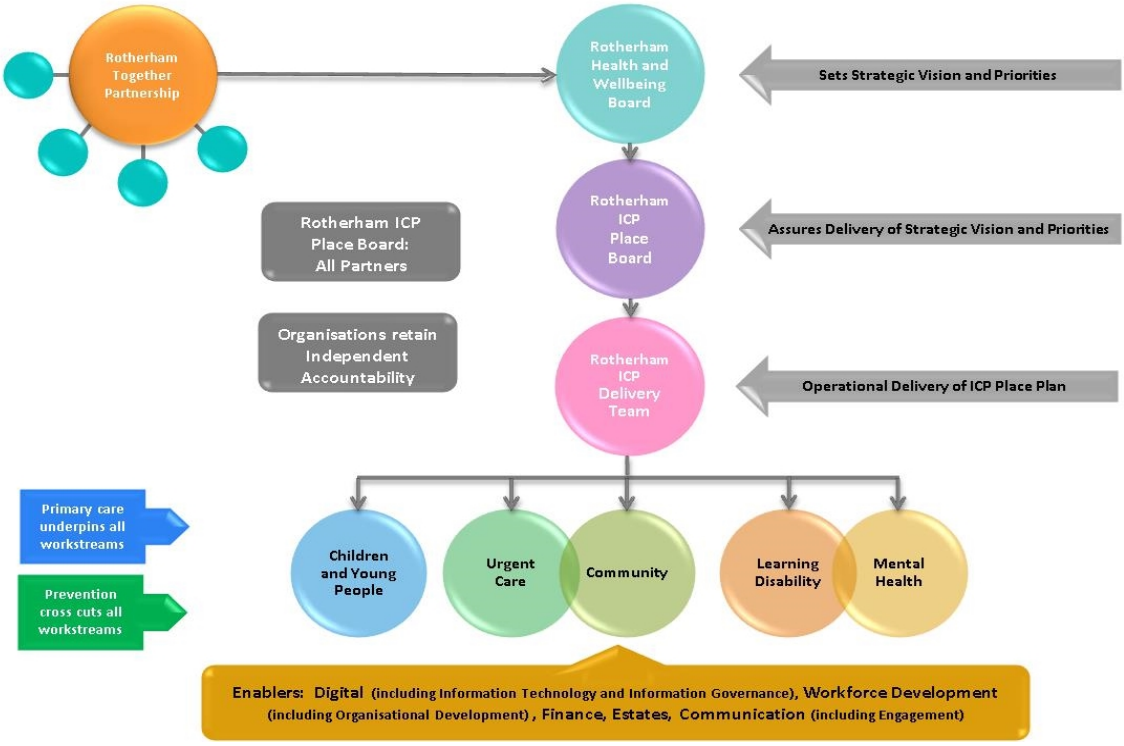
- Reduce health inequalities by ensuring that the health of our most vulnerable communities, including those living in poverty and deprivation and those with mental health problems, learning or physical disabilities, is improving the fastest.
- Prevent physical and mental ill-health as a primary aim, but where there is already an issue, services intervene early to maximise impact.
- Promote resilience and independence for all individuals and communities.
- Integrate commissioning of services to maximise resources and outcomes.
- Ensure pathways are robust, particularly at transition points, so that no one is left behind.

- Provide accessible services to the right people, in the right place, at the right time.

Governance

The Health and Wellbeing Board is a statutory sub-committee of the Council and is an integral part of Rotherham's wider strategic partnership structures, the Rotherham Together Partnership (RTP). In addition, the Integrated Care Partnership (ICP) Place Board reports into the Health and Wellbeing Board and takes strategic direction from the Health and Wellbeing Strategy.

A summary of these governance arrangements is outlined in the diagram below.



Rotherham Together Partnership (RTP)

RTP brings together statutory boards such as Safer Rotherham Partnership and the Health and Wellbeing Board, with other key strategic partnerships, such as the Business Growth Board, to deliver on Rotherham's medium term priorities. These priorities, or "game changers", are set out in the Rotherham Plan 2025.

One of the game changers is 'integrating health and social care', which requires significant input from the Health and Wellbeing Board, working closely with the Integrated Care Partnership (ICP) Place Board. The Health and Wellbeing Board also contributes to the other game changers, particularly 'building stronger communities' and 'skills and employment'.

Integrated Care Partnership

The ICP is made up of the local health and social care community, including the Council, CCG, providers of health and care services and the voluntary sector, who are working together to transform the way they care for the population of Rotherham.

The ICP Place Plan was updated during 2018 and will be further refreshed in 2019 to reflect national policy changes in the NHS Long Term Plan. It includes five transformational workstreams which closely align with the Health and Wellbeing Strategy, and is the delivery mechanism of the aspects of the Health and Wellbeing Strategy relating to integrating health and social care.

The Place Board reports progress to the Health and Wellbeing Board through quarterly performance reports, and there is also a standing agenda item for the Health and Wellbeing Board to consider any issues escalated from the Place Board.

Safeguarding

Safeguarding is a particular area of collaboration for local partners, and the Health and Wellbeing Board is a signatory to Rotherham's partnership safeguarding protocol.

The protocol describes the roles, functions and interrelationship between partnership boards in relation to safeguarding and promoting the welfare of children, young people, adults and their families. It aims to ensure that the complementary roles of the various boards are understood so that identified needs and issues translate to effective planning and action.

Delivering on the protocol includes each board delivering and receiving updates from one another on annual basis, to ensure connectivity and appropriate oversight of issues relating to safeguarding. The terms of the protocol were fulfilled for 2018/19. Ensuring we are taking an integrated and co-ordinated approach to addressing issues relating to safeguarding will continue to be a priority for 2019/20.

Delivering the Health and Wellbeing Strategy: a healthier Rotherham by 2025

The Rotherham Health and Wellbeing Strategy, 2018-2025 was agreed in March 2018, outlining four key aims:

1. All children get the best start in life and go on to achieve their full potential
2. All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life
3. All Rotherham people live well for longer
4. All Rotherham people live in healthy, safe and resilient communities

The purpose of this report is to reflect on some of the key achievements from across the partnership in 2018/19 in delivery of the Health and Wellbeing Strategy. This will include taking stock of what's working well, what we are worried about and what we need to do next.

A priority for this year has been laying the foundations for the successful delivery of the strategy. This has included:

- **Holding multi-agency engagement events with the public and voluntary and community sector organisations** to launch the strategy and feed into the development of the action plans.

- **Refreshing the Terms of Reference of the Health and Wellbeing Board** to ensure that it aligns with the strategic direction of the board and ensuring it reflects the relationship with the Integrated Care Partnership (ICP) Place Board.

- **Identifying board sponsors and lead officers for each aim** with a focus on establishing ownership and ensuring all partners are able to contribute towards the strategic direction of the board.

- **Developing action plans and a performance framework** to measure and monitor the successful delivery of the Health and Wellbeing Strategy.

What's working well?

There has been significant progress made over the past year to support delivery of the Health and Wellbeing Strategy. Examples of some of our key achievements as a partnership in 2018/19 are outlined below.

Aim 1: All children get the best start in life and go on to achieve their full potential	**Aim 2:** All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life
Young people were successfully supported to be ready for the world of work as illustrated by the achievement of the combined 2018/19 NEET/Not Known Target: 5.8%. **A new weight management service for children and young people was commissioned.** **Progress was made to ensure the effective implementation of the 'Rotherham Family Approach'** (including the Signs of Safety, Restorative Approaches and Social Pedagogy) across the wider Children's workforce.	**The CORE 24 service went live from January 2019**, with positive joint working in place with other teams including the Alcohol Liaison Team. **Clinically led review of Rotherham dementia care pathway commenced,** with consideration of new NICE guidelines. **Work was undertaken to promote workplace wellbeing,** including through the launch of the Be Well @ Work Award in partnership with other South Yorkshire local authorities.
Aim 3: All Rotherham people live well for longer	**Aim 4**: All Rotherham people live in healthy, safe and resilient communities
The Rotherham Health Record was developed enabling health and care workers to access patient information to make clinical decisions. The Rotherham Health app was also launched, providing online access to manage healthcare 24 hours a day. **Making Every Contact Count training on smoking and alcohol was delivered** to over 300 frontline staff across the partnership. **Rotherham continues to be seen as a national leader for Social Prescribing** and was formally recognised as good practice in the national Prevention Vision.	**The Health and Wellbeing Board fed into the development of a number of strategies and action plans,** including the Cultural Strategy, the Housing Strategy and the Homelessness Reduction Strategy action plan. **The Rotherham Activity Partnership was established,** involving a range of partners to plan and promote physical activity and sport across the borough. **Improvements have been made to neighbourhood working** including the co-location of services and this is ensuring a more joined-up approach to tackling neighbourhood issues such as crime, anti-social behaviour and environmental issues. **Rotherham is participating in Working Win,** the health-led employment trial which aims to help people with health conditions to find and stay in work.

What's working well?

Case Study: Stephanie who had support to stop smoking from the Rotherham NHS Foundation Trust Smoking in Pregnancy Team in 2019

Stephanie is pregnant with her fourth baby and her first to have in Rotherham, as she has only recently moved into the area. She declined support to stop smoking at her community midwife booking appointment in February 2019. Due to the OPT OUT patient pathway that is in place, the smoking in pregnancy team was informed. She was contacted by them to ensure she was aware of the risks and complications of continuing to smoke during pregnancy and to offer her support to stop smoking. Stephanie declined support again.

However, during her Community Midwifery antenatal appointment in April her Carbon Monoxide reading was 37ppm and this worried her and she accepted an appointment for support to stop smoking and was seen 2 days later. The Rotherham NHS Foundation Trust currently has a Carbon Monoxide guideline stating that ALL pregnant women, irrelevant of their smoking status, should be offered Carbon Monoxide screening at EVERY appointment. This guideline was implemented locally; this is not routinely done nationally and Stephanie has expressed that this played a key part in her stopping smoking through use of an electronic cigarette.

Stephanie has not smoked since and has no desire to smoke or return to smoking after the birth of her baby. She will continue to be supported until then and at least once after the baby's birth. The Q&A below demonstrates how valuable Stephanie found the support from the Smoking in Pregnancy Team.

Q&A with Stephanie

Have you ever stopped smoking before?
''No, and I have smoked with all my other 3 pregnancies.''

Why have you stopped smoking now?
''I didn't want to stop at first, but then the midwife did my Carbon Monoxide reading and it was 37 and I knew this was not good and it worried me so I had to stop smoking.''

What has helped you to stop smoking?
''Seeing the stop smoking midwives, I would not have stopped without their support.'

How has this helped?
''The fact that they kept contacting me, if they had not done that I would have definitely carried on smoking.''

Would you advise other pregnant women to use the service?
''Definitely, I couldn't have done it without them; I would have just carried on smoking."

Case study: Five Ways to Wellbeing

The Five Ways to Wellbeing is a national campaign which provides an alternative way to think about building personal resilience. In the same way that we take steps to maintain physical health, such as eating well and drinking at sensible levels, the five ways message promotes five key things that we can all do to maintain positive mental wellbeing: being active, connecting with people, giving to others, learning something new, and taking notice of your surroundings.

In May 2018, the Five Ways to Wellbeing campaign was launched in Clifton Park Rotherham, which features in the local film. All partners were in attendance and after the formal launch participants were encouraged to participate in Five Ways to Wellbeing activities.

Throughout the year, the Five Ways to Wellbeing have continued to be embedded in Rotherham, becoming an integral part of the services we provide and commission. For example, these steps are the basis of our campaign to address loneliness and promote connectedness in communities.

An example of one organisation that has embraced the Five Ways to Wellbeing is Crossroads. Carer A is a single woman and was the principal carer for her father: her brother has a disabled son so is only able to visit their father on a Sunday. When Carer A came to Crossroads, she was experiencing a number of issues in relation to her caring role, including career breakdown, high stress levels, effects on her mental health, risk of isolation and loneliness and physical health issues.

As well as helping Carer A to secure support from her GP and statutory services, Crossroads discussed the Five Ways to Wellbeing. This led to Carer A focussing more on what she could do to improve her own health and wellbeing, including starting yoga and tai chi classes.

Carer A continued to attend the carers group following her father's passing. Following a period of mourning and discussions around her Five Ways to Wellbeing plan and ongoing support from the carers group at Crossroads, she came to a decision that she could benefit from volunteering. Carer A approached the Volunteer Coordinator at Crossroads to discuss the opportunities available to her and what skills she had that could support a volunteering role. She agreed that telephone befriending was the role she was interested in and had the skills for. She completed training and induction at Crossroads for her volunteer role and is now supporting other carers living in Rotherham to reduce their social isolation.

Carer A is now confident enough to start looking for work and is receiving support with preparing a CV. She is in a far better place both physically and emotionally. Since contacting Crossroads and taking on board the principles of the Five Ways to wellbeing, her life has improved, and helped her both within her caring role and to cope with her bereavement.

It will continue to be a priority to promote the campaign as part of the delivery of the Better Mental Health for All Strategy and to ensure that more Rotherham people recognise the positive steps they can take to look after their mental health.

Case study: Integrated Discharge Team

Evidence suggests that patients are more likely to make a better recovery at home and regain or retain independence the earlier they return home or to a suitable care home setting. However, delayed transfers of care are a significant challenge nationally, particularly for patients who have complex needs and requirements. In response to this challenge and in delivery of Rotherham's Integrated Health and Social Care Place Plan, an Integrated Discharge Team was formed, made up of nurses, social workers and therapists.

This has had a significant impact on outcomes for patients. Mrs Hepworth *(name changed)* is an 85 year old living on her own. She has end stage Chronic Obstructive Pulmonary Disease (COPD) and complex co-morbidities. Following a urinary tract infection and exacerbation of her COPD she was unavoidably admitted to hospital. Work began on preparing for her discharge during her stay and she received therapy input to maintain mobility. The Integrated Discharge Team worked together across acute and community nursing, therapy and social care in order for Mrs Hepworth to return home. Discussions took place with her Community Matron, who was best placed to understand Mrs Hepworth's ongoing needs. Her previous care package was increased, further equipment aides were put in place including a pendent and it was arranged for a re-assessment in two weeks' time once Mrs Hepworth had settled back at home. The team also liaised with Age UK to arrange some befriending to ensure Mrs Hepworth wasn't isolated on her return.

Previously Mrs Hepworth would have had a longer length of stay, increasing the risk of infection or a fall and loss of mobility in hospital, and would most likely have been discharged to a Discharge to Assess Community Bed. The difference in this outcome demonstrates the significant impact that integrated working can have for patients.

In recognition of this impact, the Integrated Discharge Team won the Acute Service Redesign category at the HSJ Value Awards on 23rd May. This award recognised the key role of the Integrated Discharge Team in ensuring patients have the care and support in place to enable them to return home as soon as possible.

Case study: Piloting Housing First

It is a priority within the Health and Wellbeing Strategy to ensure all Rotherham people live in safe and healthy environments. Key to delivering on this priority is addressing the needs of homeless people and rough sleepers, who experience significant health inequalities.

In April 2018, the Council with partners from South Yorkshire Housing Association and Target Housing launched a Housing First Scheme providing a home for people, with highly complex needs, who were homeless or sleeping rough in the Rotherham area. The scheme offers housing to people first, with no conditions around receiving support with the belief that securing a stable home-base can be the starting point for the achievement of positive change. Whilst there are no conditions for the people receiving the accommodation the providers will always offer support, and persist with this offer.

Housing First concept is an established approach to long-term homelessness for the most disengaged and those with the most complex needs. There are three key elements to the model:

1. The offer of mainstream housing. The housing is offered on the basis that support is available, but continued occupation is not dependent on continued engagement with the support offered. The terms of tenancy do have to be abided by and people on Housing First should be subject to normal housing management processes.

2. The support offered is much different to conventional Housing Related Support (HRS). It is explicitly less goal-based and focuses on the building of relationships of trust and patient but persistent engagement with people on their own terms. This requires a highly-skilled and intensively managed set of staff, with sufficient time and space to build and maintain relationships.

3. There are no time limits for the offer of support. The key is for the support staff to persist and ensure that they are available to help at the point when people ask for help.

As of September 2019, 25 people with complex needs have been accommodated and there are 6 on the waiting list. The majority of people are now engaging more effectively with a range of support services. This creates the necessary condition for progress on issues such as reducing anti-social behaviour and anxiety leading to self-harm to be achieved.

What are we worried about?

In the final designed version, this will be presented as infographics.

- Life expectancy is nearly 11 years lower for men and 8.5 years lower for women in the most deprived areas of Rotherham compared to the most affluent areas.
- Rotherham men are expected to live an estimated 18.5 years in poor health and Rotherham women are expected to live an estimated 24.3 years in poor health.
- An estimated 18.9% of the Rotherham population smokes, which is higher than the national average.
- 25.5% of reception age students are overweight rising to 36.1% of year 6 age students.
- 62.7% of adults are classified as overweight or obese, which is higher than the national average.
- 11.2% of Rotherham people report that they are unhappy and 26.8% report feeling highly anxious.
- The gap in the employment rate between those with a long-term health condition and the overall employment rate is 10.7%.

What will we do next?

Evidence shows that the single biggest cause of ill health and health inequalities are socio-economic factors such as education, employment and income, as well as family and social support networks available to people and the physical environment in which people live. Therefore, focussing on these wider determinants of health will become an increasing priority of the Health and Wellbeing Board over the next two years.

It is proposed that key actions to address the wider determinants of health will include:

- Overseeing the development and delivery of a loneliness plan for Rotherham.
- Contributing towards the development of the action plan underpinning the Employment and Skills Strategy, with a particular focus on driving in-work health and ensuring that those excluded from the labour market are able to overcome barriers to employment.
- Overseeing the development of our strategy to improving air quality and the development of more sustainable transport options in Rotherham.
- Embedding links between the Health and Wellbeing Strategy and Rotherham's Cultural Strategy through the joint development of an action plan, reflecting the contribution the culture, sport and green spaces sectors make to increasing physical activity, emotional resilience and positive mental health.
- Exploring how we communicate positive messages across the partnership, to encourage people to be more connected with their communities and build pride in Rotherham.

In addition, other proposed areas of focus for the Health and Wellbeing Board for 2019-2021 include:

- Redesigning and relaunching the Joint Strategic Needs Assessment, moving more towards an asset-based approach with a greater focus on the wider determinants.
- Develop our approach to reducing childhood obesity, with a particular focus on the early years.
- Building a social movement to raise Rotherham people's aspirations around their own health.

- Implementing the QUIT programme to tackle tobacco addiction.

- Overseeing and monitoring the implementation of the Rotherham Suicide Prevention and Self-Harm Action Plan.

- Overseeing our approach to tackling harmful gambling, including the delivery of a programme of multi-agency training to raise awareness across the partnership workforce.

- Contribute towards regional plans and developments, including the refresh of the Integrated Care System plan and the refresh of the Sheffield City Region Strategic Economic Plan.

Following the discussion of this draft report at the Health and Wellbeing Board meeting in September 2019, a refreshed two year plan will be published, outlining the priority areas for delivery under each aim of the Health and Wellbeing Strategy. These priority areas will drive the forward plan and ensure clear areas of focus for the board for 2019-2021.

BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	18th September 2019
	LEAD OFFICER	Karen Smith, Strategic Commissioning Manager, Rotherham Metropolitan Borough Council and Rotherham Clinical Commissioning Group
	TITLE:	Better Care Fund Plan 2019/20

1. Background

1.1 The purpose of this report is to give the Health and Wellbeing Board an overview of the Better Care Fund Plan for 2019-20 and to note the contents.

1.2 The BCF planning template is in line with the 2019-20 Better Care Fund Policy Framework published in April 2019 and the Better Care Fund Planning Requirements 2019-20, which includes Key Lines of Enquiries (KLOE's) released in July 2019.

2. Key Issues

2.1 The BCF will continue to provide a mechanism for personalised, integrated approaches to health and social care that support people to remain independent at home or to return to independence after an episode in hospital.

2.2 The BCF planning and reporting has incorporated the utilisation of the IBCF and Winter Pressure Grants this year. Separate narrative plans have now been replaced with a single template that includes short narrative sections on the local approach to integration, plans to achieve metrics and plans for ongoing implementation of the High Impact Change Model for Managing Transfers of Care and Enhanced Health Care in Care Homes (EHCH) framework.

2.3 The BCF planning template (Appendix 1) covers our approach to:

- integrating care around the person, including prevention and self-care and promoting choice and independence;
- integrating services including joint commissioning arrangements, alignment with primary care services (including Primary Care Networks), alignment of services and the approach to partnership with the voluntary and community sector;
- integration with wider services e.g. Housing, the use of DFG funding to support the housing needs of people with disabilities or care needs, including arrangements for strategic planning for the use of adaptations and technologies to support independent living;
- system level alignment, including how the BCF plan and other plans align to the wider integration landscape e.g. ICS/STP plans and joint governance arrangements.

2.4 **Key Achievements since BCF Plan for 2017/19**

Key achievements since the publication of Rotherham's BCF Plan for 2017/19 are as follows:

	• The implementation of a new build Integrated Urgent and Emergency Care Centre (UECC) • Trusted Assessor model has been introduced in UECC to support admission avoidance to hospital • An Integrated Discharge Team is fully embedded in the Rotherham system and is driving down DTOC levels • Development of a more effective ambulatory care pathway to better support people with long-term conditions • Extension of social care prescribing service to support people with long term and mental health conditions. Extension of the Hospice at Home pilot for a further one year period to provide immediate advice and support for people living in community and care homes • Formal tender exercise completed to procure an Integrated Equipment and Wheelchair Service from 1.2.19, which is now delivered by an independent sector provider. • Care Co-ordination Centre (CCC), Unplanned District Nursing Hub, Integrated Rapid Response (IRR) and Community Therapies co-located which has brought together community services responsible for supporting people to remain at home. • Further development of the locality model by creating an affordable and sustainable integrated model aligned to the new primary care networks which will make the best use of resources e.g. high intensive users, MDT and case management reviews • Development of the Council's First Point of Contact team to promote independence through prevention and early intervention. This includes the secondment of an occupational therapist and pilots with specialist physical, mental health, reablement, safeguarding and community sector workers. This will continue to be based at the front door in a multi-disciplinary team, working to prevent further escalation of need through face to face and "immediate" interventions. • Reconfiguration of Rotherham Intermediate Care Centre to deliver the service in a person's home which provides therapy interventions and delivers programmes to facilitate independent living to clients who may otherwise need ongoing care packages, This is currently under review which will form part of the new offer for intermediate care and reablement.
2.5	**Enhanced Health Care in Care Homes (EHCH)** Key achievements over the last 12 months include: • Working to embed pharmacy teams into the health and social care system to support care homes and their residents with medicines optimisation. • Relaunch of red bag system to improve communication between care home, ambulance service and the hospital. • Development of an integrated health and social care training offer to support workforce development, in particular on areas such as hydration, nutrition, diabetes, respiratory, dementia, pressure areas and oral health. • Apprenticeships for trainee nurse associate are also being offered by South Yorkshire Region Excellent Centre (SYREC) to improve recruitment and retention of staff and development of career pathways. • A community physician is working with care homes will support delivery of enhance case management for those identified as at risk of hospital admission • All care homes are now registered on the NHS Capacity tracker system which provides regular 'live' updates on information, including current bed vacancies, placement costs, location, contact details and CQC ratings and supports hospital discharge planning.

- All care homes are now registered on the Data Security and Protection Toolkit and NHS mail system to ensure secure and efficient communication between hospitals, GP practices, pharmacies and care homes so that patient data is shared safely.
- Hospice at Home Care Home Pilot has now been extended until 31.3.20, which addresses both immediate advice and rapid response in emergency situations and the provision of education and supervision of front line care and residential home staff.
- Rotherham Health App has been developed which enables patients to make on-line GP appointments, view their records and order repeat medication. There is the potential to give care homes a dedicated portal to manage their residents and this would allow them to see discharge letters.
- CCG/BCF funding is continually provided to support the GP Local Enhanced Service (LES), Care Home Support, Advanced Nurse Practitioner, Mental Health Liaison Team and Clinical Quality Advisor to reduce emergency hospital admissions and improve quality standards.

2.6 **Lessons Learned**

Since the publication of Rotherham's BCF Plan for 2017/19, the lessons learnt include:

- A review of current services in 2018/19 identified an over-reliance on a large community bed base to provide Intermediate Care and Reablement. The development of a new integrated service across health and social care, which will rationalise the current 7 pathways into Intermediate Care and Reablement support services, to 3 core integrated pathways, thus improving patient/customer outcomes, is currently underway.
- The development of the Integrated Discharge Team (IDT) and an integrated MDT approach to discharge planning has consistently reduced DTOC levels. The monitoring of DTOCs now forms part of a system escalation processes. In order to embed the change and continue to reduce DTOCS, we are reviewing the IDT, with the aim of implementing a fully funded 7 day service in 2019/20.
- The OT and community sector workers in the First Point of Contact Team and the closer working relationships between the Care Co-ordination Centre and Integrated Rapid Response Service shows that integration and alignment has clear benefits to the patient/customer and to staff who become more knowledgeable of the wider health and social offer.
- There is a strong record of joint commissioning between health and social care and this has great benefits in terms of working in partnership, bringing together planning, funding and delivery of integrated services. Therefore, we want to further build on this framework and to develop an integrated commissioning hub in future.

2.7 **Income and Expenditure**

- The total Better Care Fund (BCF) for 2019/20 is £40.370m, an increase of £4.8m from 2018/19. This is due to increases in the additional and improved BCF grant (£2.6m), Disabled Facilities Grant (£0.2m), additional CCG investment (£0.6m) plus the new requirement to include the Winter Pressures Grant funding (£1.4m).

- Spending Plans continue to be allocated to the 6 themes and managed within 2 separate pooled funds, both the CCG and RMBC managing one pool fund each. This is in line with previous years and can be summarised in the table below:-

Budget 2019-20	2019/20 INVESTMENT		2019/20 SPLIT BY POOL		
BCF Investment	**RCCG SHARE**	**RMBC SHARE**	**Pool 1 RMBC Hosted**	**Pool 2 RCCG Hosted**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
THEME 1 - Mental Health Services	1,169			1,169	1,169
THEME 2 - Rehabilitation & Reablement	10,813	4,433	15,245		15,245
THEME 3 - Supporting Social Care	3,617			3,617	3,617
THEME 4 - Care Mgt & Integrated Care Planning	4,893			4,893	4,893
THEME 5 - Supporting Carers	600	50		650	650
THEME 6 - Infrastructure	241			241	241
Risk Pool	500			500	500
Improved Better Care Fund		12,710	12,710		12,710
Winter Pressures		1,345	1,345		1,345
TOTAL	**21,833**	**18,538**	**29,300**	**11,070**	**40,370**

2.8 **National Conditions**

Rotherham is fully meeting the 4 national conditions set within the Government in the BCF Policy Framework as follows:

(i) That the BCF plan (including at least the minimum mandated funding to the pooled budget specified in the BCF allocations and grant determinations), is signed off by the Health and Wellbeing Board (HWB) and by the Council and CCG.
(ii) A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution, in line with the uplift to the CCG's minimum contribution.
(iii) That a specific proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care.
(iv) A clear plan on managing transfers of care, including implementation of the High Impact Change Model for Managing Transfers of Care (HICM). As part of this, all HWBs must adopt the centrally set expectations for reducing or maintaining rates of delayed transfers of care (DToC) during 2019-20 into their BCF plans

2.9 **Maintaining Progress on Former National Conditions**

Rotherham continues to make progress towards the former national conditions contained within the BCF Plans in 2017/19 as follows:

(i) Develop delivery of 7 day services across health and social care
(ii) Improve data sharing between health and social care; and
(iii) Ensure a joint approach to assessments and care planning

BCF National Metrics

The BCF Policy Framework also sets out the four national metrics for 2019/20, which have been used in previous years as follows:

(i) Non-elective admissions
(ii) Admissions to residential and nursing care homes

	(iii) Effectiveness of reablement (iv) Delayed Transfers of Care (DToC)
3. Key Actions and Relevant Timelines	
3.1	The BCF planning template for 2019/20 is going through various stages of the approval process as follows: • Submission for Informal Feedback to ADASS/LGA Assurance – 2nd September • BCF Operational Group – 2nd September • South Yorkshire BCF Network Meeting – 4th September • BCF Executive Group – 5th September • Assurance of the Social Care Minimum Contribution to the BCF Template – 6th September • Informal Feedback received from ADASS/LGA Assurance – 13th September • Health and Wellbeing Board – 18th September • Submission to NHS England – 27th September • Scrutiny of BCF plans by regional assurers, assurance panel meetings, and regional moderation - 30th October • Regionally moderated assurance outcomes to Better Care Support Team - 30th October • Cross regional calibration - 5th November • Assurance recommendations considered by Departments and NHS England - 15th November • Approval letters issued giving formal permission to spend (CCG minimum) week commencing 18th November • All Section 75 agreements to be signed and in place by 15th December
4. Recommendations	
4.1	That the Health and Wellbeing Board note the contents of the: (i) Documentation submitted to NHS England (NHSE) on 27th September 2019

Better Care Fund 2019/20 Template

2. Cover

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

Version 1.2

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2019/20.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Rotherham
Completed by:	Karen Smith
E-mail:	karen-nas.smith@rotherham.gov.uk
Contact number:	01709 254870
Who signed off the report on behalf of the Health and Wellbeing Board:	Sharon Kemp and Christopher Edwards
Will the HWB sign-off the plan after the submission date?	No
If yes, please indicate the date when the HWB meeting is scheduled:	18/09/19

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	David	Roche	david.roche@rotherham.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	Mr	Christopher	Edwards	christopher.edwards7@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	Mr	Ian	Atkinson	ian.atkinson4@nhs.net
	Local Authority Chief Executive	Mrs	Sharon	Kemp	sharon.kemp@rotherham.gov.
	Local Authority Director of Adult Social Services (or equivalent)	Mrs	Anne Marie	Lubanski	annemarie.lubanski@rotherham.gov.uk

	Better Care Fund Lead Official	Mr	Nathan	Atkinson	nathan.atkinson@rotherham.gov.uk
	LA Section 151 Officer	Mrs	Judith	Badger	judith.badger@rotherham.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->	CCG Finance Officer	Mrs	Wendy	Allott	wendy.allott@nhs.net
	CCG Head of Commissioning (Adults - Joint CCG/RMBC)	Miss	Claire	Smith	claire.smith138@nhs.net
	LA Finance Officer	Mr	Mark	Scarrott	mark.scarrott@rotherham.gov.uk

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Complete:
2. Cover	Yes
4. Strategic Narrative	Yes
5. Income	Yes
6. Expenditure	Yes
7. HICM	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

<< Link to the Guidance sheet

Checklist

2. Cover

^^ Link back to top

	Cell Reference	Checker
Health & Wellbeing Board	D13	Yes
Completed by:	D15	Yes
E-mail:	D17	Yes
Contact number:	D19	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	D21	Yes
Will the HWB sign-off the plan after the submission date?	D23	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	D24	Yes
Area Assurance Contact Details - Role:	C27 : C36	Yes
Area Assurance Contact Details - First name:	F27 : F36	Yes
Area Assurance Contact Details - Surname:	G27 : G36	Yes
Area Assurance Contact Details - E-mail:	H27 : H36	Yes

Sheet Complete	Yes

4. Strategic Narrative ^^ Link back to top

	Cell Reference	Checker
A) Person-centred outcomes:	B20	Yes
B) (i) Your approach to integrated services at HWB level (and neighbourhood where applicable):	B31	Yes
B) (ii) Your approach to integration with wider services (e.g. Housing):	B37	Yes
C) System level alignment:	B44	Yes

Sheet Complete	Yes

5. Income ^^ Link back to top

	Cell Reference	Checker
Are any additional LA Contributions being made in 2019/20?	C39	Yes
Additional Local Authority	B42 : B44	Yes
Additional LA Contribution	C42 : C44	Yes
Additional LA Contribution Narrative	D42 : D44	Yes
Are any additional CCG Contributions being made in 2019/20?	C59	Yes
Additional CCGs	B62 : B71	Yes
Additional CCG Contribution	C62 : C71	Yes
Additional CCG Contribution Narrative	D62 : D71	Yes

Sheet Complete	Yes

6. Expenditure ^^ Link back to top

	Cell Reference	Checker
Scheme ID:	B22 : B271	Yes
Scheme Name:	C22 : C271	Yes
Brief Description of Scheme:	D22 : D271	Yes
Scheme Type:	E22 : E271	Yes
Sub Types:	F22 : F271	Yes
Specify if scheme type is Other:	G22 : G271	Yes
Planned Output:	H22 : H271	Yes
Planned Output Unit Estimate:	I22 : I271	Yes
Impact: Non-Elective Admissions:	J22 : J271	Yes
Impact: Delayed Transfers of Care:	K22 : K271	Yes
Impact: Residential Admissions:	L22 : L271	Yes
Impact: Reablement:	M22 : M271	Yes
Area of Spend:	N22 : N271	Yes
Specify if area of spend is Other:	O22 : O271	Yes
Commissioner:	P22 : P271	Yes
Joint Commissioner %:	Q22 : Q271	Yes
Provider:	S22 : S271	Yes
Source of Funding:	T22 : T271	Yes

Expenditure:	U22 : U271	Yes
New/Existing Scheme:	V22 : V271	Yes

Sheet Complete	Yes

7. HICM

^^ Link back to top

	Cell Reference	Checker
Priorities for embedding elements of the HCIM for Managing Transfers of Care locally:	B11	Yes
Chg 1) Early discharge planning - Current Level:	D15	Yes
Chg 2) Systems to monitor patient flow - Current Level:	D16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Current Level:	D17	Yes
Chg 4) Home first / discharge to assess - Current Level:	D18	Yes
Chg 5) Seven-day service - Current Level:	D19	Yes
Chg 6) Trusted assessors - Current Level:	D20	Yes
Chg 7) Focus on choice - Current Level:	D21	Yes
Chg 8) Enhancing health in care homes - Current Level:	D22	Yes
Chg 1) Early discharge planning - Planned Level:	E15	Yes
Chg 2) Systems to monitor patient flow - Planned Level:	E16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Planned Level:	E17	Yes
Chg 4) Home first / discharge to assess - Planned Level:	E18	Yes
Chg 5) Seven-day service - Planned Level:	E19	Yes
Chg 6) Trusted assessors - Planned Level:	E20	Yes
Chg 7) Focus on choice - Planned Level:	E21	Yes
Chg 8) Enhancing health in care homes - Planned Level:	E22	Yes
Chg 1) Early discharge planning - Reasons:	F15	Yes
Chg 2) Systems to monitor patient flow - Reasons:	F16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Reasons:	F17	Yes
Chg 4) Home first / discharge to assess - Reasons:	F18	Yes
Chg 5) Seven-day service - Reasons:	F19	Yes
Chg 6) Trusted assessors - Reasons:	F20	Yes
Chg 7) Focus on choice - Reasons:	F21	Yes
Chg 8) Enhancing health in care homes - Reasons:	F22	Yes

Sheet Complete	Yes

8. Metrics

^^ Link back to top

	Cell Reference	Checker
Non-Elective Admissions: Overview Narrative:	E10	Yes
Delayed Transfers of Care: Overview Narrative:	E17	Yes
Residential Admissions Numerator:	F27	Yes
Residential Admissions: Overview Narrative:	G26	Yes
Reablement Numerator:	F39	Yes
Reablement Denominator:	F40	Yes
Reablement: Overview Narrative:	G38	Yes

Sheet Complete	Yes

9. Planning Requirements

^^ Link back to top

	Cell Reference	Checker
PR1: NC1: Jointly agreed plan - Plan to Meet	F8	Yes
PR2: NC1: Jointly agreed plan - Plan to Meet	F9	Yes
PR3: NC1: Jointly agreed plan - Plan to Meet	F10	Yes
PR4: NC2: Social Care Maintenance - Plan to Meet	F11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Plan to Meet	F12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Plan to Meet	F13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F15	Yes
PR9: Metrics - Plan to Meet	F16	Yes
PR1: NC1: Jointly agreed plan - Actions in place if not	H8	Yes
PR2: NC1: Jointly agreed plan - Actions in place if not	H9	Yes
PR3: NC1: Jointly agreed plan - Actions in place if not	H10	Yes
PR4: NC2: Social Care Maintenance - Actions in place if not	H11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Actions in place if not	H12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Actions in place if not	H13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H15	Yes
PR9: Metrics - Actions in place if not	H16	Yes
PR1: NC1: Jointly agreed plan - Timeframe if not met	I8	Yes
PR2: NC1: Jointly agreed plan - Timeframe if not met	I9	Yes
PR3: NC1: Jointly agreed plan - Timeframe if not met	I10	Yes
PR4: NC2: Social Care Maintenance - Timeframe if not met	I11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Timeframe if not met	I12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Timeframe if not met	I13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I15	Yes
PR9: Metrics - Timeframe if not met	I16	Yes

Sheet Complete	Yes

Better Care Fund 2019/20 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.

2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.

3. The checker column will appear 'Red' and contain the word 'No' if the information has not been completed. Clicking on the corresponding 'Cell Reference' column will link to the incomplete cell for completion. Once completed the checker column will change to 'Green' and contain the word 'Yes'

4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.

6. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net

3. Please note that in line with fair processing of personal data we collect email addresses to communicate with key individuals from the local areas for various purposes relating to the delivery of the BCF plans including plan development, assurance, approval and provision of support.
We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.
Please let us know if any of the submitted contact information changes during the BCF planning cycle so we are able to communicate with the right people in a timely manner.

4. Strategic Narrative (click to go to sheet)

This section of the template should set out the agreed approach locally to integration of health & social care. The narratives should focus on updating existing plans, and changes since integration plans were set out until 2020 rather than reiterating them and can be short. Word limits have been applied to each section and these are indicated on the worksheet.

1. Approach to integrating care around the person. This should set out your approach to integrating health and social care around the people, particularly those with long term health and care needs. This should highlight developments since 2017 and cover areas such as prevention.

2 i. Approach to integrating services at HWB level (including any arrangements at neighbourhood level where relevant). This should set out the agreed approach and services that will be commissioned through the BCF. Where schemes are new or approaches locally have changed, you should set out a short rationale.
2 ii. DFG and wider services. This should describe your approach to integration and joint commissioning/delivery with wider services. In all cases this should include housing, and a short narrative on use of the DFG to support people with care needs to remain independent through adaptations or other capital expenditure on their homes. This should include any discretionary use of the DFG.

3. How your BCF plan and other local plans align with the wider system and support integrated approaches. Examples may include the read across to the STP (Sustainability Transformation Partnerships) or ICS (Integrated Care Systems) plan(s) for your area and any other relevant strategies.

You can attach (in the e-mail) visuals and illustrations to aid understanding if this will assist assurers in understanding your local approach.

5. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's Better Care Fund (BCF) plan and pooled budget for 2019/20. On selected the HWB from the Cover page, this sheet will be pre-populated with the minimum CCG contributions to the BCF, DFG (Disabled Facilities Grant), iBCF (improved Better Care Fund) and Winter Pressures allocations to be pooled within the BCF. These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from Local Authorities or the CCGs and as applicable enter the amounts in the fields highlighted in ‘yellow’. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be utilised to include any relevant carry-overs from the previous year.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.

4. For any questions regarding the BCF funding allocations, please contact England.bettercaresupport@nhs.net

6. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and utilised to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Condition 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.
On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is free text field to include a brief headline description of the scheme being planned.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available at the end of the table (follow the link to the description section at the top of the main expenditure table).
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- While selecting schemes and sub-types, the sub-type field will be flagged in 'red' font if it is from a previously selected scheme type. In this case please clear the sub-type field and reselect from the dropdown if the subtype field is editable.

5. Planned Outputs
- The BCF Planning requirements document requires areas to set out planned outputs for certain scheme types (those which lend themselves to delivery of discrete units of delivery) to help to better understand and account for the activity funded through the BCF.
- The Planned Outputs fields will only be editable if one of the relevant scheme types is selected. Please select a relevant unit from the drop down and an estimate of the outputs expected over the year. This is a numerical field.

6. Metric Impact
- This field is collecting information on the metrics that a chem will impact on (rather than the actual planned impact on the metric)
- For the schemes being planned please select from the drop-down options of 'High-Medium-Low-n/a' to provide an indicative level of impact on the four BCF metrics. Where the scheme impacts multiple metrics, this can be expressed by selecting the appropriate level from the drop down for each of the metrics. For example, a discharge to assess scheme might have a medium impact on Delayed Transfers of Care and permanent admissions to residential care. Where the scheme is not expected to impact a metric, the 'n/a' option could be selected from the drop-down menu.

7. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

8. Commissioner:
- Identify the commissioning entity for the scheme based on who commissions the scheme from the provider. If there is a single commissioner, please select the option from the drop-down list.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns alongside.

9. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

10. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop-down list
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

11. Expenditure (£) 2019/20:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

12. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2019/20 and will inform the understanding of planned spend for the iBCF and Winter Funding grants.

7. HICM (click to go to sheet)

National condition four of the BCF requires that areas continue to make progress in implementing the High Impact Change model for managing transfers of care and continue to work towards the centrally set expectations for reducing DToC. In the planning template, you should provide:
- An assessment of your current level of implementation against each of the 8 elements of the model – from a drop-down list
- Your planned level of implementation by the end March 2020 – again from a drop-down list

A narrative that sets out the approach to implementing the model further. The Narrative section in the HICM tab sets out further details.

8. Metrics (click to go to sheet)

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2019/20. The BCF requires plans to be agreed for the four metrics. This should build on planned and actual performance on these metrics in 2018/19.

1. Non-Elective Admissions (NEA) metric planning:
- BCF plans as in previous years mirror the latest CCG Operating Plans for the NEA metric. Therefore, this metric is not collected via this template.

2. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from ONS subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
- Please include a brief narrative associated with this metric plan

3. Reablement (REA) planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.
- Please include a brief narrative associated with this metric plan

4. Delayed Transfers of Care (DToC) planning:
- The expectations for this metric from 2018/19 are retained for 2019/20 and these are prepopulated.
- Please include a brief narrative associated with this metric plan.
- This narrative should include details of the plan, agreed between the local authority and the CCG for using the Winter Pressures grant to manage pressures on the system over Winter.

9. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2019/20 for further details.

The Key Lines of Enquiry (KLOE) underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.

2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

10. CCG-HWB Mapping (click to go to sheet)

The final sheet provides details of the CCG - HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity figures.

Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Rotherham

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,700,150	£2,700,150	£0
Minimum CCG Contribution	£19,614,894	£19,614,894	£0
iBCF	£12,709,487	£12,709,487	£0
Winter Pressures Grant	£1,345,287	£1,345,287	£0
Additional LA Contribution	£1,783,000	£1,783,000	£0
Additional CCG Contribution	£2,217,000	£2,217,000	£0
Total	£40,369,818	£40,369,818	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£5,573,997
Planned spend	£10,056,894

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£6,975,909
Planned spend	£8,818,000

Scheme Types

Assistive Technologies and Equipment	£970,000
Care Act Implementation Related Duties	£1,000,000
Carers Services	£650,000
Community Based Schemes	£3,215,000
DFG Related Schemes	£1,730,150
Enablers for Integration	£49,000
HICM for Managing Transfer of Care	£6,062,964
Home Care or Domiciliary Care	£2,283,000
Housing Related Schemes	£409,000
Integrated Care Planning and Navigation	£2,354,000
Intermediate Care Services	£5,714,947
Personalised Budgeting and Commissioning	£1,980,000
Personalised Care at Home	£1,288,000
Prevention / Early Intervention	£2,676,000
Residential Placements	£6,243,591
Other	£3,744,166
Total	£40,369,818

HICM >>

		Planned level of maturity for 2019/2020
Chg 1	**Early discharge planning**	Established
Chg 2	**Systems to monitor patient flow**	Mature
Chg 3	**Multi-disciplinary/Multi-agency discharge teams**	Exemplary
Chg 4	**Home first / discharge to assess**	Mature
Chg 5	**Seven-day service**	Mature
Chg 6	**Trusted assessors**	Mature
Chg 7	**Focus on choice**	Mature
Chg 8	**Enhancing health in care homes**	Mature

Metrics >>

Non-Elective Admissions
Delayed Transfer of Care

Go to Better Care Exchange >>

Residential Admissions

		19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	503.4535099

Reablement

		19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	0.86013986

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
	PR8	Yes
Metrics	PR9	Yes

Better Care Fund 2019/20 Template

4. Strategic Narrative

Selected Health and Wellbeing Board: Rotherham

Please outline your approach towards integration of health & social care:

When providing your responses to the below sections, please highlight any learning from the previous planning round (2017-2019) and cover any priorities for reducing health inequalities under the Equality Act 2010.

Please note that there are 4 responses required below, for questions: A), B(i), B(ii) and C)

Link to B) (i)
Link to B) (ii)
Link to C)

A) Person-centred outcomes Your approach to integrating care around the person, this may include (but is not limited to): - Prevention and self-care - Promoting choice and independence	
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A new suite of Adult Care pathways will be implemented by the Council in Q3 of 2019/20. These pathways take into account whole system requirements to move to a position where elements of the system collaborate to fully explore the potential of individuals to become as independent as possible. The community support offer within the new model will be based on people being supported via their social, community and neighbourhood assets, through joint working with partners across Rotherham to allow people to access the support they need through a variety of more sustainable support networks. An extensive consultation exercise has been carried out over several months with key stakeholders/partners, with around 400 comments received to inform and reshape the new pathways.

We fully recognise that individuals need to be at the centre of the new pathways with a stronger emphasis on encouraging and supporting people to self-manage their care. This means that people who have a care package will be re-abled so that their needs are decreased, resulting in:

• either a reduced or no care package
• an increased level of independence
• an enhanced quality of life

This will also result in a stronger understanding of what care is currently being provided and whether or not it is the most appropriate, with increased reviews and oversight, specifically with a recovery reablement model that requires close working with the provider and individuals. The aim of care and support should be for people to live the best life that they can, meaning living independently, in their own home when possible, utilising the assets and the people around them to do the things that make them happy and leading a fulfilled life.

Rotherham requires a new way of providing care and support to its people, placing the individual at the heart of decision making. The approach should fully utilise personal, social, neighbourhood and community assets, along with a transformed social care offer and this requires thinking differently about what people can do for themselves, ensuring that care and support is proportionate to need, with reablement being the focus at every step along the pathway and within every service. This will require partnering and collaboration with a wide range of key stakeholders including Public Health, Housing, CCG, Foundation Trusts and Mental Health Trusts, voluntary and independent sector to create more options for how care can be delivered through, for example, natural forms of support, universal services and community assets, as well as formal health and social care services.

The new Adult Care pathways has been established to redesign the Rotherham arrangements for supporting a person's journey through adult social care, to ensure Care Act compliance, provide better outcomes for customers and generate efficiencies/savings. Contribution to social care services has some health benefit in that people are supported to live independently in the community and contributes to reducing hospital admissions/re-admissions and reducing Delayed Transfers of Care.

4 key themes of the new Adult Care pathways are as follows:

1. Prevention – involves ensuring right information is available in all formats, that a range of options across Rotherham that promote healthy lifestyles are available and increased use of digital channels.
2. Integration – focuses on future models for integrated health and social care teams, including hospital discharge team and mental health services, future role and reconfiguration of intermediate care and reablement services, the role of health and social care in relation to the development of the primary care networks (PCNs) and integration of systems, sharing of data, information governance, understanding our people and place and future role of care homes.
3. Care co-ordination – across health and social care to resolve more issues at the first point of contact and ensure clients are effectively triaged to the right level of care, first time for effective admission avoidance and discharge and reduced reliance on primary and secondary services.
4. Maximising independence and reablement – includes development of a specialist integrated health and social care intermediate care, reablement and recovery service, extra care supported living, best use of the Rotherham pound (Multi-Disciplinary Teams (MDT), trusted assessor working, development of core competencies to support generic cross health and social care roles, CHC, joint funding, social care), working with providers and health partners to offer value for money, drive and manage the market, making sure there are the right support options available for people, personalisation of individual options utilising telecare/telehealth, internet, digital communication, Skype/face time.

The Council are focusing on developing a strength based approach, in partnership with staff, to ensure that community assets are utilised and self-directed support is maximised, thus increasing choice and control. They will focus on greater promotion of the use of individual budgets via a direct payment, strength based, focussed assessment of well-being and clear evidence of a person's needs. Consideration must be taken to eligibility criteria, support planning, completion of Continuing Health Care and Decision Support Tool checklists, alternatives to standard service provision and greater use of assistive technology.

The Assistive Technology offer has been extended to support self-care and encourage self-management in the home, as part of the early prevention and personalisation agenda. This will build on the existing profile of telecare solutions available.
Commissioning high quality services that support the health and wellbeing of adults and older people is a key priority. This will only be achieved through the Council working in close partnership with Rotherham CCG to better identify and meet the needs of adults and older people; and to ensure that the voice of the adult and older person is fully engaged in the commissioning process
Rotherham CCG has developed an IT strategy to ensure that the CCG and partners have the IT capabilities to fully support the delivery of key priorities identified within the CCG Commissioning Plan (2018-20) and also reflects the goal of the new national information framework to support the delivery of technology enabled, personalised care services.
A new digital offer in Rotherham has been developed in 2019/20 which sets out a programme for transforming information for health and social care so that services could achieve higher quality care and improved outcomes for patients and customers. The commitment is to deliver improved digital access for people to healthcare services, their clinical records and other healthcare information and to improving the sharing of information between health and care professionals.
Rotherham CCG will ensure that patients/carers can participate as far as they want to in planning, managing and deciding about their care through extending the use of personal health budgets, promoting case management for people with long term conditions , continuing the voluntary sector commissioned social prescribing programme which is financed from the BCF, aiming to improve outcomes for patients in terms of health, wellbeing, self-care and independence, Increase resilience of individuals and communities, support dependence to independence and reduce social isolation
A new Rotherham Health and Wellbeing Strategy has been developed (2018-25) ("A Healthier Rotherham by 2025") which sets out Rotherham's overarching vision to improve the health and well-being of its population, for people to continue to live fulfilling lives, to be actively engaged in their community and reduce health inequalities in the borough. Through the strategy, the Health and Wellbeing Board (HWB) has made a commitment to ensure the commissioning and delivery of services which are more integrated, person-centred, providing high quality care and accessible to all. The HWB supports collaboration and integration, and has a role in breaking down barriers between agencies, focusing on getting the most out of the whole system, thus improving outcomes and reducing health inequalities. The focus is on the health of the most vulnerable communities, including those living in poverty and deprivation and those with mental health problems, learning or ph contributes towards reducing health inequalities.
The current and future limits on resource require us to work more collaboratively than ever, integrating our commissioning of services to ensure that every pound spent in Rotherham on health and care supports improvements in health and wellbeing and the reduction of health inequalities.
The strategy includes aims which the HWB have agreed are the most important things to focus on to improve health and wellbeing outcomes for all Rotherham people, but can best be tackled by a 'whole system' approach where the involvement of a whole range of partners is needed to achieve improvement. The Better Care Fund Plan contributes to the following aims identified in the local Health and Wellbeing Strategy.

- All people enjoy the best possible mental health and wellbeing and have a good quality of life.
- All people live well for longer.
- All people live in healthy, safe and resilient communities.

As well as the Rotherham Integrated Health and Social Care Place Plan (2018-20) the CCG's Commissioning Plan (2018-20) remains the cornerstone of the CCGs strategic direction, available at http://www.rotherhamccg.nhs.uk/our-plan.htm.

B) HWB level

(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):
- Joint commissioning arrangements - Alignment with primary care services (including PCNs (Primary Care Networks)) - Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)

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The South Yorkshire and Bassetlaw Integrated Care System (ICS) is the local approach to delivering the national plan and sets out a vision of a better NHS, the steps we should take to get us there, and how everyone involved needs to work together. 25 health and care partners from across the region are involved in the ICS, along with Healthwatch and voluntary sector organisations. The ambition of the ICS is to enable everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to stay healthy and to live longer. The plan is to invest in, reshape and strengthen primary and community services so that we can provide the support people in our communities need to be as mentally and physically well as possible. Mental health will be integral to our ambitions around improving population wellbeing.

At a local level Rotherham's Health and Social Care Community has been working in a collaborative way for several years to transform the way it cares for its population of around 263,000. We have now established a mature Integrated Care Partnership (ICP) which is responsible for the delivery of the Integrated Health and Social Care Place Plan (2018-20). This can be found at http://www.rotherhamccg.nhs.uk/rotherhams-place-plan.htm

Our aim is to provide the best possible services and outcomes for our population; we are committed to a whole system partnership approach, as we recognise that it is only through working together that we can provide sustainable services over the long term. Our common vision is "supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery". Our approach to transformation is based on a multi-agency strategy of prevention and early intervention of health and social care services and we recognise the importance of addressing the wider determinants of health.

This details our joined up approach to delivering key initiatives that will help us achieve our Health and Wellbeing Strategic aims and meet the region's ICP objectives, Planning and delivery at an overarching ICP level must be co-ordinated with planning and delivery at a local (Rotherham) level, as they represent different elements of the same system.

Delivery of the Integrated Place Plan and CCG Commissioning Plan is underpinned and dependent on successful working with the Council, other key partners and stakeholders. There are great benefits from working in partnership, bringing together planning, funding and delivery of health and social care. We all aspire to reducing health inequalities and providing better care outside hospital. The CCG's Commissioning Plan aligns with the Joint Health and Wellbeing Strategy (2018-25) and the Integrated Place Plan and sets out, as a key partner, how we will support their delivery. The CCG, Council and NHS England work closely together to ensure that all commissioning plans are aligned so that together we deliver the maximum amount for each 'Rotherham pound'. This includes the System Wide Winter Plan developed annually.

The Rotherham ICP will focus on future models for integrated health and social care teams, including hospital discharge team and mental health services, future role and reconfiguration of intermediate care and reablement services across the Borough, the role of health and social care in relation to the development of the primary care networks (PCNs).

The Rotherham ICP will aim to champion prevention and integration and establish a range of initiatives in Rotherham to serve as a proof of concept that can then be rolled out further across South Yorkshire and Bassetlaw.

Rotherham partners view themselves collectively accountable for the health and wellbeing of our population and consider the Integrated Health and Social Care Place Plan to be our framework for jointly providing acute, community and primary care services forming an integrated partnership. The governance arrangements support an Integrated Care Partnership arrangement, which enables us to design and deliver services to meet the needs of our population and improve health and wellbeing outcomes, within agreed budgets.

The Rotherham ICP work in partnership with the voluntary sector and the BCF currently funds the social prescribing programme which is an approach that links patients in primary care with non-medical support in the community. Rotherham currently has two social prescribing schemes in action, Long Term Conditions (LTC) and Mental Health (MH). The LTC social prescribing model focuses on secondary prevention, commissioning services that will prevent worsening health for those people with existing long term conditions, and thus reduce costly interventions in specialist care. The MH scheme works with secondary care providers (Rotherham, Doncaster & South Humber NHS Foundation Trust) to help patients to discharge from statutory mental health services. Both services have been independently evaluated by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University and are well regarded. This initiative has recently bee initiatives featuring heavily in NHS national plans.

(ii) Your approach to integration with wider services (e.g. Housing), this should include:
- Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the (Regulatory Reform Order 2002)

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The Strategic Director of Adult Social Care, Housing and Public Health has been fully involved in the development and approval of the BCF plan for 2019/20 and is a member of the Health and Wellbeing Board and BCF Executive Group. Both the Boards and group includes representatives from the CCG including the Chief Officer and Chief Finance Officer. This ensures there is a joined up approach in improving outcomes across the health, social care and housing sector

The Disabled Facilities Grant (DFG) provides funding for the provision of aids and adaptations to disabled people's homes to enable them to live independently and to improve their quality of life. Social Care and Housing Services work collaboratively together in responding to the Care Act (2014) requirements in order to prevent, reduce or delay care and support needs.

The DFG has provided funding for aids and adaptations for 252 people with physical disabilities and care needs, living in owner occupied, private and social tenancies in 2018/19, of which 60% were for people aged 65 years and over, 27% for people with physical disabilities and 13% for children. Grant approvals range from a minimum of £1,000 and a maximum of £32,552.

The Housing Strategy (2019-21) aligns to the Integrated Place Plan and BCF Plan by supporting people to live at home for longer and has benefits for the individual's health as well as a positive impact on health and social care budgets. Instead of providing everyone with the same service regardless of need, housing support or adaptations are tailored to the individual and used to empower people to make choices for themselves. Council owned stock is also ageing and it is essential that investment continues so that the Council is able to continue to provide good quality, safe and affordable homes in sustainable neighbourhoods that meet the needs of local people. As people's needs evolve, the Council will seek opportunities to make better use of its stock and consider conversions and adaptations to provide more suitable homes where appropriate.

The Council's Adaptations Policy aims to assist people in living independently through either the provision of equipment and/or adaptations in their current home or re-housing to a suitable property that meets their needs.

Telecare Project - The Council are currently working in partnership with Alcove Ltd to implement and deliver an assistive technology six month pilot with a group of around 60 individuals. The BCF Disabled Facilities Grant will fund the project costs which will be around £140,000 per annum. The pilot will test the concept of the benefits of this type of technology in achieving improved outcomes for older people, people with learning/physical/sensory disabilities, mental health and young people transitioning from young people's services and their carers, along with creating cost efficiencies by reducing demand and dependency on high cost services. This also forms part of our new intermediate and reablement offer by increasing opportunities for reabling individuals, supporting them to self-manage and to support unpaid carers and their families. This will include the use of a SIM card/dongle, Amazon Alexa, 6 sensors, video calling device and other add-ons such as epilepsy monitor are available. The carephone allows visibility via videocall/text and voice calling members.

Telehealth - NHS England has allocated a budget to spend on a pilot to introduce telehealth in two care homes in Rotherham. The aim is to keep people out of hospital and reduce the length of stay in hospital if a person was to be admitted. This is achieved through use of a kit/tablet in care homes that is linked to the GP surgery.

The IBCF funding is currently being used to employ a Programme Lead for Assistive Technology and Occupational Therapy for a one year period from 1.7.19. This post will look at developing an Assistive Technology strategy to enhance the local offer and better utilisation of technology solutions available to support people to remain independently in their own homes. They will also support the new Intermediate Care and Reablement offer to ensure effective therapy intervention across care pathways. The Programme Lead will conduct a performance review of the Community Occupational Therapy to ensure efficient and effective use of resources and to enable single handled care by establishing funding routes for specialist pieces of activities of daily living (ADL) equipment.

The contract for the Home Improvement Agency service has been extended for a further 1 year period to support around 900 people living in poor/unsuitable housing and provide a point of contact to older, disabled and/or vulnerable to

promote independent living and enable them to remain in their homes in greater comfort, security, safety and warmth. The aims of the service is to prevent homelessness, social exclusion, preventing falls and admissions to hospital.

C) System level alignment, for example this may include (but is not limited to):	
- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans - A brief description of joint governance arrangements for the BCF plan	
Remaining Word Limit:	0

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The BCF is closely aligned to the Integrated Care Partnership's Integrated Health and Social Care Place Plan and also closely links with the Health and Wellbeing Strategy, CCG Commissioning Plan and Housing Strategy. These all enable us to implement effective joint commissioning services across the Council and CCG which will inevitably drive the integration of services. This will bring together specialists within multi-disciplinary working arrangements from primary care, social care, public health, housing, community health services and the voluntary and community sector. Rotherham CCG will further expand community based services, reducing reliance on the acute sector. The CCG will streamline and simplify care pathways and ensure that the discharge home and step up/step down approach is embedded so that people are well managed through the care system rather than it escalating to the point of crisis. The CCG and Council will ensure that there is better information sharing between health and social care.

Service integration will be used as a vehicle to deliver "parity of esteem", whereby integrated locality teams will incorporate mental health staff, working alongside health professionals whose focus is on physical health. Care planning and support will address the psychological and physical needs of the individual, recognising the huge overlap between mental and physical well-being. The CCG will ensure that the appropriate care pathway is selected to support both the patients' physical and mental health.

The Rotherham BCF Plan and the Integrated Health and Social Care Place Plan are consistent with the aims of the NHS Long Term Plan (2019) which emphasises the need to develop new care models to support integration and to provide enhanced health care in care homes to improve quality of life of residents. A central theme of our plan is the further development of integrated service models, integrated point of contact, rapid response, discharge service, localities, development of a reablement and intermediate care offer and co-ordinated approach to care home support.

Rotherham has a strong record of joint commissioning between health and social care. The CCG have a joint commissioning framework and governance structure which incorporates joint needs assessment, supply mapping, market analysis, pooled budgets and performance management. This has prepared the way for new developments in integrated care which will support people with complex needs to remain independent in the community.

There are great benefits from working in partnership with partners and stakeholders, bringing together planning, funding and delivery of health and social care so that we can together deliver the maximum amount for each 'Rotherham pound'.

The BCF Section 75 Agreement for 2019/20 is on the agenda for future approval by the Health and Wellbeing Board (HWB) which consists of Elected Members, Chief Executive, Chief Operating Officer and Directors from CCG and the Council, NHS England, GP's, Voluntary Action Rotherham (VAR), Healthwatch. The key responsibilities of this group include:

- Monitor performance against BCF Metrics and receive exception reports on the BCF action plan
- Agree the BCF Commissioning Plan/Strategies
- Agree decisions on commissioning/decommissioning of services

The BCF Executive Group consisting of Chief Executives, Elected Members, Chief Finance Officers, Directors from both the Local Authority and the CCG. Key responsibilities include;

- Agree strategic vision and priorities
- Make decisions relating to the delivery of the plan
- Monitor delivery of the BCF Plan
- Ensure performance targets are met
- Ensure schemes are being delivered and actions put in place where the plan results in any unintended consequences.
- Report directly to the HWB on a quarterly basis.

The BCF Executive Group is supported by the BCF Operational Group. The Operational group is made up of identified lead officers for each of the BCF priorities, plus other supporting officers from the Council and CCG.

- Ensure implementation of the BCF action plan
- Implement and monitor the performance management framework
- Deal with operational issues, escalating to the Task Group where need

A financial governance process is in place and the financial monitoring and performance information is to be provided at operational group meetings and quarterly at Director and Member level. The financial framework will expose those areas of high risk in year and identify areas where slippage may be available to balance the financial pressure in year. The recurrent plans will be modified, where appropriate, as part of the planning cycle for both Health and Social Care in totality through a Section 75 pooled budget agreement.

Since the publication of Rotherham's BCF Plan for 2017/19, the following has been achieved:

- Implementation of a new build Integrated Urgent and Emergency Care Centre (UECC) to ensure that patients with urgent and emergency needs get the right treatment at the right time, in the right place, thus reducing hospital admissions
- Integrated Discharge Team is fully embedded in the Rotherham system and is driving down DTOC levels through a single referral route for complex patients. The team consists of nursing, therapists and social care practitioners to ensure a holistic approach to complex discharges. The monitoring of DTOCs now forms part of a system escalation processes.
- Trusted Assessor model has been introduced in UECC to support admission avoidance to hospital and to facilitate early discharge from hospital.
- Development of a more effective ambulatory care pathway to better support people with long-term conditions
- Extension of social care prescribing service to support people with long term and mental health conditions.
- Extension of the Hospice at Home pilot for a further one year period to provide immediate advice and support for people living in community and care homes
- Formal tender exercise completed to procure an Integrated Equipment and Wheelchair Service from 1.2.19, to ensure that the service is modernised, fit for purpose and promotes value for money. This is now delivered by an independent sector provider.
- Care Co-ordination Centre (CCC), Unplanned District Nursing Hub, Integrated Rapid Response (IRR) and Community Therapies co-located which has brought together community services responsible for supporting people to remain at home during an acute episode or be discharged home from an acute setting.
- Further development of the locality model by creating an affordable and sustainable integrated model aligned to the new primary care networks which will make the best use of resources by developing stronger connections between health and social care e.g. high intensive users, Multi-Disciplinary Team and case management reviews.
- Development of the Council's First Point of Contact team to promote independence through prevention and early intervention. The Council have re-allocated resource to invest in developing expert non-qualified assessment officers, supported by robust access to qualified staff at the front door to resolve more issues at the initial point of contact. This includes the secondment of an OT and pilots with specialist physical, mental health, reablement, safeguarding and community sector workers. There are further changes planned in 2019/20 due to the establishment of new adult care pathways, with the development of the "First Point of Contact" team. This will continue to be based at the front door in a multi-disciplinary team, working to prevent further escalation of need through face to face and "immediate" interventions.
- Reconfiguration of Rotherham Intermediate Care Centre to deliver the service in a person's home which provides therapy interventions and delivers programmes to facilitate independent living to clients who may otherwise need ongoing care packages. The new adult care pathways will ensure that this team enhances the intermediate care and reablement team in Q3 of 2019/20, with re-alignment with the in-house reablement team.

Since the publication of Rotherham's BCF Plan for 2017/19, the lessons learnt include:

• A review of current services in 2018/19 identified an over-reliance on a large community bed base to provide Intermediate Care and Reablement. The development of a new integrated service across health and social care which will rationalise the current 7 pathways into Intermediate Care and Reablement support services, to 3 core integrated pathways, thus improving patient/service user outcomes.

• The development of the Integrated Discharge Team (IDT) and an integrated MDT approach to discharge planning has consistently reduced DTOC levels. The monitoring of DTOCs now forms part of a system escalation processes. In order to embed the change and continue to reduce DTOCS, we are reviewing the IDT, with the aim of implementing a fully funded 7 day service in 2019/20.

• The OT and community sector workers in the First Point of Contact Team, and the closer working relationships between the Care Co-ordination Centre and Integrated Rapid Response Service, shows that integration and alignment has clear benefits to customers/patients and to staff who become more knowledgeable of the wider health and social offer.

• There is a strong record of joint commissioning between health and social care and this has great benefits in terms of working in partnership, bringing together planning, funding and delivery of integrated services. Therefore, we want to further build on this framework and to develop an integrated commissioning hub in future.

Better Care Fund 2019/20 Template

5. Income

Selected Health and Wellbeing Board: Rotherham

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Rotherham	£2,700,150
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,700,150**

iBCF Contribution	Contribution
Rotherham	£12,709,487
Total iBCF Contribution	**£12,709,487**

Winter Pressures Grant	Contribution
Rotherham	£1,345,287
Total Winter Pressures Grant Contribution	**£1,345,287**

Are any additional LA Contributions being made in 2019/20? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Rotherham	£1,783,000	Additional contribution relates to intermediate care and community occupational services.
Total Additional Local Authority Contribution	**£1,783,000**	

CCG Minimum Contribution	Contribution
NHS Rotherham CCG	£19,614,894
Total Minimum CCG Contribution	**£19,614,894**

Are any additional CCG Contributions being made in 2019/20? If yes, please detail below	Yes

Additional CCG Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding

NHS Rotherham CCG	£2,217,000	Additional contribution relates to intermediate care and community occupational services.
Total Addition CCG Contribution	**£2,217,000**	
Total CCG Contribution	**£21,831,894**	

	2019/20
Total BCF Pooled Budget	**£40,369,818**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2019/20 Template

6. Expenditure

Selected Health and Wellbeing Board: Rotherham

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,700,150	£2,700,150	£0
Minimum CCG Contribution	£19,614,894	£19,614,894	£0
iBCF	£12,709,487	£12,709,487	£0
Winter Pressures Grant	£1,345,287	£1,345,287	£0
Additional LA Contribution	£1,783,000	£1,783,000	£0
Additional CCG Contribution	£2,217,000	£2,217,000	£0
Total	£40,369,818	£40,369,818	**£0**

Required Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£5,573,997	£10,056,894	£0
Adult Social Care services spend from the minimum CCG allocations	£6,975,909	£8,818,000	£0

Link to Scheme Type description

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Outputs: Planned Output Unit	Planned Outputs: Planned Output Estimate	Metric Impact: NEA	Metric Impact: DTOC	Metric Impact: RES	Metric Impact: REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner
1	Adult Mental Health Liaison	Co-located at the hospital's Urgent and Emergency Care Centre, with GP out of hours and social care to assess and support patients with mental heath conditions	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				High	High	Medium	Low	Mental Health		CCG
2	Home Improvement Agency	Needs, advice and support and handyperson service	Prevention / Early Intervention	Other	Carries out maintenance and repair and security tasks			Low	Low	Low	Low	Social Care		LA
2	Home Improvement Agency	Needs, advice and support and handyperson service	Prevention / Early Intervention	Other	Carries out maintenance and repair and security tasks			Low	Low	Low	Low	Social Care		LA
3	Falls Service	Community therapy provision to support prevention of falls	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				Medium	Medium	Medium	High	Community Health		LA
4	Reablement	Community based reablement service with therapy input	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge Teams				High	High	High	High	Social Care		LA

5	Domiciliary Care	Community based home care service	Home Care or Domiciliary Care			Packages	70.0	Medium	High	High	Medium	Social Care		LA
6	Community Stroke Service	Integrated community stroke service with therapy input	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				Medium	High	Medium	High	Community Health		CCG
7	Community Neurological Rehabilitation Service	Integrated community neurolig	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				Medium	High	Medium	High	Community Health		CCG
8	Breathing Space	Specialist community based respiratory service (bed based and home based)	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge Teams				High	High	High	High	Community Health		CCG
9	Expert Patient Programme	Educate patients to self-manage their long-term condition	Prevention / Early Intervention	Other	Training sessions delivered by Self Management UK			Low	Low	Low	Low	Other	Independent Sector Provider	CCG
10	Otago Exercise Programme	Community support for falls prevention	Personalised Care at Home			Packages	90.0	Medium	Low	Medium	High	Social Care		LA
11	Rotherham Equipment and Wheelchair Service	Community based service providing health and social care equipment and wheelchairs	Prevention / Early Intervention	Other	Service provided by Medequip, independent sector provider			High	High	High	High	Social Care		CCG
11	Rotherham Equipment and Wheelchair Service	Community based service providing health and social care equipment and wheelchairs	Prevention / Early Intervention	Other	Service provided by Medequip, independent sector provider			High	High	High	High	Social Care		CCG
12	Community Occupational Therapy Services	Carries out OT assessments and prescribes equipment and adaptations	Prevention / Early Intervention	Other	OT assessments carried out by community health services			High	High	High	High	Social Care		LA
12	Community Occupational Therapy Services	Carries out OT assessments and prescribes equipment and adaptations	Prevention / Early Intervention	Other	OT assessments carried out by community health services			High	High	High	High	Social Care		LA
13	Disabled Facilities Grant	Funding used for adaptations in person's own home	DFG Related Schemes	Adaptations				High	High	High	High	Social Care		LA
13	Disabled Facilities Grant	Funding used to procure equipment for community equipment service.	Assistive Technologies and Equipment	Community Based Equipment				High	High	High	High	Social Care		LA
14	Age UK Hospital Discharge Service	Hospital discharge service to support people short-term	Personalised Care at Home			Packages	783.0	Low	High	Low	Medium	Other	Charity/Voluntary Sector	CCG

15	Stroke Association Service	Community based service to provide advice, support for stroke survivors	Personalised Care at Home			Packages	218.0	Low	Medium	Low	Medium	Other	Charity/Voluntary Sector	CCG
16	Intermediate Care Pooled budget	Intermediate care bed and community based service	Intermediate Care Services	Reablement/Rehabilitation Services		Placements	245.0	High	High	High	High	Community Health		LA
16	Intermediate Care Pooled budget	Intermediate care bed and community based service	Intermediate Care Services	Reablement/Rehabilitation Services		Placements	332.0	High	High	High	High	Community Health		LA
16	Intermediate Care Pooled budget	Intermediate care bed and community based service	Intermediate Care Services	Reablement/Rehabilitation Services		Placements	198.0	High	High	High	High	Community Health		LA
16	Intermediate Care Pooled budget	Intermediate care bed and community based service	Intermediate Care Services	Reablement/Rehabilitation Services		Packages	125.0	High	High	High	High	Community Health		LA
17	Direct Payments	Enables customers to commission their own packages of care	Personalised Budgeting and Commissioning	Direct Payments				Medium	High	High	Medium	Social Care		LA
18	Supported Living	Community based scheme to support people to live more independently	Housing Related Schemes					Medium	Low	High	Low	Social Care		LA
19	Mental Health rehabilitation services	Community based residental placements for people with mental health conditions	Residential Placements	Care Home		Placements	5.0	Medium	Low	Low	Medium	Mental Health		LA
20	Learning Disability Services	Community based residential placements for people with learning disabilities	Residential Placements	Learning Disability		Placements	15.0	Medium	Low	Low	Medium	Social Care		LA
21	Care Act	To support increase in DOLS activity in application of Care Act	Care Act Implementation Related Duties	Deprivation of Liberty Safeguards (DoLS)				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA
21	Care Act	To support Care Act requirements	Care Act Implementation Related Duties	Other	Direct payments/ domicliary care			Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA
22	GP Case Management	Supports case management of people with long term conditions	Community Based Schemes					High	Medium	Medium	Low	Primary Care		CCG
23	Care Home Support Service	Provides suoport, assessments and delivers training to care homes to reduce A&E admissions	Community Based Schemes					High	Medium	Low	Medium	Community Health		CCG
24	Hospital End of Life Care	Hospice provides advice and rapid response in	Community Based Schemes					High	High	Low	Low	Community Health		CCG

		emergency situations												
25	Social Prescribing	Links people into services that promote reablement and community integration.	Personalised Care at Home			Packages	1,785.0	Medium	Medium	Low	Low	Other	Charity/Voluntary Sector	CCG
26	Social Work Support (A&E, Case Management, Supported Discharge)	Integrated Discharge Team to carry out assessments for complex discharges	HICM for Managing Transfer of Care	Chg 5. Seven-Day Services				Low	High	High	Low	Social Care		LA
27	Care co-ordination Centre	Health point of access for community servies to support admission avoidance	Community Based Schemes					High	High	Medium	Low	Community Health		CCG
28	Carers Support Services	To provide support to informal carers and to reduce stress/ breakdown of care	Carers Services	Carer Advice and Support				Medium	Medium	Medium	Low	Social Care		LA
28	Carers Support Services	To provide support to informal carers and to reduce stress/ breakdown of care	Carers Services	Carer Advice and Support				Medium	Medium	Medium	Low	Social Care		LA
28	Carers Support Services	To provide support to informal carers and to reduce stress/ breakdown of care	Carers Services	Carer Advice and Support				Medium	Medium	Medium	Low	Social Care		LA
29	Joint Commissioning Team	Supporting the commissioning function across CCG and RMBC	Enablers for Integration	Integrated commissioning models				High	High	High	High	Other	Commissioning	CCG
30	IT to Support Community Transformation	To support IT infrastructure and promote integrated working	Other		IT support			Low	Low	Low	Low	Other	Information Sharing	CCG
31	BCF Risk Pool	Funding to mitigate risks identified within the financial year	Other		Contingency			Low	Low	Low	Low	Acute		CCG
32	Sustainability & mitigation of service reduction to allow transformation	Increase capacity/ sustainability for residential care placements	Residential Placements	Care Home		Placements	116.0	High	Medium	Low	Low	Social Care		LA
32	Sustainability & mitigation of service reduction to allow transformation	Increase capacity/ sustainability for residential care placements	Residential Placements	Learning Disability		Placements	15.0	High	Medium	Low	Low	Social Care		LA
32	Sustainability & mitigation of service reduction to allow transformation	Increase capacity/ sustainability for care packages	Home Care or Domiciliary Care			Placements	142.0	Medium	High	High	Medium	Social Care		LA
32	Sustainability & mitigation of service reduction to allow transformation	Increase capacity/ sustainability for care packages	Personalised Budgeting and Commissioning	Direct Payments				Medium	High	High	Medium	Social Care		LA

32	Sustainability & mitigation of service reduction to allow transformation	Increase capacity of assessment and care planning	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				High	High	High	Medium	Social Care		LA
32	Sustainability & mitigation of service reduction to allow transformation	Increase capacity of social care prescribing for LTC and MH conditions	Personalised Care at Home			Packages	1,785.0	Medium	Medium	Medium	Low	Other	Social Prescribing	CCG
33	Information sharing and system development	To support IT infrastructure and promote integrated working	Other		Support systems			Medium	Medium	Medium	Medium	Other	Support systems	LA
33	Information sharing and system development	To support IT infrastructure and promote integrated working	Other		Support systems			Medium	Medium	Medium	Medium	Other	Information sharing	CCG
34	Leadership Capacity for System Transformation	Recruitment of Place Plan and OT/AT Managers	Other		Integration			High	High	High	High	Other	Integration	LA
35	Discharge Pathways and Patient Flow	IDT team to carry out asserssments for complex discharges	HICM for Managing Transfer of Care	Other approaches				Medium	High	High	Low	Acute		CCG
35	Discharge Pathways and Patient Flow	Increase capacity in community to deliver IC and reablement	Intermediate Care Services	Reablement/Rehabilitation Services		Packages	189.0	High	High	High	High	Social Care		LA
35	Discharge Pathways and Patient Flow	Winter planning monies to assist health and social care system e.g. winter beds	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				High	High	High	High	Other	Winter Planning	CCG
35	Discharge Pathways and Patient Flow	Age UK's additional monies to increase capacity over winter to reduce DTOC	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Low	High	Low	Medium	Continuing Care		CCG
35	Discharge Pathways and Patient Flow	Additional sw resource to support asst and case mgt	Integrated Care Planning and Navigation	Care Coordination				Medium	Medium	Medium	Medium	Social Care		LA
36	Market Capacity and sustainability	To provide financial sustainability to LD providers	Other		LD Market Sustainability			Medium	Medium	Low	Low	Social Care		LA
36	Market Capacity and sustainability	To meet increasing costs of care home placements	Other		Independent Provider Fee inflation uplift			Medium	Medium	Low	Low	Social Care		LA
36	Market Capacity and sustainability	To meet increasing costs of deliverying care packages at home.	Personalised Care at Home			Packages	14.0	Medium	High	High	Medium	Social Care		LA
37	Prevention and Early Intervention	Advice and guideance to support single point of access and prevent social isolation	Prevention / Early Intervention	Other	Advice and Guidance			Medium	Medium	Low	Low	Social Care		LA

37	Prevention and Early Intervention	Advice and guideance to support single point of access and prevent social isolation	Prevention / Early Intervention	Other	Social Isolation			Medium	Medium	Medium	Low	Social Care		LA
32	Sustainability & mitigation of service reduction to allow transformation	To meet increasing costs of care home placements including transistional placements from children's	Residential Placements	Learning Disability		Placements	23.0	Medium	High	Low	Low	Social Care		LA
38	Implementation of new staff operating model	Support tool to empower and engage staff to build capacity during implementation of new operating model	Care Act Implementation Related Duties	Other	Increase capacity and performance			Medium	High	High	Medium	Social Care		LA
38	Market Capacity and sustainability	To meet increasing costs of care home placements	Other		Independent Provider Fee inflation uplift			Medium	Medium	Low	Low	Social Care		LA
38	Integrated Discharge Team	Increase staffing capacity to support Intermediate care	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge Teams				High	High	High	High	Social Care		LA
38	Intermediate Care and reablement pathway	Increase reablement capacity	Intermediate Care Services	Reablement/Rehabilitation Services		Packages	240.0	Medium	Medium	Low	High	Social Care		LA
38	Intermediate Care Occupational Theraphy/Reablement	Additional OT capacity to support implemenation of new operating model	Other		OT support for Intermediate Care			Medium	Medium	Low	High	Social Care		LA
38	Mental Health diversion	Increase staffing support	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Low	Medium	Medium	Medium	Social Care		LA

Better Care Fund 2019/20 Template

7. High Impact Change Model

Selected Health and Wellbeing Board:	Rotherham

Explain your priorities for embedding elements of the High Impact Change Model for Managing Transfers of Care locally, including:

- Current performance issues to be addressed
- The changes that you are looking to embed further - including any changes in the context of commitments to reablement and Enhanced Health in Care Homes in the NHS Long-Term Plan
- Anticipated improvements from this work

The project to integrate the health and social care discharge team has been completed. 27 discharge destinations have been streamlined into 3 pathways, discharges home for over 65s have increased by 4.04% and DTOCs have been consistently reduced to below the national average. It is estimated that c £0.5M of acute bed days have been saved and that the introduction of a new single electronic referral process saves c 30 minutes per patient, which can now be spent on care. DSTs are now all carried out outside of the acute setting. A weekly hospital wide review of stranded patients has been introduced, based on the Emergency Care Intensive Support Team (ECIST) model. The integrated team won a national Health Service Journal award for value for money. There remains some performance variation and seasonal spikes through the year. In order to embed the change and continue to reduce DTOCS, we are reviewing the Integrated Discharge Team, with the aim of implementing a fully funded 7 day service in 2019/20. As part of the Rotherham Place Plan, intermediate care pathways will be streamlined from 7 to 3, with home based care as the default pathway. The new model will have an integrated leadership structure, enabling end to end management of patient flow starting with early discharge planning and management of patient transfers from acute discharge, through community beds (where appropriate) and back home. This will ensure that patients receive the right level of care for them and that processes are streamlined to speed up transfers and reduce duplication and gaps resulting from previous siloed working. A new therapy led community unit with nursing offer, within the independent sector, will bridge the gap for patients who do not require consultant led care, but still require some medical intervention which cannot be met at home.

Achievements within the Enhanced Health Care in Care Homes domains over the last 12 months include working to embed pharmacy teams into the health and social care system to support care homes and their residents with medicines optimisation, relaunch of red bag system to improve communication between care home and hospital, development of an integrated health and social care training offer to support workforce development, in particular on areas such as hydration, nutrition, diabetes, respiratory, dementia, pressure areas and oral health. Apprenticeships for trainee nurse associate are also being offered by South Yorkshire Region Excellent Centre (SYREC) to improve recruitment and retention of staff and development of career pathways. A community physician working with care homes will support delivery of enhanced case management for those identified as at risk of attending/admission to A&E. All care homes are now registered on the NHS Capacity tracker system which provides regular 'live' updates on information, including current bed vacancies, placement costs, location, contact details and CQC ratings. The portal assists practitioners to identify where available placements are and provides coordinated data in one place and supports hospital discharge planning. All care homes are now registered on the Data Security and Protection Toolkit and NHS mail system to ensure secure and efficient communication between organisations e.g. hospitals, GP practices, pharmacies and care homes so that patient data is shared safely. Hospice at Home Care Home Pilot has now been extended until 31.3.20, which addresses both immediate advice and rapid response in emergency situations and the provision of education and supervision of front line care and residential home staff. Rotherham Health App has been developed which enables patients to make on-line GP appointments, view their records and order repeat medication. Carers can be given "proxy" access for the people they care for, to enable them to make appointments and request medication on their behalf. There is the potential to give care homes a dedicated portal to manage their residents and this would allow them to see discharge letters. CCG/BCF funding is continually provided to support the GP Local Enhanced Service (LES), Care Home Support, Advanced Nurse Practitioner, Mental Health Liaison Team and Clinical Quality Advisor to reduce emergency hospital admissions and improve quality standards. Rotherham CCG are currently considering the implementation of Extension to Community Healthcare Outcomes (ECHO) project in 2019/20 which aims to make specialised medical knowledge accessible wherever it is needed, placing local clinicians together with specialist teams at academic medical centres in weekly virtual clinics or tele-ECHO clinics. It also has the ability to release staff to attend training courses by remotely educating staff, reduces variation in training and supports the education of care home staff through distance learning.

		Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020	If the planned maturity level for 2019/20 is below established, please state reasons behind that?
Chg 1	**Early discharge planning**	Established	Established	
Chg 2	**Systems to monitor patient flow**	Mature	Mature	
Chg 3	**Multi-disciplinary/Multi-agency discharge teams**	Exemplary	Exemplary	
Chg 4	**Home first / discharge to assess**	Mature	Mature	
Chg 5	**Seven-day service**	Established	Mature	
Chg 6	**Trusted assessors**	Mature	Mature	
Chg 7	**Focus on choice**	Established	Mature	
Chg 8	**Enhancing health in care homes**	Mature	Mature	

Better Care Fund 2019/20 Template

8. Metrics

Selected Health and Wellbeing Board: Rotherham

8.1 Non-Elective Admissions

	19/20 Plan	Overview Narrative
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	The non elective plan reflects the affordable level of admissions that has been agreed within provider contracts. This affordable level incorporates anticipated growth in activity, the financial constraints within the system and proposed improvement and productivity schemes. The plan is the position agreed with the CCG's regulator NHS England both at a CCG and an Integrated Care System (South Yorkshire and Bassetlaw) level. This is agreed as meeting the national expectations set out in NHS England and NHS Improvement shared planning guidance. This position is aligned with providers' agreed positions and signed off as part of the CCG's contract with each provider. In addition the CCGs improvement and productivity schemes go through a significant assurance process, including external review and are monitored across a number of key forums. The key schemes with expected impacts on the level of non elective admissions are: The implementation of an integrated urgent and emergency care centre Remodelling of IC and reablement model to include step-up provision to avoid hospital admission. Further interventions in mental health liaison Development of a more effective ambulatory care pathway Continued provision of social prescribing for LTC and mental health patients Continued case management in risk stratified patients Further developments in integrated locality working Hospice at Home services to provide immediate advice and support for those in community and in care homes. - Continued provision of Care-ordination Centre, Integrated Rapid Response, Advanced Nurse Practitioner Service, Intermediate Care Service and GP Local Enhanced Service (LES).

Please set out the overall plan in the HWB area for reducing Non-Elective Admissions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Plans are yet to be finalised and signed-off so are subject to change; **for the latest version of the NEA CCG operating plans at your HWB footprint please contact your local Better Care Manager (BCM)** in the first instance or write in to the support inbox:
ENGLAND.bettercaresupport@nhs.net

8.2 Delayed Transfers of Care

19/20 Plan	Overview Narrative

Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	16.1	The Rotherham HWB plan is to return to the level of 16.1 daily days, which was previously being achieved. An integrated discharge team (IDT) is fully embedded in the Rotherham system and is driving down DTOC through a single referral route for complex patients. A Multi Disciplinary Team approach across social care, nursing and therapy is in place as part of this single referral route. The monitoring of DTOCs now forms part of a system escalation processes. An increasing MH DTOC position has been identified as the greatest challenge to returning to 16.1 daily delays. This has led to the establishment of a focus group to understand the issues and address barriers. This is supporting the reduction in MH DTOCs and is expected to continue to ensure DTOCs remain in line with national expectations. The group is looking to ensure the same processes are in place for MH as they are in the IDT . Customer journey work is being undertaken and a social worker inpatient ward co-ordinator post is being created. Ensuring links across DTOC and NEA work streams, a trusted assessor in AMU/A&E has also been established to support admission avoidance. A community physician working with care homes will support delivery of enhanced case management for those identified as at risk of attending/admission to A&E.	**Please set out the overall plan in the HWB area for reducing Delayed Transfers of Care to meet expectations set for your area. This should include any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric. Include in this, your agreed plan for using the Winter Pressures grant funding to support the local health and care system to manage demand pressures on the NHS, with particular reference to seasonal winter pressures.**

Please note that the plan figure for Greater Manchester has been combined, for HWBs in Greater Manchester please comment on individuals HWBs rather than Greater Manchester as a whole.
Please note that due to the merger of Bournemouth, Christchurch and Poole to a new Local Authority will mean that planning information from 2018/19 will not reflect the present geographies.

8.3 Residential Admissions

		18/19 Plan	19/20 Plan	Comments	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	555	503	In order to provide customers with greater independence and choice within a recovery model, admission to 24 hour care is provided only for those people who can no longer be supported to have their needs met by remaining at home in the community. A challenging stretch performance target for 2019/20 of 25 fewer admissions than the 289 made in 2018/19, has been set to achieve service continuous improvement by reducing the number of total admissions to 264 which represents a 10% improvement on last year's rate (from 559 to 503 new admissions per 100,000 population). There is a proportionate range of scheme types and spend to help deliver the metric ambition, some of the higher impact schemes include: reablement, domiciliary care, Breathing Space, Rotherham Equipment and Wheelchair Service, Disabled Facilities Grant, Intermediate Care, Direct Payments, Supported Living and Discharge Pathways and Patient Flow. Performance by March 2020, resulting in fewer than 289 admissions by year end will extend the positive direction of travel trend for a 6th successive year. Based on latest (2017/18) benchmarking data, it would also further improve Rotherham to a better than national average ranking. The above improved 2018/19 performance, continues to demonstrate that the prevent; reduce and delay commitment and new models of best practice service offers, are (for the vast majority) sustaining people to achieve their preferred choice of support - of remaining at home in the community, for as long as they can be supported to do so.	**Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**
	Numerator	287	264		
	Denominator	51,693	52,438		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2016 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2016basedprojections
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a Residential Admissions rate for these two Health and Well-Being Boards.

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

8.4 Reablement

		18/19 Plan	19/20 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	89.0%	86.0%	This is an annual measure and collation of data is undertaken during January to March 2020 period to track service users who have been 'offered' (i.e. commenced) the service during October to December 2019, to identify those who were still at home 91 days following discharge from hospital. A performance target for 2019/20 of 86% has been set to achieve a moderate service continuous improvement, by increasing the proportion of people who are discharged from the service, who are subsequently still at home after 91 days later (this would mean approximately 10 extra people for every 11 extra offered the service). The new Target Operating Model for Adult Care, is due to be implemented in October 2019, with an increased focus on reablement at home. It is expected that numbers receiving reablement, within the snapshot period will increase. However, the limited target increase to 86% of individuals being at home 91 days later, should enable the service to effectively manage any negative impact of unseen change in customer profiles or complexity and to ensure that the service can meet this higher demand, whilst mitigating any increased risk to being able to maintain performance. Achievement of 86% in 2019/20 would achieve a three year upward trend and consolidate benchmarking (using 17/18 published figures), to just above national average and allows for any in year impact of the new Target Operating Model. There is a proportionate range of scheme types and spend to help deliver the metric ambition, some of the higher impact schemes include: Reablement Community Stroke Service Breathing Space Rotherham Equipment and Wheelchair Service Community Occupational Therapy Services Disabled Facilities Grant Intermediate Care Pooled budget Falls Service Discharge Pathways and Patient Flow
	Numerator	162	123	
	Denominator	182	143	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

Better Care Fund 2019/20 Template

9. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Rotherham

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions place towards meeting the requirement
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	**Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted?** Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Do the governance arrangements described support collaboration and integrated care? Where the strategic narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure, metric and HICM sections of the plan been submitted for each HWB concerned?	Yes	BCF Section 75 agreement in place in 2019/20. HWB approved on 18.9.19 which includes LA, CCG, VCS representatives and providers. Governance arrangements described under strategic narrative tab.	
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that covers:** - Person centred care, including approaches to delivering joint assessments, promoting choice, independence and personalised care? - A clear approach at HWB level for integrating services that supports the overall approach to integrated care and confirmation that the approach supports delivery at the interface between health and social care? - A description of how the local BCF plan and other integration plans e.g. STP/ICSs align? - Is there a description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? This should include confirmation that equality impacts of the local BCF plan have been considered, a description of local priorities related to health inequality and equality that the BCF plan will contribute to addressing. Has the plan summarised any changes from the previous planning period? And noted (where appropriate) any lessons learnt?	Yes	Narrative plan included within the strategic narrative tab.	
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home. In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Yes	Confirmation of DFG included within strategic narrative tab.	
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Yes	Confirmation illustrated within the income and expenditure tabs.	
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Yes	Confirmation illustrated within the income and expenditure tabs.	

NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	**PR6**	**Is there a plan for implementing the High Impact Change Model for managing transfers of care?**	**Does the BCF plan demonstrate a continued plan in place for implementing the High Impact Change Model for Managing Transfers of Care?** Has the area confirmed the current level of implementation and the planned level at March 2020 for all eight changes? Is there an accompanying overall narrative setting out the priorities and approach for ongoing implementation of the HICM? Does the level of ambition set out for implementing the HICM changes correspond to performance challenges in the system? If the current level of implementation is below established for any of the HICM changes, has the plan included a clear explanation and set of actions towards establishing the change as soon as possible in 2019-20?	Yes	Described under the High Impact Change Model tab.	
Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Have the planned schemes been assigned to the metrics they are aiming to make an impact on?Expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated)Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (tick-box)Is there an agreed plan for use of the Winter Pressures grant that sets out how the money will be used to address expected demand pressures on the Health system over Winter?**Has funding for the following from the CCG contribution been identified for the area?**- Implementation of Care Act duties?- Funding dedicated to carer-specific support?- Reablement?	Yes	Described under the expenditure tab.	
	PR8	**Indication of outputs for specified scheme types**	Has the area set out the outputs corresponding to the planned scheme types (Note that this is only for where any of the specified set of scheme types requiring outputs are planned)? (auto-validated)	Yes	Described under the expenditure tab.	
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric? Is there a proportionate range of scheme types and spend included in the expenditure section of the plan to support delivery of the metric ambitions for each of the metrics? Do the narrative plans for each metric set out clear and ambitious approaches to delivering improvements? **Have stretching metrics been agreed locally for:** - Metric 2: Long term admission to residential and nursing care homes - Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement	Yes	Described under the expenditure and metrics tab.	

CCG to Health and Well-Being Board Mapping for 2019/20

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	90.7%	87.4%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	6.9%	8.3%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.4%	0.6%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.5%	3.5%
E09000002	Barking and Dagenham	08W	NHS Waltham Forest CCG	0.1%	0.1%
E09000003	Barnet	07M	NHS Barnet CCG	91.1%	92.1%
E09000003	Barnet	07P	NHS Brent CCG	2.0%	1.8%
E09000003	Barnet	07R	NHS Camden CCG	1.0%	0.7%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000003	Barnet	07X	NHS Enfield CCG	3.0%	2.4%
E09000003	Barnet	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000003	Barnet	08D	NHS Haringey CCG	2.2%	1.6%
E09000003	Barnet	08E	NHS Harrow CCG	1.2%	0.8%
E09000003	Barnet	06N	NHS Herts Valleys CCG	0.0%	0.1%
E09000003	Barnet	08H	NHS Islington CCG	0.2%	0.1%
E09000003	Barnet	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.6%	98.1%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.4%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.4%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11E	NHS Bath and North East Somerset CCG	93.5%	98.3%
E06000022	Bath and North East Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.9%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	99N	NHS Wiltshire CCG	0.1%	0.3%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.7%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	04G	NHS Nene CCG	0.2%	0.6%
E09000004	Bexley	07N	NHS Bexley CCG	93.4%	89.8%
E09000004	Bexley	07Q	NHS Bromley CCG	0.1%	0.1%
E09000004	Bexley	09J	NHS Dartford, Gravesham and Swanley CCG	1.4%	1.5%
E09000004	Bexley	08A	NHS Greenwich CCG	7.2%	8.4%
E09000004	Bexley	08L	NHS Lewisham CCG	0.1%	0.1%
E08000025	Birmingham	15E	NHS Birmingham and Solihull CCG	78.4%	81.7%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05J	NHS Redditch and Bromsgrove CCG	3.1%	0.4%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	39.2%	17.8%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	88.9%	95.8%

E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.7%	1.7%
E06000009	Blackpool	00R	NHS Blackpool CCG	86.4%	97.6%
E06000009	Blackpool	02M	NHS Fylde & Wyre CCG	2.1%	2.4%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.5%
E08000001	Bolton	00V	NHS Bury CCG	1.5%	1.0%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000058	Bournemouth, Christchurch and Poole	11J	NHS Dorset CCG	52.4%	99.7%
E06000058	Bournemouth, Christchurch and Poole	11A	NHS West Hampshire CCG	0.2%	0.3%
E06000036	Bracknell Forest	15A	NHS Berkshire West CCG	0.5%	2.0%
E06000036	Bracknell Forest	15D	NHS East Berkshire CCG	26.1%	96.9%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.0%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.2%	0.1%
E08000032	Bradford	02N	NHS Airedale, Wharfdale and Craven CCG	67.2%	18.4%
E08000032	Bradford	02W	NHS Bradford City CCG	98.9%	23.9%
E08000032	Bradford	02R	NHS Bradford Districts CCG	98.0%	56.3%
E08000032	Bradford	02T	NHS Calderdale CCG	0.2%	0.0%
E08000032	Bradford	15F	NHS Leeds CCG	0.9%	1.4%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.2%	0.0%
E09000005	Brent	07M	NHS Barnet CCG	2.3%	2.4%
E09000005	Brent	07P	NHS Brent CCG	89.7%	86.4%
E09000005	Brent	07R	NHS Camden CCG	3.9%	2.8%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.3%	0.7%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	0.6%	0.4%
E09000005	Brent	08E	NHS Harrow CCG	5.9%	4.0%
E09000005	Brent	08Y	NHS West London (K&C & QPP) CCG	4.3%	2.7%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.9%	99.7%
E06000043	Brighton and Hove	09G	NHS Coastal West Sussex CCG	0.1%	0.2%
E06000043	Brighton and Hove	99K	NHS High Weald Lewes Havens CCG	0.3%	0.1%
E06000023	Bristol, City of	11E	NHS Bath and North East Somerset CCG	0.1%	0.0%
E06000023	Bristol, City of	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	49.3%	100.0%
E09000006	Bromley	07N	NHS Bexley CCG	0.2%	0.1%
E09000006	Bromley	07Q	NHS Bromley CCG	94.6%	95.1%
E09000006	Bromley	07V	NHS Croydon CCG	1.2%	1.4%
E09000006	Bromley	08A	NHS Greenwich CCG	1.4%	1.2%
E09000006	Bromley	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000006	Bromley	08K	NHS Lambeth CCG	0.1%	0.2%
E09000006	Bromley	08L	NHS Lewisham CCG	1.9%	1.8%
E09000006	Bromley	99J	NHS West Kent CCG	0.1%	0.2%
E10000002	Buckinghamshire	06F	NHS Bedfordshire CCG	0.6%	0.5%
E10000002	Buckinghamshire	14Y	NHS Buckinghamshire CCG	94.4%	94.9%
E10000002	Buckinghamshire	15D	NHS East Berkshire CCG	1.4%	1.2%

E10000002	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E10000002	Buckinghamshire	08G	NHS Hillingdon CCG	0.7%	0.4%
E10000002	Buckinghamshire	04F	NHS Milton Keynes CCG	1.3%	0.7%
E10000002	Buckinghamshire	04G	NHS Nene CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.6%	0.7%
E08000002	Bury	00T	NHS Bolton CCG	0.8%	1.2%
E08000002	Bury	00V	NHS Bury CCG	94.0%	94.3%
E08000002	Bury	01A	NHS East Lancashire CCG	0.0%	0.2%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	14L	NHS Manchester CCG	0.6%	2.0%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.9%
E08000033	Calderdale	02R	NHS Bradford Districts CCG	0.4%	0.6%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.4%	98.9%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.3%	0.3%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.7%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	71.8%	96.7%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.8%	0.7%
E10000003	Cambridgeshire	99D	NHS South Lincolnshire CCG	0.3%	0.0%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07J	NHS West Norfolk CCG	1.6%	0.4%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	4.0%	1.4%
E09000007	Camden	07M	NHS Barnet CCG	0.2%	0.3%
E09000007	Camden	07P	NHS Brent CCG	1.3%	1.9%
E09000007	Camden	07R	NHS Camden CCG	83.9%	88.9%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	5.6%	4.8%
E09000007	Camden	08C	NHS Hammersmith and Fulham CCG	0.4%	0.3%
E09000007	Camden	08D	NHS Haringey CCG	0.5%	0.6%
E09000007	Camden	08H	NHS Islington CCG	3.2%	3.0%
E09000007	Camden	08Y	NHS West London (K&C & QPP) CCG	0.3%	0.2%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.6%	95.0%
E06000056	Central Bedfordshire	14Y	NHS Buckinghamshire CCG	0.8%	1.5%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.9%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.3%	1.9%
E06000056	Central Bedfordshire	04F	NHS Milton Keynes CCG	0.1%	0.1%
E06000049	Cheshire East	15M	NHS Derby and Derbyshire CCG	0.1%	0.3%
E06000049	Cheshire East	01C	NHS Eastern Cheshire CCG	96.4%	50.2%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.1%	0.6%
E06000049	Cheshire East	01R	NHS South Cheshire CCG	98.6%	45.8%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.2%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02D	NHS Vale Royal CCG	0.6%	0.2%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	02F	NHS West Cheshire CCG	1.9%	1.2%
E06000050	Cheshire West and Chester	01C	NHS Eastern Cheshire CCG	1.2%	0.7%

E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	01R	NHS South Cheshire CCG	0.5%	0.2%
E06000050	Cheshire West and Chester	02D	NHS Vale Royal CCG	99.4%	29.5%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	02F	NHS West Cheshire CCG	96.9%	69.1%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.3%
E09000001	City of London	07R	NHS Camden CCG	0.2%	7.0%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.1%	2.5%
E09000001	City of London	07T	NHS City and Hackney CCG	1.8%	70.4%
E09000001	City of London	08C	NHS Hammersmith and Fulham CCG	0.0%	1.2%
E09000001	City of London	08H	NHS Islington CCG	0.1%	3.6%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.4%	15.0%
E09000001	City of London	08Y	NHS West London (K&C & QPP) CCG	0.0%	0.2%
E06000052	Cornwall & Scilly	15N	NHS Devon CCG	0.3%	0.6%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000047	County Durham	00D	NHS Durham Dales, Easington and Sedgefield CCG	97.0%	52.4%
E06000047	County Durham	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.0%
E06000047	County Durham	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.1%	0.0%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	00J	NHS North Durham CCG	96.7%	46.3%
E06000047	County Durham	00P	NHS Sunderland CCG	1.2%	0.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.5%	99.8%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.4%	0.2%
E09000008	Croydon	07Q	NHS Bromley CCG	1.6%	1.3%
E09000008	Croydon	07V	NHS Croydon CCG	95.3%	93.2%
E09000008	Croydon	09L	NHS East Surrey CCG	2.9%	1.3%
E09000008	Croydon	08C	NHS Hammersmith and Fulham CCG	0.2%	0.0%
E09000008	Croydon	08K	NHS Lambeth CCG	3.0%	3.0%
E09000008	Croydon	08R	NHS Merton CCG	0.8%	0.4%
E09000008	Croydon	08T	NHS Sutton CCG	0.8%	0.4%
E09000008	Croydon	08X	NHS Wandsworth CCG	0.5%	0.5%
E10000006	Cumbria	01K	NHS Morecambe Bay CCG	54.0%	36.6%
E10000006	Cumbria	01H	NHS North Cumbria CCG	99.9%	63.4%
E06000005	Darlington	00C	NHS Darlington CCG	98.2%	96.1%
E06000005	Darlington	00D	NHS Durham Dales, Easington and Sedgefield CCG	1.2%	3.2%
E06000005	Darlington	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.2%
E06000005	Darlington	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.6%
E06000015	Derby	15M	NHS Derby and Derbyshire CCG	26.5%	100.0%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	15M	NHS Derby and Derbyshire CCG	70.9%	92.6%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	7.9%	1.4%
E10000007	Derbyshire	01C	NHS Eastern Cheshire CCG	0.3%	0.0%
E10000007	Derbyshire	04E	NHS Mansfield and Ashfield CCG	2.1%	0.5%
E10000007	Derbyshire	04L	NHS Nottingham North and East CCG	0.3%	0.0%
E10000007	Derbyshire	04M	NHS Nottingham West CCG	5.1%	0.6%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.4%

E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	13.9%	4.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.5%	0.2%
E10000008	Devon	15N	NHS Devon CCG	65.7%	99.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.3%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.5%	0.6%
E08000017	Doncaster	02X	NHS Doncaster CCG	96.8%	97.8%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.2%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.2%
E06000059	Dorset	11J	NHS Dorset CCG	46.0%	95.6%
E06000059	Dorset	11X	NHS Somerset CCG	0.6%	0.9%
E06000059	Dorset	11A	NHS West Hampshire CCG	1.7%	2.5%
E06000059	Dorset	99N	NHS Wiltshire CCG	0.7%	1.0%
E08000027	Dudley	15E	NHS Birmingham and Solihull CCG	0.1%	0.6%
E08000027	Dudley	05C	NHS Dudley CCG	93.3%	90.7%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	3.9%	6.9%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.8%	1.5%
E08000027	Dudley	06D	NHS Wyre Forest CCG	0.8%	0.3%
E09000009	Ealing	07P	NHS Brent CCG	1.8%	1.6%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000009	Ealing	07W	NHS Ealing CCG	86.9%	90.4%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.5%	3.1%
E09000009	Ealing	08E	NHS Harrow CCG	0.4%	0.3%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.7%	0.5%
E09000009	Ealing	07Y	NHS Hounslow CCG	4.7%	3.5%
E09000009	Ealing	08Y	NHS West London (K&C & QPP) CCG	0.7%	0.4%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.3%	85.1%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	9.2%	7.9%
E06000011	East Riding of Yorkshire	03M	NHS Scarborough and Ryedale CCG	0.7%	0.2%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.6%	6.8%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.0%	0.6%
E10000011	East Sussex	09F	NHS Eastbourne, Hailsham and Seaford CCG	100.0%	34.7%
E10000011	East Sussex	09P	NHS Hastings and Rother CCG	99.7%	33.3%
E10000011	East Sussex	99K	NHS High Weald Lewes Havens CCG	98.1%	29.6%
E10000011	East Sussex	09X	NHS Horsham and Mid Sussex CCG	2.8%	1.2%
E10000011	East Sussex	99J	NHS West Kent CCG	0.8%	0.7%
E09000010	Enfield	07M	NHS Barnet CCG	1.0%	1.2%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E09000010	Enfield	07X	NHS Enfield CCG	95.2%	90.9%
E09000010	Enfield	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000010	Enfield	08D	NHS Haringey CCG	7.7%	6.9%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%

E09000010	Enfield	08H	NHS Islington CCG	0.2%	0.1%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.1%	0.0%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.2%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.2%	11.5%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.6%	0.6%
E10000012	Essex	08F	NHS Havering CCG	0.3%	0.0%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.5%
E10000012	Essex	06T	NHS North East Essex CCG	98.6%	22.7%
E10000012	Essex	08N	NHS Redbridge CCG	2.9%	0.6%
E10000012	Essex	99G	NHS Southend CCG	3.3%	0.4%
E10000012	Essex	07G	NHS Thurrock CCG	1.4%	0.2%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	07H	NHS West Essex CCG	97.1%	19.8%
E10000012	Essex	07K	NHS West Suffolk CCG	2.3%	0.4%
E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	38.5%	97.7%
E08000037	Gateshead	00J	NHS North Durham CCG	0.9%	1.2%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.8%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E08000037	Gateshead	00P	NHS Sunderland CCG	0.0%	0.1%
E10000013	Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.1%	0.1%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.6%	98.6%
E10000013	Gloucestershire	05F	NHS Herefordshire CCG	0.5%	0.1%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.6%	0.2%
E10000013	Gloucestershire	05T	NHS South Worcestershire CCG	1.1%	0.5%
E10000013	Gloucestershire	99N	NHS Wiltshire CCG	0.2%	0.2%
E09000011	Greenwich	07N	NHS Bexley CCG	5.1%	4.2%
E09000011	Greenwich	07Q	NHS Bromley CCG	1.1%	1.3%
E09000011	Greenwich	08A	NHS Greenwich CCG	89.2%	89.3%
E09000011	Greenwich	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000011	Greenwich	08L	NHS Lewisham CCG	4.4%	4.9%
E09000011	Greenwich	08Q	NHS Southwark CCG	0.1%	0.1%
E09000012	Hackney	07R	NHS Camden CCG	0.7%	0.7%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.2%	93.8%
E09000012	Hackney	08C	NHS Hammersmith and Fulham CCG	0.5%	0.4%
E09000012	Hackney	08D	NHS Haringey CCG	0.6%	0.7%
E09000012	Hackney	08H	NHS Islington CCG	4.6%	3.7%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.5%	0.6%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.5%
E06000006	Halton	01J	NHS Knowsley CCG	0.2%	0.3%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E06000006	Halton	02E	NHS Warrington CCG	0.7%	1.1%
E06000006	Halton	02F	NHS West Cheshire CCG	0.6%	1.1%

E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07R	NHS Camden CCG	0.1%	0.1%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.5%	2.5%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.6%	1.1%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	82.8%	87.6%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.7%
E09000013	Hammersmith and Fulham	08X	NHS Wandsworth CCG	0.2%	0.3%
E09000013	Hammersmith and Fulham	08Y	NHS West London (K&C & QPP) CCG	6.5%	7.2%
E10000014	Hampshire	15A	NHS Berkshire West CCG	1.7%	0.6%
E10000014	Hampshire	09G	NHS Coastal West Sussex CCG	0.2%	0.1%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	15D	NHS East Berkshire CCG	0.2%	0.0%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.5%	14.3%
E10000014	Hampshire	09N	NHS Guildford and Waverley CCG	2.9%	0.5%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.5%	12.4%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.2%	15.9%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.4%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.6%	14.6%
E10000014	Hampshire	10X	NHS Southampton CCG	5.1%	1.0%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.8%	0.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.1%
E10000014	Hampshire	99N	NHS Wiltshire CCG	1.3%	0.4%
E09000014	Haringey	07M	NHS Barnet CCG	1.0%	1.4%
E09000014	Haringey	07R	NHS Camden CCG	0.6%	0.6%
E09000014	Haringey	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.1%	3.2%
E09000014	Haringey	07X	NHS Enfield CCG	1.3%	1.4%
E09000014	Haringey	08C	NHS Hammersmith and Fulham CCG	0.4%	0.3%
E09000014	Haringey	08D	NHS Haringey CCG	87.7%	91.0%
E09000014	Haringey	08H	NHS Islington CCG	2.5%	2.1%
E09000015	Harrow	07M	NHS Barnet CCG	4.3%	6.4%
E09000015	Harrow	07P	NHS Brent CCG	3.6%	4.8%
E09000015	Harrow	07W	NHS Ealing CCG	1.3%	2.1%
E09000015	Harrow	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000015	Harrow	08E	NHS Harrow CCG	89.7%	84.1%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.5%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.8%	2.0%
E09000015	Harrow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000001	Hartlepool	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.6%
E06000001	Hartlepool	00K	NHS Hartlepool and Stockton-On-Tees CCG	32.4%	99.4%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	3.5%	2.9%
E09000016	Havering	08F	NHS Havering CCG	91.7%	96.2%
E09000016	Havering	08M	NHS Newham CCG	0.1%	0.2%
E09000016	Havering	08N	NHS Redbridge CCG	0.6%	0.7%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.0%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	0.9%

E06000019	Herefordshire, County of	05F	NHS Herefordshire CCG	98.2%	97.3%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	05T	NHS South Worcestershire CCG	0.8%	1.3%
E10000015	Hertfordshire	07M	NHS Barnet CCG	0.2%	0.0%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	14Y	NHS Buckinghamshire CCG	0.2%	0.1%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	97.0%	46.5%
E10000015	Hertfordshire	07X	NHS Enfield CCG	0.5%	0.1%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.6%	0.1%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.0%	50.7%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.2%	0.6%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.8%	0.2%
E09000017	Hillingdon	14Y	NHS Buckinghamshire CCG	0.0%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.2%	6.9%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.2%	1.8%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.3%	89.8%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.1%	1.0%
E09000018	Hounslow	07W	NHS Ealing CCG	5.4%	7.4%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.2%	0.9%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.2%	87.1%
E09000018	Hounslow	09Y	NHS North West Surrey CCG	0.3%	0.4%
E09000018	Hounslow	08P	NHS Richmond CCG	5.7%	3.8%
E09000018	Hounslow	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07R	NHS Camden CCG	4.9%	5.4%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.5%	0.5%
E09000019	Islington	07T	NHS City and Hackney CCG	3.4%	4.2%
E09000019	Islington	08C	NHS Hammersmith and Fulham CCG	0.5%	0.5%
E09000019	Islington	08D	NHS Haringey CCG	1.2%	1.5%
E09000019	Islington	08H	NHS Islington CCG	89.1%	87.9%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	07R	NHS Camden CCG	0.2%	0.3%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.0%	5.4%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	1.2%	1.7%
E09000020	Kensington and Chelsea	08Y	NHS West London (K&C & QPP) CCG	63.9%	92.5%
E10000016	Kent	09C	NHS Ashford CCG	100.0%	8.3%
E10000016	Kent	07N	NHS Bexley CCG	1.3%	0.2%
E10000016	Kent	07Q	NHS Bromley CCG	0.9%	0.2%
E10000016	Kent	09E	NHS Canterbury and Coastal CCG	100.0%	14.1%
E10000016	Kent	09J	NHS Dartford, Gravesham and Swanley CCG	98.3%	16.5%
E10000016	Kent	09L	NHS East Surrey CCG	0.1%	0.0%
E10000016	Kent	08A	NHS Greenwich CCG	0.2%	0.0%

E10000016	Kent	09P	NHS Hastings and Rother CCG	0.3%	0.0%
E10000016	Kent	99K	NHS High Weald Lewes Havens CCG	0.6%	0.0%
E10000016	Kent	09W	NHS Medway CCG	6.1%	1.1%
E10000016	Kent	10A	NHS South Kent Coast CCG	100.0%	12.9%
E10000016	Kent	10D	NHS Swale CCG	99.8%	7.1%
E10000016	Kent	10E	NHS Thanet CCG	100.0%	9.1%
E10000016	Kent	99J	NHS West Kent CCG	98.7%	30.4%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.4%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	90.8%	98.6%
E09000021	Kingston upon Thames	08J	NHS Kingston CCG	86.9%	95.9%
E09000021	Kingston upon Thames	08R	NHS Merton CCG	1.1%	1.3%
E09000021	Kingston upon Thames	08P	NHS Richmond CCG	0.7%	0.8%
E09000021	Kingston upon Thames	99H	NHS Surrey Downs CCG	0.7%	1.2%
E09000021	Kingston upon Thames	08T	NHS Sutton CCG	0.1%	0.1%
E09000021	Kingston upon Thames	08X	NHS Wandsworth CCG	0.3%	0.7%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02R	NHS Bradford Districts CCG	1.0%	0.7%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.4%	0.7%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.6%	54.7%
E08000034	Kirklees	15F	NHS Leeds CCG	0.1%	0.3%
E08000034	Kirklees	03J	NHS North Kirklees CCG	98.9%	42.4%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.5%	1.3%
E08000011	Knowsley	01F	NHS Halton CCG	1.0%	0.8%
E08000011	Knowsley	01J	NHS Knowsley CCG	86.8%	88.2%
E08000011	Knowsley	99A	NHS Liverpool CCG	2.4%	8.0%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.1%	0.1%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.8%
E09000022	Lambeth	07R	NHS Camden CCG	0.2%	0.1%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	0.9%	0.6%
E09000022	Lambeth	07V	NHS Croydon CCG	0.7%	0.8%
E09000022	Lambeth	08C	NHS Hammersmith and Fulham CCG	0.6%	0.4%
E09000022	Lambeth	08K	NHS Lambeth CCG	85.5%	92.2%
E09000022	Lambeth	08R	NHS Merton CCG	1.0%	0.6%
E09000022	Lambeth	08Q	NHS Southwark CCG	1.9%	1.6%
E09000022	Lambeth	08X	NHS Wandsworth CCG	3.5%	3.7%
E09000022	Lambeth	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.0%
E10000017	Lancashire	02N	NHS Airedale, Wharfdale and Craven CCG	0.2%	0.0%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.1%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	13.6%	1.9%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01A	NHS East Lancashire CCG	99.0%	30.0%
E10000017	Lancashire	02M	NHS Fylde & Wyre CCG	97.9%	13.8%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	16.6%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.9%	0.2%

E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Morecambe Bay CCG	44.1%	12.1%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.2%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.5%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	96.9%	8.7%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.7%	0.2%
E08000035	Leeds	02N	NHS Airedale, Wharfdale and Craven CCG	0.1%	0.0%
E08000035	Leeds	02W	NHS Bradford City CCG	1.1%	0.2%
E08000035	Leeds	02R	NHS Bradford Districts CCG	0.5%	0.2%
E08000035	Leeds	15F	NHS Leeds CCG	97.7%	98.8%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.6%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.4%	0.6%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	2.1%	1.8%
E06000016	Leicester	04C	NHS Leicester City CCG	92.8%	95.5%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.8%	2.7%
E10000018	Leicestershire	03V	NHS Corby CCG	0.5%	0.0%
E10000018	Leicestershire	15M	NHS Derby and Derbyshire CCG	0.4%	0.6%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.5%	39.8%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.2%	4.1%
E10000018	Leicestershire	04N	NHS Rushcliffe CCG	5.4%	1.0%
E10000018	Leicestershire	04Q	NHS South West Lincolnshire CCG	5.6%	1.1%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	53.1%
E09000023	Lewisham	07Q	NHS Bromley CCG	1.4%	1.5%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000023	Lewisham	08A	NHS Greenwich CCG	2.1%	1.9%
E09000023	Lewisham	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000023	Lewisham	08K	NHS Lambeth CCG	0.3%	0.4%
E09000023	Lewisham	08L	NHS Lewisham CCG	91.5%	92.0%
E09000023	Lewisham	08Q	NHS Southwark CCG	3.9%	3.9%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.3%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.2%	0.1%
E10000019	Lincolnshire	03T	NHS Lincolnshire East CCG	99.2%	32.0%
E10000019	Lincolnshire	04D	NHS Lincolnshire West CCG	98.6%	29.9%
E10000019	Lincolnshire	04H	NHS Newark & Sherwood CCG	2.4%	0.4%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	4.9%	1.1%
E10000019	Lincolnshire	99D	NHS South Lincolnshire CCG	90.8%	19.6%
E10000019	Lincolnshire	04Q	NHS South West Lincolnshire CCG	93.3%	16.1%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.5%	2.7%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.4%	96.3%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.3%	1.0%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.3%	4.5%
E06000032	Luton	06P	NHS Luton CCG	97.3%	95.5%

E08000003	Manchester	00V	NHS Bury CCG	0.4%	0.1%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	14L	NHS Manchester CCG	90.9%	95.6%
E08000003	Manchester	00Y	NHS Oldham CCG	0.9%	0.4%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01W	NHS Stockport CCG	1.7%	0.8%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	4.0%	1.6%
E06000035	Medway	09J	NHS Dartford, Gravesham and Swanley CCG	0.2%	0.2%
E06000035	Medway	09W	NHS Medway CCG	93.9%	99.5%
E06000035	Medway	10D	NHS Swale CCG	0.2%	0.0%
E06000035	Medway	99J	NHS West Kent CCG	0.2%	0.3%
E09000024	Merton	07V	NHS Croydon CCG	0.5%	0.9%
E09000024	Merton	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000024	Merton	08J	NHS Kingston CCG	3.4%	2.9%
E09000024	Merton	08K	NHS Lambeth CCG	1.0%	1.7%
E09000024	Merton	08R	NHS Merton CCG	87.7%	80.9%
E09000024	Merton	08T	NHS Sutton CCG	3.3%	2.6%
E09000024	Merton	08X	NHS Wandsworth CCG	6.6%	10.8%
E06000002	Middlesbrough	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.2%	0.2%
E06000002	Middlesbrough	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.3%
E06000002	Middlesbrough	00M	NHS South Tees CCG	52.3%	99.5%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.2%
E06000042	Milton Keynes	04G	NHS Nene CCG	0.6%	1.3%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	58.9%	95.2%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	5.9%	4.0%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.8%	0.8%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.5%	0.3%
E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.0%
E09000025	Newham	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000025	Newham	08M	NHS Newham CCG	96.6%	97.3%
E09000025	Newham	08N	NHS Redbridge CCG	0.3%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.2%	0.2%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.4%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.7%	0.7%
E10000020	Norfolk	06M	NHS Great Yarmouth and Waveney CCG	47.7%	12.2%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000020	Norfolk	06V	NHS North Norfolk CCG	100.0%	18.6%
E10000020	Norfolk	06W	NHS Norwich CCG	100.0%	25.2%
E10000020	Norfolk	99D	NHS South Lincolnshire CCG	0.2%	0.0%
E10000020	Norfolk	06Y	NHS South Norfolk CCG	98.9%	24.1%
E10000020	Norfolk	07J	NHS West Norfolk CCG	98.4%	18.5%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.6%	0.7%
E06000012	North East Lincolnshire	03T	NHS Lincolnshire East CCG	0.8%	1.2%

E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.6%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.2%	0.2%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.2%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.1%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.1%
E06000013	North Lincolnshire	04D	NHS Lincolnshire West CCG	1.0%	1.3%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	94.9%	96.9%
E06000024	North Somerset	11E	NHS Bath and North East Somerset CCG	1.6%	1.5%
E06000024	North Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	21.8%	98.3%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.6%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.2%	96.3%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E10000023	North Yorkshire	02N	NHS Airedale, Wharfdale and Craven CCG	32.5%	8.3%
E10000023	North Yorkshire	00C	NHS Darlington CCG	1.3%	0.2%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.1%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.4%	0.7%
E10000023	North Yorkshire	03D	NHS Hambleton, Richmondshire and Whitby CCG	98.3%	22.8%
E10000023	North Yorkshire	03E	NHS Harrogate and Rural District CCG	99.8%	26.2%
E10000023	North Yorkshire	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.1%
E10000023	North Yorkshire	15F	NHS Leeds CCG	0.9%	1.3%
E10000023	North Yorkshire	01K	NHS Morecambe Bay CCG	1.9%	1.0%
E10000023	North Yorkshire	03M	NHS Scarborough and Ryedale CCG	99.3%	19.2%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.6%	18.8%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	2.0%	1.2%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.6%	1.9%
E10000021	Northamptonshire	03V	NHS Corby CCG	99.2%	9.8%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	2.0%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.1%	1.2%
E10000021	Northamptonshire	04G	NHS Nene CCG	98.8%	84.9%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.1%	1.0%
E10000021	Northamptonshire	99D	NHS South Lincolnshire CCG	0.9%	0.2%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.5%
E06000057	Northumberland	01H	NHS North Cumbria CCG	0.1%	0.1%
E06000057	Northumberland	00J	NHS North Durham CCG	0.2%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	0.9%	0.6%
E06000057	Northumberland	00L	NHS Northumberland CCG	97.9%	98.7%
E06000018	Nottingham	04K	NHS Nottingham City CCG	89.9%	95.4%
E06000018	Nottingham	04L	NHS Nottingham North and East CCG	4.6%	2.0%
E06000018	Nottingham	04M	NHS Nottingham West CCG	4.1%	1.1%
E06000018	Nottingham	04N	NHS Rushcliffe CCG	4.3%	1.5%

E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	97.1%	13.5%
E10000024	Nottinghamshire	15M	NHS Derby and Derbyshire CCG	1.5%	1.8%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.6%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	04D	NHS Lincolnshire West CCG	0.4%	0.1%
E10000024	Nottinghamshire	04E	NHS Mansfield and Ashfield CCG	97.9%	22.5%
E10000024	Nottinghamshire	04H	NHS Newark & Sherwood CCG	97.6%	15.6%
E10000024	Nottinghamshire	04K	NHS Nottingham City CCG	10.1%	4.6%
E10000024	Nottinghamshire	04L	NHS Nottingham North and East CCG	95.1%	17.2%
E10000024	Nottinghamshire	04M	NHS Nottingham West CCG	90.8%	10.2%
E10000024	Nottinghamshire	04N	NHS Rushcliffe CCG	90.3%	13.6%
E10000024	Nottinghamshire	04Q	NHS South West Lincolnshire CCG	0.7%	0.1%
E10000024	Nottinghamshire	04V	NHS West Leicestershire CCG	0.1%	0.0%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.5%	1.4%
E08000004	Oldham	14L	NHS Manchester CCG	0.8%	2.1%
E08000004	Oldham	00Y	NHS Oldham CCG	94.5%	96.3%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E10000025	Oxfordshire	15A	NHS Berkshire West CCG	0.5%	0.3%
E10000025	Oxfordshire	14Y	NHS Buckinghamshire CCG	2.4%	1.8%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	04G	NHS Nene CCG	0.1%	0.1%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.4%	96.5%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.6%	0.2%
E10000025	Oxfordshire	12D	NHS Swindon CCG	2.7%	0.9%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	23.0%	96.3%
E06000031	Peterborough	99D	NHS South Lincolnshire CCG	5.1%	3.7%
E06000026	Plymouth	15N	NHS Devon CCG	22.1%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.5%	1.4%
E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.6%	98.4%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.2%	0.2%
E06000038	Reading	15A	NHS Berkshire West CCG	35.3%	99.4%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.2%	0.6%
E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	4.9%	3.3%
E09000026	Redbridge	08C	NHS Hammersmith and Fulham CCG	0.1%	0.1%
E09000026	Redbridge	08F	NHS Havering CCG	0.8%	0.7%
E09000026	Redbridge	08M	NHS Newham CCG	1.4%	1.7%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.3%	89.4%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.3%	3.1%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.7%
E06000003	Redcar and Cleveland	03D	NHS Hambleton, Richmondshire and Whitby CCG	1.1%	1.1%
E06000003	Redcar and Cleveland	00M	NHS South Tees CCG	47.3%	98.9%
E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.5%	0.5%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	4.9%	7.0%
E09000027	Richmond upon Thames	08J	NHS Kingston CCG	1.6%	1.5%
E09000027	Richmond upon Thames	08P	NHS Richmond CCG	91.7%	90.3%
E09000027	Richmond upon Thames	99H	NHS Surrey Downs CCG	0.0%	0.1%

E09000027	Richmond upon Thames	08X	NHS Wandsworth CCG	0.4%	0.7%
E08000005	Rochdale	00V	NHS Bury CCG	0.7%	0.6%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.5%	96.6%
E08000005	Rochdale	14L	NHS Manchester CCG	0.6%	1.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.9%	1.0%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.3%	3.1%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	1.0%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.1%	1.2%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.8%	1.7%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.3%
E06000017	Rutland	03V	NHS Corby CCG	0.2%	0.5%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	9.9%	86.3%
E06000017	Rutland	99D	NHS South Lincolnshire CCG	2.6%	11.5%
E06000017	Rutland	04Q	NHS South West Lincolnshire CCG	0.4%	1.4%
E08000006	Salford	00T	NHS Bolton CCG	0.2%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.8%	1.4%
E08000006	Salford	14L	NHS Manchester CCG	1.1%	2.5%
E08000006	Salford	01G	NHS Salford CCG	94.1%	94.6%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.2%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.1%
E08000028	Sandwell	15E	NHS Birmingham and Solihull CCG	1.9%	7.0%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.7%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	55.1%	88.6%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.7%	1.3%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000014	Sefton	01J	NHS Knowsley CCG	1.8%	1.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.3%
E08000014	Sefton	01T	NHS South Sefton CCG	96.0%	51.6%
E08000014	Sefton	01V	NHS Southport and Formby CCG	96.8%	41.9%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.3%	0.1%
E08000019	Sheffield	02P	NHS Barnsley CCG	0.8%	0.4%
E08000019	Sheffield	15M	NHS Derby and Derbyshire CCG	0.2%	0.4%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.4%	0.2%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.5%	99.1%
E06000051	Shropshire	05F	NHS Herefordshire CCG	0.4%	0.3%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.5%	0.3%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.7%	95.4%
E06000051	Shropshire	01R	NHS South Cheshire CCG	0.4%	0.3%
E06000051	Shropshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.2%	0.9%
E06000051	Shropshire	05T	NHS South Worcestershire CCG	1.0%	1.0%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.3%	1.4%
E06000051	Shropshire	02F	NHS West Cheshire CCG	0.1%	0.1%
E06000051	Shropshire	06D	NHS Wyre Forest CCG	0.8%	0.3%
E06000039	Slough	14Y	NHS Buckinghamshire CCG	1.8%	6.2%

E06000039	Slough	07W	NHS Ealing CCG	0.0%	0.1%
E06000039	Slough	15D	NHS East Berkshire CCG	33.8%	93.4%
E06000039	Slough	08G	NHS Hillingdon CCG	0.0%	0.1%
E06000039	Slough	07Y	NHS Hounslow CCG	0.0%	0.1%
E06000039	Slough	09Y	NHS North West Surrey CCG	0.0%	0.1%
E08000029	Solihull	15E	NHS Birmingham and Solihull CCG	17.0%	98.9%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05J	NHS Redditch and Bromsgrove CCG	0.4%	0.3%
E08000029	Solihull	05L	NHS Sandwell and West Birmingham CCG	0.0%	0.1%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.4%	0.4%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E10000027	Somerset	11E	NHS Bath and North East Somerset CCG	3.1%	1.1%
E10000027	Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.3%
E10000027	Somerset	15N	NHS Devon CCG	0.2%	0.5%
E10000027	Somerset	11J	NHS Dorset CCG	0.5%	0.7%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.3%
E10000027	Somerset	99N	NHS Wiltshire CCG	0.1%	0.1%
E06000025	South Gloucestershire	11E	NHS Bath and North East Somerset CCG	0.8%	0.6%
E06000025	South Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	28.2%	97.5%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.8%	1.8%
E06000025	South Gloucestershire	99N	NHS Wiltshire CCG	0.0%	0.1%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.2%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.2%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E06000045	Southampton	10X	NHS Southampton CCG	94.9%	99.5%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.5%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.8%	4.7%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.7%	95.3%
E09000028	Southwark	07R	NHS Camden CCG	0.3%	0.3%
E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.5%	1.6%
E09000028	Southwark	08C	NHS Hammersmith and Fulham CCG	0.7%	0.5%
E09000028	Southwark	08K	NHS Lambeth CCG	6.6%	7.7%
E09000028	Southwark	08L	NHS Lewisham CCG	2.1%	2.0%
E09000028	Southwark	08Q	NHS Southwark CCG	94.1%	87.9%
E09000028	Southwark	08X	NHS Wandsworth CCG	0.1%	0.1%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.1%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.6%	2.3%
E08000013	St. Helens	01X	NHS St Helens CCG	91.2%	96.3%
E08000013	St. Helens	02E	NHS Warrington CCG	0.1%	0.1%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.7%	1.2%
E10000028	Staffordshire	15E	NHS Birmingham and Solihull CCG	0.3%	0.4%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.3%	14.9%
E10000028	Staffordshire	15M	NHS Derby and Derbyshire CCG	0.5%	0.5%
E10000028	Staffordshire	05C	NHS Dudley CCG	1.4%	0.5%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	92.1%	14.7%
E10000028	Staffordshire	01C	NHS Eastern Cheshire CCG	0.6%	0.1%

E10000028	Staffordshire	05G	NHS North Staffordshire CCG	95.1%	23.4%
E10000028	Staffordshire	05N	NHS Shropshire CCG	1.0%	0.3%
E10000028	Staffordshire	01R	NHS South Cheshire CCG	0.5%	0.1%
E10000028	Staffordshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	96.2%	23.6%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.5%	16.7%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	8.8%	2.9%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.6%	0.5%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.1%	0.2%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.6%	0.8%
E10000028	Staffordshire	06D	NHS Wyre Forest CCG	0.2%	0.0%
E08000007	Stockport	01C	NHS Eastern Cheshire CCG	1.6%	1.1%
E08000007	Stockport	14L	NHS Manchester CCG	1.1%	2.2%
E08000007	Stockport	01W	NHS Stockport CCG	94.9%	96.5%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E06000004	Stockton-on-Tees	00C	NHS Darlington CCG	0.4%	0.2%
E06000004	Stockton-on-Tees	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.4%	0.6%
E06000004	Stockton-on-Tees	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.1%
E06000004	Stockton-on-Tees	00K	NHS Hartlepool and Stockton-On-Tees CCG	66.9%	98.4%
E06000004	Stockton-on-Tees	00M	NHS South Tees CCG	0.4%	0.7%
E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.3%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.5%	0.3%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	91.2%	97.1%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.2%
E10000029	Suffolk	06M	NHS Great Yarmouth and Waveney CCG	52.3%	16.3%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.9%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.4%	0.6%
E10000029	Suffolk	06Y	NHS South Norfolk CCG	1.1%	0.3%
E10000029	Suffolk	07H	NHS West Essex CCG	0.1%	0.0%
E10000029	Suffolk	07K	NHS West Suffolk CCG	91.1%	29.7%
E08000024	Sunderland	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.9%	0.9%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.9%
E08000024	Sunderland	00J	NHS North Durham CCG	2.2%	1.9%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.5%	0.3%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	96.0%
E10000030	Surrey	07Q	NHS Bromley CCG	0.4%	0.1%
E10000030	Surrey	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000030	Surrey	09H	NHS Crawley CCG	6.6%	0.7%
E10000030	Surrey	07V	NHS Croydon CCG	1.3%	0.4%
E10000030	Surrey	15D	NHS East Berkshire CCG	3.4%	1.2%
E10000030	Surrey	09L	NHS East Surrey CCG	96.6%	14.1%
E10000030	Surrey	09N	NHS Guildford and Waverley CCG	94.0%	16.9%
E10000030	Surrey	09X	NHS Horsham and Mid Sussex CCG	1.5%	0.3%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.7%	0.2%
E10000030	Surrey	08J	NHS Kingston CCG	4.5%	0.7%
E10000030	Surrey	08R	NHS Merton CCG	0.3%	0.0%

E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	23.0%	4.2%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	09Y	NHS North West Surrey CCG	99.4%	29.5%
E10000030	Surrey	08P	NHS Richmond CCG	0.7%	0.1%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	99H	NHS Surrey Downs CCG	97.4%	23.8%
E10000030	Surrey	10C	NHS Surrey Heath CCG	98.9%	7.6%
E10000030	Surrey	08T	NHS Sutton CCG	1.2%	0.2%
E10000030	Surrey	99J	NHS West Kent CCG	0.2%	0.0%
E09000029	Sutton	07V	NHS Croydon CCG	1.0%	1.9%
E09000029	Sutton	08J	NHS Kingston CCG	3.5%	3.4%
E09000029	Sutton	08K	NHS Lambeth CCG	0.1%	0.2%
E09000029	Sutton	08R	NHS Merton CCG	6.3%	6.7%
E09000029	Sutton	99H	NHS Surrey Downs CCG	1.3%	1.9%
E09000029	Sutton	08T	NHS Sutton CCG	94.7%	85.6%
E09000029	Sutton	08X	NHS Wandsworth CCG	0.2%	0.3%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.0%	0.2%
E06000030	Swindon	12D	NHS Swindon CCG	96.0%	98.2%
E06000030	Swindon	99N	NHS Wiltshire CCG	0.7%	1.5%
E08000008	Tameside	14L	NHS Manchester CCG	2.2%	5.8%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.9%
E08000008	Tameside	01W	NHS Stockport CCG	1.8%	2.3%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.2%	88.0%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.8%	2.9%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.7%	97.1%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.3%	0.3%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.3%
E06000034	Thurrock	08F	NHS Havering CCG	0.2%	0.4%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.5%	99.0%
E06000027	Torbay	15N	NHS Devon CCG	11.7%	100.0%
E09000030	Tower Hamlets	07R	NHS Camden CCG	1.1%	0.9%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.5%	0.3%
E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	0.9%	0.9%
E09000030	Tower Hamlets	08C	NHS Hammersmith and Fulham CCG	0.8%	0.5%
E09000030	Tower Hamlets	08H	NHS Islington CCG	0.2%	0.1%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.2%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.9%	96.9%
E08000009	Trafford	14L	NHS Manchester CCG	2.7%	7.0%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.1%
E08000009	Trafford	02A	NHS Trafford CCG	95.7%	92.7%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.9%	0.6%
E08000036	Wakefield	15F	NHS Leeds CCG	0.4%	1.0%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.5%	98.0%
E08000030	Walsall	15E	NHS Birmingham and Solihull CCG	1.1%	4.8%

E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.7%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.6%	3.1%
E08000030	Walsall	05Y	NHS Walsall CCG	92.8%	90.4%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.4%	1.4%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.4%	0.4%
E09000031	Waltham Forest	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000031	Waltham Forest	08D	NHS Haringey CCG	0.1%	0.1%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.3%	1.7%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.4%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.3%	96.1%
E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	0.9%	0.6%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	1.0%	0.6%
E09000032	Wandsworth	08J	NHS Kingston CCG	0.1%	0.0%
E09000032	Wandsworth	08K	NHS Lambeth CCG	3.2%	3.5%
E09000032	Wandsworth	08R	NHS Merton CCG	2.8%	1.6%
E09000032	Wandsworth	08P	NHS Richmond CCG	1.3%	0.7%
E09000032	Wandsworth	08X	NHS Wandsworth CCG	88.3%	92.6%
E09000032	Wandsworth	08Y	NHS West London (K&C & QPP) CCG	0.7%	0.4%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.2%	2.0%
E06000007	Warrington	02E	NHS Warrington CCG	97.6%	97.0%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.2%
E10000031	Warwickshire	15E	NHS Birmingham and Solihull CCG	0.2%	0.5%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.2%	21.5%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	04G	NHS Nene CCG	0.2%	0.2%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	05J	NHS Redditch and Bromsgrove CCG	0.7%	0.2%
E10000031	Warwickshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.1%	45.8%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.7%	30.7%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E06000037	West Berkshire	15A	NHS Berkshire West CCG	30.0%	97.6%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.7%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	99N	NHS Wiltshire CCG	0.1%	0.4%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.1%	0.4%
E10000032	West Sussex	09G	NHS Coastal West Sussex CCG	99.5%	57.5%
E10000032	West Sussex	09H	NHS Crawley CCG	93.4%	14.0%
E10000032	West Sussex	09L	NHS East Surrey CCG	0.3%	0.0%
E10000032	West Sussex	09N	NHS Guildford and Waverley CCG	3.1%	0.8%
E10000032	West Sussex	99K	NHS High Weald Lewes Havens CCG	1.1%	0.2%
E10000032	West Sussex	09X	NHS Horsham and Mid Sussex CCG	95.7%	25.9%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.1%	1.0%
E10000032	West Sussex	99H	NHS Surrey Downs CCG	0.6%	0.2%

E09000033	Westminster	07P	NHS Brent CCG	1.3%	2.0%
E09000033	Westminster	07R	NHS Camden CCG	3.0%	3.4%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	79.3%	71.3%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	0.6%	0.6%
E09000033	Westminster	08K	NHS Lambeth CCG	0.1%	0.2%
E09000033	Westminster	08Y	NHS West London (K&C & QPP) CCG	23.1%	22.6%
E08000010	Wigan	00T	NHS Bolton CCG	0.2%	0.1%
E08000010	Wigan	01G	NHS Salford CCG	0.8%	0.6%
E08000010	Wigan	01X	NHS St Helens CCG	3.8%	2.2%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.2%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.8%	1.0%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.7%
E06000054	Wiltshire	11E	NHS Bath and North East Somerset CCG	0.9%	0.4%
E06000054	Wiltshire	15A	NHS Berkshire West CCG	0.2%	0.2%
E06000054	Wiltshire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.5%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.3%	0.4%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.5%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.3%	0.4%
E06000054	Wiltshire	12D	NHS Swindon CCG	1.3%	0.6%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.2%
E06000054	Wiltshire	99N	NHS Wiltshire CCG	96.7%	96.8%
E06000040	Windsor and Maidenhead	15A	NHS Berkshire West CCG	0.4%	1.3%
E06000040	Windsor and Maidenhead	14Y	NHS Buckinghamshire CCG	0.3%	1.1%
E06000040	Windsor and Maidenhead	15D	NHS East Berkshire CCG	34.1%	96.9%
E06000040	Windsor and Maidenhead	09Y	NHS North West Surrey CCG	0.2%	0.5%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.2%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.1%	0.0%
E08000015	Wirral	02F	NHS West Cheshire CCG	0.4%	0.3%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.7%
E06000041	Wokingham	15A	NHS Berkshire West CCG	31.5%	97.0%
E06000041	Wokingham	15D	NHS East Berkshire CCG	1.0%	2.6%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.4%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.3%	1.5%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.1%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.8%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.4%	3.5%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	93.8%	93.4%
E10000034	Worcestershire	15E	NHS Birmingham and Solihull CCG	0.9%	2.0%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.7%	0.4%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	05F	NHS Herefordshire CCG	0.9%	0.3%
E10000034	Worcestershire	05J	NHS Redditch and Bromsgrove CCG	95.8%	27.7%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.3%	1.1%
E10000034	Worcestershire	05T	NHS South Worcestershire CCG	97.2%	49.3%
E10000034	Worcestershire	06D	NHS Wyre Forest CCG	98.3%	18.6%

E06000014	York	03E	NHS Harrogate and Rural District CCG	0.2%	0.1%
E06000014	York	03Q	NHS Vale of York CCG	60.2%	99.9%

Produced by NHS England using data from National Health Applications and Infrastructure Services (NHAIS) as supplied by NHS Digital.

Health and Wellbeing Strategy, 2018-2025 - Performance Framework

Scorecard updated: September 2019. Updated measures are in bold.

↑	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)	17.6% (Q3, 2018/19)	**19.6% (Q4, 2018/19)**	↑	Smoking at time of delivery (SATOD) increased from17.6% at Q3 to 19.6% at Q4 which is worse based on quarterly data (lower is better). However, the percentage for SATOD decreased from 19.9% to 17.9% between 2017/18 and 2018/19 so Direction of Travel (DOT) is shown as improving.

		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 integrated commissioning and service delivery	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 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)	88.9 (Q4, 2018/19)	**94.8 (Q1, 2019/20)**	↓	The trend for the number of children per 10K population with a Child Protection Plan (CPP) remains significantly higher (94.8) than that of statistical neighbours (54.5) and the national average (45.3). However the numbers of children becoming subject to a plan each month have been steadily reducing since June 2018 as expected. This will be monitored as part of the Performance Meetings.
	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)	15.9 (2015/17)	**13.1 (2016/18)**		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%	**-0.40%**	↑	Data from ONS APS which is released quarterly approx. 4 months in arrears. E.g. Jan - Mar quarter released in July. At 31/03/19, UK average 78.5%, Rotherham 78.1%

	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)	28 (Q4, 2018/19)	**46 (Q1, 2019/20)**		Whlist the number of repeat victims of anti-social behaviour has increased between Quarter 4 (2018/19) and Quarter 1 (2019/20) public perception of ASB (via the "Your Voice Counts" quarterly survey) has improved, going from 44% to 39%.
		4.3	**Number of households in temporary accommodation**	Rotherham Metropolitan Borough Council	Quarterly	Low	38 (Q4, 2017/18)	**45 (Q4, 2018/19)**	**47 (Q1, 2019/20)**		These are the number of households living in temporary accommodation in the borough at the end of June following investigation in accordance with the Homeless Reduction Act.
	Ensuring planning decisions consider the impact on people's health and wellbeing. 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)**		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.
	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

Report prepared by: **Gabbi Frith MSc, Dr Simon Nichols, Dr Lindsey Reece, Professor Rob Copeland**

Rotherham

ACTIVE FOR HEALTH

A Local Evaluation Report

SPORT ENGLAND LOTTERY FUNDED
NHS Rotherham Clinical Commissioning Group
Rotherham Metropolitan Borough Council
Sheffield Hallam University Centre for Sport and Exercise Science
Functional Fitness
Places Leisure Part of Places for People
Speakup

Abbreviations

CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CHF	Chronic Heart Failure
COPD	Chronic Obstructive Pulmonary Disease
CUA	Cost-Utility Analysis
ERS	Exercise Referral Schemes
GP	General Practitioner
HCP	Health Care Professionals
IPAQ	International Physical Activity Questionnaire
IPAQ - E	International Physical Activity Questionnaire - Elderly
LTC	Long-Term Condition
MSK	Musculoskeletal
MVPA	Moderate to Vigorous Physical Activity
NHS	National Health Service
PA	Physical Activity
PAM	Patient Activation Measure
RMBC	Rotherham Metropolitan Borough Council
UK	United Kingdom
QALY	Quality Adjusted Life Years
QoL	Quality of Life
VAS	Visual Analogue Scale

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1 Executive Summary

This report presents the findings from an independent evaluation of the 'Active for Health' programme conducted by Sheffield Hallam University between November 2015 and July 2018. The evaluation set out to understand how effective Active for Health was in providing condition specific support via Physical Activity (PA) pathways for seven long-term conditions (LTC). The evaluation also explored the cost effectiveness, and the process of delivering the programme. Specifically, the evaluation aimed to:

i. **Understand how Active for Health influenced PA behaviour across seven long-term conditions.**
ii. **Assess the impact of the programme on quality of life.**
iii. **Understand what works for each pathway and why.**
iv. **Explore the delivery experiences of health care professionals, providers and the project management team.**
v. **Explore the participation experiences and understand activation levels from patients.**
vi. **Assess the cost effectiveness of the programme.**

Evaluation methodology

The evaluation adopted a quasi-experimental research design with mixed methods used to obtain qualitative and quantitative data to explore the impact of Active for Health on physical activity (PA) and quality of life (QoL). It also included a formal process evaluation that explored the experiences of professionals and patients as they engaged in the programme. Data was collected through validated questionnaires, interviews and observations. Data presented in this report are from those who consented to be part of the Active for Health evaluation.

Active for Health - an integrated physical activity pathway for people with long-term conditions

Active for Health followed an integrated physical activity PA healthcare model for seven long-term condition (LTC) pathways, supported by a multi-agency collaboration between local government, public health, the National Health Service (NHS), and leisure providers.

The objective of Active for Health was to enable system-wide coordination of evidence-based PA provision whilst raising awareness of the physical, psychological and social benefits of PA to all key stakeholders locally. The seven long-term condition pathways include; Cardiac Phase IV, Chronic Heart Failure (CHF), Stroke, Cancer, Lower Back Pain (Musculoskeletal; MSK), Chronic Obstructive Pulmonary Disease (COPD) and Falls Prevention. All pathways followed the same 3-step process;

1) rehabilitation,

2) moving on and

3) keeping active (Figure 1.0).

Figure 1.0 - The 3-step model for Active for Health.

Summary of main findings

- **Active for Health increased the proportion of patients who undertook one 30 minute bout of moderate to vigorous physical activity (MVPA), from 30% to 90.5%.** For definitions of outcome measures and further detail of the results (see Sections 6.5 and 7).
- **Perceptions of Quality of Life (QoL) improved throughout the first three months of Active for Health measured by a Visual Analogue Scale (VAS). Health status improved on average from 65 to 75.** This was when support received from instructors was at its peak. **A decline in QoL was observed after six months, suggesting that specialist Level 4 instructors could be critical in helping people to maintain QoL.** However, **health status improvement scores remained significantly higher after 12 months**, compared to baseline scores (see Section 7.1.3).
- **All patients** involved in the qualitative interviews were **positive about their engagement with the Active for Health programme**. Social interaction, suitability of exercise, session structure, and instructor competency were key mechanisms for a successful physical activity (PA) programme (see Section 8.1).

  Patient's knowledge, skills, and confidence for managing their health and healthcare, were discussed as part of the qualitative interviews using questions based on the Patient Activation Measure (PAM). **Patients in the Stroke pathway were considered the least activated in their own health and those in the Cancer and Musculoskeletal (MSK) pathway were highly activated in their own health, demonstrating increased skills, knowledge and confidence in managing their condition**. This provides important information for future programme design, suggesting certain long-term condition (LTC) groups require greater support and additional mechanisms to manage their condition (see Sections 6.5.3 and 8.1).
- **At baseline, 15% of patients reported losing at least one day of work due to ill health within the previous 12 months. This decreased to 6.3% among patients who engaged with Active for Health for 12 months**. All patients, including those who were retired, were included for analysis because some patients retired during the programme (Section 7.1.3).
- **The study observed a reduction in health service use across all chronic disease pathways and in all aspects of health care, including GP use, specialist visits, admissions, A&E attendance and impatient bed days** (see Sections 7.1.2 and 7.2).
- Referral is associated with reductions in NHS costs and improvements in health as measured by Quality Adjusted Life Years (QALYs). **There is a 93% chance that the intervention is cost saving and a 99% chance that it improves health.** When considered together, there is a 99% chance that it is cost-effective at a threshold of £20,000 per QALY gained (see Sections 6.6 and 7.2).
- **Dropouts from the evaluation across the long-term condition (LTC) pathways was high. Approximately 20% of patients remained in the evaluation after 12 months** (Figure 5.0). Drop-out reasons collected on a sample of patients revealed that ill-health and taking part in other physical activity were the main causes. Future evaluations of similar programmes should explore attrition in more detail. This was out of the scope of this evaluation (see Section 7.1.1).
- As a result of Active for Health, professionals across the health care system endorse the programme and the promotion of physical activity (PA) in all stages of care (see Section 8.6).
- Trust and communication between all stakeholders was deemed essential for a successfully commissioned PA model of care.
- Universal stakeholder engagement was essential for the effective referral of patients to the programme. The process for the long term continuation of referrals should be addressed at the end of the Active for Health funding.

Conclusions

- **A key objective of the Active for Health programme was to develop an integrated pathway of referral to long-term exercise training for patients who have heart disease, chronic heart failure (CHF), stroke, Chronic Obstructive Pulmonary Disease (COPD), cancer, Musculoskeletal (MSK) problems, and have had a fall. Active for Health achieved this objective.**
- **The Active for Health programme increased physical activity (PA) levels among patients who remained in the evaluation. Increases in PA behaviour were accompanied by improvements in Quality of Life (QoL).**
- **During the Active for Health evaluation (November 2015 to July 2018), results from the professional interviews demonstrated how the Active for Health programme created a culture where physical activity is perceived as an important component of enabling patient self-management across Rotherham.**
- **Referral is associated with reductions in NHS costs and improvements in health, measured by Quality of Life Years (QALYs). The future sustainability of this service should be assessed for this reason.**

2 Introduction

2.1 Report overview

2.1.1 The aim of the report

This report presents the findings of an independent evaluation of the Active for Health programme. Findings are supported by empirical evidence, with key interpretations and recommendations highlighted to inform the design of future community based physical activity (PA) programmes that wish to integrate PA into chronic disease healthcare pathways.

The report provides the following:

- An overview of the Active for Health programme and its solution-focused approach to tackling physical inactivity and self-management of long-term conditions (LTCs).
- An outline of the evaluation approach.
- Findings from the formal process evaluation, including the experiences of patients and professionals assessed through surveys and stakeholder interviews.
- Recommendations for commissioners, practitioners and the academic community working to promote the health and wellbeing of individuals living with chronic diseases.

2.1.2 How to read this report

This is a large document and it is unrealistic to expect all stakeholders to read the report in its entirety. With the intention of making it easier for the reader, we propose three ways of reading this evaluation report:

1. **Executive summary** - If you want a brief overview of the evaluation findings - read the executive summary in section 1.
2. **Headlines only** - If you would like a more detailed overview of the evaluation findings - read the executive summary in section 1, plus sections 7.3, 8.2, 8.4, 8.8, 8.10 and 9.7.
3. **Read all sections in sequence** - If you have time, you can read each section as it appears in the document, including the appended disease cards. This will give you a full understanding of the Active for Health programme and its evaluation.

3 Background to Active for Health

3.1 Long-term conditions (LTCs) and the impact of inactivity

LTC's are a global and national healthcare challenge (The Kings Fund, 2010). LTCs can be defined as "a health problem that cannot currently be cured but can be managed through medication, therapy and/or lifestyle modification" (Department of Health, 2012). **In the last 10 years, the number of people diagnosed with a LTC has increased from 1.9 to 2.9 million.** In England, more than 15 million people now have at least one LTC (Department of Health, 2012).

Physical activity (PA) is defined as 'any bodily movement produced by skeletal muscles that requires energy expenditure' (World Health Organisation, 2011; WHO). **Physical inactivity has been identified as the fourth leading risk factor for global mortality (World Health Organisation, 2018)**. The Chief Medical Officer in the United Kingdom (UK) provides clear PA guidelines which aim to reduce the healthcare burden of LTCs. **Adults and older people should participate in 150 minutes of moderate intensity PA per week. Additionally, strength exercises should be conducted on two or more days of the week (Department of Health, 2011)**. Despite this, 40% of adults in the UK do not meet these guidelines and only 20% of individuals with a LTC achieve the recommendations (Public Health England, 2018).

Increasing PA is a key public health objective (World Health Organisation, 2018) and data suggests that insufficient participation in it costs the UK £7.4 billion per year (Public Health England, 2014). **A 1% reduction in physical inactivity could save £1.2 billion per year (Cabinet Office, 2014).**

Improvements in health, as a result of taking part in regular PA are greater when undertaken by those who are the least active (UK Active, 2013). The benefits of PA for those with a LTC are well documented and include improvements in wellbeing, a reduction in depression and anxiety, enhancement of cognitive function and improvements in overall Quality of Life (QoL) (Bize, Johnson & Plotnikoff, 2007; Gillison et al., 2009; Rebar et al., 2015). In addition, increased PA improves patient survival (, 2011) and reduces NHS healthcare service utilisation (Rahl, 2010).

While not all inactive people are NHS patients, the increased prevalence of LTCs means that the NHS is a key environment for the promotion of PA. Approximately 70% of the primary care budgets in England are spent on health care and treatment costs of people living with a LTC (National Institute for Health and Care Excellence, 2015). With an increasing demand on the NHS to manage population health needs and the operation on tighter budgets, this is a critical juncture to reduce costs associated with NHS service use (House of Lords, 2017).

Paradoxically, while the evidence base for the importance and positive benefit associated with integrating PA in chronic disease pathways has been rising, evidence on how best to implement it within the real-world setting remains low. Exploring the impact of programmes such as Active for Health is therefore essential to add to the evidence base of pragmatic community-based PA interventions and to embed effective components within chronic disease care.

3.2 The challenge of physical activity promotion in Rotherham

Physical activity (PA) and health are heavily influenced by social characteristics such as age, gender and ethnicity. **Individuals living in areas of deprivation are more likely to be physically inactive and have a long-term condition (LTC).**

Rotherham is in the highest 20% for deprivation (Indices of Deprivation, 2007), has a population of over 260,000; of which 12,000 are economically inactive (neither in work nor looking for a job or available to work) due to long-term sickness (Public Health England, 2017). The main drivers of excess year's life lost in Rotherham are problems of the circulation (principally stroke and ischaemic heart disease), respiratory disease and cancer. Individuals living in Rotherham are less likely to participate in PA, compared to those nationally (Public Health Outcomes Framework, 2014). **This is why increasing PA in adults in Rotherham is a priority (Public Health England, 2017).**

Rotherham's joint needs assessment forms a key evidence base for the health and wellbeing strategy and deems regular PA a priority in managing chronic conditions in Rotherham.

> "Rotherham will be a place where people feel good, are healthy and active, and enjoy life to the full."
>
> **Rotherham Joint Strategic Needs Assessment**

3.3 Finding a solution to physical inactivity

3.3.1 Physical activity and self-management

Empowering and supporting people living with LTCs to develop their knowledge, skills and confidence to manage their own health is a key strategic objective for health providers (Spijker & MacInnes, 2013). Supported self-management optimises the quality, effectiveness and efficiency of care for people living with a LTC. Self-management has the potential to improve health outcomes and help patients make better, more informed use of available healthcare support (The Kings Fund, 2013).

Increasing a patient's ability to 'self-manage' their condition has the potential to reduce the burden that LTCs place on healthcare systems. The Department of Health (2010) included self- management in their strategic framework for improving the health status of individuals with multiple LTCs. For patients with a LTC, PA has become a core focus of this 'self-management' strategy (Booth, Roberts and Laye, 2012). Supporting and empowering patients through condition-specific PA, could enhance their capability in managing their own health needs and reduce their reliance on health care provision. In primary and secondary care, the evidence is clear; there is a lack of action taken to integrate recommended PA as part of LTC treatment and management.

3.3.2 Health care service integration for long-term condition management

Healthcare funding systems have traditionally focused on isolated episodes of care, rather than the patient journey and the needs of the individual. Improvements in communication between primary, secondary and community care are needed. This could be one solution for ensuring an efficient patient journey (The King's Fund, 2013).

Creating a seamless pathway across a number of healthcare providers for different LTCs makes service provision more efficient and effective (Kings Fund, 2012). By doing so, patients may use healthcare services to their full potential. A 'joined-up' approach to healthcare, where health care professionals (HCPs) and allied health professionals can refer for non-medicalised treatment solutions is recommended. **Doing so may increase PA, reduce hospital resource use and,** General Practitioner (GP) visits (Kimberlee, 2016; Dayson & Bashir, 2013; Kimberlee, Ward & Jones, 2014).

When a pathway integrates treatment, rehabilitation and exercise maintenance, there is a greater likelihood of patient's sustained engagement in PA and or independent exercise.

3.3.3 An integrated physical activity pathway

A statement by the International Olympic Committee calls for health services to unite, collaborate and communicate with the entire of the health, sport and fitness industry (Matherson et al., 2013). Yet, the reality is community PA programmes frequently work in isolation to clinical care services.

Current evidence focuses on the implementation of Exercise Referral Schemes (ERS), a structured, supervised programme, typically delivered over a 10 to 12 week period. The effectiveness of sustaining PA behaviour post programme completion, in the LTC population remains mixed (NICE, 2014).

This presents an opportunity to enhance patient care, through the integration of healthcare with community PA provision (Trappenburg et al., 2013). Maintaining PA levels can be challenging in patients with LTCs (Poltawski et al., 2015; Blanchard et al., 2003), the focus of pathway design should be on relapse prevention and sustainability, prioritising programme adherence strategies and long-term maintenance.

The Public Health Advisory Committee put forward a number of recommendations for the development and delivery of rehabilitation schemes. This includes the importance of the referral mechanism and the qualifications of Exercise Specialists, which both encourage the uptake of and adherence to PA programmes. Other evidenced based guidelines identify support from providers (accessibility, cost, location session timing, and session content), as well as support from peer networks, as crucial for PA attendance and adherence (Morgan et al., 2016).

In Rotherham, an integrated PA pathway coupled with community based PA provision does not exist across a range of LTCs. The Active for Health programme was designed to close this provision gap.

4 Active for Health - a physical activity pathway

4.1 Active for Health pilot

Active for Health included a multi-agency collaboration between local government, public health, the NHS, and leisure providers. The objective was to enable system-wide coordination of evidence based PA provision whilst raising awareness of the physical, psychological and social benefits of PA to all key stakeholders.

The design of Active for Health was informed using pilot data from a local falls rehabilitation pathway (a more detailed review is available, Hawley-Hague & Roden, 2017). This work identified that after 12 weeks, the majority of patients improved their function, confidence and one third of patients were at a lower risk of falling. The continuity of delivery, the role of the Exercise Specialist, engagement of health care professionals (HCPs), and social and physical outcomes were essential for maintenance. Using pilot findings, stakeholder knowledge and insights, Public Health Rotherham designed seven PA pathways, specifically for priority LTC groups.

Active for Health was designed as a PA care model for seven LTC pathways, these include; Cardiac Phase IV, CHF, Stroke, Cancer, Musculoskeletal (lower back pain; MSK), Chronic Obstructive Pulmonary Disease (COPD) and Falls Prevention. There is compelling evidence across each of these pathways to highlight the benefits of PA, details of which can be found in Appendix 1.a to 1.e.

4.2 Programme overview

The aim of the Active for Health programme was to support individuals with long term conditions to become and stay more physically active. The programme aimed to link NHS clinical rehabilitation services to community physical activity programmes. All pathways follow the same **3-step process; 1) rehabilitation, 2) moving on and 3) keeping active.** Initial referrals to Step 2 are from rehabilitation services or a GP / HCP. These steps can be seen below in Figure 2.0.

Figure 2.0 - The 3-step model for Active for Health.

5 The Evaluation Approach

5.1 Standard evaluation framework

The Active for Health evaluation was conducted in line with the National Obesity Observatory Standard Evaluation Framework for PA interventions (Cavill, Roberts & Rutter, 2012) which guides the design and implementation of evaluations.

5.2 Aims and objectives of the evaluation

The aim of the evaluation of Active for Health was to answer the following questions:

Primary research question:

To what extent is Active for Health effective and cost effective in supporting and sustaining inactive individuals into physical activity opportunities/sport?

Secondary research questions:

- **What is the impact of Active for Health on quality of life and patient activation?**
- **What is the feasibility and acceptability from the patients and practitioner perspective?**
- **How cost effective is the Active for Health programme?**

5.3 Evaluation caveats

When interpreting the findings of the Active for Health data, it is important to be mindful of the following caveats:

- The report only provides information from the patients who engaged and / or completed the evaluation which could lead to self-selection bias.
- Self-reported findings coupled with qualitative data should be used together to consider the success of this project.
- The Active for Health evaluation was pragmatic and because it was conducted in the 'real world', absent of experimental conditions.
- All data presented was accurate at the time of reporting (November 2015 - July 2018). Any subsequent delivery and/or changes to programme delivery or pathway are not reflected here.

6.1 Evaluation structure

This complex programme evaluation was embedded into a pragmatic framework that was mindful of 'real world' context. Adapting to the organic nature of the project was important. A quasi- experimental research design with mixed methods was used to obtain qualitative and quantitative data which explored the impact and implementation of Active for Health. Methods included self - reported outcome measures (PA, QoL and NHS service use) and semi structured interviews which explored the experiences of all key stakeholders.

The following evaluation methods were implemented to help deliver a comprehensive evaluation of the Active for Health programme, using three evaluation approaches; formative, outcome and process evaluation:

6 Evaluation Methods

1. Formative evaluation:

A formative evaluation collated information to help improve and strengthen the implementation of Active for Health. The formative aspects of the evaluation sought to provide ongoing feedback on key aspects of learning or good practice. This included piloting surveys with individuals who were involved with, as well as unconnected to, the project. This process helped to design, develop and test programme materials before the implementation of the programme.

2. Outcome evaluation:

The outcome evaluation measured if the programme achieved its outcomes; asking specifically, 'Are the patients more active, or have they sustained their activity as a result of taking part in Active for Health?'. Findings from patient questionnaires were used to determine if the Active for Health programme successfully achieved its primary and secondary outcome measures. Pathway specific case studies based on patient interviews are also provided in the outcome evaluation to provide context, and enrich the quantitative data.

3. Process evaluation:

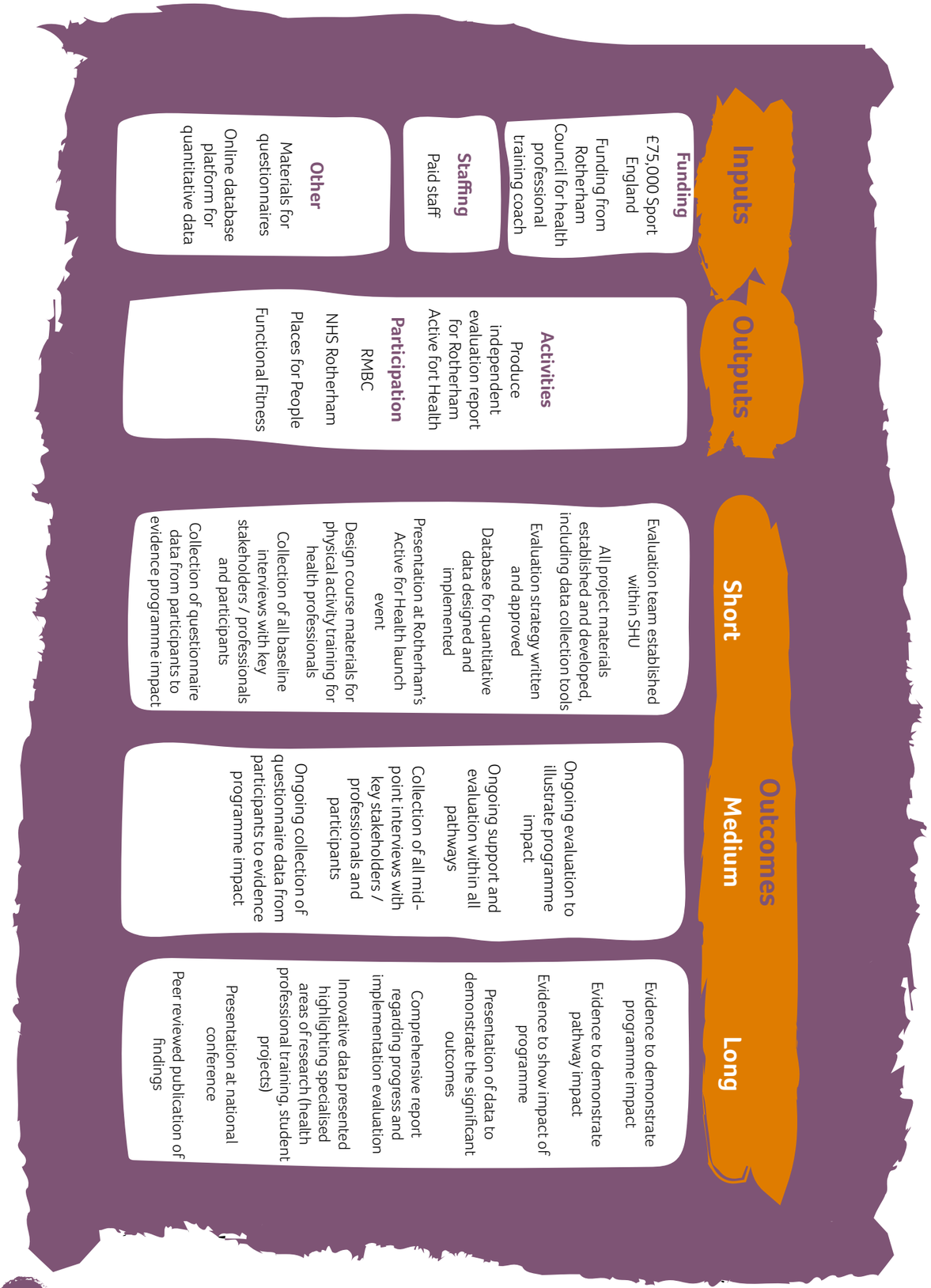
The process evaluation was implemented to understand Active for Health in relation to project delivery, and to understand if and how the processes involved were appropriately aligned to achieve anticipated outcomes. Simply, it enabled us to understand 'what works and what doesn't?'. This was incorporated into the qualitative interviews with patients, professionals and project management staff to identify the activities designed to assess the success of the programme.

The summative aspects of the evaluation answered questions about whether the Active for Health initiative worked or not, for whom and why.

Evaluation team logic model

It is recommended by the Standard Evaluation Framework (Cavill, Roberts & Rutter, 2012) that a logic model is implemented by the evaluation team to identify the outcome measures of a project. See Figure 3.0 for the Active for Health evaluation team logic model.

Figure 3.0 Active for Health evaluation team logic model.



6.3 Patient pathway allocation and data collection for the outcome evaluation

- Patients were given an information sheet before written informed consent was obtained by an Exercise Specialist. Consent was obtained prior to any data being collected.
- Patients were assigned a condition specific pathway by a HCP and Exercise Instructor at their first exercise session. Patients were also asked to record any other health condition or disability.
- Outcome data were collected from service users through a questionnaire booklet at baseline, three, six and 12 months.
- Demographics including, age, gender, employment status and postcode were collected for each patient, in order to understand the representation of the sample in the evaluation; these were collected at baseline only.

6.4 Ethical approval

This project was granted ethical approval from the NHS Research Ethics Committee. Informed consent was attained from all patients, HCPs, leisure providers and the project management team who were included in the evaluation. All data generated within the report was anonymised and treated confidentially. All data has been stored in accordance with the Data Protection Act (2018) and in line with the General Data Protection Regulation (2018).

6.5 Measures used to inform the outcome evaluation

A range of outcome measures were used to evaluate the impact of Active for Health as outlined below.

6.5.1 Physical activity and sport participation

PA was determined by the self-administered short form version of the International Physical Activity Questionnaire (IPAQ; Craig et al., 2003). This version and the International Physical Activity Questionnaire - Elderly (IPAQ-E; Hurtig-Wennlöf, Hagströmer, & Olsson, 2010) contains 9 items relating to activity level over the last seven days and refers to the number of days and time spent doing PA at either moderate or vigorous intensity.

Additional questions on time spent walking and time spent sitting are included. The median values of each activity category were calculated in minutes per week and days per week. Sports participation was measured using a single item. Patients were asked 'On how many days during the last week did you take part in sport?'. They were then asked to state the amount of time they usually spent doing sport on one of those days.

6.5.2 Quality of life (QoL)

The EuroQol index (EQ-5D-3L) and the EuroQol Visual Analogue Scale (VAS) are widely implemented measures of health status and health-related QoL retrospectively. The EQ-5D index assesses a patient's health state across five dimensions (self-care, mobility, anxiety / depression, usual activities and pain/ discomfort). The VAS is measured on a continuous scale from zero to 100 (with 100 representing full health). Patients were asked how they would rate their health on that day; with higher scores representing better health.

6.5.3 Patient activation

The Patient Activation Measure (PAM) measures patient's engagement and self-management competency.
The PAM has been designed to assess an individual's knowledge skills and confidence in managing their health and health care (for a full review see Hibbard et al., 2004). The PAM assesses patient activation, which refers to the knowledge, skills and confidence an individual has in managing their condition. This emphasises an individual's willingness and ability to take independent action to manage their health care.

Individuals are categorized into four levels of activation, with level one representing the least activated and level four the most. The score incorporates responses to thirteen statements about beliefs, confidence in managing health-related tasks, and self-assessed knowledge.

For the purpose of this evaluation, the questions from the PAM were used to inform the interview schedule with patients. There is evidence that links better patient outcomes with more engaged and activated patients (The Kings Fund, 2014). This is a novel and innovative approach to this evaluation and provides a measure of engagement and empowerment and the emphasis on patient engagement; activation and self- management. It provides a useful insight into patient engagement and activation across each LTC pathway. Implementing the PAM through qualitative interviews provides greater detail and understanding around patient's knowledge, skills in managing their own health and healthcare.

6.6 Economic evaluation

Respondents were asked to select their employment status (e.g., full-time paid employment, part- time paid employment, self-employed, retired etc.) along with; 1) the number of days lost to sickness if applicable and 2) the number of times they have accessed NHS services in the last 12 months. NHS service use included; the number of times they had contact with their GP, specialist appointments, A&E attendance and inpatient days. Patients were asked this question at baseline and 12 months.

Using this information, a Health Economist performed a cost-utility analysis (CUA), which calculates the costs and quality-adjusted life-years (QALYs) for two courses of action. In this study, the two courses of action are 'no referral scheme' and 'exercise referral scheme'; these are proxied by pre-referral and post-referral for the same patients. The CUA estimated the costs and health consequences from referral to the 12 month follow-up point. The longer-term effects of any change in activity were not modelled.

National unit costs for each of the items of resource use have been identified and are shown in Table 1. The costs are at 2015/16 price levels, which is consistent with the start of the referrals and also represents the most recent year for which NHS Reference Costs are available.

Table 1 - Unit costs for economic analysis

Item	Unit cost	Source	Note
Exercise programme	£105	Sheffield Hallam University	This is the tariff paid for all referrals
GP attendance	£27	Unit Costs of Health and Social Care 2016	GP surgery consultation, excluding direct care staff costs and qualification costs
Specialist attendance	£62.61	NHS Reference Costs 2015/16	Community Health Services, Specialist Nursing, activity weighted average cost of adult services
Emergency department attendance	£137.74	NHS Reference Costs 2015/16	Emergency Medicine, activity weighted average cost
Inpatient admission	£3242.03	NHS Reference Costs 2015/16	Elective and non-elective inpatients stays, activity weighted average cost
Inpatient day	£650.89	NHS Reference Costs 2015/16	Elective and non-elective inpatients stays, activity weighted average cost

6.7 Recruitment and sampling for the process evaluation

The process evaluation qualitatively explored the experiences of stakeholders as they engaged with the Active for Health programme. The process evaluation covered two discrete groups; Patients and Professionals (including the project management team). All interviews that comprised the process evaluation were conducted by the same researcher and took place via telephone or face to face. The researcher conducting the interviews followed a pre-defined semi-structured interview schedule to minimise the potential bias. All interviews were audio recorded and transcribed verbatim. Table 2 provides a breakdown of the total number of interviews undertaken by role type.

6.7.1 Patients

The evaluation team contacted patients by telephone at random from each of the seven pathways to gauge their willingness to participate in the process. If willing, an interview was scheduled at a convenient time for the patient. The recruitment period was January 2017 to July 2018. Interviews were carried out at one-time point throughout the patient's journey across all seven pathways, with 35 interviews conducted in total (5 per pathway), including a mixture of males (n=18) and females (n=17). The patient interviews were informed by a topic guide based on an adapted version of PAM (see section 6.5.3). An activation level was also provided for each patient (1= not activated, 4 = highly activated). Interviews lasted between 15 and 30 minutes. See sections 8.1 -8.2 for more details.

6.7.2 Professionals and project management staff

Project management staff based in Rotherham Metropolitan Borough Council (RMBC; n=2), two leisure providers (n=4) and Health Care Professionals working for the NHS (n=17) were invited to take part in the process evaluation. The interviews took place at three-time points; baseline, 18 months and project close. Interviews lasted between 30 and 45 minutes and were informed by a topic guide. The interviews with HCPs purposefully included those working across primary and secondary care and across all seven pathways to obtain a broad exploration of the programme experience. The sample size of HCPs reduced over time (18 months, n=14, project close, n=11).

Table 2 - A breakdown of all professional interviews per role type

Stakeholder type		Roles interviewed
Project management RMBC		• Project Lead • Project Coordinator
Leisure providers	**Site 1** - Responsible for stroke, COPD, MSK, falls and cancer	• Programme Manager and Lead Exercise Specialist • Lead Exercise Specialist
	Site 2 - Responsible for Cardiac phase IV and heart failure	• Health and Wellbeing Programme Manager • Contract Health and Wellbeing Manager
Healthcare professionals	Cancer	• Macmillan Clinical Nurse Specialist • Macmillan Project Manager
	COPD	• Clinical Specialist Physiotherapist • Rehabilitation Assistant Practitioner
	Falls	• Therapy Practitioner
	MSK	• Clinical Specialist and Team Leader • MSK and Orthopaedic Clinical Lead
	Stroke Cardiac phase IV	• Team Leader and Speech and Language Therapist • Psychologist
		• Cardiac Rehabilitation Physiotherapist
	Heart failure	• Heart Failure Specialist Nurse

6.8 Transcription, data management and analysis

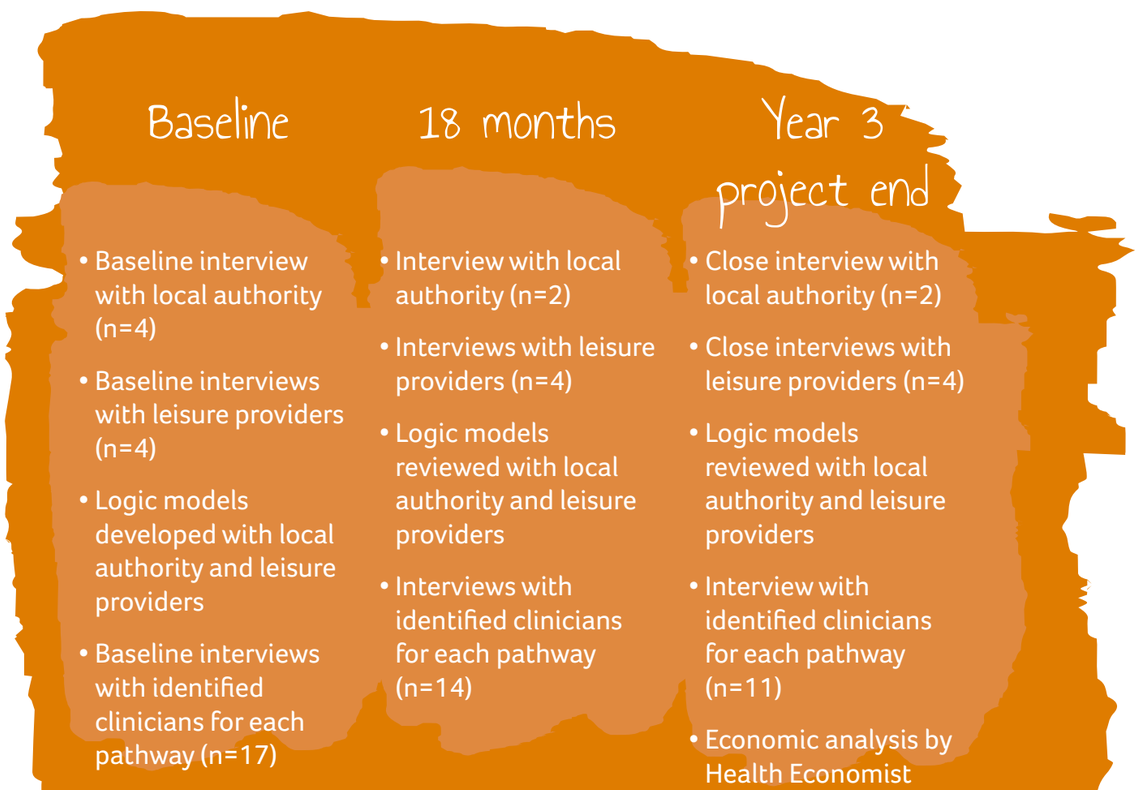
6.8.1 Qualitative Data Analysis

All audio recordings of patients, HCPs, leisure providers and the project management team were transcribed verbatim for analysis. This was carried out by an external transcription company and all processed data was stored securely under the Data Protection Act (2018). Data was transcribed verbatim and examined using thematic analysis. The approach involved the development of an initial coding index based on the interview guide. The coding index was then implemented to organise the data into themes. Three researchers independently read the transcriptions and coded the data to identify emerging concepts. These concepts formed themes that are presented in results section 8. The data of each patient was considered separately for each pathway and then emergent themes for each pathway were collated to provide an overview of the opinions within that subgroup. After coding, a consensus process was used to allocate concepts into sub-themes. During these discussions, the researchers considered whether a theme or subtheme represented the views of all pathways and descriptions were used to exemplify this.

6.9 Evaluation time line

Figure 4.0 illustrates the evaluation activities and the data collected at each time point. Data collection points varied across all stakeholder groups. Baseline data collection took place before a patient or professionals engaged with the Active for Health programme, in all LTC groups.

Figure 4.0 Evaluation activities and data collection time points.



The programme offers people with a long term condition the opportunity to participate in physical activity and have access to a trained exercise specialist.

7 Results outcome evaluation

7.1 Results overview

The following sections report the key quantitative results from the Active for Health evaluation from all seven LTC pathways as a whole. A more in-depth analysis for each LTC pathway can be found in Appendix 1a to 1e. Section 7.4 includes pathway impact case studies, which add data on outcomes drawn from patient interviews.

The primary outcome measure for the Active for Health evaluation was the proportion of patients who achieved one 30 minute bout of moderate to vigorous physical activity (MVPA). Other variables of interest included the impact of the Active for Health evaluation on sport-specific PA, total weekly PA and QoL (measured using the EQ-5D-3L measurement instrument).

7.1.1 Active for Health patient characteristics

- One-thousand and eighty-two (n=1082) out of a possible 1460 (74.1%) patients were recruited to the Active for Health evaluation (Table 2). Patients were mostly female (56.9%) and had a mean age of 62.9 ± 13.5 years. Patients were youngest in the MSK group, and oldest in the falls and fractures group.
- Five-hundred and sixty-six patients (n=566; 52.3%) remained in the evaluation after three months. This fell to 366 (33.8%) after six months and 191 (17.7%) after 12 months, respectively.
- Patients in the Cardiac Phase IV group had the best programme adherence (28.9%; Figure 5.0), whereas patients in the MSK group had the highest evaluation attrition.
- A small cohort of 80 participants were contacted and asked their reason for dropping out of the programme. The main reasons recorded for dropout of the evaluation across all seven conditions included ill-health (30%), and participation in other PA (28%). The remaining 32% reported their reason for drop-out as; other commitments, back to work, completion of 12 free sessions, and inconvenient session location or time.

7.1.2 Healthcare utilisation

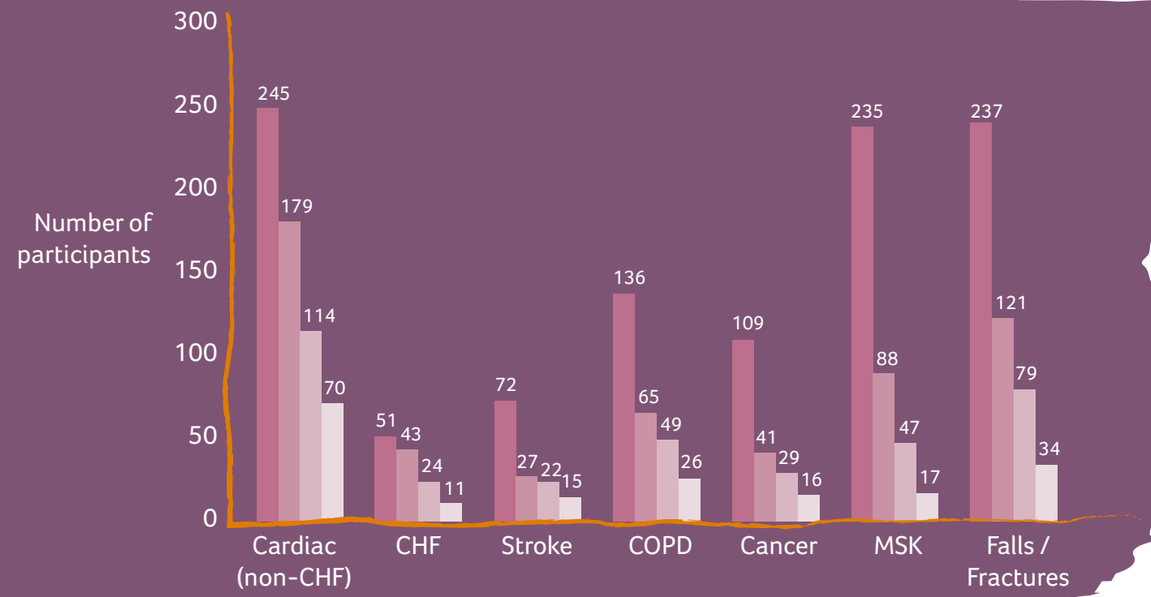
- To explore if the Active for Health program had an effect on how individuals were managing their condition, analysis of the number of interactions with healthcare services over a 12 month period were collected.
- A reduction in health service use was observed across all chronic disease pathways and in all aspects of health care (Figure 6.0).

Table 3 - Participant characteristics at baseline

Characteristic	All	Cardiac (non-CHF)	CHF	Stroke	COPD	Cancer	MSK	Falls / Fractures
Participants (% female)	1082 (56.9)	242 (35.5)	51 (37.3)	72 (43.1)	36 (50.7)	109 (83.5)	235 (60.4)	237 (75.1)
Age (± years)	62.9 ± 13.5	61.8 ±11.0	63.3 ±12.6	68.1 ± 10.0	67.2 ± 7.5	57.8 ± 10.4	50.8 ± 13.0	74.4 ± 9.5
IPAQ / IPAQ-E (*n*)	457 / 622	112 / 130	21 / 30	22 / 50	27 / 109	68 / 41	181 / 54	27 /210
Ethnicity								
Caucasian (%)	1034 (95.6)	221 (91.3)	46 (90.2)	72 (100.0)	135 (99.3)	109 (100.0)	220 (93.6)	231 (97.5)
Asian (%)	29 (2.7)	13 (5.4)	3 (5.9)	0 (0.0)	1 (0.7)	0 (0.0)	8 (3.4)	4 (1.7)
Black (%)	7 (0.7)	2 (0.8)	1 (5.9)	0 (0.0)	0 (0.0)	1 (0.0)	3 (1.3)	1 (0.4)
Arabic (%)	2 (0.2)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (0.0)	2 (0.9)	0 (0.0)
Mixed Race (%)	0 (0.0)	0 (0.0)	1 (2.0)	0 (0.0)	0 (0.0)	3 (0.0)	1 (0.4)	0 (0.0)
Not stated (%)	8 (0.7)	6 (2.5)	0 (0.0)	0 (0.0)	0 (0.0)	4 (0.0)	1 (0.4)	1 (0.4)

CHF = Chronic Heart Failure; **COPD** = Chronic Obstructive Pulmonary Disease; **MSK** = Musculoskeletal; **IPAQ** = International Physical Activity Questionnaire; **IPAQ-E** = International Physical Activity Questionnaire - Elderly.

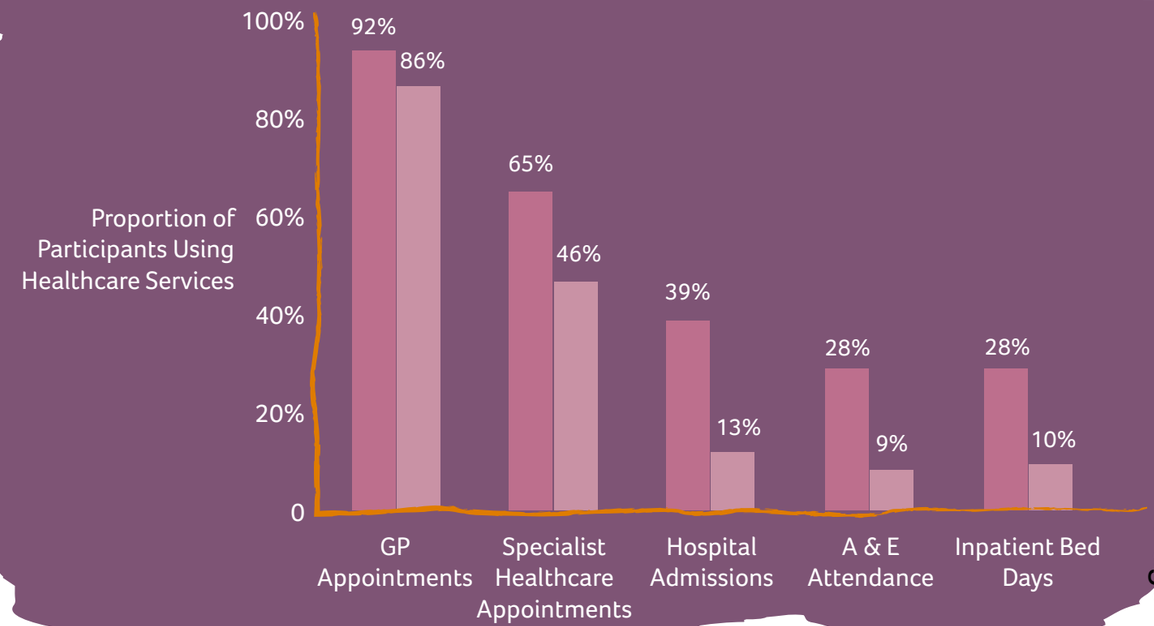
Figure 5.0 - Evaluation attrition by referral pathway.



Dark purple lines indicate baseline assessment. Lighter purple lines indicate three month, six month and twelve month follow-up.

CHF = Chronic Heart Failure; **COPD** = Chronic Obstructive Pulmonary Disease; **MSK** = Musculoskeletal.

Figure 6.0 - Healthcare utilisation within the Active for Health cohort.



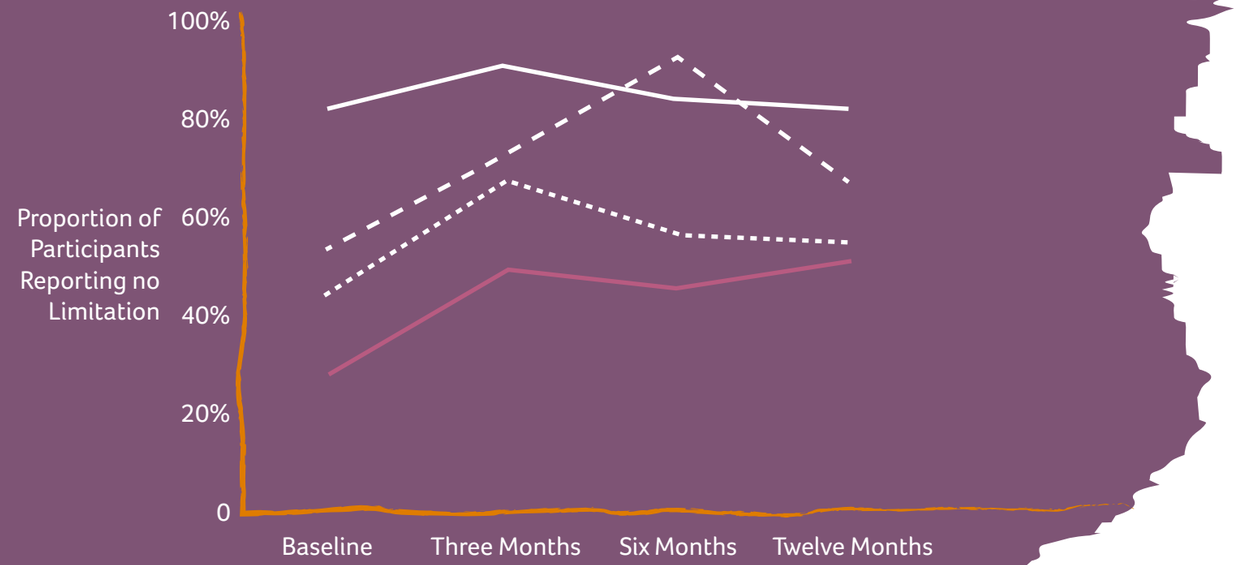
Dark purple bars and light purple bars indicate the proportion of patients who accessed healthcare services at baseline and twelve months, respectively.

G.P = General Practitioner; **A & E** = Accident and Emergency.

7.1.3 Quality of Life (QoL)

- For the purpose of the Active for Health evaluation, quality of life refers to the specific domains of daily living included in the EQ-5D 3L questionnaire.
- Days lost to sickness within the work environment are an important indicator of an individual's ability to manage their condition, but it is also economically beneficial for people to stay in work.
- Upon commencing Active for health, n=702 (64.8%) of patients were retired. Some patients may have retired as a result of developing a LTC, so the number of working days lost to sickness were reported for the whole evaluation population. In total 15% of all patients reported losing at least one day of work to sickness in the 12 months prior to enrolling on the Active for Health programme. After 12 months, this had reduced to 6.3% (n=12).
- It is important to note that without understanding some of the wider influences on a person's life, it is difficult to ascertain exactly the reasons behind these sickness days.
- Perceptions of QoL improved throughout the first three months of Active for Health when support received from Exercise Specialists was at its peak. A decline in QoL is observed after six months, suggesting that maintenance of support could be critical in helping maintain positive wellbeing scores.
- QoL, measured using the VAS rose from 65 to 75 after three months, and remained higher than baseline after 12.
- Changes in specific domains relating to patient QoL are shown in Figure 7.0. Compared to baseline, there were fewer patients who reported difficulties with usual activities and pain after 12 months. Patients did not report any improvements in their ability to perform self-care activities after 12 months.

Figure 7.0 - Proportion of patients reporting no limitation to selected domains of physical health and quality of life.



White solid lines indicate problems with self-care, white dashed lines indicate limitations to usual activities, dotted lines indicate mobility difficulties and purple solid lines indicate the proportion of people who do not suffer from physical pain.

7.1.4 Measurement of physical activity

Single Item Measure

- At baseline, most patients (70.0%) did not participate in at least one, 30 minute bout of moderate intensity PA, per week. This decreased to 9.5% after 12 months.
- Importantly, **77.2% of patients who were engaged after 12 months had initially reported failing to achieve one, 30 minute bout of moderate intensity PA when they were enrolled to the evaluation.**

Walking

- **Patients in the IPAQ and IPAQ-E groups both increased the number of days where walking activities were performed, from four at baseline, to six after three months.**
- The duration of walking activities increased from 30 to 40 minutes in the IPAQ group and the IPAQ-E group.

Moderate Intensity Physical Activity

- **Compared to baseline, patients in the IPAQ and IPAQ-E groups undertook moderate intensity PA on more days of the week after three months (Table 4).** This was accompanied by increased durations of moderate intensity, from zero at baseline, to 60 minutes at three months. The increase in duration was maintained at six and 12 months.
- For patients in the IPAQ group, no further changes in the number of days that moderate intensity PA were reported. However **after 12 months, the number of days where patients reported undertaking moderate intensity PA remained higher than baseline.**
- Despite a reduction, patients in the IPAQ-E group undertook moderate intensity PA on two days of the week after 12 months, compared with zero days at baseline.

Table 4 - Median number of days that patients took part in physical activity (range)

Time Point	IPAQ Group (Range)	IPAQ-E Group (Range)
Baseline	0 (0 to 7) [abc]	0 (0 to 7) [abc]
Three months	2 (0 to 7) [c]	3 (0 to 7) [a]
Six months	2 (0 to 7) [b]	3 (0 to 7) [bd]
Twelve months	2 (0 to 7) [c]	2 (0 to 7) [cd]

PA = Physical Activity;
a = Significant difference between baseline and three month values
b = Significant difference between baseline and six month values
c = Significant difference between baseline and twelve month values
d = Significant difference between six and twelve month values

7.2 Economic analysis

The economic analysis showed that NHS resources and costs reduced in the year after referral to Active for Health. Even after accounting for the cost of the scheme.

Overall health, measured by QALYs (Quality of Life Years) derived from the EQ-5D and the EQ-5D VAS measurement instruments, also improved (Table 5).

Based on the 135 patients where cost and QALY data were available, referral to Active for Health was associated with a reduction in NHS costs and improvements in health, as measured by QALYs generated by the EQ-5D-3L instrument.

In these cases, an incremental cost-effectiveness ratio* has not been produced as there is no trade-off between costs and QALYs. Instead, the intervention is said to dominate the control group.

When sampling uncertainty is considered, there is a 93% chance that Active for Health was cost saving, and over a 99% chance that it improved health.

When considered together, there is a 99% chance that it is cost-effective at a threshold of £20,000 per QALY gained.

This is a key finding, although the small sample size means caution should be used when considered the evidence.

** Incremental cost-effectiveness ratio (ICER) is a measure representing the economic value of an intervention, compared with an alternative form of care. It is usually the main output or result of an economic evaluation. An ICER is calculated by dividing the difference in health care costs (incremental cost), by the difference in the health outcome measure (incremental effect), which in this case was the EQ-RD-3L. This provides a ratio of 'extra cost per extra unit of health effect' for the more expensive therapy vs the alternative.*

Table 5 - NHS costs across the seven referral pathways

	n	NHS costs pre-referral	NHS costs post-referral	Baseline utility	QALY gain	Difference in NHS costs
Cardiac phase IV	56	2406	698	0.739	0.036	-1709
Heart failure	8	2764	1372	0.583	0.042	-1392
Stroke	11	3803	325	0.676	0.036	-3479
COPD	22	961	3527	0.786	0.019	+2565
Cancer	8	3072	691	0.759	0.020	-2382
MSK	10	1506	882	0.674	0.058	-624
Falls/fractures	20	1528	771	0.662	0.030	-757

7.3 Summary of outcome evaluation

The following bullet points summarise the key quantitative findings of the Active for Health programme. A more detailed quantitative analysis for each LTC pathway can be found in Appendix 1a to 1e.

1. Each pathway initially reported high levels of physical inactivity at baseline. In total 70.0% of patients did not achieve at least one, 30 minute bout of MVPA. By 12 months, however this had fallen to 9.5%.
2. The frequency and duration of walking activities increased in the Phase IV, CHF, MSK and Falls Prevention group. Patients in the COPD and Cancer pathways were undertaking walking activities on most days of the week throughout the study.
3. With the exception of Stroke and MSK patients, the number of days where moderate intensity PA was performed increased across the different LTC pathways. By six months, patients were typically taking part in moderate intensity PA on two to four days per week.
4. Most LTC pathways showed a trend towards improved QoL (assessed using VAS) after three months. Stroke and COPD patients were the only groups not to report significant improvements in VAS at any time point. Individuals who have had a stroke or have COPD usually deteriorate in health status over time with age, which results in a reduction in QoL. This is concurrent to previous research into LTCs (Ståhlb et al.,2005; Haacke et al., 2006).
5. In summary, most groups reported increased levels of PA throughout the evaluation. Older patients generally reported better outcomes than younger patients, although this may be due to some groups having fewer younger respondents at individual follow-up time points.
6. The intervention was clearly effective at recruiting patients. It was also effective at improving PA levels for the people who were followed up at 12 months.
7. Active for health has provided a potential solution for reducing barriers to participation in PA, although more work is needed to understand how programmes can be designed to increase long-term patient adherence.

Case studies highlighting patient's stories have been presented in section 7.4.

7.4 Participant case studies per condition

Cardiac Phase IV pathway case study

"Back in 2006 I was diagnosed with a heart condition called supraventricular tachycardia and I have had about 47 episodes where I have had to go to the hospital and have my heart stopped and re-started. So I was advised to attend Active for Health for the free 12 weeks of sessions. I loved it that much that I have continued going ever since".

Since attending the Active for Health programme:

- It has increased my confidence in walking
- It has built up the strength in my legs and given me the stamina to go swimming as well
- I don't feel as out of breath
- I don't go to the doctors as much as I used to

"I can now actually do things in everyday life, such as doing things for myself. Obviously it has given me a massive confidence boost and it is a massive social aspect for me now. Before I did this I was a bit of a hermit and I didn't go anywhere, I didn't see anybody. The people that I go to the class with, I have come to love and know. It's a massive comradery and then it's really nice afterwards when we all sit and have a drink in the café. I think that is what makes me go even more than the exercise alone".

Cardiac phase IV patient

Chronic Heart Failure pathway case study

"When I was diagnosed with heart failure it was shock and I lived in fear in doing any kind of activity and wasn't physically active at all. I was unable to walk hills and fearful of doing too much. I haven't been able to do everyday things such as walking to the hair dressers and doing other chores around the house due to fatigue, fear, and breathlessness. I am now exercising in one of the maintenance classes and have recently become a community buddy to support other patients who are now starting their journey in becoming more active whilst living with heart failure and have other heart conditions"

Since attending Active for Health:

- I am much more confident and am doing things I haven't done in years. I walked to the hairdresser for the first time on 2 years to have my hair done
- I didn't exercise before through fear and feeling ill. I'm now exercising 5 times a week
- I have made new friends and even gone onto to a further exercise class at the Rotherham Leisure Complex too
- Reduced my medication
- Reduced the feeling of being breathless

"In the future this can be available for others who have heart failure. The team were fantastic and they have really helped me at this difficult time on my life. The programme has been given me my life back".

Chronic Heart failure patient

Stroke pathway case study

"He suffered a stroke in 2015 which initially affected all his right side, with limited movement in his right arm. He was in a bed downstairs as he didn't have the mobility to get upstairs. He started rehabilitation with the enablement team and Physiotherapy at Park Rehabilitation; he was then referred to the Active for health programme and has been attending for the last 10 months. When he first started the programme he would attend in his wheelchair, and would exercise in his chair. From this he progressed to being out of the chair assisted by the instructor on a 1 to 1 basis with a walking aid, 10 months into the programme he is now talking part in the exercise independently with little instructor support".

Since attending Active for Health

- He is now able to get upstairs to sleep
- Completes the full session with no walking aid/ limited 1 to 1 support.
- He now walks independently around his home
- His right side had improved greatly and his leg movement is more aligned

"When he first attended he was a little nervous, apprehensive and anxious. He was unable to be left alone on a work station due to his strength, balance and control, 10 months into the programme his strength, balance, co-ordination and confidence has improved beyond belief, we no longer support him through the whole class, he can undertake exercise independently. I have seen a difference in not just his physical abilities, but also his interaction and confidence with other group members".

Lead Exercise Specialist of Stroke class and patients wife

COPD pathway case study

"Before attending the Active for Health programme I was very out of breath, I used my mobility scooter regularly and didn't walk far at all. I was very unsteady on my feet and lacked the confidence to go out alone. I relied heavily on my husband and family to take me places. I have now completed 12 weeks Step 2 and now continued into Step 3, as part of the Active for Health programme".

Since attending Active for Health:

- I rarely use my mobility scooter now, and most of the time I now walk
- I have tried skipping for the first time in 70 years
- My breathing is better and I can be active for longer periods of time, including taking part in the full one hour class now

"My family have noticed I am more independent, I am not asking for lifts so often, my family think it's great that I am now doing things myself instead of sitting".

COPD Patient

Cancer pathway case study

"I was diagnosed with breast cancer in May 2015, after both chemotherapy and radiotherapy I had lumpectomy axillary node clearance. I felt very tired, had a low mood/poor self-image, my weight had increased by two and a half stone due to treatment. I wanted to get fitter and move forward this was when my breast cancer nurse referred me to the Active for Health programme. I have now been taking part in the programme for 12 weeks. Since starting on the programme, I am feeling more positive about myself and I am doing something to improve my worry of reoccurrence".

Since attending Active for Health:

- I have lost a stone in weight
- Reduced my fatigue
- I can now run 400 meters and march up hills
- It has improved my mood

"I know the exercise part of the programme is important, but it is also the social aspect which really helps me. I would recommend the programme whole heartedly; the instructors are so knowledgeable in their area and everyone is treated as an individual. This course is amazing. I have no hesitation in continuing into Step 3 and paying for this service".

Cancer patient

MSK pathway case study

"My quality of life prior to the programme was poor due to a car accident 8 years ago which resulted in me having a chronic back problem. I was severely struggling with movement and day to day activities. I lacked motivation in daily life and had lost faith in all prior rehab services. I was referred to this programme by my physiotherapist."

Following the Active for Health programme:

- I rarely leave my house but I have managed to attend nearly every session, this group is not just exercise, it is fun! Attending the classes has given me more confidence to believe I might actually return to work
- I have learned to be able to get up and down from the floor using the aid or furniture if required which now enables me to get on the floor and play with my granddaughter

"These sessions have a wide variety of abilities who attend but the exercise is tailored to suit the individual. I find this is great as I can work to my own level and capabilities and I do as much as I feel is comfortable. The staff who deliver the sessions are highly trained professionals and work with you every step of the way". This programme has given me 12 weeks of tailored exercise which I am able to continue by attending so that I can continue to be more active and improve on the benefits I have already gained. I have seen numerous amounts of physios, pain specialists and psychologists from all over the country but I can honestly say I have found this the most rewarding and the fact that I can continue on this programme for as long as I choose to is great".

MSK Patient

Falls Prevention pathway case study

"Six years ago my mother, suffered a minor stroke, resulting in loss of peripheral vision in left eye and damaging the part of the brain effecting balance, resulting in sporadic episodes of dizziness/ loss of balance. After hospital investigations, loss of balance was due to having a mini-stroke. My mother had a couple of bad falls. These episodes have all had a significant impact on her confidence, making her frightened to leave the house alone. Following my dad's death, she gradually became withdrawn, disinterested in things she used to enjoy and eventually stopped going out alone, fearing she would have another dizzy spell, convincing herself she would fall".

Following the Active for Health programme:

- There is a significant improvement in her confidence, she's more mentally alert, her concentration has improved and she's generally a much happier person
- She is now able to attend the sessions alone
- She has met new friends
- Her confidence has increased and she is less concerned about having another fall

Even though the session in only once a week, it's the highlight of her week and often her main topic of conversation. The family feels more confident and less worried about leaving mum alone now, knowing she's happier, having the sessions to look forward to. This programme has been pivotal and vital in my mum's enhanced quality of life, both physically and mentally, for which I and my family, will be eternally grateful".

Daughter of falls patient

8 Results from the process evaluation

8.1 Key findings across all long-term condition pathways

8.1.1 Themes for all patients

Table 6 represents the main themes and sub themes derived from the qualitative interviews with patients from each pathway. For more detail around the qualitative findings per pathway, refer to condition cards in Appendix 1a to 1e.

Table 6 - Main themes and sub themes for patients

Main themes	Sub themes
1. Active for Health Programme	1a. Social interaction 1b. Exercise session and structure 1c. Exercise Specialists and Health Care Professionals 1d. Impact of physical activity 1e. Referral process
2. Patient activation	2a. Confidence in managing condition 2b. Knowledge and skills to manage condition 2c. Responsibility of health

1. The Active for Health programme

1a. Social interaction

- All patients discussed social interaction as an important part of the Active for Health programme. This included the impact of making friends and having time after the class to socialise.
- Social links and relationships were important to individuals with LTCs. Interacting with people through Active for Health enabled individuals to feel connected.
- Some had struggled with social interaction in the past, feeling isolated or having low confidence. Active for Health provided them with an opportunity to engage with others. Most people believed that there were significant benefits to being in a group of individuals with a similar condition to themselves.

"It is a lovely group, it's nice and relaxed. I think a lot of people come and they don't know what to expect and, as I said, we've got an absolute fantastic group of us and we all gel together lovely"

Stroke patient 2

"Being able to talk to likeminded people. Because as I say you talk to your family, but nobody really understands what you're going through or what you've been through, or your concerns. And sometimes I don't want to worry them if I'm concerned. I can tell my husband, but I wouldn't tell my kids"

Cancer patient 2

1b. Exercise session and structure

- Personalising the session based on the needs of the individual was important. It ensured that patients were challenged where appropriate, but not pushed too hard to cause disengagement in the session.
- The intensity of PA was considered appropriate and tailored for each individual. Perceived effort of the exercise was often referred to, with most patients being cautious not to over exert themselves. Many of the patients were risk adverse, not wanting to worsen their condition.
- Patients discussed the significance of having a scheduled appointment each week, which increased their motivation to attend.
- Patients tended to compare their activity levels to what they think they 'should' be doing, often based on their expectations of what was appropriate for a person of their age. They wanted to be comfortable and safe when being physically active.
- Patients didn't want to engage in activities that made them feel embarrassed or made their symptoms worse. Patients discussed their preference for circuit based exercises. Participants commonly referred to the enjoyment of the type of equipment used (vipr and TRX) and the variation of functional training tools, which differ to typical gym equipment.
- Music choice was deemed important and should be adapted to the group demographics, to enhance engagement with exercises.
- Patients also discussed the benefits of choosing an appropriate location and time to suit their needs.

"I think if you want to push yourself you can, and if you don't then you don't. I mean some of the ladies are probably moving up to 70, you can only do so much, and you don't feel under pressure to do more than you can do"

MSK patient 1

"You're with people that have gone through what you've gone through, and some worse than yourself. And I think it's not too vigorous exercise; you don't feel like you've got lots to prove. I think in a gym I feel like I'd got lots to prove; whereas I enjoy these exercises. I push myself, and I want to, I mean there's a range of ages, and some can't push themselves as hard, or some have just joined. It adapts to everybody..."

Cancer patient 1

1c. Exercise Specialists/ instructor and Health Care Professionals

- Active for Health patients often indicated that they were motivated to engage with and participate with the programme because of the instructors.
- The personality traits of the instructors were considered important, such as being friendly and approachable.
- The camaraderie in the group was often referred to by patients. The instructors were proactive in engaging the patients in the social component of the classes, which emerged as 'banter' between the patients and the instructor.
- Exercise Specialists and HCPSs were considered as important sources of advice on the safety and appropriateness of PA.
- Most respondents had comorbidities and therefore felt the need for instructors to be suitably qualified, and to have experience and expertise with a number of LTCs
- The type of instructor leading the session was very important to patients. Experience, knowledge of exercise, knowledge of condition, spontaneity, empathy and listening skills were all viewed as particularly important.
- A large proportion of patients discussed having a trusting and supportive relationship with their HCPs. This was particularly evident in the cancer group.

"...you can put your trust in the instructors that they're only going to push you as hard as you can go at that point...they were really supportive of just having gradual progression every week. So I felt because they were in control and they were there to support us that I wasn't ever going to overdo it or not do as much as I could"

Cancer patient 3

"The instructors couldn't make the sessions any better... keeping their eye on you"

CHF patient 1

1d. Impact of physical activity

- All patients discussed some form of benefit from attending the programme including physical, social or psychological.
- Having a positive or negative experience of PA in their life, either through the NHS or otherwise, influenced their attitudes and motivation towards PA. Patients discussed past PA and had already 'bought-in' due to past experiences.
- Patients identified a wide-range of benefits from PA, but most emphasize the 'feel good factor'.

"...it makes you get up and got out and be active, instead of just sitting at home feeling sorry for yourself"

COPD Patient 2

"You have to get up, get dressed, get washed and changed and clean your teeth and get out to that place at a particular time, so I like that regime of don't lounge about at home doing nothing and not meeting different people and chatting and talking. I like that"

Falls Patient 1

1e. Referral process

- Patients frequently discussed the ease of the referral process, including the speed at which they were referred and attended their first session. Within the referral process, patients discussed the established trust and relationship with the HCPs.
- The HCP's were seen as an advocate of the programme and patients were therefore willing to try the programme.
- Participants stated that the Active for Health programme was de-medicalised, as the sessions are delivered in a community based or leisure facility away from the hospital.
- Some of the patients from the Cardiac and CHF pathways commented that the referral process took some time; however this didn't negatively impact on their engagement. Originally these two pathways were delivered as cohort programmes, which changed to a rolling programme; this can impact on referral times.

" ...you've still got that support where you can phone your Macmillan nurse up and things like that. But you get better support from the people doing something like Active for Health than phoning your breast care nurse up. You seem to get more out of this Active for Health. It's more of a lifestyle thing rather than the hospital thing"

Cancer patient 4

1f, Long term physical activity

- Instructors promoted additional exercises at home, providing safe and practical options by adapting the exercises learnt within the session.
- Most patients felt disappointed at the prospect of the classes being stopped in the longer- term. They believed that not having a scheduled session to attend would negatively affect their motivation and encourage disengagement.
- Those in the Cancer and MSK pathways were primarily engaged and motivated to carry out alternative PA.
- Patients in all pathways discussed the continuation of PA in the long-term; those in the Stroke and Falls Prevention pathways were more reliant on the continuation of Active for Health. These patients discussed lower confidence in carrying out unsupervised PA and increased dependence on the social support from others.

"I would be miserable and I would also be very cautious about doing exercises myself...if I hadn't been to this class I wouldn't be doing these exercises that we do. I mean they're simple, but there is quite a selection of movements and that. But I think if you're on your own at home, you wouldn't try and do these exercises...you've got the weights and lifting the, the right weights up, you'd think ooh no, would that hurt me, is that detrimental to heart trouble? But when you're there they guide you through these and you think ooh I can do that"

CHF Patient 2

2. Patient Activation

Patient activation scores were given to each patient, based on their comments in the interviews; these can be seen in Table 7. More details can be seen in Appendix 1a to 1e per pathway.

Table 7 - Patient Activation Level for each pathway

Long-term condition pathway	Patient activation			
	Level 1	Level 2	Level 3	Level 4
Cardiac Phase IV	n=0	n=2	n=1	n=2
Chronic Heart Failure	n=0	n =1	n=2	n=2
Stroke	n=0	n=4	n=1	n=0
COPD	n=0	n=0	n=3	n=2
Cancer	n=0	n=0	n=3	n=2
MSK	n=0	n=0	n=3	n=2
Falls	n=0	n=2	n=3	n=0

Level 1 = low level patient activation; Level 4 = high level patient activation

Patients in the MSK and Cancer pathways were considered the most activated in their own health, based on their skills, knowledge and confidence of managing their own condition.

They generally deemed themselves to be the most responsible for their own health, had high confidence in managing their own condition, and their ability to continue with PA. They had good knowledge of their condition and its management. Patients in the Stroke pathway were considered the least activated in their own health and mostly believe that others are responsible for their own health, including loved ones and HCPs. A breakdown of PAM scores per patient and pathway can be seen in Table 7.

2a. Confidence

- Confidence in LTC management varied across all seven conditions, with those in the Stroke group rating their confidence as lower in comparison to the other conditions. These patients feel that they need continual supervision.
- Those in the other pathways rated their confidence in managing their condition as high. Confidence was often referred to on a Likert scale between one to ten, with one being low and ten being maximum.
- Most patients discussed how their overall confidence and confidence to manage their condition in the long-term had increased as a result of Active for Health.
- Across all conditions, patients compare their success based on the ability of others. If they perceive someone less capable or with a higher severity of their condition, it makes them feel more confident and able.

"I'm a lot more confident now in doing things, and doing things on my own as well than what I ever have been. Like I said this keep fit, the Active for Health, that's the first thing I've ever done on my own"

Cancer patient

" It's the best thing you can do because it gets you out, it gets you with other people in the same predicament and that I think being with other people, it helps you long, it gives you the confidence to think well I'm not dying and I'm strong and I can do these exercises like everyone else"

CHF patient

2b. Knowledge and skills

- Those in the Cancer, MSK, Cardiac, CHF, Falls Prevention, COPD pathway, seemed particularly knowledgeable about their condition. Those in the Stroke class seemed less knowledgeable about their condition. This includes knowledge of medication, causes of condition and long-term management.
- Skills were coded based on patients' ability to transfer skills learnt in the session with application into other settings, like a home based activity. Patients in each pathway discussed the importance of transferring exercises from the Active for Health session to home based exercises, and/or adapting exercises learnt in the session to better enable activities of daily living.

"It's about me and if there's anything that I do wrong it's my fault. I don't think that other people can take responsibility for my health in the broad term. The health people the people I've dealt with have always been very supportive and very sensible ant they've always done what I consider to be the right thing"

Cardiac patient 1

"Well, it's my body, so I've never really thought anybody else was responsible for it. It never even entered my head that they were"

Cancer patient 5

"Well because I think if you think there's something wrong with you, whether it's because of what I've gone through, but I think now if there's anything I think is wrong it's up to me to go and find the answer, go and speak to somebody"

MSK patient 4

"I think it was mostly down to my age. That's the explanation. I don't smoke, I drink glasses of wine with my tea and things, and I can't say I don't drink alcohol. But I don't smoke, and they always say that's the worst thing. I'm not overweight"

Cancer patient 1

8.2 Summary of patient interviews

- All patients involved in the qualitative interviews were positive about their engagement with the Active for Health programme; it was commonly voiced that the suitability of the exercise was important, to prevent any exacerbation of their LTC.
- Proficiency of exercise professionals, including correcting technique, the suitability of the exercise and reassurance was important. This highlights the need to address patient fears, before engagement in a PA programme, which may ultimately act as a barrier to participation.
- Within each LTC group, patients frequently discussed the importance of type of PA, social support and post session social time. So, an attempt to develop a PA pathway containing these components is important.
- Patient activation levels varied between conditions, with those in the Cancer and MSK pathway to be more highly activated and believed they were the most responsible for their own health.
- Patients in the Stroke pathway were considered the least activated in their own health and mostly believed that others are responsible for their own health, including loved ones and HCPs.

8.3 Insights from exercise providers on delivering Active for Health

The following results are taken from the two leisure providers in Rotherham. Leisure provider 1 was responsible for the Cardiac Phase IV and CHF pathways. Leisure provider 2 was responsible for the COPD, MSK, Cancer, Falls Prevention and Stroke pathways. Figure 8.0 and 9.0 depicts the logic model developed by Leisure Provider 1 and Leisure Provider 2 before the project commenced. This was revisited at 18 months and project close, in order to draw conclusions on the development of the project.

Figure 8.0 Provider 1 logic model for Cardiac Phase IV and Chronic Heart Failure.

8.3.1 What worked well - Leisure provider 1

- Collaborative partnerships with key stakeholders including public health, HCPs, and the evaluation team.
- An approachable and nurturing steering group with clear objectives which supports the needs of the delivery team.
- Marketing and awareness-raising events, including the one year celebration event, international and national conferences.
- Training for exercise providers such as the British Heart Foundation Motivational Interviewing course, enabled exercise providers to assess patients effectively, and deliver a high-quality programme.
- Committed staff who often contributed hours to patients outside of their normal work allocation. Whilst this indicates enthusiasm for the programme, providers should be cognisant about additional staffing needs for high quality exercise provision.
- Social buddies were instrumental in supporting other patients within the exercise classes. They also organised a range of external social activities leading to increased motivation and programme adherence.
- Having patients with similar conditions together in sessions, which enabled concerns and challenges to be discussed with one another.

8.3.2 What's worked well - Leisure provider 2

- Each pathway created its own community through the social support of others with a similar condition. Patients made friends and supported one another.
- The providers observed psychological and physical benefits in patients which exceeded their expectations. This includes reduced medication and improved ability to perform activities of daily living.
- Patients wanted to support the programme and become community buddies. Patients also took on roles in the sessions such as making cups of tea, which provided autonomy and purpose.
- The providers took responsibility and ownership of pathways and did not rely on RMBC.
- The diverse knowledge and skills of delivery staff accommodate patient with complex healthcare needs. Having a number of Level 4 qualifications was beneficial for this.
- Providers were engaged with the Active for Health programme and overall endorsement of the programme.
- More Level 4 instructors were trained and have the skills to deliver classes to multi-morbid individuals.

Figure 9.0 Provider 2 logic model for Stroke, Chronic Obstructive Pulmonary Disease, Cancer, Musculoskeletal and Falls Prevention providers.

Inputs	Outputs	Outcomes: Short	Outcomes: Medium	Outcomes: Long	Impact
Staffing Appointment of 1 FTE instructor per pathway **Other** Facilities (community halls / gyms) Administration Equipment Online referral software	Delivery of step 1 acute services awareness raising activities and including service visits / information about programme (4 hours) Delivery of step 2 exercise classes x 3 sessions each week 48 weeks per year Delivery of step 3 maintenance exercise classes x 5 each week for 48 weeks per year	**Staffing** Appointment of 1 instructor per pathway **Delivery of PA Sessions** 2-4 x step 2 sessions being delivered 6% of completers at step 2 go on to start step 3 2-4 x step 3 sessions being delivered Celebration event **Patient benefits** Improved CV fitness Improved strength Improved resilience Improved wellbeing Better pain management Increased mobility Increased flexibility Increased confidence	**Delivery of PA Sessions** 3 x step 2 session being delivered 3-6 x step 3 sessions being delivered **Patient benefits** Improved CV fitness Improved strength Improved resilience Better pain management Increased mobility Increased flexibility Increased ability and confidence of ADLs Reduction in falls Increase in social activities Increased independence	**Referrals / physical activity sessions** Over 3900 total visits per pathway Over 60% of completers at step 2 go on to step 3 5-8 x step 3 sessions being delivered (10-15 per class) **Patient benefits** Improved CV fitness Improved strength Improved resilience Better pain management Increased mobility Increased flexibility Increased ability and confidence of ADLs Reduction in falls Increase in social activities Increased independence Back to work Reduced medication	Reduced usage of NHS services Increased ability to independently exercise and be more physically active

Please note: this is a combined logic model for all pathways. There was some variance between individual pathways.

8.3.3 What were the challenges - Leisure provider 1

- As pathways developed and numbers of patient referral increased, the delivery staff reported that time constraints led to increased patient waiting lists.
- In some groups, a smaller number of patient referrals meant that providers perceived those groups to be unsustainable.
- Some staff left their post during the programme, resulting in a loss of expertise.
- Patients with unstable and unpredictable health conditions sometimes took longer to complete their exercise programme, and required greater staffing.
- CHF patients were often not ready to engage with Active for Health.
- GPs lacked knowledge and understanding of the referral criteria for identifying suitable cardiac patients.
- Some training courses were cancelled, leading to delays in qualified staff engaging with Active for Health.
- Referral numbers based on Key Performance Indicators (KPIs) were difficult to meet.

8.3.4 What were the challenges - Leisure provider 2

- Sometimes referrals between Step 1 to Step 2 took longer than anticipated.
- Breast cancer referrals constituted most of the referrals to the Cancer pathway, which led to a primarily female group.
- The opt-out referral process in the Cancer group was beneficial for referral numbers. However, some patients were not ready to engage in PA and providers spent time calling patients who were not interested in attending.
- Due to the progressive nature of the disease, COPD patients were often referred back into rehabilitation meaning adherence was low.
- Patients in the MSK group were of working age, and once the 12 free sessions were completed they returned to work and did not have time to attend further sessions.
- Referral numbers based on Key Performance Indicators (KPIs) were difficult to meet and the quality of referrals should take priority.

8.4 Summary and recommendations made by providers

- Targets were often over ambitious and prioritised referral number KPIs and attendance figures. Targets should instead focus on patient specific outcomes and be driven by quality, not quantity.
- A referral criterion needs to be agreed between the HCPs and leisure providers. Open discussions should be had around stakeholder remit. This is to reduce referral of unsuitable patients.
- The importance of continuation of PA should be clearly communicated to MSK patients to ensure long-term activity. More exploration needs to be carried out around MSK patients returning to usual activities.
- Individuals who disengage with the programme should be followed up to ensure they are aware that they can re-engage when the time is right for them.
- The feasibility of merging pathways could be looked at e.g. COPD/CHF, MSK and Cancer, while maintaining patient centred delivery. This is dependent on the nature of the condition, and would require Exercise Specialists to have multiple level 4 specialist qualifications.
- More support is needed from the clinical commissioning group (CCG) to influence GPs to refer appropriate patients.
- The perceptions of some HCPs about exercise professionals' expertise needs to be addressed. Trust and confidence in their ability needed to be affirmed and exercise professionals should be embraced as part of a multidisciplinary team.
- Staff turnover in HCPs and change in job roles across the project management team created difficulty for aligning next steps, future direction and sustainability.
- Communication of the programme's aims, direction and purpose crucial for new starters to ensure that the delivery and the development of Active for Health remains consistent.

8.5 Themes for Health Care Professionals

Table 8 represents the higher and lower order themes which emerged from the qualitative interviews with healthcare professionals (HCPs). These will be discussed in more detail below, alongside some key quotes with HCPs from each condition pathway.

Table 8 - Main themes and sub themes for Health Care Professionals

Main themes	Sub themes
1. Active for Health Programme	1a. Addressing the patient on an individual basis 1b. Beliefs and endorsement of physical activity 1c. Professional responsibility and trust 1d. Integration of physical activity in the care pathway
2. Process	2a. Communication 2b. Referral process

8.6 Insights from healthcare professionals perspectives

The following results are taken from all HCPs from the seven LTC pathways. A summary per pathway will be discussed separately in section 8.7.

1. Active for Health programme:

1a. Addressing the patient on an individual basis

HCPs acknowledged that patients' comorbidities should be considered when advising about PA. HCPs considered the personalisation of PA important for individuals with LTCs. HCPs stated that a 'one size fits all' approach does not exist and PA should be tailored to the individual within a person-centred treatment plan. HCPs suggested that PA in the Active for Health programme should also be personalised on an individual basis within the group setting. Utilising other resources and other HCPs is important for addressing the complexity of patients' comorbidities.

"... it's all individualised as well and they know it's they're not going to go onto a group where they're going to be pushed and pushed. I think that's a bit of a motivator for them isn't it

Falls HCP

"It is about a personalised pathway that we try to develop for someone. It needs to be identified in that first holistic assessment, even at that point where you're breaking bad news, identifying then as part and parcel of what's best for the individual"
Cancer HCP

"Patients don't come to us in isolation, they've often got co-morbidities like stroke, COPD, lots of other conditions, so it's tapping into the resources for the other parts of the pathway, I suppose...we can tap into diabetes specialist nurses, Breathing Space and working as a team is a good way to use everybody's expertise isn't it for that patient"

CHF HCP

1c. Professional responsibility and trust

HCPs believed that it was their professional responsibility to promote PA, but there was a concern about the risks of PA for individual patients and how to assess their suitability for the referral into Step 2. HCPs want to ensure suitable exercise provision is provided in Step 2 and Step 3; this trust and confidence from HCPSs in the providers increased over time.

"We are confident that that it's going to be delivered at a level that's appropriate and it's going to be progressive..."

MSK HCP

"Bringing in exercise instructors that are qualified to work with people with cancer is always very appealing that we know we've got people out there that have done their training, and they understand the condition and they understand the emotional and psychological things that happen to people..."

Cancer HCP

1b. Beliefs and endorsement of physical activity

There was a consensus that PA is important in the care pathway across all conditions. HCPs had a clear understanding of the benefits of PA for LTC management. This includes physical (e.g. mobility, increased muscle mass) psychosocial (e.g. mental health, social isolation) and NHS benefits (e.g. reduced hospitalisation). All HCPs endorsed the role that PA plays and its importance away from the patient's medical treatment, highlighting the importance of community based activity. PA is also deemed essential to prevent a relapse.

"There needs to be an element of fun away from the patient's medical treatment"

Cancer HCP

"...reducing general deterioration, improving, maintaining mobility, maintaining functional ability, to allow them to do their activities in the day. It improves mood, so if you improve mood, you improve compliance, you reduce hospitalisation, you improve outcomes and patients who are less mobile or are low mood, they generally do much worse"

CHF HCP

1d. Integration of physical activity in the care pathway

HCPs had a clear understanding of the purpose of the Active for Health programme, and how it aligns with the current model of care. They recognised the importance of embedding PA at all stages of the care pathway, including integrated community exercise delivery.

"We need to find a way of supporting [in physical activity] people external to the hospital"

"It's about the instructions in the leisure centre side of the treatment that inform what's happening in the medical side. And the medical side informing what can then happen in the leisure centre side" "So it's about making sure that, again it's this crossover between the medical and the non-medical, but finding a way to emphasise the importance of it"

"Offering a stepped programme of exercise. So somebody with a diagnosis of cancer would have a treatment plan, a medical treatment plan. But the active aspect of it is about making sure that people get involved in exercise that's suitable for their condition"

Cancer HCP

2. Process:

2a. Communication

The HCPs suggested that the purpose and goals of the Active for Health programme were clearly communicated from the start of the programme. Communication also played an important role between providers and HCPs. Effective communication instilled confidence and trust. It was also considered one of the most important factors for running a seamless pathway. Collaboration between the HCPs and providers underpinned the identification of problems, and the ability to resolve them quickly and efficiently. Having a steering group meeting with all stakeholders involved in the programme also enabled problems to be shared.

"I think communication. I think it's been nice to have the meetings... so that we all know what's going on...I mean it's a new project, it's a big thing and there's going to be little tweaking and little teething pains but as long as we're all sort of communicating"
Falls HCP

"Being open and honest you know it's about sort of feeding back negatives that are not working rather than just oh yeah we're all alright"

Stroke HCP

"... it's very much a collaborative approach... There's no heart failure exercise programme in Rotherham, there's a huge gap... They have to be stable; they can't have had any cardiac events within the last six months. But they do take; they do allow patients with devices which is really important"

CHF HCP

2b. Referral process

At the beginning of the project, there was some uncertainty around the referral processes. This may have been a barrier to patient referral. Refinement of patient referral criteria was suggested. These included; severity of illness and co-morbidities and the patient's functional capacity and referral time. Clarification of these criteria improved patient referral. Throughout the project efforts were also made to simplify the referral process for HCPs. After modification to referral processes, HCPs working in secondary care were efficient at enacting patient referrals. Conversely, HCPs working in primary care did not frequently refer to the Active for Health programme. GPs in particular need to be more pro-active in referring to Active for Health. HCPs suggested it would be beneficial to involve GPs to champion the service. However, others believed that the referrals from GPs would not work, due to the process taking too long.

"I don't think there is any barriers to referring because we invest so much time in them don't we 'from the beginning that we'd be cheating ourselves by not"
Falls HCP

"The form is quite complicated and asks for a lot of information. I think it could just be a lot simpler...I think it maybe puts GPs off. If they come and see that form they'll just be like I can't be bothered. Too complicated"

Stroke HCP

8.7 Summary of key insights from Health Care Professionals per pathway

Views expressed about the Active for Health programme were broadly similar across the LTC pathways, however some differences were identified.

8.7.1 Cardiac Phase IV Health Care Professionals

- The Active for Health referral process was considered labour intensive because of staffing constraints. Some of these issues had been resolved by the end of the evaluation.
- The preference in referring motivated patients was highlighted.
- Managing the waiting list for Cardiac Phase IV was challenging due to a high volume of people with heart disease and limited staff. Despite this, the benefits for patients engaging in PA longer term were highlighted.

"The form is very lengthy, about two sides of A4 for every patient and with quite a lot of detail so that's quite onerous really. And it's increased my workload quite a bit really over the time it's been on over the last two or three years, and obviously having more patients wanting to do it as well so it has been fairly time consuming"

"If they can keep it going long term and integrate it into their daily life and that's obviously going to benefit them longer term, heart, health wise as well as general health wise and there's a lot more chance of that happening if they're doing something for 20 weeks rather than just eight weeks"

8.7.2 Chronic Heart Failure and Health Care Professional summary

- The referral criteria was well understood, due to well established referral criteria defined by the British Association for Cardiovascular Prevention and Rehabilitation.

- A gap in exercise provision for patients with CHF was identified in Rotherham. The importance for seamless referral pathway was identified.
- The collaboration between the HCPs and Leisure Provider 1 enabled a clear understanding of the referral process. For CHF patients, a self-referral option was deemed important, due to resource constraints.

"It's very much a collaborative approach... There's no heart failure exercise programme in Rotherham, there's a huge gap... They have to be stable; they can't have had any cardiac events within the last six months. But they do take; they do allow patients with devic-es which is really important"

8.7.3 Stroke Health Care Professionals summary

- At the start of the project, HCPs working with stroke patients were less clear about the referral process and which patients would be suitable for the programme. This uncertainty reduced over the duration of the programme. Regular communications with Leisure Provider 2 and RMBC, plus PA training delivered by Public Health England were important in resolving these uncertainties.
- It was suggested by HCPs that conversations about PA with patients' should be embedded earlier within the healthcare journey of a stroke patient. After year one, HCPs had a good understanding of the pathway and had embedded their own 'Step 1' in the Active for Health pathway. Active for Health has shaped the acute service model in the Stroke pathway, by embedding PA as part of their usual rehabilitation, this didn't exist prior to Active for Health.

"...it's viewed more as part of the pathway now. And since Active for Health started we've developed an independent rehab group which didn't exist before. So since Active for Health has started it prompted us to think we need an exercise group and then that acts as a feeder into referrals into the service"

"I think we could introduce it earlier. I think it's a conversation you have later on when really, like if we had these groups running on ward and the benefits of exercise and activity, if we could introduce it ear-lier then people wouldn't be as kind of shocked by it"

8.7.4 COPD Health Care Professionals summary

- In the COPD pathway, HCPs initially expressed concerns about differences between the type of exercise offered at Step 1, and 2. However, throughout the programme, a strong professional relationship between HCPs and exercise providers developed and concerns were addressed. HCPs in the COPD pathway now view the exercise providers as an integral part of the rehabilitation team.
- HCPs would still like to see similarities between the exercises provided at each stage of the Active for Health programme.
- Due to the progressive nature of COPD, HCPs believed that maintenance of physical function is a successful outcome of the programme. Improvements in physical function were not deemed necessary for a patient to have benefitted from the programme. HCPs considered Step 2 and Step 3 beneficial in decreasing the demand on their resources, because of a reduction in the 'revolving door' scenario.

"...when people access the exercise groups you don't get that revolving door scenario where people just keep getting re-referred and boomeranging back in.... with our group it's about managing physical function, not necessarily increasing it"

"in terms of our role it would affect us, so we'd have nowhere to refer the patients to after they'd completed their maintenance programme, so we'd have to start looking at other options really, which could then prove more challenging. I'm not 100%, I don't know whether gyms would accept, I wouldn't know"

8.7.5 Cancer Health Care Professionals summary

- HCPs working with cancer patients had a clear understanding of the Active for Health programme from the outset. They believed that PA is part of a 'whole person' model of mental, physical and social health. For example, stress, diet, sleep and other lifestyle behaviours.
- PA was strongly endorsed in the Cancer pathway. To increase the referral rate, an opt-out process was implemented after year one.
- Group based sessions were seen as essential for Cancer pathway patients to ensure social support and shared experiences.

- Collaboration between HCPs and leisure providers and reinforcing whole systems collaboration is key.

"It is about the pathway changing so that people look at their whole lifestyle as opposed to just that medical diagnosis...Getting people ready for surgery, getting people ready for the aftermath of treatment that's very radical and debilitating"

"Having people fit enough to do that, there's not enough time really on the medical pathway to do that. So a lot of the emphasis is about what happens during treatment to keep you mobile. When you're having chemotherapy sitting around doing nothing isn't good for you. So it's about making sure that, again it's this crossover between the medical and the non-medical, but finding a way to emphasise the importance of it"

8.7.6 MSK Health Care Professionals summary

- The HCPs viewed those lacking in motivation, confidence and with low mood, to be the most suitable individuals to refer into the Active for Health programme. HCPs believed these patients would accrue the greatest health benefits.
- HCPs working with MSK patients thought that tailored PA was particularly important.
- PA which could be conducted outside of the Active for Health programme was also considered important to reduce relapse.

"...most ideal for me would be the people that come into our week one quite low in mood, low in confi-dence and not wanting to come and then by the end of the 12 weeks they've had such growth you can see they want to maintain that, rather than some-body coming in quite well and not having such a big improvement"

"...because it's all individualised as well and they know it's they're not going to go onto a group where they're going to be pushed and pushed. I think that's a bit of a motivator for them isn't"

8.7.7 Falls Health Care Professionals summary

- The Falls Prevention Pathway is well established and understood by the HCPs. Receiving positive feedback from attending patients motivated HCPs to continue making referrals.
- The continuation of Step 2 and 3 of the referral process were seen as essential for the smooth operating of the Falls Prevention Pathway.
- Less motivated patients who would gain the greatest health benefits were considered the most suitable to refer.
- Falls Prevention HCPs felt the Active for Health programme was most attractive those who have been active in the past.
- The ability of the Active for Health programme to improve the confidence of referred patients in relation to their fear of falling, their overall health status and physical ability to participate in activities of daily living is considered one of the most important factors in programme attendance.

"...we're getting is that patients are beginning to form friendships following on from the pathway and they're keeping in touch with each other and they've got lunch clubs going on. So the feedback that we're getting is really positive. That people are keeping in touch with each other and maintaining that contact..."

"I think just maintaining a higher level of strength and balance, having less falls, having more confidence, being able to do those things that they might have stopped doing because of the falls and they didn't feel as confident"

8.8 Summary and recommendations made by Health Care Professionals

- Making the referral process straightforward is important. For other commissioned service models of PA in the future, this point needs to be seriously considered to ensure HCPs engage.
- Classifying patients by condition can be beneficial for HCPs to manage referral.
- HCPs felt confident to send patients to a session which was specific to their needs, with an Exercise Specialist who was relevantly trained.
- A large proportion of individuals have co-morbidities, therefore it is imperative that Exercise Specialists are proficient across a range of health conditions. Having a Level 4 condition specific qualification instils trust and increases referral numbers across the pathways.
- HCPs need to communicate a positive message of PA and have conversations with patients as early as possible in their journey.
- HCPs and exercise providers need to work closely to ensure quality referrals.
- Quarterly steering group meetings and regular communication is essential.
- Providers and HCPs should be clear on the type of exercise carried out in each step of the pathway to help establish trust and clarity. It is advised that HCPs and providers observe each other's PA sessions.

8.9 Insights from a project management perspective

The results reported in this section are taken from the interviews that were conducted with the project management team from RMBC. Key insights, including what has worked well and what has been challenging are presented below. Figure 10.0 depicts the logic model developed by RMBC before the project commenced. In order to understand the projects development, logic models were revisited at 18 months, and at project close.

Figure 10.0 - Rotherham Metropolitan Borough Council logic model.

8.9.1 What worked well - RMBC?

- Having a clear vision between HCPs, providers and RMBC. This ensured there was a common goal across the multiple pathways. Regular email updates and the quarterly steering group were key factors which contributed to communication of the clear vision.
- Managing relationships between HCPs and leisure providers were important, and RMBC saw themselves as the 'broker' for this activity.
- HCPs in secondary care who referred to the Active for Health programme had a high level of confidence and trust in the quality and knowledge of the commissioned leisure providers. Having Level 4 Exercise Professionals who were qualified to deliver exercise to a specific population of patients appeared essential for ensuring that the referral process was utilised effectively by HCPs.
- The leisure providers and 'buddies' offer a voice to the project patients through social media, for example, sharing video footage of the classes on Twitter, Instagram and Facebook. RMBC believe that this was a powerful marketing tool that raised awareness of the programme, and overall engagement.
- The buddy scheme was also important for engaging with stakeholder groups such as universities, exercise professionals and programme patients across the region.

8.9.2 What were the challenges?

- The project was more expensive to run than anticipated. This was due to the project requiring more management and coordination staff than planned for. Promotion of the project internally and externally, through project engagement initiatives (e.g. conferences), was also costly and time intensive.
- The changing needs and processes of the healthcare pathway meant that the PA referral process was not always up to date, which proved a challenge to embed PA into the pathway.
- GPs lacked confidence in patients' ability to participate in PA due to their health conditions. As such, GP referrals to the Active for Health programme were low.
- Strategic 'buy-in' from the CCG was a challenge to facilitate.
- The ambitious referral targets depicted on the logic model in Figure 10.0 were a challenge to meet. The importance of the 'quality' over 'quantity' of referrals was discussed as a more appropriate target for future projects.
- Long-term sustainability of Active for Health due to funding challenges, CCG engagement and changing remits.
- Training aimed at upskilling HCPs knowledge and confidence in the Active for Health programme was offered. However the initial interest was lower than anticipated and subsequently a superior training programme was identified through Public Health England.

8.10 Summary of recommendations made by RMBC

- Continue to tailor PA services to the needs of specific healthcare pathways.
- Continue to provide training for HCPs to understand the benefits of PA for LTC's so they feel confident in referring patients to services, and understand their role and how it contributes to the whole agenda.
- Ensure the referral criteria are clearly set out in each pathway and simplify the referral process to reduce burden on HCPs workload and ensure suitable patients receive the right referral.
- Project stakeholders should maintain a flexible working partnership to overcome challenges and meet the needs of all parties involved in AFH.
- Build and maintain operational relationships between individuals, organisations and communities who can influence the PA agenda in Rotherham. This includes public health specialists, commissioners, delivers and the voluntary sector.
- Develop a marketing strategy aimed at increasing engagement in the target population with clinical champions delivering consistent messages to the community.
- Empowering the community to establish ownership and inform the delivery of the project has been critical to the success if the programme. Future programmes should consider how to streamline this approach with the use of 'buddies'. These individuals can be from the community, from academic institutions or healthcare settings who have an interest in the area.

9 Overall discussion

9.1 The Impact of Active for Health on physical activity and quality of life

- The primary outcome measure for Active for Health was the proportion of patients who undertook one, 30 minute bout of moderate to vigorous physical activity (MVPA) per week.
- The Active for Health evaluation found an increase in patient's PA levels and QoL, most notably between baseline and three months.
- A small increase in PA levels can lead to important improvements in psychosocial and physical health and Active for Health appears effective for people who remain in the programme.
- Active for Health was delivered to patients once per week. The principal reason for the high proportion of patients achieving one, 30 minute bout of MVPA per week by 12 months is likely due to attendance at Active for Health exercise classes.
- Changes in other PA patterns such as increased regular walking activities were also observed as a result attending the programme. The Active for Health programme may equip patients with the skills to be autonomous exercisers outside of the Active for Health environment.
- Effective community-based condition specific exercise programmes, designed for people with LTCs may help reduce the disease burden and improve health and wellbeing through increased adherence with exercise guidelines.
- The social component of Active for Health may have contributed to the observed improvements in QoL. This relationship was identified through the patient interviews, where the social component of the sessions was important across all seven LTC pathways.

9.3 Participant experience of Active for Health and patient activation

- Patients who took part in Active for Health viewed the programme positively. Irrespective of LTC pathway, qualitative interviews highlighted the importance of socialising during exercise programmes. This was often reported as being more important than exercise itself.
- It is possible that socialising during the programme was only important to the population who remained in the evaluation. Social isolation is linked with poor health outcomes. The possibility that Active for Health may reduce social isolation in selected individuals should not be ignored.
- Taking part in PA with people who have a similar condition was also important to patients, possibly because it provides opportunities to discuss and share similar experiences (Bruunet al., 2014; Luoma et al., 2014).
- Patient 'activation' describes a person's awareness of the important role they play in managing their own health. Previous research has reported varying levels of activation between patients (Bernhardsson, Larsson, Johansson & Öberg, 2017). This agreed with the Active for Health evaluation, which found that patient activation varied between patients and pathways. Those in the MSK and Cancer pathways were most activated with their own health, which is consistent with other research (O'Malley et al., 2018).
- Patient activation appeared to be a key determinant of whether people increased their PA levels. For example, patients in the Cancer LTC pathway believed that their own actions had a central role in their own health outcomes, whereas patients in the stroke group tended to defer this responsibility to third parties, such as their spouse or G.P.
- Previous research suggests that individuals who are considered highly activated are two times more likely to know treatment guidelines for their condition, and seek further health information for it, including PA opportunities (Tabrizi , Wilson, & O'Rourke, 2011; Hibbard et al., 2007; Mosen et al., 2007). So patient activation may underpin the more overt changes in PA levels and QoL observed in certain LTC pathways, such as Cancer.
- Participants in the Cancer and MSK groups were most motivated to continue being active without the Active for Health sessions. These patients may recover from their conditions, and are more likely to return back to everyday activity. Whereas some LTCs, including COPD are associated with disease progression and are incurable. This could link to higher attrition rates in certain pathways and should be further explored.

- Past experiences and previous engagement with exercise-type activities appears to influence patient's behaviour. Patients who remained in the Active for Health programme often reported that they had previously taken part in regular exercise earlier in their life. It is possible that Active for Health was more effective at retaining patients who are more experienced and more comfortable in an exercise environment. The natural selection bias that occurs from interviewing people who remain in the evaluation means that this effectively cannot be explored.
- Patients identified exercise instructor qualifications, perceived competence and instructor personality to be key factors in deciding whether or not they adhere to Active for Health.
- The suitability of a person's exercise programme prescription was also an important consideration. The importance of personalised exercise has previously been highlighted by the Department of Health (2009) and should be encouraged in all PA programmes.
- Whilst the Active for Health programme was not underpinned by a specific behaviour change theory, the programme appears to draw on the components of Self Determination Theory. Self Determination Theory hypothesises that patients are motivated by intrinsic factors (Ryan & Patrick, 2009). A well-documented description is available elsewhere (Deci &Ryan, 2009).

9.4 Stakeholder experience of Active for Health

- HCPs and patients considered Exercise Specialists to be an important consideration when designing an exercise programme for patients with a LTC. HCPs and Exercise Specialists should discuss physical activity content prior to programme delivery, to ensure trust and confidence is embedded between professionals. This could increase programme referrals.
- Professionals working in a range of settings, including primary and secondary health care, tertiary service providers, evaluation partners and the local authority were involved in developing the referral pathways. This strong collaborative approach likely led to the high patient uptake.
- HCPs felt confident to send patients to a session which was specific to their needs, with an Exercise Specialist who was relevantly trained.
- HCPs play a significant part in patient's attitudes about PA and the willingness to maintain PA. Therefore, it is important that HCPs involved are clear of the benefits of PA and are supportive of the programme. The role of the HCP is fundamental to a seamless care pathway.
- A large proportion of individuals had comorbidities, therefore it is imperative that Exercise Specialists are proficient across a range of health conditions. Having a Level 4 condition specific qualification instils trust and increases referral numbers across the pathways.

- Professionals and patients emphasised the importance of a suitable referral pathway that met their needs. In most cases the patients felt that the Active for Heath programme provided an appropriate referral pathway.
- Providers and HCPs should be clear on the type of exercise carried out in each step of the pathway to help establish trust and clarity. It is advised that HCPs and providers observe each other's PA sessions.
- Health care and exercise professionals may need to address patient fears and misconceptions about exercise training. Educating patients during the early phases of recovery (e.g. inpatient phase) about the highly valued role of exercise instructors in our healthcare system may form the basis of future research.

9.5 The cost effectiveness of Active for Health

- Active for Health has been successful in increasing the proportion of patients who undertook one 30 minute bout of MVPA per week. However, in order to set priorities and allocate finite public funds, it is important for policymakers and health funders to know whether the programme is cost effective. The lack of economic evidence for community based PA interventions has been recognised in previous research (Garrett et al., 2011).
- Cost and outcome data for patients within the evaluation cohort were assessed. Data showed a reduction in healthcare costs, and improvements in health in the year following referral to Active for Health, as measured by QALYs.
- Our evaluation cannot conclude to what extent these changes would have occurred if patients had not participated in the Active for Health programme. A controlled trial is required to establish this.

9.6 Methodological strengths and limitations

- The strengths of this evaluation lie in the rigor of the pragmatic approach used to guide the evaluative process. Health promotion interventions are complex and multifaceted (Tariq and Woodman, 2010) requiring a multitude of methods to provide context and meaning to outcome data. Pragmatic evaluation uses mixed-methods and enabled the exploration of a multi- angled view of the Active for Health programme.
- This evaluation of Active for Health draws on some novel data collection methods. Conducting a process evaluation and identifying multiple stakeholders draws on multiple perspectives. In addition, adapting the PAM, to provide qualitative interpretation provided more realistic and meaningful evaluation findings.
- A number of methodological limitations should be considered when interpreting the findings of the Active for Health evaluation. The sample size at each follow-up time point decreased substantially which reduces the likelihood of finding significant differences between our variables of interest, particularly when analysing LTC sub-groups. Caution must be exercised when interpreting data derived from small sample sizes and it may be more appropriate to interpret data trends, rather than statistical significance.
- This evaluation preferentially reports outcomes from patients who are engaged in the Active for Health programme. Readers of the report should be aware of the potential self-selection bias of the data.
- Without an experimental control group it is difficult to distinguish the change brought about by the Active for Health programme, from changes that would occur during usual care. A randomised control trial would provide the most reliable evidence on the effectiveness of the Active for Health programme; however this was out of the scope of this research.

9.7 Concluding remarks

- A key objective of the Active for Health programme was to develop an integrated pathway of referral to long-term exercise training for patients who have heart disease, CHF, stroke, COPD, cancer, MSK problems, and have had a fall; Active for Health achieved this objective.
- Active for Health shaped the acute service model for pathways such as Stroke, by embedding PA as part of their rehabilitation pathway. This didn't exist within the Stroke pathway prior to Active for Health and so the programme should be commended for this.
- The Active for Health evaluation found that PA and QoL increased among patients who adhered to the programme. The evaluation suggests that, like other ERS, many patients drop out over a 12 month period. Based on the dropout reasons which were anecdotally collected as part of this evaluation, ill health (30%) and participation in other PA (28%) made up the majority. Participation in other PA is positive and warrants further exploration. It is possible that Active for Health instils confidence to exercise autonomously. Exploration of this was out of the scope of this evaluation.
- People who remained in the evaluation appear more likely to have had a positive referral experience when commencing the programme. The profile of a patient who remained in Active for Health was one who had high patient activation, enjoyed the delivery format, valued social interaction and, may have participated in previous exercise activities earlier in their life. The latter point is important, as large sectors of society may have engaged in regular exercise at a previous stage of life. Programmes designed to re-engage this population may be a valuable area of future research.
- Active for Health has created a culture where PA is perceived as an important component of enabling patient self-management across Rotherham. Referral to Active for Health is associated with reductions in NHS costs and improvements in health as measured by QALYs, therefore future sustainability of this service should be assessed.

10 Future recommendations

10.1 Public health

- The Active for Health programme provides a pragmatic reference point which other exercise-based public health initiatives should use to estimate referral targets.
- Key performance indicators (KPIs) need to consider the volume of appropriate referrals as well as the total referrals.
- The integrated approach to patient referral was effective, other public health initiatives may wish to adopt this approach.
- As a result of Active for Health, professionals across the health care system endorse the programme and the promotion of PA in all stages of care.
- Active for Health has created a culture where PA is now perceived as an important component of enabling patient self-management across Rotherham. Referral is associated with reductions in NHS costs and improvements in health as measured by QALYs, therefore future sustainability of this service should be considered.

10.2 Leisure Providers

- Level 4 qualifications are an appropriate benchmark for delivering exercise to patients with complex healthcare needs and to instil trust in HCPs and patients.
- Programmes for individuals with LTCs should be designed so that there are opportunities for patients to socialise.

10.3 Health care professionals

- Education about patient referral processes increases the likelihood of it being done appropriately. This should be incorporated into the design of new services.
- Communication between HCPs and providers can help resolve uncertainties in the referral process.

10.4 Evaluators

- Provide training to evaluation personnel to minimise variations in data collection and recording processes.
- When designing and implementing logic models with stakeholders, it is recommended that an initial training session is carried out to ensure understanding of the logic model process e.g. what it is, what it comprises of.

11 What's next?

11.1 Active for health continuation

In order to sustain the 12 week free offer as part of Step 2, the Active for Health programme requires continued funding. Interim delivery options have been sourced for individual LTC pathways. Both the cancer and Falls Prevention pathway have secured funding to deliver Active for Health on a smaller scale. Patients in the Cardiac Phase IV, CHF, Stroke, COPD and MSK pathways will no longer be able to receive Active for Health Step 2 and the free 12 week exercise provision that currently exists. However, patients can still be referred to Active for Health Step 3, where they will receive between one (MSK, COPD, stroke) and three (Phase IV and CHF) free exercise sessions due to the kind actions of the exercise providers. Communications and links with providers, healthcare services, partners and commissioners must continue if the continued provider offer is to be successful.

11.2 Potential funding opportunities

There are several potential opportunities for providers to seek external funding, once the final evaluation results are published. These include local, regional and national funding streams from a variety of organisations.

11.3 Awards and project recognition

Work from the Active for Health project has been acknowledged and disseminated via:

- An article in the British Medical Journal (a full review is available, Atchinson et al., 2017).
- Named a finalist in the Association for Public Service Excellence (APSE), in the Best Health and Wellbeing initiative category, winning through to the final nine in the category.
- An award for the best poster presentation at the National Centre for Sports and Exercise Science Conference.

11.4 Project dissemination

Findings from the Active for Health evaluation have been presented at the following national and international conferences:

- Conference of Behavioural Nutrition and Physical activity - Vancouver, Canada.
- Public Health England Conference - Warwick, UK.
- National Centre for Sports and Exercise Science Conference - Loughborough, UK.
- Health Enhancing Physical Activity Conference - Zagreb, Croatia.
- Yorkshire and Humber Physical Activity Knowledge Exchange - Sheffield, UK.
- The International Society for Physical Activity and Health - London, UK.

The final evaluation findings are also projected to be disseminated further, including international research conferences and publication of evaluation findings in academic journals (to be confirmed).

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13 References

Active, S. A. S. (2011). A report on physical activity for health from the four home countries' Chief Medical Officers. The Department of Health.

Atchinson, R., Frith, G., Roden, A., Copeland, R. J., & Reece, L. J. (2018). Active for Health Rotherham: be active to stay healthy. Br J Sports Med, bjsports-2017-098676.

Bernhardsson, S., Larsson, M. E., Johansson, K., & Öberg, B. (2017). "In the physio we trust": A qualitative study on patients' preferences for physiotherapy. Physiotherapy theory and practice, 33(7), 535-549.

Bize, R., Johnson, J. A., & Plotnikoff, R. C. (2007). Physical activity level and health-related quality of life in the general adult population: a systematic review. Preventive medicine, 45(6), 401-415.

Blanchard, C. M., Denniston, M. M., Baker, F., Ainsworth, S. R., Courneya, K. S., Hann, D. M., . . . Kennedy, J. S. (2003). Do adults change their lifestyle behaviors after a cancer diagnosis? American journal of health behavior, 27(3), 246-256.

Booth, F. W., Roberts, C. K., & Laye, M. J. (2011). Lack of exercise is a major cause of chronic diseases. Comprehensive Physiology, 2(2), 1143-1211.

Bruun, D., Krustrup, P., Hornstrup, T., Uth, J., Brasso, K., Rørth, M., . . . Midtgaard, J. (2014). "All boys and men can play football": A qualitative investigation of recreational football in prostate cancer patients. Scandinavian journal of medicine & science in sports, 24, 113-121.

Cabinet Office (2014). Moving More, Living More The Physical Activity Olympic and Paralympic Legacy for the Nation. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279657/moving_living_more_inspired_2012.pdf

Cavill, N., Roberts, K., & Rutter, H. (2012). Standard evaluation framework for physical activity interventions.

Craig, C. L., Marshall, A. L., Sjöström, M., Bauman, A. E., Booth, M. L., Ainsworth, B. E., . . . Sallis, J. F. (2003). International physical activity questionnaire: 12-country reliability and validity. Medicine & science in sports & exercise, 35(8), 1381-1395.

Dayson, C., & Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing Pilot: main evaluation report.

Deci, E. L., & Ryan, R. M. (2009). 25 Self-determination theory: a consideration of human motivational universals. The Cambridge handbook of personality psychology, 441.

Department of Health.(2009). Let's Get Moving. Retrieved from http://www.theleisurereview.co.uk/articles11/

Department of Health. (2012). Long term conditions compendium of information. Retrieved from http://www.workingtowardswellbeing.com/wp-content/uploads/2012/09/2012-LTC- Compendium- of-Information-Third-Edition-FINAL-2.pdf

Department of Health (2012). Long Term Health conditions outcome strategy: summary of accelerated design event. Retrieved from https://www.gov. uk/government/publications/long-term- health conditions- outcomes-strategy-summary-of accelerated- design-event

Garrett, S., Elley, C. R., Rose, S. B., O'Dea, D., Lawton, B. A., & Dowell, A. C. (2011). Are physical activity interventions in primary care and the community cost-effective? A systematic review of the evidence. Br J Gen Pract, 61(584), e125-e133.

Garcia-Rio, F., Rojo, B., Casitas, R., Lores, V., Madero, R., Romero, D., . . . Villasante, C. (2012). Prognostic value of the objective measurement of daily physical activity in patients with COPD. Chest, 142(2), 338-346.

Gillison, F. B., Skevington, S. M., Sato, A., Standage, M., & Evangelidou, S. (2009). The effects of exercise interventions on quality of life in clinical and healthy populations; a meta-analysis. Social science & medicine, 68(9), 1700-1710.

Haacke, C., Althaus, A., Spottke, A., Siebert, U., Back, T., & Dodel, R. (2006). Long-term outcome after stroke: evaluating health-related quality of life using utility measurements. Stroke, 37(1), 193-198.

Hawley-Hague, H., Roden, A., & Abbott, J. (2017). The evaluation of a strength and balance exercise program for falls prevention in community primary care. Physiotherapy theory and practice, 33(8), 611-621.

Hibbard, J. H., Mahoney, E. R., Stock, R., & Tusler, M. (2007). Do increases in patient activation result in improved self-management behaviors? Health services research, 42(4), 1443-1463.

Hibbard, J. H., Stockard, J., Mahoney, E. R., & Tusler, M. (2004). Development of the Patient Activation Measure (PAM): conceptualizing and measuring activation in patients and consumers. Health services research, 39(4p1), 1005-1026.

House of Lords. The Long-term Sustainability of the NHS and Adult Social Care. Retrieved from https://publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/151.pdf

Hurtig-Wennlöf, A., Hagströmer, M., & Olsson, L. A. (2010). The International Physical Activity Questionnaire modified for the elderly: aspects of validity and feasibility. Public health nutrition, 13(11), 1847-1854.

Kimberlee, R., Jones, M., & Powell, J. (2013). Measuring the economic impact of the wellspring healthy living centre's social prescribing wellbeing programme for low level mental health issues encountered by GP services. Proving our Value.

Kings Fund (2012). From vision to action. Making patient centred care a reality. Retrieved from https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Richmondgroup-from- vision-to-action-april-2012-1.pdf

Kings Fund (2013). Delivering better services for people with long-term conditions. Retrieved from https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

Lee, I. M. (2003). Physical activity and cancer prevention--data from epidemiologic studies. Medicine and science in sports and exercise, 35(11), 1823 1827.

Luoma, M.L., Hakamies-Blomqvist, L., Blomqvist, C., Nikander, R., Gustavsson-Lilius, M., & Saarto, T. (2014). Experiences of breast cancer survivors participating in a tailored exercise intervention–a qualitative study. Anticancer research, 34(3), 1193-1199.

Matheson, G. O., Klügl, M., Engebretsen, L., Bendiksen, F., Blair, S. N., Börjesson, M., . . . Ioannidis, J. P. (2013). Prevention and management of non-communicable disease: the IOC consensus statement, Lausanne 2013. Sports medicine, 43(11), 1075-1088.

McGinnis, J. M., Stuckhardt, L., Saunders, R., & Smith, M. (2013). Best care at lower cost: the path to continuously learning health care in America: National Academies Press.

McGlone, S., Venn, A., Walters, E. H., & Wood-Baker, R. (2006). Physical activity, spirometry and quality-of-life in chronic obstructive pulmonary disease. COPD: Journal of Chronic Obstructive Pulmonary Disease, 3(2), 83-88.

Morgan, F., Battersby, A., Weightman, A. L., Searchfield, L., Turley, R., Morgan, H., . . . Ellis, S. (2016). Adherence to exercise referral schemes by participants–what do providers and commissioners need to know? A systematic review of barriers and facilitators. BMC public health, 16(1), 227.

Mosen, D. M., Schmittdiel, J., Hibbard, J., Sobel, D., Remmers, C., & Bellows, J. (2007). Is patient activation associated with outcomes of care for adults with chronic conditions? The Journal of ambulatory care management, 30(1), 21-29.

National Institute of Health and Clinical Excellence (2014), Physical activity exercise referral scheme recommendations. Retrieved from .https://www.nice.org.uk/guidance/ph54/chapter/1

National Institute of Health and Clinical Excellence (2015). Costing statement: Implementing the NICE guideline on social care of older people with social care needs and multiple long-term conditions (NG22). Retrieved from https://www.nice.org.uk/guidance/

O'Malley, D., Dewan, A. A., Ohman□Strickland, P. A., Gundersen, D. A., Miller, S. M., & Hudson, S. V. (2018). Determinants of patient activation in a community sample of breast and prostate cancer survivors. Psycho Oncology, 27(1), 132-140.

Poltawski, L., Boddy, K., Forster, A., Goodwin, V. A., Pavey, A. C., & Dean, S. (2015). Motivators for uptake and maintenance of exercise: perceptions of long-term stroke survivors and implications for design of exercise programmes. Disability and rehabilitation, 37(9), 795-801.

Public Health England (2014). Developing a national physical activity approach. Retrieved from https://www.gov.uk/government/consultations/development-of-anational- physical-activity- approach

Public Health England (2017). Rotherham Health Profile 2017. Retrieved from https://fingertips.phe.org.uk/profile/health-profiles/area-search-results/E08000018?place_name=Rotherham&search_type=parent-area

Public Health England (2018). Physical activity: applying All Our Health. Retrieved from https://

www.gov.uk/government/publications/physical-activityapplying- all-our-health/physical-activity-applying-all our- health

Public Health Outcomes Framework (2014). Retrieved from https://www.gov.uk/government/statistics/public-health-outcomes-framework november- 2014-quarterly-data-update

Rahl, R. (2010). Physical activity and health guidelines: recommendations for various ages, fitness levels, and conditions from 57 authoritative sources: Human Kinetics.

Rebar, A. L., Stanton, R., Geard, D., Short, C., Duncan, M. J., & Vandelanotte, C. (2015). A meta-meta-analysis of the effect of physical activity on depression and anxiety in non-clinical adult populations. Health psychology review, 9(3), 366-378.

Ryan, R. M., & Patrick, H. (2009). Self-determination theory and physical. Hellenic journal of psychology, 6, 107-124.

Spijker, J., & MacInnes, J. (2013). Population ageing: the timebomb that isn't? bmj, 347, f6598.

Ståhl, E., Lindberg, A., Jansson, S.-A., Rönmark, E., Svensson, K., Andersson, F., . . . Lundbäck, B. (2005). Health-related quality of life is related to COPD disease severity. Health and quality of life outcomes, 3(1), 56.

Tariq, S., & Woodman, J. (2013). Using mixed methods in health research. JRSM short reports, 4(6), 2042533313479197.

Tabrizi, J. S., Wilson, A. J., & O'Rourke, P. K. (2011). Customer quality and type 2 diabetes from the patients' perspective: a cross-sectional study. Journal of research in health sciences, 10(2), 69-76.

Thune, I., & Furberg, A.-S. (2001). Physical activity and cancer risk: dose-response and cancer, all sites and site-specific. Medicine and science in sports and exercise, 33(6 Suppl), S530-550; discussion S609-510.

Trappenburg, J., Jonkman, N., Jaarsma, T., van Os-Medendorp, H., Kort, H., de Wit, N., . . . Schuurmans, M. (2013). Self-management: one size does not fit all. Patient education and counseling, 92(1), 134-137.

Troosters, T., Casaburi, R., Gosselink, R., & Decramer, M. (2005). Pulmonary rehabilitation in chronic obstructive pulmonary disease. American journal of respiratory and critical care medicine, 172(1), 19-38.

UK Active. (2013). Turning the tide of inactivity. Retrieved from https://www.ukactive.com/wp- content/uploads/2018/09/ukactive_Turning_the_tide_of_inactivity.pdf

Waschki, B., Spruit, M. A., Watz, H., Albert, P. S., Shrikrishna, D., Groenen, M., . . . Edwards, L. D. (2012). Physical activity monitoring in COPD: compliance and associations with clinical characteristics in a multicenter study. Respiratory medicine, 106(4), 522-530.

World Health Oranganisation (2011). Global recommendations on physical activity for health Retrieved from https://www.who.int/dietphysicalactivity/pa/en/

World Health Organization (2018). Saving lives, spending less: a strategic response to noncommunicable diseases (No. WHO/NMH/NVI/18.8).

World Health Organisation (2011). Global Health Observatory Data Repository. Retrieved from http://apps.who.int/ghoda ta/

14 Appendices

Appendix 1a - Cardiac Phase IV and Heart Failure condition card

About the condition

Heart disease is an umbrella term that describes a structural, mechanical or electrical abnormality in the heart. Examples include coronary heart disease (CHD), defective heart valves, irregular heart rhythms or inefficient heart muscle function (chronic heart failure; CHF). For the Active for Health evaluation, patients with heart disease were grouped as either 1) heart disease or 2) CHF. The heart disease group included all heart disease diagnoses except CHF. This approach was taken because CHF can be a complex condition with markedly different PA and psychological profiles.

The benefits of physical activity

Exercise training and PA interventions are established treatments for heart disease, and form the cornerstone of secondary prevention services (cardiac rehabilitation). Exercise-based cardiac rehabilitation can improve cardiovascular risk factors such as cholesterol and blood pressure and, improve patient's quality of life.

Cardiac IV patient characteristics

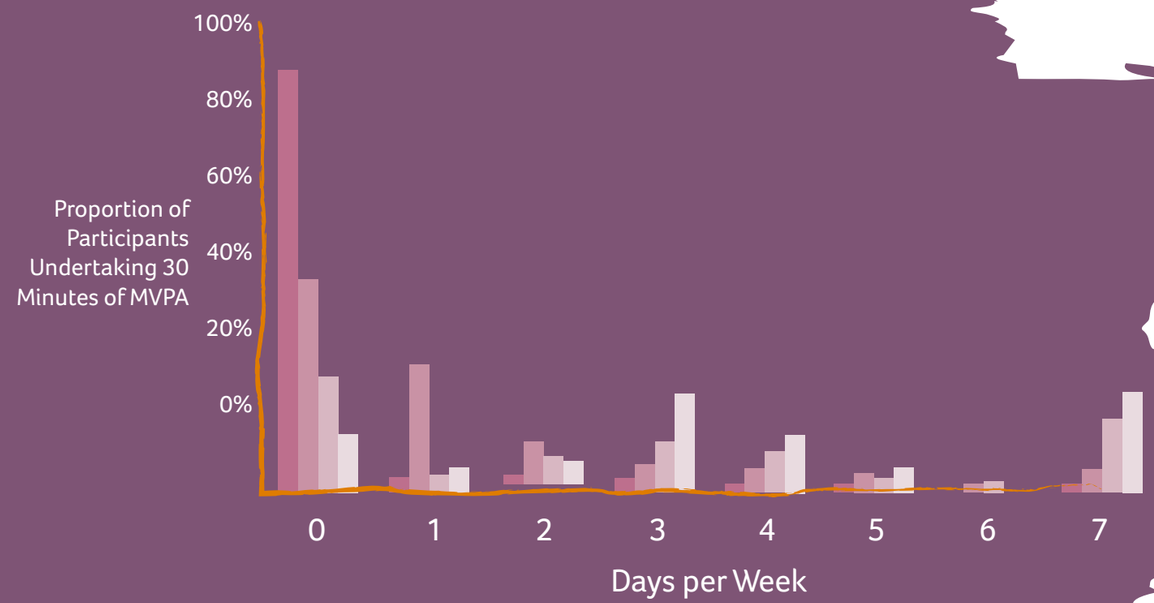
The Cardiac Phase IV pathway had the highest recruitment rate of all LTC pathways. Two-hundred and forty-two (n=242) patients with a mean age of 61.8 ± 11.0 years were enrolled. The majority of patients were Caucasian (90.2%) males (64.4%; n=155). Seventy (n=70) patients (29% of the original cohort) were followed-up at twelve months.

Cardiac IV physical activity results

Single item measure

The proportion of people not participating in at least one, 30 minute bout of MVPA decreased from 88.8% (n=159) at baseline, to 11.4% (n=4) at 12 months (Figure 11a). Importantly, 88.6% (n=62) of people who responded at 12, did not participate in at least one, 30 minute bout of MVPA per week at baseline 11.4% (n=4).

Figure 11a - Number of days participants report MVPA participation



Purple through to light purple lines indicate baseline, three month, six month and twelve month data, respectively.

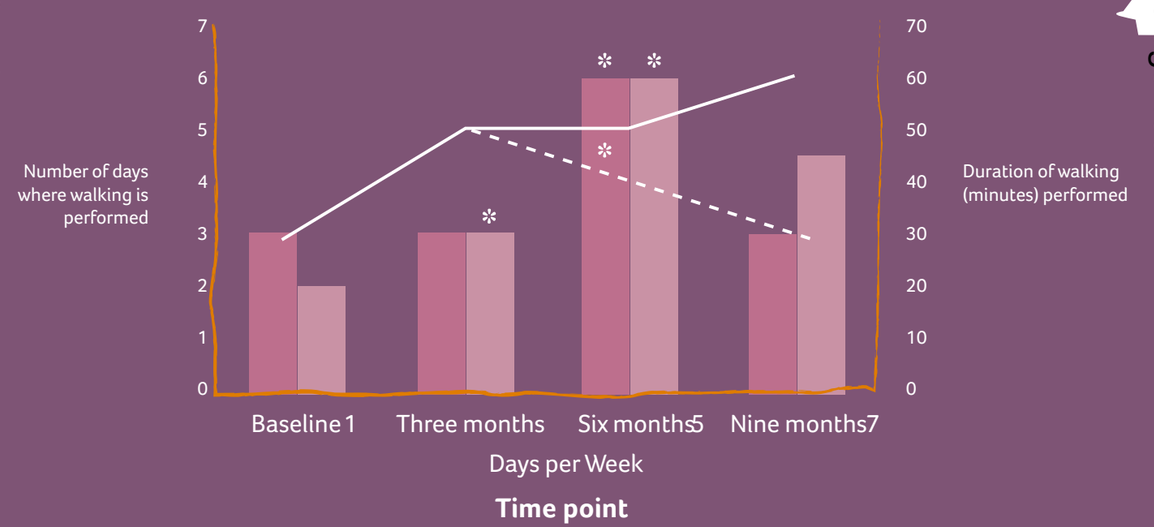
Sport-specific activity

At baseline, seven people (3.9%) participated in sporting activity. The number of patients engaged in sporting activity decreased to three (1.7%) after three months, but increased to 11 (9.6%) after six months. The number of people engaged in moderate physical activity was lower after 12 months (11.4%).

Walking

Patients in the IPAQ and IPAQ groups both increased the number of days where walking activities were performed, from three at baseline, to five after three months. For patients in the IPAQ-E group, this was also accompanied by an additional 10 minutes of walking per day (Figure 11b). By six months, the duration of walking activities increased to 60 minutes for patients in both groups, however only patients in the IPAQ-E group were able to sustain longer walking durations up until 12 months. By six months, the duration of walking activities increased to 60 minutes for patients in both groups, however only patients in the IPAQ-E group were able to sustain longer walking durations up until 12 months.

Figure 11a - Number of days participants report MVPA participation



Where walking was undertaken (lines) and duration of walking activities (bars) for patients in the IPAQ (dotted lines/ dark purple bars) and IPAQ-E groups (solid white lines/light purple).

* Significantly different from baseline.

Moderate intensity physical activity

Patients in the IPAQ and IPAQ-E groups undertook moderate intensity physical activity on more days of the week after three months, compared to baseline (Table 9). For patients in the IPAQ group, no further increases in the number of days that moderate physical activity were reported, however values at six months remained greater than those reported at baseline. For patients in the IPAQ-E group, the number of days where walking was performed was significantly greater than baseline after six months and 12.

Table 9 - Median number of days that patients took part in physical activity (range)

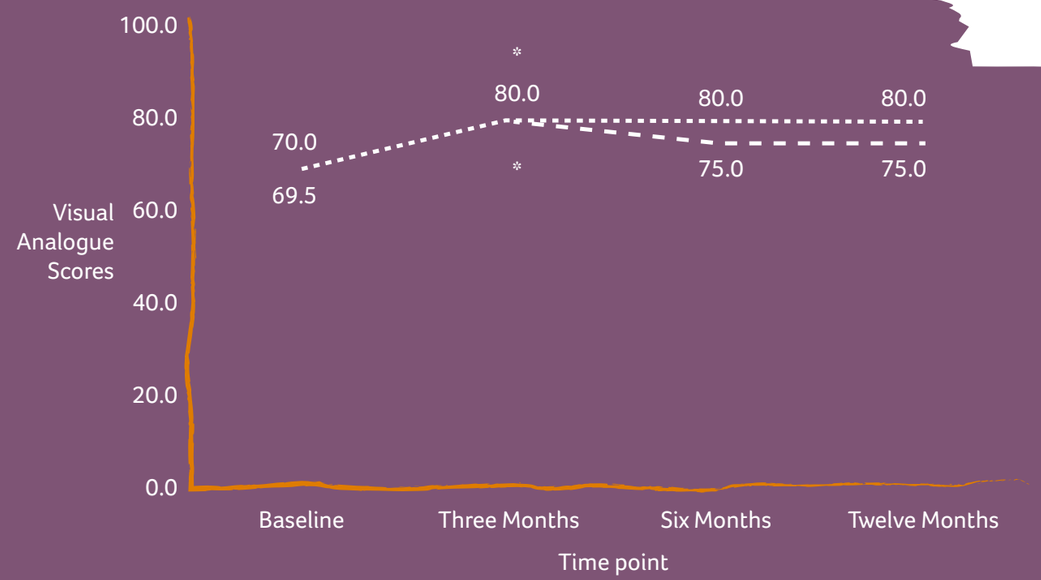
Time Point	IPAQ Group (Range)	IPAQ-E Group (Range)
Baseline	0 (0 to 7)[a]	0 (0 to 5)[ab]
Three Months	1 (0 to 7)[a]	2 (0 to 7)[a]
Six Months	2 (0 to 7)	3 (0 to 7)[bc]
Twelve Months	2 (0 to 7)	2 (0 to 7)[c]

PA = Physical Activity;
a = Significant difference between baseline and three month values.
b = Significant difference between baseline and six month values.
c = Significant difference between six and twelve month values.

Cardiac IV Quality of Life – Visual Analogue Score

Quality of life (assessed using the VAS) was for higher for both groups, compared to baseline (Figure 11c).

Figure 11c – Changes in visual analogue scores during the Active for Health intervention



Dashed lines indicate patients in the IPAQ group and dotted lines represent patients in the IPAQ-E group.
* = Significantly different from baseline.

Qualitative results - Cardiac IV

Active for Health Programme

- Patients engaged with the instructors and felt they were friendly, supportive and empathetic.
- The sessions increased confidence levels due to and improved fitness and quality of life

Patient activation

- All patients interviewed had good knowledge of their condition, including understanding of medication and diagnosis. Some patients suggested they were responsible for their own health (n=3), with others deferring the responsibility of their health to others (GP n=1 and spouse n=1).
- Patients had high confidence in managing their physical activity levels and felt they had learnt skills in the session which they can apply to everyday life. This included carrying out autonomous exercise away from the session.

Patient activation level

- Patient activation levels in heart failure patients were varied, with some patients having lower levels of activation, scoring level 2 (n=1) and some patients scoring high levels of activation at level 3 (n=2) and level 4 (n=1).

Chronic Heart Failure patient's characteristics

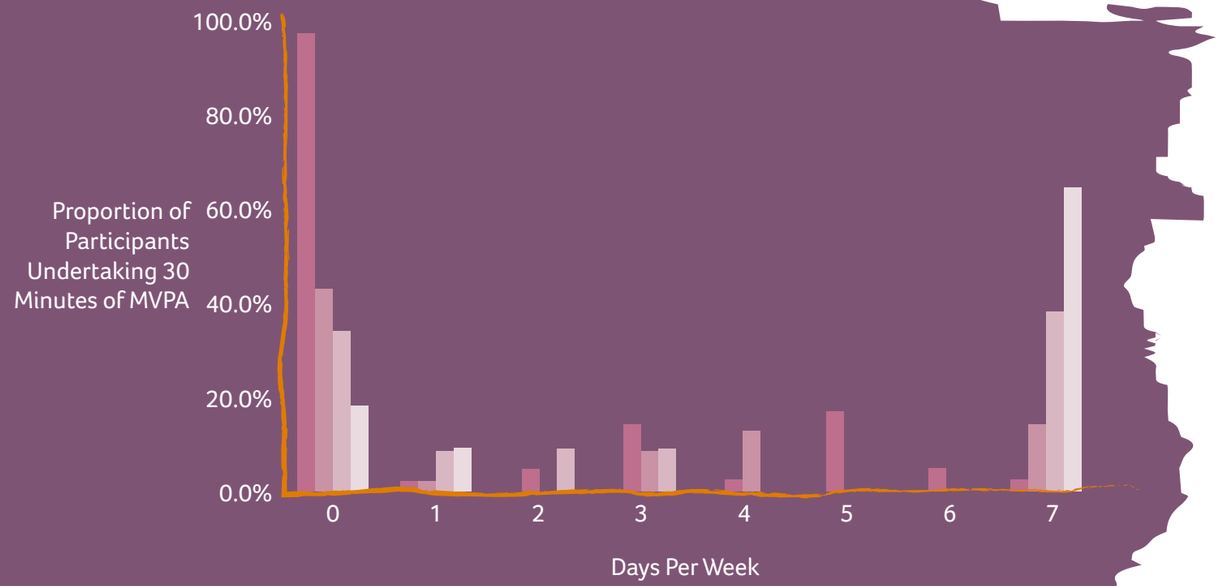
The chronic heart failure pathway (CHF) had the lowest recruitment of all LTC pathways. Fifty-one (n=51) patients with a mean age of 63.3 ± 12.6 years enrolled. The majority of patients were Caucasian (91.3%) males (62.7%; n=32) making it the most diverse LTC pathway. After three months, 15.6% (n=8) patients were lost to follow-up. Eleven (n=11) patients (21.6% of the original cohort) were followed up at 12 months.

Chronic Heart Failure physical activity results

Single item measure

At baseline, 95.3% (n=41) of patients did not undertake at least one, 30 minute bout of MVPA (Figure 12a). After three months, this has reduced to less than half of patients (41.9%; n=18). This trend continued at six (33.3%; n=8) and 12 months (12.2%; n=2). All patients who remained in the evaluation at 12 months (n=12) had reported not participating in at least one, 30 minute bout of MVBA at baseline.

Figure 12a – Number of days that patients report participating in 30 minutes of MVPA.



Purple to light purple indicate baseline, three month, six month and twelve month data, respectively.

Sport-specific activity

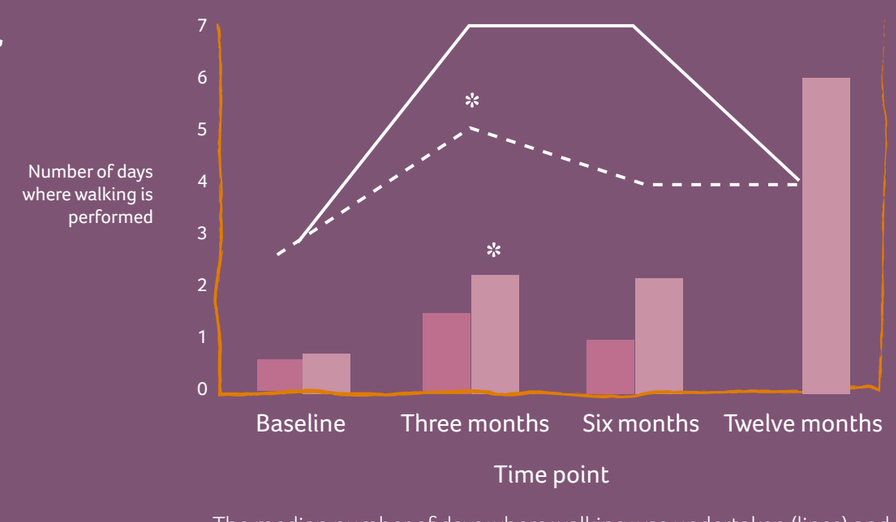
There were no patients engaged in sporting activity at baseline (0.0%) or three months. After six months, one patient was engaged in sporting activity (4.2%). One person also reported participating in sporting activity after 12 months (9.1%).

Walking

For patients in the IPAQ group, there was no change in the number of days where walking activities were undertaken, or the duration of those activities throughout the evaluation (Figure 12b). Patients in the IPAQ-E group had different outcomes. The duration of walking activities increased from 20 minutes at baseline, to 45 minutes after three months.

The number of days where walking was undertaken also increased, from three days at baseline, to 7 days after six months. By 12 however, this had reduced to four days which was not significantly different from baseline values.

Figure 12b – The median number of days where walking was undertaken



The median number of days where walking was undertaken (lines) and duration of walking activities (bars) for patients in the IPAQ (light purple bars / dotted lines) and IPAQ-E groups (dark purple bars / solid lines).

* = Significantly different from baseline.

Moderate intensity physical activity

Patients in the IPAQ and IPAQ-E groups undertook moderate intensity physical activity on more days of the week at three months, compared to baseline (Table 10). Patients in the IPAQ-E group also reported more days where moderate intensity physical activity was performed after six months. Importantly, the number of days that moderate intensity exercise was performed on was greater after 12, compared to baseline values.

Table 10 - Median number of days that patients took part in physical activity (range)

Time Point	IPAQ Group (Range)	IPAQ-E Group (Range)
Baseline	0 (0 to 2)[a]	0 (0 to4)[abcd]
Three Months	3 (0 to7)[a]	3 (0 to 7)[ab]
Six Months	1 (0 to 7)	4 (0 to 7)[bc]
Twelve Months	4 (1 to 6)	2 (0 to 7)[cd]

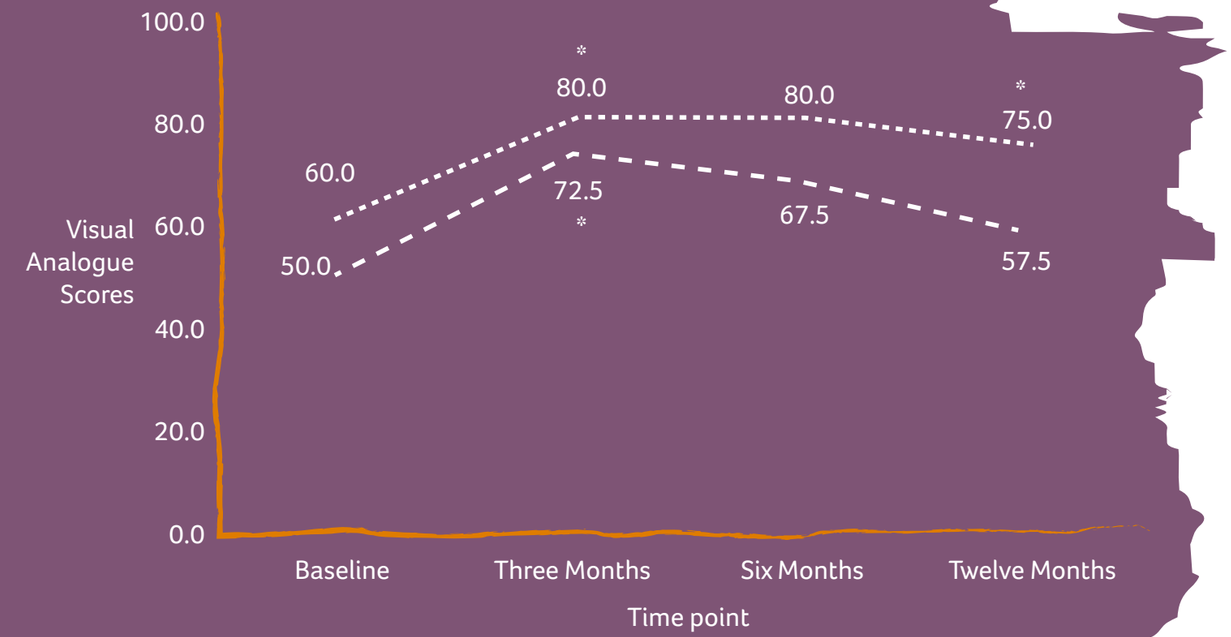
PA = Physical Activity;
a = Significant difference between baseline and three month values.
b = Significant difference between baseline and six month values.
c = Significant difference between six and twelve month values.

Chronic Heart Failure Quality of Life – Visual Analogue Score

Quality of life was assessed using visual analogue scores (VAS) from the EQ-5D questionnaire. Figure 12c shows that in patients with CHF, both the IPAQ (p=0.008) and IPAQ-E groups (p<0.001) had higher VAS scores at three months, compared to baseline.

No further increases were observed in either group. VAS scores were significantly higher than baseline values for patients in the IPAQ-E group (p=0.020) but not for patients in the IPAQ group.

Figure 12c – Changes in visual analogue scores during the Active for Health intervention.



Dashed lines indicate patients in the IPAQ group and dotted lines represent patients in the IPAQ-E group.

* = Significantly different from baseline.

Qualitative results - Heart Failure

Active for Health programme

The referral process was viewed as slow by three of the patients; however it did not impact their engagement with the programme.

Patients discussed how Active for Health was the first activity session they had ever found which was suitable for their condition.

Patient Activation

All patients were knowledgeable about their heart condition. Patients had a good understanding of their health including, knowledge and understanding of condition management. Patients believed that they were responsible for their own health (n=4) as well as the GP (n=1).

Some patients made reference to being overprotected by family members. Patients were able to implement skills learnt in the session to better manage their condition. Participates had high confidence to manage condition and confidence in managing condition, including continuation of physical activity.

Patient activation level

Patient activation levels in Cardiac Phase IV patients were varied, with some patients having lower levels of activation, scoring level 2 (n=2) and some patients scoring high levels of activation at level 3 (n=1) and level 4 (n=2).

Appendix 1b - Stroke condition card

About the condition

A stroke is a term used to describe one of two medical scenarios. One scenario, known as a haemorrhagic stroke, describes the rupture of a blood vessel in the brain leading to significant bleeding. The second scenario is known as an ischaemic stroke, which refers to a blood clot causing a blockage in a blood vessel. The common factor to both situations is the resultant inadequate blood supply to the brain. This can lead to significant physical disability.

The benefits of physical activity

Taking part in exercise training and PA is increasingly acknowledged as a key component of a stroke patient's recovery and rehabilitation. Evidence suggests that exercise may improve survival, cardiovascular risk factors, physical fitness, function and mobility and, quality of life (McGinnis et al., 2013). For the Active for Health evaluation, both types of stroke were included in one pathway.

Stroke patient characteristics

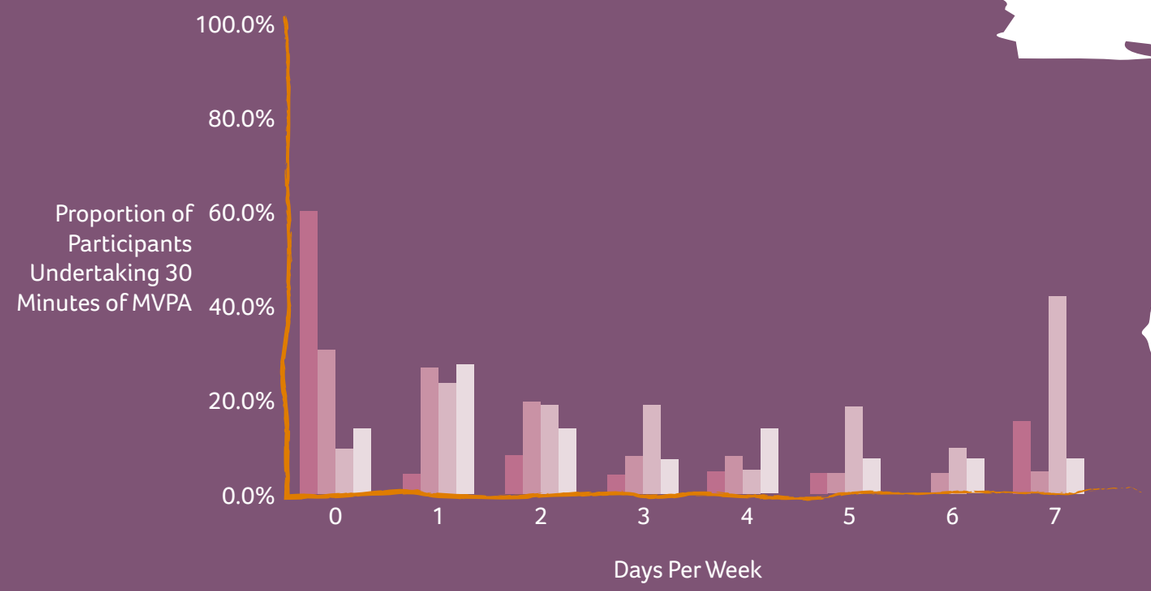
Seventy-two (n=72) patients with a mean age of 68.1 ± 10.0 years enrolled to the Active for Health Stroke pathway. All patients (100.0) were Caucasian. There were 41 (56.9%) males and 31 (43.1%) females. After three months, more than half of the stroke cohort (62.5%; n=45) were lost to follow-up. Twenty-two (n=22) patients (30.5% of the original cohort) were followed up at 12.

Stroke physical activity results

Single item measure

At baseline, most patients did not participate in at least one, 30 minute bout of MVPA (59.3%; n=41; Figure 13a), however, by 12, this had fallen to 13.3%; n=2).Of the patients who remained in the evaluation after 12 months, 60.0% (n=9) had reported not participating in at least one, 30 minute bout of MVBA at baseline.

Figure 13a– Number of days that patients report participating in 30 minutes MVPA.



Purple through to light purple lines indicate baseline, three month, six month and twelve month data, respectively.

Sport-specific activity

No patients (n=0) took part in sporting activity at baseline or three months (0.0%). After six months, there was one person engaged in sporting activity (4.5%). This remained unchanged after 12 (n=1; 6.7%).

Walking

For patients in the IPAQ group, the number of days where walking was undertaken did not significantly increase over time (Figure 13b). Patients in the IPAQ-E group reported walking on significantly fewer days after 12 months. Neither the IPAQ, nor IPAQ-E group reported significant changes in walking duration.

Figure 13b – The median number of days where walking was undertaken

Where walking was undertaken (lines) and duration of walking activities (bars) for patients in the IPAQ (dotted lines/ dark purple bars) and IPAQ-E groups (solid white lines/light purple).

* Significantly different from baseline.

Moderate intensity physical activity

There was no change in the number of days that moderate physical was performed on throughout the study for patients in either the IPAQ group or IPAQ-E groups (Table 11).

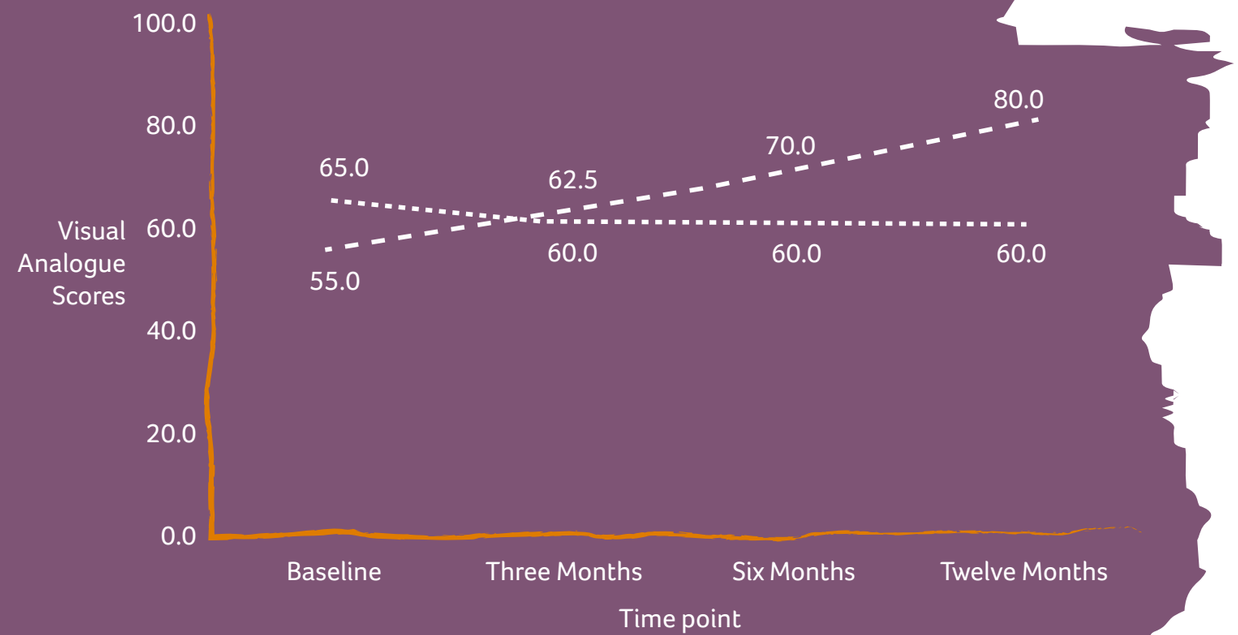
Table 11 - Median number of days that patients took part in physical activity (range)

Time Point	IPAQ Group (Range)	IPAQ-E Group (Range)
Baseline	0 (0 to 2)	1 (0 to 7)
Three Months	1 (0 to6)	1 (0 to 7)
Six Months	2 (1 to 7)	2 (0 to 7)
Twelve Months	1 (1 to 2)	1 (0 to 7)

Stroke Quality of Life – Visual Analogue Score

Neither the IPAQ (p=0.480) or the IPAQ-E group (p>0.999) reported a significant change in VAS scores after three months (Figure 13c).

Figure 13c – Changes in visual analogue scores during the Active for Health intervention.



Dashed lines indicate patients in the IPAQ group and dotted lines represent patients in the IPAQ-E group.

* = Significantly different from baseline.

Qualitative results - Stroke

Active for Health

Patients in the Stroke pathway talked largely about the structure of the exercise and find monitored exercise, with simple exercises beneficial for their condition. Overall, stroke patients seemed to have more reliance on instructors compared to other LTC pathways.

Perceived patient benefits of physical activity were primarily based on improvements in activities of daily living.

Patient Activation

Patients had some knowledge about their condition, but large gaps exist in both their understanding of their health condition and also self-management. There was a belief that others were generally responsible for their health. Only one patient in the Stroke pathway believed that they were responsible for their own health. Others believed it was the responsibility of their partner (n=3) or HCP (n=1).

Confidence levels in this group tended to be mixed, with some patients rating their confidence in managing their condition as low and others as high. Without the Active for Health sessions these patients may find continued activity difficult, without some additional support.

Patient activation score

Based on the comments above, patient activation levels are mid to low, with patients scoring between level 2 (n=4) and level 3 (n=1).

Appendix 1c - COPD condition card

About this condition

Chronic obstructive pulmonary disease or COPD refers to a group of conditions that cause inefficient air movement in and out of the lungs. Patients with COPD often complain of being breathless at light levels of PA, or even at rest. Patients with COPD are less physically active lifestyle than healthy people (Troosters et al., 2005; Waschki et al., 2012). Low PA levels are associated with lower quality of life (McGlone et al., 2006), more frequent hospitalisations and higher mortality rates (Garcia-Rio et al., 2012) in patients with COPD.

Benefits of physical activity

Lower levels of physical inactivity caused by shortness of breath are thought to result in further physical deconditioning, and subsequent developing psychosocial problems such as depression and social isolation (GOLD, 2010). This can lead to reduced symptoms of breathlessness. Exercise training and PA are also thought to improve patient's ability to manage and tolerate symptoms of breathlessness.

COPD patient characteristics

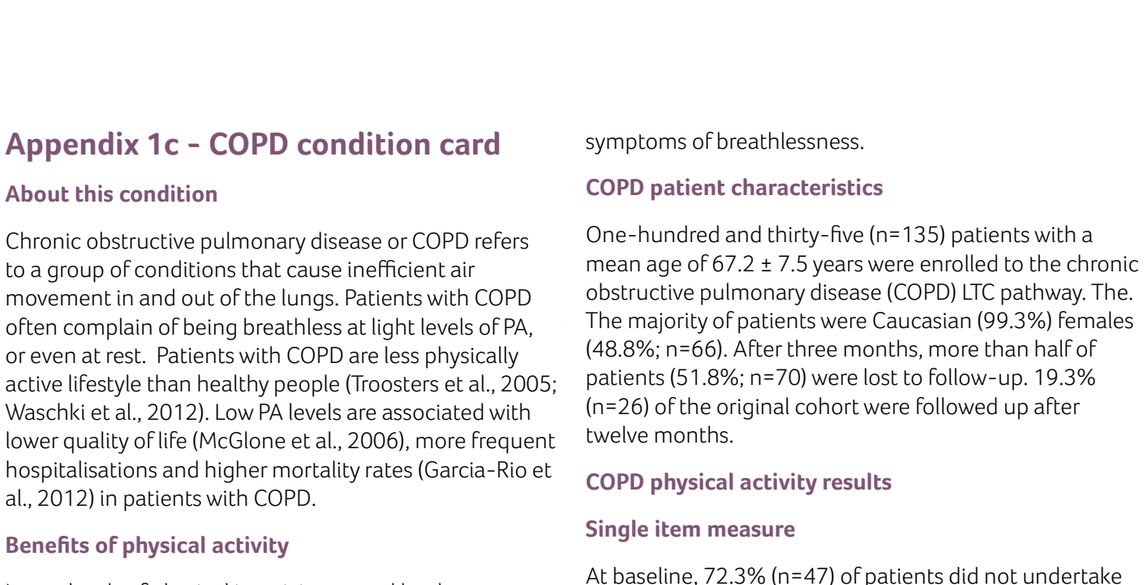
One-hundred and thirty-five (n=135) patients with a mean age of 67.2 ± 7.5 years were enrolled to the chronic obstructive pulmonary disease (COPD) LTC pathway. The. The majority of patients were Caucasian (99.3%) females (48.8%; n=66). After three months, more than half of patients (51.8%; n=70) were lost to follow-up. 19.3% (n=26) of the original cohort were followed up after twelve months.

COPD physical activity results

Single item measure

At baseline, 72.3% (n=47) of patients did not undertake at least one, 30 minute bout MVPA (Figure 14a). Only one person did not take part in at least one 30 minute bout of MVPA after 12 months (3.2%). Of the patients who remained in the evaluation after 12 months, more than three quarters (76.9%; n=20) had reported not participating in at least one, 30 minute bout of MVBA at baseline.

Figure 14a – Number of days that patients report participating in 30 minutes of MVPA



Purple through to light purple lines indicate baseline, three month, six month and twelve month data, respectively.

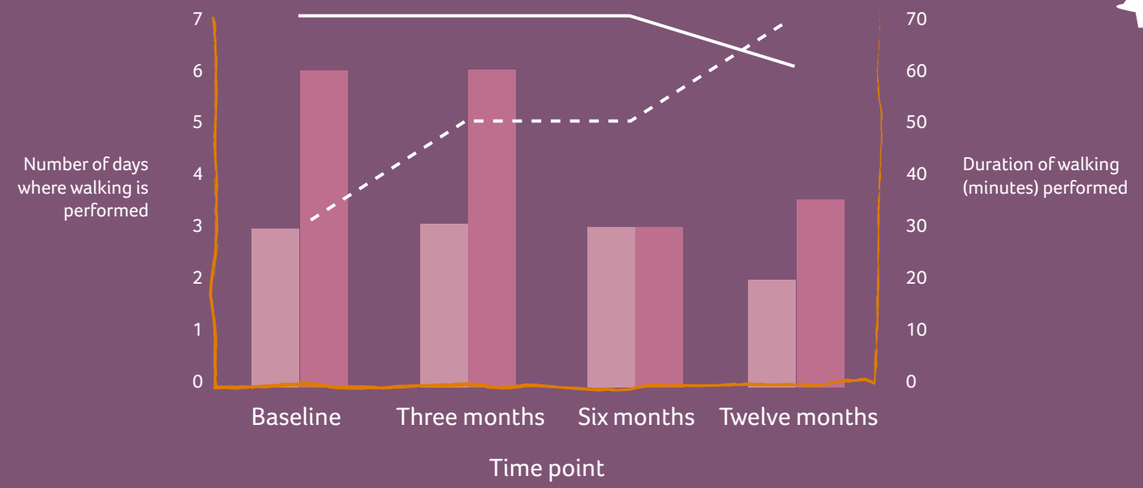
Sport-specific activity

At baseline, four people (2.9%) participated in sporting activity. The number of patients engaged in sporting activity decreased to three, at three months (4.6%), and remained at 3 after six (6.1%) and 12 months (11.5%).

Walking

For patients in the IPAQ group, there was a trend towards more days where walking activities were undertaken, however none of the reported changes were statistically significantly (Figure 12d). Patients in the IPAQ-E group, undertook walking activities on every day of most days of the week throughout the evaluation. For patients in the IPAQ group, there was a trend towards more days where walking activities were undertaken, however none of the reported changes were statistically significantly (Figure 14b). Patients in the IPAQ-E group, undertook walking activities on every day of most days of the week throughout the evaluation. Variations in walking activity duration did not change significantly throughout the intervention.

Figure 14b – The median number of days where walking was undertaken



Where walking was undertaken (lines) and duration of walking activities (bars) for patients in the IPAQ (dotted lines/ dark purple bars) and IPAQ-E groups (solid white lines/light purple).

* Significantly different from baseline.

Moderate intensity physical activity

Patients in the IPAQ-E group, but not the IPAQ group undertook moderate intensity physical activity on more days of the week at three months, compared to baseline (Table 12).

Table 12 - Median number of days that patients took part in physical activity (range)

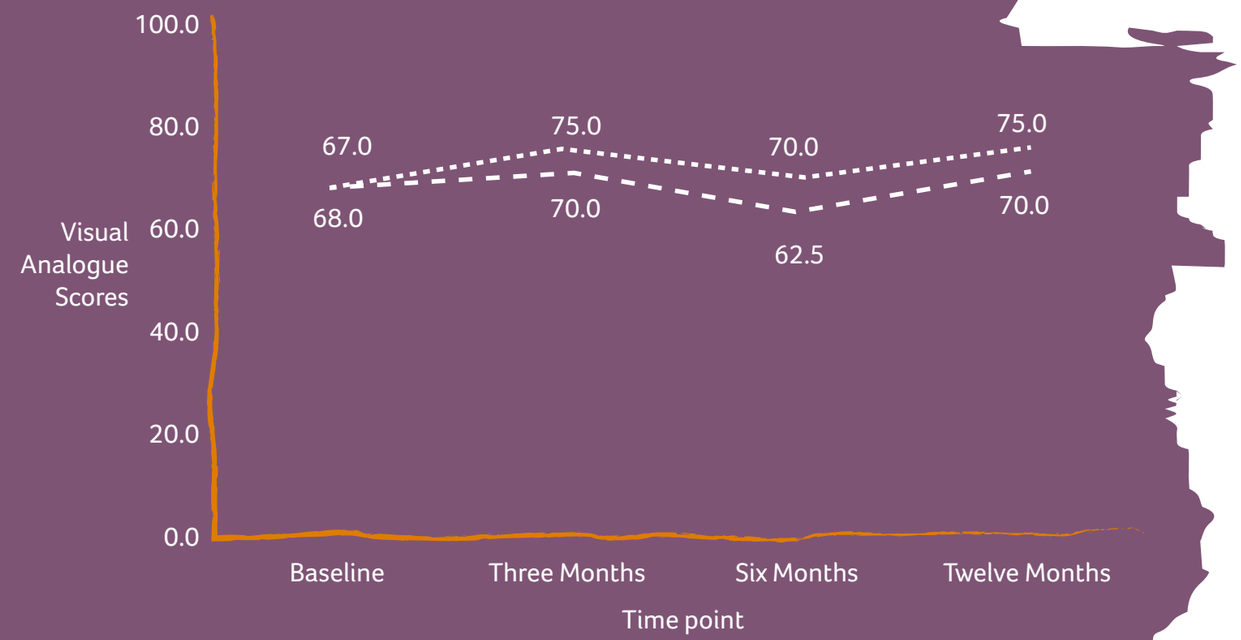
Time Point	IPAQ Group (Range)	IPAQ-E Group (Range)
Baseline	3 (0 to 7)	3 (0 to 7)[a]
Three Months	3 (0 to 7)	4 (0 to 7)[a]
Six Months	3 (1 to 3)	3 (0 to 7)
Twelve Months	1 (0 to 7)	3 (0 to 7)

a = Significant difference between baseline and three month values

COPD Quality of Life – Visual Analogue Score

Neither the IPAQ nor IPAQ-E groups had a significant change in VAS score during the evaluation (Figure 14c).

Figure 14c – Changes in visual analogue scores during the Active for Health intervention



Dashed lines indicate patients in the IPAQ group and dotted lines represent patients in the IPAQ-E group.

* = Significantly different from baseline.

Qualitative results - COPD

Active for Health

Patients, who engaged with the COPD pathway, discussed the importance of the Active for Health programme, for some the programme has been a lifeline and given them purpose, not simply in terms of managing and improving their condition, but in giving them a reason to get out of bed. If the Active for Health sessions stopped some individuals would struggle without the support.

Physical benefits were discussed including; reduced breathlessness, increased muscle mass. All patients commented on the social benefits of being together for exercise, making friends and the different roles they have taken up with the group.

Patient activation

Patients had good knowledge of their condition and medications and managed well. Some had already attended COPD education sessions at Breathing Space and knowledgeable about their condition. All patients agreed that they were responsible for their own health and that they should do more to help themselves and not rely on medications.

One patient regretted previous behaviours which may have contributed to their condition. Confidence in their ability to do more exercise increased and patients were more motivated to take up other activities.

Patient activation score

Patients in this pathway were highly activated in managing their health condition, with patients scoring between level 3 (n=3) 4 and the other patients scored level 4 (n=2).

Appendix 1d - Cancer condition card

About this condition

Cancer is the abnormal growth of cells within an area of the body. Cancer has multiple causes including certain viruses, exposure to radiation or chemicals, and lifestyle behaviours. Sedentary behaviour is a major risk factor for developing cancer. People living with cancer often feel depressed, anxious and tired.

Benefits of physical activity

Engaging in exercise training and PA can improve many of these symptoms. Once someone has gone in to remission, exercise and PA may also help prevent the recurrence of cancer (Macmillan, 2017, Lee, 2003; Thune, 2001; Homes et al., 2005).

Cancer patient characteristics

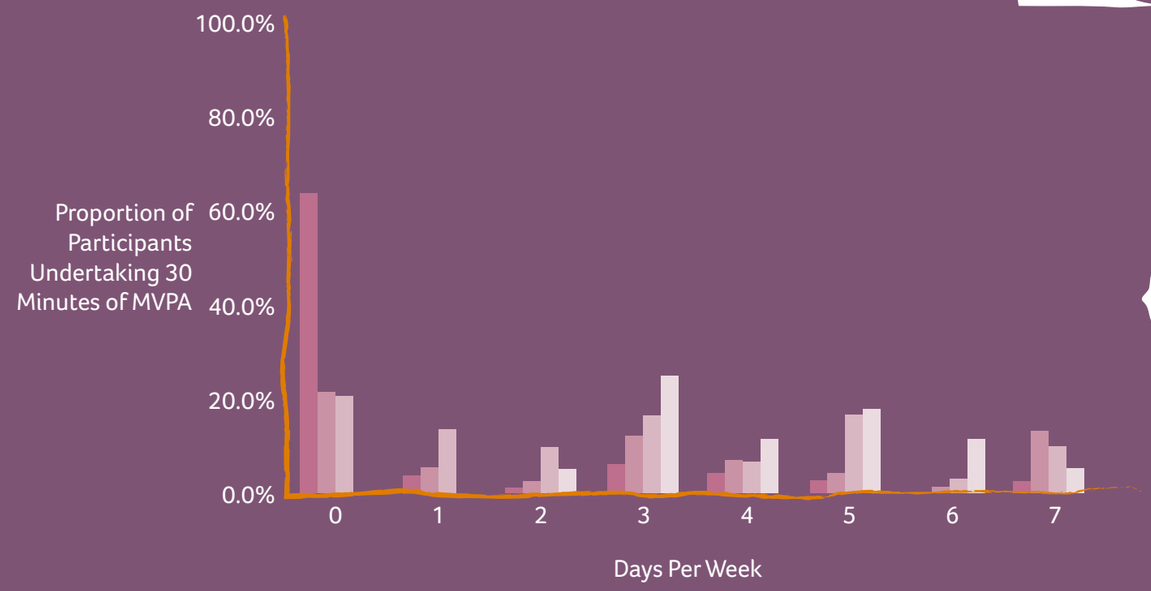
One-hundred and nine (n=109) patients with a mean age of 57.8 ± 10.4 years enrolled to the Active for Health cancer LTC pathway. All patients were Caucasian (100.0%) and most were female (83.3%; n=91). After three months, more than half (62.4%; 68) of patients were lost to follow-up. 14.7% of the original cohort were followed up after 12 months.

Cancer physical activity results

Single item measure

Nearly two-thirds of cancer patients did not participate in at least one, 30 minute bout of MVPA per week at baseline (63.4%; n=26). After 12 months however, all patients undertook at least one, 30 minute bout of MVPA per week (100.0%; n=16; Figure 15a). Of the patients who remained in the evaluation after 12 months, 50.0% (n=8) had reported not participating in at least one, 30 minute bout of MVBA at baseline.

Figure 15a – Number of days that patients report participating in 30 minutes of moderate to vigorous physical activity (MVPA)



Purple through to light purple lines indicate baseline, three month, six month and twelve month data, respectively.

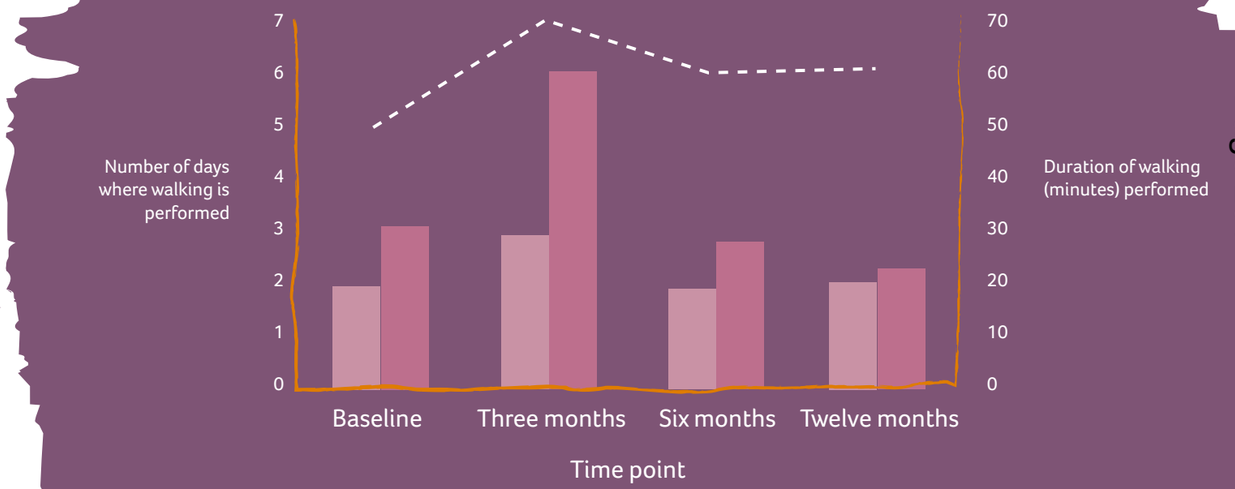
Sport-specific activity

At baseline, two patients (4.9%) said that they took part in sporting activity. After three months, eight patients were engaging with sporting activity (19.5%). Only two patients reported participation in sporting activity at six (6.9%) and 12 (12.5%).

Walking

The median number of days that patients reported taking part in walking activities was the same the same for the IPAQ and IPAQ-E groups throughout the evaluation (Figure 15b).The number of days where walking activity was performed was not significantly different after 12, compared to baseline, however the number of days where patients engaged in walking activities remained high throughout the study. No significant changes in the duration of walking activities performed were noted.

Figure 15b –The median number of days where walking was undertaken



Where walking was undertaken (lines) and duration of walking activities (bars) for patients in the IPAQ (dotted lines/ dark purple bars) and IPAQ-E groups (solid white lines/light purple).

* Significantly different from baseline.

Moderate intensity physical activity

Despite a trend for greater participation (Table 13), patients in the IPAQ group did not participate in moderate physical activity on significantly more days of the week after 12, compared to baseline. Patients in the IPAQ-E group however, reported taking part in physical activity on more days of the week after three months.

Table 13- Median number of days that patients took part in physical activity (range)

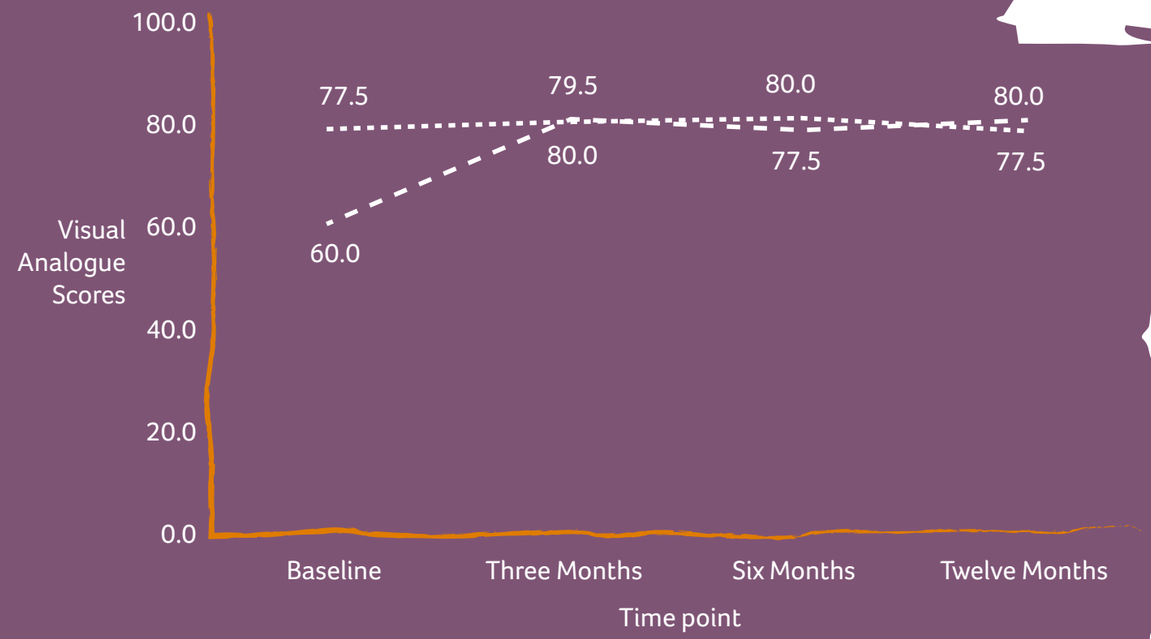
Time Point	IPAQ Group (Range)	IPAQ-E Group (Range)
Baseline	0 (0 to 7)	3 (0 to 7)[a]
Three Months	2 (0 to 7)	4 (0 to 7)[a]
Six Months	2 (0 to 7)	3 (1 to 7)
Twelve Months	3 (0 to 5)	6 (0 to 7)

a = Significant difference between baseline and three month values

Cancer Quality of Life – Visual Analogue Score

At three months, patients in the IPAQ and IPAQ-E groups both had higher VAS scores compared to baseline (Figure 13e). There was no further increase in physical activity days after six and 12 for patients in the IPAQ group. Values did not significantly change from values.

Figure 15c – Changes in visual analogue scores during the Active for Health intervention.



Dashed lines indicate patients in the IPAQ group and dotted lines represent patients in the IPAQ-E group.

* = Significantly different from baseline.

Qualitative results- Cancer

1. Active for Health

Individuals, who engaged with the Cancer pathway, discussed social support as particularly important. Cancer patients didn't feel others understood their experiences; hence they discussed the importance of support of others in a similar position.

They referred to having a social group as a way to not feeling abandoned. One of the younger patients found the social side difficult and alleged that the group discussions could evoke some anxiety if the discussions were around cancer. This was not a shared opinion by the other group members.

Patients referred to having a good relationship with HCPs and considered this important. The believed Active for Health offers the non-medicalised support, which was viewed as essential.

2. Patient Activation

All patients interviewed were knowledgeable about their condition and understand; treatment, medication, self-management strategies including lifestyle management (keeping active, eating well, weight management).

They identified themselves as responsible for their own health. Patients were generally confident about managing their health now and in the long-term and believed the sessions had helped with increasing confidence. Based on their knowledge and information taught in the exercise sessions, patients have skills to carryout exercise in their own time away from the session.

Patient Activation score

Based on the comments above, patient activation levels were high, with patients scoring between level 3 (n =3) and level 4 (n=2).

Appendix 1e - MSK condition card

About this condition

In the Active for Health programme, the musculoskeletal pathway (MSK) refers to patients who have lower back pain. The lower part of the spine supports the upper body and helps to move the hips when walking. The lower parts of the spine are therefore an integral part of the mechanical processes that facilitate human movement. When injury to the soft tissues in the lower spine occurs, inflammation usually follows. This can be very painful and cause a reduction of physical mobility and quality of life.

Benefits of physical activity

Current evidence suggests that exercise training can reduce the symptoms of pain, strengthens the joints, improves physical function and improves quality of life.

MSK patient characteristics

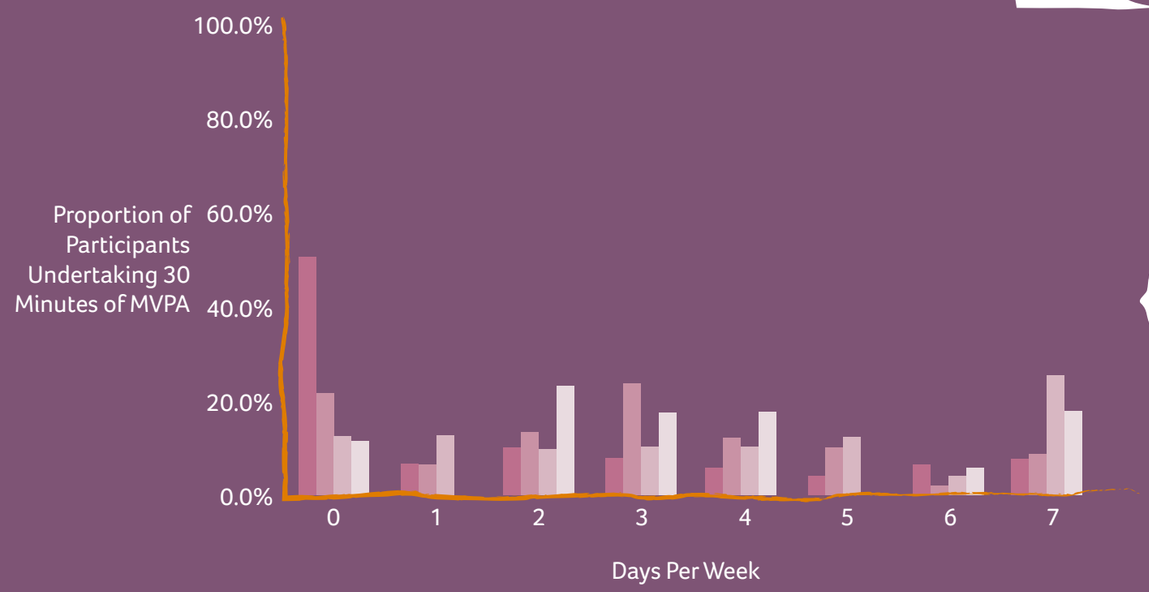
Two-hundred and thirty-five (n=235) patients with a mean age of 50.1 ± 13.0 years enrolled to the Active for Health musculoskeletal (MSK) LTC pathway. Most patients were Caucasian (93.6%) females (60.4%; n=142). After three months, more than half of the cohort (62.6%; n=147) were lost to follow-up. Seventeen patients (n=17; 7.2%) were followed up at 12.

MSK Physical activity results

Single item measure

At baseline, half (50.0%; n=44) of patients did not participate in at least one, 30 minute bout MVPA (Figure 11f). At 12, this had declined to (11.8%; n=2). Of the patients who remained in the evaluation after 12 months, 58.8% (n=10) had reported not participating in at least one, 30 minute bout of MVBA at baseline; Figure 16a.

Figure 16a– Number of days that patients report participating in 30 minutes of MVPA



Purple through to light purple lines indicate baseline, three month, six month and twelve month data, respectively.

Sport specific activity

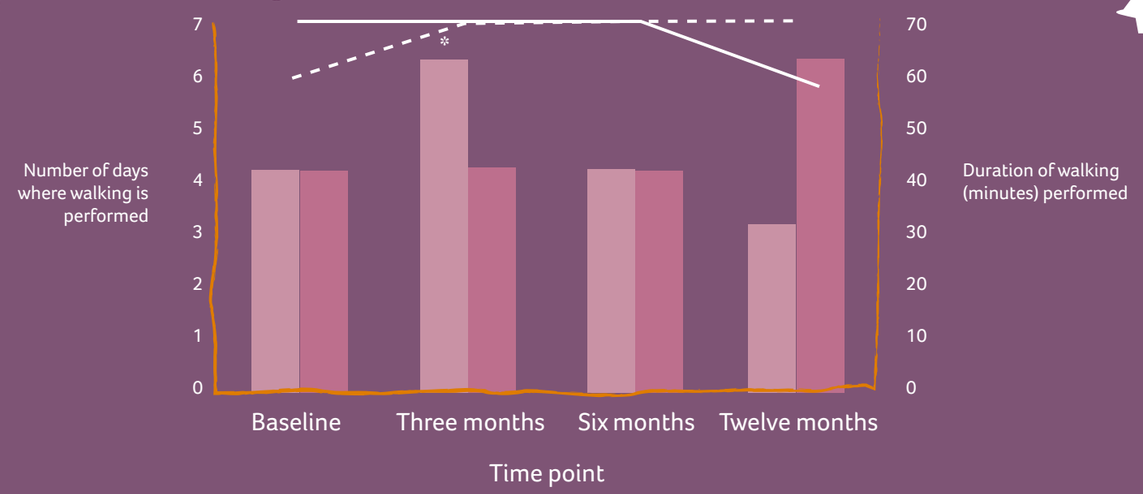
At baseline, two patients (2.3%) said that they took part in sporting activity. After three months, ten patients were engaged in sporting activity (11.4%). At six months and 12, this had reduced to six (12.8%) and two (11.8%), respectively.

Walking

Patients in the IPAQ group were already undertaking walking activities on six days of the week (Figure 16b). The number of days where walking was undertaken increased to seven days after three months and remained unchanged after 12.

The number of days were walking activities were performed by patients in the IPAQ-E group remained high throughout the evaluation, and no significant changes were reported. Neither the IPAQ nor IPAQ-E group reported changes in the duration of walking activities over the course of the evaluation.

Figure 16b–The median number of days where walking was undertaken (lines) and duration of walking activities



Where walking was undertaken (lines) and duration of walking activities (bars) for patients in the IPAQ (dotted lines/ dark purple bars) and IPAQ-E groups (solid white lines/light purple).

* Significantly different from baseline.

Moderate intensity physical activity

Patients in the IPAQ, but not the IPAQ-E group, undertook moderate intensity physical activity on more days of the week after three months, compared to baseline (Table 7f). No further changes in the number of days that patients engaged in moderate physical activity were noted.

Table 14 - Median number of days that patients took part in physical activity (range)

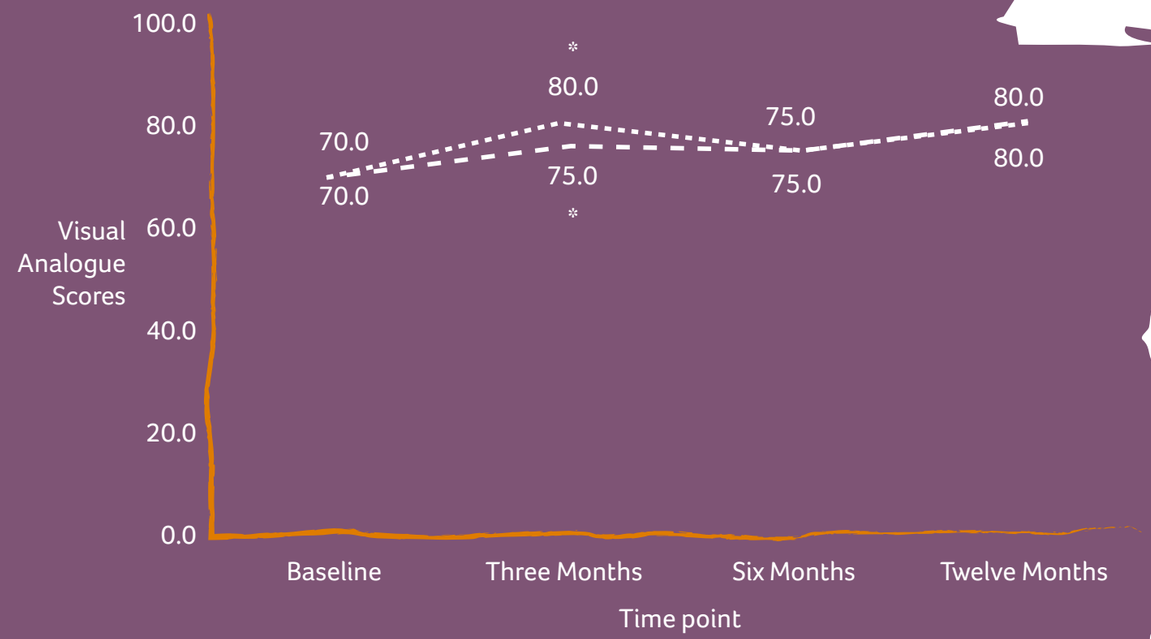
Time Point	IPAQ Group (Range)	IPAQ-E Group (Range)
Baseline	1 (0 to 7)[a]	2 (0 to 7)
Three Months	3 (0 to 7)[a]	4 (0 to 7)
Six Months	2 (0 to 7)	2 (0 to 7)
Twelve Months	2 (0 to 3)	4 (2 to 7)

a = Significant difference between baseline and three month values

MSK Quality of Life – Visual Analogue Score

At three months, patients in the IPAQ and IPAQ-E groups both had higher VAS scores compared to baseline (Figure 16c). No further changes in VAS scores were identified.

Figure 16c – Changes in visual analogue scores during the Active for Health intervention



Dashed lines indicate patients in the IPAQ group and dotted lines represent patients in the IPAQ-E group.

* = Significantly different from baseline.

Qualitative results - MSK

Active for Health

Patients in this pathway presented with a range of co-morbidities including mental health issues and dementia. Patients were knowledgeable about their condition and condition management.

Many benefits were noted including mobility and energy levels and overall quality of life improvements. Dedicated social time after the session was viewed as a nice added extra, but not deemed essential.

Most patients interviewed had been active in the past.

Patient Activation

Patients were knowledgeable about their back problems and management of relapse prevention.

All but one patient believed that they were responsible for their own health. With the other patient viewing HCPs at the most important.

Patients believed they were part of their health care team and their own advocate for their healthcare.

Patients had the key facts for building self-management strategies and are goal orientated. All patients were skilful in managing condition through reducing sedentary time, doing exercises from the class at home and walking to increase movement.

Patient activation score

Patients in this group were considered the most activated in their own health with patients scoring between 3 (n=2) and 4 (2=3).

Appendix 1f - Falls Prevention condition card

About this condition

One in three people over the age of 65 will have at least one fall a year. Falls can cause physical injury such as broken bones or abrasions. Of equal importance however, is the loss of confidence that people may face if they have a fall. Loss of confidence when undertaking daily activities may cause people to become withdrawn and socially isolated. There are many reasons why people may have a fall, for example, a drop in blood pressure can cause someone to become dizzy or disorientated, or poor co-ordination may cause someone to trip.

Benefits of physical activity

Regular participation in exercise training and PA is integral to the maintenance of good health and functional independence in older age, and reduces the risk for falls and fall-related injuries. Where a fall has occurred, exercise training and PA may restore physical function and confidence to a level that preserves physical and social independence.

Falls prevention patient characteristics

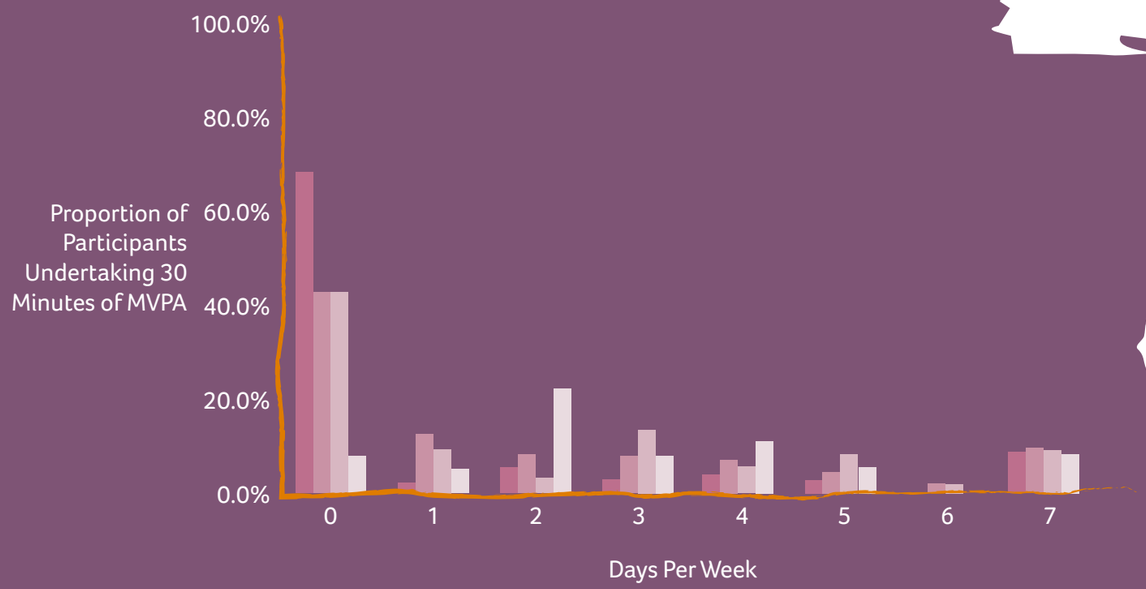
Two-hundred and thirty-seven (n=237) patients with a mean age of 74.4 ± 9.5 years enrolled to the Active for Health falls and fractures LTC pathway. Most patients were Caucasian (97.5%) females (75.0%; n=178). After three months, more than half of patients (51.3%; n=121) were lost to follow-up. Thirty-four (n=34) patients (14.3% of the original cohort) were followed up at 12.

Falls Prevention physical activity results

Single Item Measure

At baseline, the majority of patients (71.1%; n=86) reported that they did not participate in at least one, 30 minute bout MVPA (Figure 11g). Conversely, the majority of patients were performing one 30 minute bout of MVPA per week after 12 (91.2%; n=31). Of the patients who remained in the evaluation after 12 months, 76.5% (n=26) had reported that they did not participate in at least one, 30 minute bout of MVBA at baseline.

Figure 17a – Number of days that patients report participating in 30 minutes of MVPA



Purple through to light purple lines indicate baseline, three month, six month and twelve month data, respectively.

Sport-specific activity

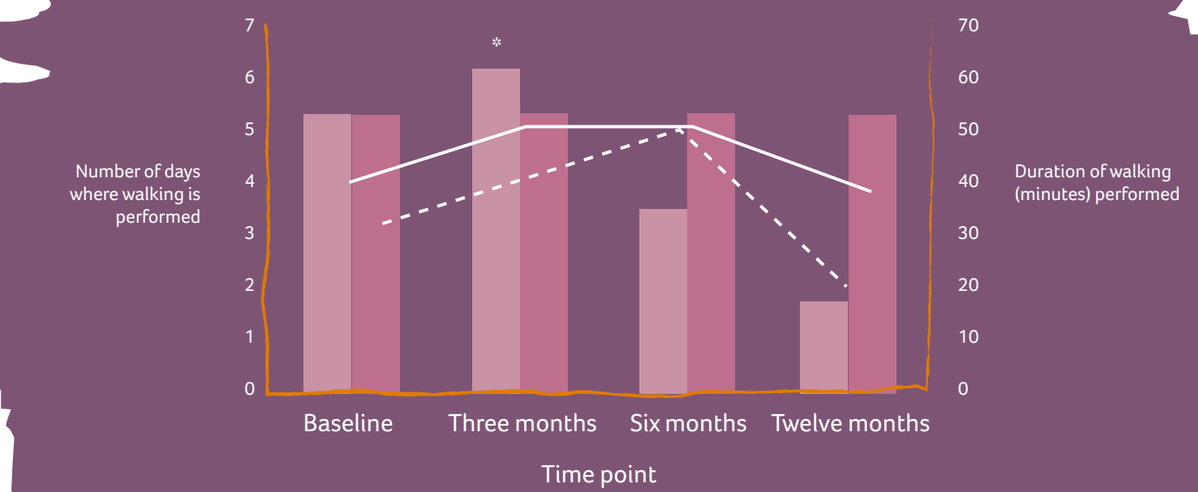
At baseline, and at three months, one person (0.8%) participated in sporting activity. No (n=0) patients engaged in sporting activity at six and 12.

Walking

Patients in the IPAQ group undertook walking activities on three days per week at baseline (range: 0 to 7 days). The number of days where walking was undertaken increased at three and six months; however this was not statistically significant (Figure 12g).

In the IPAQ-E group, the number of days where walking activities were undertaken was greater after three and six months, but not at 12. Changes in the duration of walking activities over the course of the evaluation did significantly change in either group.

Figure 17b –The median number of days where walking was undertaken



Where walking was undertaken (lines) and duration of walking activities (bars) for patients in the IPAQ (dotted lines/ dark purple bars) and IPAQ-E groups (solid white lines/light purple).

* Significantly different from baseline.

Moderate intensity physical activity

Patients in the IPAQ and IPAQ-E groups undertook moderate intensity physical activity on more days of the week after three months, compared to baseline (Table 7g).

Patients in the IPAQ further increased the numbers of days where moderate physical activity after six months.

Table 7g - Median number of days that patients took part in physical activity (range)

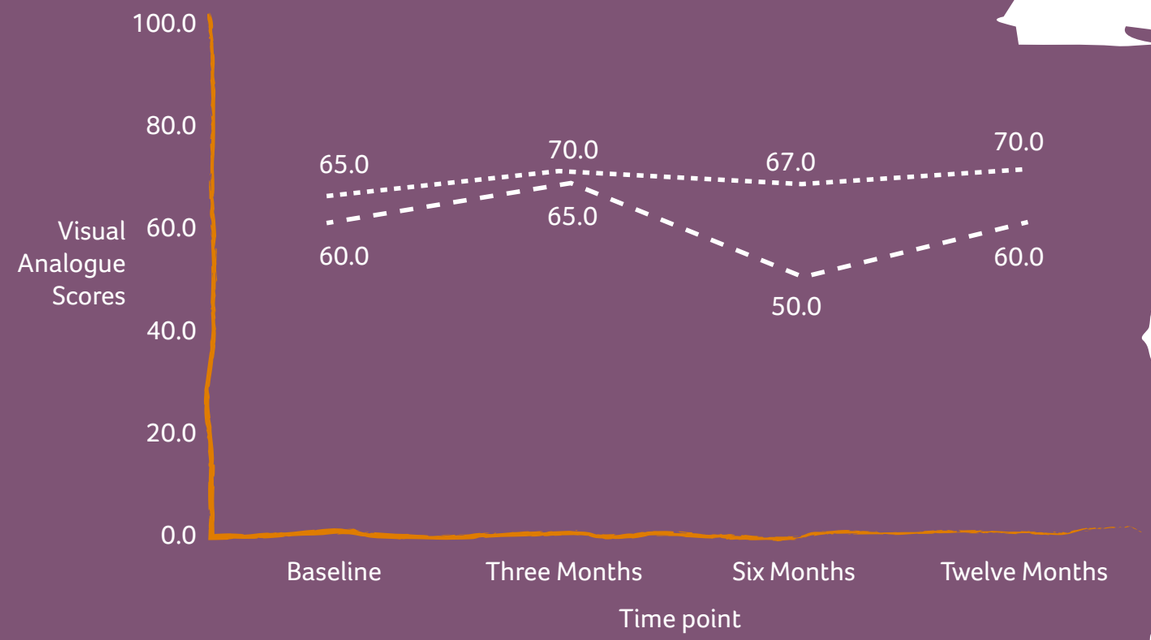
Time Point	IPAQ Group (Range)	IPAQ-E Group (Range)
Baseline	0 (0 to 7)[ab]	1 (0 to 7)[a]
Three Months	2 (0 to 7)[a]	3 (0 to 7)[a]
Six Months	1 (0 to 4)[b]	2 (0 to 7)
Twelve Months	1 (0 to 1)	1 (0 to 6)

a = Significant difference between baseline and three month values
b = Significant difference between baseline and six month values.

Falls Prevention Quality of Life – Visual Analogue Score

There was no change in VAS (Figure 13g) among patients in the IPAQ group at three months. Patients in the IPAQ-E group however had a significant increase in VAS after three months.

Figure 17c – Changes in visual analogue scores during the Active for Health intervention



Dashed lines indicate patients in the IPAQ group and dotted lines represent patients in the IPAQ-E group.

* = Significantly different from baseline.

Qualitative results - Falls Prevention

Active for Health programme:

These patients exhibited symptoms of anxiety around; additional falls, changes to the session structure (change of instructor) and feeling conscious about the number of falls they have had in comparison to others. However all of these anxieties were improved over time.

This group found the social support particularly important, with comments made around reducing isolation. Patients had a preconceived idea of age related decline in PA; however the Active for Health sessions changed this attitude.

Patient Activation:

All patients had a good understanding around their prevalence of falling and knowledge of their condition.

They frequently discussed skills that have been learnt in the session, which could be applied to everyday life, including backward chaining (teaching someone how to get up following a fall) and foot positioning.

Patients believed that others were responsible for their health including loved ones (n=1), instructors (n=2) and HCPs (n =2). One patient also discussed their own responsibility when prompted.

Patients discussed confidence frequently and generally felt confident in managing their condition; this was as a result of attending the Active for Health sessions.

Patient activation levels

Based on the above comments, patient activation levels were varied in this group scoring between level 3 (n-3) and level 2 (n=2).




Rotherham ACTIVE FOR HEALTH

A Local Evaluation Report

SPORT ENGLAND LOTTERY FUNDED
NHS Rotherham Clinical Commissioning Group
Rotherham Metropolitan Borough Council
Sheffield Hallam University | Centre for Sport and Exercise Science
FUNCTIONAL FITNESS
Places Leisure Part of Places for People
Speakup

Rotherham Integrated Care Partnership

Rotherham ICP Place Board – 4 September 2019

Quarter 1 Performance Report for ICP Place Plan

Lead Executive	**Ian Atkinson**
Lead Officer	**Lydia George**

Purpose

For members to note the progress with delivery of the ICP Place Plan as at the end of Quarter 1 2019-20.

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 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.

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

The performance report has been refreshed for 2019/20,however it should be noted that a further refresh will be necessary once the new ICP Place Plan has been produced and agreed (Rotherham response to the NHS Long Term Plan)

Analysis of key issues and of risks

Further analysis will take place in Q2 to show comparisons to Q1.

<u>Children and Young People</u>

Milestones

- There are 23 milestones in total, of which 2 are red:
  - Work with all stakeholders to review the RDaSH CAMHS ASD/ADHD diagnosis pathway.
  - To address the barriers to 0-19 IPHN EHAs and increase the numbers submitted by the service.

RAG Rate	Number	%
Red	2	7%
Amber	6	26%
Green	7	31%
Tbc	5	22%
Not due to start	3	14%
	23	**100%**

KPIs

- There are 14 KPIs in total, of which 2 are red:
  - Increased Early Help Assessments completed by 0-19 practitioners to a min 10 per month
  - Reduction in the number of exclusions

RAG Rate	Number	%
Red	3	14%
Amber	4	29%
Green	4	29%
Tbc	4	29%
	14	**100%**

Mental Health and Learning Disabilities

Milestones

- There are 15 milestones in total, none are red

RAG Rate	Number	%
Red	0	0%
Amber	4	27%
Green	7	46%
Tbc	4	27%
Not due to start	0	0%
	15	**100%**

KPIs

- There are 15 KPIs in total, and 1 is red:
  - Proportion of adults with a learning disability in paid employment

RAG Rate	Number	%
Red	1	7%
Amber	1	7%
Green	10	66%
Tbc	3	20%
	15	**100%**

Urgent and Community

Milestones

- There are 15 milestones in total, none are red:

RAG Rate	Number	%
Red	0	0%
Amber	1	7%
Green	9	60%
Tbc	0	0%
Not due to start	5	33%
	15	**100%**

KPIs

- There are 16 KPIs in total, none are red

RAG Rate	Number	%
Red	0	0%
Amber	4	25%
Green	10	63%
Tbc	2	12%
	16	**100%**

Overall Position

- 43% of milestones are on track for Q1 2019/20 compared to 57% in the same period last year.
- 53% of KPIs are on track in Q1 2019/20 compared to 44% in Q1 in the same period last year.

Approval history

ICP Delivery Team – 21/08/2019
ICP Place Board – 04/09/2019

Recommendations

Members are asked to:

- note the performance for Q1 2019/20; and
- note that Q2 report will have all gaps complete which will enable further analysis and comparisons to be made.

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 1819	Q1 1920	Q2 1920	Q3 1920	Q4 1920	
CH1.1	Work with all stakeholders to review the RDaSH CAMHS ASD/ADHD diagnosis pathway.	Q4 19/20	G	R				This has been rated 'red' due to the unacceptable waiting times for ASD / ADHD diagnosis. There is a whole system action plan in place to reduce waiting times in a sustainable way over the next 2-3 years. An update report will be provided by RDaSH by the end of September 2019
CH1.2	Integration of the CAMHS Single Point of Access (SPA) and RMBC Early Help access point.	Q4 19/20	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 19/20	A	A				This is a long term area 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.	Q4 19/20	A	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	Q3 19/20	G	G				The Mental Health Schools Trailblazer will be implemented in schools from the beginning of September 2019 and fully operational by December 2019. Engagement with schools is positive.

Priority 2 C&YP – Maternity and Better Births								
No.	Description	Target	Progress					Comments
			Q4 1819	Q1 1920	Q2 1920	Q3 1920	Q4 1920	
CH2.1	To reduce stillbirths and neonatal deaths	Q4 2021	1.61%	N/A until Sept				Q4 2018/2019 was 1.61%. The Q1 2019/2020 data is unavailable until early September.
CH2.2	For all women to have a Personalised Care Plan (PCP)	Q4 2021	100%	100%				All women are now provided with a personalised Care Plan and work is on-going with a review to ensure the plan meets the needs of the women.
CH2.3	To reduce the number of women smoking in pregnancy	Q3 2022	19.6%	N/A until Sept				Q3 position was 17.6%, which increased to 19.6% in Q4. The Q1 2019/2020 data is unavailable until early September.

Priority 3 C&YP – 0-19 Healthy Child Pathway								
No.	Description	Target	Progress					Comments
			Q4 1819	Q1 1920	Q2 1920	Q3 1920	Q4 1920	
CH3.1	To address the barriers to 0-19 IPHN EHAs and increase the numbers submitted by the service.	Q4 19/20	A	R				There is a deep dive underway to look at the flow of EHA's from TRFT to RMBC and to further consider with commissioners how EHA's sit alongside the Healthy Child Programme
CH3.2	All 0-19 Practitioners will have completed Signs of Safety training by the end of 2018/19.	Q4 19/20	A	A				Health practitioners accessed the ½ day SoS training. Clarity to be obtained whether SOS to be included for this financial year

Priority 4 C&YP – Acute and Community Integration								
No.	Description	Target	Progress					Comments
			Q4 1819	Q1 1920	Q2 1920	Q3 1920	Q4 1920	
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	tbc				NO UPDATE PROVIDED
CH4.2	Establish links between Rapid Response Team & Early Help	Q3 18/19	G	tbc				NO UPDATE PROVIDED
CH4.3	Pilot a direct link between Children's Ward and Children's Service to support timely discharge plans	Q3 18/19	G	tbc				NO UPDATE PROVIDED

Priority 5 C&YP – SEND								
No.	**Description**	**Target**	**Progress**					**Comments**
			Q4 1819	**Q1 1920**	**Q2 1920**	**Q3 1920**	**Q4 1920**	
CH5.1	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 19/20	G	G				• Joint Resourcing Panel in place • SEND Sufficiency Strategy approved • SEND Health Sufficiency Strategy approved and at implementation phase • Review of SEMH Support Centres complete; focused work to commence in September 2019 • Strategic Inclusion Steering Group in place to review traded models • High Needs Budget Recovery Plan submitted to DfE
CH5.2	Create a plan to reduce placements outside Rotherham (including **residential provision** offer, Reduce **OOA provision** arrangements	Q2 19/20	G	G				SEND Sufficiency Strategy approved by RMBC Cabinet SEND Sufficiency proposals agreed with schools; pending approval by Cabinet in Sept 19

Please note, the Signs of Safety Priority is under review with a view to being transferred to the Workforce and OD Enabling Group:

Priority 6 C&YP – Implementation of 'Signs of Safety'								
No.	**Description**	**Target 1920**	**Progress**					**Comments**
			Q4 1819	**Q1 1920**	**Q2 1920**	**Q3 1920**	**Q4 1920**	
CH6.1	The RLSCB will be sighted on the roll out to partners and this will include training to all levels of practitioner	Q2 19/20	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 for August 2019 to July 2020. Partners have continued to attend SoS half day partner briefings. The future training plan includes developing a quarterly 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 19/20	G	G				All of current SC and EH practitioners have attended 2 day training. We are reviewing our practice lead cohorts and offering a 2 day advanced training offer. We had 6 in house trainers but some have left so we are planning how we develop our new trainers from our solid practice leads
CH6.3	Phase 2 of roll out of training	Q4 19/20	G	G				The Training plan has been reviewed in August 2019 for the next 12 months. There is a clear plan of engagement across CYPS and the partnership through the 2 day training offer, ongoing half day sessions and some planned conference and looked after training that will be opened up via the RSCP to wider partners who lead practice in these pathways..
CH6.4	Evaluation and next steps	Q4 19/20	BR	A				L and Improvement Subgroup to supporting oversight and evaluation. There has been an Alignment of Multi-agency forms and documentation underway with conference reports developed and EMARF is in final stages of consulation.

Priority 7 C&YP – Transitions								
No.	**Description**	**Target**	**Progress**					**Comments**
			Q4 1819	**Q1 1920**	**Q2 1920**	**Q3 1920**	**Q4 1920**	
CH7.1	Develop an operational transition pathway based on Preparing for Adulthood model and publish the transition pathway on the Council website (local offer).	Q2 19/20	A	A				Milestones from 2018/19 plan (7.2 & 7.4) merged and carried over. A draft pathway was developed, although further work is underway to also ensure the inclusion of universal and targeted help group elements. The high level needs pathway will be published on completion of full activity.
CH7.2	Hold an engagement event to ensure young people, families and schools are aware of the employment and skills strategy	Q3 19/20	N/A	BR				
CH7.3	Producing a video for schools / colleges setting out local job market information, including educational routes and career progression opportunities for the preparing for Adulthood Cohort	Q4 19/20	N/A	BR				
CH7.4	Transition pathways for long-term health conditions to be developed	Q3 19/20	N/A	BR				

KEY PERFORMANCE INDICATORS

CHILDREN AND YOUNG PEOPLE TRANSFORMATION GROUP

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

					Performance					
No.	**Description**	**Trajectory**	**Target 1920**	**Priority**	**Q4 1819**	**Q1 1920**	**Q2 1920**	**Q3 1920**	**Q4 1920**	**Comments**
CH/KPI 1	Percentage of referrals assessed within 6 weeks	Increase	95%	CH1 - CAMHS	A 84%	A 89.5%				As at 30 June 2019 excluding ASD/ADHD (in line with the Contract Reporting). The dip in Q4 was caused by short-term staffing issues and Q1 shows the impact of remedial actions.
CH/KPI 2	Percentage of referrals receiving treatment within 18 weeks	Increase	95%	CH1 - CAMHS	A 87%	A 93%				As at 30 June 2019 excluding ASD/ADHD (in line with the Contract Reporting) The dip in Q4 was caused by short-term staffing issues and Q1 shows the impact of remedial actions.
CH/KPI 3	Percentage of referrals triaged for urgency within 24 hours of receipt of referral	Increase	100%	CH1 - CAMHS	G 100%	G 100%				As at 30 June 2019 excluding ASD/ADHD (in line with the Contract Reporting)
CH/KPI 4	Percentage of all appropriate urgent referrals assessed within 24 hours of receipt of referral	Increase	100%	CH1 - CAMHS	G 100%	G 100%				As at 30 June 2019 excluding ASD/ADHD (in line with the Contract Reporting)
CH/KPI 5	A reduction in the rate of stillbirths and neonatal deaths	Reduce	3.76%	CH2 – Maternity	G 1.61	Not available until Sept				Q4 2018/2019 is 1.61%, unfortunately, Q1 2019/2020 data is unavailable until early September.
CH/KPI 6	All pregnant women have a Personalised Care Plan by March 2021	Increase	70%	CH2 – Maternity	G 100%	G 100%				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/KPI 7	A reduction in the percentage of women smoking at time of delivery	Reduce	5% reduction	CH2 – Maternity	R 19.6%	Not available until Sept				Q3 position was 17.6%, which has increased to 19.6% in Q4. The Q1 2019/2020 data is unavailable until early September.
CH/KPI 8	Increased Early Help Assessments completed by 0-19 practitioners to a min 10 per month	Increase	10 per month	CH 3 - 0-19	A 8	R				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
CH/KPI 9	Reduction in the number of exclusions	Reduce	Reduction on previous year	CH 5 - SEND	R 19	R 15				Q1 - 10 registered with SEN Support and 1 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 10	Increased number of Children in Local Provision (reduced OOA)	Increase	17/18 – 93.5%	CH 5 - SEND	A 88.9%	A 89.1%				End of Q1 (June 19) there were 236 CYP in an OOA provision out of 2167 CYP who have a EHCP in place (This is 117 Post -16 CYP and 119 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 11	Number of practitioners from across the Multi-agency partnership who have accessed the Rotherham Family Approach and Signs of safety Training (½ days & extended 2 day for safeguarding leads).	Increase	TBA 17/18 baseline = 0	CH 6 - 'Signs of Safety'	G 600	G 128				In this quarter a further 128 practitioners from across the partnership attended half day awareness sessions. This half day session will be incorporated into the safeguarding induction – the core offer of the LSCB across the partnership A 2 day training offer commenced In April and has included wider partnership practitioners.
CH/KPI 12	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 29.5%	A 19.6%				In July 19.6 % of contacts from partner agencies in went on to a referral i.e. police, schools and health. This is currently amber – 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 has been a revised CP pathway for the 0-19 service agreed by the RSCP and partners, which should start to see a more positive increase in EHA assessments and a reduction in contacts that do not convert. There is also discussion ongoing with SYP force wide around how we manage low level DA referrals, which make up a high proportion of the contacts that are appropriate but do not usually progress to a referral.
CH/KPI 13	Numbers of SEND Tier 1 tribunal applications	Reduce	8 plus 1 in court	CH 7 - Transitions	G 3 cases pending	tbc				
CH/KPI 14	Proportion of young people with SEND needs in paid employment (Working Age Adults)	To base line	TBC	CH 7 Transition	N/A	tbc				New KPI developed for the 2019/20 plan. Baseline is yet to be confirmed.

MILESTONES

MENTAL HEALTH AND LEARNING DISABILITY TRANSFORMATION GROUP

Chair: Ian Atkinson, RCCG

Priority 1 MH - IAPT

No.	Description	Target 1920	Progress					Comments
			Q4 1819	Q1 1920	Q2 1920	Q3 1920	Q4 1920	
MH1.1	Identify and agree workforce development and training requirements (LTC & Core) – IAPT	Q1- Q4 19/20	G	G				On target, staff recruited
MH1.2	All GP practice review support visits completed – IAPT	Q1-Q4 19/20	A	Tbc				
MH1.3	Delivery of 5 year forward IAPT 18/19 plan – IAPT	Q4 19/20	G	G				Access rates Slightly lower than anticipated, further work needed to promote

Priority 2 MH - Dementia Diagnosis and Support

No.	Description	Target 1920	Progress					Comments
			Q4 1819	Q1 1920	Q2 1920	Q3 1920	Q4 1920	
MH2.1	Develop new dementia pathway for post diagnostic care	Q4 19/20	G	G				Work undertaken. Implementation delayed due to interdependency with diagnostic pathway.
MH2.2	Review dementia diagnosis pathway	Q4 19/20	A	A				An interim measure has been agreed with LMC and in place. A revised model is worked up and discussions around implementation have commenced.

Priority 5 MH - Improve Community Crisis Response (including Core Fidelity, suicide-prevention)

No.	Description	Target 1920	Progress					Comments
			Q4 1819	Q1 1920	Q2 1920	Q3 1920	Q4 1920	
MH5.1	Complete CORE Fidelity review, recommendations and action plan for improvement (including investment requirements)	Q4 19/20	A	G				Review complete, bid submitted to ICS for community crisis money. RDaSH 19/20 contract agreed crisis investment profile
MH5.2	SY&B ICS NHS England Suicide-prevention – delivery of Rotherham element of the plan (year 2)	Q4 19/20	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 19/20	A	Tbc				

Priority 6 MH – Public Health: Better Mental Health for All Strategy								
MH6.1	Evidence of integration of Five Ways messages within provider and commissioned services	Q1-Q4 19/20	A	Tbc				

Priority 7 LD – Oversee Delivery of Transforming Care								
No.	**Description**	**Target 1920**	**Progress**					**Comments**
			Q4 1819	**Q1 1920**	**Q2 1920**	**Q3 1920**	**Q4 1920**	
LD7.1	RMBC and CCG to agree process for funding learning disability joint placements	Q2 19/20	A	A				The policy text has been agreed. Work is ongoing to agree the detail behind the policy.
LD7.2	Identify Indicative costs for transforming care cohort (including those on the risk register)	Q2 19/20	G	G				Transforming Care caseload finance information held by RMBC and RCCG Finance. Information is regularly refreshed to reflect the cohort shift.
LD7.3	Commissioning solutions to be in place to meet individual trajectories	Q4 19/20	G	A				Close partnership working across the system has taken place to identify possible placement opportunities for identified transforming care caseload. Despite some positive progress, one placement is behind the anticipated trajectory from NHS England.

Priority 8 LD – Support the Implementation of the My Front Door – Learning Disability Strategy								
No.	**Description**	**Target 1920**	**Progress**					**Comments**
			Q4 1819	**Q1 1920**	**Q2 1920**	**Q3 1920**	**Q4 1920**	
LD8.1	Delivery of joint Learning Disability transformation strategy	Q4 19/20	A	G				The My Front Door strategy has been adopted as part of the Place Plan for LD and is the delivery vehicle for transformation of the LD service offer.

Priority 9 LD – Support the development of an Autism Strategy								
No.	**Description**	**Target 1920**	**Progress**					**Comments**
			Q4 1819	**Q1 1920**	**Q2 1920**	**Q3 1920**	**Q4 1920**	
LD9.1	Complete the development of the Autism Strategy (including Action Plan)	Q3 19/20	A	A				The draft Autism strategy has been further refreshed following key stakeholder comments. The content of the latest version has been agreed by the Autism Partnership Board with the intention of further dissemination in Q2.
LD9.2	Development of Rotherham based Autism and ADHD diagnostic pathway	Q4 18/19	G	Tbc				

KEY PERFORMANCE INDICATORS

LEARNING DISABILITY AND MENTAL HEALTH TRANSFORMATION GROUP

Chair: Ian Atkinson, RCCG

					Performance					
No.	**Description**	**Trajectory**	**Target 1920**	**Priority**	**Q4 1819**	**Q1 1920**	**Q2 1920**	**Q3 1920**	**Q4 1920**	**Comments**
MH/KPI 1	Percentage of people referred to IAPT commencing treatment within 6 weeks of referral.	Maintain	75%	MH 1 - IAPT	G 91.8%	G 84.4%				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	G 4.77%	G 4.36%				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 55.6%	G 54%				On track
MH/KPI 4	Dementia diagnosis rates (%)	Maintain	National = 67% Local = ≥80%	MH 2 - Dementia	G 86.4%	G 85.2%				National target is 67%. Local target set to maintain or improve on 80%. June 85.2%
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	G 97%	tbc				
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	A 84%	G 100%				Referrals 108. Within 1 hour 108
MH/KPI 7	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	A	tbc				
MH/KPI 8	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 98.2%				On track
LD/KPI 9	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 100%				On track.
LD/KPI 10	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 100%	G 100%				On track

LD/KPI 11	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	G 100%	G 100%				On track
LD/KPI 12	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 tbc	LD 7 - Transforming Care	G 3 = CCG 4=NHSE	G				On track
LD/KPI 13	Proportion of eligible adults with a learning disability having a GP health check	Increase	1058	LD 8 - LD Strategy	A	A				Work is being undertaken to ensure that GP's correctly submit to NHSE to ensure that activity is recorded. Work will also be done with providers to ensure that people with a learning disability access health checks
LD/KPI 14	Proportion of adults with a learning disability in paid employment	Increase	5% increase on 17/18 outturn = 4.3% or 31/726 (NB. 17/18 Revised published figures show 4.1% or 30 individuals in paid employment from a cohort of 726)	LD 8 - LD Strategy	R 3.2% Revised submitted 18/19 outturn or 23 individuals in paid employment from a cohort of 720	R 3.0% or 20 individuals in paid employment from a Q1 cohort of 670 NB The denominator changes during year to capture total number on service during the year, so likely to increase.				Year end 2019/20 ASCOF target set to achieve a narrowing of the gap between 18/19 outturn of 3.2% (23 people) and the 17/18 national average of 6.0% (44 people). As at Qtr 1 a further 24 more people need to be in employment to hit 6% or 12 more to achieve the 5% increase on 2017/18 outturn of 4.3% (31 people). The My Front Door strategy/work stream is reviewing the LD employment pathway and improvements are expected to impact during Qtr 2 onwards.
LDKPI/ 15	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	Tbc				

MILESTONES

URGENT CARE AND COMMUNITY TRANSFORMATION GROUP

Chairs: Chris Preston, TRFT and Anne Marie Lubanski RMBC

Priority 1 UC&C - Integrated Point of Contract

No.	Description	Target	Progress					Comments
			Q4 1819	Q1 1920	Q2 1920	Q3 1920	Q4 1920	
1.1	Develop and implement integrated intermediate care and reablement pathways into points of contact	Q4 19/20	NEW	G				An integrated approach to accessing and triaging referrals to the 3 intermediate care and reablement pathways will be defined through the pathway design work stream which has been scoped
1.2	Identify further opportunities for integrated working into points of contact	Q4 19/20	NEW	G				RMBC and TRFT are reviewing and integrating in house contact points and processes as a precursor to improved inter-organisation integrated working

Priority 3 UC&C - Integrated Discharge (Phase 2)

No.	Description	Target	Progress					Comments
			Q4 1819	Q1 1920	Q2 1920	Q3 1920	Q4 1920	
UC 3.1	Complete review of Integrated Discharge Team	Q3 19/20	NEW	G				Review initiated
UC 3.2	Service re-design for 7 day working with nursing	Q4 19/20	NEW	BR				Not yet due to start

Priority 4 UC&C - I Integrated Working into Localities

No.	Description	Target	Progress					Comments
			Q4 1819	Q1 1920	Q2 1920	Q3 1920	Q4 1920	
4.1	Implement social care locality framework in response to Primary Care Networks (PCNs)	Q3 19-20	NEW	G				This work is being progressed through the RMBC Target Operating Model
4.2	Develop integrated intermediate care and reablement pathways as a platform for integrated working into PCNs/localities	Q4 19-20	NEW	G				Integrated working into localities will be progressed through the integrated intermediate care and reablement project in 2019/20 and used as a platform for future development
4.3	Identify and develop further opportunities for integrated working in PCNs/localities informed by the Intermediate Care & Reablement Evaluation	Q4 19/20	NEW	BR				Not due to start

Priority 5 UC&C – Reablement and Intermediate Care								
No.	**Description**	**Target**	**Progress**					**Comments**
			Q4 1819	**Q1 1920**	**Q2 1920**	**Q3 1920**	**Q4 1920**	
UC 5.1	Approval of business case	Q2 19/20	G	A				The Outline Business Case (OBC) has been approved in principle by partner governance groups. Final approval will not be received until July 2019 due to the scheduling of governance meetings.
UC 5.2	Develop service model and service specifications	Q3 19/20	BR	G				High level model articulated in the OBC. Pathway development and service specification work will be initiated in July
UC 5.3	Phase 1 of new service model implemented: investment in home based teams and implementation of the off-site community unit	Q4 19/20	BR	BR				
UC 5.4	Phase 2 New model of care fully implemented	Q3 20/21	BR	BR				
UC 5.5	Embedding of the new model and evaluation	Q4 20/21	BR	BR				

Priority 6 UC&C - Care Home Support								
No.	**Description**	**Target**	**Progress**					**Comments**
			Q4 1819	**Q1 1920**	**Q2 1920**	**Q3 1920**	**Q4 1920**	
6.1	Identify opportunities to integrate activity and review spend	Q4 19/20	NEW	G				
6.2	Continue to implement enhanced health in care home	Q4 19/20	NEW	G				This is a long term national initiative. A report on 2018/19 is being drafted
6.3	Roll out of registration on DPST/Use of NHS Mail to all Care Homes	Q3 19/20	NEW	G				All care homes are now registered on the DSPT/Use of NHS mail

KEY PERFORMANCE INDICATORS

No.	Description	Trajectory	1920 Target	Priority	Performance Q4 1819	Q1 1920	Q2 1920	Q3 1920	Q4 1920	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	40%	UC 1 - IPC	G 37.8%	A 39.30%				Council Plan Measure. The description has been updated to replicate changes in the Council Plan. In Q1 DoT trend positive, performance is better than final year end / Q4. Q1 % performance is within the expected outcome range of between 37% to 40%
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 319	G 363				April 168, May 97, Jun 98 = green
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	TBC in Q2	UC 1 – IPC UC 4 – Int Locality	61%	53.5%				Regional data/ benchmarking is being monitored to inform targets moving forward, target to be confirmed for Q2 update. 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	90%	UC 1 – IPC UC4 – Int Loc UC 5 – IC /Reab	G 93.5%	G 91.2%				In DoT trend although downward, in comparison to Q4, the comparable Q1 position shows improvement rate is 2% higher than Q1 in 2018/19 89%. The Q1 performance is above year-end target and trajectory is on track to meet target. The national and regional averages are much lower at approximately 78% and 72% respectively.
UC/ KPI 5	New permanent admissions to residential nursing care for adults – 65+ *BCF/ASCOF 2a (2)/ BCF (per100,000)*	Decrease	517.41 (264 admissions)	UC 1 – IPC UC 4 – Int Loc UC 5 – IC /Reab	A 572.67 (289 admissions)	G 148.95 (76 admissions)				BCF Indicator, also contributes to Council Plan measure "All Age Admissions". In Q1 DoT trend positive, but Qtr 1 comparison to 2018/19 is higher. The reason for some of the increased numbers of admissions is that the service has been undertaking early in Qtr 1 the reviewing of those people with a current short stay status. This has meant effectively front loading in Q1 rather than a gradual increase over the four quarters and a year-end spike of those people formally on short stays who become permanent during the year.
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	86%	UC 1 – IPC UC 4 – Int Loc UC 5 – IC /Reab	A 85.6%	TBC Q4				Data collected Oct 2019 – Mar 2020 as part of snapshot period. Performance on this indicator will next be available in March 2020.

UC/ KPI 7	Number of emergency admissions for people over 65 Out of Hours	Reduction	8760 (2190 per qtr)	UC 1 – IPC UC 4 – Int Locality	G 1915	G April / May 1170				April 590, May 580
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 4 – Int Locality	11.2% (Feb figure)	11.9% (May19)				This data used to be available nationally, there is no national target. TRFT local target for 28 days is 13.3%.
UC/ KPI 9	Length of stay in hospital (over 64's)	Reduction	2018/19 baseline: All = 6.7, NE = 7.05	UC 4 – Int Locality	All - 6.62 NE - 6.96	All = 6.6 NE = 7.0				Using TRFT reporting: 2017/18 baseline: All = 6.9, NE = 7.5 ***Not including 0 LOS***
UC/KPI 10	Average length of stay - includes acute and community beds combined	Reduction	42	UC 4 – Int Locality						April 80, May 76, Jun 8 Average over Q1 = 54
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	2018/19 baseline All = 53.04% NE = 49.60%	UC 3 - IDisc UC 5 – Int Locality	All = 45.26% NE=42.93 %	All = 55.8% NE = 52.39%				
UC/KPI 12	Average length of stay to below national intermediate care target (general rehabilitation) (beds only)	Reduce	Less than 21	UC 3 - IDisc UC 5 – Int Locality	G Year end = 20.25 average	G 19.2 av				Q1 = 17, 19 , 22 = average of 19.3
UC/KPI 13	Average length of stay to below national intermediate care target (specialist rehabilitation) (beds only)	Reduce	Less than 46	UC 3 - IDisc UC 5 – Int Locality	A Year end = 47.0 average	A 47.3 av				Q1 = 44, 56, 42 = 47.3
UC/ KPI 14	Delayed transfer of care from hospital (I&AF 127e).	Reduction	3.5%	UC 3 – IDis	G 1.5%	A 3.9%				
UC/ KPI 15	Number of A&E attendances from care home residents (local)	Reduction	3400 (850 per qtr)	UC 6 – Care Homes	G 477	G April / May 115				April 53, May 62
UC/ KPI 16	Number of unscheduled hospital admissions Care Homes	Reduction	1950 (490 per qtr)	UC 6 – Care Homes	G 311	G April / May 258				April 126, May 132

Rotherham Integrated Care Partnership

Minutes	
Title of Meeting:	**PUBLIC Rotherham ICP Place Board**
Time of Meeting:	9:00am – 10:00am
Date of Meeting:	Wednesday 5 June 2019
Venue:	Elm Room (G.04), Oak House
Chair:	Chris Edwards
Contact for Meeting:	Lydia George 01709 302116 or Lydia.george@nhs.net

Apologies:	Kathryn Singh
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:

Sharon Kemp (**SK**), Chairing, Chief Executive, RMBC
Chris Edwards (**CE**), Chief Officer, Rotherham CCG
Louise Barnett (**LB**), Chief Executive, TRFT
Dr Goks Muthoo (**GK**), Medical Director, Connect Healthcare Rotherham CIC
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 / ICP
Gordon Laidlaw (**GL**), Head of Communications, Rotherham CCG / ICP
Andrew Clayton (**AC**), Head of Digital, Rotherham CCG / ICP
Jayne Watson (**JWa**), PA to Chief Nurse

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

Further information was requested about the relationship with the ICP and the CCG, and on the integration of health and social care.

Chris Edwards reiterated that the CCG is one of 6 members of the ICP, and the relationship is documented on the ICP structure as are other members.

Sharon Kemp added that the Integrated Care Partnership are working to improve co-ordination across health and social care, that each organisation retains its own sovereignty and that all members of ICP are equal and work together as partners.

2	**Transformation Group Updates**

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

Children & Young People's Transformation Group
Subject – Child & Adolescent Mental Health Services (CAMHS)
Presented by Jenny Lingrell

The locality advice and consultation model was well established.

CAMHs - The plan was working really well and had enabled them to focus. They had also identified a need to develop workforce development where schools were accessing a lot of training and support. Looking to advertise for a member of staff to develop an audit to develop a single point of access.

Trailblazer implementation, two events with schools and another planned before the end of term. Part of bid was that part of delivery would be outside of the NHS.

Recruitment for a mental health support team was on track; placements would begin before the end of term and the teams would be fully operational by December 2019.

Waiting times were a concern. More work was being undertaken.

Chris Edwards felt it was positive that we had secured the funding for the Mental health Trailblazer but we needed a plan for the end of the funding well in advance

Sharon Kemp asked how many schools were taking part. Jenny Lingrell felt it was approximately 12 but would provide information to be circulated with her presentation.

GL added that information and communication is to be produced to inform what the service would look like.

IA added that autism work needs to be kept at the forefront of activity.

An action plan would be developed which would enable work to go ahead with CDC. The action plan should be complete within a month.

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

Mental Health & Learning Disability Transformation Group
Subject – Community Crisis and Home Treatment (Core Fidelity)
Presented by Ian Atkinson

Enhance crisis provision and home treatment is part of the CCG commissioning plan. Over the 2018/19 winter period a number of successful pilots had been undertaken with police street triage, mental health police nurse posts. Place partners had worked with Samaritans to raise awareness of their service across the borough.

Further work was required to enhance the current Crisis Helpline provision and scoping would be completed by the end of quarter one, with delivery in quarter two.

CCG growth money was allocated in April and had been informed of further funding to put bids in for a further two years. Challenges were staff resilience and availability withy further work required on plans for retention and recruitment.

Mental Health Winter pressures plan needed to be developed for 2019/20. That would build on learning from the 2018/19 winter pressures programme.

South Yorkshire Crisis Pathways Sub-Group policies needed to be considered and approved at a local level.

Rotherham's submission for the NHS England Community Crisis Care Proposal submission needed to be completed by 17 June 2019.

Place Board members noted the progress being made and thanked Ian and the MH & LD Transformation Group for the update.

3	**Digital Enabler Group Update – Rotherham Population Segmentation Model**

Andrew Clayton was present to give ICP Place Board an update on progress with the development of a Population Health Management Segmentation Model.

Work had started in 2017 to develop a tool for The Place and it was always the intention to develop that further.

Phase one, was the development of virtual budgeting tool, designed based on local needs, which enabled targeted intentions for priority population cohorts and assessment to support transformational programme planning. Phase two of the project was intended to produce a super-utilised Patient Level Analysis Tool. The aim was to allow patient level analysis upon which different personae could be developed to support and inform the various cases for change options.

Proposed our own segmentation model based on splitting population into three areas:

- 0-16
- 16-69
- 70+

A task and finish group that included members from all place partners had been established to steer the development of the model.

Next Steps:

- Priority areas for use of the segmentation model in the Rotherham Place to be agreed.
- All partners to approve the Data Protection Impact Assessment
- Information sharing and data processing agreements to be developed and agreed by all partners.
- Proposed segmentation model to be reviewed and validated by the clinical and academic leads.
- First draft run of data queries to be carried out to determine whether the algorithms planned looked realistic and to establish where there were data gaps.
- More detailed task planning to be undertaken based on insights gained from the review of the model and the run of the draft queries.

Place Board members noted the progress being made and gave thanks to Andy and his team for the work involved.

4	**Primary Care Networks Update**

Six Primary Care Networks had been approved by NHSE for Rotherham and six Clinical Directors had been appointed. All were engaging well with the NHS Federation and regular meetings would take place.

5	Terms of Reference

Rotherham ICP Delivery Team

Approved

Rotherham ICP Digital Enabler Group

Approved

Rotherham Communications & Engagement Enabler Group

Approved

6	Rotherham CCG 360° Stakeholder Survey

Chris Edwards gave thanks to everyone for completing the survey.

NHSE had contacted Rotherham who had been identified as best practice for this area.

7	Healthier Rotherham Event Agenda – 3 July 2019

AGM Meeting – members to note the programme and that the event is taking place at the New York Stadium.

7	Impact of Brexit

Same risks of non-availability of prescription drugs.

8	Draft Minutes from Public ICP Place Board – 1 May 2019

The minutes from the May meeting were **APPROVED** as a true and accurate record. There were no matters arising.

9	Communications to Partners

The Integrated Discharge Service had received a HSJ Award.

Sharon Kemp asked that note be sent to team leaders from the Board to congratulate them. Gordon Laidlaw added that press release was being developed.

The Acute Medical Unit and Catering Departments were also commended

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) –
    - Rotherham Health Record Roadmap
    - Population Health Management Plan
    - Rotherham ICP Digital Strategy
- Terms of Reference Reviews – All ICP Groups (Jul)
- Place Board Forward Agenda

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 3 July 2019, *at 9am at New York Stadium*	

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

Rotherham Integrated Care Partnership

Minutes	
Title of Meeting:	**PUBLIC Rotherham ICP Place Board**
Time of Meeting:	9:00am – 10:00am
Date of Meeting:	Wednesday 3 July 2019
Venue:	Elm Room (G.04), Oak House
Chair:	Chris Edwards
Contact for Meeting:	Lydia George 01709 302116 or Lydia.george@nhs.net

Apologies:	Kathryn Singh, Chief Executive, RDaSH Sharon Kemp, Chief Executive, RMBC Janet Wheatley, Chief Executive, Voluntary Action Rotherham Rebecca Woolley, Policy & Partnerships Officer, RMBC
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
Dr Goks Muthoo (**GK**), Medical Director, Connect Healthcare Rotherham CIC
Louise Barnett (**LB**), Chief Executive, TRFT
Annemarie Lubanski (**AML**), (for Sharon Kemp), Strategic Dir of Adults, Housing & Public Health, RMBC
Matt Pollard (**MP**), (for Kathryn Singh), Service Director, RDaSH

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 / ICP
Gordon Laidlaw (**GL**), Head of Communications, Rotherham CCG / ICP
Jon Stonehouse (**JS**), Director of Childrens Service, RMBC
Chris Preston (**CP**), (for Louise Barnett), Deputy Chief Executive, TRFT
Wendy Commons (**WC**), ICP Support Officer, RCCG

There were 8 members of the public present.

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

A member of the public representing 'Save our NHS' verbally raised the points below:

1. When does funding end for the Mental Health Trailblazer Pilot?

   Ian Atkinson advised that the term of this NHS England funded pilot was initially for 2 years. There are currently 25 pilots taking place and working at pace across the country. When the time comes for the evaluation a view will be taken at both a national and local level.

2. How is the street triage project working?

   Matt Pollard explained the purpose of this mental health street triage project as helping to divert people with mental health needs away from police custody and from detention under Section 136 of the Mental Health Act. It has been particularly successful in diverting away from hospital services over the Christmas/Winter period which is why it has been continued. It is hoped to develop, embed and expand the service going forward. People can access the service through a number of points via the crisis line. The 'Save our NHS' representative welcomed this innovative initiative and Place commitment to implementing by this unusual approach.

3. Besides age bands, what other formulae, if any, are being used to query the system for population segmentation purposes.

   As the Digital Lead for SYB Integrated Care System, Dr Cullen confirmed that a number of ways are being used to extract data which will ultimately help us to better map and target services to meet local need. Dr Cullen offered to explain in more detail outside the meeting.

2	**Transformation Group Updates**

The Place Board received year-end updates from each of the transformation areas ie Children & Young People's, Mental Health & Learning Disability and Urgent & Community Care. The presentations detailed what has worked well throughout implementation, any areas of concern and the next steps required with the expected timeframes.

Three videos were also shown, one by 'Chat and Chill', a Rotherham based youth group for young people with Autism. Another was shown explaining the work of the Integrated Health & Social Care Discharge Team. It was noted that this service has recently won a Health Service Journal Value Award for acute redesign.

Finally, a video was presented on the Rotherham Health Record and the Rotherham Health App. These digital developments are bringing together information about patients in one place which will help to improve and better co-ordinate care. Thousands have already signed up to the local health app. However, it is the ambition of Rotherham Place to get all Rotherham residents signed up to the app which will enable them to book appointments, order repeat prescriptions and access further information on their symptoms.

Chris Edwards thanked the presenters for the year-end updates and congratulated all teams on the achievements so far, as well as the Integrated Discharge Team on their recent award. Place Board will continue to have oversight on all transformation areas by way of scheduled updates.

3	**ICP Place Plan Year End Performance Report – 2018-19**

Lydia George presented the year end performance report showing the position at the end of Quarter 4. It was noted that there had been steady improvements on milestones overall with 60% either implemented or on track for completion. There has been little fluctuation in KPI performance throughout the year against the national measures used.

In relation to the urgent and community care transformation, there were two of the integrated locality milestones and one intermediate care/re-ablement milestone still to be RAG rated. This was due to new guidance being issued and awaiting the outcome of a business case.

Members noted the performance for Quarter 4 as being similar to the position reported in Quarter 3, although there had been a positive shift to completed milestones. It was acknowledged that once the ICP Place Plan has been refreshed to take account of the recently published NHS Long Term Plan, a

new performance framework will be developed.

In line with the governance structure, this year-end performance report will be received by the Health & Wellbeing Board. Partners may also wish share it within their own organisations by way of acknowledging the achievements of partnership working.

Action: All

4	**Impact of Brexit Update**

Reporting has now recommenced, following a pause due to the extended Brexit deadline. Although, there were no new risks to be reported this month the non-availability of some prescription medications remains an issue. It was agreed that this item will continue to be a standing agenda item to enable partners to report any risks that may impact on the transformation and delivery of services.

5	**Draft Minutes from Public ICP Place Board – 5 June 2019**

The minutes from the June meeting were **APPROVED** as a true and accurate record. There were no matters arising.

6	**Spotlight Updates to Place Board**

A schedule of spotlight updates from transformation and enabling groups to Place Board was received and noted for information.

The guidance and plan for implementing the NHS long term plan has recently been issued. Rotherham Place's response will be outlined in the refresh of the ICP Place Plan. A draft of which will be received for approval in September.

Action: LG (for agenda)

7	**Communication to Partners**

Gordon Laidlaw will be working on the communications required for the ICP Place Plan development and press releases throughout the developments with the intermediate care and re-ablement service.

7	**Risk/Items for Escalation**

Members received the newly developed risk log which is used to enhance oversight of risks that may impact on the implementation of the ICP Place Plan. It is <u>not</u> intended to replace risk registers held within individual organisations.

There were **NO** new risks identified for escalation, however the risk of suicide prevention reported on the log will be escalated to Health & Wellbeing Board to be managed.

Action: IA

8	**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 (tbd) • Rotherham ICP Digital Strategy (Aug) • Terms of Reference Reviews – All ICP Groups (Aug) • Place Board Forward Agenda Standard Agenda Items • Delivery Dashboard/Performance Framework (quarterly) • Transformation Groups Spotlight Updates (monthly) • Rotherham Provider Alliance Update (monthly) • Impact of Brexit Updates (as required)
9	**Date of Next Meeting**

Wednesday 7 August 2019, *at 9am at Oak House, Bramley.*

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 Goks 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
Head of Communications, RCCG – Gordon Laidlaw
Strategy & Development Lead, RCCG – Lydia George

Rotherham Integrated Care Partnership

Minutes	
Title of Meeting:	**PUBLIC Rotherham ICP Place Board**
Time of Meeting:	9:00am – 10:00am
Date of Meeting:	Wednesday 7 August 2019
Venue:	Elm Room (G.04), Oak House
Chair:	Sharon Kemp
Contact for Meeting:	Lydia George 01709 302116 or Lydia.george@nhs.net

Apologies:	Dr Richard Cullen, Rotherham CCG Chair Kathryn Singh, Chief Executive, RDaSH Gordon Laidlaw, Head of Communications, Rotherham CCG
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:

Sharon Kemp (**SK**), Chairing, Chief Executive, RMBC
Chris Edwards (**CE**), Chief Officer, Rotherham CCG
Dr Goks Muthoo (**GK**), Medical Director, Connect Healthcare Rotherham CIC
Louise Barnett (**LB**), Chief Executive, TRFT
Janet Wheatley (**JW**), Chief Executive, Voluntary Action Rotherham
Matt Pollard (**MP**), (for Kathryn Singh), Care Group Director, RDaSH

Participating Observers
Cllr David Roche (**DR**), Joint Chair, Heath & Wellbeing Board, RMBC

In Attendance:
Ian Atkinson (**IA**), Chair, Rotherham ICP Delivery Team
Lydia George (**LG**), Strategy & Development Lead, Rotherham CCG / ICP
Annemarie Lubanski (**AML**), Strategic Director of Adults, Housing & Public Health, RMBC
June Lovett (**JL**), Head of Midwifery, TRFT
Paul Theaker (**PT**), Commissioning Manager – C&YP and Maternity Services, Rotherham CCG
Rebecca Woolley (**RW**), Policy & Partnerships Officer, RMBC
Wendy Commons (**WC**), ICP Support Officer, Rotherham CCG

There were no members of the public present.

Item Number	Discussion Items
1	**Public & Patient Questions**
There were no questions raised.	
2	**Transformation Group Updates**

Children & Young People's Transformation Group
Subject – **Maternity & Better Births/Signs of Safety**
Presented by June Lovett/Paul Theaker/Ian Atkinson

June Lovett explained the robust working arrangements in place and the collaborative approach being taken with Maternity and Better Births across Rotherham and South Yorkshire & Bassetlaw. TRFT has been awarded the hosting of the Maternity Network.

Paul Theaker reported that achieving key trajectories and the provision of 'fit for purpose' estate will be a key part to delivering this element of the Place Plan, as is sustaining the funding and staffing to embed the new service model to provide better choice for births, achieve continuity of carer, implement on call processes, improve dataset information and market Rotherham maternity services.

June went on to highlight the approach being taken to address these issues which includes refreshing the maternity transformation plan by the end of August with a strong focus on prevention and digital, particularly smoking prevention and obesity which is being supported by public health and other key stakeholders.

A number of approaches are being taken around estate and developing hub services in the community. Recruitment is currently underway to appoint to staffing vacancies and staffing is being increased which will assist with the new model, although further investment is required to enable the new model to be embedded and sustained.

June explained that the intention is to offer four choices for births with pop up birth centres being one of them although this is in the very early stages. Clinical views will be sought via the Children & Young People's Transformation Group and the Rotherham Maternity Transformation Plan will be shared with the Federation to obtain feedback. Communicating this development will also be included in the Communications and Engagement Plan and consideration given to ensuring that Primary Care Networks are given an understanding of the new birth choices so that they have the appropriate information to promote them.

Action JL/PT/GP

As Senior Responsible Officer for SY&B Local Maternity Services, Chris Edwards highlighted the key areas to be delivered locally as; developing choice and the continuity of care, although it was acknowledged that the national targets set to improve health outcomes are high. He asked Place Board partners to consider how they can assist with supporting the service to address the Rotherham smoking in pregnancy rates.

Cllr Roche felt that improving the 'stop smoking' messages communicated by all services will help to bring Rotherham closer to national average.

Louise Barnett said that the maternity service has clear expectations and offers each individual support and referral into the smoking cessation service. Where the QUIT programme is taken up, it is very effective. Better promoting and communicating the successes of the service may be an approach to adopt.

In respect of younger mums, links have been made through the Early Help Service with a representative from the service being invited to join the Rotherham Better Births Group.

Signs of Safety
Ian Atkinson confirmed that signs of safety processes are now embedded in social work practice. The number of partners engaging is increasing and the profile is being raised through the Safeguarding Partnership Board. The adoption of the model across the wider partnership's children's workforce will be embedded via the workforce enabling group who will be responsible for its performance management reporting going forward.

The Chair requested clarity around the numbers of staff going through signs of safety training from partners. It was agreed that this will be incorporated into the Place performance report.

Action: IA/LG

Urgent & Community Care Transformation Group
Subject - Intermediate Care & Re-ablement
Presented by Annemarie Lubanski

Annemarie Lubanski informed members that the Intermediate Care and Re-ablement business case had been approved by Partner Boards and mobilisation has commenced with positive partnership working. Recruitment is also underway to allow home based pathways to be pump primed operationally.

Annemarie highlighted a number of risks and mitigations. These included:

- a proposal for 'double running' for around six months to manage the implementation of the Home First model
- providers and commissioners working together to identify the totality of community bed requirements in the event of insufficient bed capacity
- additional support has been identified to assist with administering the approval and procurement process should additional off-site beds be required
- to assess resourcing challenges such as nursing, medical and social care staff, work is being undertaken across teams/organisations to identify mitigation within the system. TRFT will be moving to NHS Providers to reduce future agency costs.

Place Board members noted the phased implementation plan and acknowledged that winter may be a factor that could increase the risks associated with the implementation. Mature discussions are being undertaken across partners with winter planning being integral to the risk and mitigations being put in place this to enable to the right capacity and quality of care to be provided in right place with sufficient surge capacity. It was acknowledged that early signs with the home first model are positive but these will continue to be tracked and evaluated.

In order to ensure that the Primary Care Networks (PCNs) get a full understanding of this model in its entirety and is aware that that they are an integral part of the system going forward, a meeting has been arranged with PCN Clinical Directors for locality working principles will be reinforced.

It was noted that there have been increasing attendances and admissions at the hospital of late which mirrors national trends. Addressing these significant issues is the role of the A&E Delivery Board who are analysing the sources of admissions and attendances to sufficiently support the winter plan. A&E Delivery Board is the forum for escalating issues and challenge. Assurance will be given to Delivery Board on the implementation of the intermediate care and re-ablement model and the risks and mitigations and any issues reported to the Place Board.

Action: CE/SK/LB

The Chair thanked the Urgent & Community Care Transformation Group for the work undertaken in this reconfiguration which it was felt reflected true partnership working. However, it was acknowledged that this is the largest Place transformation being undertaken and therefore Place Board needs to have more oversight to ensure it is achieved. Currently six monthly spotlight updates are scheduled for review. The Delivery Team will consider whether this is sufficient.

Action: AML/IA

Mental Health & Learning Disability Transformation Group
Subject - Dementia
Presented by Ian Atkinson

Ian Atkinson reported that dementia diagnoses remain high. He highlighted that a new dementia care diagnosis pathway that has been co-produced with clinicians has now been shared, the new carers resilience service is proving popular and being well received and as part of the GP quality contract a new carers training package is being introduced across primary care.

The current challenges for the MH&LD Group are around the agreement and delivery of the new dementia pathway and the transition of resource from secondary care to primary care. Mature discussions have taken place with colleagues in primary care and work is underway to ensure that partnership principles are not destabilised.

Ian went on to advise that the dementia pathway is continuing to be agreed through governance processes with the new pathway being commissioned. An implementation plan will be developed and agreed. It is intended to undertake some dual running whilst pathways are implemented. Ian explained

that Place arrangements have assisted in allowing the development of this new pathway and the spirit of place working has been adopted throughout.

Dr Gok Muthoo advised that the GP Federation has assisted some smaller practices who currently don't have capacity to carry out dementia diagnosis. He reported that the increase in diagnosis is as a result of how practices working together to undertake the assessments.

Janet Wheatley commented that there is also a non-clinical aspect of this transformation around the significant impact for carers and dementia cafes, etc. The Social Prescribing Service will need to have the capacity to be able to support with interventions.

Sharon Kemp thanked the MH& LD Transformation Group for the presentation. In considering what the transformational changes have meant for the patients and residents in the borough she requested that the Delivery Team consider reflecting this in future spotlight presentations.

Action: IA

Members reflected that Place Board has been receiving presentations in the format of 'what's working well', 'what are we worried about' and 'what needs to happen'. Following discussion it was felt that it would be useful to incorporate what difference the changes are making or what it will mean for patients and residents after transformation. It was agreed that these could be based on 2-3 metrics for each transformation group which will help with evaluations and reputational benefit.

The Delivery Team will look at refreshing the themes for future Place Board spotlight presentations whilst refreshing the plan.

Action: IA

3	**Provider Alliance Update**

Members noted that a date had been agreed earlier that day to hold a facilitated development session with provider partners to agree the details for the Rotherham Provider Alliance. The approach taken will be similar to that of the Place partnership. The initial scoping session will take place on Thursday 19 September with a view to holding a wider partnership/engagement session later in the year.

4	**Impact of Brexit Update**

Sharon Kemp advised that RMBC were continuing to engage with the Local Resilience Forum to assess and plan for potential impacts.

From a CCG perspective, Chris Edwards advised that prescription drugs availability continues to be an issue.

Place partners are confident that key links are in place across organisations to liaise on Brexit but will review arrangements at the Rotherham Partnership CEO Group on Thursday 8 August.

5	**Draft Minutes from Public ICP Place Board – 3 July 2019**

The minutes from the previous meeting were **APPROVED** as a true and accurate record. There were no matters arising.

6	**Communication to Partners**

Marketing and communicating Maternity, Better Births and Smoking in Pregnancy.

Communicating the development of PCNs to the wider public to give an understanding of what it will mean. This will be incorporated into the Communications & Engagement Plan.

Action: GL

Detail on recent Department of Health funding announcements on Capital and Primary Care to be shared and placed on a future Place Board agenda.

Action: CE/LG

Dr Gok Muthoo advised that each Primary Care Network is to have a social prescribing advisor and these posts are to be advertised. He advised that these will not have any adverse impact on the social prescribing service provided by Voluntary Action Rotherham. Rotherham may be a trailblazer in this approach as it doesn't appear to have been implemented anywhere else in the country.

7	**Risk/Items for Escalation**

Members noted the risk log.

There were **NO** new risks identified for escalation.

8	**Any Other Business**

CQC Report - Smiling Matters: Oral Health Care in Care Homes

Cllr Roche explained that CQC social care inspectors had undertaken visits to care homes in England to assess experiences of oral care. The findings have been published in a report which highlighted issues around joined up practice between care homes and dentists. Accessing routine dental care was often difficult and dentists appeared to have a limited understanding of people's complex needs. Often treatment was only sought when people were in pain and accessing emergency NHS dental care meant that care homes would call a GP, NHS111 or even attend A&E.

Members discussed the resulting impact this may have on primary and secondary care services and, acknowledging that dental services are not locally commissioned, it was agreed to write to NHS England to request how the report's recommendations are being addressed.

For clarity, Louise Barnett will advise what dental services are provided locally.

Action: CE/LB

9	**Future Agenda Items**
	Future Agenda Items • Social Prescribing – (Sept) • Estates Update – tbd • OD & Workforce Update – Workforce Maturity Index (tbd) • Primary Care Network Progress Update – Public & Confi (tbd) • Rotherham ICP Digital Strategy (Sept) • Rotherham ICP Communications & Engagement Strategy (Nov) • Terms of Reference Reviews – All ICP Groups Standard Agenda Items • Delivery Dashboard/Performance Framework (quarterly) • Transformation Groups Spotlight Updates (monthly) • Rotherham Provider Alliance Update (monthly) • Impact of Brexit Updates (as required) • Primary Care Network Updates (as required) • Risk Log (monthly)
10	**Date of Next Meeting**

Wednesday 4 September 2019, *at 9am at Oak House, Bramley.*

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