HEALTH AND WELLBEING BOARD

Venue: **Wentworth Woodhouse, Rotherham. S62 7TQ**

Date: **Wednesday, 22nd January, 2020**

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

Delivery of the Health and Wellbeing Strategy

8. Rotherham Loneliness Action Plan 2020-2022 (Pages 9 - 34)
   Ruth Fletcher Brown, Public Health, to present

Key Developments

9. Voice of the Child - Rotherham Lifestyle Survey 2019 (Pages 35 - 85)
   Bev Pepperdine, Performance Assurance Manager, to present

10. Spotlight: Climate Change (Pages 86 - 88)
    Presentation by Jackie Mould, Head of Service, Performance, Intelligence and Improvement

11. Additional factors influencing the delivery of the Health and Wellbeing Strategy

Board Assurance

12. Winter Pressures Update
Verbal update by Ian Atkinson, RCCG

Board Development

13. Issues escalated from Place Board

For Information

14. Child Death Overview Panel Annual Report 2018/19 (Pages 89 - 119)

15. Rotherham Integrated Care Partnership Board Performance Report: Quarter 2 (Pages 120 - 139)

16. Integrated Care Partnership Place Board Minutes (Pages 140 - 144)

17. Better Care Fund Section 75 Agreement 2019/20 (Pages 145 - 296)

18. Date and time of next meeting
Wednesday, 11th March, 2020, at 9.00 a.m. venue to be confirmed

HEALTH AND WELLBEING BOARD
20th November, 2019

Present:-

Councillor David Roche	Cabinet Member, Adult Social Care and Health **(in the Chair)**
Sue Cassin	Chief Nurse, Rotherham CCG (representing Chris Edwards)
Tony Clabby	Chief Executive, Healthwatch Rotherham
Sally Hodges	Interim Strategic Director, Children and Young People's Services
Viviennie Knight	The Rotherham Foundation Trust (representing Louise Barnett)
AnneMarie Lubanski	Strategic Director, Adult Social Care and Health
Dr. Jason Page	Rotherham CCG
Terri Roche	Director of Public Health
Janet Wheatley	Chief Executive, Voluntary Action Rotherham
Paul Woodcock	Strategic Director, Regeneration and Environment

Report Presenters:-

Gilly Brenner	Public Health Specialist
Ruth Fletcher-Brown	Public Health Specialist
Rebecca Wall	Head of Safeguarding, Quality and Learning, RMBC

Also Present:-

Steve Adams	South Yorkshire Fire and Rescue Service
Miles Crompton	Policy and Partnerships Officer, RMBC
Councillor R. Elliott	Vice-Chair, Health Select Commission
Jackie Scantlebury	Rotherham Safeguarding Adults Board
Janet Spurling	Governance Advisor, on behalf of Health Select Commission
Becky Woolley	Policy and Partnerships Officer, RMBC

Apologies for absence were received from Steve Chapman (South Yorkshire Police), Chris Edwards (Rotherham CCG), Sharon Kemp (RMBC), Gordon Laidlaw (Rotherham CCG), Carole Lavelle (NHS England), Dr. Richard Cullen (Rotherham CCG) and Kathryn Singh (RDaSH).

49. JANET WHEATLEY

The Chair reported that it was Janet's last meeting before her retirement at the end of December, 2019.

On behalf of the Board he thanked her for support and contributions and wished her a happy and healthy retirement.

50. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at this meeting.

51. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

52. MINUTES OF THE PREVIOUS MEETING

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

Resolved:- That the minutes of the previous meeting held on 18th September, 2019, be approved as a correct record.

Arising from Minute No. 35 (Be the One – Suicide Prevention Campaign), it was noted that the Campaign had been an outstanding success with over 1M hits on the website, far in excess of comparable national campaigns. Work was taking place with Communication leads to ensure the message was continued.

Arising from Minute No. 35 (Rotherham Show), Public Health had continued the "what keeps Rotherham healthy, safe and well" message and had received over 500 cards and spoke to over 1,000 members of the public. There had been very successful participation and engagement in the activities on offer.

Arising from Minute No. 36 (Improving Air Quality in Rotherham), it was noted that at the recent Council Meeting a Motion had been passed on Climate Change Emergency. From March 2020, every report submitted within the Council would have to include an equality assessment as to how the particular report affected climate change. A Members Working Party was to be established to propose an informed target for the Council's carbon reduction by 2025 and that the Working Group report back to the Council no later than March 2020 on how it would improve air quality.

This could not be done by the Council alone and would be reaching out to partners to help improve Rotherham's air quality.

Arising from Minute No. 41 (Supplementary Planning Documents), it was noted that due to Purdah, comments from the Board had not been submitted as yet but would be submitted shortly.

53. COMMUNICATIONS

Janet Spurling, Governance Advisor, on behalf of Councillor Keenan, Chair of the Health Select Commission, submitted the following question in relation to the Suicide Prevention and Self-Harm Plan:-

"The Select Commission had had an indepth workshop session and probed into a number of issues more widely than the Plan. It was pleased with the work taking place.

In terms of the Help is at Hand booklet, are we ensuring that it is widely circulated and provided to bereaved families as a matter of course; does it go to funeral directors as well to pass onto families?"

Ruth Fletcher-Brown, Public Health Specialist, confirmed that the booklet was circulated to families affected by suicide. It was also supplied to GP practices who were encouraged to routinely give it out to families that had been bereaved. Where Public Health had the details, a referral to the listening service was also offered. If a family did not wish to have a referral, they were automatically provided with a copy of the Help is at Hand booklet.

In the past Public Health had worked with funeral directors; this had not been done recently but could be picked up again.

54. POPULATION HEALTH VIDEO

The Board viewed a YouTube video produced by the Kings Fund on Population Health which linked with Aim 4 of the Health and Wellbeing Strategy.

(https://www.kingsfund.org.uk/audio-video/population-health-animation?utm_source=The%20King%27s%20Fund%20newsletters%20%28main%20account%29&utm_medium=email&utm_campaign=10821829_MKPUB_population%20health%20animation%202019-08-22&utm_content=btn&dm_i=21A8,6FY6D,P4WA59,PJF0Q,1)

55. SOUTH YORKSHIRE AND BASSETLAW INTEGRATED CARE SYSTEM STRATEGIC 5 YEAR PLANS

The Board viewed the Plan on a Page of the South Yorkshire and Bassetlaw Integrated Care System Strategic 5 Year Plans (https://www.healthandcaretogethersyb.co.uk/application/files/6015/7045/0668/SYBICS_LTP_Slides_27_September_WORK_IN_PROGRESS.pdf).

It was made up of:-

- 3 Life Stages
  Start Well
  Live Well
  Age Well

- 4 Themes
  Develop a population health system
  Strengthening our foundations
  Building a sustainable health and care system
  Broadening and strengthening our partnerships to increase our opportunity

- 5 Focus Areas
  Best start in life
  Reduce harm from smoking, alcohol and obesity
  Improve cardio-respiratory health
  Improve mental health and wellbeing
  Early diagnosis and increased survival from cancer

Rotherham had its own Place Plan focussing on Rotherham's integration and partnership. In order to access extra Government funding at a regional level, South Yorkshire and Bassetlaw had produced its own vision for the future of the ICS.

Although the themes were a little different, the Plan was similar to that of the Rotherham Place Plan. It provided another "arm" in terms of working at scale and place.

Resolved:- That the Plan be noted and circulated to the Board.
ACTION:- Becky Woolley

56. PHASE ONE: REDESIGN OF THE JOINT STRATEGIC NEEDS ASSESSMENT

Gilly Brenner, Public Health Specialist, gave a presentation of the redesigned Joint Strategic Needs Assessment website which had been redeveloped in light of feedback received with regard to making it more relevant/interactive and presenting data differently.

The redesign had involved the purchase of new software, re-evaluating what sort of data was wished to be included and links between the different data sources.

Phase 1 was nearing completion with the website to go live in the New Year (www.rotherham.gov.uk/data).

Attention was drawn to:-

- Information would include the population of Rotherham, ethnicity makeup, health behaviours, culture and leisure, transport, climate change, Housing, Children's Services, health care etc. and include a breakdown by Ward
- The links would be explicit and bring any patterns into context
- The JSNA would be used to develop and drive policy

- Map of community assets was part of Phase 2 as well community voice
- Need to make really clear the "so what"
- Signup option to receive a quarterly newsletter

Discussion ensued with the following issues raised:-

- Was there an ability to look at correlations and if not could you download from the website to carry out the exercise yourself?
  Excel spreadsheets could be downloaded to enable that work to take place
- The Fire and Rescue Service had a similar facility and mapped where home safety checks etc. had been carried out. Could the 2 systems coincide?
  If the Service were happy for their datasets to be made public a template could be shared and populated
- VAR had updated the GISMO directory which contained information regarding community assets. Could it be linked to the JSNA?
  It had been the intention to host a map where the physical assets were and have a link straight to GISMO
- How did it help Healthwatch answer the question on health and inequalities between Wards and disparity in life expectancy?
  Some of that will be drawn out of the recommendations that were in there. It would provide the evidence and fighting power to keep fighting those battles and show a continuing problem and issue that existed
- Ward profiles were not included as yet due to the Ward boundary changes that were to come into effect in May 2020

Resolved:- That the presentation be noted.

57. SUICIDE PREVENTION AND SELF-HARM REDUCTION PLAN - UPDATE

Ruth Fletcher-Brown, Public Health Specialist, presented the Rotherham Suicide Prevention and Self-Harm Action Plan 2019-2021.

The previous action plan had been a much lengthy document; the refreshed document focussed on 4 key areas which was in line with a report produced by the Samaritans in conjunction with Exeter University.

The key areas were:-

- Working with the media in relation to suicide prevention
- Establishing, implementing and evaluating one real time surveillance data system across South Yorkshire
- Supporting those people bereaved and affected by suicide
- 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

Consultation had taken place with partners and to the Mental Health and Learning Disability Transformation Group. Scrutiny had also taken place by the Health Select Commission.

AnneMarie Lubanski drew attention to the Zero Suicide Alliance Training (https://www.zerosuicidealliance.com/) which she would encourage all managers to undertake.

Resolved:- That the report be noted.

58. SAFEGUARDING ADULTS BOARD ANNUAL REPORT AND ROTHERHAM SAFEGUARDING CHILDREN'S PARTNERSHIP ANNUAL REPORT

Terri Roche, RSAB Member for Public Health, presented a powerpoint giving an overview of both the Rotherham Safeguarding Adults Board and the Rotherham Safeguarding Children's Partnership Annual Reports 2018/19 highlighting the following:-

Achievements 2018/19

- Worked with Children's Safeguarding Partnership to develop a joint self-assessment for all partners to complete electronically
- Launched a new 3 year strategic plan for 2019-22
- Worked across South Yorkshire to update and refresh the Principles and Approach to Safeguarding
- Safeguarding Awareness Week 2018

Common Themes

- Mental Health - RDaSH Board and Sub-Group members, Chair of Workforce Training and Development Group
- Self-Neglect - Policy for Self-Neglect and Hoarding early 2020
- Domestic Abuse – working with SRP and Children's Services to ensure shared learning
- CSE – close partnership working and monitoring
- Users and Carers – attendance at Carers Group and VAR events

Future

- Case file audits/quality assurance, continue to challenge
- Assurance (Safeguarding and Learning Disability), SAR action plans and dissemination, advocacy take up)
- Update the training plan and deliver training across the Partnership
- Campaigns - financial abuse, self-neglect, discriminatory abuse and physical abuse. Posters and leaflets
- Development (joint work with Community Safety and Children's Boards)

Rebecca Wall, Head of Safeguarding, drew attention to the following points in the Rotherham Local Safeguarding Children Board annual report:-

- The Board had ceased to exist as from 19th September, 2019, and was now replaced by the Rotherham Safeguarding Children Partnership
- Rotherham's Lifestyle Survey, provided the ability to reflect the voice of the young people
- The performance dataset and partnership work showed the biggest issues for Rotherham were the increased demand, journey of improvement, how to stabilise the demand and effectiveness
- Clear performance framework allowing audits of work – need to refine/improve timescales
- Where possible right child with the right plan and right care
- Very targeted actions/high level of accountability which allowed real positive discussions and focus on what partners thought needed to happen
- A lot of work in the past year to move from the LSCB to the Partnership as well as a real connectivity between the Adults Board, SRP and HWBB
- One of the key priorities for the Board had been linked into the Place Plan
- 2019/20 priorities:-
  Safe at Home
  Safe in Community
  Safe Systems

Discussion ensued with the following issues raised/highlighted:-

- The electronic self-assessment was working very well
- Possible cessation of the Intensive Intervention Programme Therapeutic Care for Looked After Children
  It was clarified that the Programme was currently under review. Careful consideration was being given to future funding with feedback being taken into account

Resolved:- That the Rotherham Safeguarding Adults Board and Rotherham Safeguarding Children's Partnership's annual reports 2018/19 be noted.

59. ISSUES ESCALATED FROM PLACE BOARD

A copy had been circulated previously of the ICP Digital Strategy to enable Board members to make comments. This was a key part of the Place Board's work.

60. FUTURE AGENDA ITEMS

Loneliness
Lifestyle Survey focussing on Health and Wellbeing issues
Indices of Multiple Deprivation

61. ROTHERHAM INTEGRATED CARE PARTNERSHIP BOARD - 4TH SEPTEMBER AND 2ND OCTOBER, 2019

The Board noted the minutes of the Rotherham Integrated Care Partnership Place Board held on 4th September and 2nd October, 2019.

62. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting be held on Wednesday, 22nd January, 2020, commencing at 9.00 a.m. at Wentworth Woodhouse.

BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	22nd January 2020
	LEAD OFFICER	Ruth Fletcher-Brown Public Health Specialist Rotherham Metropolitan Borough Council
	TITLE:	Rotherham Loneliness Action Plan 2020 – 2022

Background

1.1 Loneliness is not a new issue, but it is being recognised as a major public health issue.

1.2 Research has shown that loneliness is as harmful to our health as smoking 15 cigarettes a day. Loneliness has been linked to numerous health issues like coronary heart disease, stroke, depression, cognitive decline and an increased risk of Alzheimer's.

1.3 If people feel connected to others it can reduce the risk of mortality or developing certain diseases. There is some evidence to suggest that people who are lonely are more likely to place a higher demand on public services, for example visiting their GP and A&E more often.

Key Issues

2.1 Loneliness is a priority within the Health and Wellbeing Board Strategy (Aim 4) and a priority within the refreshed Place Plan.

2.2 Loneliness can fluctuate over the life course and most people at some point in their life will experience loneliness. It is difficult to say what exactly causes loneliness but there are some known trigger factors which can be seen at an individual, community and societal level.

2.3 In order to tackle loneliness and promote good social connections a response is required from individuals, communities, statutory partners, voluntary and community sector and local businesses.

2.4 Actions to tackle loneliness can be very simple and in many cases low cost, building on local assets.

Key Actions and Relevant Timelines

3.1 Draft action plan to go out to partners of the Health and Wellbeing Board for consultation during January 2020.

3.2 Final action plan to be signed off by the Health and Wellbeing Board March 2020.

3.3 Better Mental Health for All Group to oversee the implementation of the Loneliness Action Plan.

3.4

3.5	Bimonthly updates to be provided to the Mental Health and Learning Disability Transformation Group. Quarterly updates to the Place Board. Annual updates to the Health and Wellbeing Board.
Recommendations	
4.1	Note the draft plan and agree the timescales for consultation.
4.2	Health and Wellbeing Board to ensure that their organisation comments and contributes to the draft plan.
4.3	Health and Wellbeing Board to receive the final version in March 2020.

Rotherham Loneliness Action Plan 2020 – 2022

Introduction

Vision Statement:

People of all ages in Rotherham feel more connected to others and loneliness is reduced.

Introduction

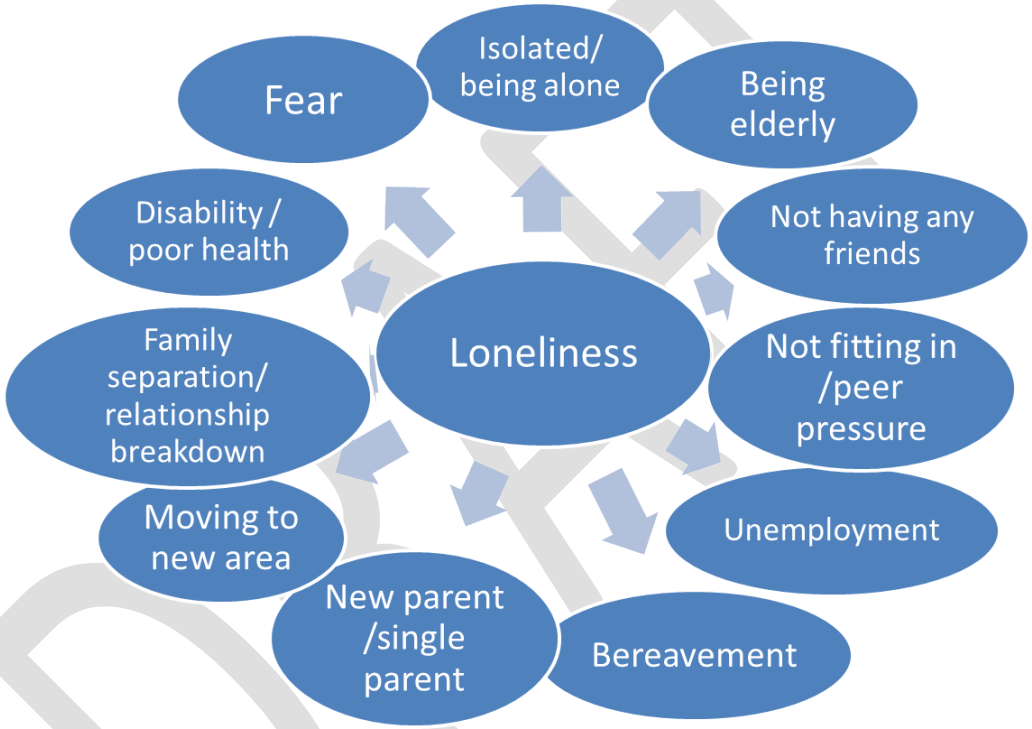
Loneliness is a very personal issue and people will describe it very differently. For the purposes of this action plan the following definition will be used for loneliness:

"Loneliness can be defined as a subjective, unwelcome feeling of lack or loss of companionship. It happens when we have a mismatch between the quantity and quality of social relationships that we have, and those that we want." Perlman, D. and Peplau, 1981, cited in HM (2018), 'A connected society: a strategy for tackling loneliness'.

The way people lead their lives in society is changing, for example the nature of jobs has changed with developments in technology which means more solitary working. Many of the public services are moving towards a digital offer which means less human interaction. Whilst this can bring many positives it has led to changes in the way we now live, work and interact with each other. Loneliness is not a new issue, but it is being recognised as a major public health issue. Research has shown that loneliness is as harmful to our health as smoking 15 cigarettes a day. Loneliness has been linked to numerous health issues like coronary heart disease, stroke, depression, cognitive decline and an increased risk of Alzheimer's. If people feel connected to others it can reduce the risk of mortality or developing certain diseases. There is some evidence to suggest that people who are lonely are more likely to place a higher demand on public services, for example visiting their GP and A&E more often. Anecdotal evidence from frontline staff suggests that some demands placed on public services in Rotherham may be due in part to individuals feeling lonely.

"Young or old, loneliness doesn't discriminate." Jo Cox

Loneliness can fluctuate over the life course and most people at some point in their life will experience loneliness. It is difficult to say what exactly causes loneliness but there are some known trigger factors which can be seen at an individual, community and societal level. Some of the factors are illustrated in the picture below:



Other factors which operate at community and societal levels include, transport, neighbourhood safety, access to services, financial hardship, insular communities, stigma and discrimination, digital technology and work life balance.

Loneliness affects all ages within society and national and local data reflects this. National estimates are that between 55 and 18% of the adults in the UK feel lonely often or always. Despite this there is a great deal of stigma attached to loneliness with a third of the adult population stating that they would be too embarrassed to say that they were lonely, making it more difficult for people to ask for help. (Mental Health Foundation (2010) The lonely society; https://www.mentalhealth.org.uk/sites/default/files/the_lonely_society_report.pdf)

It is because loneliness presents as a public health issue that a whole system response is required in Rotherham. In Rotherham actions to address loneliness are referenced in the Health and Wellbeing Board Strategy (Aim 4) and the refreshed Place Plan. This important public health issue has been championed by the Chair of the Health and Wellbeing Board (H&WbB).

Rotherham Loneliness event, 24th September 2019- Working Together to Tackle Loneliness

On the 24th September 2019 partners of the H&WbB were invited by Councillor Roche to a workshop to share their experiences of loneliness, showcase some of the many examples of good practice and to start to contribute to Rotherham's action plan to address this public health issue.

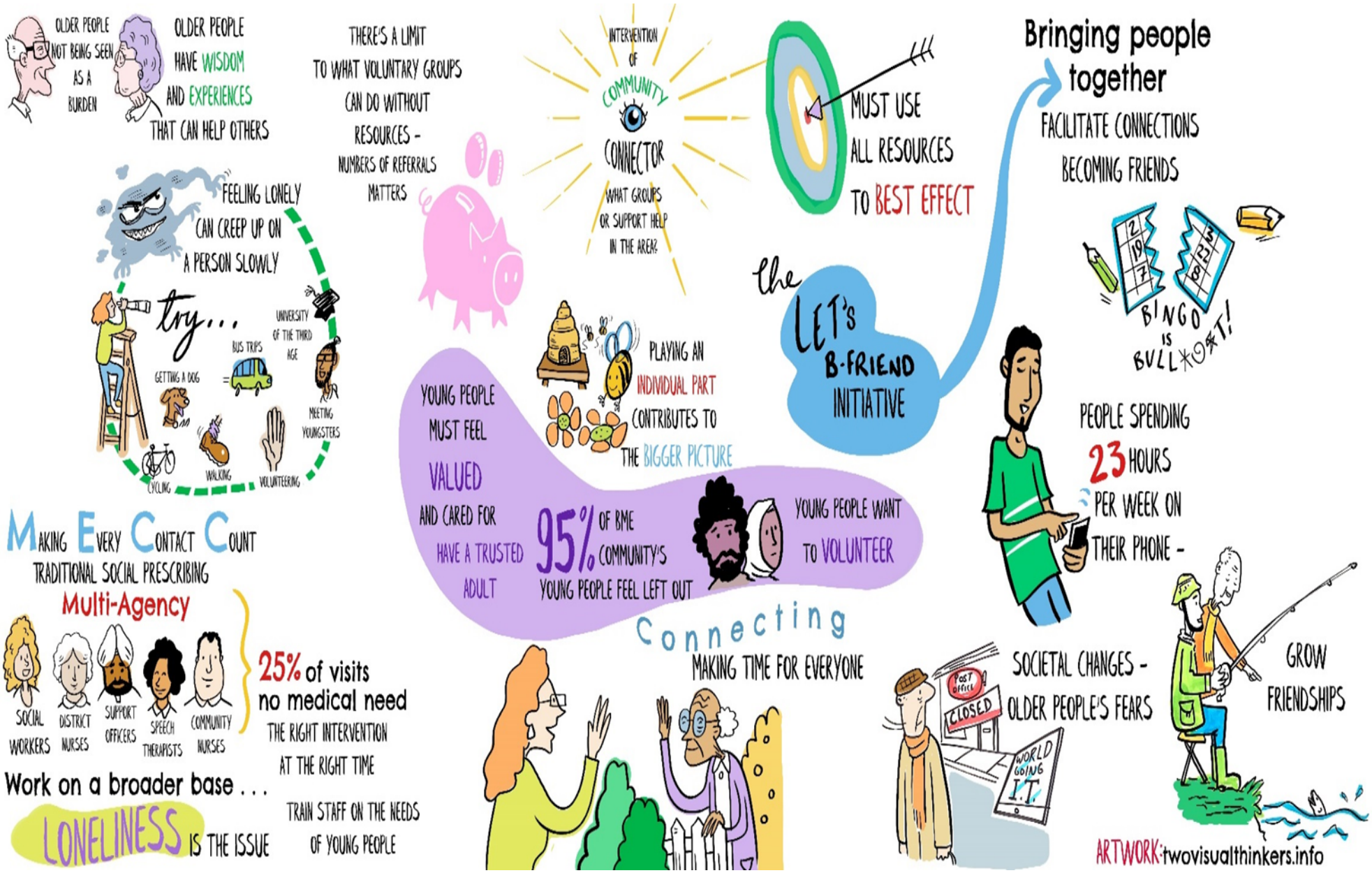
The day focused on:

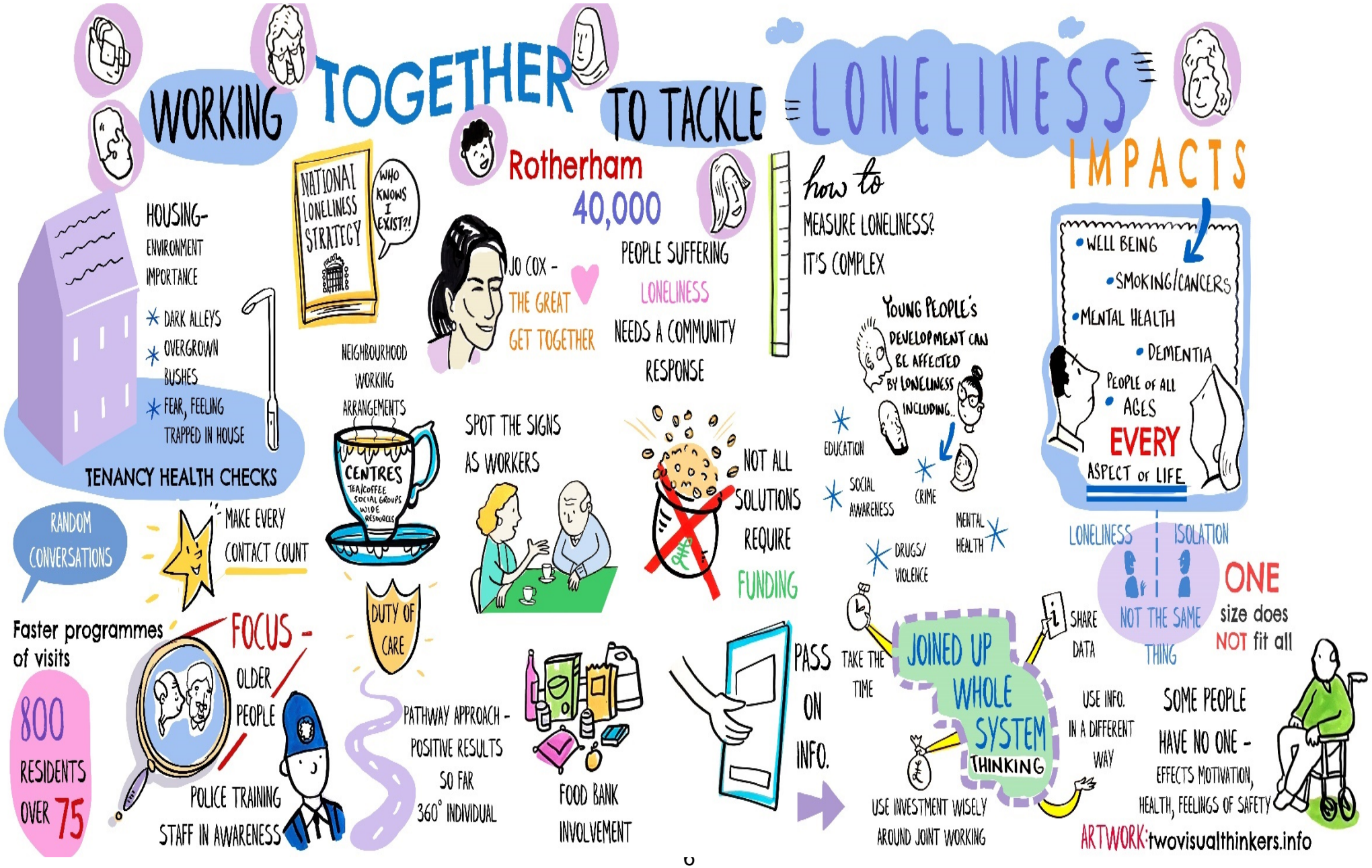
- The vision for Rotherham and what good looks like.
- What is working well?
- The gaps and opportunities.

The discussions from the event were captured visually and appear in this action plan. A full summary appears in Appendix 1. The presentations and discussions highlighted the abundance of initiatives across Rotherham which are helping address loneliness and build social connections, particularly in the voluntary and community sector. Delegates gave example of positive joint working between the different sectors and commented on the fact that loneliness is seen as a cross sector issue. There are many opportunities to take this work forwards including the need to work with people, empowering them to find solutions.

The other themes which were raised on the day by partners these were:

- the value of partnership and neighbourhood working
- the great contribution the voluntary and community has and can make to this issue
- the need for intergenerational and inclusive working
- the need to identify and reach out to people
- the need for better communication, marketing and information technology.


OLDER PEOPLE NOT BEING SEEN AS A BURDEN
OLDER PEOPLE HAVE WISDOM AND EXPERIENCES THAT CAN HELP OTHERS
THERE'S A LIMIT TO WHAT VOLUNTARY GROUPS CAN DO WITHOUT RESOURCES - NUMBERS OF REFERRALS MATTERS
INTERVENTION OF COMMUNITY CONNECTOR
WHAT GROUPS OR SUPPORT HELP IN THE AREA?
MUST USE ALL RESOURCES TO BEST EFFECT
Bringing people together
FACILITATE CONNECTIONS
BECOMING FRIENDS
FEELING LONELY CAN CREEP UP ON A PERSON SLOWLY
try...
BUS TRIPS
UNIVERSITY OF THE THIRD AGE
GETTING A DOG
MEETING YOUNGSTERS
WALKING
VOLUNTEERING
CYCLING
the LET'S B-FRIEND INITIATIVE
BINGO IS BULLSHIT!
PLAYING AN INDIVIDUAL PART CONTRIBUTES TO THE BIGGER PICTURE
YOUNG PEOPLE MUST FEEL VALUED AND CARED FOR
HAVE A TRUSTED ADULT
95% OF BME COMMUNITY'S YOUNG PEOPLE FEEL LEFT OUT
YOUNG PEOPLE WANT TO VOLUNTEER
PEOPLE SPENDING 23 HOURS PER WEEK ON THEIR PHONE -
Making Every Contact Count
TRADITIONAL SOCIAL PRESCRIBING
Multi-Agency
SOCIAL WORKERS
DISTRICT NURSES
SUPPORT OFFICERS
SPEECH THERAPISTS
COMMUNITY NURSES
25% of visits no medical need
THE RIGHT INTERVENTION AT THE RIGHT TIME
Work on a broader base . . .
LONELINESS IS THE ISSUE
TRAIN STAFF ON THE NEEDS OF YOUNG PEOPLE
Connecting
MAKING TIME FOR EVERYONE
SOCIETAL CHANGES - OLDER PEOPLE'S FEARS
POST OFFICE
CLOSED
WORLD GOING I.T.
GROW FRIENDSHIPS
ARTWORK:twovisualthinkers.info


WORKING TOGETHER TO TACKLE LONELINESS
Rotherham
40,000
PEOPLE SUFFERING LONELINESS NEEDS A COMMUNITY RESPONSE
NATIONAL LONELINESS STRATEGY
WHO KNOWS I EXIST?!
JO COX - THE GREAT GET TOGETHER
how to MEASURE LONELINESS? IT'S COMPLEX
IMPACTS
WELL BEING
SMOKING/CANCERS
MENTAL HEALTH
DEMENTIA
PEOPLE OF ALL AGES
EVERY ASPECT OF LIFE
YOUNG PEOPLE'S DEVELOPMENT CAN BE AFFECTED BY LONELINESS INCLUDING..
EDUCATION
SOCIAL AWARENESS
CRIME
MENTAL HEALTH
DRUGS/ VIOLENCE
HOUSING- ENVIRONMENT IMPORTANCE
DARK ALLEYS
OVERGROWN BUSHES
FEAR, FEELING TRAPPED IN HOUSE
TENANCY HEALTH CHECKS
NEIGHBOURHOOD WORKING ARRANGEMENTS
CENTRES TEA/COFFEE SOCIAL GROUPS WIDE RESOURCES
RANDOM CONVERSATIONS
MAKE EVERY CONTACT COUNT
DUTY OF CARE
SPOT THE SIGNS AS WORKERS
NOT ALL SOLUTIONS REQUIRE FUNDING
LONELINESS
ISOLATION
NOT THE SAME THING
ONE size does NOT fit all
Faster programmes of visits
800 RESIDENTS OVER 75
FOCUS - OLDER PEOPLE
POLICE TRAINING STAFF IN AWARENESS
PATHWAY APPROACH - POSITIVE RESULTS SO FAR 360° INDIVIDUAL
FOOD BANK INVOLVEMENT
PASS ON INFO.
TAKE THE TIME
JOINED UP WHOLE SYSTEM THINKING
SHARE DATA
USE INFO. IN A DIFFERENT WAY
USE INVESTMENT WISELY AROUND JOINT WORKING
SOME PEOPLE HAVE NO ONE - EFFECTS MOTIVATION, HEALTH, FEELINGS OF SAFETY
ARTWORK:twovisualthinkers.info

Governance

The implementation of this loneliness action plan will be overseen by the Better Mental Health for All Group. These meetings are chaired by a Consultant in Public Health and have representation from H&WbB partners. The multi-agency group meets bimonthly and is tasked to implement this plan and the Better Mental Health for All Action Plan. The Partners represented on this group include:

- Crossroads, representing the Adult VCS
- Rotherham Clinical Commissioning Group (RCCG)
- RDaSH (mental health provider)
- Rotherham NHS Foundation Hospital Trust
- RMBC- Adult Care, Housing and Public Health (including Neighbourhoods)
- RMBC Children and Young People's Services
- RMBC Communications
- Rotherham United Community Sports Trust (RUCST)
- South Yorkshire Police

Progress against this action plan will be reported to the Mental Health (MH) and Learning Disability (LD) Transformation Group, a subgroup of the Rotherham Place Plan Board. Annual updates will be given to the Rotherham Health and Wellbeing Board.

National Picture

- Over 9 million adults are often or always lonely. (British Red Cross and Co-op)
- 43% of 17 – 25-year olds using Action for Children services experienced problems with loneliness. (Action for Children)
- Over half of parents (52%) have had a problem with loneliness with 21% feeling lonely in the last week. (Action for Children)
- 50% of disabled people will be lonely on any given day. (Sense)
- For 3.6 million people aged 65 television is the main form of company. (Age UK)
- 38% of people with dementia said that they had lost friends after their diagnosis. (Alzheimer's Society)
- 8 out of 10 carers have felt lonely or isolated as a result of looking after a loved one. (Carers UK)
- More than 1 in 10 men say they are lonely but would not admit it to anyone. (Royal Voluntary Service)

- 58% of migrants and refugees in London described loneliness and isolation as their biggest challenge. (The Forum)
- More than 1 in 3 people aged 75 and over say that feelings of loneliness are out of their control. (Independent Age)

- Loneliness costs UK employers £2.5 billion per year. (Co-op)
- Three out of four GPs say they see between 1 and 5 people a day who have come in mainly because they are lonely, and one in ten sees between six and ten such patients daily. (Campaign to End Loneliness)
- Disconnected communities could be costing the UK economy £32 billion every year. (Big Lunch)
- £1 invested in tackling loneliness saves society £1.26. (Public Health England)
- 81% of people agreed that there are lots of actions everyone can take in their daily lives to help those feeling lonely. (British Red Cross and Co-op)

The Jo Cox Commission on Loneliness was inspired by the MP's vision that by working together a real difference could be made to the lives of those affected by loneliness. Thirteen charities and businesses worked together to look at what could be done to tackle the issue and the resulting report sets out their findings: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/rb_dec17_jocox_commission_finalreport.pdf.

The strong message from the report is that tackling loneliness will require a response from public sector staff, employers and businesses, communities and individuals.

In response to the work of the Jo Cox Commission on Loneliness, the Government committed to implementing many of the recommendations including the publication of a national strategy to tackle loneliness which was published in October 2018. The national strategy acknowledges the role that every part of society needs to take in order to tackle loneliness. Action needs to be taken by local authorities, public and health services, businesses, voluntary sector, communities, families and friends to support a more connected society.

The Strategy set out the challenge of how national Government, Local Authorities, businesses and society can work together to promote social connections. These three guiding principles, together with the feedback from the stakeholder event, will form the basis of this action plan:

- Improve how organisations and services connect people at risk of experiencing loneliness.
- Make it easier to access information about local community groups, activities and support services.
- Catalyse the sharing of knowledge and good practice on tackling loneliness.

In January 2018, the Prime Minister tasked the Office for National Statistics (ONS) with developing national indicators of loneliness suitable for use on major studies to inform future policy in England, including people across society and of all ages. ONS worked with experts in the field to agree a working definition of loneliness, and ideal criteria for the indicators and for the collection of data.

In December 2018 the Office of National Statistics published guidance and analysis on the National Measurement of Loneliness. One of the recommendations made by researchers was that; *the introduction or preamble should not mention loneliness and should introduce the topic as focusing on the participant's relationships with others.* (ONS, (2018), *Testing of loneliness questions in surveys*. Accessed online: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/compendium/nationalmeasurementofloneliness/2018/testingoflonelinessquestionsinsurveys)

The Local Government Association (LGA) have produced a guide for councils to enable them to see how effectively they are tackling loneliness. The guide makes the case for this important public health issue to have a whole system preventative approach and encourages local areas to define the nature of loneliness in their local area, knowing who is at risk. https://www.local.gov.uk/sites/default/files/documents/22.28%20-%20Loneliness%20Must%20Know_02.pdf. The LGA guide comments that whilst many people may know about the need to make healthy lifestyle choices there is less awareness about the importance of having social connections.

One of the announcements in the 2019 NHS Long Term was for people to have more control over their health and more personalised case when they needed it. The introduction of link Workers for Primary Care Networks (PCNs), under the GP contract reforms, was one of the actions to address this. Social prescribing link workers are one of five additional roles being funded within primary care, to bring additional capacity into the multi-disciplinary team, under the Network Contract Directly Enhanced Services (DES).

With one in five GP appointments focusing on wider social needs, rather than acute medical issues, many GPs report that they spend significant amounts of time dealing with the consequences of poor housing, debt, stress and loneliness. Social prescribing and community-based approaches aim to assist with this by reducing pressure on clinicians like GPs, improving people's lives, helping with community resilience and ensuring that the needs of diverse and multi-cultural communities can be met.

https://www.england.nhs.uk/wp-content/uploads/2019/07/pcn-reference-guide-social-prescribing.pdf

Regional ICS

Tackling loneliness is a common challenge across the ICS that requires a response that is broader than can be delivered by health and care partners alone. Work to tackle loneliness was identified in March 2019 as one of the three priority areas in which to explore potential collaborative

work between Local Authorities in South Yorkshire and Bassetlaw and the South Yorkshire and Bassetlaw Integrated Care System. It is acknowledged that given the breadth and complexity of this area it will not be practically possible to scope out all existing activities that are taking place that contribute to promoting social connections and tackling loneliness. However, it makes sense to work with stakeholders in each place to understand the main areas of activity, the local plans to respond to the National Strategy and together identify any gaps, common challenges, barriers and potential opportunities that may benefit from collaborative action.

Local picture

Public Health England (PHE) profile data shows that in Rotherham:

- Just below half (47.5%) of adult social care users aged 18+ had as much social contact as they would like in 2017/18. For those aged 65+ this was 42.6%.
- In 2016/17 37.3% of adult carers aged 18+ had as much social contact as they would like. For those aged 65+ this was 44.1%.
- 32% of people aged 65 and over lived alone as at the 2011 Census. By ward this ranged from 24% in Anston and Woodsetts to 40% in Rotherham East.
- 7.3% of households were occupied by lone parent families as at the 2011 Census.

PHE plan to include loneliness indicators in the Public Health Outcomes Framework this year, which will give a more detailed picture for Rotherham. However, there have been some focused work with specific communities of interest in Rotherham to establish how loneliness affects them.

Older people

In January 2017 the Rotherham Older Peoples Forum (ROPF) secured funding from South Yorkshire Community Foundation to survey older people in Rotherham to find out exactly what loneliness means to them and the effect it has. The survey found that 82% of the respondents felt lonely sometimes or most of the time. The respondents commented that loneliness affected their confidence, motivation and health and wellbeing. Most often loneliness was triggered by a life event such as change in health or bereavement. The full report can be found below however the main summary points were:

- Loneliness is a feeling – it is how we perceive ourselves to be rather than physically being alone.
- Loneliness means different things to different people.
- There is a clear need to generate social activities in the more rural areas of Rotherham and to make sure information about available activities reaches older people in those areas.

- There are strong links between loneliness and mental health. People become unable to help themselves as it firstly affects their confidence and motivation which in turn affects their health, and so it becomes a downward spiral.
- The long-term effects of loneliness can be so profound we need to find effective ways to tackle it or the demand on statutory health and social care services will only continue to increase.

The older people consulted suggested three solutions; befriending support, personal self-help strategies and joining local groups.

https://www.varotherham.org.uk/wp-content/uploads/2017/11/Ropf-Report-on-Loneliness-2017.pdf

Tenants

Two focus groups were held with RMBC tenants in summer and autumn of 2019. Tenants were asked:

How often do you feel left out?
How often do you feel you like companionship?
How often do you feel isolated?

The majority of TARA members stated that they lived alone (75%) Tenants were more likely to say they were lonely if they were in poor health (self-described) or had recently arrived in the area. While the data set is small it does support national findings of the ONS.
Expanding TARA groups was the most common suggestion for how loneliness might be tackled in the area.

Young people

Nationally it is known that loneliness can be experienced throughout childhood, even amongst very young children and this is particularly the case where parents themselves experience loneliness. Some research has in fact indicated that younger people (16-24 year olds) may experience loneliness more often than older people. In Rotherham there has been little consultation with young people into their experiences of loneliness. Rotherham Public Health wanted to explore with young people what the issues were for them. Rotherham Children, Young People and Families Consortium were approached and asked to work with young people to provide a snapshot of youth loneliness in Rotherham.
The five organisations of the Children, Young People and Families Consortium held focus groups with 130 young people aged 10-25 years of age, between April and June 2019. These organisations were:

- Endeavour
- Clifton Learning Partnership
- YWCA Yorkshire

- Rush House
- United Multicultural Centre

The focus groups asked the young people the following questions:
- What the issues are for young people in relation to loneliness?
- How common is loneliness amongst young people?
- Are any triggers or sub-groups that can predict loneliness?
- What is working well and what could be done to alleviate the problems?

The focus groups found that loneliness was an important issue for the young people consulted. The following themes were important to the young people consulted:

- Having a relationship with a trusted adult.
- Having opportunities to celebrate diversity and difference, allowing young people to learn about each other.
- Giving young people opportunities to take on responsibilities, fundraising was given as an example.
- Educating others about loneliness and the signs and symptoms young people may present with.
- Supporting young people's emotional wellbeing since mental health and loneliness are inextricably linked.

Helpful resources on loneliness

- Bellis, A (2019), Tackling Loneliness, Briefing Paper, Number 8514, 5 August 2019, House of Commons Library. https://researchbriefings.files.parliament.uk/documents/CBP-8514/CBP-8514.pdf
- Campaign to End Loneliness, guidance for councils and commissioners. https://www.campaigntoendloneliness.org/%20guidance
- Department for Digital Culture, Media and Sport (2019), Loneliness Fact Sheet from the Community Life Survey for England 2018-19 https://www.gov.uk/government/statistics/community-life-survey-2018-19
- Jo Cox Commission on Loneliness: A call to action https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/rb_dec17_jocox_commission_finalreport.pdf
- Local Government Association (2018), Loneliness How do you know your council is actively tackling loneliness? https://www.local.gov.uk/sites/default/files/documents/22.28%20-%20Loneliness%20Must%20Know_02.pdf
- NHS England and NHS Improvement (2019) Social prescribing link workers: Reference guide for primary care networks; https://www.england.nhs.uk/wp-content/uploads/2019/07/pcn-reference-guide-social-prescribing.pdf
- Royal College of General Practitioners, (2018), Tackling Loneliness A Community Action Plan https://www.rcgp.org.uk/-/media/Files/News/2018/RCGP-tackling-loneliness-may-2018.ashx?la=en
- What Works Wellbeing (2018), What do we know about tackling loneliness. https://whatworkswellbeing.org/wp/wp-content/uploads/woocommerce_uploads/2018/10/briefing-tackling-loneliness-Oct-2018.pdf

Aim 1. To make loneliness everyone's responsibility.

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
Raise awareness amongst all partners, businesses and the general public of the importance of social connections. Create a social movement to empower people to see that everyone has a role in tackling loneliness Use the Rotherham Five Ways to Wellbeing as the campaign to encourage a whole society	• To develop clear and consistent messages in relation to loneliness, the affects and impact on people across the whole life course. • Partners of the H&WbB to use agreed messages in communications to their workforce and general public. • To develop clear self-care/self-help messages which encourage and help people to develop and maintain good social connections using the themes of Five Ways to Wellbeing:	Communication Leads and identified champions from all H&WbB partners.	Starting March 2020	• Consistent messages about loneliness which are supported and communicated by all H&WbB partners. • People living and working in Rotherham having a good understanding of how they can help themselves and others. • Five Ways to Wellbeing messages prominently used as a way of promoting wellbeing. • People reporting that they feel that they feel	

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
response to address loneliness.	To be Active To Connect To Give To keep Learning To Take Notice. • To develop clear messages about how people can look out for others. • To work with Comms colleagues to have a scheduled programme to promote these messages throughout the year, linking in with national campaigns where appropriate. • To promote and celebrate examples of good practice.			connected and supported by the people they live and work with.	
Utilise local assets to address loneliness and improve opportunities for people to	• H&WbB partners to understand how local assets can be used as community hubs. • Actions in place to use local assets as	H&WbB partners		• Creation of more community hubs/opportunities for people to connect.	

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
connect.	places for people to connect.				
Involve local people in coproducing solutions to tackle loneliness, utilising local assets.	• To work with local communities where loneliness is identified in Ward plans. • To work with community of interest groups to look at solutions to address loneliness. • To look to use local assets to address loneliness within geographical communities and communities of interest. • To share learning and best practice from ward activity with other areas.	Neighbourhoods, RMBC working with Elected Members Local community Communities of interest- CYPS, AC, H & PH, VCS and partners of the H&WbB.	Ward plans- work ongoing.	• More inclusive and connected communities. • More people engaged in community volunteering roles. • Empowered communities which use their local assets to address loneliness. • Shared good practice being adopted in other areas.	
For partners to mitigate against loneliness in the planning, commissioning and development of	• To agree a set of measures to ensure social connectivity is considered in place-based initiatives such as planning,	Champions from H&WbB.		• Evidence of social connections being considered in place-based initiatives such as planning, commissioning of	

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
services/policies.	commissioning of services, housing and transport.			services, housing and transport.	

Aim 2. Improving how organisations and services in Rotherham connect people at risk of experiencing loneliness to support.

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
Identify the levels of loneliness in Rotherham overall, paying attention to specific communities, groups and in relation to rurality.	• To include the new Public health outcomes Framework data on loneliness in JSNA. • To build on the initial needs analysis with older people, young people and tenants, identifying other specific groups/communities to listen to. • To ensure that the JSNA makes specific reference to loneliness and its impact on specific groups/communities.	Neighbourhoods, PH with support from partners of the H&WbB.		• JSNA data on loneliness informing commissioning intentions and provision of services. • Service providers and commissioners having a good understanding of the needs of vulnerable and at-risk groups.	

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
	• Partners of the H&WbB to make use of the JSNA data in their commissioning intentions and provision of services thereby ensuring that actions are not contributing to increased loneliness.				
Agree measures/questions for identifying people at risk of experiencing loneliness which can be used by all partners.	• To agree and test questions as part of the MECC pilot in the south of the borough. • To finalise questions and use in all MECC training. • To roll out MECC and loneliness across Rotherham.	PH working with H&WbB partner organisations including VAR.		• Staff from H&WbB partners using the same questions/measures to identify people at risk of loneliness. • Number of staff trained in MECC and loneliness. • Case studies showing how people have been identified and signposted.	
Raise awareness amongst public sector, local businesses and communities of the causes, triggers and impact of loneliness, using training and	• To incorporate this into MECC training. • To update training with any new information from the JSNA. • To use the Five Ways to Wellbeing as Rotherham's local	PH working with H&WbB partner organisations		• Frontline staff aware of at-risk groups and trigger points for loneliness. • Increased knowledge used to identify people and signpost to appropriate support	

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
local campaigns.	campaign to promote the importance of good social connections. • To coproduce with groups simple actions everyone can take to look out for others.			and give tailored self-help self-care information.	
Work with Primary Care Network (PCN) to agree actions to address loneliness.	• Provide MECC training for Link Workers. • To assist Link Workers in understanding their local communities and the assets available which support good social connections. • Link Workers operating within the Making Every Contact Count model.	PCN, PH and Voluntary Action Rotherham and H&WbB partners.		• Link workers having attended MECC and loneliness training. • Link Workers working within the MECC model. • Reduction clinician time spent supporting people whose main issue is loneliness. • Improved wellbeing of people experiencing loneliness.	
Engage local businesses/employers in actions to combat loneliness.	• To co-produce with businesses suggested actions to combat loneliness. • To look to include loneliness as a theme within the Be Well@Work Scheme.	PH working with colleagues across South Yorkshire and local businesses.		• Loneliness is an element within the Be Well@Work scheme. • Evidence of good practice from employers/businesses in their actions to address loneliness from both within the	

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
	(For example; allowing community groups use of premises, staff trained to identify people at risk, staff time to have conversations with vulnerable people).			workforce and to the wider community. • Shared examples of good practice.	
Employers of the H&WbB to consider what actions they can take to encourage staff to have good social connections both in and out of work, paying attention to the remote and internet-reliant workforce.	• To work with HR in H&WbB partner organisations to develop policies and working practices which outline responsibilities for employers, managers and staff in maintaining good social connections.	HR Leads from H&WbB organisations working (linking into the Be Well @ Work)		• Specific policies and practices being implemented which support good social networks. • Evidence of initiatives where staff support each other. • Evidence of workforce supporting the wider community through volunteering opportunities.	

Aim 3 Make it easier for people living and working in Rotherham to access information about local community groups, activities and support services for loneliness.

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
To promote one directory of information for the general public and practitioners to access. (GISMO)	• Partners of the H&WbB to agree to use and promote one directory of services in Rotherham- GISMO. • To ensure that this one directory is maintained.	VAR working with H&WbB partners.		• One directory of services which is used by all H&WbB partners. • Website advertised and promoted widely across the borough. • Directory updated regularly.	
Increase awareness amongst the general public of opportunities to access free and affordable activities.	• Promoting the one directory (GISMO) to people who live and work in Rotherham. • All H&WbB partners to promote the activities/initiatives they deliver using the Five Ways to Wellbeing branding.	VAR, Comms Leads from H&WbB partners.		• People living and working in Rotherham know where to access information on local activities.	

Aim 4. Spread good practice and encourage knowledge sharing on tackling loneliness across Rotherham.

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
Build up the evidence base of what works locally.	• To learn from and disseminate good practice at a ward & community level. • To consider holding network/ sharing events for practitioners and communities to come together and share good practice.	Neighbourhoods, PH working with H&WbB partners.		• Better communication about what works amongst partner organisations. • Better use of resources. • Strong local evidence base on which to build upon.	
Encourage communities/businesses to engage with national based initiatives.	• Support local communities/employers to take part in initiatives like Jo Cox Great Get Together weekend & #MincePieMoments Christmas campaign	Neighbourhoods, PH, H&WbB partner leads working with local communities schools, colleges, University and local businesses.		• Reduction in stigma surrounding loneliness. • Greater community cohesion. • Examples of national initiatives being implemented in Rotherham. • Positive media coverage.	

Progress Summary

Date of meeting	Actions Outstanding	Lead	Actioned By

Grey	Not due to start
Red	Not on target
Amber	Almost achieving target
Green	Achieving Target On track
Blue	Complete

BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	22nd January 2020
	LEAD OFFICER	Bev Pepperdine Performance Assurance Manager Rotherham Metropolitan Borough Council
	TITLE:	Voice of the Child Rotherham Lifestyle Survey 2019

Background

1.1 The Voice of the Child Lifestyle Survey is an annual anonymous survey that aims to capture the voice and views of young people around topics relating to their health, wellbeing, their views about Rotherham and their future.

1.2 The full results for 2019 are detailed in the borough wide annual report.

1.3 In 2019, 61% of the relevant population participated in the survey.

1.4 The survey results give the council and their partners an insight into the experiences of children and young people living in the borough. Partners will receive data with information from the results and trend data specific to their service in order to highlight where resources may be required to improve the health of children and young people.

1.5 Schools receive their own confidential results that they can compare to the borough wide results that can be used to plan resources and shape curriculums.

1.6 The report covers key findings from the 2019 Borough Wide Lifestyle Survey Report, along with trends from previous years.

1.7 The key areas that are particularly relevant to Health and Wellbeing Board, from the overall 2019 Lifestyle Survey report are from sections:

- A Little Bit About Me
- Healthy Eating & Exercise
- Feelings
- Safeguarding
- Young Carers
- Smoking, Alcohol & Drugs
- Sexual Health & Relationships

Key Issues

2.1 The results of the 2019 survey have been compared to previous years' and the Health and Wellbeing summary report highlights what appears to be working well and areas that may be a cause for concern.

2.2 The full results from the borough-wide survey can be found in the Lifestyle Survey borough wide report, which a copy can be requested. The 2019 results included in this report are extracted from the 2019 borough wide report.

2.3 Schools, council services and partners will receive their data and in return there is an expectation that they will provide feedback on how they have used the results to improve or shape their services to make a difference to the lives of children and young people.

2.4 **What is working well?**

The trend data shows that the following areas have improved:

- More children and young people have said they are eating the recommended portions of fruit and vegetables
- Less children have said they would choose to drink high sugar drinks and high energy drinks
- Young people have said that safety around Rotherham bus and train stations has improved
- Less young people have identified themselves as a young carer
- Young people who identified themselves as young carers feel more confident that they could continue with further education
- Less young people have said they have tried regular cigarettes
- Less young people have said they have tried alcohol
- More young people have been educated about child sexual exploitation

2.5 **What are we worried about?**

- Young people have told us that improving the mental health of young people needs to be a priority
- Less young people have said they are visiting their dentist on a 6 monthly basis
- Less young people have said they are drinking the recommended amount of water each day
- Young people who identified themselves as a young carer, have said it is having an impact on their lives
- Less young people have said their home is a smoke free home
- More young people have said they have tried an electronic cigarette
- Although slightly less young people have said they have tried drugs, the types of drugs they are trying are the harder type of drugs.
- Although slightly less young people have said they have had sexual intercourse, out of those who said they have, more of them have done this after drinking alcohol or taking drugs.

Key Actions and Relevant Timelines

3.1 The CYPS Performance Team will be presenting the Lifestyle survey results to:

- Improving Lives Scrutiny Sub Group – 21st January 2020
- Children & Young People Partnership Board - 28th January 2020
- South Yorkshire Passenger Transport Executive – 10th March 2020
- Voice Influence Partnership – March 2020

3.2 Copies of the borough wide report and if required summary information will be provided to:

- Safer Rotherham Partnership
- South Yorkshire Police
- Young Carers Provider – Barnados
- Commissioning Team CYPS
- Commissioned Providers
- Youth Cabinet
- LAC Council
- CAMHS
- Regeneration & Environment

	• Rotherham Local Children's Safeguarding Board
Recommendations	
4.1	Note the report and consider the approval of its content.
4.2	Identify any actions to address key areas.
4.3	Identify if the distribution of information needs to be expanded.
4.4	Identify partners who feel may be accountable for acting upon results.
4.5	Endorse the recommendation of CYPS DLT that the survey continues for future years.

Rotherham Metropolitan Borough Council

Rotherham
Voice of the Child
Lifestyle Survey
2019

Health & Wellbeing Report
Inc. Trend Data

Contents

Acknowledgements
We would like to express our thanks to all of the Head teachers and staff at schools who co-ordinated the completion of the Lifestyle Survey from 2014 to 2019.

In 2019, 12 out of 16 secondary schools in Rotherham participated in the survey along with 3 pupil referral units. In 2019 the survey was also offered to students at all Special Schools using their new survey which has been designed with support from the pupils and staff. Schools participating in the survey gave their commitment to enabling pupils to have their voice heard to share their views on health, well-being, safety and their views about Rotherham and their local areas.

Also thank you to the 4,260 young people who participated and shared their views by taking part in the 2019 survey. Out of the 4,260 young people, there are 4,091 young people in years 7 and 10. (It is these results that are the basis of this report). The additional 169 pupils are either in Y9 at Maltby who requested that a dedicated Y9 survey or pupils from special schools. Each of these will receive a report detailing these results.

1. Background Information

This report presents the findings from the 2019 Lifestyle Survey from the year 7 and year 10 results. Also included in the Health & Wellbeing report will be trend information that could go back as far as 2014 or the year a particular question was introduced. The report will highlight the changes from previous years, compared with 2019.

It will be highlighted in the body of the report, the services or partners that the results relate to. This will enable services to see the views of young people about the services they support or provide.

Each year the survey is open to all pupils in Y7 and Y10 at secondary schools and pupil referral units. Since 2017 the survey has been offered to those who are elective home educated and special schools. Pupils are 11/12 and 14/15 years of age. In 2019 the survey was open from Tuesday 7th May 2019 and closed on Wednesday 17th July 2019. Overall in this cohort for 2019 there were 6696 young people attending a secondary school, a pupil referral unit or electively home educated.

This survey is open annually for young people in Rotherham and is the only opportunity regularly given for so many young people to have their say about their health, well-being and their future. The sample of 4091 young people, who chose to participate in the 2019 survey from Y7 and Y10, is 61**%** of the relevant population. A further 142 pupils from Maltby Y9 participated in the survey, following a request from the Personal, Social & Health Education (PSHE) Lead staff member at Maltby. These results have not been included in the 2019 borough wide report, but they have been shared confidentially with Maltby. There were a further 27 pupils from special schools who participated in their newly designed survey, again these results will be shared confidentially with the schools but were not included in the 2019 borough wide report.

The lifestyle survey provides an opportunity for young people to have their views and voices heard; this gives the council and their partners an insight into the experiences of children and young people living in the borough. This contributes to measures that partners have in place to monitor progress against their aims and objectives.

The questions in the survey are not mandatory, following a request from young people; they wanted to choose to opt out of questions if they felt it was not relevant to them.

Schools are able to use their own individual school reports to assist them in gauging how well they are meeting their own health and wellbeing objectives and help shape their PSHE curriculum. This is highlighted as outstanding practice and gives evidence in relation to Ofsted grade descriptors.

"*Grade descriptors: the quality of the curriculum in PSHE education Note: The imaginative and stimulating PSHE education curriculum is skilfully designed, taking into account local health and social data and the full range of pupils' needs, interests and aspirations. The programme ensures highly effective continuity and progression in pupils' learning across all key stages. "*

Information about the lifestyle survey and the content of the survey are shared with parents/carers and they are given the opportunity to ask school any questions about the survey. Schools are encouraged to share their results with pupils, parents and carers.

2. Executive Summary

In total 4091 pupils from Y7 and Y10 participated in the 2019 lifestyle survey out of a potential 6696 young people who attend either secondary school, elective home educated or pupil referral unit in this age range. This is an overall 61% participation rate.

Overall since 2014, 21,440 young people have shared their views with us through the Lifestyle Survey, on average this being 3,573 per year.

Four schools did not offer the survey to pupils in 2019, two of which have historically not participated. One school made us aware they would not be in a position to offer the survey and one school did not communicate their reason for not participating. Two schools, who have previously not offered the survey to their pupils, did participate in 2019.

2.1 Results

The results of the 2019 Lifestyle survey will be compared to the results from previous years which may go back as far as 2014 or a year when a particular subject was introduced. The results show where there has been an improvement or where there appears to be an issue and this will be highlighted in the trend information. Each of these will be highlighted to the service or partner organisation the data is relevant to, so that they can take any necessary action. All areas that show what is working well and what we may be worried about will be highlighted to schools to enable them to benchmark against their own individual school results.

The results from the 2019 survey, which show a comparison to one previous year for all questions included in the lifestyle survey can be found in the full borough wide report for 2019.

2.2 What is Working Well? – Trends from previous years included

- There has been a 3.6% increase since 2015 of the % of children and young people who are eating the recommended amount of fruit and vegetables each day.
  Change for Life resources have been promoted in primary schools and they deliver free fruit and vegetables to encourage and promote health eating.

- There has been a 5.7% increase in the % of children and young people who said they do not drink high sugar drinks and also a 2.7% increase in the % of children and young people who said they do not drink high energy drinks since 2015.
  Schools making the decision to ban the sale of high energy drinks, appears to be having a positive impact. Also schools have reported that they have been promoting information about the sugar content in drinks appears to be supporting pupils to make healthier choices.

- Young people have said they feel much safer when they are out. There has been a continued increase in the % of pupils who have said they always feel safe at Rotherham bus and train station since 2017. This could be attributed to the new layout of both the bus and train stations. Since 2017 there has been a 6.1% increase in the % of young people saying they always feel safe at the bus stations and 8.6% increase in those saying they always feel safe at the train station. The Youth Cabinet as part of their drive to improve safety and transport for young people have continued to work with South Yorkshire Passenger Transport and Rotherham Young Inspectors have also made recommendations to improve safety following an inspection. These results will be shared with South Yorkshire Passenger Transport.

- There has been a significant decrease in the % of young people who identified themselves as a young carer since 2014. There has been a 13.8% decrease in this period of time. The figure of 15.2% of young people identifying themselves as a young carer is more consistent with the 2011 census figure.

- More young carers feel they would be able to continue with their education and go onto college or university. This has increased by 1.2% since 2018 when this question was added to the survey. Young carers from Rotherham were given the opportunity to go to young carers residential in April 2019. This gave young carers a feel for university life and was offered free of charge by University of Hull and supported by Barnardos.

- There has been a decrease since 2015 of the % of young people who said they smoke regular cigarettes. In 2019 88.2% of pupils said they have never smoked, compared to 79% in 2015. There is a national ambition in the government's tobacco control plan to reduce the number of 15 year olds who regularly smoke down to 3% or less by 2022.

- There has been an increase in the % of young people who have said they have never tried alcohol. For year 7 pupils this has increased by 14.1% since 2014 and for year 10 pupils this has increased by 11% since 2014. In 2018 NHS England published a report saying that young people are turning their back on alcohol, therefore the lifestyle survey results are consistent with the information included in this report.

- There has been 20.6% increase in the % of year 7 pupils who have received education on the subject of child sexual exploitation since 2015. Barnardos Reachout and Barnardos Real Love Rocks programme offer training and train the trainer sessions at schools around sexual health and relationship subjects, this appears to be having a positive impact for young people in year 7. Although there has been a slight decrease since 2015 of the % of Y10 pupils who said they have received education around this subject.

- There has been a 9% decrease in the % of year 10 pupils who said they have had sexual intercourse since 2014.

2.3 What are we worried about? Trends from previous years included

- Information from the Child & Adolescent Mental Health Service (CAMHS) is consistent with the results in the lifestyle survey. CAMHS has confirmed that they are seeing an increase in referrals to support young people with their mental health. The lifestyle survey results show that there has been a 5.6% increase in the % of pupils who said they have a diagnosed mental health medical condition since 2015.
  This information is consistent with the results from pupils about their feelings, since 2017 there has been a 3.3% increase from Y7 pupils who rate their mental health as poor and a 5.5% increase from Y10 pupils. There has also been an increase in the % of young people who have said they did not have anyone they could talk to, if they had a problem, which could be an indicator of loneliness; in 2019 the results show that 145 young people gave this response. This information has been highlighted to schools and has been shared with CAMHS service.

- There has been a 2.5% decrease in the % of pupils who said they visit their dentist on a 6 monthly basis since this question was introduced in 2017.
  This information will be shared with Oral Health Improvement Group. Members of this group are working in partnership to promote access to dental care for children.

- There has been a 6.4% decrease since 2015 of the % of pupils who said they are drinking the recommended amount of water each day. This information has been highlighted to schools.

- Young carers have said that their caring role is having an increased impact on their lives, since 2018, when these questions were introduced. There has been a 3.7% increase in young carers saying they feel they cannot cope and a 1.1% increase in the % of young carers saying they lose sleep worrying about the person they care for. This information has been highlighted to schools and to Barnardos, who are commissioned to provide Young Carer Service.

- Young people who have said their homes are smoke free has decreased by 9.5% since 2014. This decrease could be attributed to the inclusion of e-cigarettes in this question. National data shows that 7.1% of the overall population are vaping. The most popular age range for those vaping is 35 to 54 year old. This information has been highlighted to schools.

- There has been an increase in the % of pupils who have said they are regularly using an electronic cigarette. In 2014 this was as low as 3%, this has increased to 4.9% in 2019.

- The overall results show there were 209 young people who said they have tried some form of drug in 2019. This is a slight decrease in the % of young people who said they have tried some form of drug since 2015. The concerning factor is that the 3 most popular drugs in 2019 are cannabis, ecstasy and cocaine. Since 2015 there has been a 12.2% increase in the % of pupils who said they have tried cannabis, a 5.7% increase in those trying ecstasy, a 4.7% increase in those trying cocaine and a 4.6% increase in those trying heroin. Also young people have said they are using drugs more often, since 2016 there has been a 9.1% increase in the % of pupils who have said they have tried drugs more than 10 times. This information has been highlighted to schools.

- Although there has been a % decrease from year 10 pupils who said they have had sexual intercourse, there has been an increase in those who said they have had sexual intercourse after drinking alcohol or using drugs. This has increased by 27.5% since 2014. Also pupils who said they have not used any form of contraception has increased by 10.3% since 2014. This information has been highlighted to schools.

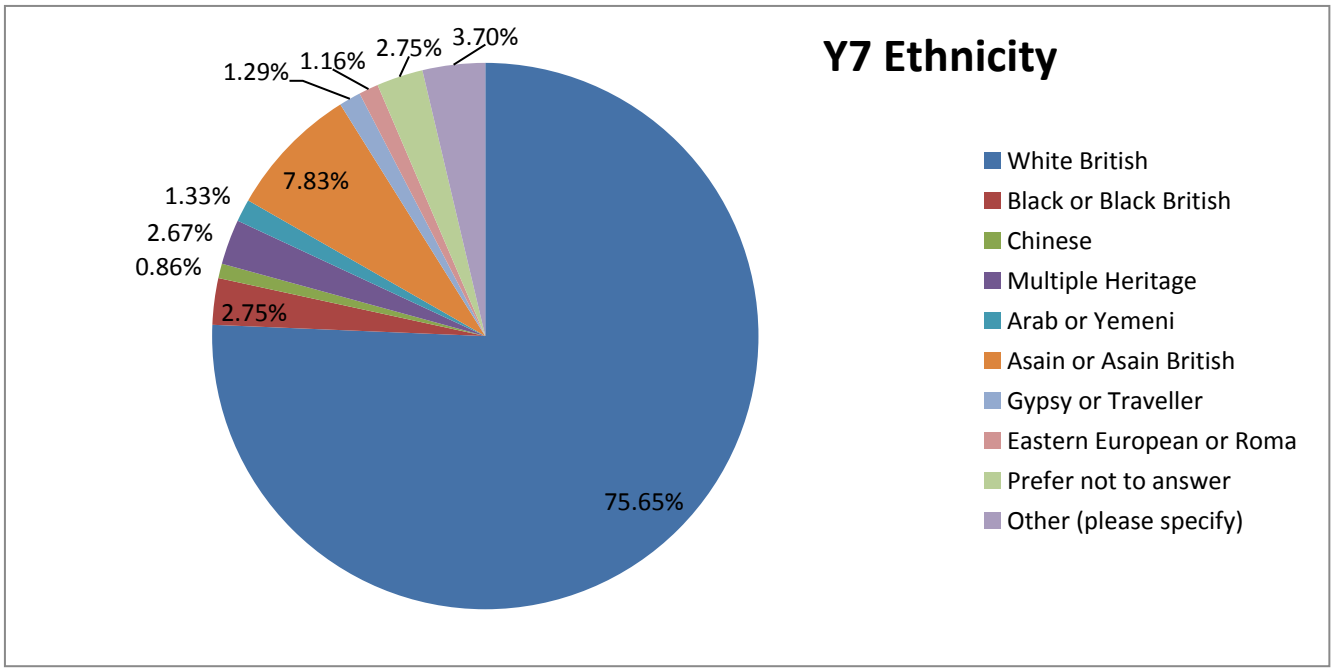
3. A little bit about me

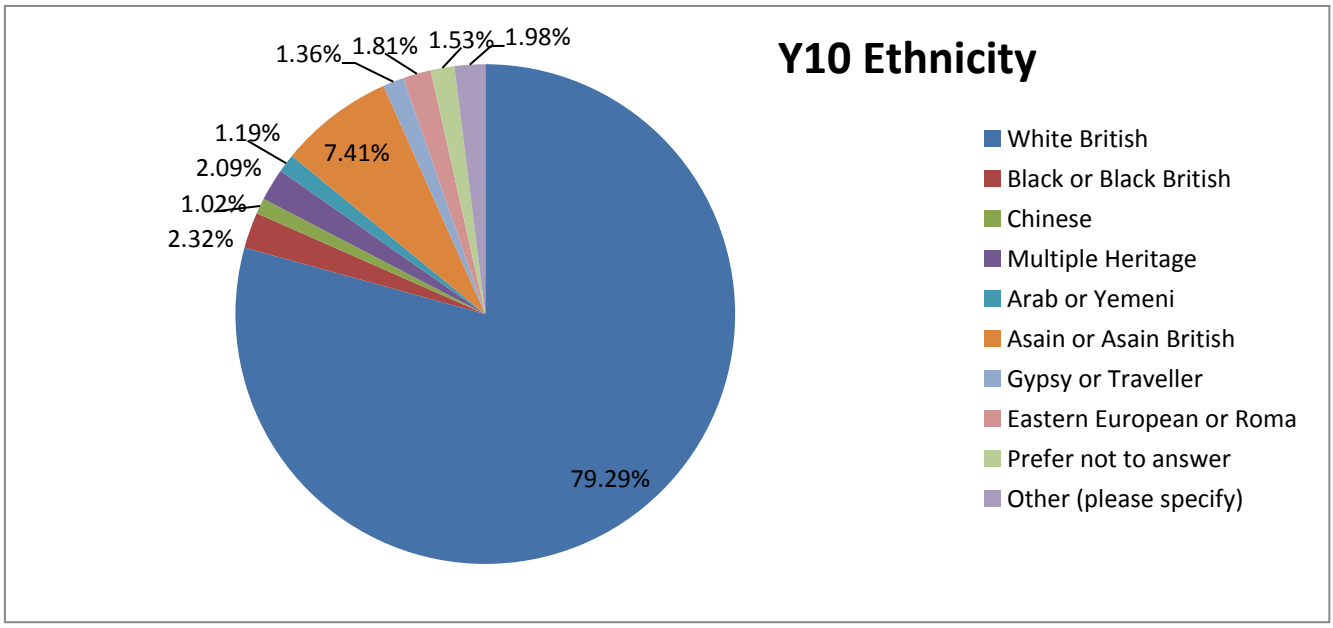
Of the pupils that completed the 2019 survey, 2041 (49.8%) were female and 2050 (50.2%) were male. 2324 (56.8%) were in year 7 and 1767 (43.2%) were in year 10.

Pupils are asked to say where in the borough they live, this information has enabled some of the results from 2018 (and this will be replicated in 2019) to be localised and shared with the Neighbourhoods and Safer Rotherham Partnership. Neighbourhoods have used this information to help identify their priorities and priority geographical areas. Safer Rotherham Partnership (in particular around the safeguarding questions), have used this information to identify areas where things appear to be working well and areas where there is cause for concern. Information is shared by ward data and not by each school. School data is confidential to each individual school and has not been shared wider as part of this ward breakdown.

3.1 Ethnic Origin 2019

The two charts below, show the breakdown of ethnicity of Y7 and Y10 pupils.





The overall 2019 results show that when asked about their ethnicity, 77.2% (3159) of pupils described themselves as White British (compared to 84% in 2014).

17.6% (720) described themselves as from Black or Minority Ethnic group (BME) (this compared to 13% in 2014). 2.2% (91) pupils preferred not to disclose information about their ethnicity and 2.9% (121) described themselves from 'other' ethnicity group. This is in line with the school census.

3.2 Looked After Children

Pupils were asked to say if they are a looked after child, with an option not to say if they so wished. CYPS data shows that during the period of time that the lifestyle survey was open, there were 95 young people in the age range for Y7 and Y10 who were looked after. 72 pupils in this age range completed the survey and identified themselves as a looked after child. This indicates that 75% of looked after children in this age range completed the 2019 lifestyle survey.

Out of these 72 pupils, 32 were in Y7 and 40 in Y10.

- 45.8% (33) pupils indicated they were in a foster care placement
- 43.1% (31) pupils indicated they were in other residential placement
- 11.1% (8) pupils indicated they were in a children's residential placement

The information from the looked after children results will be shared with Looked after Children's teams. This will enable the teams to compare the results about health and wellbeing of looked after children with borough wide results, helping identify best practice and where action needs to be taken.

The questions to capture feedback from children and young people who told us they are looked after, was introduced in 2017, the results show:

- 2017 – 30 looked after children completed the survey out of a cohort of 55
- 2018 – 59 looked after children completed the survey out of a cohort of 69
- 2019 – 72 looked after children completed the survey out of a cohort of 95

The results of the surveys completed by children and young people who identified themselves as looked after, will be shared with the Looked after Children Teams.

3.3 Health – Disabilities

Pupils were asked if they had a diagnosed long term illness, health problem, disability or medical condition. In 2019, 22% (902) of pupils said they had a diagnosed condition. This is a 6% increase from 2015 when overall 16% (496) of pupils said they had a diagnosed medical condition.

In 2019 with a comparison to 2015, the 3 main medical conditions that young people said they had been diagnosed with are:

Medical Condition	**2019 (out of 902)**	**2015 (out of 496)**
Asthma, Breathing & Fatigue	24.7%	23%
Autism	12.1%	11%
Mental Health	10.6%	5%

Asthma related conditions and autism have remained relatively similar in past 5 years. Mental health has increased by 5.6%. CAMHS have confirmed this information is consistent with their data, they have seen an increase in referrals to support young people with their mental health. This information is also consistent with the results of the questions relating to feelings. 5.1.
The data relating to health and disability questions will be shared with Public Health and the results relating to young people and mental health will be shared with CAMHS.

3.4 Oral Health

The data around oral health will be shared with the Public Health Specialist lead for tobacco control and Oral Health Improvement Group. The questions around oral health were introduced to the survey in 2017.

Frequency	**2019**	**2017**
Visit Dentist 6 Monthly	76.5%	79%
Visit Dentist Yearly	15.2%	13.9%
Visit the Dentist less than once per year	3.7%	3.6%
Do not visit the Dentist	4.6%	3.5%

The results show that there has been a slight decrease since 2017 of the % of pupils who said they go to the dentist at least once per year. This has decreased from 92.9% in 2017 to 91.7%

in 2019. There has also been an increase of 1.1% of pupils who said they do not visit the dentist at all.

What's working well?

In 2019 NHS England has increased the number of available appointments at some dental practices in Rotherham.

It has been identified that the potential barriers for families not attending dentists are:
Adults cannot afford treatment and may not take children to the dentist (even though NHS treatment is free for children); another common barrier is dental anxiety

What is happening?
The data from the Rotherham Lifestyle survey will be shared to be discussed at Oral Health Improvement Group and members will work in partnership to promote access to dental care, especially for children

4. Healthy Eating & Exercise
The data around healthy eating & exercise will be shared with the Public Health Specialist lead for weight management and will be highlighted to all schools.

4.1 Fruit & Vegetables
It is recommended that young people should aim to have 5 or more portions of fruit and vegetables each day.

There has been an increase since 2015 in the % of young people who said they are eating the 5 recommended pieces of fruit or vegetables each day. There has also been a decrease in the % of young people who said they are not eating any fruit or vegetables.

Fruit & Vegetable Consumption	2019	2015
Eating the recommended 5 or more pieces of fruit or vegetables	16.6%	13%
Not eating any fruit or vegetables at all	6.4%	8%

What's working well?
'Change for Life' resources have been promoted in Primary Schools and are delivering free fruit and vegetables to encourage and promote healthy eating. This could contribute to Y7 pupils being more likely to eat fruit and vegetables.
In 2019 over 20% of Y7 said they are eating the recommended 5 portions compared to 12% of Y10.

4.2 Water
It is recommended that young people should aim to have 6 or more glasses of water each day.

There has been a 6.4% decrease in the % of young people who said they are drinking the recommended amount of water each day since 2015, but there has been a very slight improvement of the pupils saying they drink no water at all since 2014. The results show:

Drinking Water	2019	2015
Drinking recommended 6 or more glasses of water per day	17.6%	24%
Drinking no water at all	7.6%	8%

The % of pupils drinking the recommended 6 glasses has consistently declined since 2015.

What are we worried about? (2019)
There has been a decline in the % of pupils who are consuming the recommended water per day and also an increase in the % of pupils who said they do not drink water at all from 2018 to 2019.

What is happening?
This result will be highlighted to Public Health and all schools.

4.3 High Sugar Drinks

It is recommended that high sugar drinks should be avoided.

There has been an increase in the % of young people who said they do not drink any high sugar drinks. Although there has also been a % increase in those young people who said they drink 3 or more high sugar drinks each day.

Drinking High Sugar Drinks	2019	2015
Drinking no high sugar drinks at all	40.9%	35.2%
Drinking 3 or more high sugar drinks each day	10.3%	7.6%

What's working well?
The promotion of the content of sugar in drinks that schools have adopted appears to be having a positive impact, with the increase of the % of pupils not drinking any high sugar drinks.

4.4 High Energy Drinks

Schools have made the decision to ban the sale of high energy drinks and highlight the negative impact excessive consumption can have.

The promotion of the issues around drinking high energy drinks that schools have adopted, appears to be having a positive impact. More young people are not consuming these types of drinks and less young people are consuming these in high quantities.

Drinking High Energy Drinks	2019	2015
Drinking no high energy drinks at all	65.7%	63%
Drinking 10 or more high energy drinks each week	1.3%	2.6%

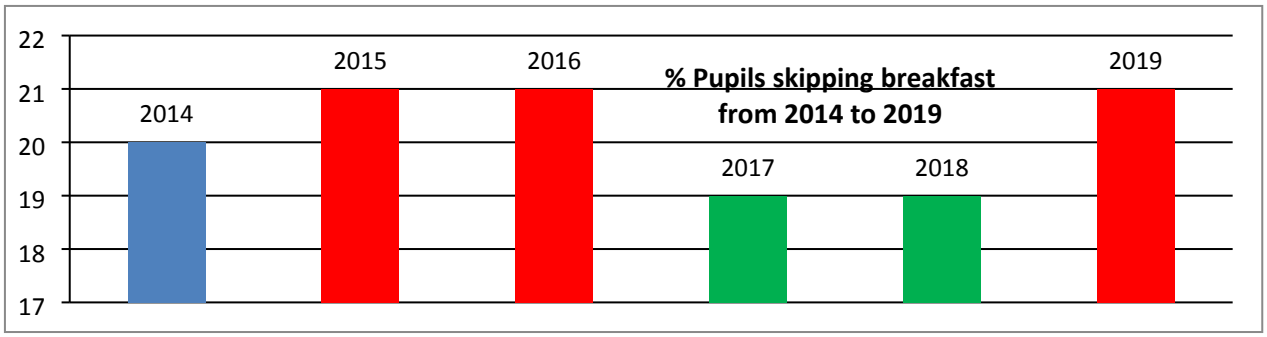
What's working well?

The decision made by schools to ban the sale of high energy drinks, could have contributed to the improvement in the % of pupils saying they do not consume these types of drinks.

4.5 Breakfast

A number of national studies have shown that between 25% to 32% of children of school age go to school without breakfast. The national picture from studies carried out show that girls are more likely to skip breakfast with the main reason given, it will help them lose weight. Boys gave the main reason, they didn't have enough time.

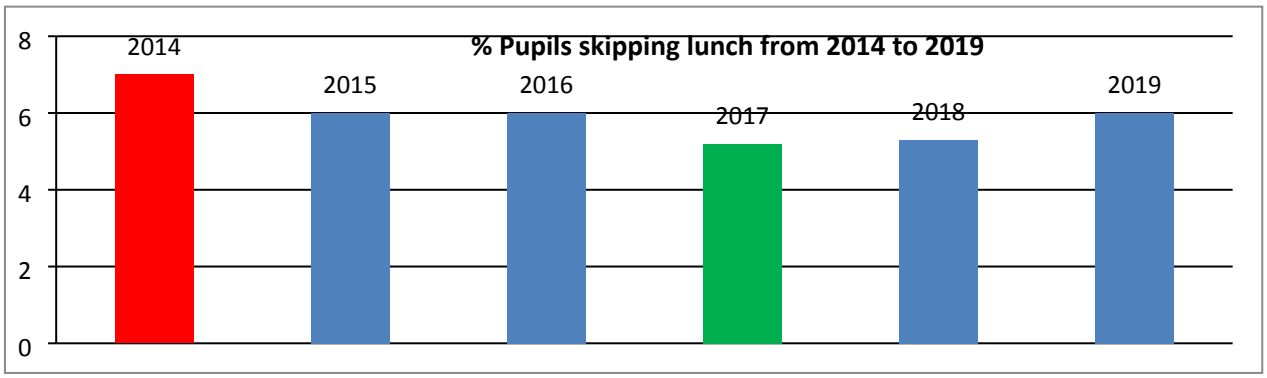
The Rotherham Lifestyle survey results have consistently shown between 2014 and 2019 that around 19% to 21% of pupils in Y7 and Y10 said they skip breakfast.



The trend has increased in 2019, back up to 21% after falling to 19% in 2017 and 2018.

4.6 Lunch

Pupils are asked in the survey to say where they have their lunch during school time.



What are we worried about?

A trend has continued with a % increase of pupils saying they do not have any lunch.
In 2017 – 5.2% of pupils said they missed lunch
In 2018 – 5.3% of pupils said they missed lunch
In 2019 6% of pupils said they missed lunch

What is happening?
This data will be highlighted to all schools

4.7 Exercise, Health & Weight.

It is recommended that young people should aim to get at least one hour moderate physical activity most days of the week. The minimum recommended is 30 minutes, 3 times per week.

The lifestyle survey results show:
There has been an improvement in the % of young people who said they regularly take part in sport or exercise

- In 2019, 82.6% (3097) said they regularly take part in sport or exercise
- In 2014 77% said they regularly take part in sport or exercise

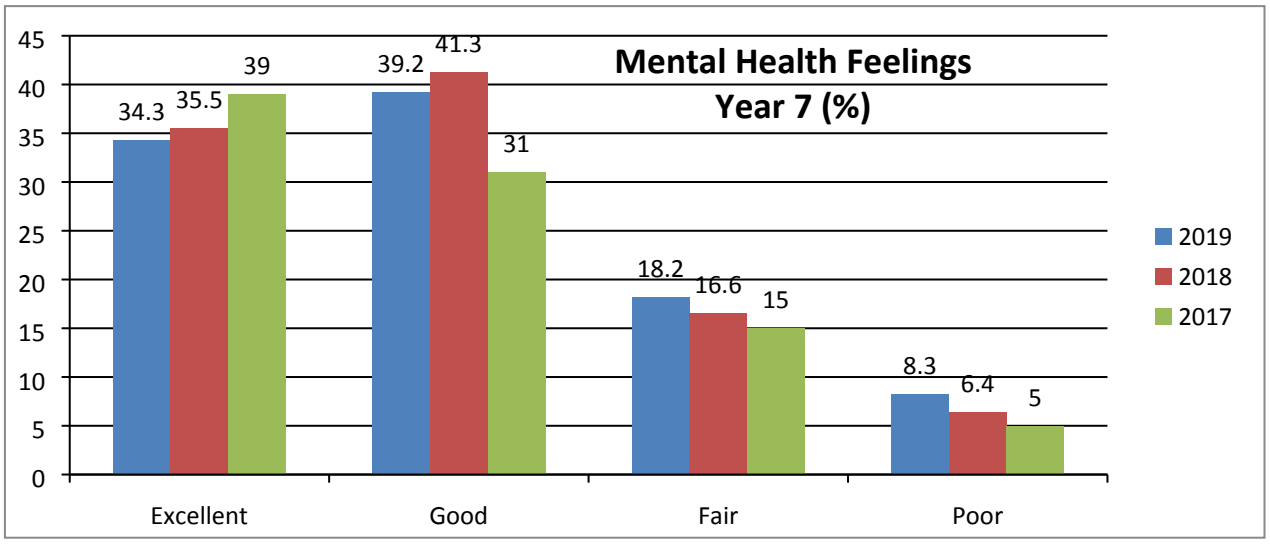
This indicates that young people have become more active since 2014, with a % increase of 5.6% saying that they regularly take part in sport or exercise.

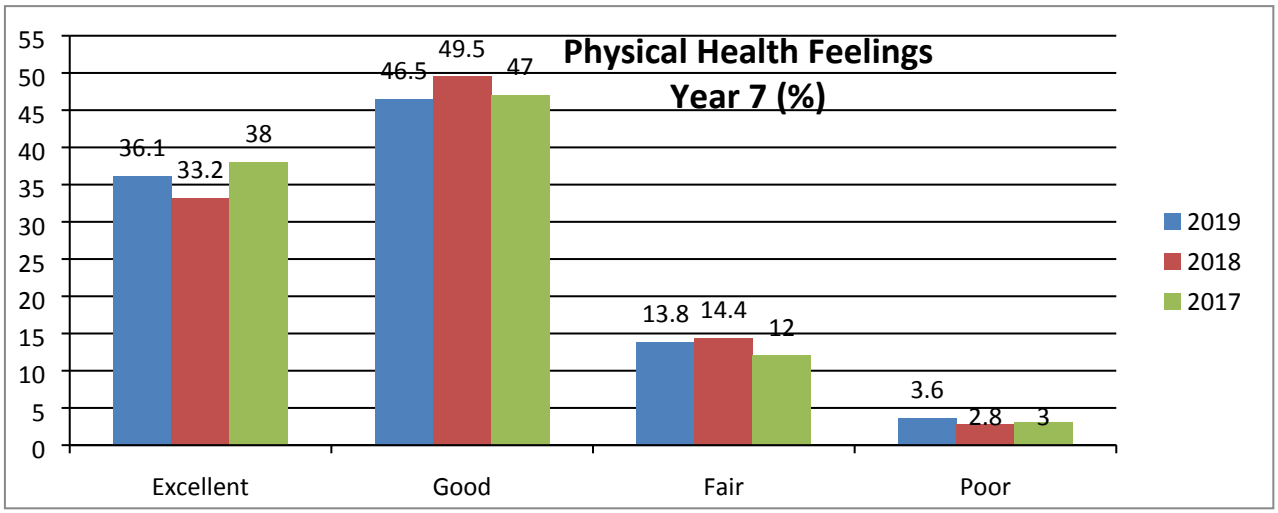
5. Feelings

5.1 Feelings Physical & Mental Health

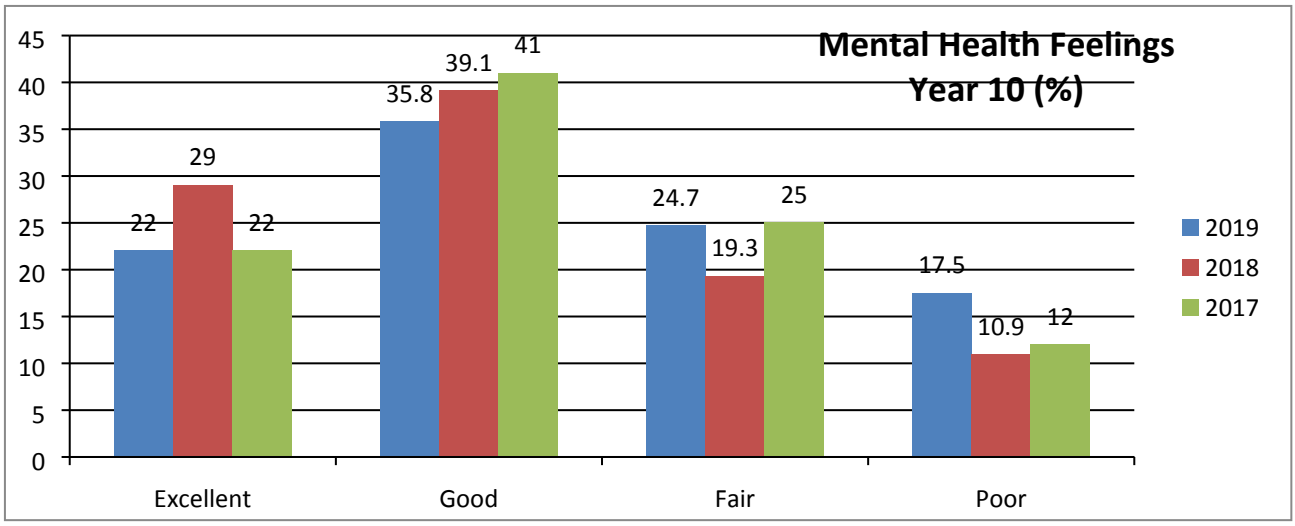
The questions asking young people about their feelings around physical health and mental health were introduced in 2017.

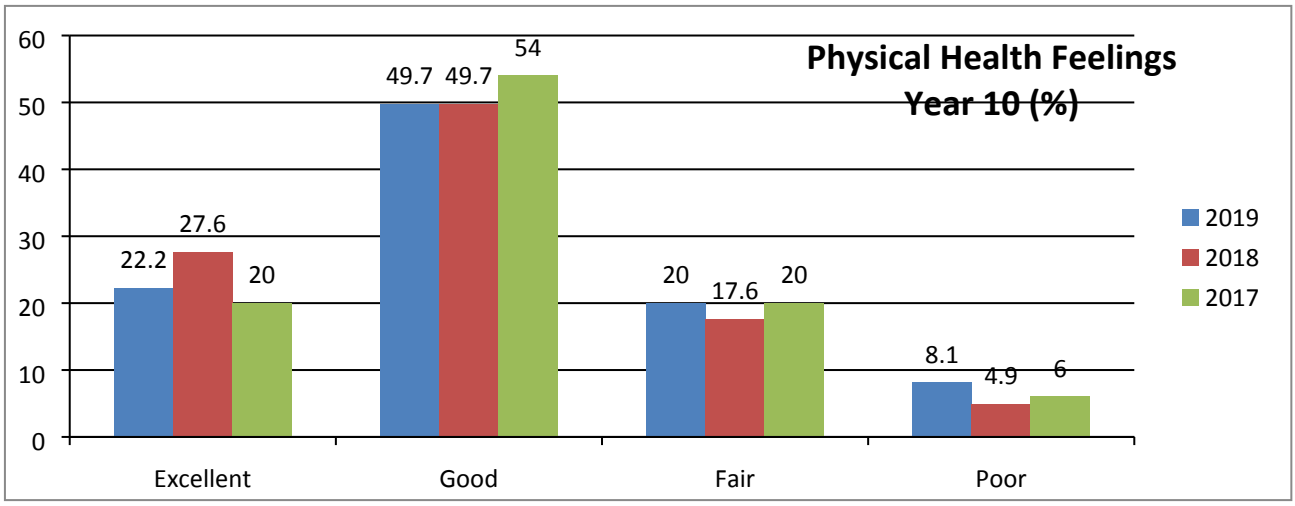
The responses are detailed in the charts below for Y7 and Y10 with a 2017, 2018 and 2019 trend information for comparison on young people's feelings about their physical health and mental health.





The Year 7 results show that there has been a trend of a decrease in % of pupils who expressed they felt excellent about their mental health, this has decreased by 4.7% since 2017. There is also a trend of an increase in % of pupils who expressed they felt poor about their mental health this has increased by 3.3% since 2017.





The Year 10 results show that there has been a decrease in 2019 in the % of pupils who felt their mental health was excellent, it has decreased to 22% the same as in 2017. There has been an increase in the % of pupils who felt their mental health was poor, this has increased by 5.5% since 2017.

This information is consistent with the diagnosed medical conditions question 3.3, which has highlighted that more young people have said they have a diagnosed medical condition relating to mental health.

What are we worried about?

The trend information shows that less young people feel good about their mental health and more young people feel their mental health is poor.

This information in conjunction with the data from 3.3 (Disabilities) that told us more young people informed us they have a diagnosed medical condition, relating to mental health, highlighting mental health is a priority for young people.

What is happening?

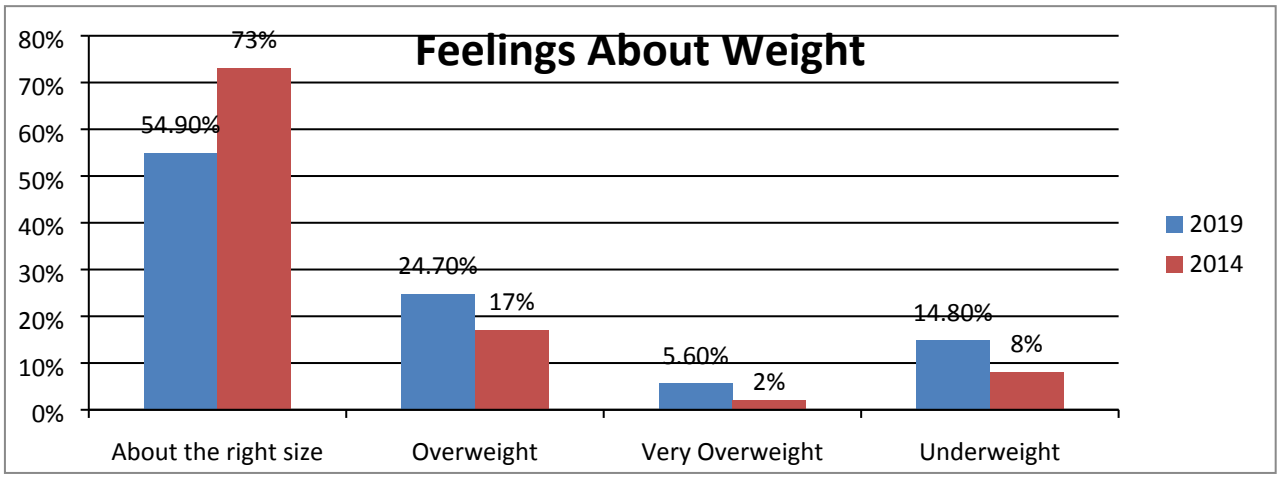
This information will be highlighted to
Health & Wellbeing Board; CAMHS; Public Health Specialist for Mental Health & all schools.

The Health & Wellbeing Board have objectives to reduce the occurrence of common mental health problems among young people

This data is consistent with the experience of CAMHS, who have seen an increase in the volume of referrals for young people to support with their mental health.

5.2 Feelings about Weight

Young people have been asked to share their feelings about their weight and there have been changes to how pupils feel since 2014. It is clear there has been a changed how young people are feeling about their weight and body image. Young people saying they feel they are about the right size has decreased by 18% since 2014.



Benchmarking
Public Health England
Child & Maternal Health Data

Obesity Data for 10-11 Years
Rotherham 22.2%
Regional Yorkshire & Humberside 20.4%
National 20%

What Are We Worried About?

From National Benchmarking Data
Rotherham has a higher % of children in age group 10-11 years that are defined as obese compared to regional and national data.

The 2019 Lifestyle survey results highlight that there has been an increase overall of pupils who feel they are overweight/very overweight

What is happening?

The newly commissioned child weight management service WHAM – (Weight, Health and Attitude Management) is now part of the 0-19 service (delivered by The Rotherham Foundation Trust (TRFT)) which has been in place since 2019. This provides support for children, young people (age 4-19 years) and families who have been identified with a BMI that suggests a child is overweight (from National Child Measurement Programme (NCMP), or other health professionals). One to one sessions give advice and guidance and a 6 week healthy lifestyle programme.
WHAM service is developing a training package to be rolled out to NHS and CYPS staff in October 2019 to support this programme.
For the first wave of families who have completed the 6 week programme the early indications show positive results

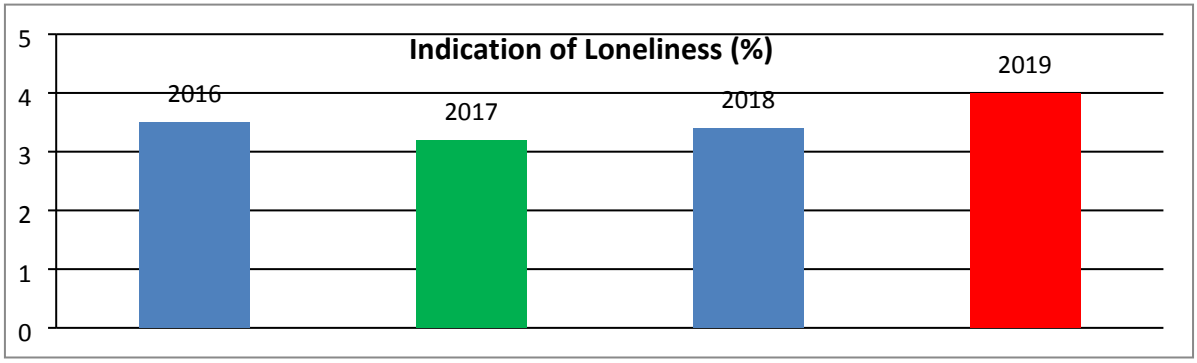
5.3 How Pupils Feel

There has been a consistent picture since 2014 about young people mostly feeling good about home life. This has always come out the highest % of what young people feel good about in both Y7 and Y10, each year since 2014. The least rated of what young people feel good about has also remained consistent since 2014, this has always been the way they look, this is consistent with the data around young people and their feelings about their weight and how they feel about their mental health.

5.4 Feelings and Talking About Problems

Young people are asked to say who they would most likely talk to about their problems, it has been consistent since 2014 that the people they are more likely to talk to if they had a problem would be a family member or an adult living at home.

In 2019, 145 (4%) of young people said they did not have anyone they could talk to, this option has increased from 2016, when this option was introduced. This information could be an indicator that a young person is lonely.



This information will be highlighted to schools, for them to review their own individual school results, compared to the borough wide results.

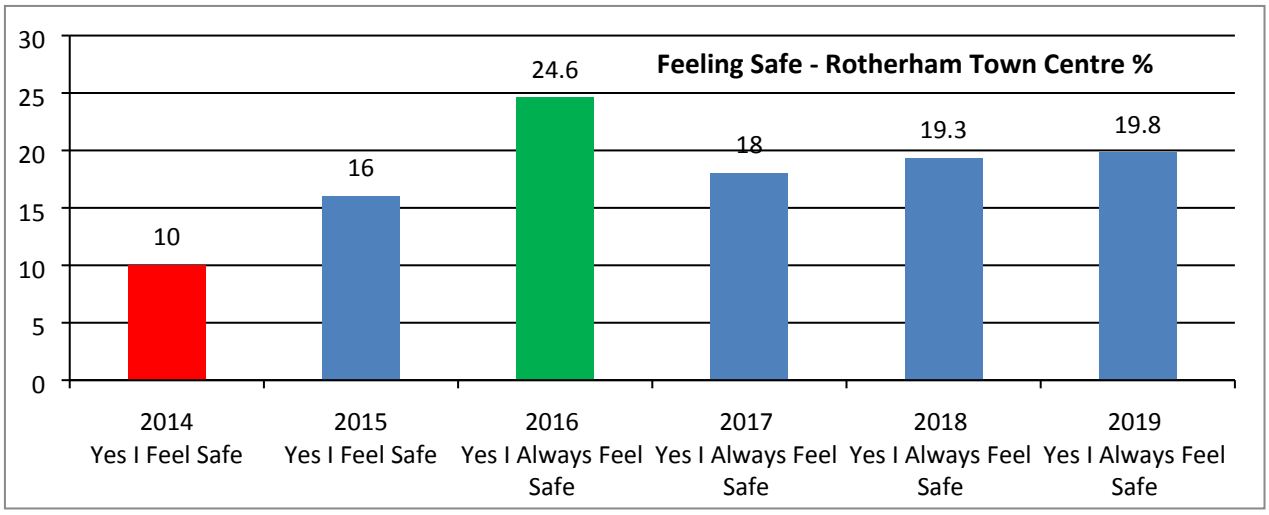
6.0 Safeguarding

Pupils are asked a series of questions about their safety, feeling safe in and around the town centre, their local community, on-line and bullying issues.

6.1 Feeling Safe Rotherham Town Centre

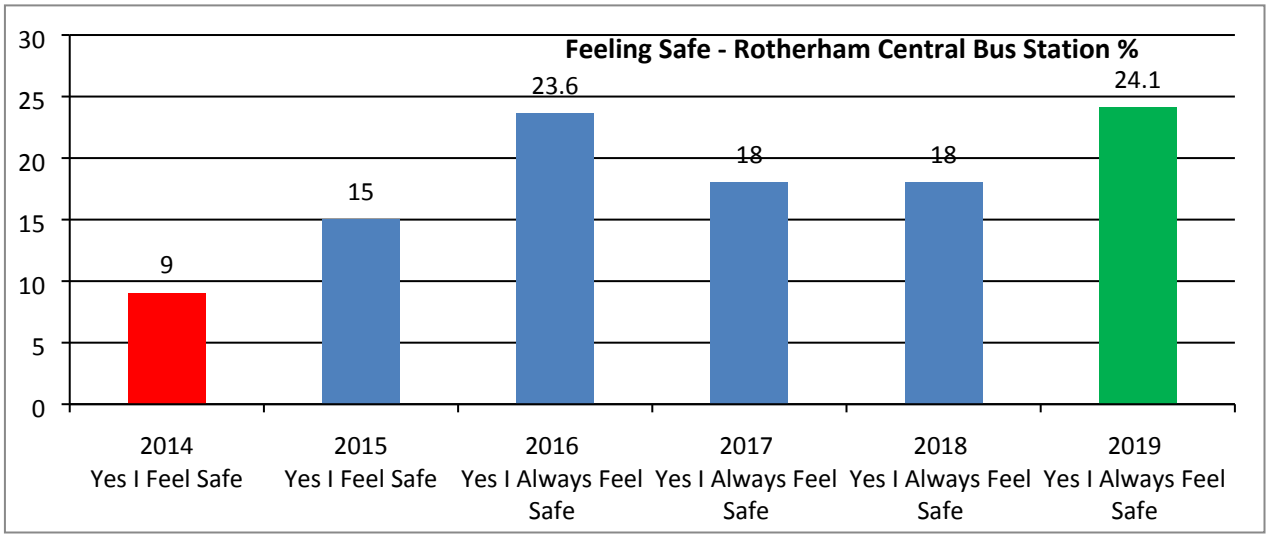
Pupils have been asked about feeling safe in and around the town centre since 2014, although the options were changed in 2016. Prior to 2016, young people were asked - Do you feel safe? (Yes/No). Post 2016, young people are asked – Do you feel safe? (Always/Sometimes/Never).

It is evident since 2014 there have been improvements and young people are feeling safer in Rotherham town centre than they did in 2014, this has improved from 10% up to 19.8%.



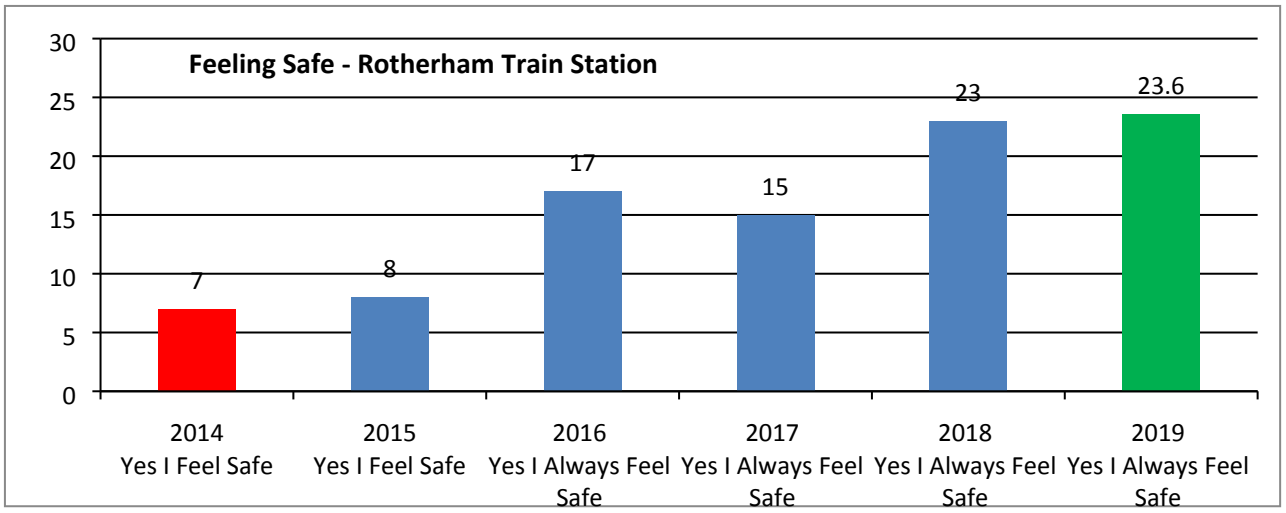
6.2 Feeling Safe Rotherham Town Centre Bus Station

The changes to the question are the same as Rotherham town centre, the options offered were changed in 2016. It is evident since 2014 there have been improvements and young people are feeling safer in Rotherham central bus station than they did in 2014. This has improved by 15.1%. In 2019 it was the highest % of children saying they feel safe since questions around safety were added to the Lifestyle survey in 2011. This could be attributed to the opening of the new layout of Rotherham bus station and the work of the Rotherham Youth Cabinet and Rotherham Young Inspectors.



6.3 Feeling Safe Rotherham Train Station

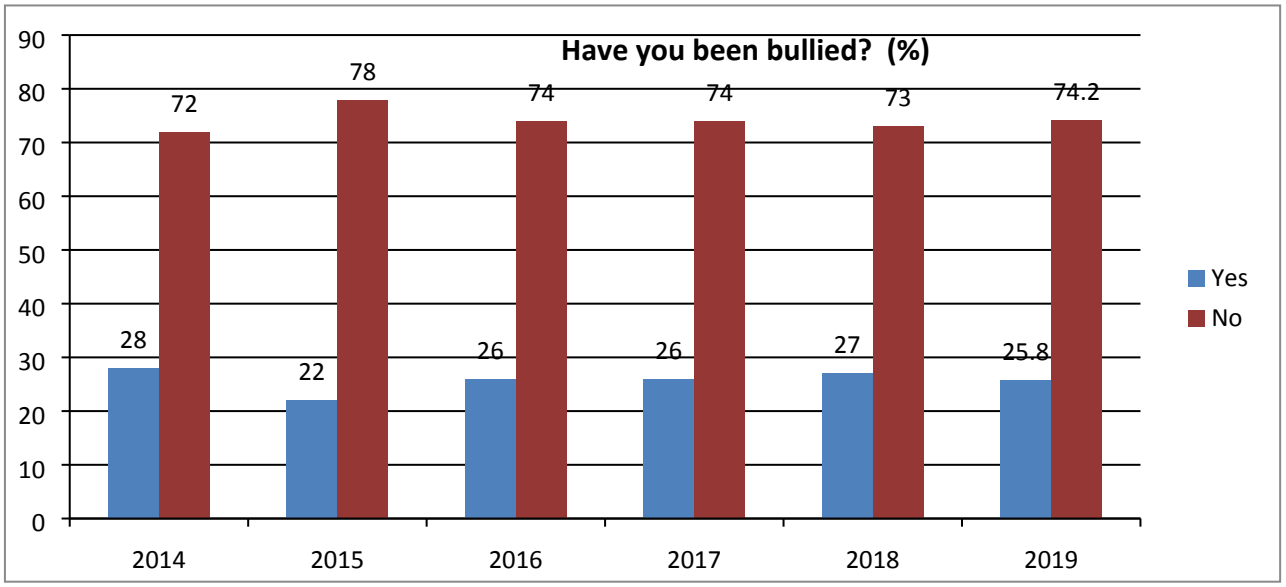
The changes to the options were also introduced for the train station.
It is evident since 2014 there have been improvements and young people are feeling safer in Rotherham train station than they did in 2014. This has improved by 16.6%. In 2019 it was the highest % of children saying they feel safe since questions around safety were added to the Lifestyle survey in 2011. The improvements in 2018 and 2019 could be attributed to the opening of the new layout of Rotherham train station.



6.4 Bullying

Pupils are asked to say if they have been bullied in the past 6 months.

These results from the Lifestyle Survey will be shared to be included in the plans for the Children's Capital of Culture 2025, Safer Rotherham Partnership, and Rotherham Children's Safeguarding Board and highlighted to schools.



The trend shows that since 2014, the % of pupils saying they have been bullied has decreased by 2.2%, although the rates in 2019 are 3.8% higher than in 2015, when they were as low as 22%.

6.4.1 Bullying Reasons

Pupils were asked to say if they knew the reason why they may have been bullied.

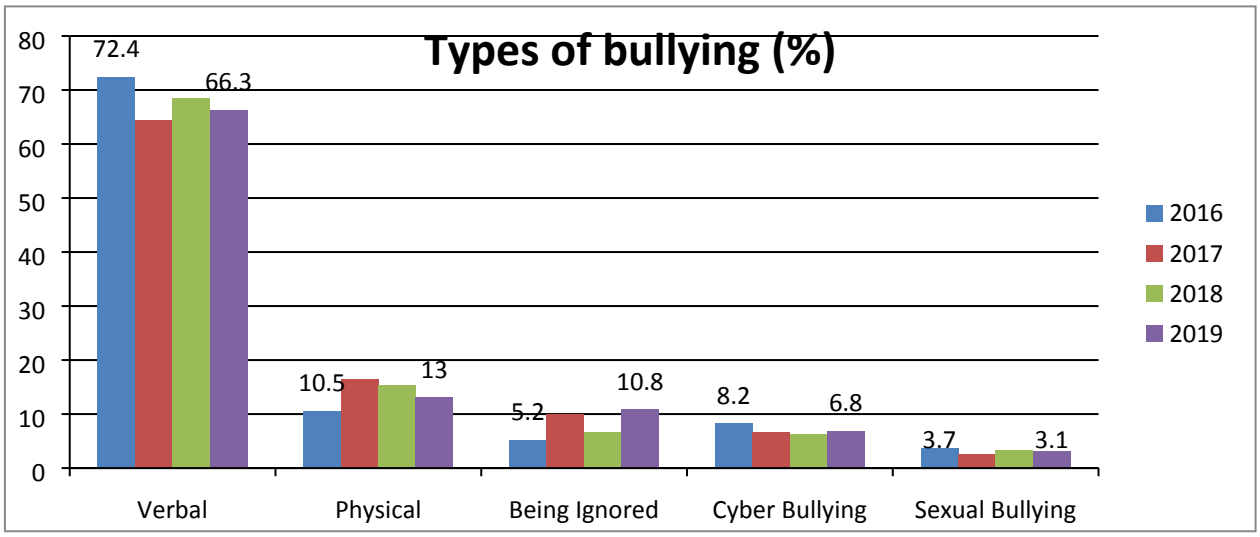
The main consistent reasons that young people have said they have been bullied since 2015 are:

Reason	2019	2018	2017	2016	2015
No specific reason	26.6%	25.6%	26%	30.2%	51%
Your weight	13.2%	14.6%	15.3%	11.9%	16%
The way you look and/or dress	13.1%	14.6%	12%	17.2%	16%

These have been the 3 highest % that young people have said they have been bullied since 2015. The options were changed for the survey in 2015, following consultation with young people who requested a change to the options. The main change was to add the option; no specific reason that the young person could think of.

6.4.2 Forms of Bullying

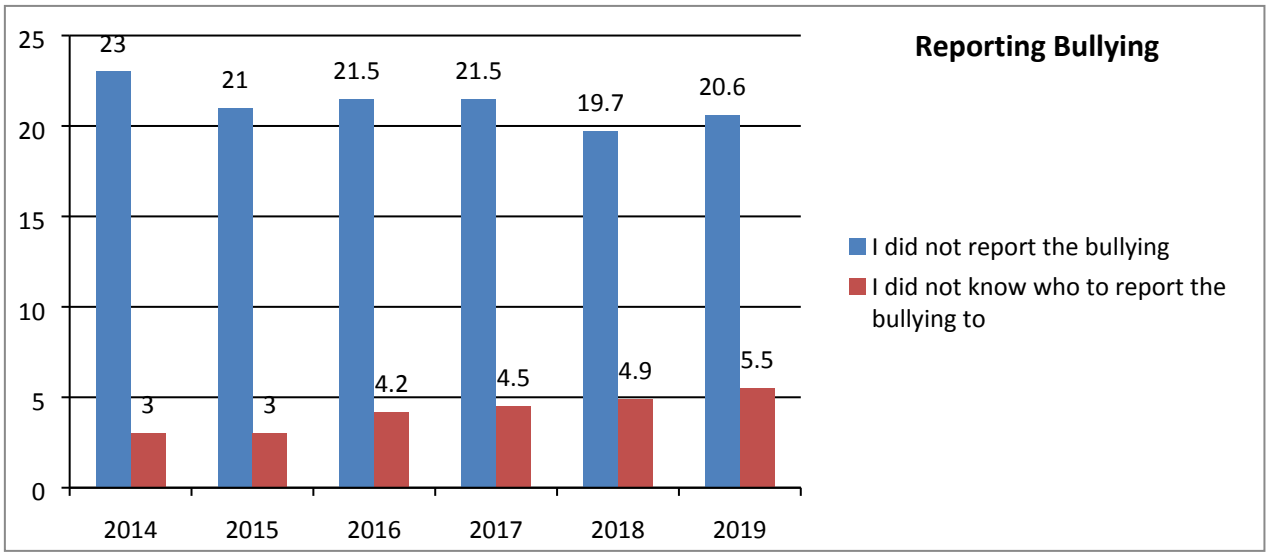
Pupils are asked to say what form of bullying they have been subject to. This question was introduced to the survey in 2016, since 2016 the results show that pupils said they have been bullied by:



The trend information show that the forms of bullying that have increased since 2016 are, physical bullying and being ignored and the biggest decrease is pupils being verbally bullied.

6.4.3 Reporting Bullying

Pupils are asked to say who they reported the bullying to, if they did report it. The results since 2014 show that consistently pupils are most likely to report the bullying to parents/carers or a staff member at school. The results show that since 2014 there has been a 2.4% decrease in the % of pupils who said they did not report the bullying, although there has also been an 2.5% increase in the % of pupils who said they did not know who to report the bullying to.



6.4.4 Bullying Benchmarking

Ditch The Label National Bullying Charity
Between 1st November 2017 and 28th February 2018 there was a national survey about bullying

This survey was offered to 12 to 20 year old young people
The survey was fully completed by 9,150 young people
1% of these were from Yorkshire & Humberside region

The results from 9,150 young people showed that 22% said they had been subject to a form of bullying
35% of these young people did not report the bullying

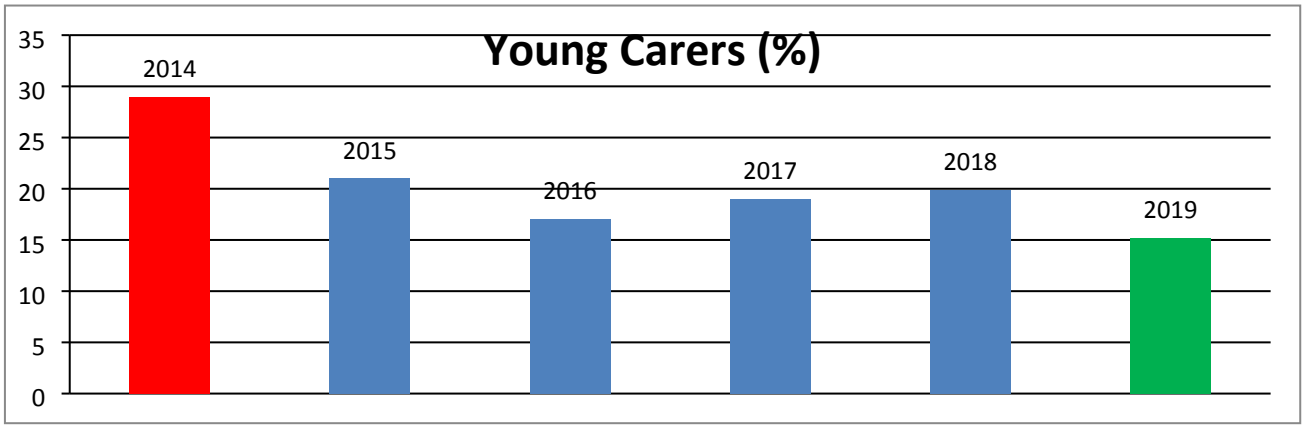
<u>Comparison – Rotherham Lifestyle Survey 2019 Results</u>

The results for 2019 show that 25.8% (835) said they have been bullied
Out of these

26.1% did not report the bullying or did not know who to report bullying to

7. Young Carers

Pupils are asked to share information about themselves and if they are a young carer.
The young carer questions were developed with the support of Barnardos young carers council. The trend shows that since 2014 there has been a significant decrease in the % of young people who identify themselves as young carers, this has decreased from 29% in 2014 to 15.2% in 2019.



These results from the Lifestyle Survey will be shared to be included in the plans for the Children's Capital of Culture 2025, Barnardos Young Carers Service and CYPS Commissioning.

The overall figure from the 2011 Census for Rotherham identifies that 12% of young people in Rotherham are young carers. The lifestyle figure for 2019 is 3.2% higher than this figure, but this could be attributed to a number of factors. The survey is open to year 7 and year 10 pupils not all children of school age in Rotherham. The survey was not completed by all schools, 75% of secondary schools participated in the lifestyle survey in 2019. Pupils may have also identified themselves as a young carer if they are taking a young sibling to school or babysitting. A further reasons why there was a significant drop after 2014, there was a definition added to the question and an explanation in more detail of what a young carer is, provided by Barnardos Young Carers Service.

7.1 Caring Tasks
Pupils were asked about what tasks they help out with, they could choose more than one, if they are needed to do multiple tasks to help support and care.

Young carers have consistently told us since 2014 that the main tasks they carry out when they are caring are:

- Helping around the house
- Keeping someone company and not wanting to leave them on their own
- Helping look after and care for a brother or sister

7.2 Young Carers – Number of Hours Caring
Young carers are asked to say on average how many hours they provide care each day.
There has not been much change in the % of young people saying they are caring for 8 or more hours per day.

- 2014 – 11% of young people said they were caring 8 hours or more
- 2019 – 11.7% of young people said they were caring 8 hours or more

7.3 Impact of Caring
The Barnados Young Carers Council, requested in 2018 to add some further questions to the survey, around the impact of their caring role.

The significant changes since 2018 show that

- The % of young carers feeling they cannot cope, has increased to 12.3% in 2019 from 8.6% in 2018
- The % of young carers saying that caring makes them feel they are doing something good has decreased to 43.2% in 2019 from 44.3% in 2018.
- The % of young carers saying they lose sleep worrying about the person they care for has increased to 6.5% in 2019 from 5.7% in 2018.
- The % of young carers saying they feel stressed has decreased to 23.6% in 2019 from 25.4% in 2018
- The % of young carers saying they do not get to see their friends as often as they would like has decreased to 7% in 2019 from 13.1% in 2018
- The % of young carers saying they feel that they will be able to go to college or university has increased to 81.2% in 2019 from 80% in 2018.

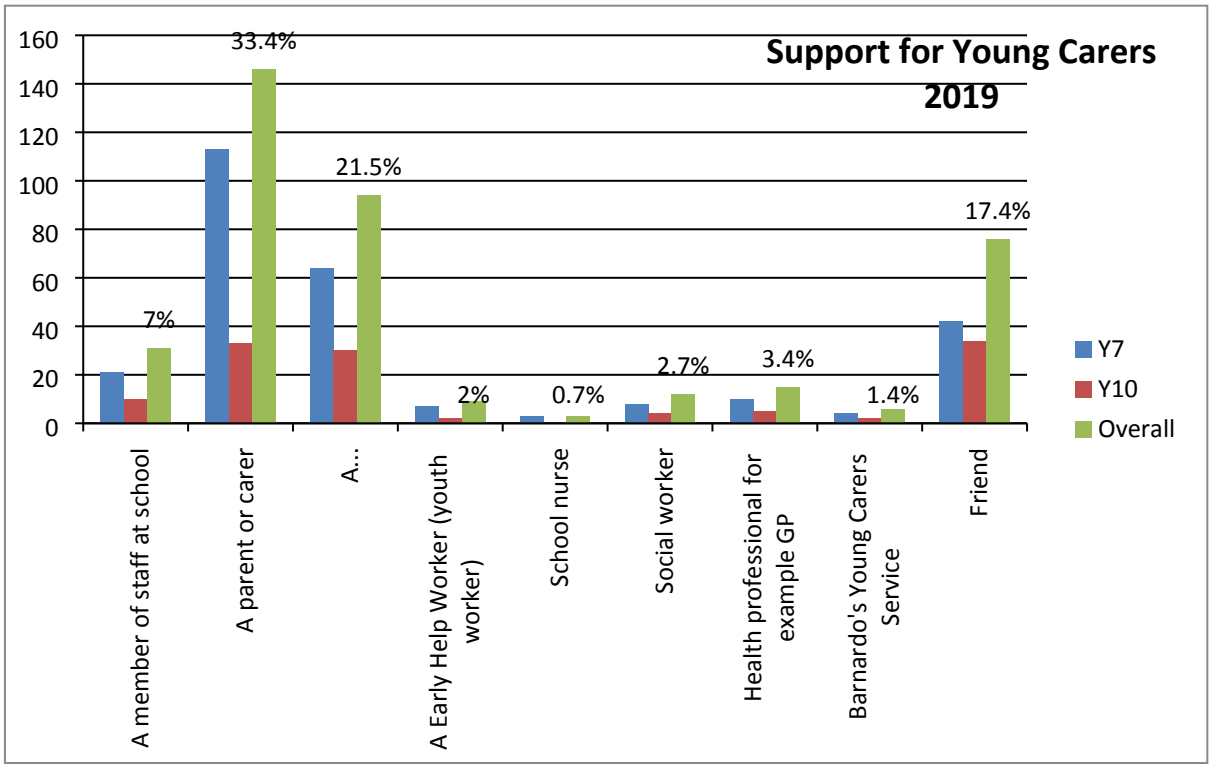
What is working well?
Barnardos supported Young Carers from Rotherham to have the opportunity to go on a Young Carers Residential in April 2019

This gave young carers the opportunity to have an introduction to university life and all it can offer

This residential was offered free of charge to young carers by the University of Hull

This was an opportunity for young carers to have a break from caring and experience university life

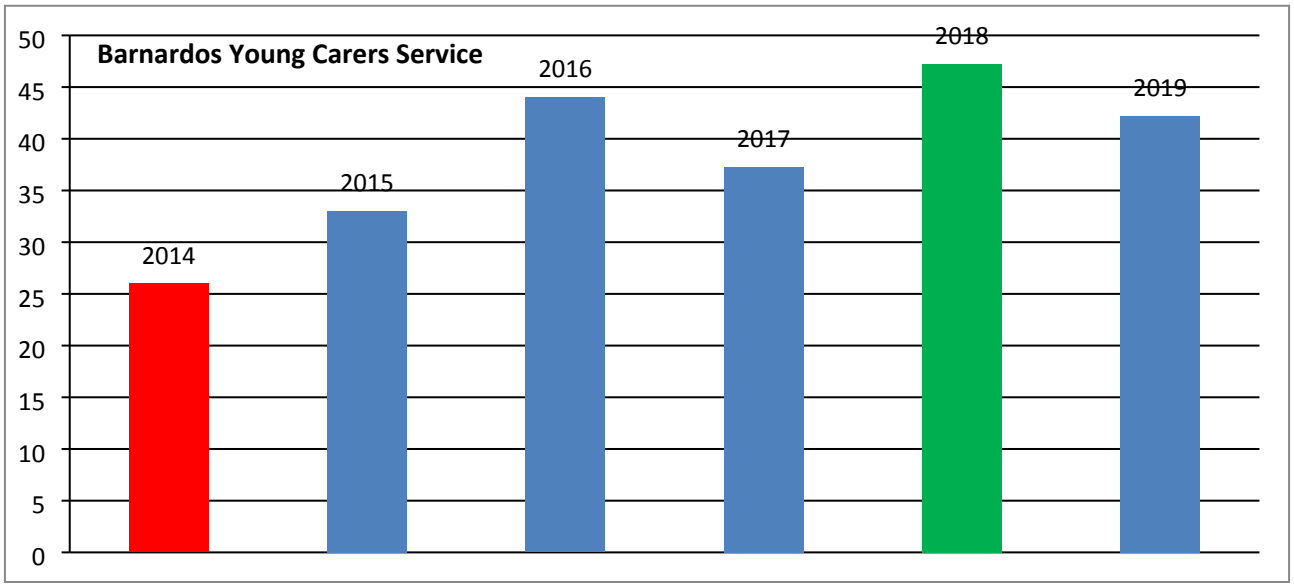
7.4 Supporting for Young Carers
Young carers are asked to say if they were struggling with the pressure of being a young carer who would they choose to speak to. It has been consistent since 2014 that the majority of young carers would speak with a parent/carer, a family member or a friend. These have been the highest % choices consistently between 2014 and 2019. The results from 2019 are:



It has been a consistent % since 2014 around the young carers who would choose to speak with the Barnardos Young Carers Service. Each year 1.4% have said they would speak with this service.

7.4.1 Barnardos

Pupils who had identified themselves as a young carer are asked if they have heard of the support available from Barnardos young carers services, the trend from 2014 shows:



Since 2014 there has been a 16.2% increase in the % of pupils identifying themselves as young carers that have heard of the Barnardos Young Carers Service. In 2014 26% of young carers had heard of this service and in 2019, 42.2% said they were aware of this service.

The results around the young carers questions will be highlighted to schools, shared with Barnardos Young Carers service and RMBC Commissioning Team.

8. Smoking, Alcohol and Drugs

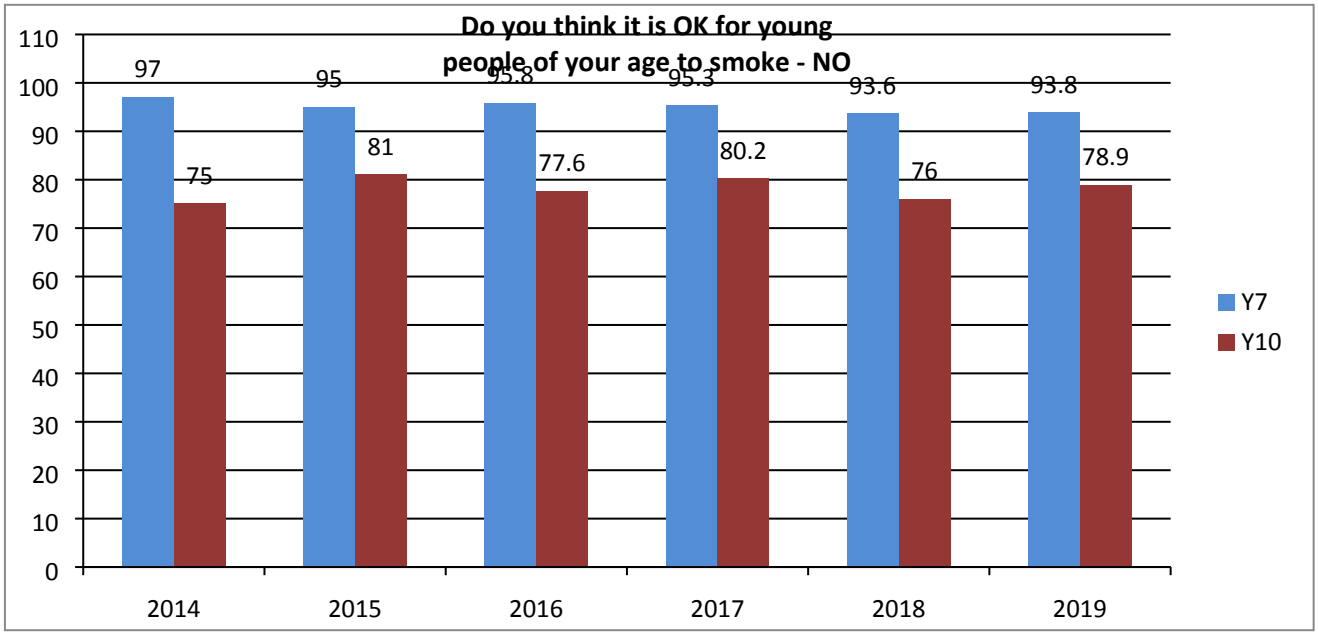
Pupils are asked to respond honestly to a series of questions asked about smoking, drinking alcohol and drug use. Information is shared throughout the survey where young people can go for advice and support. This is particularly highlighted in the smoking, alcohol and drugs questions. Schools are provided with an information pack prior to the commencement of the survey which also details where support and advice can be obtained for young people on these subjects.

8.1 Smoking

Pupils can opt out in answering questions around smoking if they think it is not relevant to them. These results from the Lifestyle Survey will be shared with Health & Wellbeing Board, lead officer for smoking in Public Health, Commissioning and Licensing Enforcement.

8.2 The views of young people and smoking

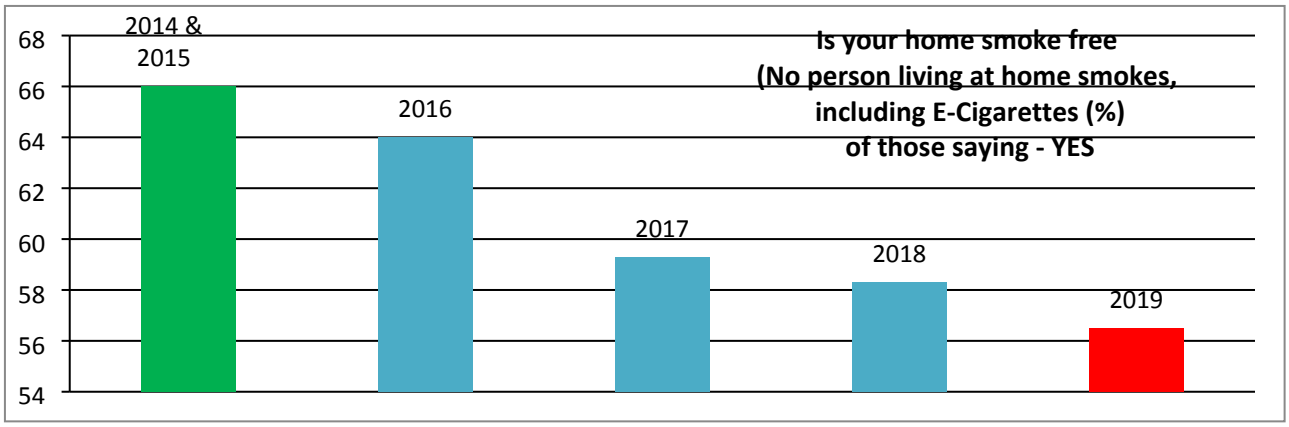
Pupils are asked to say if they feel it is OK for young people of their age to smoke cigarettes, the trend data show:



Year 7 pupils are more likely to say it is OK to smoke in 2019 since 2014. In 2014, 97% of pupils in Y7 thought it was not OK to smoke, this has decreased by 3.2% to 2019.
Year 10 pupils are more likely to say no, it is not OK to smoke in 2019 since 2014. In 2014, 75% of pupils in Y10 thought it was not OK to smoke, this has increased by 3.9% to 2019.

8.3 Smoking and Home Environment

Pupils are asked to say whether they live in a smoke-free home.
This would mean that no person who lives in the home smokes any type of cigarette, including an E-Cigarette. The trend data show:



The data shows that since 2014:

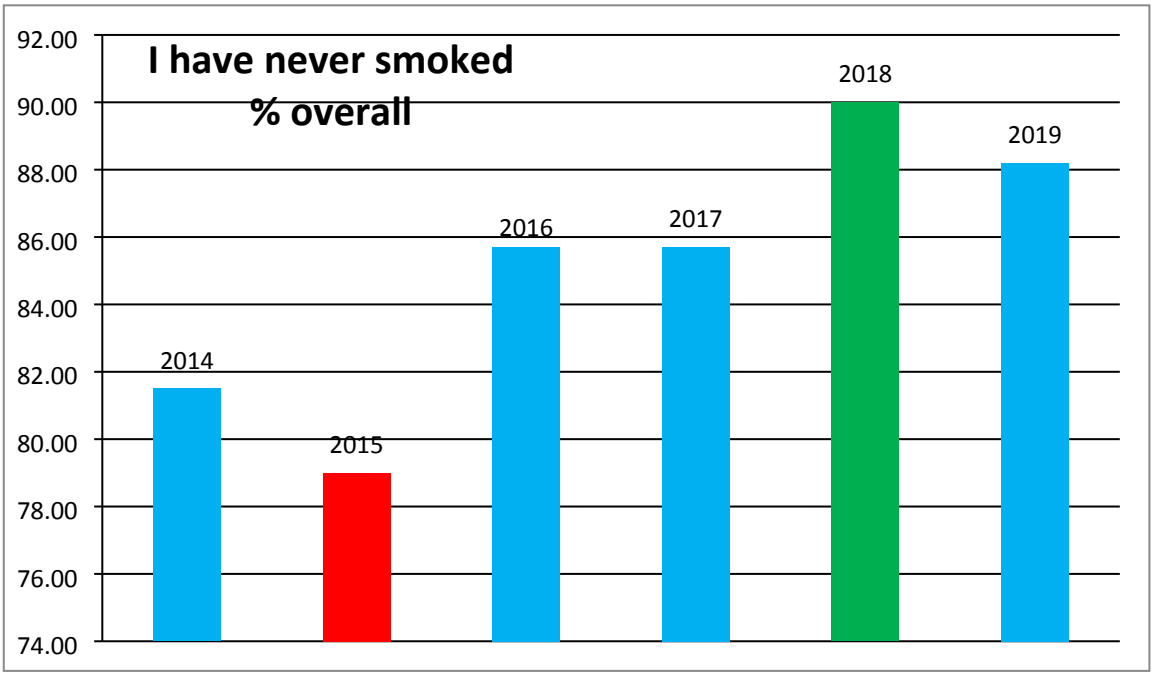
- 9.5% decrease of those saying their home is smoke free
- Since 2015 electronic cigarettes were included in this question, this is likely to have contributed to this decline.

National Data (September 2019)
3.6 million people in the UK are vaping, a rise of 12.5% in one year.
Those using electronic cigarettes make up 7.1% of Britain's population, meaning more people are using e-cigarettes.
The products are most popular with 35 to 44 year olds, followed by 45 to 54 year olds

What Happens Next
Highlight this data with each school and smoking lead for Public Health

8.4 Smoking Regular Cigarettes

Pupils are asked to share their information around smoking habits.
The trend data from 2014 show the % of pupils who are saying they do not smoke.



The data shows that since 2014, there has been a 6.7% improvement in the % of pupils who have said they have never smoked. In 2015 the % of pupils saying they have never smoked

was the lowest over past 6 years at 79% and in 2018 this peaked at 90% of pupils saying they have never smoked.

Benchmarking Information (Published 20.8.2019)
NHS Digital: Statistics on Smoking
The 2018 survey was conducted by Ipsos Mori, and questioned 13,664 pupils, mostly aged 11 to 15, from 193 schools across England, between September 2018 and February 2019.

84% of 11-15 year olds have never smoked this has improved from 81% in 2016

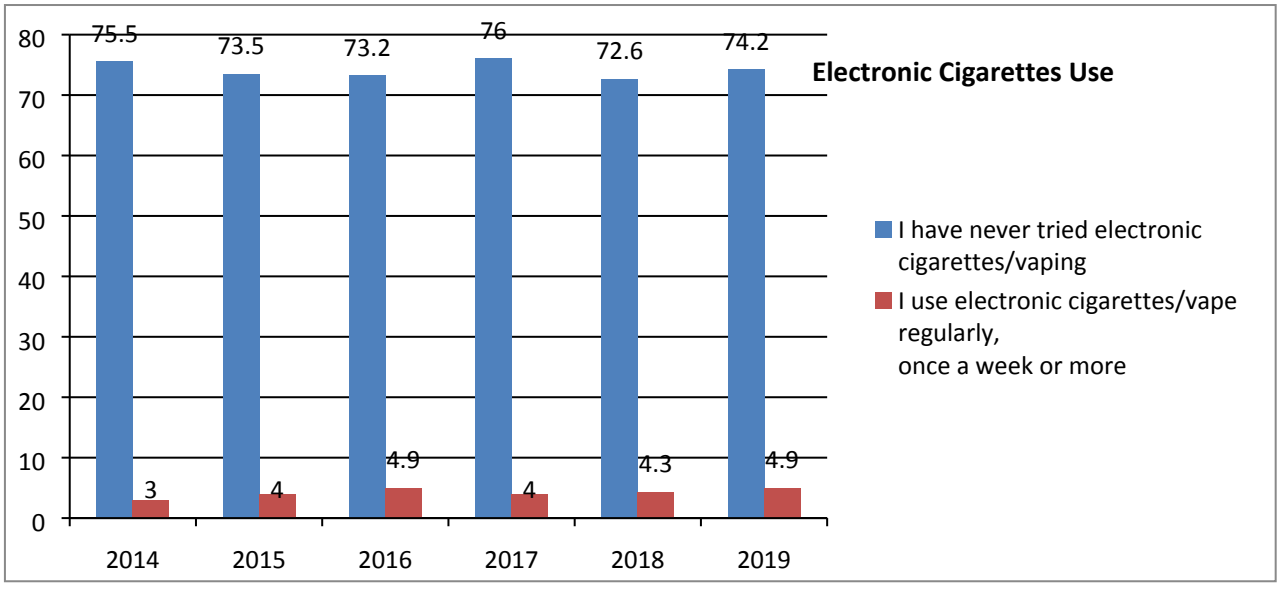
Rotherham Lifestyle Survey 2019
88.2% of all pupils have never smoked
94.1% (1563) of Year 7 (ages 11/12)
79.6% (912) of Year 10 (ages 14/15)

8.2% (256) said they currently smoke
117 smoking not as many as one a week
51 smoking between one to six cigarettes each week
88 smoking more than six per week

National Target
A national ambition in the Government's new tobacco control plan published in 2017
Reduced the number of 15 year old who regularly smoke to 3% or less by 2022

8.5 Electronic Cigarettes

Pupils are asked to share information, whether they are using or have tried electronic cigarettes. The trend data around those who have never tried an electronic cigarette and those who are using them regularly since 2014 is:



There has been a 1.3% decrease in the % of young people who have said they have never used an electronic cigarette since 2014. There has been a 1.9% increase in the % of young people who have said they are using them regularly since 2014.

These results from the Lifestyle Survey will be shared with Health & Wellbeing Board and lead officer for smoking in Public Health.

Benchmarking Information

Action on Smoking & Health Information from Ash.org.uk
Their key findings show that 76.9% of 11-18 year olds have never tried an electronic cigarette. The Rotherham Lifestyle survey figures are lower than this for Y7 and Y10 pupils at 74.2%.

Their conclusion around e-cigarettes is:
The data from the 2019 ASH YouGov Smokefree youth GB survey suggest that while some young people, particularly those who have tried smoking, experiment with e-cigarettes, regular use remains low, the data from Rotherham Lifestyle survey shows that from those who said they smoke e-cigarettes, 4.9% (150) said they use them regularly

Source of Information
http://ash.org.uk/wp-content/uploads/2019/06/ASH-Factsheet-Youth-E-cigarette-Use-2019.pdf

NHS Digital: Statistics on Electronic Cigarettes (Published 20.8.2019)

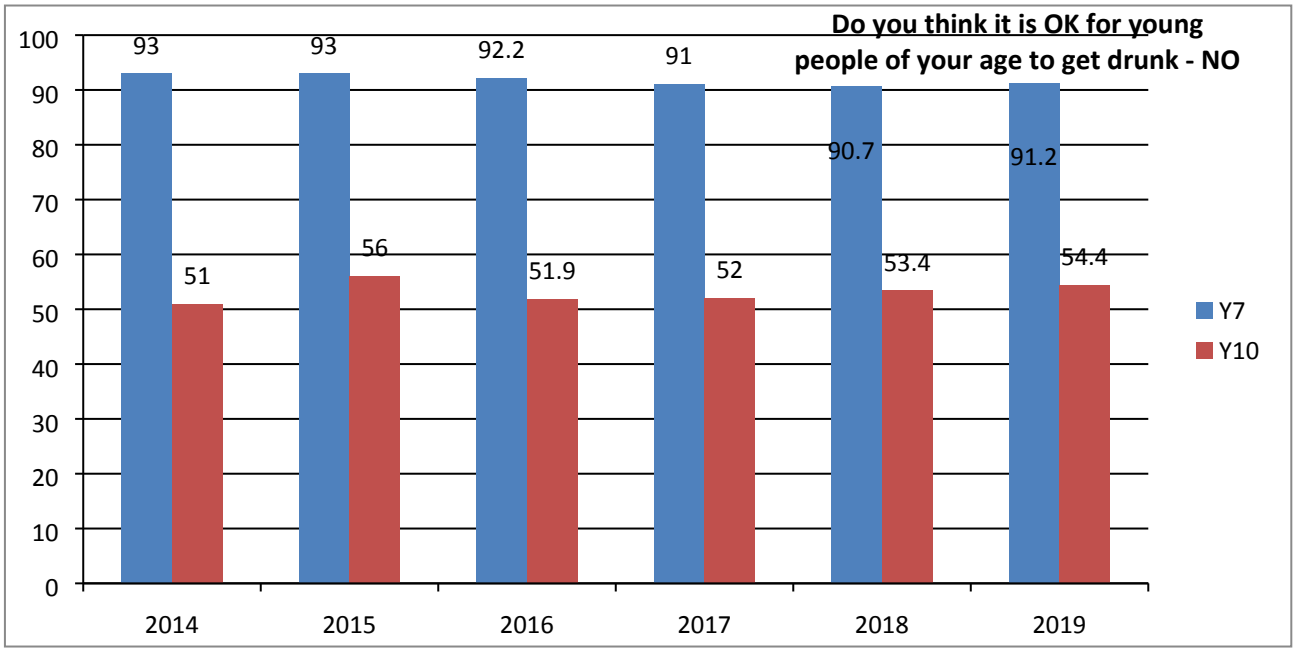
The 2018 survey was conducted by Ipsos Mori, and questioned 13,664 pupils, mostly aged 11 to 15, from 193 schools across England, between September 2018 and February 2019.
75% said they have never tried an electronic cigarette; this is consistent with Rotherham Lifestyle Survey data.

8.6 Alcohol

The results from the Lifestyle Survey will be shared with Health & Wellbeing Board, lead officer for alcohol/drug support in Public Health, Commissioning and Licensing Enforcement.

8.7 The views of young people and drinking alcohol

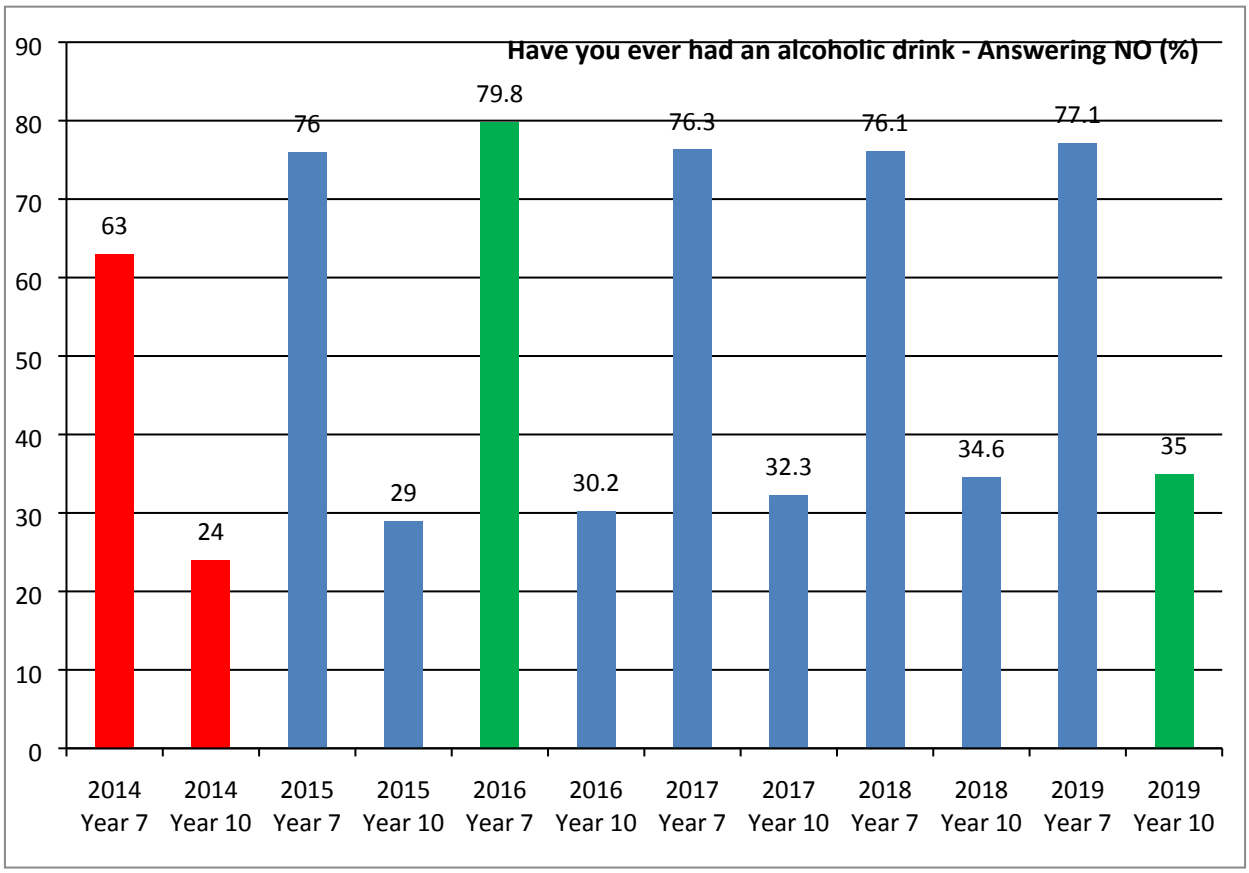
Pupils are asked to say if they feel it is OK for young people of their age to get drunk, the trend data from 2014 show:



Since 2014 there are fewer Y7 pupils who feel it is wrong for young people of their age to get drunk, this has reduced by 1.8%, although there are 3.4% more young people in Y10 who feel it is wrong for young people their age to get drunk.

8.8 Drinking Alcohol

Pupils are asked to say if they have ever had an alcoholic drink, even if this was just a small sip of alcohol, the trend data from 2014 show:

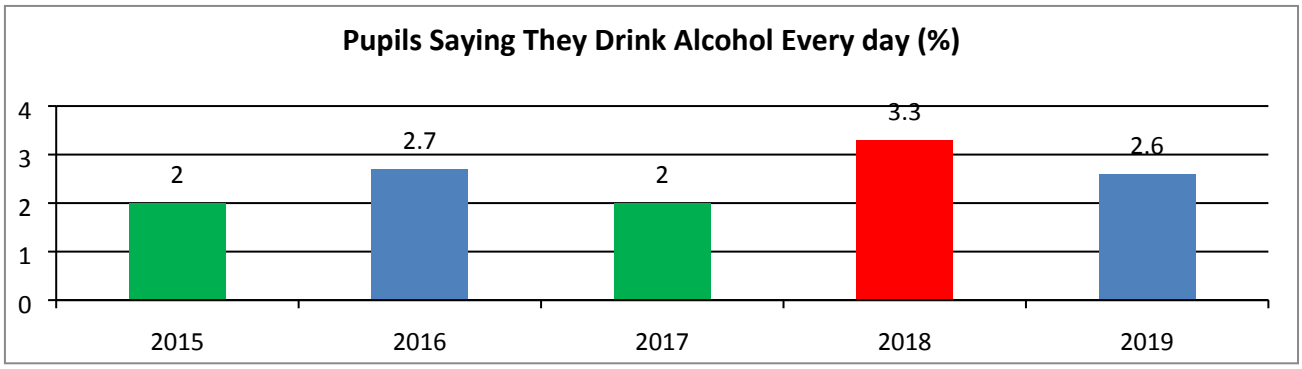


There has been an 11% increase in the % of Y10 pupils who said they have never had an alcoholic drink. In 2014 24% of Y10 pupils said they have never had a drink and this has increased to 35% in 2019.

There has been a 14.1% increase in the % of Y7 pupils who said they have never had an alcoholic drink. In 2014 63% of Y7 pupils said they have never had a drink and this has increased to 77.1% in 2019. This option did peak in 2016, when almost 80% of Y7 pupils said they have never had an alcoholic drink.

8.8.1 Frequency of Drinking Alcohol

Pupils who said they have had an alcoholic drink, are asked to say how often they drink. The trend data since 2015 that shows the % of pupils who say they are drinking alcohol every day. The data shows:



The % of young people who have said they have a drink of alcohol each day has slightly increased since 2015, although the results in 2019 are not as high a % as in 2018.

Benchmarking Information

The What About Youth (WAY) survey was carried out in 2014 and results published in 2015. This survey was designed to collect robust local authority level data about a range of health behaviours of 15 year old young people.
Rotherham's eligible sample size was 2,126

841 children from Rotherham answered the question, Have you ever had an alcoholic drink? - 74.3% said yes
England overall figure – 62.4% said yes

Overall the Lifestyle survey results from 2019 show that 58.7% said they have tried an alcoholic drink, this could be due to the Lifestyle Survey is more recent data.

NHS Digital: Statistics on Alcohol (Published 20.8.2019)

The 2018 survey was conducted by Ipsos Mori, and questioned 13,664 pupils, mostly aged 11 to 15, from 193 schools across England, between September 2018 and February 2019.
56% said they have never tried alcohol.

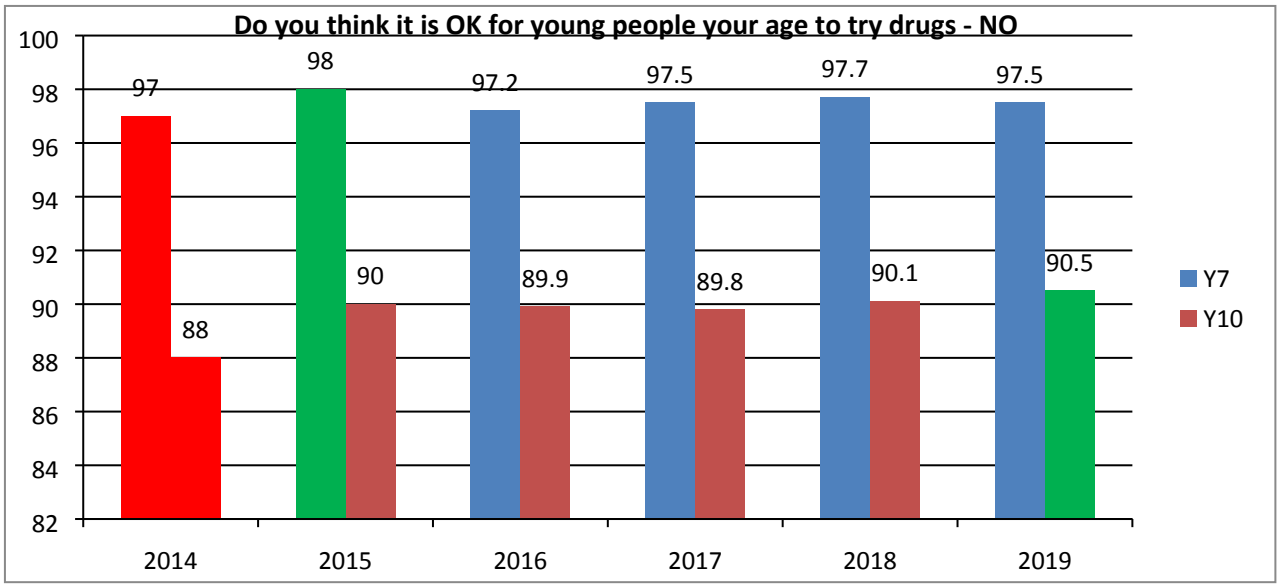
Over a 3 year period 2015/2018 there were 38 admissions to hospital of Rotherham under 18 year olds for alcohol specific conditions

8.9 Drugs

Pupils can opt out of answering questions around drugs if they think it is not relevant to them. . The results from the Lifestyle Survey will be shared with Health & Wellbeing Board, lead officer for alcohol/drug support in Public Health, Commissioning and the new commissioned service to support young people with drug and alcohol support.

8.10 The views of young people and the use of drugs

Pupils are asked to say if they feel it is OK for young people of their age to use drugs, the trend data from 2014 shows:

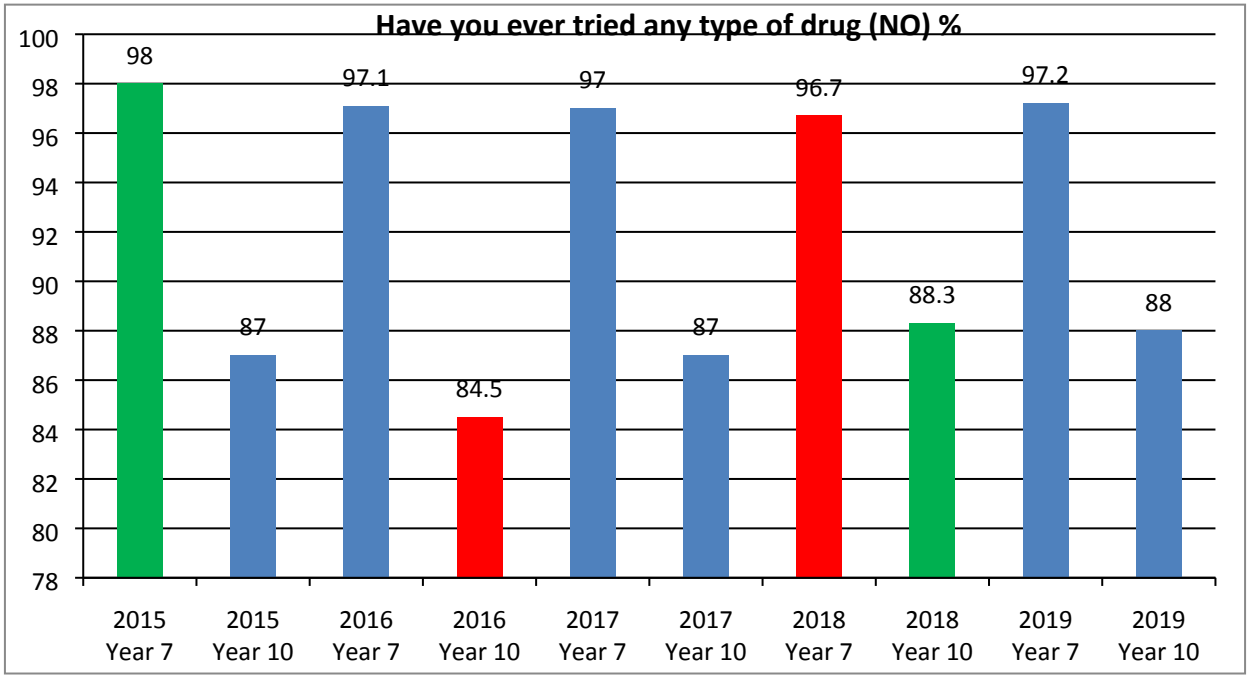


The results show that there is consistency for Y7 pupils between 2014 and 2019 ranging between 97% and 98% saying they feel it is wrong for young people of their age to try drugs.

For Y10 there has been a 2.5% increase in the % of young people in this age group who feel it is wrong to try drugs. This has increased in 2019 to 90.5%.

8.11 Using Drugs

Pupils are asked to say if they have ever tried any drugs, the trend data from 2014 show:



The trend data shows that since 2014 to 2019 both Y7 and Y10 results are within 1% of each other of the pupils who have said they have tried drugs.

8.11.1 Types of Drugs

The trend data shows that there has been an increase in the % of young people who have said they have tried the harder type of drugs. The trend data shows from 2015, when a question was added to the survey to ascertain the types of drugs young people were trying, the information shows:

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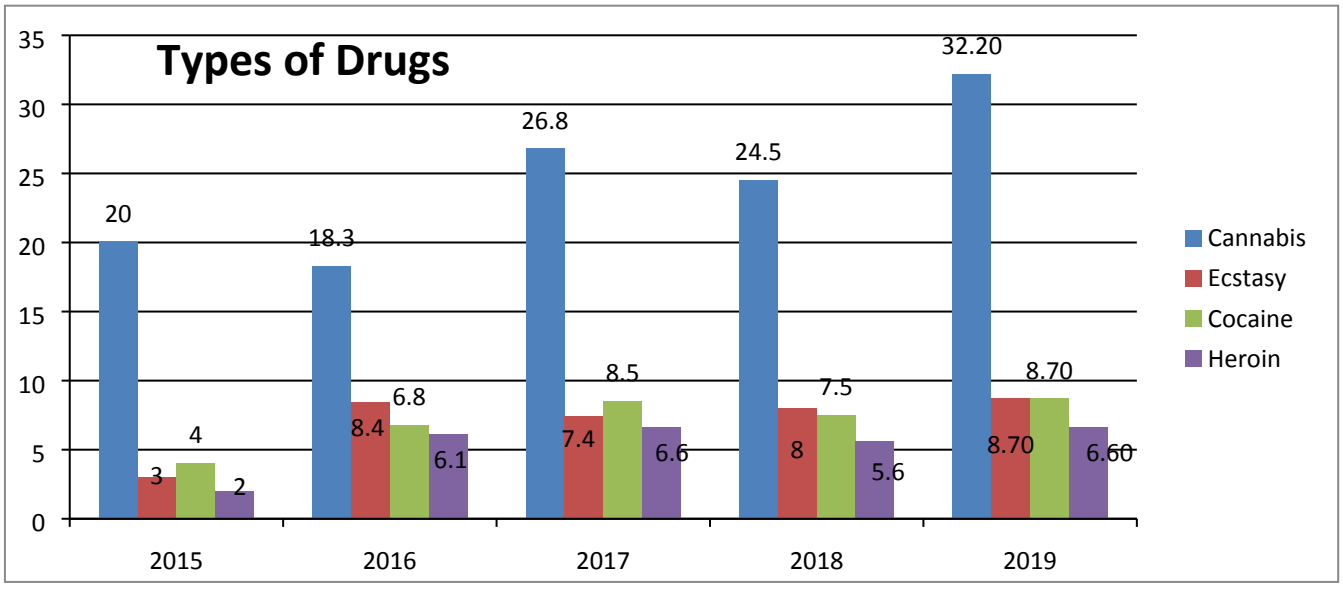
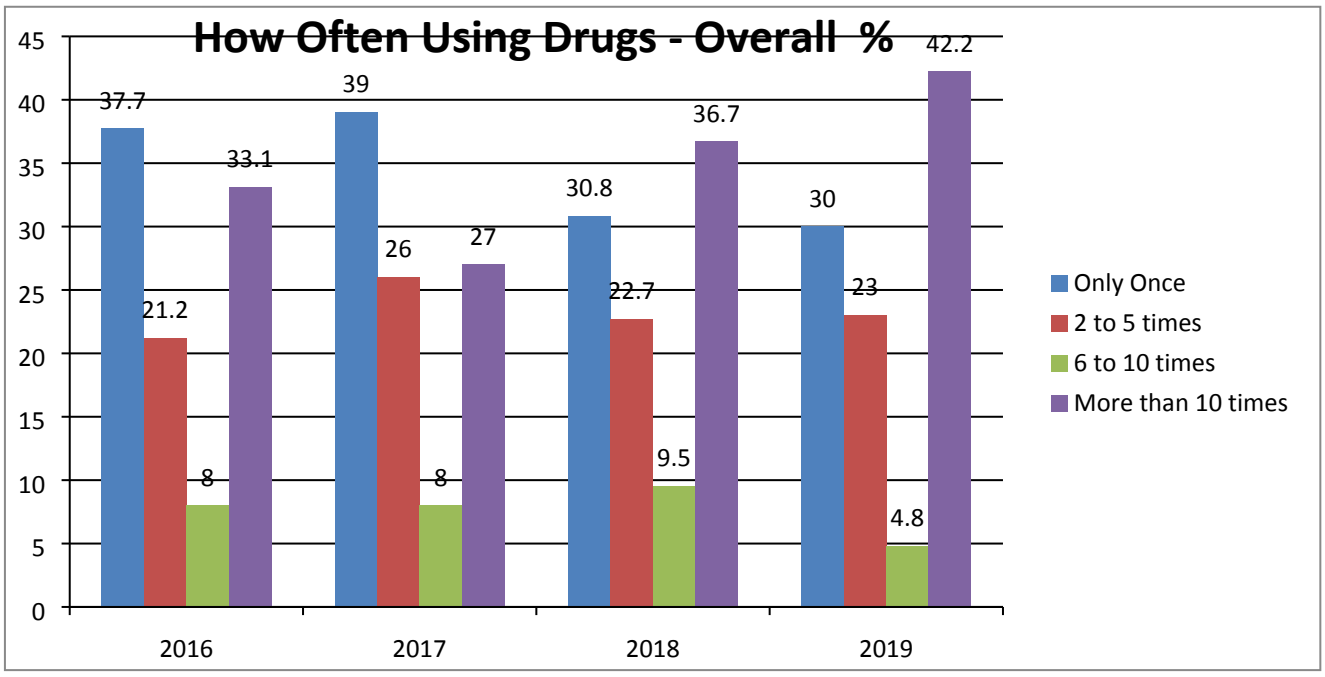


The results show overall for there has been increases of:

- 12.2% increase in the % of those who have said they have tried drugs, saying they have tried cannabis since 2015.
- 6.7% increase of those who have tried ecstasy
- 4.7% increase of those who have tried cocaine
- 4.6% increase of those who have tried heroin.

8.11.2 Use of Drugs – How Often

Pupils are asked to say how many times they have tried a form of drug, the results show the responses since 2016 when this questions was added to the lifestyle survey.



The results since 2016 show that there has been an increase in the % of young people who have said they are using drugs more frequently. Young people saying they have used drugs more than 10 times has increased by 9.1% in 4 years. Those saying they have only tried them once has decreased by 4.6% in the same period.

What Are We Worried About?

The 2019 Lifestyle survey results give an indication that more young people are trying drugs, and how frequent and how many times they are trying them appears to be on the increase.

The types of drugs that are being tried appear to be the stronger type of drug
The most popular drugs now being cannabis, cocaine and ecstasy.

Benchmarking Information

The What About Youth (WAY) survey was carried out in 2014 and results published in 2015. This survey was designed to collect robust local authority level data about a range of health behaviours of 15 year old young people.
Rotherham's eligible sample size was 2,126

842 children from Rotherham answered the question, Have you ever tried cannabis?
8.9% said yes
England overall figure – 10.7% said yes

Overall the Lifestyle survey results from 2019 show that 6.9% (209) said they have tried a form of drug. Out of these 209, 32.2% (141) said they have tried cannabis.

Over a 3 year period 2015/2018 there were 68 admissions to hospital of Rotherham for 15-24 year olds due to substance misuse.

BBC News

A recent BBC news article reported on the worry that children as young as 12 are being targeted by county line drug gangs expanding their markets into dealing.

Social media apps are increasingly likely to be used by young people to buy illegal drugs
It is reported that young people think cannabis is safer than alcohol.

Action

Rotherham Young Inspectors will be carrying out an inspection of the commissioned service to support young people with drug and alcohol problems in Rotherham. This inspection will take place February 2020

9. Sexual Health & Relationships

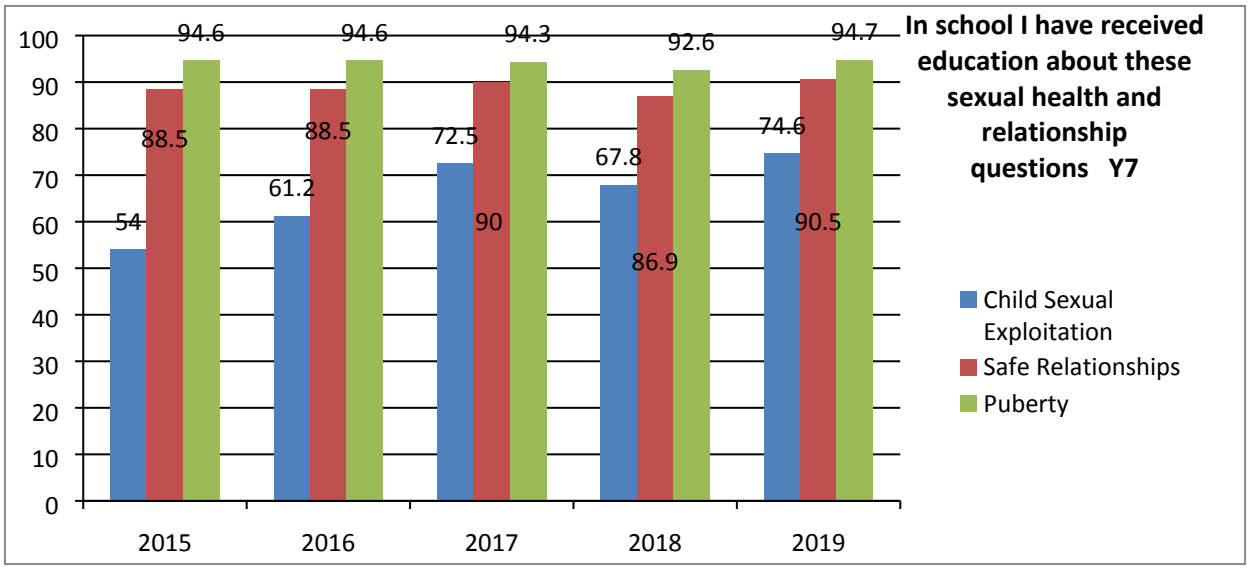
Pupils are asked a series of questions about sexual health and relationships. A number of these questions are age appropriate questions and are for year 10 pupils only. The report will indicate if the questions have been answered by year 10 only.
The results will be highlighted to schools and shared with lead for sexual health in Public Health.

9.1 Sexual Health and Relationships Education

Pupils are asked to share information about the sexual health and relationship education they have received at school. There are different options for year 7 and year 10 pupils, to make the options age appropriate.

9.1.1 Year 7 Results

Pupils are asked to say what they have been taught at school as part of their personal, social and health education in relation to sexual health and relationships.

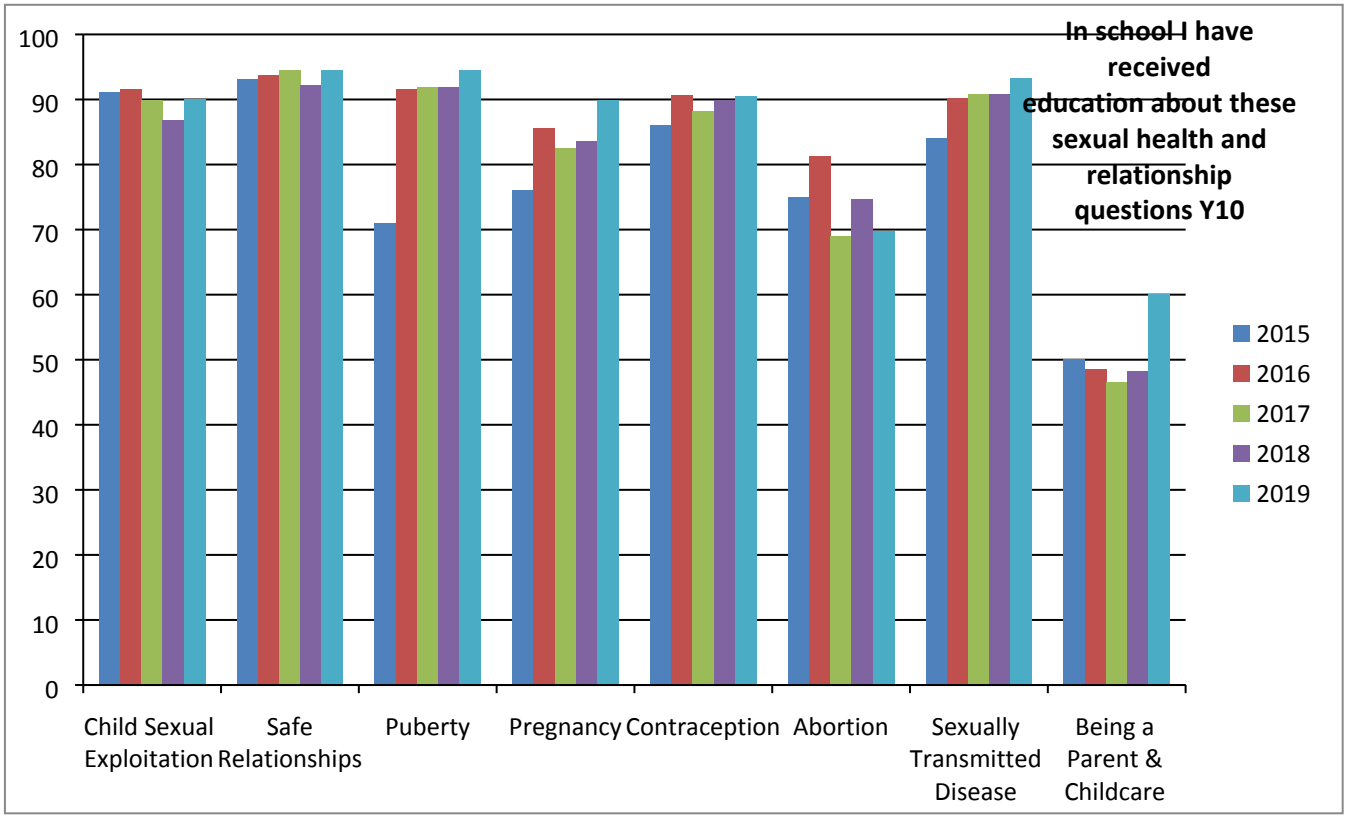


The results show that there has been an increase in the % of pupils in year 7 that have been taught about these subjects since 2015:

- CSE education has increased by 20.6%
- Safe Relationships education, including healthy relationships has increased by 2%
- Growing up and body changes education is relatively the same, with an increase of 0.1%

9.1.2 Year 10 Results

Pupils are asked to say what they have been taught at school as part of their personal, social and health education in relation to sexual health and relationships.



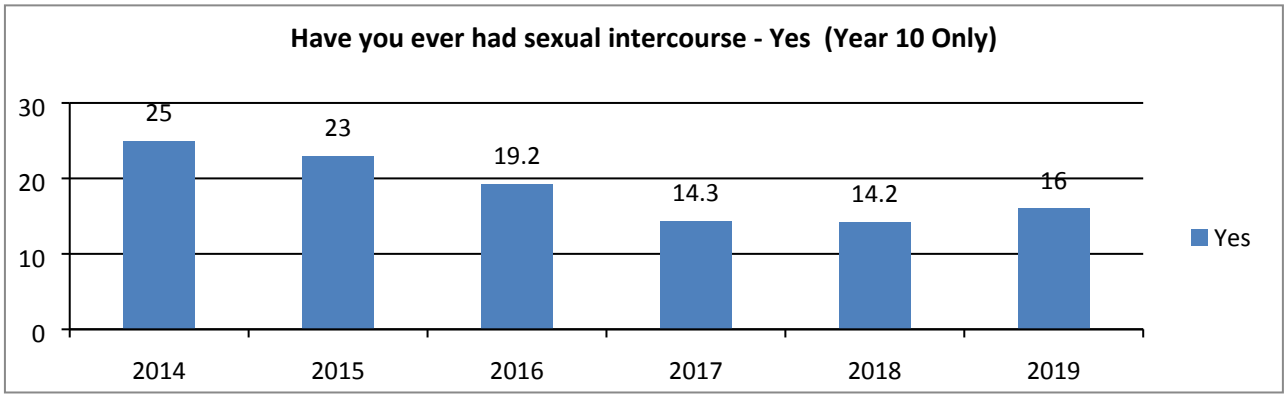
The results show that there have been changes in the % of pupils in year 10 that have been taught about these subjects since 2015:

- CSE education has decreased by 1% since 2015
- Safe Relationships education, including healthy relationships has increased by 1.4%
- Growing up and body changes education has increased by 23.5%
- Pregnancy education has increased by 13.9%
- Contraception education has increased by 4.5%
- Abortion education has decreased by 5.3%
- Sexually Transmitted Infections education has increased by 9.3%
- Being a Parent education has increased by 10%

It is worth noting that the results in the survey are the perception of young people. There is no specific evidence that shows information around % of young people and the subjects they have been taught. Barnardos Reachout and Barnardos Real Love Rocks Programme deliver training to schools and they support train the trainer programmes, (training staff at schools to deliver their own training in particular around CSE).

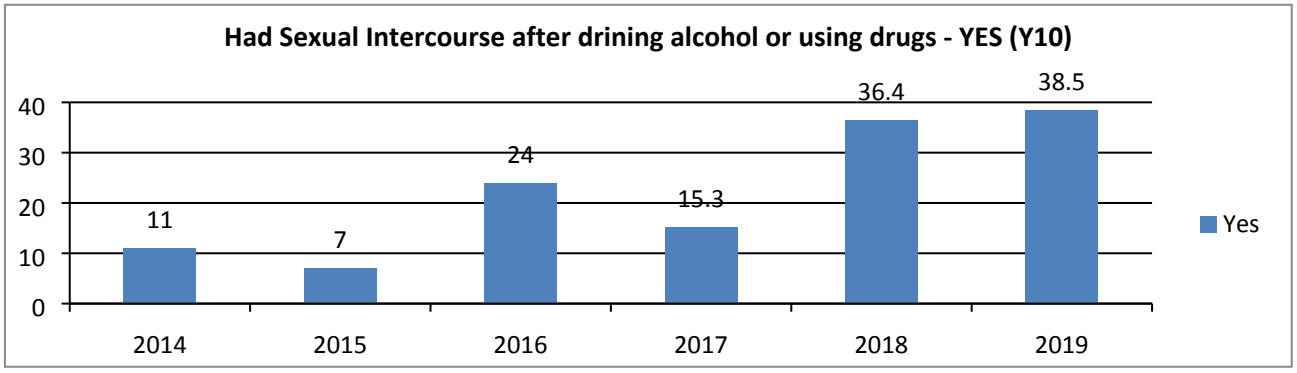
9.2 Sexual Relationships Y10 Only questions.
Pupils in Y10 were asked if they have had sexual intercourse.
It is not compulsory for pupils to answer sexual health and relationship questions

There has been a 9% decrease since 2014 from the Y10 pupils who have said they have had sexual intercourse.



Pupils who answered yes, to the question have you ever had sexual intercourse, are asked follow on questions. They are asked to say if they have had sexual intercourse after they have drunk alcohol or taken drugs.

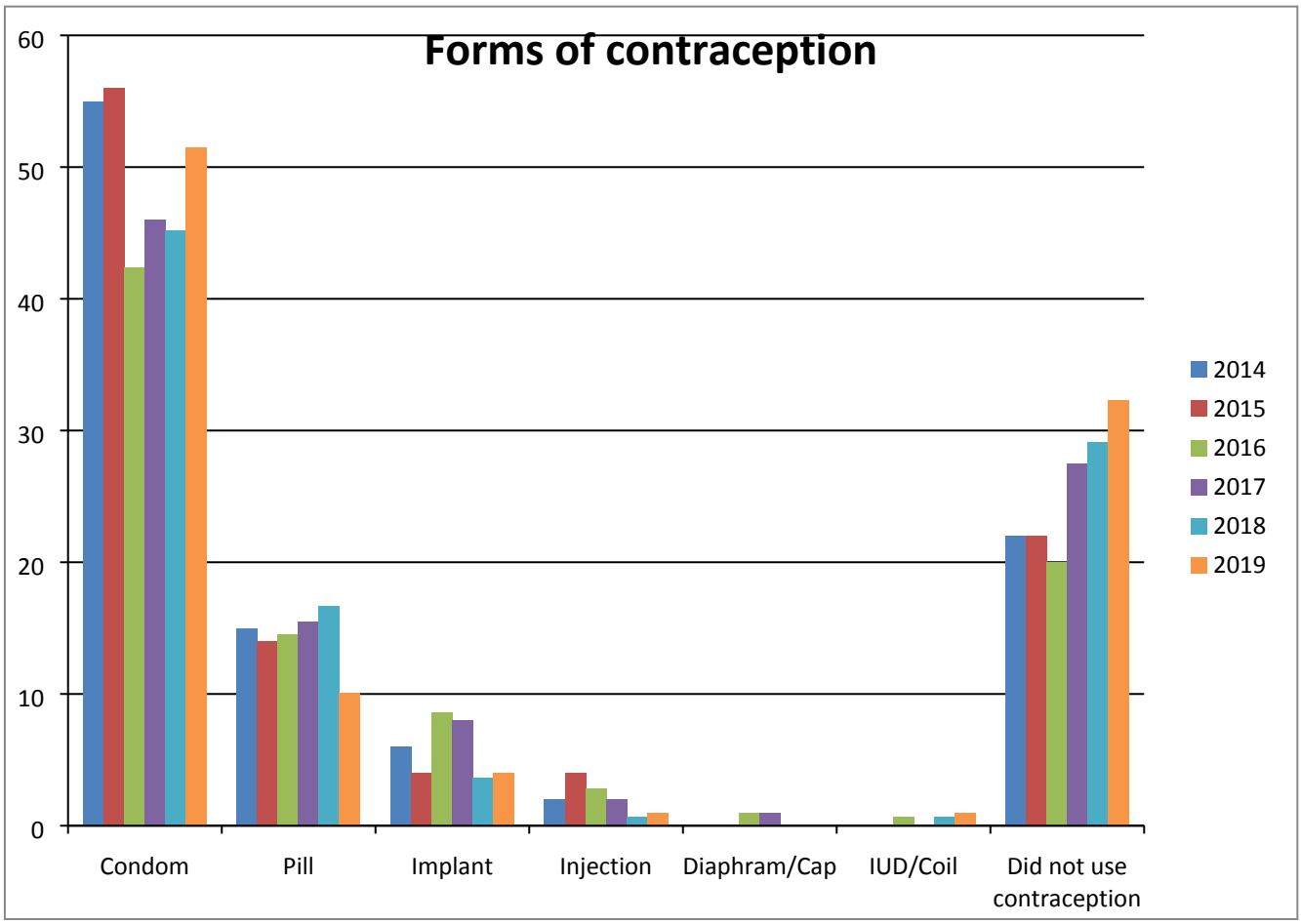
9.2.1 Have you had sexual intercourse after drinking alcohol or using drugs?



Although the % of Y10 pupils who said they have had sexual intercourse has decreased since 2014, there has been an increase of 27.5% of those pupils who have said they have had sexual intercourse after drinking alcohol or using drugs.

9.2.2 Contraception

Pupils who have said they have had sexual intercourse, are asked to share what type of contraception they used. The results since 2014 show:



The main changes from Y10 pupils sharing information about the form of contraception that they used are:

- Pupils saying they have used a condom as a form of contraception has decreased since 2014 by 3.5%
- Pupils saying they have used the pill as a form of contraception has decreased since 2014 by 4.9%
- Pupils saying they did not use contraception has increased by 10.3% since 2014

10. References

Information other than the results of the 2019 lifestyle survey information has been sourced from:

- Rotherham Lifestyle Survey Reports 2014 to 2019
- Rotherham Health & Wellbeing Strategy
- Department for Education
- Barnardo's Young Carers Plan
- NHS Digital 2018
- What About Youth Survey 2014/2015
- www.nutrition.org.uk
- Public Health England
- Ditch The Label National Bullying Charity
- BBC News Article 4 March 2019
- BBC News Article 13 August 2019

Rotherham Metropolitan Borough Council

Voice of the Child
Lifestyle Survey 2019

Children and Young People's Services

Bev Pepperdine

Performance Assurance Manager

Rotherham Metropolitan Borough Council
Voice of the Child
Lifestyle Survey 2019

- Background to Lifestyle Survey
- Feedback from Health & Wellbeing Board
- Long Term Trends
- Trends - What appears to be working well
- Trends - What are we worried about
- What to do next

Rotherham Metropolitan Borough Council
Voice of the Child
Lifestyle Survey 2019

- Lifestyle Survey is an annual survey
- Lifestyle Survey is open to pupils in year 7 and year 10
- Capture voice of children and young people
- Aim to highlight the results to support the allocation of resources to improve health of children and young people
- Aim to provide a baseline for monitoring the impact of services provided to improve health and wellbeing
- To enable benchmarking and comparison between other areas
- To provide information that could be used to plan resources and shape curriculums
- To highlight areas to explore further, in terms of health inequalities

Rotherham Metropolitan Borough Council
Voice of the Child
Lifestyle Survey 2019

- Summary for Health & Wellbeing Board
- Trends between 2014* to 2019
- Main Changes

Rotherham Metropolitan Borough Council
Voice of the Child
Lifestyle Survey - Trends

What has worked well?

More eating recommended amounts of fruit and veg

Less drinking high sugar drinks

Less drinking high energy drinks

More doing regular exercise

More feeling safe around

- Bus station
- Train station
- Town Centre

Less bullying

Fewer young carers

Less smoking regular cigarettes

Less trying alcohol

More received education about CSE

Less Y10 saying they have had sexual intercourse

What are we worried about?

More mental health diagnosis

Less regularly visiting the dentist

Less drinking recommended amounts of water

More skipping lunch

More feeling their mental health is poor

Less feeling their weight is OK

More people feel they have no one to talk to

Increase in young carers saying they have struggles

Less homes smoke free

More trying E-Cigarettes

Harder drugs being tried

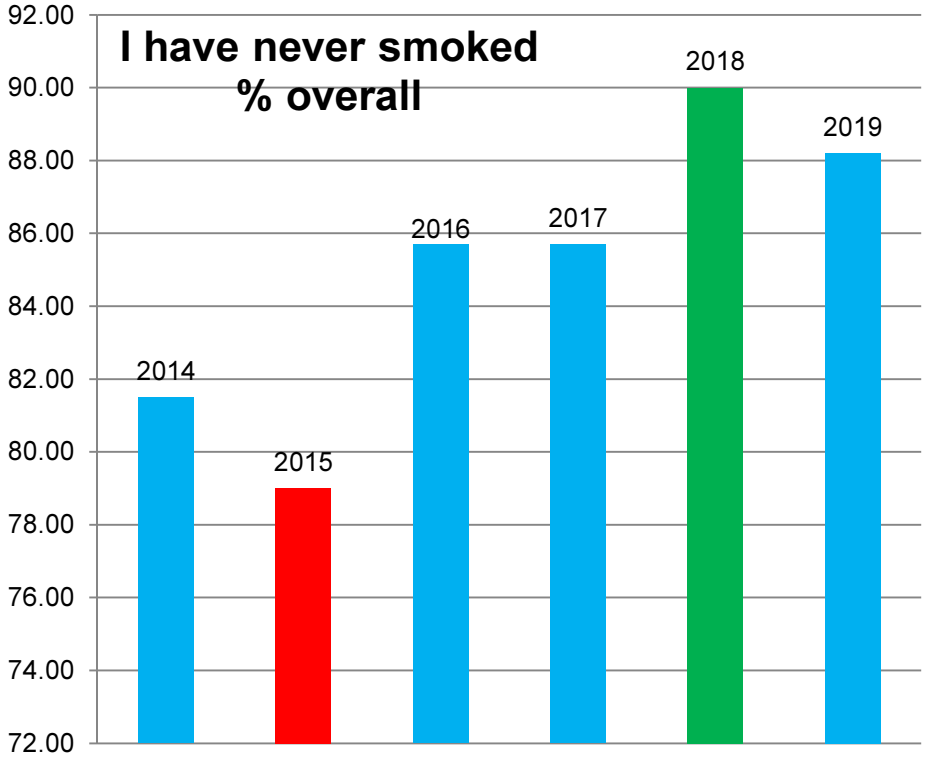
Frequency of drug use increased

More Y10 saying they have had sex after drugs or alcohol use

More Y10 saying they do not use contraception

Voice of the Child
Rotherham Lifestyle Survey 2019
What is working well?

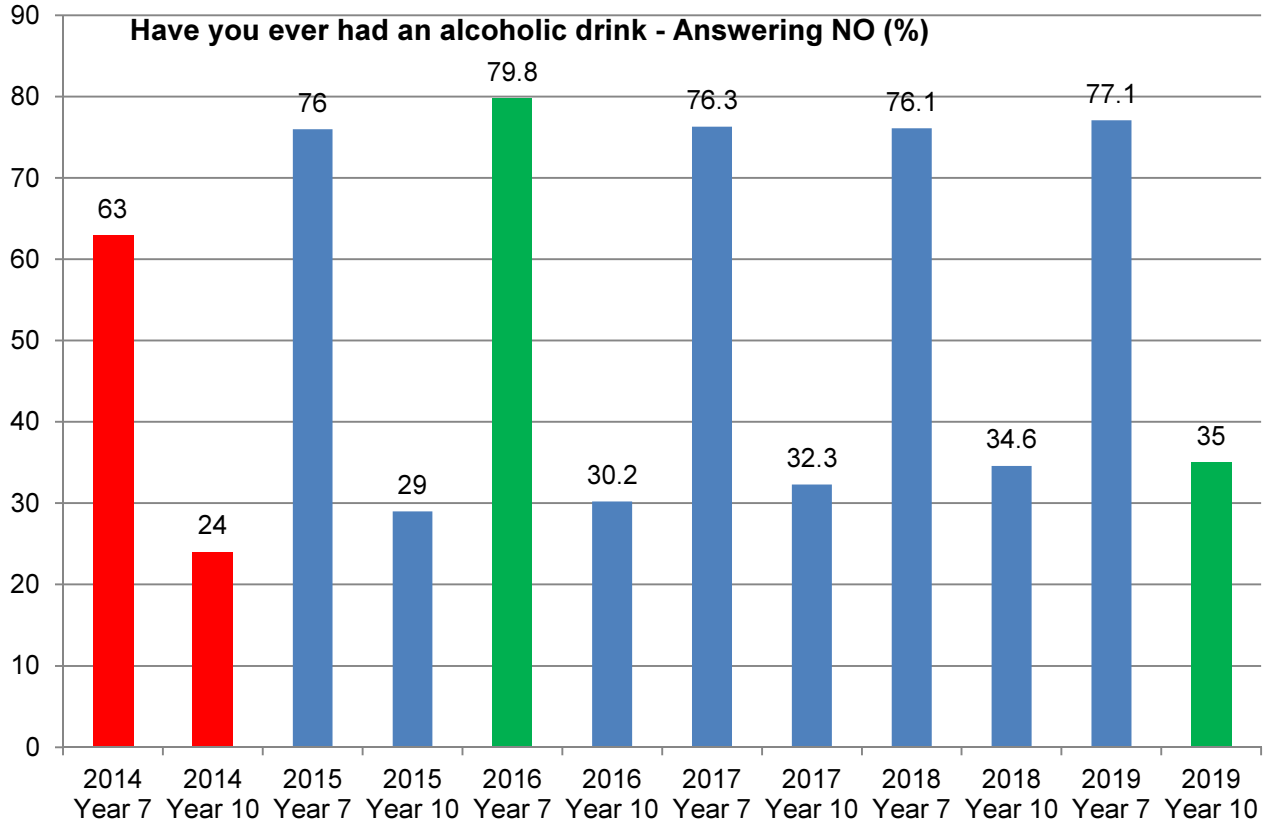
Trend Data 2014 to 2019 - Smoking



- 6.7% increase of those saying they have never smoked since 2014.
- Schools each year hold national non-smoking events
- NHS Digital: Statistics on Smoking (20.8.19)
  - Nationally 84% of 11-15 year olds have never smoked
  - Rotherham statistics from 2019 show that 88.2% of pupils age 11/12 and 14/15 say they have never smoked.
- What happens next?
  - Highlight this data with Public Health & Schools
  - Request that schools share data with all pupils to make them aware

Voice of the Child
Rotherham Lifestyle Survey 2019
What is working well?

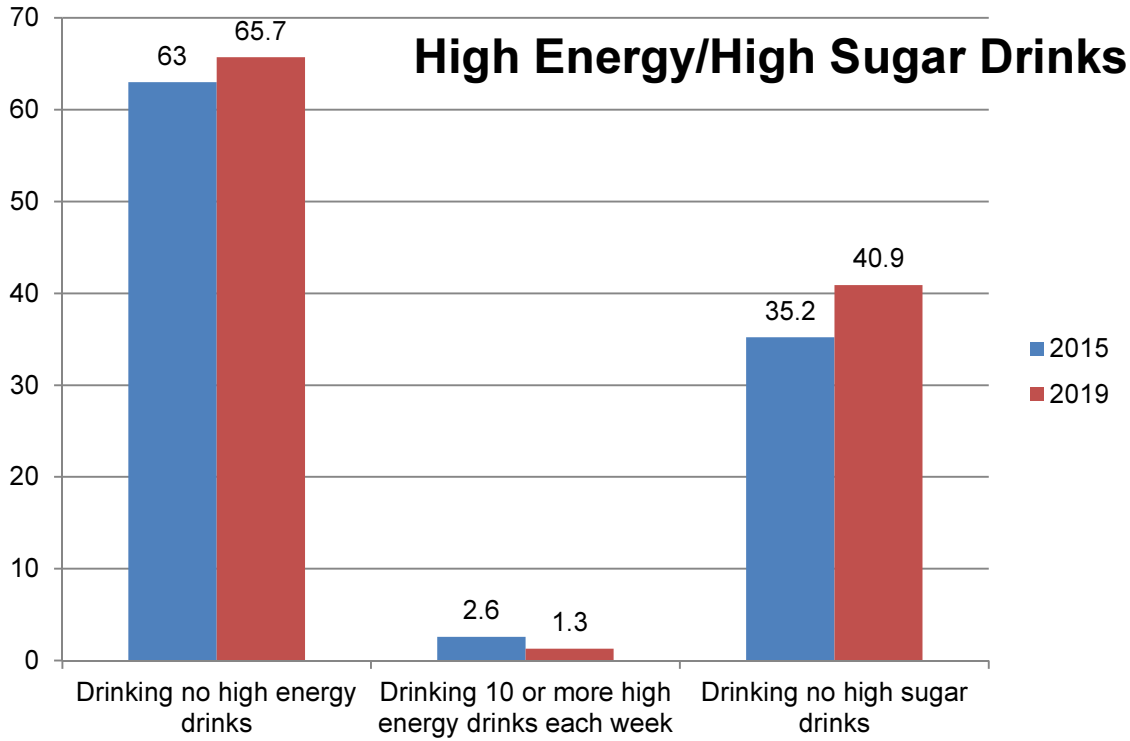
Trend Data 2014 to 2019 - Alcohol



- 14.1% increase in the % of Y7 pupils who said they have never had an alcoholic drink from 2014 to 2019
- 11% increased in the % of Y10 pupils who said they have never had an alcoholic drink from 2014 to 2019
- Underage drinking has been targeted nationally and schemes such as ‘Challenge 21’ has been a contributing factor in the reduction of young people drinking alcohol.

Voice of the Child
Rotherham Lifestyle Survey 2019
What is working well?

- Trend Data 2015 to 2019 - High Energy/High Sugar Drinks



Schools have banned the sale of high energy drinks – this has had a positive impact – fewer pupils drinking them regularly and more pupils saying they do not drink them at all

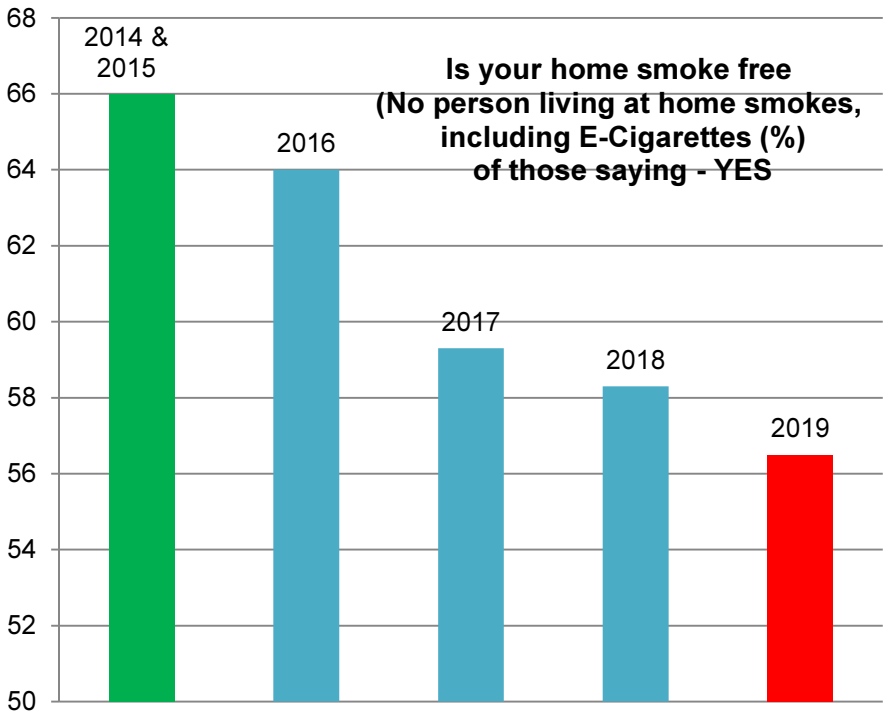
Schools have campaigned to highlight the levels of sugar in some drinks – this has had a positive impact with more pupils saying they do not drink high sugar drinks

Young People and Mental Health

- 2019 – 10.6% of young people said they have a diagnosis of a mental health condition, compared to 5% in 2015
- 2019 Year 7 – 8.3% rated their mental health as poor, compared to 5% in 2017
- 2019 Year 10 – 17.5% rated their mental health as poor, compared to 12% in 2017
- 2019 – 4% (145) of young people said they would not have anyone they could talk to if they had a problem, compared to 3.4% (90) in 2016.
- CAMHS Service – 2019 Increase in the volume of referrals to support young people with their mental health

Voice of the Child
Rotherham Lifestyle Survey 2019
What are we worried about?

Trend Data 2014 to 2019 – Smoke Free Homes



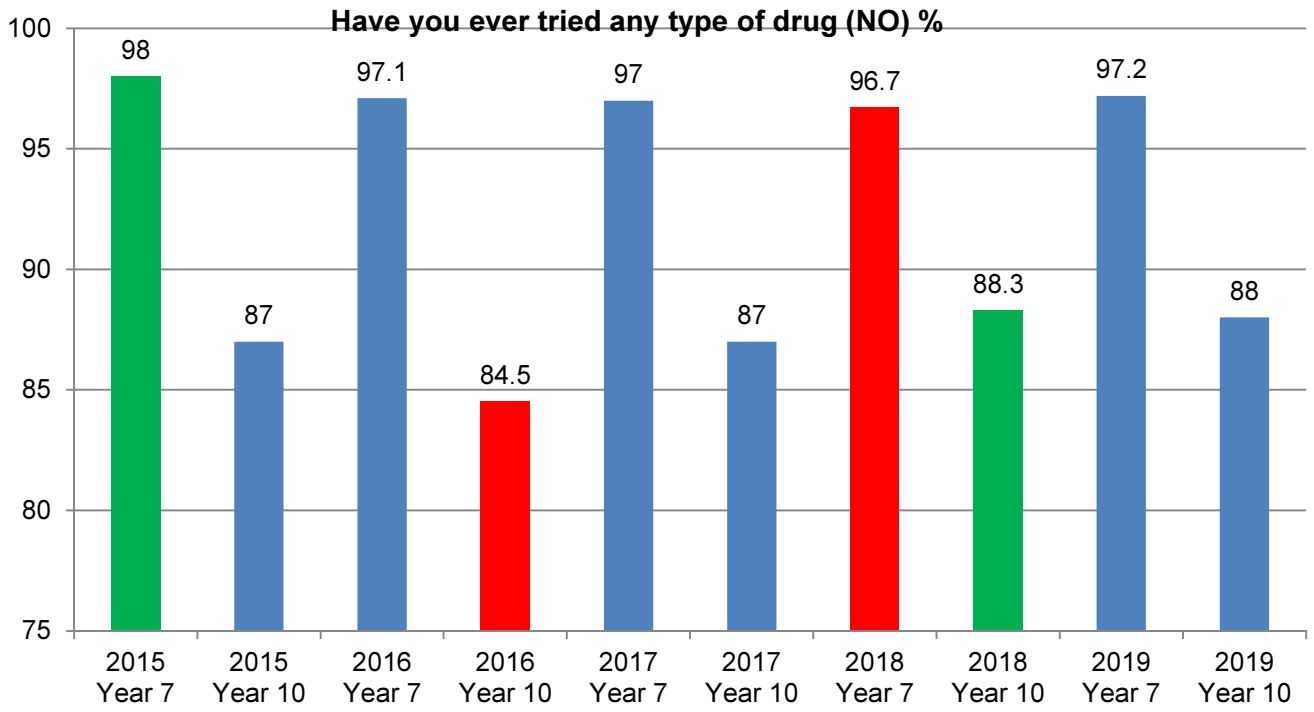
- 9.5% decrease of those saying their home is smoke free since 2014.
- Since 2015 Electronic Cigarettes were included in this question, this is likely to have contributed to this decline.
- National data shows - (September 2019)

  3.6m people in the UK are vaping, a rise of 12.5 per cent in one year. Those using electronic cigarettes make up 7.1% of Britain's population, meaning more people are using e-cigarettes. The products are most popular among 35- to 54 year olds.
- What happens next?

  Highlight this data with Public Health & Schools

Voice of the Child
Rotherham Lifestyle Survey 2019
What are we worried about?

Trend Data 2015 to 2019 - Drugs



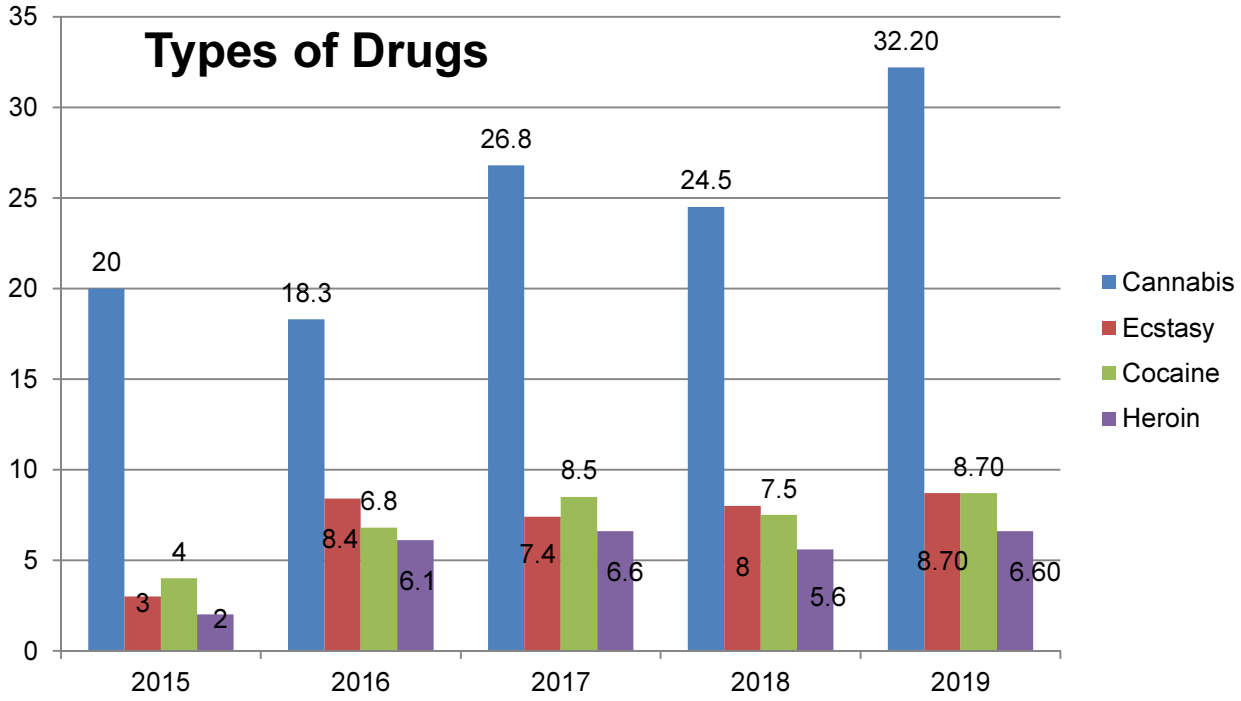
The data from young people saying whether they have tried drugs is relevantly consistent since 2015.

On average overall Rotherham data show that around 92% of pupils who have completed the lifestyle survey say they have not tried drugs.

A national survey results showed that 85% of 11 to 15 year old are saying they have not tried drugs.

In 2017 Rotherham had 84 admissions to hospital with drug related specifically to drugs for under 18's, this is below our regional average.

Voice of the Child
Rotherham Lifestyle Survey 2019
What are we worried about?



The trend data shows that there has been an increase in the % of young people who have told us they have tried the 'harder' type of drugs

In 2015 the most popular choices chosen for they type of drug that had been tried was

- Cannabis
- Legal Highs
- Solvents

In 2019 – 209 young people

Rotherham Metropolitan Borough Council
Voice of the Child
Lifestyle Survey 2019

What Happens Next

- Relevant data will be highlighted to partners
- Feedback will be requested from schools on actions they plan to take
- Data will be shared with Neighbourhoods by ward data – support their priorities
- Feedback will be requested from partners around any actions they plan to take
- Information will be shared with:
  - Children & Young People Partnership
  - Improving Lives Scrutiny Panel
  - Different But Equal Board
  - Youth Cabinet Board
- Plan for the delivery of 2020 Lifestyle Survey

Rotherham Metropolitan Borough Council
Voice of the Child
Lifestyle Survey 2019

QUESTIONS?

Thank You

Climate Emergency Action Plan

Health and Wellbeing Board
22/01/20

Climate Emergency

- State of the UK climate report 2017 – warming climate, rising sea levels and increased weather variability/extremes all expected to continue in the future; necessitates a state of “climate emergency”
- IPCC Special Report on Global Warming (2018) recommends 12 years to make drastic action against climate change
- Government target date of 2050 for Britain to produce “net zero emissions”
- RMBC recent reductions of carbon emissions by 3% per year (fifth greatest reductions over the past decade)
- Pressure is mounting to take further action within the context of central government targets, increased direct action (and other forms of participation) from citizens, and the real effects of climate change (e.g. recent floods)

Rotherham climate emergency motion

The council declared a climate emergency in October 2019 and resolved to:

- propose an informed target for the Council's carbon reduction by 2025
- develop a "Carbon Action Plan" towards these goals
- promote the strategy and engage with community, public and business
- lobby government for additional resources to support this strategy
- produce an annual Rotherham Climate Emergency progress report
- Enlist support from partner organisations across Rotherham
- Require all future cabinet reports to include climate change Impact assessments.

Rotherham Child Death Overview Panel

Annual Report 2018-2019

Alex Hawley, Consultant in Public Health, Rotherham Metropolitan Borough Council

August 2019

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Wendy Griffith, Stop Smoking Specialist Midwife, The Rotherham NHS Foundation Trust

Catherine Hall, Deputy Chief Nurse/Designated Nurse Safeguarding and Looked After Children, NHS Rotherham Clinical Commissioning Group

Stephanie Davern, Manchester CDOP Co-ordinator

The members of the Rotherham Child Death Overview Panel

Introduction

Child death reviews

The death of a child is a devastating loss with profound impacts on any and all involved in caring for the child in any capacity. Families in such circumstances deserve empathy and compassion and clear and sensitive communication. They also need to understand what happened to their child and know that people will learn from what happened.

The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths. In view of this, in England every child death must have a review carried out regardless of the cause of death. A child is deemed to have been live-born when any sign of life is noted following birth, which can include a movement, breath, cry or heartbeat (as clarified by the Chief Coroner, following a challenge by Kingston's Child Death Overview Panel).

Child Death Overview Panels

The Child Death Overview Panel (CDOP) is a multi-agency panel with a specific geographical footprint, which reviews the death of any child aged from 0-18 years who is normally resident within that area, irrespective of where the child died.

CDOPs were established in England on 1st April 2008, since when all child deaths have been reviewed by such panels, which comprise representatives from a range of organisations and professional disciplines, both within and outside healthcare.

CDOPs are required to review child deaths in order to identify whether there is any learning that could influence better outcomes for children at both a local and national level. CDOPs promote the sharing of information and learning to all organisations, in both the statutory and voluntary sector, about how to reduce the likelihood and impact of modifiable risks which might lead to the death of a child.

Modifiable factors

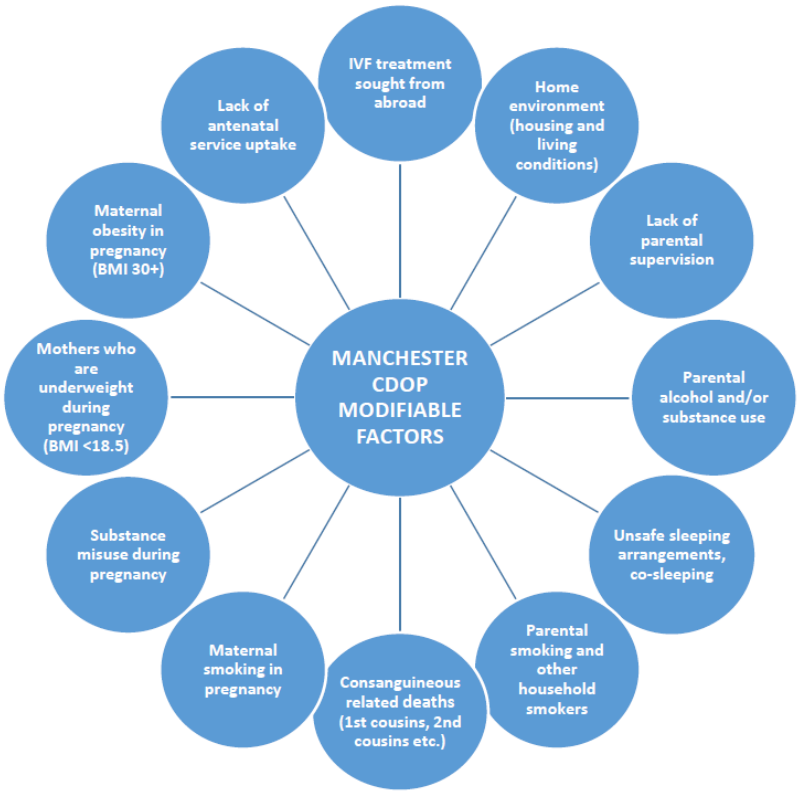
In reviewing the death of each child, the CDOP should consider modifiable factors in relation to the individual child, the environment, parenting capacity or service provision, and consider what action, if any, could be taken locally and what action could be taken at a regional or national level.

According to The Lancet, modifiable factors can be identified in 20% of child deaths nationally (Dr Sidebotham, Fraser, Fleming, Ward-Platt, & Hain, 2014). These can include factors in service delivery, factors relating to parental behaviour, including

maternal smoking in pregnancy, maternal obesity in pregnancy, and smoking within the household, and factors relating to parenting skills and levels of care, including unsafe sleeping practices. As all cases are unique, there is no definitive list of modifiable factors.

However, the four CDOP panels within the Greater Manchester CDOP network have taken the step of developing a standard for identifying particular modifiable factors in relation to different categories of death, in order that there is a locally consistent approach. It remains to be seen whether the implementation of the new national child mortality database might lead to a more general standardisation of modifiable factors. In the meantime, this could be something for the four South Yorkshire CDOPs to consider as they begin to work to respond to sub-regional trends in child deaths.

The Manchester CDOP report for 2017-18 also includes a helpful graphic, summarising all modifiable factors identified by their reviews of children of all ages.



Modifiable factors identified in Manchester CDOP Annual Report 2017-2018 (page 9). Reproduced with kind permission of Manchester Child Death Overview Panel.

The Rotherham panel

Rotherham's CDOP panel meetings are generally half-day meetings, with representation from a range of agencies, including the local authority's Public Health team, Children's social care, The Rotherham NHS Foundation Trust (designated doctor and nursing and midwifery representatives), Rotherham Doncaster and South Humber NHS Foundation Trust, the Rotherham Clinical Commissioning Group, Bluebell Children's Hospice, and South Yorkshire Police. The main business of the meetings is to present and review child deaths for which sufficient data has been collated from relevant agencies. The meetings also follow up agreed actions from previous meetings, and discuss other related business as it arises.

CDOPs as an arm of prevention

The multi-agency viewpoint that CDOPs adopt means they aim to influence a range of factors within health services, within the home, the school, the local environment, and in relation to parenting capacity and early childhood experiences. In other words, they have an important role to play to reduce risks and improve protective factors within the wider system. This means that the principal objective of reducing infant mortality should not be the only benefit from the efforts of CDOPs. There should also be a wider positive health and wellbeing impact for our children.

The work of the CDOP should be seen alongside a very welcome shift within the policy context for our health services towards preventing ill-health and tackling health inequalities, in preference to simply treating. The NHS Long Term Plan is the latest expression of this shift, which acknowledges that "the health of children and young people is determined by far more than healthcare" and that "income, education, housing, stable and loving family life and a healthy environment all significantly influence young people's health and life chances" (paragraph 3.6), but which nevertheless sets out to use the resources of the NHS to "accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025" (paragraph 3.9).

The NHS Long Term Plan contains much to be welcomed in respect of intended improvements in maternity and neonatal care, and the expansion of community based mental health services for children and young people. However, although making a fleeting reference to "the cross-government ambition for women and children focusing on the first 1001 critical days of a child's life" (paragraph 3.16), this is one area in which the long term plan is disappointingly light. The first 1001 days (from conception to age 2) can set the pattern for the rest of a person's life and therefore represent our best opportunity to prevent health inequalities. Furthermore, it is a period of crucial interest to CDOPs – 26% of babies in the UK are estimated to be living in complex family situations, and babies in England are said to be seven times more likely to be killed than older children (Building Great Britons. All Party Parliamentary Group for Conception to Age 2).

Work done by or on behalf of Rotherham CDOP this year

Some key strands of work are highlighted below, ranging from work done by the panel itself and its administrative support function to make direct quality improvements to the panel's processes for collating and presenting information, to work done in partner agencies and services on behalf of CDOP, which should lead to a reduction in risk and an improvement in the prospects of Rotherham children.

New guidance for child death reviews

The recent national review of 'Working Together' guidance for safeguarding arrangements has meant that much of the work by Rotherham's CDOP members outside of its core business of reviewing cases has been to prepare for the implementation of these new arrangements (the main changes to guidance are outlined later in this report).

A Rapid Response Task and Finish Group has been established, which has met three times since March 2018. Its purpose is to consider the expected impacts of the new guidance on aspects of the child death review process, including: child death notifications; the process for rapid response to unexpected child deaths; and how bereavement support is provided to families. Some of the changes are also being progressed at a sub-regional level, through joint work by the four South Yorkshire CDOP panels.

With respect to the changes to child death notification, partly to prepare for the launch of the new National Child Mortality Database (NCMD) in April 2019, all four South Yorkshire CDOPs decided to move to the use of the eCDOP system. Not only will this enable automatic data transfer to the NCMD, but it should also result in better data quality, security and ability to draw out trends both locally and sub-regionally.

Local quality improvements

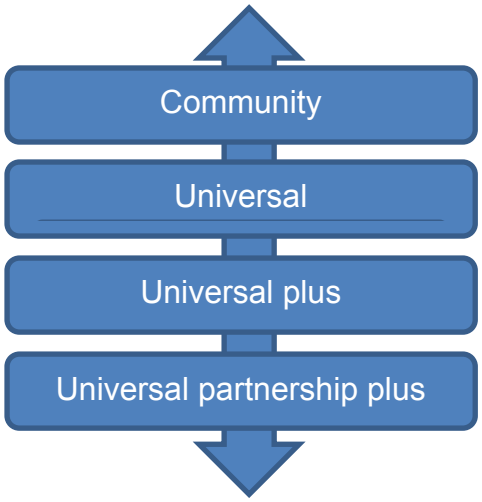
Amongst the many learning points that emerged during the year, the need for better communication both within and between agencies was clearly identified. This includes the issue of the quality of the written reports within the wider child death review process, some of which were thought to be overly descriptive in nature.

Training has continued to be offered to a range of professionals (since it commenced in April 2017), with a focus on improving the quality of CDOP processes, and information collation and submission. There is evidence that this has led to an improvement in the quality of information received by the panel.

Healthy Child Programme Pathways

Following a particular issue identified by CDOP in relation to an individual case who appeared not to be receiving the appropriate level of intervention from the 0-19s

service, an assurance process has been instigated in the service. Improved service quality in this respect is now assured by the 0-19s service, through a quarterly review of caseloads to ensure that children and young people are assigned the correct pathway commensurate with their level of need. The pathways range between community, universal, universal plus and universal partnership plus.



Range of community services for children

Healthy Child Programme delivered to give every child best start in life

Timely additional support provided for a specific issue or need

Ongoing support for more complex needs

Safer Sleeping

During 2018 – 19, CDOP further embedded the Safe Sleep guidance, which was originally developed in partnership with TRFT, led by Public Health. This was adopted by the Learning and Improvement Sub Group of the Rotherham Local Safeguarding Children Board (RLSCB) in 2017-18. The guidance was added to the RLSCB procedures portal in June 2017, which professionals have access to. Its purpose is to:

- Provide the multi-disciplinary workforce in Rotherham with clear and consistent evidence-based information;
- Provide workers with the confidence and knowledge to facilitate an open and honest discussion to support baby's carers to make informed safer sleeping choices for their babies;
- Ensure consistent advice about safer sleeping arrangements is given across Rotherham by all workers.

Each agency is responsible for reviewing the guidelines and embedding it as part of their own processes and protocols, in a way that is meaningful to staff.

Safe sleep audits

Progress is being measured through regular audit. An audit in 2017 revealed that the use of the safe sleep questionnaire included on SystmOne had successfully been

embedded within midwifery, but not yet within the 0-19s service. In the most recent audits, midwifery and 0-19s have reported separately.

The maternity safe sleep audit from January 2019 showed 100% compliance – i.e. every new born baby in Rotherham had an initial safe sleep assessment performed by community midwifery.

A similar audit of SystmOne records carried out in the 0-19s service for the month of January 2019 showed 140 safe sleep assessments carried out by the 0-19s service, representing 72% of new births. Whilst this shows an ongoing need for improvement, this already represents a very large improvement on the previous year, when only 24% of new births had a safe sleep assessment. The audits did not simply look at quantity considerations, but also looked for identification of risk factors arising from safe sleep assessments and whether these had been appropriately escalated and followed up.

Dip sampling of child health records is being conducted at intervals in order not to lose a focus on maintaining and improving performance, in the interests of making sure all Rotherham children have the best start.

Ongoing care

There is now an increased and increasing level of understanding across all services to support families that safe sleeping is an ongoing concern throughout a child's early life, especially the first twelve months. A single assessment or advice pack cannot be sufficient to be assured that safe sleep practices continue.

This continuum starts in the hospital, before the pre-discharge assessments and the discharge information package issued to new parents. Any unsafe sleeping practices identified prior to discharge from the hospital and the community midwifery service will lead to an intervention to rectify the issue, to give advice to families and to ensure that information is handed on to the 0-19s service for follow-up in the community, including for the first safe sleep assessment carried out in the family home.

Multi-agency training

The responsibility for being alert to unsafe sleeping should lie with all frontline staff (including non-healthcare staff) who engage with families, and training is now being rolled out for this purpose. Two training sessions were first delivered in March 2019, with a further two to be delivered in September. It is anticipated that this pattern of two training days per year (four sessions) will then continue on an annual basis. The training is advertised via the Safeguarding Board's prospectus for multi-agency training, and is therefore open to anyone who accesses that facility. The first training sessions evaluated very well.

Safer Sleep Champions

Momentum for the importance of safe sleep is also maintained through identifying safe sleep champions across related services, and the model appears to be growing. There is now a safer sleep champion for each of the 0-19s area teams; and there are three safer sleep champions in midwifery; two within the hospital; safer sleep champions are being recruited within Early Help; and enquiries have recently also been received for establishing two champions within childminding.

Smoking in pregnancy

One of the biggest risk factors for sudden infant death syndrome (SIDS) is smoking. This risk arises not just from smoking within the household where an infant is sleeping, but arises as a result of smoking during pregnancy. Smoking during pregnancy also increases the risk of complications such as miscarriage, premature birth, a low birth weight baby and stillbirth, and is therefore a key modifiable factor concern for CDOP.

Smoking at time of delivery

Rotherham has a high proportion of mothers who are smokers at the time of delivery – 19.9% in 2017/18 – the highest of the South Yorkshire local authority areas and considerably worse than the England position - 10.8% in 2017/18 *(Proportions calculated by PHE from the NHS Digital return on Smoking Status At Time of delivery, for Public Health Outcomes Framework indicator 2.03).*

The Rotherham Stop Smoking Service has a specialist service for women and their families comprising specially trained Midwives and Stop Smoking personnel. All women are offered carbon monoxide monitoring at every appointment. The service has a 100% target for CO monitoring at booking, and is currently achieving well above 80%. Pregnant women who are smokers are immediately referred for smoking cessation support – this is provided as an opt-out service, and women will always be advised of the risks of smoking in pregnancy even if they do wish to opt out of the service. The service provides ‘one to one’ appointments including at outreach locations, offering support throughout pregnancy and after the birth.

The team has an aim to reduce the percentage of women smoking at time of delivery by 0.5% by 2020, and they successfully achieved a 0.5% reduction for 2018/19.

This work is now being overseen by the Better Births Group – a multi-agency group including representation from the CCG, Public Health, the Local Maternity System, the Maternity Voices Partnership, clinicians and others. The group meets on a monthly basis to progress action against its action plan. Some examples of related ongoing and planned activities are given below.

1. Capacity for achieving the smoking at time of delivery targets has been increased through a one-year secondment into the team of a Band 6 midwife.

2. In order to help engage harder to reach mothers in the service, the team has secured funding to procure two placenta demonstration models to assist the smoking cessation midwives in better communicating risk and impact of smoking in pregnancy.
3. Funding has also been secured for a future money box incentive scheme.
4. A YouTube video to promote the service is planned, and a script has been devised for this purpose.
5. The Maternity Voices Partnership has engaged supportively with the service, and has carried out an audit.
6. Invoicing for the nicotine replacement therapy (NRT) voucher scheme for community pharmacies has been improved by deploying the PharmOutcomes system for this purpose since the beginning of January 2019.
7. The standard operating procedure for the NRT voucher has been reviewed and made electronically available.
8. A flowchart for prescribing NRT for inpatients has been developed and distributed to clinical areas.
9. A service level agreement (SLA) for community pharmacies has been implemented, which includes the Patient Group Directions (PGD) protocol for dispensing treatments, as of April 2019.
10. Smoking in pregnancy team leaders have been upskilled to lead Very Brief Advice (VBA) training. A number of staff have now received VBA training and have given very positive evaluation feedback.

Child safety

CDOP has had specific cause for concern in respect of choking hazards for babies and infants, and planned to use Child Safety Awareness week (June 2019) as an opportunity to raise parental awareness of this. The Paediatric Liaison Service worked in conjunction with the 0-19 service and with hospital departments (Urgent and Emergency Care Centre and the children's ward) to set up a public stand in the hospital foyer, displaying resources from the Child Accident and Prevention Trust (CAPT) and the Royal Society for the Prevention of Accidents (RoSPA) .There was a particular focus on small babies choking on small things, with the message "put them out of my sight and reach".

For children's safety awareness, Rotherham benefits from the unique facility of the Lifewise Centre, which uses film-set style realistic scenarios to provide safety training to Year 6 pupils in Rotherham and across the whole of South Yorkshire.

Consanguinity

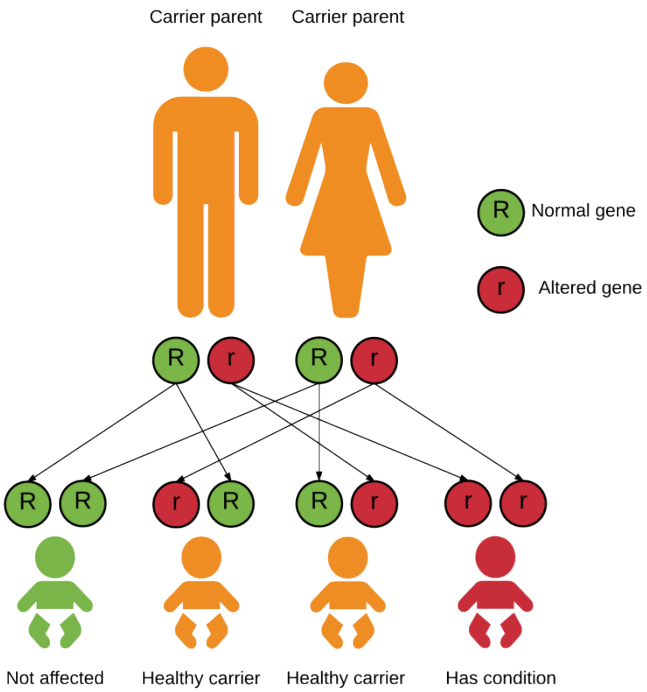
The Panel highlighted a concern with respect to the increased risk arising of genetic conditions associated with marriage between cousins. This is considered in greater depth in the following chapter. CDOP has arranged for a workshop to explore this issue to take place as part of the Safeguarding Awareness Week events in July 2019.

Consanguinity (or close relative marriage)

Consanguinity refers to a relationship in which the couple share a close common ancestor - in general, where the couple are related as second cousins or closer. In fact, where consanguineous marriage is customary it is most often between first cousins, i.e. where the couple shares a set of grandparents. It is a matter of concern to CDOP because marrying a close relative increases the likelihood that partners will share a genetic mutation, and thereby increase the risk of giving birth to children with rare but life-threatening genetic diseases.

Consanguinity is a customary practice in many parts of the world – around 1 billion people live in countries where it is common, and at least 8.5% of children globally are estimated to have consanguineous parents. Within regions of the UK, the prevalence of consanguinity varies according to the prevalence of certain minority ethnic groups, including those originating from Pakistan, Bangladesh and the Middle East, as well as some groups with an Indian heritage and some Irish Travellers. Consanguinity in the UK is most prevalent amongst the British Pakistani community, where 55% of marriages are estimated to be consanguineous. Where such populations are very substantial, such as in Bradford, for example, the impact on rates of congenital anomalies is detectable – the Born in Bradford study found that consanguineous marriages accounted for nearly a third of abnormalities amongst 11,300 babies.

Rotherham's demographic profile means that the effect at a population level is likely to be much less evident than in Bradford, but at the level of each consanguineous couple, the risk for each of their children is likely to be the same. In fact, the level of risk is not dissimilar to that of babies born to older women, and our approach to the problem ought to follow a similar pattern – raising awareness of risks, and of testing available to enable an informed choice.



In effect, when both parents carry the same recessive gene, the risks for their offspring are always the same (irrespective of whether they are related): a 1 in 4 chance of being completely unaffected (receiving two normal copies of the gene) a 1 in 2 chance of being a healthy carrier (receiving one normal and one altered copy); a 1 in 4 chance of inheriting the genetic condition (receiving two altered copies of the gene).

In the general population, the chances of both parents being

carriers of a particular gene are low. The chances are greater where the parents are cousins, known within the extended family.

The risk of a birth defect occurring amongst the general population is about 3%, but this doubles to about 6% amongst consanguineous couples. However, it is important to note that the absolute risk remains low, and the vast majority of babies born to couples who are blood relatives are unaffected.

Consanguinity in Rotherham

Estimating the number of consanguineous couples living in Rotherham is not straightforward. In general, rates are higher among non-White groups, and highest amongst the Pakistani population. Rotherham's BME population is not particularly substantial for an urban area (about 8% of the overall population), but the largest group is the Pakistani community, which comprises about 3% of the Rotherham population. National modelled estimates (Bernadette Modell) produced for the old PCT areas, using 2010 population estimates, suggest there might be in the region of 200 new consanguineous couples per year in Rotherham. Such estimates are likely to have very wide margins of error, but may be broadly indicative. For comparison purposes, the same model suggests that the former Bradford and Airedale PCT would have around 1600 new consanguineous couples annually.

Consanguinity and child deaths

There are a great number of autosomal recessive conditions, and many will have a severe effect on the life of a child, including resulting in life-limiting physical or intellectual impairment, and some are effectively incompatible with life or may ultimately result in death in early or late childhood.

Rotherham's CDOP always attempts to record the consanguinity status of parents for each child death it reviews. From the records of 193 cases considered by the panel, consanguinity is recorded on ten occasions.

The fact that consanguinity is present is not itself evidence that it was a material factor in the child death – five of the ten cases where consanguinity is definitely recorded also have chromosomal, genetic and congenital anomalies as the category of cause of death, which would be consistent with a recessive condition as the primary cause. However, only one of these cases has been identified by the panel as having a modifiable cause of death, one other death is also recorded as modifiable, but in this case the cause of death was malignancy, which seems unlikely to be related to consanguinity.

The number of child deaths coming to panel that might be related to a recessive condition associated with consanguineous parents seems encouragingly low. A maximum of 10 out of 193 cases is just over 5%, whereas the modelled data referred to above (Bernadette Modell) predicts an increase in under-5 mortality in Rotherham of close to 18%.

Addressing the issue – a family-centred approach

The World Health Organisation has acknowledged that attempts to discourage the practice of consanguineous marriage at the population level are “undesirable and inappropriate”, and has instead advocated a family-centred approach, based on identifying those families at risk and enabling properly informed choice, backed up by supportive services.

For CDOP the extent to which a death can be seen as modifiable is therefore likely to relate to the perceived level of informed choice that is at the disposal of the local population. Informed choice is likely to include a good understanding of genetic risk associated with close relative marriage, information within extended families and kinship groups relating to risk of specific conditions within that family group, provision of informed and supportive information from healthcare workers, and access to genetic testing (including carrier testing and prenatal testing) and advice from specialist genetics services.

Recommendations for further action

Rotherham CDOP has contacted Sarah Salway, Professor of Public Health at the University of Sheffield. Sarah has undertaken research and service development relating to consanguinity at both local and national levels over the past 8 years, and currently co-chairs the national steering group on Close Relative Marriage and Genetic Risk (with Naz Khan, Manchester Genomics Centre).

As the next step for this work, Professor Sarah Salway has agreed to facilitate a workshop in Rotherham on close relative marriage and genetic risk as part of Rotherham’s Safeguarding Awareness Week (July 2019). She will be joined for this purpose by Saima Ahmed, who works as a community outreach worker for this topic providing genetic literacy input to neighbourhoods in Sheffield, and also Julia Thompson, from Sheffield City Council’s Children and Young People’s Public Health Team.

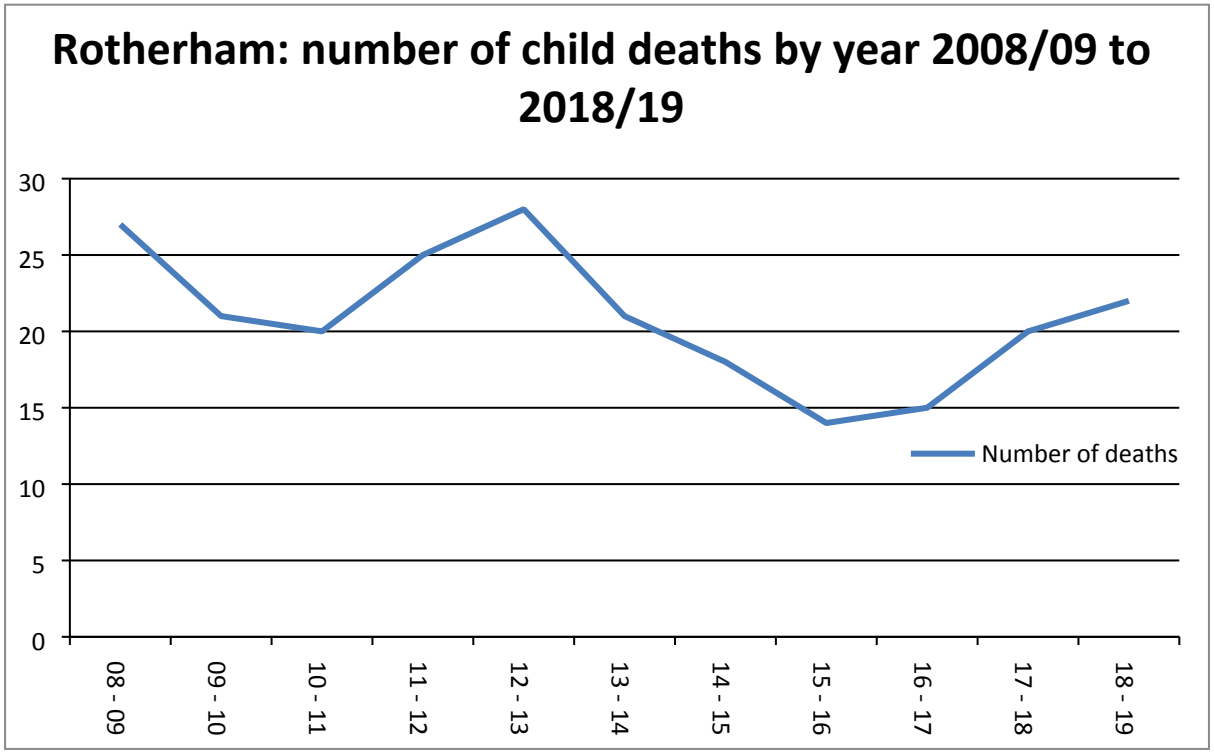
Sarah Salway is keen to develop some standards for sustainable approaches locally that avoid some of the short-lived interventions of the past, and help to engender a culture of informed choice. In addition, she has shared some resources with Rotherham, developed by Sheffield, which Rotherham CDOP may wish to adapt for use in Rotherham. They include public information leaflets and a YouTube video and associated guide developed for training purposes.

Evaluation feedback from the workshop will be discussed at a future meeting of CDOP, along with the potential use of these resources, and opportunities for taking the work forward within Rotherham, and potentially at a South Yorkshire level, by means of a themed sub-regional panel discussion, for example.

Child death data analysis.

Number of deaths

The number of child deaths in Rotherham in 2018-19 was 22, which is similar to the average number of deaths in each panel year (April – March) since its inception in 2008, during which period there have been 231 deaths at an average of 21 per year. Whilst the number of deaths in an individual year has been as high as 28 in 2012-13 and as low as 14 in 2016-17, in general the annual variation seems to be explained by random variation, and there is no discernible trend in numbers of deaths.



A large proportion of child deaths occur in the neonatal period (the first 28 days of life). Of the 231 child deaths in Rotherham since CDOP began in 2008, 105 have been aged 28 days or less at death, of which 72 were perinatal deaths (i.e. they died in the first week of life). 52 non-neonatal deaths were within the first year of life; 18 were aged between 1 and 5 years; 56 were aged 5 and over.

A large proportion of child deaths occurred to children with postcodes within the most deprived lower super output areas (LSOAs). 44% of 223 matched postcodes were within the most deprived quintile of LSOAs in England. Just under a third of the general Rotherham population live within such deprived locations, so 44% of child deaths looks like a large proportion, suggesting that living in high levels of deprivation in Rotherham confers a greater risk of infant mortality. This is an example of health inequality that has been observed more generally across the UK (Weightman, Morgan, Shepherd, Kitcher, Roberts, & Dunstan, 2012)

Deaths reviewed by the Panel

Child Death Reviews 2018-19

During 2018-19 CDOP met on two occasions, with a total of 10 deaths being reviewed to completion (other cases came to panel, but with actions or information still outstanding at the end of the year).

CDOP would normally expect to meet more frequently than this, but sets the number of meetings to match the number of cases in the pipeline that are ready to come to panel (i.e. there is sufficient information for a well-informed review and there are no essential outstanding items).

Reviews since 2008

Over the life of the panel, on average about 18 cases are reviewed per year. Since 2008, the Panel has reviewed a total of 194 cases, with each case taking an average of just over 12 months to come to panel. This should be considered alongside the new guidance for child death reviews, which, whilst not stipulating a required review timeframe, does envisage the majority of cases being reviewed by CDOP within six weeks of receiving the report from the child death review meeting, which itself should ideally happen within three months of a child death occurring.

Modifiability

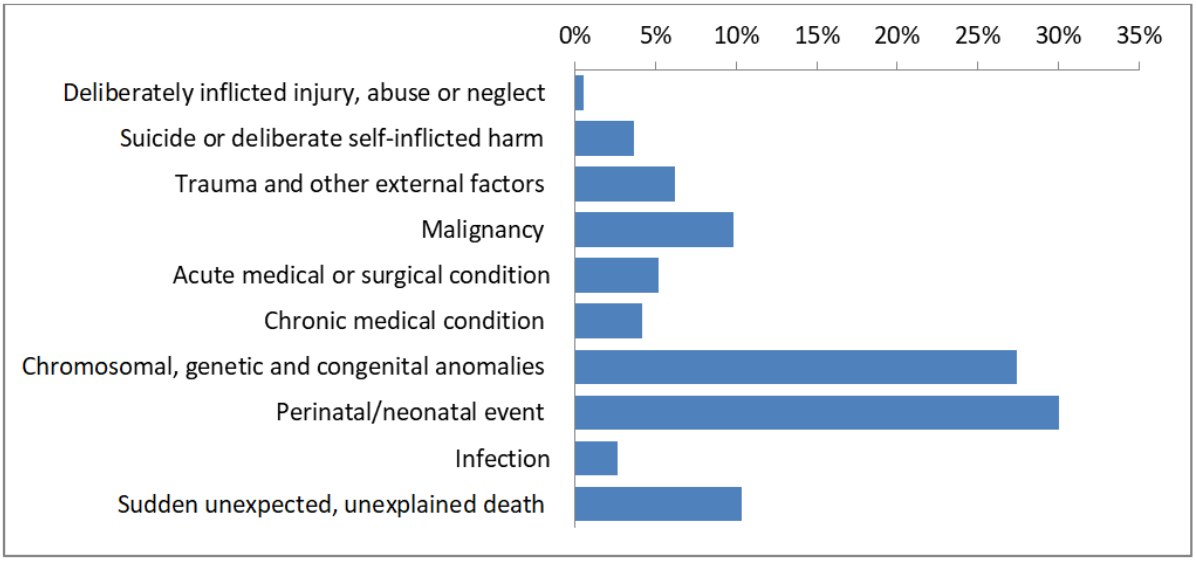
Of the ten cases reviewed during the year 2018-19, two were regarded by the panel as being modifiable - i.e. there were factors that may have contributed to the death or increased the risk of death, which could potentially have been altered in a way that might have reduced the risk or even led to a different outcome.

It is rarely straightforward for the panel to make a decision about modifiability, and there is some variability evident over the years in the propensity to view a death as modifiable. Over the life of the panel, out of 194 cases reviewed, 35 were regarded as modifiable deaths by the panel. The proportions for each year are shown below.

Year	Number of cases reviewed	Number regarded as modifiable	Porportion modifiable
08 - 09	12	4	33%
09 - 10	21	3	14%
10 - 11	21	7	33%
11 - 12	18	2	11%
12 - 13	22	4	18%
13 - 14	19	1	5%
14 - 15	29	2	7%
15 - 16	7	1	14%
16 - 17	24	8	33%
17 - 18	11	1	9%
18 - 19	10	2	20%
Grand Total	**194**	**35**	**18%**

Category of death

The panel assigns a category to each death that it thinks most usefully summarises the main cause. There are ten such categories, with “chromosomal, genetic and congenital anomalies” and “perinatal/neonatal event” being the most frequently chosen. The categories are shown below, along with the proportions assigned by the panel over its eleven years of reviewing cases:



Other summary tables

Tables below summarise all cases reviewed since 2008 by age range, expected vs unexpected death, ethnicity and gender.

Age range	Expected	Unexpected	Total
<28 days	76	10	86
28-364 days	23	22	45
1-4 yrs	<5	8	12
5-9 yrs	8	<5	12
10-14 yrs	11	5	16
15-17 yrs	<5	19	23
Grand total	**126**	**68**	**194**

Ethnic group	Female	Male	Total
Asian/Asian British	13	7	20
Black / African / Caribbean / Black British	<5	<5	<5
Mixed / Multiple ethnic groups	<5	<5	6
Other or Not known	8	13	21
White British	54	83	137
White Other	<5	<5	8
Grand total	**83**	**111**	**194**

Changes to national guidance for Child Death Reviews

Background to child death reviews

The Children Act 2004 introduced a requirement for local authorities in England to review the death of every child residing in their area, to determine whether there were any modifiable factors that could lead to system improvements. Local Child Death Review partners were established to take ownership of the process, who in turn established local Child Death Overview Panels (CDOPs) that were charged with the role of investigating the circumstances and contexts for the death of every child in their region. From 1 April 2008 child death review (CDR) processes were made mandatory for Local Safeguarding Children Boards in England for all child deaths up to the age of 18 years.

As arrangements were agreed locally, the child death review processes have been variable across England. For example, there has been no minimum caseload requirement; large variation in governance arrangements; limited standardisation of administration and data collection; and varying levels of engagement outside the medical sphere with wider stakeholders to achieve a breadth of learning through the reviews.

Recent Changes

In 2016 Sir Alan Wood was appointed to undertake a fundamental review of Local Children Safeguarding Boards (LSCBs) including Serious Case Reviews (SCRs) and Child Death Overview Panels (CDOPs). Subsequently, the legal framework covering these areas has been amended by The Children and Social Work Act (2017), implementing his recommendations. Key recommendations of the review included the replacement of existing statutory arrangements for LSCBs with a new framework for multi-agency arrangements for child protection, and the discontinuation of SCRs in favour of new national and local arrangements.

With respect to CDOPs, Sir Alan was asked to identify what makes an effective Child Death Overview Panel and explore which body is best placed to review child deaths to ensure that CDOPs are managed and held to account effectively. His recommendations included moving the national sponsor from CDOPs from the Department for Education to the Department of Health, and considering how best to organise CDOPs regionally and sub-regionally to promote learning and dissemination.

Following the Children and Social Work Act (2017), new statutory guidance was published in 2018 - Working together to safeguard children 2018 (replacing the 2015 guidance) – along with more specific further statutory and operational guidance for Child Death Reviews.

Some of the key changes to the child death review processes arising from this new guidance are set out below:

1. **Governance**

   Change in responsibility for the child death review process from Local Safeguarding Children Boards to local CDR partners, which are the local authorities and clinical commissioning groups (CCGs) within the relevant geographical footprint. *From Rotherham's point of view, however, governance is likely still to fall within the remit of the new child safeguarding arrangements.*

2. **Minimum footprint**

   Possible need for merger of existing Child Death Overview Panels, given that CDR partners should represent a geographical footprint that will enable the review a minimum of 60 deaths each year. *Whilst Rotherham's CDOP only reviews around 20-30 child deaths each year, the footprint will remain unchanged, as it mirrors the local patient flows and agency responsibilities that best enable data collection and review. In order for thematic learning to take place across a larger footprint, a sub-regional thematic panel will meet on a less frequent basis to consider review findings from the four South Yorkshire CDOPs.*

3. **Joint Agency Response**

   Requirement to perform a Joint Agency Response – Resource will need to be identified to coordinate a new multi-agency response (on-call health professional, police investigator, duty social worker), if a child's death: is or could be due to external causes; is sudden and there is no immediately apparent cause (including SUDI/C); occurs in custody, or where the child was detained under the Mental Health Act; where the initial circumstances raise any suspicions that the death may not have been natural; or in the case of a stillbirth where no healthcare professional was in attendance.

4. **Child Death Review Meetings**

   Establishment of local multi-agency Child Death Review Meetings (CDRM). A resource will need to be identified to co-ordinate new local multi-agency meetings, and relevant professionals may need additional time in order to attend or feed into CDRMs.

5. **Role and responsibilities**

   A number of new or enhances roles in the CDR process are identified, including:

   a. Establishment of a '**key worker**' role to act as a single point of contact with the bereaved family for the duration of the death review process. Some additional resource is likely to be needed to be identified to fulfil

this function – it may need to be included in relevant job plans. In addition to the key worker, an appropriate 'medical lead' (i.e. consultant neonatologist or paediatrician) should also be identified after every child's death to support the family, and to liaise with the key worker.

b. In the case that a Joint Agency Response is needed, a **lead health professional** should be assigned, in order to co-ordinate health responses and liaise with police and other agencies. The lead health professional will be also be responsible for organising and chairing the CDRM.
c. Child Death Review partners should appoint a **Designated doctor for child deaths** to be responsible for the child death review process, to work closely in an advisory and co-ordinating capacity with the CDOP Administrator and the Chair of CDOP, and to work with the Chair in preparing an annual report of CDOP acitivities.

6. Child Death Overview Panels

a. CDOP panels are expected to include representation from: public health; the Designated doctor for child deaths (and a hospital clinician if the Designated doctor is a community doctor or vice versa); social services; police; safeguarding; primary care; nursing and/or midwifery; lay representation; other professionals on the merits of the cases being considered.
b. The Chair should be independent of the key providers.
c. Panel members should not lead discussions if they are the named professional with responsibility for the care of the child.
d. Panels should aim to review all children's deaths within six weeks of receiving the report from the CDRM or the result of the coroner's inquest (except where a themed panel is planned).
e. They may (for pragmatic reasons) choose to review the death of a child who died in their area, but who is not normally resident there.
f. May choose to review some cases within a themed panel discussion. *In Rotherham, it is likely that such themed panels would take place at the South Yorkshire level.*
g. Reporting – CDOP should continue to prepare an annual report for CDR partners. The guidance also refers to the requirement for CDR partners to publish a report "at such intervals as they consider appropriate", to cover what they have done through CDOP arrangements and how effective this has been.
h. They should submit data on each child death to the National Child Mortality Database (NCMD) from 1st April 2019 - CDRMs will need to ensure data is captured systematically in order to enable efficient and consistent flow of data to NCMD.

Timeline for implementation of changes

The key dates for the new requirements are:

1st April 2019 – The National Child Mortality Database goes live. Department of Health & Social Care transitional arrangements outline that from 1st April 2019, all new child deaths and any open cases (those not yet reviewed by a child death overview panel) of children who died before that date should be added to the NCMD. The data collection requirements to support the review of each child's death also change on this date.

29th June 2019 – All Child Death Review Partners in England must publish their plans to meet the new requirements and send these plans to NHS England at England.cypalignment@nhs.net.

29th September 2019 – All Child Death Review Partners in England must complete the transition to the new arrangements. After this date they must be compliant with the new statutory requirements.

Looking ahead

Preparations for the implementation of new guidance have been a key concern of the panel in the past year, and will continue to be so in the coming year, as the proposed local implementation of the national guidance on child death reviews is due to commence in September 2019.

With this in mind, the Rotherham panel will continue to operate locally, but cognisant of the proposed two-tier approach across South Yorkshire, it will keep its current terms of reference under review (see appendix), whilst continuing to work to develop the purpose and role of the South Yorkshire group (initial terms of reference appended).

Rotherham CDOP does not currently have lay representation within its core membership. A lay member is a recommendation within the new guidance – this will be explored during the coming year.

Rotherham will continue to build on the excellent progress made so far with embedding safe sleep assessment and advice within community midwifery and the integrated public health nursing service, and to extend awareness and skills through other frontline professions through training programmes and the further recruitment and deployment of safe sleep champions.

As special interest topics arise, whether in response to local, regional or national concerns, CDOP will seek to engage positively as far as the resources at its disposal make this possible. It has achieved this this year with respect to the issue of consanguinity, and there is further work to do on this, arising from the workshop organised for Safeguarding Awareness Week, including strengthening the local connections with the regional genetics service, and also seeking to take this issue forward at the South Yorkshire level, and to maintain our connection to the national work on this topic being driven by Sheffield University.

Appendix 1 – Rotherham CDOP current terms of reference

Rotherham

Child Death Overview Panel

TERMS OF REFERENCE

(under review pending implementation of the new Child Death Review Arrangements from September 2019)

1. Purpose

1.1 This paper sets out terms of reference for the Rotherham Local Safeguarding Children Board, Child Death Overview Panel. It replaces previous documents titled Terms of Reference.

2. Responsibilities

2.1 Core responsibilities of the Child Death Overview Panel are:

2.1.1 Review the information available on all child deaths of children up to 18 years to determine whether the death was preventable.

2.1.2 Implement, in consultation with the coroner local procedures and protocols that are in line with Working Together on enquiring into unexpected deaths, and evaluating these as part of the information set held on all deaths in childhood.

2.1.3 Collect and collate an agreed minimum dataset on each child who has died, seeking relevant information from professionals.

2.1.4 Hold meetings at regular intervals to review and evaluate the routinely collected data on the deaths of all children, and thereby identifying lessons to be learnt or issues or concerns, with a particular focus on interagency working to safeguard and promote the welfare of children.

2.1.5 Monitor the appropriateness of the response of professionals to an unexpected death of a child, reviewing the reports produced by the rapid response team in each unexpected death of a child.

2.1.6 Refer to the chair of RLSCB any deaths where, on evaluation the available information, the Panel considers there may be grounds to undertake further enquiries, investigations or a Serious Case Review.

2.1.7 Monitor the support and assessment services offered to families of children who have died.

2.1.8 Monitoring and advising the RLSCB on the resources and training required locally to ensure an effective interagency response to child deaths.

2.1.9 Organise and monitor the collection of data for the nationally agreed minimum data set.

2.2 The Child Death Overview Panel roles:

2.2.1 The Chair and Vice Chair will ensure that membership comprises of representatives from all statutory and voluntary agencies involved in working directly or indirectly with children. Attendance will be monitored and reported upon regularly.

2.2.2 Chair and Vice Chair to be agreed by RLSCB on a 2 year agreement.

2.2.3 The Panel will maintain a current work plan and provide information as requested to Rotherham Local Safeguarding Children Board Annual Report and Business Plan.

2.2.4 The Chair and Vice Chair will ensure that membership comprises of representatives from all statutory and voluntary agencies involved in working directly or indirectly with children. Attendance will be monitored and reported upon regularly.

2.2.5 The Panel will produce an annual report, relevant aspects of which will be included in the RLSCB Annual Report, describing the activities and outcomes of the Child Death Overview Panel.

2.2.6 Terms of Reference to be agreed with Rotherham Local Safeguarding Children Board on an annual basis.

2.2.7 Establish where necessary task and finish groups that will report back to the Panel. It is the responsibility of the Panel to monitor and support task and finish groups.

3. Membership

3.1 The Panel will have a partner member of RLSCB as Chair. The Chairing arrangements will be agreed by RLSCB. A Vice Chair, who will be a

member or advisor to the Board, will be elected by Panel members on an annual basis.

3.2 The Panel will receive expert advice from an appropriate member of the Safeguarding Children Operational and/or Strategic Unit.

3.3 Agencies attendance required from:

3.3.1 Public Health
3.3.2 The Rotherham NHS Foundation Trust – Designated Doctor, Midwifery and 0-19 Services
3.3.3 South Yorkshire Police
3.3.4 CYPS - Social Care / Safeguarding
3.3.5 Rotherham, Doncaster and Humber Mental Health Foundation Trust
3.3.6 Coroner's Office (where needed)
3.3.7 Yorkshire Ambulance Service
3.3.9 RMBC Legal Services (where needed)
3.3.10 NHS Rotherham Clinical Commissioning Group
3.3.11 Bluebell Wood Children's Hospice

3.4 The Child Death Overview Panel reserves the right to co-opt other members for time limited pieces of work. The Child Death Overview Panel will be administered (by way of agenda preparation, production and circulation of action notes) by support supplied from the Board's joint funding.

3.5 At the start of each meeting, attendees will be asked to sign an attendance sheet. A record of attendance for each member will be reported as part of the annual report to the Rotherham Local Safeguarding Children Board. Members will be expected to attend no less than 75% of meetings. Any member not attending 3 consecutive meetings will be invited to consider their membership position and this will be reported to the Rotherham Local Safeguarding Children Board and the Board Member of their agency.

3.6 Deputies should attend if a member of the Child Death Overview Panel is not available, but it is incumbent upon members to accept their responsibility for routine attendance and to complete any actions required of them, irrespective of whether they are in attendance or not.

3.7 For the Child Death Overview Panel to be considered quorate, at least 3 partner agencies must be represented.

3.8 **Escalation –** if any case discussed gives rise to safeguarding concerns relating to the safety or welfare of any child (eg sibling) then either (i) assurance will be sought from the relevant organisation; and or (ii) a safeguarding referral will be made to the MASH.

4. Agenda etc

4.1 Meetings will be held a minimum of every 2 months and unless there are exceptional circumstances, will last for no longer than three hours.

4.2 The agenda for each meeting will be agreed with the Chair prior to publication. Any member of the Child Death Overview Panel is entitled to put an item forward for the agenda. Agendas should be issued at least 5 working days before the meeting and all paperwork should be subject to Chair/Vice Chair control. Minutes from meetings will usually be issued within 10 working days of the meeting.

4.3 At the end of each meeting, any key messages for the Rotherham Local Safeguarding Children Board will be agreed. The Child Death Overview Panel will identify a person at the end of each meeting if appropriate to work with the editor of the Rotherham Local Safeguarding Children Board Newsletter to communicate the key messages.

5. Linkage to other groups

5.1 The Child Death Overview Panel work will be undertaken on behalf of Rotherham Local Safeguarding Children Board. An annual report, work plan and reporting on an exceptional basis will therefore be an expected outcome from the Panel.

6. Declaration of interest

6.1 It is the responsibility of each member to declare any conflict of interest with an agenda item either at the start of the meeting or as the discussion unfolds.

7. Business Conduct

7.1 All meetings will:

7.1.1 Start and end on time as agreed

7.1.2 Show respect for, and value the contribution of each member

7.1.3 Encourage all members to participate

7.1.4 Ensure that the agreed work plan is developed and progressed at each meeting

8. Monitoring

8.1 The effectiveness of the Child Death Overview Panel will be monitored against:

8.1.1 Number of times the meeting is held in accordance with its Terms of Reference

8.1.2 Number of times the meeting is quorate

8.1.3 Level and spread of attendance at meetings

8.1.4 Delivery of the work plan

8.1.5 Feedback from participants by way of the annual report

9. Governance Arrangements

9.1 The Terms of Reference will be agreed by the Chair and Panel Members.

9.2 Once agreed, the Terms of Reference will be ratified by Rotherham Local Safeguarding Children Board

9.3 Terms of Reference will be reviewed annually

9.4 Minutes of meetings, works plans and exceptional reporting is open for scrutiny by Rotherham Local Safeguarding Children Board.

Panel Chair……..Designation……

Signature…… Date……

To RLSCB Date……..……Ratified……...

Review Date……..

Appendix 2 – Terms of reference for new South Yorkshire CDOP

SOUTH YORKSHIRE (BARNSLEY, DONCASTER, ROTHERHAM & SHEFFIELD) CHILD DEATH REVIEW PARTNERSHIP

TERMS OF REFERENCE

1. Purpose

1.1 The responsibility for ensuring child death reviews are carried out is held by 'child death review partners' who in relation to a local authority area are defined as the local authority for that area and any clinical commissioning group in that area.

1.2 Child death review partners must make arrangements to review all deaths of children normally resident in the local area, and for any non-resident child who has died in their area if appropriate.

2. Principles

2.1 The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths.

2.2 To improve the experience of bereaved families, as well as professionals, after the death of a child.

2.3 To ensure that information from the child death review process is systematically captured to enable local learning and, through the planned National Child Mortality Database, to identify learning at the national level, and inform changes in policy and practice.

3. Responsibilities

3.1 Review and analyse data and information about all deaths (across the South Yorkshire footprint) that have had a local review undertaken to enable further analysis, trends and learning to be gained, in order to prevent future child deaths.

3.2 To hold themed discussions on a quarterly basis to review deaths from a particular cause or group of causes. This should provide an opportunity for greater understanding and shared learning. Additionally, any required actions can be developed as a region and resources and ideas pooled. Such arrangements will facilitate appropriate professional experts being present to inform discussions, and

allow easier identification of themes when the number of deaths from a particular cause is small. By necessity themed panels will need to have access to more detailed case information. In order to ensure the effectiveness of these discussions the level of information sharing should be proportionate but allow for meaningful analysis to take place. The cases presented, however, will always be anonymised.

3.3 Provide a forum where practice issues that have a regional impact can be discussed and taken forward collectively by the South Yorkshire Panel.

3.4 Where appropriate develop strategies, in conjunction with local CDOPs, with the aim of preventing future child deaths; this may include communicating with national bodies or those outside of the South Yorkshire area.

3.5 To make recommendations to all relevant organisations where actions have been identified which may help to prevent future child deaths or promote the health, safety and wellbeing of children.

4. Chairing

4.1 Chairing will take place on a rotational basis, drawn from the 4 local CDR Chairs for the period of one year.

4.2 Where necessary, a Deputy Chair will be arranged by the local area, who are currently hosting.

5. Meeting Frequency

5.1 The panel will meet for 3 hours on a quarterly basis, and be held in the area where the chair and business administration is being provided for that year.

5.2 Provision will be made for ad hoc or extraordinary meetings as required.

6. Membership

6.1 The CDOP is a multi-professional panel whose core membership may include senior representatives from the following agencies or roles:

- Public health
- Designated Doctor for child deaths
- Children's Social Services
- Police
- Bluebell Wood Children's Hospice
- Safeguarding Health Practitioner
- Primary Care (GP or health visitor)
- Nursing and/or midwifery

- Lay representation
- Additional professionals should be considered in relation to specific themes or specialist role, for example; coroner's office, ambulance service or hospices.

6.2 In order for the meeting to be quorate, there must be at least one representative from each local authority, with a maximum of 4.

7. Meeting Administration

7.1 Administration for the South Yorkshire CDR will be provided from the same area as the incumbent chair.

7.2 This will require input and support from the other CDOP administrators.

7.3 Draft minutes from the South Yorkshire CDR should be distributed to all members within 2 weeks of the meeting, for ratification at the next meeting.

7.4 Agenda items for the forthcoming meeting are required to be submitted 2 weeks before the meeting.

7.5 The eCDOP system will be the central point for data on which the South Yorkshire CDR will base its business.

8. Conflict and Declaration of interest

8.1 At the beginning of each meeting the Chair should inquire as to conflicts of interest among the attendees. The chair and panel will then need to consider how this is taken into account for the purpose of the meeting.

9. Business Conduct

9.1 Panel members should be familiar with their responsibilities and ensure that they have read all relevant material in advance of the panel meetings.

9.2 All meetings will:

- Start and end on time as agreed
- Panel members will show respect for, and value the contribution of each member
- Ensure that members are encouraged to participate
- Hold members to account for any actions that have been agreed

9.3 All members of the CDOP are required to maintain confidentiality in respect of the children and families subject of their consideration.

10. Governance Arrangements

10.1 The terms of reference will be ratified by the respective Child Death Review Partners (CCG and Local Authority).

10.2 The Terms of reference will be reviewed annually.

10.3 A memorandum of understanding will be implemented between the Child Death Review Partners, which sets out how they will work together.

Rotherham Integrated Care Partnership

Rotherham ICP Place Board – 4 December 2019

Quarter 2 Performance Report for ICP Place Plan

Lead Executive	**Ian Atkinson** Deputy Chief Officer, NHS Rotherham CCG
Lead Officer	**Lydia George** Strategy and Delivery Lead, NHS Rotherham CCG/Rotherham Integrated Care Partnership

Purpose

For members to note progress with the delivery of the ICP Place Plan as at the end of Quarter 2 2019/20.

Background

A performance report for the ICP Place Plan has been developed so that ICP Place Board members can assess progress against the key priorities and on 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.

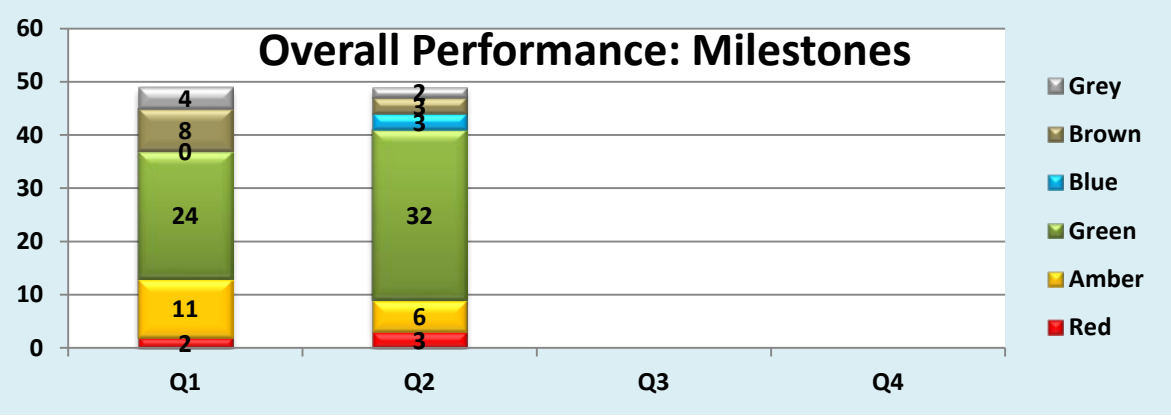
The performance report will be reported 4 times a year and received at ICP Place Board in September, December, March and June.

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

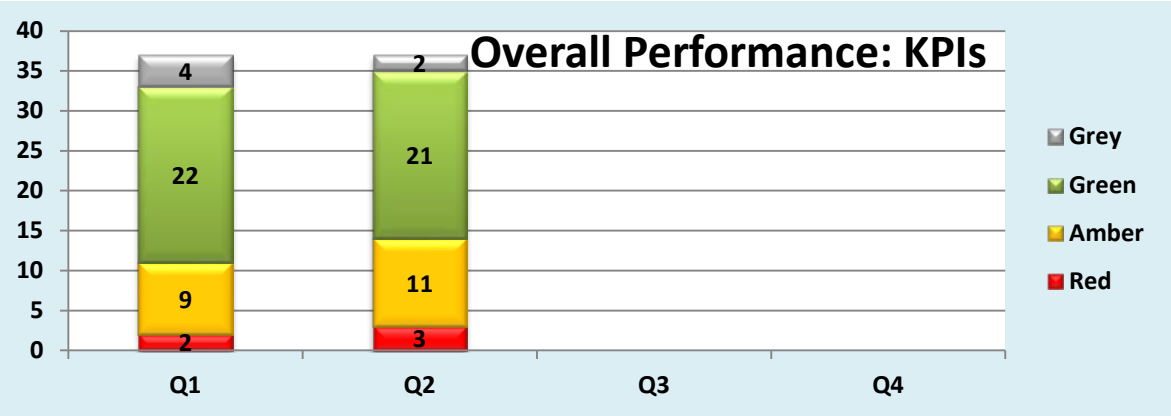
The performance report has been refreshed for 2019/20,however it should be noted that a further refresh will be necessary once the new ICP Place Plan has been produced and agreed (Rotherham response to the NHS Long Term Plan)

Analysis of key issues and of risks

The graph below shows overall performance for the 49 milestones:



The graph below shows overall performance for the 37 Key Performance Indicators:



Key to RAG rate:

Brown	Milestone	Not due to start
Red	KPI / Milestones	Not achieving target/Significant issues
Amber	KPI / Milestones	Almost achieving target/Started but not on track
Green	KPI / Milestones	Achieving Target/On track
Blue	Milestones	Complete
Grey	KPI / Milestones	To be confirmed

Further information and analysis can be seen in the attached Performance Report.

Approval history

ICP Delivery Team – 20/11/2019
ICP Place Board – 04/12/2019

Recommendations

Members are asked to note the performance for Q2 2019/20, comparisons to Q1and that overall the position has improved since Q1.

Rotherham Integrated Care Partnership

2019/20 Performance Report: Quarter 2

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

	Delivery Team	Place Board
Q1	22 August 2019	4 September 2019
Q2	20 November 2019	4 December 2019
Q3	19 February 2020	4 March 2020
Q4	20 May 2020	3 June 2020

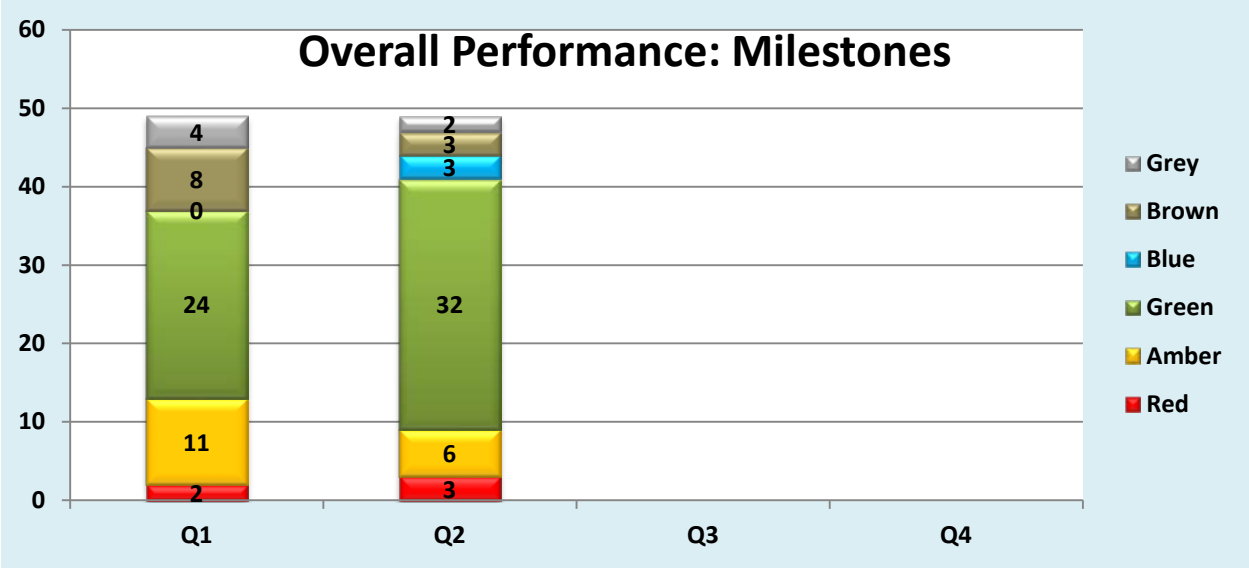
Key to ratings:

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

There are five transformational workstreams, led by three Transformational Groups. All workstreams have key priorities as shown below (note that in 2019/20 some priorities are complete and have been removed):

	Children and Young People		Mental Health and Learning Disability		Acute and Community
C&YP 1	Implementation of Children and Young People Mental Health Services (CAMHS) Transformation Plan	LD&MH 1	Deliver improved outcomes and performance in the Improving Access to Psychological Therapies service	UC&C 1	Creation of an integrated point of contact for care needs in Rotherham
C&YP 2	Maternity and Better Births	LD&MH 2	Improve dementia diagnosis and support	UC&C 3	Development of an integrated health and social care team to support the discharge of people out of hospital
C&YP 3	Oversee delivery of the 0-19 healthy child pathway services	LD&MH 5	Improve community crisis response and intervention for mental health.	UC&C 4	Implementation of integrated locality working across Rotherham
C&YP 4	Children's Acute and Community Integration	LD&MH 6	Implement Public Health 'Better Mental Health for All' Strategy	UC&C 5	Development of the re-ablement and intermediate care offer
C&YP 5	Special Educational Needs and Disability (SEND) – Journey to Excellence	LD&MH 7	Oversee delivery of Learning Disability Transforming Care	UC&C 6	Development of a coordinated approach to care home support.
C&YP 7	Transitions	LD&MH 8	Support the implementation of the 'my front door' Learning Disability Strategy		
		LD&MH 9	Support the development of the Autism Strategy		

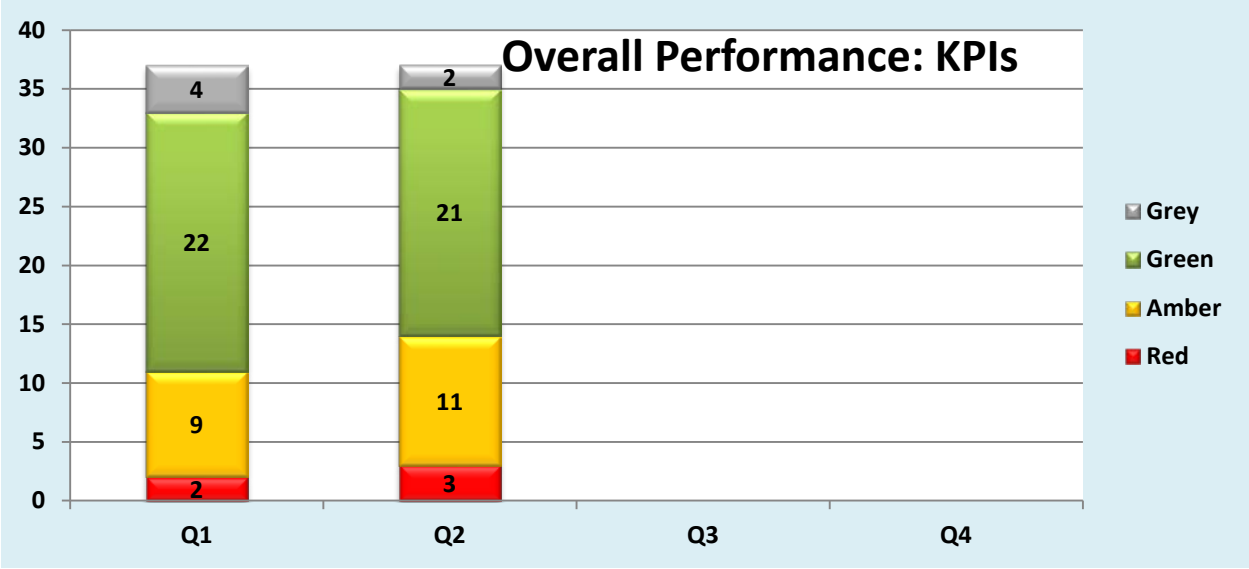
Summary of Performance Quarter 1 - 2



Of note:
The combined number of milestones either **on track or complete** has significantly **increased** in Q2.

The number of milestones either **TBC or Not Started** has **decreased** in Q2.

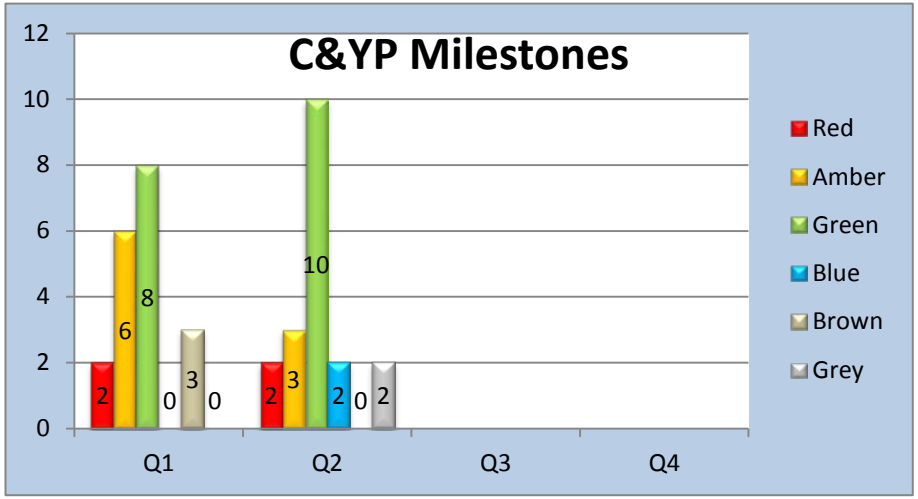
There is one **additional** milestone of **concern** in Q2



Of note:
The overall figures show that there has been **little fluctuation** in performance over Quarters 1 – 2 for **any** of the RAG ratings.

Summary of Children and Young People Performance

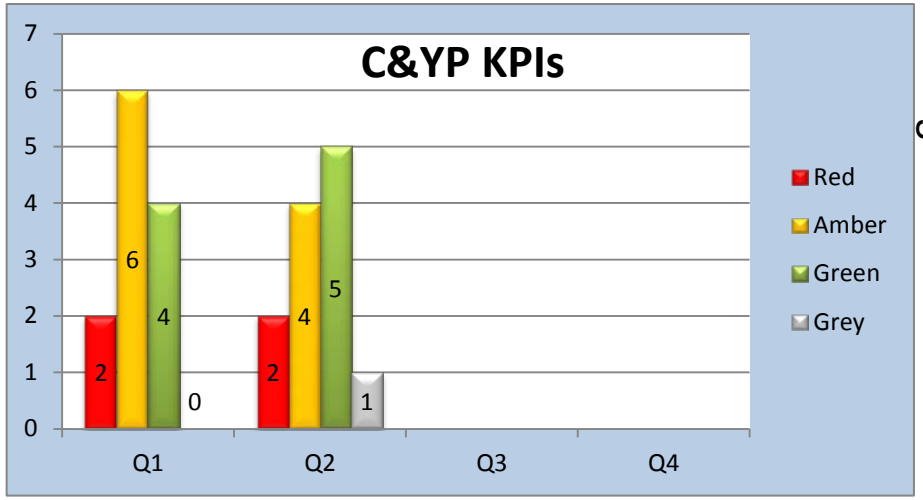
Milestones									
RAG	Descriptor	Q1		Q2		Q3		Q4	
		No	%	No	%	No	%	No	%
Red	Of concern	2	10.5	2	10.5				
Amber	Slightly off track	6	31.6	3	15.8				
Green	On track	8	42.1	10	52.6				
Blue	Complete	0	0.0	2	10.5				
Brown	Not due to start	3	15.8	0	0.0				
Grey	Still to be confirmed	0	0.0	2	10.5				
Totals		19	100	19	100				



Of note:

- The number of milestones in Q2 complete or on track increased from 42.1%, to 63.1%
- In Q2, the number of red milestones remained the same as in Q1 at 10.5%

Key Performance Indicators									
RAG	Descriptor	Q1		Q2		Q3		Q4	
		No	%	No	%	No	%	No	%
Red	Of concern	2	16.7	2	16.7				
Amber	Slightly off track	6	50.0	4	33.3				
Green	On track	4	33.3	5	41.7				
Grey	Still to be confirmed	0	0.0	1	8.3				
Totals		12	100	12	100				



Of note:

- The number of KPIs on track in Q2 has improved to 41.7% from 33.3% in Q1
- Although based on provisional data there has been an improvement in the reduction in the percentage of women smoking at time of delivery
- Also CAMHS referrals assessed within 6 weeks is back on track
- In Q2 the number of red KPIs remained the same as in Q1 at 16.7%

Children and Young People

Milestones

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

Please note, the Signs of Safety Priority is under review with a view to being transferred to the Workforce and OD Enabling Group:

As at November 2019, no training has been delivered in the last quarter due to changes in staffing so the position remains the same, however, wider partnership advanced training is due to be delivered in the next three months.

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	R			This has been rated 'red' due to the unacceptable waiting times for ASD / ADHD diagnosis. However progress is being made to deliver the whole system action plan in place to reduce waiting times.
CH1.2	Integration of the CAMHS Single Point of Access (SPA) and RMBC Early Help access point.	Q4 19/20	A	A	A			The CAMHS locality model is now embedded. Early Help and CAMHS work together. CAMHS is co-located within the Special Educational Needs and Disabilities (SEND) hub at Kimberworth Place. Partners will adopt the principle of "no wrong door" rather than the physical integration of the two services points of access – which could potentially de-stabilise the strong links already working with SEND services. Trailblazer work will strengthen links between CAMHS and schools.
CH1.3	Improved CAMHS Crisis service out of hours.	Q4 19/20	A	A	A			This is a long term area of work. RDaSH are working with TRFT as part of a national pilot for Urgent and Emergency Care Access Standard. RDaSH are focusing on young people who present at Rotherham general
CH1.4	Clarification of the pathways between the CAMHS service and Youth Offending Team (YOT) and 'Liaison & Diversion' service.	Q4 19/20	A	A	A			This action has been incorporated into the SEMH Strategy/Action Plan to progress
CH1.5	Scoping out of a Schools 'CAMHS' service in line with the government 'Green Paper' recommendations	Q3 19/20	G	G	G			Mobilisation Of the CAMHS Trailblazer is on-going. A soft launch is planned for December ahead of the staff completing training.

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%	1.61%	N/A until Dec 2019			The Q2 2019/2020 data will be published by NHS England in late December 2019.
CH2.2	For all women to have a Personalised Care Plan (PCP)	Q4 2021	100%	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%	20.2%	16.4% (prov)			The percentage of women in Rotherham smoking at time of delivery decreased from 20.2% to 16.4%between Quarter 1 and Quarter 2 2019/20 (lower is better) and is below the target of 18%. Therefore,overall status is green and direction of travel is improving. This is the lowest rate of smoking at time of delivery achieved to date.

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	R			There has been an increase in number of EHA assessments completed in the last Quarter. Q2 – 18 for 0 -19 service
CH3.2	All 0-19 Practitioners will have completed Signs of Safety training by the end of 2018/19.	Q4 19/20	A	A	G			SOS to be included for this financial year : 70 % of staff attended this training, awaiting new dates.

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	G	G			The work is now embedded across the children's ward, children's CAU and UECC. This work is going to move forward to G.P's. Further discussions need to be had with the CCG regarding funding.
CH4.2	Establish links between Rapid Response Team & Early Help	Q3 18/19	G	G	G			The CCN /PARROT team have links with early help. The teams are both based at Kimberworth and are aware of the process for referral.
CH4.3	Pilot a direct link between Children's Ward and Children's Service to support timely discharge plans	Q3 18/19	G	G	G			There is a direct link between the Rapid response Team (PARROT)

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	B			• 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	B			SEND Sufficiency Strategy approved by RMBC Cabinet SEND Sufficiency proposals agreed with schools

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	A			The transitional pathway has been developed and will be published as part of the Adult Care Pathway transformation. This has been published internally: see http://rmbcintranet/Directorates/ACH/Pages/Adult-Social-Care-Pathways.aspx A date for public publication will be confirmed with comms.
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	G			The E&S strategy is featured on the RiDO website and will be promoted to residents and young people at the LEAF Job and Careers Fair on Monday 11th. A scoping meeting to discuss a careers' fair and event aimed at young people with SEND will be discussed with special school representatives on 28th Nov. The E&S strategy will be promoted at these events and Rotherham Show in Sept 20
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	G			A local labour market video is planned as part of the ESF Business Education Alliance project. However delays to funding by DWP have resulted in delays beyond our control. We will be looking at planning for this Dec/Jan.
CH7.4	Transition pathways for long-term health conditions to be developed	Q3 19/20	N/A	BR	G			A plan is being prepared as part of the Preparing for Adulthood Board. This is to be shared in late November.

Children and Young People

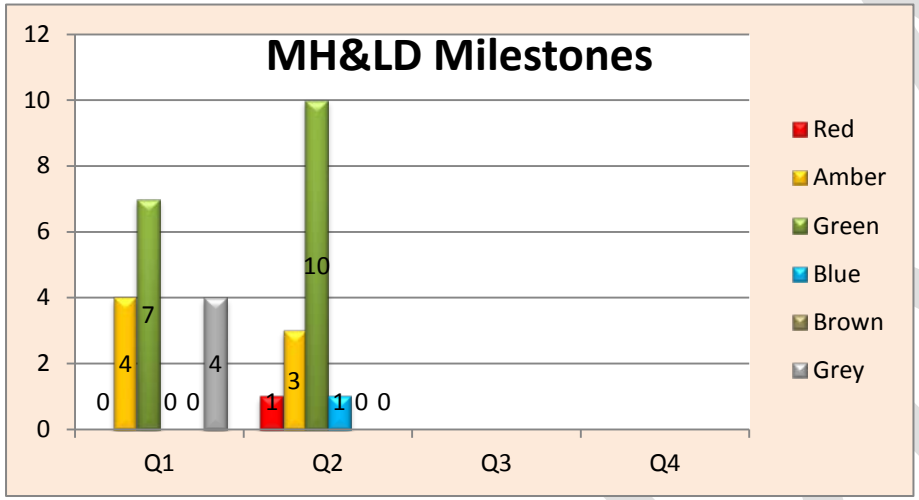
KPIs

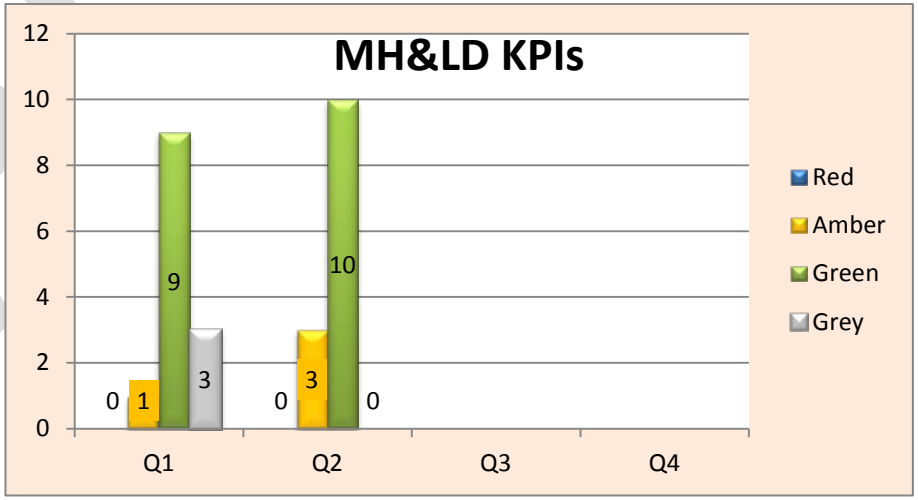
No.	Description	Trajectory	Target 1920	Priority	Performance					Comments
					Q4 1819	Q1 1920	Q2 1920	Q3 1920	Q4 1920	
CH/KPI 1	Percentage of referrals assessed within 6 weeks	Increase	95%	CH1 - CAMHS	A 84%	A 89.5%	G 100%			As at 30 September 2019 excluding ASD/ADHD (in line with the Contract Reporting).
CH/KPI 2	Percentage of referrals receiving treatment within 18 weeks	Increase	95%	CH1 - CAMHS	A 87%	A 93%	A 97.4%			As at 30 September 2019 excluding ASD/ADHD (in line with the Contract Reporting)
CH/KPI 3	Percentage of referrals triaged for urgency within 24 hours of receipt of referral	Increase	100%	CH1 - CAMHS	G 100%	G 100%	G 100%			As at 30 September 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%	G 100%			As at 30 September 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	G 1.61%	Not available until Dec 19			The Q1 2019/20 rate is 1.6%, a slight reduction on the previous quarterly figure. The Q2 2019/2020 data will be published by NHS England in late December 2019.
CH/KPI 6	All pregnant women have a Personalised Care Plan by March 21	Increase	70%	CH2 – Maternity	G 100%	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%	A 17.8%	16.4% (prov)			The percentage of women in Rotherham smoking at time of delivery decreased from 20.2% to 16.4%between Quarter 1 and Quarter 2 2019/20 (lower is better) and is below the target of 18%. Therefore,overall status is green and direction of travel is improving.
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 13	R 19			Another increase between quarter one and quarter two, although this is still behind the target of completing 10 per month.
CH/KPI 9	Reduction in the number of exclusions	Reduce	Reduction on previous year	CH 5 - SEND	R 19	R 15	R 12			Q2 – 9 registered with SEN Support and 3 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%	A 85.2%			End of Q2 (Sept 19) there were 225 CYP in an OOA provision out of 2235 CYP who have a EHCP in place (This is 122 Post -16 CYP and 103 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 13	Numbers of SEND Tier 1 tribunal applications	Reduce	8 plus 1 in court	CH 7 - Transitions	G 3	A 3	A 3			
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	A	A			This baselining is still ongoing. It is planned to use the national defined ASCOF measure – we are already monitoring this on a monthly basis, there is benchmarking available and the service have started improvement work as part of My Front door and the adult care pathway

Summary of Mental Health and Learning Disabilities Performance

Milestones									
RAG	Descriptor	Q1		Q2		Q3		Q4	
		No	%	No	%	No	%	No	%
Red	Of concern	0	0	1	6.7				
Amber	Slightly off track	4	26.7	3	20.0				
Green	On track	7	46.7	10	66.7				
Blue	Complete	0	0.0	1	6.7				
Brown	Not due to start	0	0.0	0	0.0				
Grey	Still to be confirmed	4	26.7	0	0.0				
Totals		15	100	15	100				

Key Performance Indicators									
RAG	Descriptor	Q1		Q2		Q3		Q4	
		No	%	No	%	No	%	No	%
Red	Of concern	0	0	0	0				
Amber	Slightly off track	1	7.7	3	23.1				
Green	On track	9	69.2	10	76.9				
Grey	Still to be confirmed	3	23.1	0	0				
Totals		13	100	13	100				





Of note:

- In Q1 the number of red milestones has increase to 6.7% from 0 in Q1
- The number of milestones on track or complete has increased to 73.7% from 46.7% in Q1
- All milestones are confirmed in Q2, compared to 26.7% that were not in Q1

Of note:

- The number of KPIs on track has increased to 76.9% in Q2, compared to 69.2% in Q1

Mental Health and Learning Disability

Milestones

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	G			On target, staff recruited
MH1.2	All GP practice review support visits completed – IAPT	Q1-Q4 19/20	A	Tbc	R			To date only 2 GP visits have taken place in 2019/20. Further work planned in Winter 1920.
MH1.3	Delivery of 5 year forward IAPT 18/19 plan – IAPT	Q4 19/20	G	G	G			

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	G			New pathway developed with Partners. Report being prepared to go through CCG governance processes.
MH2.2	Review dementia diagnosis pathway	Q4 19/20	A	A	G			As above

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 (inc investment requirements)	Q4 19/20	A	G	G			Model for ICS crisis investment agreed with RDaSH and TRFT
MH5.2	SY&B ICS NHS England Suicide-prevention – delivery of Rotherham element of the plan (year 2)	Q4 19/20	G	G	G			The second round of small grants has been advertised and the panel met in October to award the grants. 11 practitioners from across the partnership were trained in September as part of the Train the Trainer Self Harm project (Y1 identified activity). Progress is underway to commission another course as part of the year 2 activity. Discussions are being held with SY &B colleagues re the joint commissioning across the area of a suicide listening service.
MH5.3	Refresh of the Rotherham suicide prevention and self-harm action plan	Q3 19/20	A	Tbc	G			The refreshed action plan has been out for consultation and will be signed off by the H&WB at the November meeting.

Priority 6 MH – Public Health: Better Mental Health for All Strategy								
No.	Description	Target 1920	Progress					Comments
			Q4 1819	Q1 1920	Q2 1920	Q3 1920	Q4 1920	
MH6.1	Evidence of integration of Five Ways messages within provider and commissioned services	Q1-Q4 19/20	A	Tbc	A			Better Mental health for All Action is currently being refreshed and will look at all opportunities to promote this H&WB campaign. Five Ways was promoted at the Rotherham Show with the general public being asked to share how they looked after their health and wellbeing in relation to one or more of the five principles.

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	A			This work is now incorporated into: 1)the section 117 aftercare work, 2)CHC funding working – to commence
LD7.2	Identify Indicative costs for transforming care cohort (including those on the risk register)	Q2 19/20	G	G	B			Complete
LD7.3	Commissioning solutions to be in place to meet individual trajectories	Q4 19/20	G	A	G			Close partnership working across the system has taken place to identify possible placement opportunities for identified transforming care caseload. To continue into 2019/20

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	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	A			The pathway is in development and on track. However, in dialogue with RDaSH, it is clear the risks in relation to recruitment are still evident and this reflects the change from green to amber. Mitigation: regular meetings occur to ensure that the risks are reviewed and appropriate action is taken to reduce this risk
LD9.2	Development of Rotherham based Autism and ADHD diagnostic pathway	Q4 18/19	G	Tbc	G			Initial clinically led dialogue undertaken to scope opportunities for development of pathway. Looking at options. This is on track.

Mental Health and Learning Disaiblities

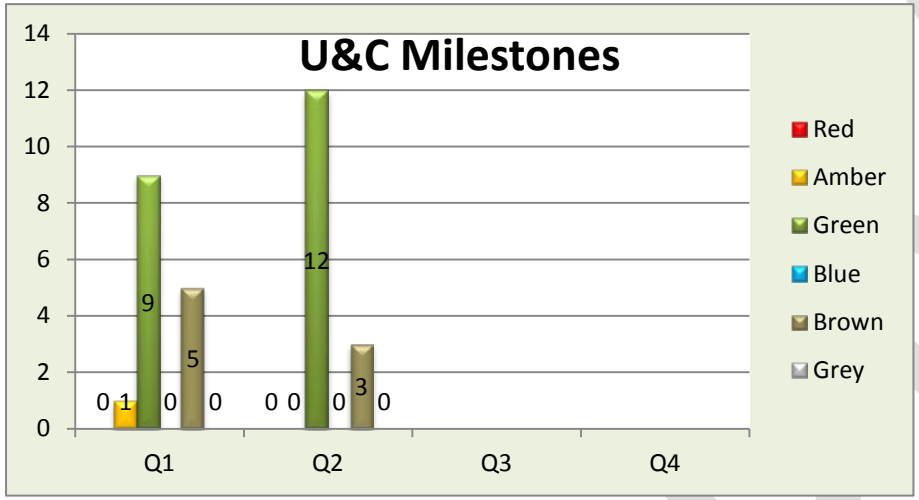
KPIs

					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%	G 97.8%			On track
MH/KPI 2	% Compliance of those who have entered (i.e. received) treatment as a proportion of people entering treatment with anxiety or depression	Increase	19% Accumulative total of population with depression -reported to NHSE	MH 1 - IAPT	G 4.77%	G 4.36%	G 4.58%			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%	G 53.6%			On track
MH/KPI 4	Dementia diagnosis rates (%)	Maintain	National = 67% Local = ≥80%	MH 2 - Dementia	G 86.4%	G 85.2%	G 84.4%			National target is 67%. Local target set to maintain or improve on 80%.
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	G 60%			
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%	G 89%			
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	A			**Fingertips Profiles (PHOF and Suicide Prevention Profiles) Rotherham - September 2019 Update** The latest update to 2016-18 shows a decrease to 13.1 deaths per 100,000 reducing the gap with England which remained at 9.6 per 100,000.
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%	G 100%			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%	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%	G 100%			On track

					Performance					
No.	**Description**	**Trajectory**	**Target 1920**	**Priority**	**Q4 1819**	**Q1 1920**	**Q2 1920**	**Q3 1920**	**Q4 1920**	**Comments**
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	G 3 = CCG 4=NHSE			An admission was required in April 2019. The person is scheduled to be discharged in July 2019. This will return Rotherham to Green
LD/KPI 13	Proportion of eligible adults with a learning disability having a GP health check	Increase	1058	LD 8 - LD Strategy	A	A	A			An increase in completed GP health checks is reported. Waiting confirmed number.
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	A			As part of the neurological pathway work the CCG has identified that the current provider has a developed a waiting list. Work is being undertaken to clarify the length of time people are waiting to receive a diagnosis. Moved to amber while this work is completed. This is work is due by the end of Q3.

Summary of Urgent and Community Performance

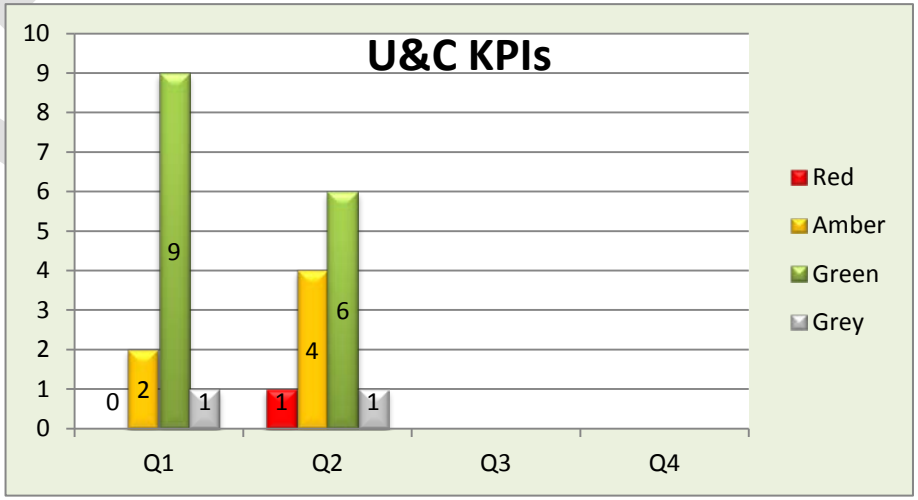
Milestones									
RAG	Descriptor	Q1		Q2		Q3		Q4	
		No	%	No	%	No	%	No	%
Red	Of concern	0	0	0	0.0				
Amber	Slightly off track	1	6.7	0	0.0				
Green	On track	9	60.0	12	80.0				
Blue	Complete	0	0.0	0	0.0				
Brown	Not due to start	5	33.3	3	20.0				
Grey	Still to be confirmed	0	0	0	0.0				
Totals		15	100	15	100				



Of note:

- The number of milestones in Q2 has increased to 80%, compared to 60% in Q1

Key Performance Indicators									
RAG	Descriptor	Q1		Q2		Q3		Q4	
		No	%	No	%	No	%	No	%
Red	Of concern	0	0	1	8.3				
Amber	Slightly off track	2	16.7	4	33.3				
Green	On track	9	75.0	6	50.0				
Grey	Still to be confirmed	1	8.3	1	8.3				
Totals		12	100	12	100				



Of note:

- The number of red KPIs has increased in Q2 to 8.3%, compare to 0 in Q1, this is for new permanent admissions to residential nursing care for adults
- The number of KPIs on track has decreased in Q2 to 50%, compared to 75% in Q1

Urgent and Community

Milestones

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	G			A pathway design and implementation group has been established including representation from the core points of contact. An integrated multi-disciplinary health and social care triage hub with nursing, therapies and reablement is a core element of the new model. Draft pathways will be tested with stakeholder groups in November.
1.2	Identify further opportunities for integrated working into points of contact	Q4 19/20	NEW	G	G			The Care Co-ordination Centre are working more closely with the Unplanned Hub and Community Therapies now they are co-located. This will be further developed through the Intermediate Care and Reablement Project. The RMBC SPA is being re-developed as part of the Target Operating Model to be implemented in October. Links across health and social care are being explored in relation to this.

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	G			On track to deliver in Q3
UC 3.2	Service re-design for 7 day working with nursing	Q4 19/20	NEW	BR	G			All vacancies have now been recruited to. Once the post holders are in place the team will be able to provide 7 day cover.

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	G			This work is being progressed through the RMBC Target Operating Model which is due to launch on 21 October 2019
4.2	Develop integrated intermediate care and reablement pathways as a platform for integrated working into PCNs/localities	Q4 19-20	NEW	G	G			Integrated working into localities is being progressed through the integrated intermediate care and reablement project in 2019/20. The learning and successful outcomes will be 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	G			Initial scoping has been undertaken at an Urgent & Community Transformation group workshop to agree the approach and identify potential opportunities for further integrated working. This will continue to be developed through 2019/20 and in to 2020/21

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	G			The Outline Business Case (OBC) has now been approved by partner governance groups. In addition the TRFT Board of Directors approved a business case for a therapy led off-site 24 bed community unit with nursing for one year to mitigate risks within the Trust. This will be delivered as part of the project in order to maximise opportunities and manage interdependencies.
UC 5.2	Develop service model and service specifications	Q3 19/20	BR	G	G			A high level model has been articulated in the OBC. A specification has been developed for the therapy led off-site community unit with nursing. Pathway work will be completed in quarter 3 and tested during the period of double running over the winter. Therefore specifications will not be finalised until quarter 4, in time for the launch in April.
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	G			Mobilisation is underway. Task and Finish groups have been established to progress pathway design, workforce and IT and information governance elements, underpinned by communication and engagement and financial and contracting enablers.
UC 5.4	Phase 2 New model of care fully implemented	Q3 20/21	BR	BR	BR			
UC 5.5	Embedding of the new model and evaluation	Q4 20/21	BR	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	BR			A task group will be established in Quarter 4 to drive the next stage forward.
6.2	Continue to implement enhanced health in care home	Q4 19/20	NEW	G	G			A report went to Quality Board in September which included key achievements over last 12 months and progress against the EHCH domains. This is a long term national initiative and a key element of the NHS Long Term Plan.
6.3	Roll out of registration on DPST/Use of NHS Mail to all Care Homes	Q3 19/20	NEW	G	G			All care homes are now registered on the DSPT/Use of NHS mail. Care homes providing community unit and winter pressure beds have an NHS mail assigned to the care home to safely transfer patient sensitive data with the Integrated Discharge Team, pharmacies and GP practices.

Urgent and Community

KPIs

					Performance					
No.	**Description**	**Trajectory**	**Target 1920**	**Priority**	**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%	A 38.3%			Council Plan Measure. The description has been updated to replicate changes in the Council Plan. In Q2 DoT trend worsened by 1% to 38.3%; performance is slightly below last year's outturn of 38.8. A review of records and actions has shown a proportion of this is due to incorrect recording by new staff members. Learning has been to positively support performance recovery through to year end. It is worth noting that the continuation of this KPI will need to be reviewed at year-end. This is due to the ongoing redevelopment and promotion of online self-service IAG resources. These improvements should positively stop inappropriate calls and increase contact centre capacity but will therefore reduce IAG contact outcomes and result in a positive reduction.
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	G 256			April 168, May 97, Jun 98 = green Jul 83, Aug 85, Sep 88 = 256 = 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%	59.3%			Regional data/ benchmarking is being monitored to inform targets moving forward, target to be introduced from 2020-21. Adult Care are working on new pathways to support a more preventative model of working.
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%	A 89.8%			Performance has reduced to 89.8% in Quarter 2 compared to 91.2% in Quarter 1, (against a target of 90%), but remains significantly higher than national averages. Management actions are monitoring the Qtr 2 activity to identify reasons for month on month downturn but this may be due to recent service pathway transformational changes and the wider cohort profile of adults now accessing the service. As the new pathway embeds and the service begins to support a wider range of needs, there is an accepted known risk within the service that performance against this indicator may reduce further and be more aligned to the national and regional averages of approximately 78% and 72% respectively. However, in real terms, the number of customers successfully supported should increase as more are accessing this early intervention and preventative service. Targets therefore may need reviewing periodically to ensure they remain realistic.

					Performance					
No.	**Description**	**Trajectory**	**Target 1920**	**Priority**	**Q4 1819**	**Q1 1920**	**Q2 1920**	**Q3 1920**	**Q4 1920**	**Comments**
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)	R 272.76 (141 admissions)			BCF Indicator, also contributes to Council Plan measure "All Age Admissions". Admission rates remain higher than expected in Quarter 2 and the measure is now rated off target. A performance clinic was held in September 2019 and a number of actions have been identified to improve performance through to year end where possible. It was acknowledged that Rotherham's recent year on year improvement reduction on permanent admissions, may now be approaching its natural 'floor' and flattening out making further reductions harder to achieve unless alternative long term solutions can be made available.
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*	Increase	86%	UC 1 – IPC UC 4 – Int Loc UC 5 – IC /Reab	A 85.6%	TBC Q4	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/	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	G 1742			April 590, May 580 Jul 561, Aug 592, Sep 589
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)	G 10.1% (Sept 19)			General readmission rate has stabilised over the last few months but remains higher than previous years.
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	All = 7.18 NE = 7.52			
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%	All = 54.55% NE = 51.38%			
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	A 31 av			Q1 = 17, 19 , 22 = average of 19.3 Q2 = 31,31,31 = average of 31
UC/KPI 13	Average length of stay to below national intermediate care target (specialist rehabilitation) (beds only)	Reduce	Less than 42	UC 3 - IDisc UC 5 – Int Locality	A Year end = 47.0 average	A 47.3 av	A YTD 44.5			Q1 = 44, 74, 28 = 48.6 (amended at Q2) Q2 40,43,38 = average of 40.3
UC/ KPI 14	Delayed transfer of care from hospital (TRFT) (I&AF 127e).	Reduction	3.5%	UC 3 – IDis	G 1.5%	A 3.9%	G 3.44%			July 3.8%, Aug 2.9%, Sep 3.6% = average of 3.44% The national standard is a maximum of 3.5% of total occupied bed days taken up by delayed transfers of care. TRFT are currently within that standard
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	G 232			April 53, May 62 Jul 62, Aug 86, Sep 84 = green
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	G 450			April 126, May 132 Jul 141, Aug 133, Sep 176 = green

Rotherham Integrated Care Partnership

Minutes	
Title of Meeting:	**PUBLIC Rotherham ICP Place Board**
Time of Meeting:	9:00am – 10:00am
Date of Meeting:	Wednesday 6 November 2019
Venue:	Elm Room (G.04), Oak House
Chair:	Chris Edwards
Contact for Meeting:	Lydia George 01709 302116 or Lydia.george@nhs.net

Apologies:	Sharon Kemp, Chief Executive, RMBC Louise Barnett, Chief Executive, TRFT Janet Wheatley, Chief Executive, Voluntary Action Rotherham Kathryn Singh, Chief Executive, RDaSH
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
Shafiq Hussain (**SH**), Chief Executive (Designate) Voluntary Action Rotherham
Annemarie Lubanski (**AML**), Strategic Director of Commissioning Adult Care, RMBC
Dr Gok Muthoo (**GM**), Medical Director, Connect Healthcare Rotherham CIC
Chris Preston (**CP**), (Deputising for L Barnett) Acting Director of Strategy & Transformation, TRFT
Matt Pollard (**MP**), Care Group Director, RDaSH

Participating Observers
Dr Richard Cullen (**RC**), Rotherham CCG Chair
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, RCCG
Gordon Laidlaw (**GL**), Head of Communications, Rotherham CCG
Rebecca Woolley (**RW**), Policy & Partnerships Officer, RMBC
Andrew Clayton (**ACl**), Head of Digital, Rotherham CCG
Jenny Lingrell (**JL**), Joint Assistant Director of Commissioning, RMBC
Paul Smith (**PS**), Head of Asset Management, 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. However, it was confirmed that written public questions relating to clinical thresholds have been received. These will be responded to by the CCG.

Action: CE

2	**Transformation Group Updates**

Children & Young People's Transformation Group
Subject – **0-19 Healthy Child Pathway**
Presented by Jenny Lingrell (JL)

Jenny Lingrell advised that this will be the final update on this specific pathway as it is to become part of a family oriented approach in future. JL highlighted several areas that are progressing well within the integrated public health nursing service including the implementation of the universal partnership plus team in central area where an evaluation is currently taking place and the development of a dedicated looked after children nursing team which has received good feedback in terms of consistency of contact. In order to deliver a more integrated approach, the 0-19 distance learning module is being rolled out to a further 12 staff. The achieving of Breast Feeding Initiative Accreditation has now commenced and the Weight Health and Attitude Management (WHAM) project is progressing well. The team has also recently reviewed its' key performance indicators to realistic, outcome focussed targets.

A plan is in place to deliver the universal antenatal offer to improve engagement with mums and the group is also focussing attention on ensuring the reporting system meets the current contracting requirements and that appropriate targets are in place which reflects the service as well as maintaining the gradual improvement in completing early help assessments.

Looking ahead a service review will commence and internal preparations will commence in readiness for the 2022 tender process. Work will continue with public health colleagues to implement a caseload weighting tool to improve efficiency. The rollout of the universal partnership plus team will be a focus in the new Place Plan and an action plan for the first 1001 day will be developed to support it.

Discussion followed about engaging Primary Care Network Clinical Directors (PCN CDs) in the public health nursing service review. It was agreed that this would be best through GP Members Committee where all six CD's and the GP Federation are members. JL will feedback these preferred arrangements into the review process.

Action: JL

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

Urgent & Community Care Transformation Group
Subject – Implementation of Integrated Working
Presented by Chris Preston (CP)

Chris Preston advised that the Group had been paused to reflect, a refreshed approach and priorities for integrated working has now been agreed by Partners. The integration of the intermediate care and reablement initiative continues to progress well. Its primary focus has been the 24 bed intermediate care ward which has now been procured and is being implemented alongside winter planning. Other priorities for the group includes modelling current state services to link with Primary Care Networks (PCNs), developing an integrated approach to primary care streaming and GP out of hours and developing service integration priorities for 2020/21 onwards, linking with population health analyses.

Work is continuing around maintaining ongoing support from all partners and key stakeholders, managing capacity and capability constraints as well as keeping focus to deliver the scope agreed.

The group is now looking towards finalising the scope and timelines for 2019-20 priorities, identifying and appointing professional lead and project teams, implementing new governance arrangements and mobilising resources to deliver agreed objectives.

Two workshops are planned to develop the intermediate care and reablement pathways with staff and

public engagement.

Discussion took place around the terminology to be used for consistency ie localities or networks. Ian Atkinson advised that Urgent & Community Care Transformation Group had previously agreed that the principle is 'to align system resource to service localities'. IA will share the narrative with Members for information.

Action: IA

Chris Edwards thanked CP for the update on progress.

Mental Health & Learning Disability Transformation Group
Subject – Learning Disability
Presented by Ian Atkinson (IA)

Ian Atkinson gave an update on progress with transforming care, autism and My Front Door strategy. Extensive work has been undertaken to map potential cost pressure of people stepping down from NHS funded provision into the community. Place Board noted the positive picture with transforming care and that Rotherham has improved from worst in the country to best.

Work is continuing to maintain the current transforming care provision level and to secure another 2 discharges by Quarter 4. However, this was proving challenging due to the complexity. IA assured members that the Group's focus remains to mitigate the financial risk in this area.

The Autism strategy is being developed with a diagnostic pathway in place by February 2020 due to successful recruitment. The strategy is being reviewed by the Council's Health Select Committee and will also being produced in an accessible format.

Work continues on the transformation of the offer to people with learning disabilities, known as the My front door strategy, focussing on the Council's in house offer and expanding day opportunities.

Place Board members thanked Ian Atkinson for the update and assurance provided.

3	**Enabling Group Update - Estates**

Paul Smith attended to give an update on progress with 'Place' estate. He outlined the existing co-locations as Kimberworth, the SEND hub, Rawmarsh, Maltby and Aston Joint Service Centres and Clifton the Place, the Children and Young People's social care hub.

PS advised that the Rotherham strategic estates group current work includes the review of the Rotherham Community Health Centre to begin maximising usage, reviewing and implementing the Rotherham CCG estates strategy and RDaSH rollout of agile working and estate reduction. Work with the SY&B ICS Strategic Estates Board includes supporting primary care projects across the region using the capital grant and piloting the efficient space utilisation project.

Chris Edwards thanked Paul Smith for the update to Place Board.

4	**Rotherham Digital Strategy**

Andrew Clayton explained the work that had been undertaken to produce Rotherham's digital strategy including engagement. Feedback has been included at every stage. The strategy's vision is to provide a digital first culture that improves experiences for all Rotherham people within the six main objectives outlined in the strategy. These presented a number of challenges with underpinning capabilities to ensure delivery. The four main programmes of work are based around infrastructure, sharing care records, patient access and engagement, intelligence and analytics. AC went on to give brief overview of strategy. Work has already commenced on implementing the strategy. Members noted that funds have not been identified within the strategy. Each programme will be costed separately as it is expected that there will be the opportunity to bid for central funds to support delivery.

AC is working with Gordon Laidlaw to produce a patient/public friendly summary of the strategy.

Cllr Roche highlighted that not all the Rotherham population have access to facilities or wish to engage using technology. AC responded that the approach adopted is 'digital first - not digital by default' so support is to be offered through other forums and alternative methods, like the voluntary sector, practice support etc.

Place Board approved the strategy and agreed to take it through their respective partner organisational

processes to be signed off by Christmas. Due to the timeframes, Health & Well Being Board Members will be asked to do this virtually.

Action: All/(RW for H&WBB)

5	**Social Prescribing Update**

Shafiq Hussain explained the social prescribing service (SPS) that is unique to Rotherham in its approach of micro commissioning services for targeted patients. He highlighted the outcomes in that it sits alongside clinical interventions and helps people to live their lives in a way they like rather than coping and surviving. It also positively impacts on services reducing demand in non-elective impatient stays and in the use of A&E Services.

The Rotherham model has gained significant national attention, shaping NHS development in SPS, attracting attention from all over the country including discussions with senior Ministers, Academics and Clinicians. The service has also influenced the role of the new Social Prescribing Link Workers based within each of the 6 Primary Care Networks to work with practices. The appointed applicants commence on Monday 11 November.

Place Board noted the positive patient comments about the service from a local GP and a service user and thanked SH for the update.

6	**Provider Alliance Update**

A meeting had been held in October to consider next steps.

It had been agreed to pilot the provider alliance approach on a couple of small service areas. A further meeting has been arranged to agree the areas and put in place a structure and discuss a more informal approach to risk sharing to move forward with.

Place Board will receive an update and consider further at its meeting in February.

Action: CP/LG

7	**Impact of Brexit Update**

Daily reporting has been paused until the end of January. Place Board will revisit required reporting arrangements at the February meeting.

Action: CE/(LG for agenda)

8	**Draft Minutes from Public ICP Place Board – 2 October 2019**

The minutes from the previous meeting were **APPROVED** as a true and accurate record. There were no matters arising.

9	**Communication to Partners**

None to note.

10	**Risk/Items for Escalation**

There were **NO** new risks identified for escalation.

11	**Future Agenda Items**
	• OD & Workforce Update – Workforce Maturity Index (tbd) • Rotherham ICP Communications & Engagement Strategy (Feb) • Rotherham ICP Place Plan (Feb) • Winter Plan and Preparedness Verbal Update - All (Dec) • Quarter 2 Performance Framework (Dec) • Rotherham Provider Alliance Update (Feb) Standard Agenda Items • Delivery Dashboard/Performance Framework (quarterly) • Transformation Groups Spotlight Updates (monthly) • Enabling Group Updates (monthly) • Rotherham Provider Alliance Update (monthly) • Impact of Brexit Updates (as required)

	• Primary Care Network Updates (as required)
13	**Date of Next Meeting**
Wednesday 4 December 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 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
Head of Communications, RCCG – Gordon Laidlaw
Strategy & Development Lead, RCCG – Lydia George

BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	22nd January, 2020
	LEAD OFFICER	Karen Smith, Strategic Commissioning Manager (RMBC/RCCG)
	TITLE:	Section 75 Framework Agreement and Better Care Fund (BCF) Call-Off Partnership/Work Order

Background

1. The purpose of this report is to outline progress on the development of a new Section 75 Framework Agreement and Better Care Fund (BCF) Call-Off Partnership/Work Order for 2019/20.

Department of Health and Social Care, Ministry of Housing, Communities and Local Government and NHS England have specifically requested within the BCF Planning Requirements (2019-20) that plans will be approved, subject to all funding agreed as part of the BCF plan, and that this must be transferred into one or more pooled funds, established under Section 75 of the NHS Act (2006).

Key Issues

2. The Better Care Fund (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. The BCF was established by Government to provide funds to local areas to support the integration of health and social care.

The BCF Plan for Rotherham has been developed to promote and implement integration, and these schemes are set out in the Rotherham BCF Planning Template for 2019/20 - a plan which has now been informally approved by the Yorkshire and Humber BCF Assurance Plan on 17th October, 2019. One of the key requirements of the BCF plan is for a Section 75 Framework Agreement to be in place and fully signed by both partner organisations by 15th December, 2019.

The BCF Planning Requirements 2019/2020 shows that a formal agreement needs to be established in each local area to enable the Council and the CCG to work collaboratively in delivering the services set out in the BCF plan for 2019/20. The requirement is for an agreement using Section 75 of the National Health Service Act, 2006. This partnership framework agreement gives powers to local authorities and health bodies to establish and maintain pooled funds, out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed National Health Service (NHS) functions.

A Section 75 framework agreement is used when there is some cross-over of functions between the two organisations; to allow them to act in partnership to pool budgets or create non-pooled funds, to agree that staff carrying out the inter-related functions can undertake work for both parties and to delegate functions to provide a more seamless service. A Section 75 framework agreement records a wider working relationship between health and social care organisations, with a view to arrangements being developed across a number of different services or it can be used for a single discrete service.

Rotherham Clinical Commissioning Group (RCCG) and Rotherham Metropolitan Council (RMBC) in a series of meetings have jointly developed a new overarching Section 75 Framework Agreement and BCF Call-Off Partnership/Work Order, customising this document to reflect local need and priorities. This has now been approved and signed by both partner organisations in December 2019.

	The Section 75 Framework Agreement has established two pooled budgets. With each authority hosting one fund, the proposal allows the local authority to maximise the benefits of hosting a pooled fund. A performance management programme has been developed which will allow a close focus on each of the BCF schemes. The schemes have been mapped into two pooled budgets to allow similar services to explore opportunities for further integrated working, and to work together to collect and monitor data, ensuring duplication is avoided. The BCF Operational Group gathers reviews and interprets performance data, and ensures targets are monitored and met. The BCF Executive Group is the body which has strategic oversight of the whole BCF plan. The officer groups will be held accountable across the system and have key representatives from both RCCG and RMBC. Terms of Reference for each of these groups are set out in BCF Call-Off Partnership/Work Order. This partnership will ensure there is maximum focus on reducing the number of non-elective admissions and admissions to residential care, The CCG and Council have agreed a risk fund, spread across the two pooled budgets, which will be used to fund any shortfall due to targets being missed, or unexpected overspends. The details of the two pooled funds are set out in the BCF Call Off Partnership/Work Order. In brief, there are two funds within the £40m BCF Plan for 2019/20. One fund, hosted by the CCG, is valued at £11.070m and the other fund, hosted by the Council, is valued at £29.3m. Both funds sit under the same Section 75 Framework Agreement which provides governance for the BCF plan. A risk pool of £0.5 million for the fund has been set up to cover unintended pressures arising from workstreams in other parts of the system and the pay for performance element of the BCF for 2019/20. Risk sharing agreements have been agreed to protect both parties from areas of overspend and financial risk. The Council and CCG have finalised, agreed and signed the Section 75 Framework Agreement and BCF Call-Off Partnership/Work Order, and this has now been fully agreed by the BCF Executive Group.
Background Papers	
3.	Appendix 1 – Rotherham Section 75 Framework Agreement for the Commissioning of Services Appendix 2 – Rotherham BCF Call-Off Partnership/Work Order Appendix 3 – Rotherham BCF Planning Template 2019/20
Recommendations	
4.	**That the Health and Wellbeing Board:** **(i) Receive the Section 75 Framework Agreement and the BCF Call-Off Partnership/Work Order for 2019/20 and note the contents**

Appendix 1

Rotherham Metropolitan Borough Council

NHS Rotherham Clinical Commissioning Group

Section 75 Framework Agreement for the Commissioning of Services

Table of Contents

Rotherham Metropolitan Borough Council

NHS Rotherham Clinical Commissioning Group

Section 75 Framework Agreement for the Commissioning of Services

Date of this Framework Agreement:	The execution date of the parties indicated below, or if the parties indicate different dates, on the later date

Participants

Details	The Council	The CCG
Name	Rotherham Metropolitan Borough Council	Rotherham Clinical Commissioning Group
Current address for notices	Riverside House, Main Street, Rotherham, S60 1AE	Oak House, Moorhead Way, Bramley, S66 1YY
Point of contact	The Council's Strategic Director of Adult Care, Housing and Public Health or the equivalent at the time, or his/her delegate.	The CCG's Chief Officer or the equivalent at the time, or his/her delegate.

1. Background to this Framework Agreement

1.1	About the Council	It is a local authority with a responsibility for commissioning and providing certain health and social care services for residents of Rotherham.
1.2	About the CCG	It is an NHS body with responsibility for commissioning health services under the 2006 Act in Rotherham.
1.3	Why the Participants are establishing this Framework	From time to time the Participants may wish to enter into Call-off Partnerships for the commissioning of services in relation to any of the following: • Council Functions; and/or • CCG Functions.
1.4	Purpose of this Framework Agreement	• To set out the following: - This contractual terms in relation to the Framework generally; and - The contractual terms of each Call-off Partnership, in addition to the other documents described in item 2.6. • To enable the Participants to pool funds and to align budgets as agreed between the Participants.
1.5	Powers of the Participants	The Participants enter into each Call-off Partnership under section 75 of the 2006 Act and/or section 13Z(2) and 14Z(3) of the 2006 Act as applicable.

2. The agreement between the parties

Each Participant agrees as follows:

2.1	Establishment of Framework	By signing this Framework Agreement, the Participants establish the Framework.
2.2	How the Participants are to operate under this Framework	• They may from time to time enter into Call-off Partnerships under this Framework. • Each Call-off Partnership is a separate partnership between the Participants for the purposes of section 75 of the 2006 Act and/or section 13Z(2) and 14Z(3) of the 2006 Act as applicable.
2.3	Consideration payable by a Participant to the other Participant for entering into • This Framework Agreement; and • Each Call-off Partnership from time to time.	• £1.00 if demanded by the other Participant in writing. • The parties agree this is sufficient consideration.
2.4	This Framework Agreement applies to each **'Call-off Partnership'**, being a partnership to which all of the following apply	
	(a) Who has established the Call-off Partnership	Both Participants.
	(b) How the Participants are to establish the Call-off Partnership	It is established under a Work Order that: • Cross-references this Framework Agreement sufficiently clearly; and • Is substantially in the form indicated in this Framework Agreement, or in such other form as the Participants agree. • Is wholly within the scope of the Framework described in item 2.5. • Has been appropriately executed by each Participant according to its own internal rules.
	(c) When the Participants may establish a Call-off Partnership from time to time	Any time: • On or after the commencement date of this Framework, as indicated in item 3.1; and • On or before the end date of the Framework indicated in item 4.1.
2.5	What is the scope of Framework	Any commissioning activities in relation to any services which may be the subject of a partnership between the Council and the CCG under section 75 of the 2006 Act and/or section 13Z(2) and 14Z(3) of the 2006 Act as applicable.

2.6 **The contractual terms of a particular Call-off Partnership**

- The following comprise the contractual terms each Call-off Partnership
- In order of priority if there are inconsistencies and as amended according to this Framework Agreement and/or the Call-off Partnership, as relevant
- To be legally binding on the Participants when executed by each Participant according to its own internal rules.

(a)	Work Order	The relevant Work Order of the Call-off Partnership, including any schedules, appendices or the like.
(b)	This Framework Agreement	This Framework Agreement.

2.7 The **terms of this Framework Agreement** comprise **all** of the following

- As amended from time to time according to this Framework Agreement
- According to the following priority if there are inconsistencies

These are legally binding on the Participants when this Framework Agreement is executed by each Participant according to its own internal rules

(a)	Schedules etc.	Any schedules, annexures or the like to this Framework Agreement which are not described elsewhere in this item 2.7.
(b)	Other documents	Any and all other documents, websites identified by a link, or the like of any of these • Which are cross-referenced in any document described in a document listed elsewhere in this item 2.7; and • Which this Framework Agreement Framework Agreement indicates are incorporated into this Framework Agreement; and • Which are communicated (or in the case of a website, the relevant link has been communicated) between the parties.
(c)	Cover pages	These pages before the execution clauses.
(d)	Schedule 1	The contractual terms of this Framework Agreement indicated in schedule 1.

Executed by the parties (or on their behalf by their respective authorised representatives) as an agreement on the respective dates indicated below

	The Council	The CCG
Signature		
Date of signature		
Name of signatory (print)		
Title or role of signatory (print)		

Schedule 1: the terms of this Framework Agreement

Duration

3.	**Commencement of Framework, Call-off Partnerships**	
3.1	When this Framework commences	On the date of this Framework Agreement.
3.2	When each Call-off Partnership commences	As indicated in the relevant Work Order.
4.	**End of Framework, Call-off Partnerships**	
4.1	When this Framework ends	There is no expiry date of the Framework. The Framework continues until the first of the following occurs: • The Participants agree in writing to end the Framework. In this case, the end date is the date on which the Participants agree in writing that the Framework is to end. • Either Participant communicates to the other Participant in writing that the relevant Participant wishes to discontinue the Framework. The relevant Participant is not required to give a reason for making the communication. In this case, the end date is the date on which the relevant Participant requests the Framework to end. • There is a change in the Law resulting in the Participants being no longer able to enter partnerships for the commissioning of goods, services and/or works.
4.2	Whether the end of the Framework **in itself** results in the end of any Call-off Partnership then in place	No. That Call-off Partnership continues until it ends according to item 4.3.
4.3	When each Call-off Partnership ends Either of the following, as relevant:	
	(a) If there is **no Commissioned Contract** in place at the relevant time in relation to the Call-off Partnership	On the first of the following to occur: • Any expiry date indicated in the relevant Work Order (as extended by written agreement of the Participant); or • The effective date of any early termination of the Call-off Partnership, if that Call-off Partnership is terminated early: - By a Participant unilaterally under the terms of this Framework Agreement or under the relevant Work Order; or - By written agreement of the Participants.
	(b) If there is **at least one Commissioned Contract** in place at the relevant time in relation to the Call-off Partnership On the later of the following:	• The date indicated in item (a); or • The first date on which neither Participant has any remaining obligations, liabilities (or the like) whatsoever (whether known or prospective) in relation to at least one Commissioned Contact in connection with the Call-off Partnership.

4.4	Consequences of the end of a Call-off Partnership according to item 4.3	• The rights, powers, obligations, liabilities, prohibitions and restrictions (or the like of any of these) of the Participants in connection with the Call-off Partnership shall discontinue. • This is subject to item 4.5 in relation to those which continue after the end of the Call-off Partnership.

4.5 The following rights, powers, obligations, liabilities, prohibitions and restrictions (or the like of any of these) of the Participants **shall continue** in relation to a Call-off Partnership which has otherwise ended under item 4.3

- These shall continue until they are completed, until they expire, or indefinitely, as relevant, regardless of the end of the relevant Call-off Partnership
- These are to be read independently

(a)	Already arisen, accrued	Those in connection with the relevant Call-off Partnership which had already arisen or accrued on or before the end date of the Call-off Partnership.
(b)	Relating to certain events or circumstances	Those which relate to events or circumstances • Which are connected with the relevant Call-off Partnership; and • Which occurred on or before the end date of that Call-off Partnership.
(c)	Interest	Any interest accruing on any debts between the Participants in connection with the relevant Call-off Partnership which relate to events or circumstances which had already occurred or arisen on or before the end date of the Call-off Partnership.
(d)	Continuing nature	Those in connection with the relevant Call-off Partnership which are expressed (or which are reasonably implied) in the terms of the Call-off Partnership to continue after the end date of the relevant Call-off Partnership.

About Call-off Partnerships generally

5. Obligation to enter Call-off Partnerships

5.1	Extent to which either Participant is contractually obliged to enter into **any particular** Call-off Partnership	No obligation.
5.2	Extent to which either Participant is contractually obliged to enter into **any minimum number** of Call-off Partnerships	No obligation.

6. Procedures to establish Call-off Partnerships

6.1	Each Participant must follow the following procedures if the Participants wish to establish a particular Call-off Partnership from time to time	Each Participant must comply with any and all procedures required in all of the following: • The relevant Work Order • The relevant Participant's constitutional arrangements • In any case, the Law.

General principles

7. General obligations

7.1	Standards to which each Participant must operate in carrying out its activities in connection with any Call-off Partnership	To the highest of the following standards: • With reasonable skill and care. • **In any case:** in compliance with relevant Law. This is a paramount obligation, which overrides anything to the contrary in this Framework Agreement and/or in the contractual terms of any Call-off Partnership.
7.2	Keeping informed	• Each Participant must keep the other Participant informed of any matters significant to this Framework and/or any one or more Call-off Partnerships. • That Participant must do so promptly on becoming aware of the matter.
7.3	Obligations not to create certain risks etc.	Neither Participant (**'X'**) may do any act which causes (or which creates an unreasonable risk of causing) any of the following: • The other Participant to breach any Commissioned Contract. • The other Participant to breach any Law in connection with a particular Call-off Partnership. • The other Participant to breach any other duty which it owes any third party (whether in contract or otherwise) where X either knew or reasonably should have known about that duty.
7.4	Other general obligations of each Participant in relation to its activities connected with each Call-off Partnership and this Framework generally	Each Participants must act honestly and in good faith in relation to such activities and in its dealings with the other Participant in connection with each Call-off Partnership and this Framework generally.
7.5	Miscellaneous obligations of each Participant	
	(a) Compliance with Partnership Board resolution etc.	Each Participant must comply with all of the following: • A resolution of the Partnership Board then in place. • Any written agreement then in place between all of the Participants in connection with the Partnership.

(b)	Not to assist	• No Participant is permitted to assist or instruct another person to do any act that would breach this Framework Agreement and/or the contractual terms of a Call-off Partnership if that act were done by the Participant and/or its Affiliate directly. • If a Participant's Affiliate or any Personnel of the Participant or its Affiliate does any such act, the onus will lie with that Participant to prove the act was NOT done with the Participant's instructions and/or assistance.
(c)	Not to attempt	No Participant is permitted to attempt to breach this Framework Agreement and/or the contractual terms of a Call-off Partnership (e.g. by entering into an agreement with someone with obligations on the Participant that would put it in breach of this Framework Agreement and/or the contractual terms of a Call-off Partnership).

Arrangements of each specific Call-off Partnership

8. Type of commissioning arrangement

8.1	Whether a relevant Call-off Partnership is to involve any one or more of the following: • A joint commissioning arrangement; and/or • A lead commissioning arrangement	As indicated in the Work Order.

9. Delegations between the Participants

9.1	What the **Council** delegates to the **CCG** under a particular Call-off Partnership when the Participants enter into that Call-off Partnership	It delegates to the CCG those Council Functions if any • As indicated in the relevant Work Order • To the extent those delegations are reasonably necessary to enable the CCG to perform its obligations under that Call-off Partnership The CCG • Accepts that delegation; and • On such acceptance, agrees to exercise those Health Related Functions in conjunction with the CCG's CCG Functions.
9.2	What the **CCG** delegates to the **Council** under a particular Call-off Partnership when the Participants enter into that Call-off Partnership	It delegates to the Council those CCG Functions if any • As indicated in the relevant Work Order • To the extent those delegations are reasonably necessary to enable the Council to perform its obligations under that Call-off Partnership The Council • Accepts that delegation; and • On such acceptance, agrees to exercise those CCG Functions in conjunction with the Council's Council Functions.
9.3	When a delegation is deemed to have been made by the delegating Participant and accepted by the Participant who receives the delegation	On the date the Participants enter into the relevant Call-off Partnership, or on such later date indicated in the Work Order.

9.4	Whether there are any restrictions on a Participant's powers to delegate its powers or functions by Law	Those restrictions apply to any delegation described in this section 9 to the minimum extent necessary to comply with the Law.

10. Scope of a Call-off Partnership

10.1	The scope of a particular Call-off Partnership (i.e. the Services which may be commissioned within that Call-off Partnership)	As indicated in the relevant Work Order.

11. Aims and objectives

11.1	The aims and objectives of the Participants in relation to a particular Call-off Partnership	As indicated in the relevant Work Order.

12. Service standards

12.1	Specific service standards (or similar) to which a Participant must carry out its obligations under a particular Call-off Partnership	As indicated in the relevant Work Order.

13. Commissioned Contracts

13.1	Description of each Commissioned Contract to be commissioned in connection with a particular Call-off Partnership	• As indicated in the relevant Work Order. • Any additional contracts as agreed by the Participants in writing.
13.2	Which Participant is to be a party to each Commissioned Contract described in item 13.1	• As indicated in the relevant Work Order. • As agreed by the Participants in writing.
13.3	How the Participants are to decide on the contractual terms of each Commissioned Contract, including any specification or the like	According to the decision making rules of this Framework described in section 34.

14. Client group

14.1	Description of the client group for whose benefit the Services are to be provided under a particular Call-off Partnership	As indicated in the relevant Work Order.

15. Improvements for client group

15.1	Expected improvements for the client group in relation to a particular Call-off Partnership	As indicated in the relevant Work Order.

16. Consultations

16.1	Consultation activities which the Participants have undertaken with the relevant client group in relation to a particular Call-off Partnership	As indicated in the relevant Work Order.

17. Host Participant

17.1	Which Participant is the Host Participant in relation to a particular Call-off Partnership	• **Current Host Manager:** as indicated in the relevant Work Order. • **From time to time:** as agreed in writing by the Participants.
17.2	Responsibilities and tasks of the Host Participant in relation to a relevant Call-off Partnership from time to time	As indicated in the relevant Work Order.
17.3	Authority of the Host Participant to make decisions and to otherwise act alone for the purposes of the Partnership in relation to a relevant Call-off Partnership	• It may do so under its Individual Authority from time to time according to section 35. • Any decision or other act by the Host Participant in connection with the Partnership that is within its Individual Authority is binding on the Participants.
17.4	The Host Participant's obligations to keep the Partnership Board informed of events and circumstances affecting the relevant Call-off Partnership as and when they occur	The Host Participant will be obliged to keep the Partnership Board informed of: • Any adverse complaints/legal challenges that impact or impede the operation of the Call-off Partnership • Specific statistical information as agreed between the Host Participant and the Partnership Board
17.5	How a Host Participant must carry out its responsibilities in relation to a relevant Call-off Partnership	It must do so as follows: • With reasonable skill and care • In accordance with the contractual terms of the Call-off Partnership as described in item 2.6 . • In any case, in accordance with the following: • Any relevant Law, particularly (in relation to the procurement of any public contract and where relevant) the Public Contracts Regulations (2015), as amended. • The Host Participant's constitution or the equivalent.

18. Pooled Fund, Non-Pooled Fund

18.1	Whether there is to be a Pooled Fund or a Non-Pooled Fund in relation to a particular Call-off Partnership	As indicated in the relevant Work Order.
18.2	If there is to be a Pooled Fund in relation to a particular Call-off Partnership, who is to be the Pool Manager of the Pooled Fund in relation to a particular Call-off Partnership	• **Current Pool Manager:** as indicated in the Work Order or in any case, any suitably qualified officer of the Host Participant as the Host Participant nominates from time to time. • **From time to time:** as agreed in writing by the Participants.

19. Notifications

19.1	Which Participant is responsible for making all notifications required to the Department of Health (or other body as necessary regarding the establishment of a particular Call-off Partnership	As indicated in the relevant Work Order.

20. Minimum volumes

20.1	Whether a Participant is obliged under this Framework Agreement to purchase a **minimum volume of goods, services or works** under any Commissioned Contract of a Call-off Partnership	Only to the extent indicated in the relevant Work Order.

21. Exclusivity

21.1	Whether any Participants is obliged under this Framework Agreement to do any of the following **on an exclusive basis** • Use a Commissioned Contract of a particular Call-off Partnership • Purchase any services from any particular Relevant Provider	Only to the extent indicated in the relevant Work Order.

Financial issues

22. Contributions under Call-off Partnerships including Overspends

22.1	Liability of the Participants to make **initial contributions** to any **Pooled Fund** of a particular Call-off Partnership	
	(a) Period covered by the initial contribution	As indicated in the relevant Work Order.
	(b) Liability of the CCG to make **initial contributions**	As indicated in the relevant Work Order.
	(c) Liability of the Council to make **initial contributions**	As indicated in the relevant Work Order.
	(d) When payment is due	As indicated in the relevant Work Order.
22.2	Liability of the Participants to make **regular further contributions** to any **Pooled Fund** of a particular Call-off Partnership	
	(a) Period covered by each regular further contribution	As indicated in the relevant Work Order.
	(b) Liability of the CCG to make **regular further contributions**	As indicated in the relevant Work Order.
	(c) Liability of the Council to make **regular further contributions**	As indicated in the relevant Work Order.
	(d) When payment is due	As indicated in the relevant Work Order.

22.3	Liability of the Participants to make **ad hoc further contributions** to any **Pooled Fund** of a particular Call-off Partnership **due to any Overspends** from time to time	
(a)	Definition of an **'Overspend'**	Actual expenditure is greater than planned in the approved budget/contribution to the pooled fund
(b)	Liability of the CCG to make **ad hoc further contributions due to any Overspends**	As indicated in the relevant Work Order.
(c)	Liability of the Council to make **ad hoc further contributions due to any Overspends**	As indicated in the relevant Work Order.
(d)	Whether there are any events or circumstances causing the liability of the CCG (in item (b)) and/or the liability of the Council (in item (c)) to change on a particular occasion	As indicated in the relevant Work Order.
(e)	When payment is due	As indicated in the relevant Work Order.
22.4	Arrangements regarding any underspends from time to time	As indicated in the relevant Work Order.

23. Charging service users

23.1	Right of **either Participant** to impose any charges on service users for whose benefit any services are provided under a Commissioned Contract	As indicated in the relevant Work Order. Only in relation to Council functions.
23.2	Treatment of any charges received by a Participant in the circumstances described in item 23.1	Retained by the Council.
23.3	Right of either Participant to **allow a Relevant Provider under a Commissioned Contract** to impose any charges on service users for whose benefit any services are provided under a Commissioned Contract	It may do so.
23.4	Treatment of any charges received by a Relevant Provider in the circumstances described in item 23.3	Retained by the Relevant Provider.

24. Rebates, credits, refunds

24.1	To what this section 24 applies (any of the following)	• Any of the following paid from time to time by a particular Relevant Provider to a Participant in connection with any Commissioned Contract - A refund - Compensation (whether awarded by a court, under a settlement or otherwise) - A rebate • Proceeds of any insurance claim made by a particular Relevant Provider for the benefit of any Participant in connection with any Commissioned Contract • A credit given by a particular Relevant Provider to a Participant • Any other payment similar to those described above.
24.2	How a Participant must deal with any payment or credit described in item 24.1 which that Participant receives in connection with a Commissioned Contract	
	(a) If that Participant receives it **before** the end of the relevant Call-off Partnership	Into the Pooled Fund unless indicated in the relevant Work Order.
	(b) If that Participant receives it **after** the end of the relevant Call-off Partnership	Into the Pooled Fund unless indicated in the relevant Work Order.

25. Interest on late payment

25.1	What interest accrues on overdue debts or other liabilities owed between the Participants • In connection with the Framework and any Call-off Partnership • Whether arising in tort, contract or otherwise • Regardless of which of them is the debtor or creditor	The relevant debtor shall be obliged to pay interest to the relevant creditor as follows: • In addition to the relevant principal. • At the following rate: **4%** per year above the Bank of England base rate at the time (but if the Bank of England base rate falls below 0%, for this purpose it shall be deemed to be 0%). • To compound monthly from the due date until payment, whether before or after judgement. • Except to the extent and for as long as the debt or other liability is subject to a genuine dispute which the debtor is using reasonable and genuine efforts to attempt to resolve.

26. No set off

26.1	Whether a Participant and its Affiliates have any right of set off, counterclaim, deduction (or the like of any of these) against another Participant and that other Participant's Affiliate in connection with the Framework and/or any Call-off Partnership	• No. • All such rights (whether arising in law, equity or otherwise) are waived to the fullest extent permitted by Law.

27. No liens

27.1 Whether a Participant (**'X'**) has any lien over the property of another Participant and its Affiliates (**'Y'**) in relation to any liabilities which Y owes X in connection with the Partnership	• No. • These are waived to the fullest extent permitted by Law.

Reimbursements

28. Certain reimbursements

28.1 From what a Participant is entitled to be reimbursed under this section 28	
(a) If a Call-off Partnership has a Pooled Fund	From the Pooled Fund.
(b) If a Call-off Partnership does not have a Pooled Fund	By the Participants in the proportions indicated in the relevant Work Order.
28.2 For what a Participant is entitled to be reimbursed according to item 28.1 in relation to a particular Call-off Partnership Each of the following to the extent relevant	
(a) Payment of charges	• Charges, fees or the like paid by a Participant to a Relevant Provider which that Participant is liable to pay under a Commissioned Contract. • This only applies if the liability relates to goods, services and/or works supplied by the Relevant Provider **for the collective benefit of the Participants** and not for the **sole benefit** of the relevant Participant with the liability to make the payment.
(b) **Host Participant Remuneration** in relation to a particular Call-off Partnership Being remuneration of the Host Participant for its staff costs and overhead costs incurred in its activities in carrying out the role of Host Participant of a particular Call-off Partnership	
(i) Amount or calculation of the **current** Host Participant Remuneration of a particular Call-off Partnership	Only as indicated in the relevant Work Order.
(ii) How the Host Participant Remuneration of a particular Call-off Partnership changes over time Routine changes, and events resulting in changes	Only as indicated in the relevant Work Order.
(iii) When the Host Participant becomes entitled to its Host Participant Remuneration	Annually in arrears (on each 31st March) unless agreed by the Participants, whether in the Work Order or otherwise.

(c)	Third party expenditure incurred by a Participant in connection with a particular Call-off Partnership	Only those approved by the Partnership Board as being 'joint expenses' of the Partnership • Where the Host Participant incurs the expense with a third party; and • Where that expense is incurred for the joint benefit of the Participants generally.
(d)	For a Participant's Losses resulting from any Claim made or threatened against that Participant separately by a third party where all of the following apply	
	(i) About the claimant	It can be anyone other than • Any Affiliate of that Participant; and/or • The other Participant and/or its Affiliate.
	(ii) To what the Claim must relate	Where the Claim relates to, or is the consequence of, either or both of the following: • That Participant's own acts or failures to act (and/or those of X's separate agents) in connection with the relevant Call-off Partnership. • Acts or failures to act by anyone else in activities connected with the Call-off Partnership (e.g. a Relevant Provider etc.).
	(iii) Obligations of the relevant Participant if it wishes to claim the reimbursement under item 28.1	The relevant Participant must be able to demonstrate it has taken reasonable steps to mitigate its relevant Losses for which it seeks reimbursement.
	(iv) Exception	This item (d) does not apply to the extent the act (or failure to act) by the relevant Participant and/or by anyone else is the result of a Deliberate Default of the relevant Participant.
28.3	Whether a Participant's right to reimbursement under this section 28 continues after the end of the relevant Call-off Partnership	The right to reimbursement still applies for the benefit of the Participant even if its claim for reimbursement is first made or threatened after the end of the relevant Call-off Partnership.

Partnership Board and governance

29. Governance arrangements

29.1	Governance arrangements for a particular Call-Off Partnership (e.g. nature of any board arrangements to govern the Call-Off Partnership according to the powers indicated in item 31.1)	As indicated in the relevant Work Order.

30. Partnership Board – composition

30.1	Number of representatives of each Participant on the Partnership Board	As indicated in the relevant Work Order.

30.2	How each Participant appoints its representative on the Partnership Board from time to time	• Each Participant may select any individual (as it chooses) to be its representative on the Partnership Board from time to time. • If a Participant's representative is unable to attend Partnership Board meetings or other Call-off Partnership activities for any reason (e.g. illness, holidays, competing work demands, he/she has a personal conflict of interest on a particular matter), the relevant Participant may appoint anyone else to be a temporary replacement. That individual shall be considered a member of the Partnership Board for this temporary period.
30.3	Which Participant is to provide administration support to the Partnership Board	As indicated in the Work Order of a relevant Call-Off Partnership, unless otherwise decided from time to time by a resolution of the Partnership Board.

31. Partnership Board powers

31.1	Powers of the Partnership Board	To manage the affairs generally of the Framework and each Call-off Partnership in place at the time. To make decisions on any matter affecting the Framework and each Call-off Partnership in place at the time, including the Reserved Matters indicated in section 36.

32. Partnership Board – resolutions

32.1	Number of votes held by each member of the Partnership Board	One each.
32.2	How resolutions the Partnership Board are to be passed	At least one of the following • By **a simple majority** of votes cast by the Partnership Board members in attendance at a validly called Partnership Board meeting, • By each member of the Partnership Board signing a single document (or across a number of documents) containing the relevant decision, indicating the date and time of his/her signature. The decision is passed when the last member of the Partnership Board signs.
32.3	Consequence of a Partnership Board resolution	Each Participant is legally bound to comply with it, unless either of the following applies • It is later overridden by a later Partnership Board resolution. • Each other Participant agrees in writing that the relevant Participant is not legally bound to comply with the Partnership Board resolution.

33. Partnership Board meetings

33.1	Arrangements regarding regular meetings of the Partnership Board To apply unless the members of the Partnership Board (whom the Participants must direct to act reasonably) otherwise agree at the time		
	(a)	Location	As indicated in the relevant Work Order.
	(b)	Frequency	As indicated in the relevant Work Order.
	(c)	Day If not falling on a Business Day, on the next Business Day	As indicated in the relevant Work Order.
	(d)	Time	As indicated in the relevant Work Order.
33.2	Additional meetings		
	(a)	Participant responsible for calling additional meetings of the Partnership Board	As indicated in the relevant Work Order.
	(b)	Obligations of the Participant indicated in item (a) if the other Participant requests an additional Partnership Board meeting from time to time	That Participant must not unreasonably refuse that request of the other Participant.
	(c)	How additional meetings are called by the Participant indicated in item (a)	• By written communication to each representative of the other Participant. • No other formalities are required.
	(d)	Setting the day, time and location for additional Partnership Board meetings	The Participant indicated in item (a) shall act reasonably and in good faith in setting the day, time and location of the additional meeting.
	(e)	Minimum notice period for additional Partnership Board meetings	• At least **5 Business Days** excluding the day on which the notice is sent and the date of the meeting; or • Such shorter notice agreed in writing by all members of the Partnership Board, at their discretion.
33.3	Quorum for meetings		
	(a)	Quorum for meetings of the Partnership Board	As indicated in the relevant Work Order.
	(b)	Consequence if no quorum is present	If the quorum of a meeting is not met within **30 minutes** of the time the meeting was proposed to commence, the meeting shall be cancelled, and items postponed to the next meeting. Urgent items for decision will be dealt with outside of the formal meeting through via e mail approval.
33.4	Which Participant's representative on the Partnership Board is to chair the meetings of the Partnership Board		As indicated in the relevant Work Order.

33.5	Eligibility of representatives of a Participant to attend a Partnership Board meeting (or relevant part of it)	Each one is eligible to attend. Exception: • Where the individual personally has a conflict of interest on a matter which the Partnership Board is considering. • In this case, the relevant Participant which he/she represents must (if it wishes to be represented at the meeting or part of it) temporarily appoint a replacement in his/her place for the purposes of considering the relevant matter.
33.6	**Observers:** each Participant may send observers to attend Partnership Board meetings, acting reasonably, and subject to all of the following	
	(a) Conflict of interest	The relevant Participant must not knowingly allow its observer to remain in any part of a meeting where the observer has a conflict of interest on any of the matters under discussion.
	(b) Confidentiality	The relevant Participant must ensure the observer is appropriately bound to observe confidentiality obligations to the other Participant and its Affiliates (e.g. in a separate confidentiality agreement, in his/her employment contract, as reasonably required by the other Participant).
	(c) Space	The relevant Participant must have reasonable regard to room space when inviting observers.
	(d) Voting	The observer is not entitled to vote at a relevant meeting.
	(e) Speaking	The observer is not entitled to speak at the relevant meeting, unless permitted by the representatives of the Participants: • Who are eligible to vote at the meeting; and • Who are at the meeting.
33.7	Holding meetings of the Partnership Board electronically (e.g. conference calls etc.)	
	(a) When meetings of the Partnership Board must be held electronically according to this item 33.7	By agreement of the Participants. Neither Participant may refuse the other Participant's request for a meeting to be held this way without good reason.
	(b) How electronic meetings are to be held	By any suitable electronic means (e.g. by telephone, videoconferencing, over a computer etc.) where the attendees can hear each other (or where what is said is communicated in another suitable method for the benefit of anyone with impaired hearing).
	(c) Consequences if meetings of the Partnership Board which are held electronically under this item 33.7	The individuals taking part in the meeting shall be regarded as if they were physically present for all purposes (e.g. determining whether a quorum is met).
33.8	**General obligations:** each Participant must direct its respective representatives to do the following in relation to meetings of the Partnership Board from time to time	
	(a) Prepare	To prepare properly for the meeting.
	(b) Attend	To attend the meeting.

(c)	Absence	To give advance notice to the chairperson of any absence, where reasonably possible.
(d)	Conflict of interest	To declare any personal conflict of interest on any matter under consideration from time to time.
(e)	Personnel	• To direct its other Personnel to attend parts of meetings where the relevant individual's presence is reasonably required. • To direct its Personnel to give appropriate explanations etc. in relation to matters under discussion.
(f)	Status of minutes of a particular meeting of the Partnership Board	If none of the individuals representing a Participant at the meeting has raised any complaint about the accuracy or completeness of contents of the circulated minutes more than **7 days** after the minutes are circulated, that Participant shall be deemed to have accepted the minutes as an accurate record of that meeting.

Decision making

34. Decision making – summary

34.1 Summary of how decisions are to be made on behalf of the Participants:

In any of the following ways, as relevant

(a)	Individual Authority	By the Host Participant acting alone within its Individual Authority (see section 35).
(b)	Partnership Board resolution	By a Partnership Board resolution (see item 32.2).
(c)	By agreement	• By agreement of the Participants evidenced in writing. • This may include (for example) an exchange of e-mails or other correspondence in which each Participant clearly indicates agreement to the decision.

35. Individual Authority

35.1	Definition of **'Individual Authority'**	The authority of a Participant (making decisions or otherwise acting alone) to act or otherwise make decisions • For the purposes of a particular Call-off Partnership • Without being required to consult the Partnership Board and/or any other Participant • As indicated in this section 35.
35.2	Consequences of the Host Participant's act within its Individual Authority in relation to the relevant Call-off Partnership	It shall be regarded by the Participants as a valid act of the Host Participant in connection with the Partnership.

35.3 Where the Host Participant has Individual Authority to make a decision or to otherwise act in connection with the relevant Call-off Partnership

- In any of the following circumstances
- Each of them to be read independently
- To be read subject to the rest of this section 35

(a)	Not Reserved Matter	The decision or other act is on any matter that is not a Reserved Matter for the Partnership Board.
(b)	The decision or other act is a Reserved Matter but is carried out in a genuine emergency Where all of the following conditions are met	
	(i) What kind of emergency	There is a genuine emergency to which both of the following apply • It is not caused by any Deliberate Default of the Host Participant. • If the Host Participant did not carry out the relevant decision or other act, it would create an unreasonable risk of serious adverse consequences for the Partnership (and/or any Participant in connection with the Partnership, including the Host Participant itself).
	(ii) Tried to get authorisations	• The Host Participant was unable to obtain the necessary Partnership Board resolution that would otherwise have been required. • The Host Participant can reasonably demonstrate that it used reasonable endeavours to attempt to do so, where reasonably practicable in the circumstances.
	(iii) Informed	The Host Participant has informed each Partnership Board member of its relevant decision or other act no later than **30 days** after that act was completed.
(c)	Other authorisations	The decision or other act is a Reserved Matter but is carried out under the express or clearly implied authority of any of the following • A Partnership Board resolution and/or • The agreement in writing of the Participants in place at the time. • Elsewhere in this Framework Agreement.
(d)	Deemed authorised	The decision or other act is a Reserved Matter, but the Host Participant is deemed to have Individual Authority under item 35.4.

35.4 The Host Participant's decision or other act is deemed to be within its Individual Authority for the purposes of item 35.3(d) where **all** of the following conditions are met

(a)	Member	The Host Participant is still a member of the Partnership at the time that act was carried out.

(b)	Outside Individual Authority	None of the other items in item 35.3 applies to give the Host Participant the Individual Authority to carry out that decision or other act (other than item 35.3(d)).
(c)	Later accepted or no complaint	At least one of the following applies: • The decision or other act is later accepted by Partnership Board resolution or agreement in writing of the Participants; and/or • The other Participant has not raised a complaint about the decision or other act according to item 35.5.

35.5 **All** of the following requirements apply if the other Participant (**'X'**) wishes to raise a complaint in relation to the act of the Host Participant for the purposes of item 35.4(c)

(a)	How X raises the complaint	In writing to the Partnership Board.
(b)	Contents when raising the complaint	X must describe (in the written communication) the relevant act of which is outside the Host Participant's Individual Authority.
(c)	Deadline by which X must raise the complaint	No later than **30 days** after X has been made aware of the relevant act.

35.6 Whether any Participant other than the Host Participant has any Individual Authority to act in connection with the Partnerships — Only to the extent authorised by a resolution of the Partnership Board or the written agreement of each Participant.

35.7 The Host Participant does not have Individual Authority to make any decision or carry out any act purportedly on behalf of the Partnership if and to the extent any of the following applies to that Participant's act

- Except to the extent the Participants otherwise lawfully agree in writing
- (each of the following to be read independently)

(a)	Outside scope	The act is not reasonably incidental to the scope of activity of the relevant Call-off Partnership according to section 10.
(b)	Joint	The act is not intended for the benefit of the Participants collectively.
(c)	Breach of Partnership Board resolution or agreement in writing of the Participants	The act is contrary to any Partnership Board resolution or agreement in writing of the Participants in place at the time (excluding trivial and technical breaches).
(d)	Breach of Framework Agreement	The act is in breach of this Framework Agreement (excluding trivial and technical breaches).

35.8 **Treatment of any liability arising from the act of a Participant ('X') purportedly in connection with the Partnership which is outside that Participant's Individual Authority according to this section 35:** all of the following

- Where relevant
- **If X is the Host Participant:** if that act is a **Default** by X
- Not to exclude other consequences or to limit any person's rights and remedies in relation to that act
- To be read independently; and
- Except to the extent the Participants otherwise lawfully agree in writing

(a) Who is liable for the liability	It shall be regarded as X's own separate liability.
(b) Indemnity	X must indemnify each other Participant for their respective Losses arising as a result of any Claim made or threatened against them respectively in relation to such debt or other liability.
(c) Whether the Host Participant is entitled to reimbursement for expenses incurred under section 28 in relation that liability	No.
(d) To what this item 35.8 is subject	It is subject to item 35.9.

35.9 Extent to which the consequences in item 35.8 apply where the relevant Participant (**'X'**) does not have Individual Authority due to its **unlawful act**

These consequences **do not** apply to X's act to the extent **all** of the following apply

- The unlawful act involves a technical breach of the Law.
- It would not be reasonable in the circumstances to have expected X to have done either of the following before carrying out the act:
  - Known of the breach before carrying out the act, or
  - Taken appropriate legal advice on the matter.
- Either of the following applied before X carried out that act:
  - X had not been given advice to the effect that the act is unlawful; or
  - X had been given advice from an appropriately qualified person that the act is not unlawful.

35.10 If a Participant's act is partly within its Individual Authority, and partly outside it

(a) If the consequences of the act CAN reasonably be apportioned	The consequences of the act outside that Participant's Individual Authority indicated in item 35.8 shall only apply to that part of the act which is outside the Individual Authority.

(b)	If the consequences of the act CANNOT reasonably be apportioned	The consequences of the act outside that Participant's Individual Authority indicated in item 35.8 shall only apply to the entire act.

36. Reserved Matters

36.1 Matters which are reserved for a decision by the Partnership Board or written agreement between the Participants

Each of them is a **Reserved Matter'**

37. Deadlocks

37.1	Definition of a **'Deadlock'**	At a meeting of the Partnership Board, there have been an equal number of votes cast in favour of and against a proposed resolution.
37.2	How Deadlocks are to be resolved	• By each Participant escalating the matter to its respective most senior officer (or his/her delegate). • Each Participant must direct its relevant representative to use reasonable efforts to attempt to resolve the Deadlock promptly and without causing unnecessary disruption or cost for either Participant.

General property issues

38. Property issues

38.1	Arrangements regarding any interest in any property acquired by a particular Participant under any Call-off Partnership to which that Participant is a party (as between the Participants)	
	(a) In relation to Intellectual Property	It shall belong to the relevant Participant That Participant shall grant each other Participant and its Affiliates a licence to use that Intellectual Property. The terms of that licence are as follows • Worldwide, royalty-free, non-exclusive. • Perpetual from the date the Intellectual Property first belongs to the relevant Participant • For any use the licensee wishes. • Capable of assignment or sublicensing without requiring the consent of the licensor Participant. • The licence shall include the following - Any licence which the relevant Participant is granted over arising Intellectual Property in connection with any Call-off Partnership (whether that licence is granted in the Call-off Partnership itself of in a connected licence). - Any background Intellectual Property of the licensing Participant on which the relevant Intellectual Property depends. - The benefit of any licence which the licensor Participant has to any background Intellectual Property of the Relevant Provider on which the licensed Intellectual Property depends.
	(b) In relation to all other property	Such property shall belong that Participant. No other Participant shall have any right or interest in that property, except as agreed in writing by the relevant Participants (e.g. under a separate licence agreement).

General monitoring

39. Keeping Partnership Records

39.1	What is a '**Partnership Record'**	Any record from time to time of any Call-off Partnership held in any form (whether electronic, hard copy or otherwise) including (without limitation) its books of account, minutes of meetings, documents evidencing title to or interests in assets, original deeds or contracts, correspondence, files, invoices and other documents evidencing purchases of goods or services, drawings or the like, documents relating to any application for planning permission or the like, tenant records, insurance certificates, tax and other regulatory records and bank statements.

39.2	For how long each Participant must keep Partnership Records in its possession	• **6 years** from the date on which the Partnership Record is first created, or • Such longer or shorter period as required by Law according to the type of Partnership Record.
39.3	Rights of access of another Participant to the Partnership Records held by a Participant	
	(a) Inspection rights of a Participant	Each Participant (**'X'**) may inspect any Partnership Records in the possession or control of the other Participant (**'Y'**) if requested by X.
	(b) When X may make the request described in item (a)	At any time during the relevant Call-Off Partnership and up to a further **6 years** after the end of the Call-Off Partnership.
	(c) Minimum notice X must give Y before the inspection	At least **5 Business Days'** prior notice, unless Y agrees to shorter notice.
	(d) Y's obligations	Y must give X's representatives reasonable cooperation in relation to such inspections, including access to relevant premises and Partnership Records, and instructing Y's Personnel to provide reasonable explanations in relation to such Partnership Records.
	(e) Confidentiality arrangements	Section 43 applies to the confidentiality obligations of Y in relation to its inspections under this item 39.3.

40. Relevant Provider monitoring

40.1	**Reports:** obligation of a Participant to circulate any monitoring reports it receives from the Relevant Provider in connection with its Call-off Partnerships	As indicated in the relevant Work Order.
40.2	**Monitoring meetings:** right of representatives of a Participant to attend monitoring meetings with a Relevant Provider	As indicated in the relevant Work Order.
40.3	**Inspections:** right of a Participant (in addition to the Host Participant) to exercise any rights of inspection, audit or the like against any Relevant Provider under a Commissioned Contract	Each Participant (in addition to the Host Participant) has the right to exercise the right of inspection, audit or the like against any Relevant Provider under the relevant Commissioned Contract.
40.4	**Performance and/or statistical data:** obligations of each Participant to disclose to the Partnership Board **performance and/or statistical data** relating to a Call-off Partnership which that Participant has in its possession from time to time Indicate • The types of data • The frequency and due date for disclosure • Any particular format in which it must be disclosed.	As indicated in the relevant Work Order.

40.5	**Other information:** other events or circumstances in relation to the Call-off Partnership which a Participant must inform the Partnership Board The Participant must do so in a timely and open manner on first becoming aware of the event or circumstance	Any situation/ circumstance that would negate the service/providers acceptance on the framework. For example, but not limited to: • Local Authority Service/provider suspensions • Loss or suspension of CQC registration

41. Keeping informed

41.1	General obligations of each Participant	• Each Participant must keep the other Participant informed of any matters significant to this Framework and/or any one or more Call-off Partnerships. • That Participant must do so promptly on becoming aware of the matter.

TUPE

42. TUPE

42.1	Arrangements as between the Participants in relation to any service provision change resulting from the commencement or cessation of any services under a Participant's Call-off Partnership (for the purposes of the Transfer of Undertakings (Protection of Employment) Regulations (2006) and other relevant law covering the transfer of employees in these circumstances)	Each Participant must make its own arrangements in relation to the transfer of the employment of affected employees in connection with any such service provision change.

Information

43. Confidentiality

43.1 What is Confidential Information of each Participant and/or its Affiliates as a **'Discloser'**

(each of the following to be read independently)

(a)	Business activities	Information relevant to its activities generally, including without limitation, • The Discloser's operations, strategies, plans, financial arrangements, financial information and third party disputes. • The Discloser's Personnel and human resources activities generally, • The Discloser's research activities, know-how and trade secrets and Intellectual Property which is not in the public domain. • The Discloser's data (including personal data in relation to which it is the data controller or data processor for the purposes of the Data Protection Legislation). • Details relating to the Discloser's customers, clients, service users, patients or the like. • Information relating to any other person to whom the Recipient knows (or reasonably ought to know) the Discloser owes a duty of confidentiality (whether under contract, by Law or otherwise).
(b)	Under Commissioned Contract	Information in relation to which either Participant is subject to confidentiality obligations under any Commissioned Contract.
(c)	Dispute resolution	Disclosures made in the course of any dispute resolution procedure described in section 56.

43.2 Rules regarding how the information must be disclosed etc to be considered the Discloser's Confidential Information under this Framework Agreement

(a)	How the information must be disclosed or made or available to the Recipient	• In any manner or in any medium (e.g. in writing, verbally, by observation at the Discloser's premises, contained in any device or material etc.) • But only in activities reasonably connected with the Partnership.
(b)	By whom must the information be disclosed or made available (according to item (a))	It may be disclosed or made available to the Discloser and/or anyone acting on its behalf.
(c)	Whether the information must be labelled as 'confidential'	Not necessary.

43.3 A piece of information of the Discloser is not in any case Confidential Information of the Discloser if any of the following applies to that piece of information at the time

(a)	Public domain	• It is in the public domain from time to time • **Exception:** as a result of any breach of a duty of confidentiality owed by the Recipient under this Framework Agreement.
(b)	Independently developed	The Recipient can reasonably prove it (or its Affiliates and/or their Personnel) had developed that information independently of its association with the Discloser and/or the Discloser's Affiliates and/or their Personnel.
(c)	Independently acquired	• The Recipient and/or its Affiliate and/or their respective Personnel receive that information in good faith from a third party in circumstances unconnected with this Framework Agreement. • **Exception:** where the Recipient knows or has reasonable grounds to suspect that the third party is in breach of confidentiality obligations owed to the Discloser and/or its Affiliate.
(d)	Trivial	The information is of a trivial nature.

43.4 **The Recipient's obligations:** the Recipient must comply with all of the following obligations in relation to each piece of Confidential Information of the Discloser in the possession of the Recipient from time to time

(for the period indicated in item 43.5)

(a)	Non-disclosure (subject to item 43.5)	The Recipient • Must keep that Confidential Information strictly in confidence, and • Must not disclose it or make it available to third parties.
(b)	Not to misuse	• The Recipient must not copy, modify, reverse engineer or otherwise use that Confidential Information for any purpose other than for legitimate purposes connected with the relevant Services. • Without limiting the above, the Recipient must not use that Confidential Information to conduct any venture (whether for profit or otherwise) independently of the Discloser.
(c)	Not to direct others	The Recipient must not direct or assist any person to do anything in breach of the rest of this item 43.4.
(d)	Comply with the Law	The Recipient must comply with relevant Law in relation to the keeping, disclosure or use of that Confidential Information.

43.5	Duration of the Recipient's obligations in item 43.4 in relation to each piece of the Discloser's Confidential Information	Either • **3 years** from the date on which the relevant Confidential Information was first disclosed; or • Such longer period required by Law in relation to that piece of Confidential Information.
43.6	**Permitted disclosures:** the Recipient is permitted to disclose or make available any Confidential Information of the Discloser in any of the following circumstances, regardless of item 43.4(a)	
	(a) Consent	With the prior written consent of the Discloser, subject to the Recipient's compliance with any conditions attached to that consent.
	(b) To any of the following	
	(i) Personnel (subject to item 43.7)	To the genuine existing or prospective Personnel of the Recipient and/or its Affiliates.
	(ii) Advisors etc. (subject to item 43.7)	To the Recipient's genuine existing or prospective advisers, contractors, consultants, agents, insurers, auditors and banks.
	(iii) Public body (subject to item 43.7)	Any public body authorised to review this Framework Agreement.
	(iv) Assignment, novation (subject to item 43.7)	Any person to whom the Recipient wishes to make a genuine novation and/or assignment of any part of this Framework Agreement.
	(v) Disputes (subject to item 43.7)	Relevant third parties engaged for the purpose of resolving disputes under section 56.
	(vi) Third parties (subject to item 43.7)	Third parties described in item 61.1 for the purpose of advising them of their rights, powers and benefits under this Framework Agreement.
	(vii) Required by Law (subject to item 43.8)	To the extent the Recipient is required to disclose or make available the Confidential Information by Law, including without limitation: • A court, • A regulatory body, • A law enforcement body, • A genuine public auditor, the UK Parliament or other genuine public body, or as required under any FOI Act (see section 44).
43.7	Rules regarding the Recipient disclosing (or making available) any Confidential Information of the Discloser to any person indicated in item 43.6 • To the extent indicated in item 43.6 that this item 43.7 applies • All of the following	
	(a) Need to know	The Recipient may only disclose (or make available) that Confidential Information to that person • In good faith. • On a 'need to know' basis.

(b)	Treating unauthorised disclosures etc.	The Discloser may regard any unauthorised disclosure or other misuse of such Confidential Information by any such person as if it were the Recipient's own act.
(c)	Separate confidentiality agreement	• The Recipient must require the relevant person to enter into a suitable written confidentiality agreement with the Discloser on reasonable terms. • But only if requested to do so by the Discloser, acting reasonably and proportionately in the circumstances.

43.8 The Recipient must comply with all of the following if it is compelled by Law to disclose or make available any Confidential Information of the Discloser

(except where disclosure is required under any FOI Act, which is covered in section 44)

(a)	Inform	The Recipient must inform the Discloser of the circumstances • With sufficient detail and accuracy and • Promptly on becoming aware of the obligation to make the compelled disclosure.
(b)	Make person aware	The Recipient must make the person compelling the disclosures aware of the duty of confidentiality owed to the Discloser in relation to the relevant information.
(c)	Assist the Discloser to challenge	• The Recipient must provide the Discloser with reasonable and timely assistance on request if the Discloser wishes to challenge the compelled disclosure. • The Discloser must reimburse the Recipient for the Recipient's reasonable and sufficiently evidenced costs in providing that assistance.
(d)	Keep to minimum	The Recipient must keep such disclosures to the minimum it is compelled to disclose or make available.

44. Freedom of information

44.1	What are the FOI Acts for the purposes of this section 44	The Freedom of Information Act 2000 and/or the Environmental Information Regulations 2004
44.2	**In relation to a Participant ('X'):** the extent to which another Participant **(Y'**) considers any of its information to be 'commercially sensitive' for the purposes of the FOI Acts	• To the extent indicated by Y to X in writing from time to time. • This is for indicative purposes only, and is not binding on X

44.3 Obligations of a Participant (**'X'**)

- If X receives any request under any FOI Act intended for another Participant **(Y'**); and/or
- If X holds any record on behalf of Y in connection with the Partnership which is relevant to a request made to Y under the FOI Acts

(a)	Bring matter to attention (if X receives any request under any FOI Act intended for Y)	X must promptly bring the matter to the attention of Y in sufficient time to allow Y to make the appropriate determinations and (where appropriate) the relevant disclosures.

(b)	Assistance	• X must provide Y with reasonable and timely assistance in complying with the request where appropriate. • To enable Y to comply with the request under the FOI Act in accordance with relevant Law. • This includes (where relevant and without limitation) supplying Y with records which X holds on its behalf in connection with the Partnership.
(c)	Who bears the costs of X in complying with item (b)	Y must reimburse X for its reasonable and sufficiently-evidenced third party costs in complying with X's obligations in item (b). Y is not liable to reimburse X for its own internal Personnel time except to the extent X and Y otherwise agree in writing.
(d)	Other obligations	X must not respond to that request directly, unless permitted in writing by Y.

44.4 Consequences if a Participant (**'X'**) receives a request for information under any FOI Act involving information of another Participant (**'Y'**) in connection with the Partnership

(all of the following)

(a)	Rights of X	It may make its own determination according to Law as to whether or not to provide that information to the person making the request.
(b)	Extent to which X is required to consult etc.	X is not obliged to consult Y or anyone else in relation to that request for information.
(c)	Consequence if X does consult Y and/or anyone else	X is not obliged to have regard to the views of Y and/or anyone else.
(d)	To what this item 44.4 is subject	It is subject to X's compliance with the Department of Constitutional Affairs' Code of Practice on the Discharge of Functions of Public Authorities under Part I of the Freedom of Information Act 2000 to the extent that compliance is permissible and reasonably possible.

45. Announcements and publicity

45.1	Restrictions on a Participant making announcements and/or giving publicity in connection with the Partnership (e.g. press releases, public circulars, interviews)	The Participant must not do so without the authorisation of the Partnership Board. The authorisation of the Partnership Board is not required if the relevant Participant is required to do so by Law.

46. Data protection

46.1 Arrangements between the Participants in relation to data protection

(a)	If a Participant is to **act as a data processor** for the other Participant in connection with a particular Call-off Partnership Whether according to the Work Order of the Call-off Partnership, any Partnership Board Resolution or any agreement between the Participants	See schedule 47 for details of the arrangements between the Participants as controller and processor respectively.

(b)	Otherwise In relation to any personal data held by a Participant in connection with a particular Call-off Partnership in relation to which the other Participant **is not** a data processor	• Each Participant is the data controller in relation to that person data. • Each Participant must comply with the Data Protection Legislation (and the Law generally) in relation to that personal data.

47. Processing certain Processed Personal Data

47.1	Purpose of this section 47	To set out the arrangements between the Participants if one Participant is (for the purposes of any Call-off Partnership) processing any personal data in relation to which the other Participant is a data controller.
47.2	Some definitions and interpretation	
(a)	**Data Loss Event**	Any event that causes (or creates an unreasonable risk of causing) any of the following: • Unauthorised access to any Processed Personal Data then in the possession or control of the Relevant Processor or its Sub-processors in connection with a relevant Call-off Partnership. • Loss or destruction of Processed Personal Data which puts the Relevant Processor in breach of a particular Call-off Partnership, including any Personal Data Breach.
(b)	**Data Protection Impact Assessment**	An assessment by a Relevant Controller of the impact of the Processing of the Processed Personal Data in connection with the relevant Call-Off Partnership on the protection of that Processed Personal Data.
(c)	**Protective Measures**	Technical and organisational measures for the purposes of item 47.7.
(d)	**Processed Personal Data** in relation to a Relevant Controller	Any Personal Data if and for as long as all of the following apply to it • A Relevant Controller is a Controller according to Law. • The Relevant Processor and/or its Sub-processor is a Processor in connection with a particular Call-off Partnership, according to Law.
(e)	**Relevant Controller** each of the following in relation to Processed Personal Data where it is the Controller	The relevant Participant who is the Controller of the relevant Processed Personal Data.
(f)	**Relevant Processor**	The relevant Participant who is the Processor of the relevant Processed Personal Data.
(g)	**Sub-processor**	Any third party (including any contractor of the Relevant Processor) appointed by the Relevant Processor to Process any Processed Personal Data in connection with a particular Call-off Partnership.
(h)	**Interpretation**	The definitions of **'Controller', 'Processor', 'Data Subject', 'Personal Data', 'Personal Data Breach'** and **'Protection Officer'** in the GDPR also apply to a particular Call-off Partnership.

47.3	Roles of the Relevant Controller and the Relevant Processor (for the purposes of the Data Protection Legislation) in relation to any Processed Personal Data which the Relevant Processor is to Process in connection with a particular Call-off Partnership	The Relevant Controller is the Controller and the Relevant Processor is the Processor in relation to the Processed Personal Data.
47.4	Purposes for which the Relevant Processor and/or its Sub-processors are authorised under a particular Call-off Partnership to Process any Processed Personal Data (and **not** for other purposes)	Any of the following • For purposes genuinely connected with the relevant Call-off Partnership. • As agreed by the Relevant Controller, in writing. • To meet any obligation of the Relevant Processor and/or the Sub-processor under the Law, particularly the Data Protection Legislation.
47.5	Paramount obligation of the Relevant Controller and the Relevant Processor in relation to Processed Personal Data of the Relevant Controller	• Each of them must comply with their respective obligations under the Law, particularly the Data Protection Legislation in relation to Processed Personal Data of the Relevant Controller. • This overrides anything to the contrary elsewhere in this Framework Agreement and/or in the contractual terms of the relevant Call-off Partnership.
47.6	The Relevant Processor must comply with all of the following if and for as long as it (or its Sub-processor) Processes any Processed Personal Data in connection with a particular Call-off Partnership (whichever imposes the highest standard)	
(a)	Policies, instructions	Reasonable, lawful, relevant and adequately communicated policies and/or instructions of the Relevant Controller from time to time in connection with the Processing of the Processed Personal Data.
(b)	Relevant Processor's policy	The Relevant Processor's own relevant polices in place from time to time.
(c)	Law	• In any case, relevant Law, particularly the Data Protection Legislation, including where relevant all of the data protection principles indicated in the Data Protection Legislation. • This overrides any other obligation elsewhere in this section 47 to the extent of any inconsistency.

47.7	Obligations of the Relevant Processor in relation to **Protective Measures**	• The Relevant Processor must have Protective Measures in place to Process the Processed Personal Data in connection with a particular Call-off Partnership which are appropriate to the processing of Processed Personal Data by the Relevant Processor or its Sub-processor • Those Protective Measures must be appropriate to the risks to that Processing of any serious adverse consequences to the relevant Processed Personal Data, including unlawful access, unlawful Processing, accidental loss, modification or destruction. • Such Protective Measures may include the following (for example and where relevant): - Encrypting and pseudonymising the Processed Personal Data. - Ensuring confidentiality, integrity, availability and resilience of systems and services - Ensuring that availability of and access to Personal Data can be restored in a timely manner after an incident, and regularly assessing and evaluating the effectiveness of such measures adopted by it. - Regularly testing and evaluation of the relevant security measures.
47.8	**Obligation to inform:** the Relevant Processor must inform the Relevant Controller of any of the following events or circumstances in relation to any Processed Personal Data which the Relevant Processor is the Processor in connection with a particular Call-off Partnership • The Relevant Processor must do so promptly on first becoming aware of the event or circumstance • But only to the extent it is lawful for the Relevant Processor to do so	
(a)	Requests, complaints or other communication	As indicated in item 47.18 in relation to certain requests, complaints and other communications.
(b)	Unauthorised access	Any incident of unauthorised access to that Processed Personal Data.
(c)	Data Loss Event	A Data Loss Event in relation to the relevant Processed Personal Data.
(d)	Breach	Any incident of Processing of that Processed Personal Data that is materially in breach of any of the following • The contractual terms of a relevant Call-off Partnership. • The Data Protection Legislation and/or any other Law. • This obligation is not required if the Relevant Processor is not permitted by Law to inform the Relevant Controller.

47.9	In relation to the Relevant Processor's obligation **to inform** the Relevant Controller about any event or circumstance described in item 47.8(b) and/or in item 47.8(c) and/or in item 47.8(d) if it occurs or arises		
	(a)	Deadline by which the Relevant Processor must inform the Relevant Controller	The earliest of the following: • **If there is any deadline on the Relevant Processor to inform the Relevant Controller according to Law (particularly the Data Protection Legislation):** by that deadline. • **If there is any deadline on the Relevant Controller to respond to the relevant event of circumstance according to Law (particularly the Data Protection Legislation):** no later than **5 days** before the Relevant Controller's deadline. • **Otherwise:** promptly (and in any case not more than **5 days**) after the Relevant Processor first becomes aware of the event or circumstance.
	(b)	Information the Relevant Processor must provide the Relevant Controller (all of the following to the extent relevant)	• A reasonable description of the relevant event or circumstance. • The number of Data Subjects affected. • How the Relevant Controller can obtain further information (e.g. a contact person within the organisation of the Relevant Processor or the Sub-processor). • The likely consequences of the relevant event or circumstance • The measures the Relevant Processor or the Sub-processor has taken (and/or proposes to take) in response to the event or circumstance to mitigate the harm to the Processed Personal Data and/or to the relevant Data Subjects and/or the Relevant Controller.
	(c)	Further obligations of the Relevant Processor in relation to its obligations to inform the Relevant Controller under this item 47.9	• The Relevant Processor must also provide appropriate Personnel of the Relevant Controller **with further relevant information on the relevant events or circumstances in phases** as details become available. • The Relevant Processor must do so promptly on becoming aware of the relevant information
47.10	Other obligations of the Relevant Processor if any of the events or circumstances described in item 47.8(b) and/or in item 47.8(c) and/or in item 47.8(d) occurs or arises in relation to any Processed Personal Data which the Relevant Processor is the Processor in connection with a particular Call-off Partnership (all of the following to the extent relevant)		
	(a)	Assist	The Relevant Processor must provide the Relevant Controller with reasonable assistance in relation to the Relevant Controller's response to the relevant event or circumstance.
	(b)	Preventative steps	The Relevant Processor must take appropriate steps (having reasonable regard to the views of the Relevant Controller) to reduce the reoccurrence of the relevant event or circumstance.

(c)	Non-disclosure	The Relevant Processor must not disclose any information about the relevant event or circumstance to a Data Subject, the Information Commissioner (or other regulatory or law enforcement body) or anyone else except to the extent: • The Relevant Controller permits the disclosure in writing. • The disclosure is to the Relevant Controller or its other authorised agents. • The Relevant Processor is required to make that disclosure by Law.
(d)	If notification of the relevant event or circumstance is required under the Data Protection Legislation	The Relevant Processor must do the following • Give the Relevant Controller reasonable assistance in preparing that notification. • Reimburse the Relevant Controller for its reasonable and sufficiently-evidenced costs in giving that notification. The Relevant Processor must do so no later than **30 days** after the Relevant Controller's written demand. **Exception where the Relevant Processor is not obliged to comply with the above obligations:** where the relevant event or circumstance is substantially caused by the negligence or deliberate misconduct of the Relevant Controller and/or its separate agents.
(e)	Investigate	The Relevant Processor must investigate the relevant event or circumstance.
(f)	Mitigate harm	• The Relevant Processor must take reasonable action (within its reasonable power and in accordance with the Relevant Controller's reasonable instructions) to mitigate the harm the relevant event or circumstance may cause to the relevant Data Subjects and/or the Relevant Controller. • The Relevant Processor must keep records of any such action which it takes.
(g)	No offer of remedy	The Relevant Processor must not offer any remedy to any Data Subject in relation to the relevant event or circumstance without the Relevant Controller's prior written consent.
(h)	Comply with Law	In any case, the Relevant Processor must comply with the Data Protection Legislation and the Law generally in its response to the relevant event or circumstance.
47.11	How the Relevant Processor must inform the Relevant Controller if required to do so anywhere in this section 47	As directed by the Relevant Controller from time to time, acting reasonably.

47.12	Assistance which the Relevant Processor must give the Relevant Controller in relation to the Processed Personal Data	The Relevant Processor must give the Relevant Controller **reasonable assistance** to for any of the following purposes • To enable the Relevant Controller to meet its obligations in relation to the Processed Personal Data under Law, particularly the Data Protection Legislation. • To enable the Relevant Controller to respond to any **request, complaint or other communication** received by the Relevant Controller and/or the Relevant Processor relating to the Processing of the Processed Personal Data by the Relevant Processor and/or its Sub-processor. This request, complaint or other communication may come from - The relevant Data Subject; and/or - The Information Commissioner or other regulatory or law enforcement body. - Any person not described above who is entitled by Law to a response to its request, complaint or other communication.
47.13	When the Relevant Processor must give the Relevant Controller the assistance described in item 47.12	• In a timely manner on the Relevant Controller's reasonable request having regard to the circumstances (e.g. any deadlines imposed on the Relevant Controller by Law). • The Relevant Processor is only required to provide that assistance if the Relevant Controller has made the request for at least one of the purposes indicated in item 47.12.
47.14	How the Relevant Processor's costs in providing the assistance described in item 47.12 are to be met	The Relevant Controller must reimburse the Relevant Processor for the Relevant Processor's **reasonable and sufficiently evidenced** costs in providing that assistance.
47.15	Examples of assistance which the Relevant Processor must provide for the purposes of item 47.12 • Each of the following • In relation to any Processed Personal Data which the Relevant Processor and/or its Sub-processor is then Processing for the purposes of a particular Call-off Partnership • To the extent relevant in the circumstances • Not an exhaustive list of the assistance the Relevant Processor must provide for the purposes of item 47.12	
(a)	Supplying Processed Personal Data	Supplying the Relevant Controller, at its request, with any of the relevant Processed Personal Data.
(b)	Requests, complaints or other communication	As indicated in item 47.18 in relation to cooperation required in relation to any requests, complaints, communications etc.
(c)	Assessment of operations	Providing the Relevant Controller an assessment of the necessity and proportionality of the Processing operations in relation to the Processed Personal Data.
(d)	Risk assessment	Providing a risk assessment in relation to the rights and freedoms of Data Subjects.

	(e) Data Loss Event	Providing the Relevant Controller with reasonable assistance following any Data Loss Event relating to the Processed Personal Data.
	(f) Information Commissioner	Providing the Relevant Controller with reasonable assistance as requested by the Relevant Controller with respect to any of the following insofar as it relates to the Processed Personal Data • Any request from the Information Commissioner (or other regulatory body exercising its functions as such) • Any consultation by the Relevant Controller with the Information Commissioner (or other regulatory body exercising its functions as such).
47.16	**Queries:** the Relevant Processor's obligations in relation to any **query** which the Relevant Controller raises from time to time in relation to any Processed Personal Data	• The Relevant Processor must respond to that query in a prompt and proper manner. • The Relevant Processor must do so at the Relevant Processor's own cost.
47.17	Obligation of the Relevant Processor to assist the Relevant Controller in preparing any **Data Protection Impact Assessment**	• The Relevant Processor must provide the Relevant Controller with reasonable assistance when the Relevant Controller prepares any Data Protection Impact Assessment prior to the Relevant Processor (or its Sub-processor) commencing any Processing of any Processed Personal Data in connection with a particular Call-off Partnership. • But only in relation to those parts of the Data Protection Impact Assessment relevant to that Processing.

47.18 **Requests, complaints, communications:** the Relevant Processor must comply with all of the following obligations:

- In relation to any request complaint or other communication which the Relevant Processor or its Sub-processor receives in connection with any Processed Personal Data
- In connection with the Processed Personal Data
- Whether relating to the obligations of the Relevant Controller, the Relevant Processor and/or the Sub-processor
- Including those from any of the following
  - A Data Subject (e.g. an access request, a request to rectify)
  - The Information Commissioner and/or any other regulatory or law enforcement body.
  - Any other person entitled to a response by Law.

(a)	Obligation to **inform**	• The Relevant Processor must inform the Relevant Controller of the request complaint or other communication relevant matter In a prompt manner, and in any case no later than **2 Business Days** (or any shorter deadline as required by the Data Protection Legislation) after the Relevant Processor first receives the relevant request., complaint or other communication. • But only to the extent it is lawful for the Relevant Processor to do so.
(b)	**Obligation to cooperate:** the Relevant Processor must provide the Relevant Controller with reasonable and timely cooperation in relation to the request, complaint or other communication relating to any Processed Personal Data including the following This cooperation may include any of the following (for example and where relevant)	
	(i) Providing copies	The Relevant Processor must provide the Relevant Controller with full copies of the relevant request, complaint or other communication.
	(ii) If it is an access request	The Relevant Processor must either: • Comply with the access request according to deadlines required by Law; or • Assist the Relevant Controller to do so As requested in writing by the Relevant Controller.
	(iii) Instructions	The Relevant Processor must comply with reasonable and relevant instructions of authorised representatives of the Relevant Controller in responding to the relevant request, complaint or other communication.

	(iv) Supply the Processed Personal Data	If requested by the Relevant Controller, the Relevant Processor must supply the Relevant Controller with relevant Processed Personal Data to which the request, complaint or other communication relates, to enable the Relevant Controller to respond to the relevant request, complaint or other communication.
47.19	Liability of the Relevant Controller to make any additional payment to the Relevant Processor in return for the Relevant Processor providing the cooperation described in item 47.18(b)	
47.20	Obligations of the Relevant Processor in **transferring** any Processed Personal Data	The Relevant Processor must not host or otherwise transfer any Processed Personal Data **outside of the European Economic Area** (or the area comprising the United Kingdom and the European Economic Area, if the United Kingdom is not in the European Economic Area at the time) unless **both** of the following apply: • The Relevant Processor has the written consent of the Relevant Controller. • **All** of the conditions in item 47.21 are met.
47.21	Conditions for the purposes of item 47.20 (all of these must be met)	
	(a) Safeguards	The Relevant Controller and/or the Relevant Processor and/or its Sub-processor has provided appropriate safeguards in relation to the transfer as decided by the Relevant Controller, whether in accordance with GDPR Article 46 or Article 37 of Law Enforcement Directive (Directive (EU) 2016/680).
	(b) Obligations under the Data Protection Legislation	The Relevant Processor complies with its obligations under the Data Protection Legislation by providing an adequate level of protection to any Processed Personal Data that is hosted or otherwise transferred.
	(c) Rights for the Data Subject	The Data Subject has enforceable rights and effective legal remedies which are enforceable and effective in relation to the Processed Personal Data which is hosted or otherwise transferred.
	(d) Standard clauses	If requested by the Relevant Controller in writing, the Relevant Processor (or Sub-processor where relevant) has become legally bound (in favour of the Relevant Controller and its Affiliates) to • The standard contractual clauses applicable to the hosting or other transfer of Personal Data between Controllers and Processors as set out in the European Commission decision of February 5, 2010 (C (2010) 593), as amended; or • Such other contractual clauses approved by the Relevant Controller (such approval not to be unreasonably withheld where these other contractual clauses provide at least equivalent protection to the Processed Personal Data.

47.22 The Relevant Processor must comply with all of the following obligations in relation to each of its (and/or its Sub-processor's) **Personnel**

- In relation to the individual's **access to, or his/her involvement in, the Processing of, any Processed Personal Data** in connection with a particular Call-off Partnership
- (all of the following)

(a)	Level of access	The Relevant Processor may only give the relevant individual access to the Processed Personal Data if he/she has a genuine 'need to know' for the purposes of carrying out his/her duties.
(b)	How they Process	The Relevant Processor must ensure the relevant individual does not do anything to cause the Relevant Processor to breach the contractual terms of a particular Call-off Partnership and/or (in any case) the Law.
(c)	Understanding of obligations	The Relevant Processor must use reasonable endeavours to ensure the individual understands and complies with the Relevant Processor's obligations under the contractual terms of a particular Call-off Partnership and under the Law in relation to the Processing of the Processed Personal Data.
(d)	Training	The Relevant Processor must ensure that the individual has undertaken adequate training in the requirements of the Law and the Relevant Processor's policies and procedures in the Processing of the relevant Processed Personal Data.
(e)	If Processing of the Processed Personal Data involves the Relevant Processor having direct access to any electronic system of the Relevant Controller	The Relevant Processor must comply with all of the following to the extent requested to do so in writing by the Relevant Controller, acting reasonably: • The Relevant Processor must make relevant Personnel the Relevant Processor expects to have access to such system from time to time in connection with the Services undergoes any training supplied by the Relevant Controller in relation to the access and use of the system. • The Relevant Processor must not give such access to such system to any Personnel who has not completed that training to the reasonable satisfaction of the Relevant Controller.
(f)	Confidentiality undertakings	The Relevant Processor must ensure the individual has given **legally binding confidentiality obligations** to the Relevant Processor or relevant Sub-processor, as relevant (e.g. under his/her contract of employment) **which are sufficient to protect the confidentiality of the Processed Personal Data**.
(g)	Informed of confidential nature	The Relevant Processor must ensure all of the following • That the individual has been informed of the confidential nature of the Processed Personal Data. • That the individual has undertaken adequate training in the use, care, protection and handling (or the like of any of these) of the relevant Processed Personal Data.

	(h) Not to breach confidentiality	The Relevant Processor must ensure the individual does not disclose or publish (or the like of any of these) any of the relevant Processed Personal Data to any third party except to the extent: • Permitted elsewhere in the terms of a particular Call-off Partnership. • Required by Law. • Instructed by appropriate Personnel of the Relevant Controller.
	(i) Removal	The Relevant Processor must promptly discontinue a member of its Personnel's access to, and/or involvement in, the Processing of, any Processed Personal Data if • The Relevant Processor is aware of circumstances that reasonably indicate that the individual is not a fit and proper person to have such access and/or involvement; and/or • The Relevant Controller requires the Relevant Processor to discontinue that individual's access or involvement in that Processing where either of them first becomes aware of those circumstances.
47.23	Record keeping obligations of the Relevant Processor	• The Relevant Processor must keep complete and accurate records and information to demonstrate its compliance with this section 47. • This is subject to the exemptions in item 47.24.
47.24	Exemptions to item 47.23	The Relevant Processor is not obliged to comply with item 47.23 if from time to time the Relevant Processor employs fewer than 250 employees **Exception where the Relevant Processor is required to comply with item 47.23 if even if it has fewer than 250 employees:** if the Relevant Controller (or the Relevant Controller on its behalf if it is not the Relevant Controller in relation to the Processed Personal Data) concludes (acting reasonably) that **all of the following** applies • The Processing of the relevant Processed Personal Data is not occasional. • The relevant Processed Personal Data includes any of the following - Special categories of data as referred to in Article 9(1) of the GDPR. - Personal Data relating to criminal convictions and offences referred to in Article 10 of the GDPR. - The Processing of the relevant Processed Personal Data is likely to result in a substantial risk to the rights and freedoms of relevant Data Subjects.

47.25 Inspection and audit rights of the Relevant Controller (and obligations of the Relevant Processor)

- In relation to the Processing of any Processed Personal Data in connection with the relevant Call-Off Partnership
- In relation to which the Relevant Controller is the Controller and the Relevant Processor is the Processor

(a)	Main obligations of the Relevant Processor	It must do all of the following for the purposes indicated in item (d) • Give the Relevant Controller and/or its Personnel and/or other agents appropriate access to relevant premises, records, systems, and equipment (and the like of any these). • Direct the Relevant Processor's relevant Personnel to give the Relevant Controller and/or its authorised agents materially sufficient and materially accurate explanations of the relevant premises, records, systems, and equipment (and the like of any these) under inspection.
(b)	When the Relevant Processor must comply with its obligations in item (a)	Promptly on the Relevant Controller's written request.
(c)	Purposes for item (a)	To enable the Relevant Controller to verify the Relevant Processor's compliance with the following in relation to its Processing of the Processed Personal Data: • The Data Protection Legislation and the Law generally; and • This Framework Agreement, particularly this section 47.
(d)	Purposes for item (a)	To enable the Relevant Controller to verify the Relevant Processor's compliance with the following in relation to its Processing of the Processed Personal Data: • The Data Protection Legislation and the Law generally; and • This Framework Agreement, particularly this section 47; and • The terms of a relevant Call-Off Contract.

(e)	Confidentiality	The Relevant Processor may (acting reasonably and in good faith) request the Relevant Controller to give the Relevant Processor • Legally binding written confidentiality obligations • On reasonable terms - To be given by the Personnel and/or other agents appointed by the Relevant Controller to carry out the inspection on the Relevant Controller's behalf under this item 47.25. - For the benefit of the Relevant Processor, its Sub-processors and their respective Affiliates • The Relevant Processor may delay complying with item (a) until the Relevant Controller has properly complied with the above request. • This does not in itself limit the Relevant Controller's obligations (if any) in relation to the Confidential Information of the Relevant Processor under section 47. • If any such Personnel and/or other agent of the Relevant Contractor - Does any act in relation to information obtained in the course of the inspection under this item 47.25. - Where that act would breach section 43 if that act were done directly by the Relevant Controller, the Relevant Processor may treat that act as if it were done by the Relevant Controller directly.

47.26 **Processing by Sub-processors:** the Relevant Processor must do the following if its directly or indirectly appointed Sub-processor Processes any relevant Processed Personal Data in connection with a particular Call-off Partnership

(not to limit the Relevant Processor's obligations in relation to such Sub-processor generally)

(a)	Consents of the Relevant Controller	• The Relevant Processor must not appoint a Sub-processor without the prior written consent of the Relevant Controller. • The Relevant Controller must not unreasonably withhold that consent.
(b)	Reasonable grounds to refuse consent under item (a)	If and for as long as any of the following apply • The Sub-processor is not legally bound to obligations to the Relevant Processor which are at least as onerous to the Sub-processor as those in this section 47 are to the Relevant Processor. • The Relevant Controller has reasonable grounds to believe (having been given a reasonable opportunity to check) that the Sub-processor's Protective Measures are not adequate.
(c)	Ensure compliance	The Relevant Processor must ensure the Sub-processor's compliance with relevant obligations under this section 47 in connection with the Sub-processor's Processing of the relevant Processed Personal Data.

47.27	Delete or return	• The Relevant Processor must do any of the following in relation to any particular Processed Personal Data in relation to which the Relevant Processor is the Processor in connection with a particular Call-off Partnership - Delete it - Return it (including copies) to the Relevant Controller. • The Relevant Processor must do so - Promptly on the Relevant Controller's request (to be made when the Relevant Processor has no further need to retain that Processed Personal Data for the purpose of a particular Call-off Partnership); or - In any case promptly on the final discontinuation the relevant Call-off Partnership, unless similar activities are to continue under a new contract • **Exception:** this obligation does not apply to the extent the Relevant Processor or its Sub-processor is required by Law to retain the relevant Processed Personal Data.
47.28	Restrictions on modification	The Relevant Processor must not modify any of the Processed Personal Data except to the extent: • The Relevant Processor is required by Law to do so. • The Relevant Processor is permitted or required elsewhere in this Framework Agreement and/or in the contractual terms of a particular Call-off Partnership to do so. • The Relevant Controller permits or requires the Relevant Processor to do so.
47.29	Suspension of Processing	• The Relevant Processor must promptly suspend (and must require its Sub-processor to promptly suspend, where relevant) the Processing of any Processed Personal Data if the Relevant Controller requests the Relevant Processor to do so in writing. • The Relevant Controller may only make that request if the Relevant Controller has reasonable grounds to believe there is a substantial risk of the Relevant Processor and/or its Sub-processor Processing any of the Processed Personal Data in breach of the terms of a particular Call-off Partnership, and in any case, in breach of the Data Protection Legislation and/or the Law generally.
47.30	In relation to an Claim made or threatened against the Relevant Controller and/or its Affiliate In connection with any one or more of the following in relation to any Processed Personal Data in the possession or control of the Relevant Processor in connection with a particular Call-off Partnership: • Its loss, and/or • Its misuse, and/or • Any unauthorised access to it.	The Participants shall bear the Losses as follows: • From any Pooled Fund • **If there is no Pooled Fund or to the extent the Pooled Fund is insufficient:** by the Participants according to the same proportions as they would be required to contribute to an Overspend.

47.31	Whether this section 47 limits the confidentiality obligations (if any) owed by the Relevant Processor under a this Framework Agreement (see especially, section 43) and/or under the terms of a particular Call-off Partnership	No.
47.32	Duration of the rights and obligations (or the like of any of these) of the Relevant Controller and the Relevant Processor under this section 47	• Those rights and obligations (or the like of any of these) continue for as long as the Relevant Processor and/or Its Sub-processor continues to Process any Processed Personal Data of the Relevant Controller in connection with a particular Call-off Partnership. • This applies even if the Relevant Processor is no longer carrying on any activities in connection with a particular Call-off Partnership (e.g. after the termination of a particular Call-off Partnership).

Liability issues

48. Promises about success of Call-off Partnership

48.1	Promises given by any Participant to another Participant about the success of any Call-off Partnership and/or the Partnership generally (e.g. any benefits etc.)	None given.

49. Liability for Functions

49.1	Whether this Framework Agreement and/or any Call-off Partnership in itself affects the liability of a Participant to third parties (e.g. to client groups, to the public generally) in relation to the exercise of its functions.	No.

50. Uncontrollable Circumstances

50.1	What are 'Uncontrollable Circumstances' in relation to the activities of a Participant (**'X'**) in relation to this Framework Agreement and each Call-off Partnership (effectively 'force majeure' events)	Any event or circumstance to which all of the following apply: • It is outside X's reasonable control; and • It genuinely prevents X from carrying out its obligations in relation to this Framework Agreement and/or a Call-off Partnership.
50.2	**Suspension:** the following apply to the **right or obligation** of X to suspend obligations under this Framework Agreement or a Call-off Partnership as a result of relevant Uncontrollable Circumstances	
	(a) Obligation to communicate	X must communicate its intention to suspend carrying out such obligations as follows • To the other Participant's Representative or (in any emergency) other suitable Personnel of the other Participant; and • In writing where reasonably possible.

(b)	Keeping informed	X must keep the other Participant informed in a proper and timely manner of significant events or circumstances in relevant to the suspension of the relevant obligations.
(c)	Resumption	X must resume the relevant activities promptly when it is no longer substantially and directly prevented from doing so under the relevant Uncontrollable Circumstance.

50.3 Consequences if X suspends its obligations according to item 50.2

- All of the following
- As relevant
- To be read independently

(a)	Right to relief	X shall be relieved of liability (all of the following) • To any person with rights under this Framework Agreement • For failing to carry out any of its obligations under this Framework Agreement • To the extent those obligations are suspended under item 50.2.
(b)	Consequences for the contributions which either Participant is required to make in relation to the Call-off Partnership if X's activities are disrupted due to any Uncontrollable Circumstance	Unaffected.
(c)	**Right to take certain steps:** the other Participant shall not unreasonably refuse a proposal from X to take certain steps if X's proposal meets all of the following requirements	
	(i) How the proposal must be made	• In writing. • Communicated to the other Participant's Representative.
	(ii) Steps that may be proposed	The other Participant and X agreeing to amendments to this Framework Agreement, including (for example and where relevant) amendments relating to any of the following to take account of the relevant Uncontrollable Circumstance: • Extending any deadlines of X in connection with the Services. • Changing to the financial arrangements between the parties under this Framework Agreement (e.g. increasing any amounts payable by the other Participant to X). • Changing the Specification and/or X Proposal (whether temporarily or permanently) to reduce the burden of X.
	(iii) Requirements of the proposal	• It must be reasonable and proportionate. • In preparing the proposal, X must have proper regard to the extent to which the suspension of activities as a result of the relevant Uncontrollable Circumstance affected X's ability to carry out its obligations.

51. Caps on a Participant's liability

51.1	Cap on the liability of a Participant to other Participants for liabilities described in item 51.3	That Participant's liability to each other Participant is capped to **£1.00** per event or circumstance. The Participants agree this is reasonable given the nature of their relationship.

51.2 The caps and exclusions of a Participant's liability indicated elsewhere in this Framework Agreement, particularly item 51.1

- Do not apply and shall not be taken into account in calculating any caps on its liability
- To the extent the liability relates to any of the following (each of these is to be read independently)

(a)	Death etc.	Death or personal injury caused by the negligence of that Participant.
(b)	Deliberate	That Participant's deliberate act or deliberate failure to act. A Participant shall be regarded as having deliberately acted or failed to act where that act as done (or failed to be done) where there is reasonable evidence that the act was done (or not done) under the instruction of that Participant's Representative and/or any other member of its senior management.
(c)	Fraudulent misrepresentation	That Participant's fraudulent misrepresentation.
(d)	Indemnity	Any indemnity given by the Participant to another Participant under item 35.8(b).
(e)	Specific debts	• Specific debts arising under or in connection with this Framework Agreement including interest accruing on any such debts. • **Examples:** Host Participant Remuneration under item 28.2(b).
(f)	Elsewhere in this Framework Agreement	As indicated elsewhere in this Framework Agreement.
(g)	Not permitted by Law	Anything else to the extent liability cannot be capped and/or excluded by Law.

51.3	Interpretation of caps and exclusions of the liability of a Participant (**'X'**) in this section 51	They apply to X's liabilities of any kind in connection with this Framework Agreement. • Regardless of whether the liability arises in tort, contract, under statute or otherwise. • Any cap on X's liability is to be aggregated between - The liability X owes to the other Participant; and - The liability X owes any third party connected with that other Participant under this Framework Agreement.
51.4	Apportionment where the loss of Participant ('**X'**) is only partly due to the fault of the other Participant (**'Y'**)	Where X's losses in particular circumstances relevant to this Framework Agreement • Are partly caused by the fault of Y and/or anyone acting on Y's behalf (whether in tort, contract, under statute or otherwise); and • Are partly due to other factors (including X's own acts and failures to act), Then the liability of Y to X for compensation or the like shall be reduced fairly and proportionately to reflect the extent to which Y's act or failure to act contributed to causing X's losses.

Termination and exit

52. Termination of Commissioned Contracts

52.1	If • Only one Participant is a party to a particular Commissioned Contract; and • That Participant has a right to terminate that Commissioned Contract for any reason (e.g. due to the default of the Relevant Provider, or without its fault) How the decision is made to terminate that Commissioned Contract	• **Usually:** as decided either by written agreement between the Participants or by a Partnership Board resolution. • **If the Participants cannot agree or there is a deadlock on the issue within the Partnership Board:** the Participant wishing to terminate shall prevail. Accordingly: – **If the Participant wishing to terminate is a party to the Commissioned Contract:** if may terminate the Commissioned Contract. – **If the Participant wishing to terminate is NOT a party to the Commissioned Contract:** the other Participant wish is a party to the Commissioned Contract must terminate it promptly if and for as long as it is entitled to do so under the terms of that Commissioned Contract.
52.2	If • Only both parties are a party to a particular Commissioned Contract; and • They have a right to terminate that Commissioned Contract for any reason (e.g. due to the default of the Relevant Provider, or without its fault) How the decision is to be made between the Participant s to exercise that right to terminate	As in item 52.1.

53. Termination of this Framework

53.1	Right of a Participant to terminate this Framework	• There is no formal procedure for a Participant to terminate this Framework. • Neither Participant is obliged to enter any further Call-off Partnership if it does not wish to. • This does not affect existing Call-off Partnerships in place at the time.

54. Termination of a Call-off Partnership

54.1	Whether either Participant may terminate a Call-off Partnership if it wishes to do so	• Either Participant may do so at any time. • That Participant is not required to give any reason for termination and is not required to prove any fault on the part of the other Participant.
54.2	How a Participant terminates a Call-off Partnership if it wishes to do so	By notice in writing to the other Participant. That notice must be given strictly according to section 62.
54.3	Consequence if a Participant gives a notice under item 54.2	
	(a) Enter new Commissioned Contracts	Neither Participant may **enter into any new Commissioned Contract** under that Call-off Partnership without the written agreement of the other Participant.
	(b) Extend existing Commissioned Contracts	Neither Participant may **extend any existing Commissioned Contract** under that Call-off Partnership without the written agreement of the other Participant.
	(c) Rights and obligations to terminate existing Commissioned Contracts	The rights or obligations of the Participants to **terminate any existing Commissioned Contract** under that Call-off Partnership are indicated in section 52.
	(d) Rights and obligations in relation to existing Commissioned Contracts	The obligations of the Participants in relation the Call-off Partnership (including any obligations to make payments) shall continue in respect of **existing** Commissioned Contracts under that Call-off Partnership (including ongoing obligations in relation to such Commissioned Contracts terminated under section 52) until those obligations are fully completed or until they expire or until they are terminated (as relevant, depending on the nature of those obligations).

Ending the Partnership

55. Exit

55.1	Exit obligations of the Participants at the end of this Framework	None required.
55.2	Exit obligations of the Participants at the end of a particular Call-off Partnership	As indicated in the relevant Work Order.

Miscellaneous

56. Dispute resolution

56.1	Application of this section 56	It applies to any dispute between Participants in connection with this Framework Agreement and/or any Call-off Partnership (**'Relevant Dispute'**).
56.2	**First step** - resolution by Representatives	• The Participants shall direct their Representatives to use their reasonable endeavours to resolve the Relevant Dispute in a timely manner and in good faith. • The Participants shall bear their own costs in doing so.
56.3	**Next step:** if the Participants' Representatives cannot resolve the Relevant Dispute within **30 days**	• The Participants shall escalate the matter to their respective Escalated Persons. • The Participants shall direct their Escalated Persons to use their reasonable endeavours to resolve the Relevant Dispute in a timely manner and in good faith. • The Participants shall bear their own costs in doing so.
56.4	Next step if the Relevant Dispute has not been resolved within **60 days** of commencing the previous step The Participants must attempt to resolve the Relevant Dispute **by mediation**, according to all of the following	
(a)	How the Participants are to commence the mediation	• By either Participant giving the other Participant a notice (strictly according to section 48) requesting mediation. • Such notice must summarise in reasonable detail the Relevant Dispute (as understood in good faith by the Participant giving that notice).
(b)	Mediation procedure the Participants are to use	The Model Mediation Procedure of the Centre for Effective Dispute Resolution or the comparable rules of any successor body (**'Centre'**).
(c)	How the Participants must appoint the mediator	• By agreement of the Participants (acting promptly and in good faith). • They shall appoint a suitably qualified, independent mediator. • If they cannot agree on a mediator within 7 days of first considering the issue, they shall request the Centre to recommend a mediator. The Participants must accept the person who is recommended unless there are genuine and serious concerns about that person's independence.
(d)	General obligations of Participants in the course of the mediation: all of the following	
(i)	Good faith	The Participants must act generally in good faith in attempting to resolve the Relevant Dispute.

(ii)	Cooperation	The Participants must co-operate fully and promptly with the mediator, including promptly doing such acts (including signing a document substantially in the form of the Centre's model agreement in force from time to time) as the mediator reasonably requires.
(iii)	Directions to Personnel	The Participants must direct their respective Personnel to attend and cooperate with the mediation properly and in good faith, as reasonably necessary.
(iv)	Confidentiality	• The Participants must carry out the mediation in strict confidence. • A Participant shall not be regarded as having breached its confidentiality obligations in this Framework Agreement (see section 43) if it or its Affiliate makes disclosures of Confidential Information of the relevant Discloser for purposes connected with the mediation.
(v)	Without prejudice	The Participants acknowledge that anything said or done by a Participant in the course of the mediation shall not in itself prejudice its rights in any later proceedings between it and the other Participant.
(vi)	Engagement	The Participants shall not engage (in connection with further proceedings involving the Relevant Dispute) the mediator as an advisor and/or to call him/her as a witness.
(vii)	How mediation costs are to be borne	• The Participants shall share equally the costs of engaging the mediator • They shall otherwise bear their own costs in connection with the mediation.
56.5	Right of a Participant to commence legal proceedings in relation to the Relevant Dispute **if mediation** is used under item 56.4	It may do so if the Relevant Dispute is not resolved by mediation after at least **90 days** from commencement of mediation.
56.6	Various remedies	Nothing in this Framework Agreement (including this section 56) shall prevent a Participant from seeking specific performance or injunctions or other remedies of a similar nature in relation to matters relevant to this Framework Agreement.

57. Local authority powers

57.1	Status of the Council in its capacity as a local authority	
(a)	Right to carry out powers etc.	Nothing in this Framework Agreement and/or in the contractual terms of any Call-off Partnership in any way affects the right of the Council as a local authority to exercise (or to not exercise) any of its statutory powers and/or its statutory functions.
(b)	Examples	Without limiting this, this includes the power of the X to grant or not to grant any kind of application for planning, any particular licence or the like of any of these which is submitted by any other Participant, even if it results in any activities contemplated in this Framework Agreement and/or in the contractual terms of any Call-off Partnership being unable to commence or continue.

(c)	Interpretation	The above paragraphs shall apply even if the exercise (or non-exercise) of such powers and functions causes the Council or another Participant to breach its obligations under this Framework Agreement and/or in the contractual terms of any Call-off Partnership.

58. Relationship between the Participants

58.1	Relationship between the Participants created by this Framework Agreement	The relationship of partners under each Call-off Partnership in place from time to time for the purposes of the 2006 Act.
58.2	Relationships between the Participants which are not created by this Framework Agreement (any of the following)	
(a)	Partnership	Any partnership between the Participants for the purposes of the Partnership Act 1890.
(b)	Principal-agent	• Any relationship of principal and agent between the Participants authorising one Participant to do anything (e.g. incur liabilities or obligations, make statements) on behalf of the other Participant. • **Exception:** to the extent otherwise: - Clearly indicated or reasonably implied in this Framework Agreement, and/or - Agreed in writing by the Participant.

59. Assignment

59.1	If a Participant wishes to assign its rights and benefits under this Framework Agreement and/or under any Call-off Partnership	That Participant may only do so with the prior written consent of the other Participant, at discretion.

60. Entire agreement

60.1	In relation to this Framework Agreement	
(a)	Status of this Framework Agreement	Subject to this section 60, this Framework Agreement represents the entire agreement on its subject matter between the Participants on the subject matter of the Framework Agreement.
(b)	Status of any previous agreements entered between the Participants on the subject matter of this Framework Agreement	They are fully extinguished immediately when this Framework Agreement is executed.
(c)	Liability of a Participant in relation to any statement, warranty, representation, opinion or prediction of the future which that Participant may have made which is not described in this Framework Agreement and/or any document clearly cross-referenced in it	To the fullest extent permitted by Law: • These are excluded from this Framework Agreement. • That Participant's liability in relation to any of these is excluded. This does not exclude any Participant's liability for fraudulent misrepresentation.

60.2 In relation to a particular Call-off Partnership

(a) Status of the contractual terms of that Call-off Partnership	Subject to this section 60, the contractual terms of that Call-off Partnership represent the entire agreement on its subject matter between the Participants on the subject matter of the relevant Call-off Partnership.
(b) Status of any previous agreements entered between the Participants on the subject matter of a particular Call-off Partnership	They are fully extinguished immediately when that Call-off Partnership is executed.
(c) Liability of a Participant in relation to any statement, warranty, representation, opinion or prediction of the future which that Participant may have made which is not described in the contractual terms of that Call-off Partnership and/or any document clearly cross-referenced in those terms	To the fullest extent permitted by Law: • These are excluded from the contractual terms of that Call-off Partnership. • That Participant's liability in relation to any of these is excluded. This does not exclude any Participant's liability for fraudulent misrepresentation.

61. Third party rights

61.1 Rights of third parties with rights under this Framework Agreement for the purposes of the Contracts (Rights of Third Parties) Act 1999	These are excluded to the fullest extent permitted by Law. **Exception:** the rights under that Act of any Affiliate from time to time of a Participant to enforce its rights under this Framework Agreement are retained.

62. Notices

62.1 Application of this section 62	It applies to all of the following: • Communications between the Participants described as 'notices' in this this Framework Agreement and/or in the contractual terms of a particular Call-off Partnership. • Any other communications between the Participants which are expressed in this this Framework Agreement and/or in the contractual terms of a particular Call-off Partnership to be subject to this section 62. The formalities in this section 62 are not required in relation to other communications between the Participants.
62.2 To whose attention a communication described in item 62.1 is to be addressed if sent to a Participant	To the Participant's Representative at the time.

62.3 Methods by which notices must be given to be valid (in at least one of the following ways)

Method	When notice is deemed to have been given
Hand delivery to the recipient's Representative	On the date it is given to him/her.
By registered mail or courier to the recipient's last known address (addressed to the recipient's Representative unless otherwise indicated)	2 Business Days after the day it was sent (as evidenced by the post mark, despatch notice or other relevant evidence), unless it is returned as undelivered.

62.4	Whether an exchange of e-mails is sufficient for the relevant notices or other communications described in item 62.1	• No. • This does not prevent use of e-mail for less formal communications between the Participants.

63. Amendment

63.1	How this Framework Agreement and/or the contractual terms of a particular Call-off Partnership are to be validly amended	• By agreement in writing between the Participants. • The relevant document must clearly indicate an intention to amend this Framework Agreement. and/or the contractual terms of the relevant Call-off Partnership • **If no consideration is indicated in the relevant document:** the Participants shall pay each other £1.00 as consideration (if demanded), which they consider to be reasonable consideration.

64. Remedies

64.1	Consequence of this Framework Agreement and/or the contractual terms of a particular Call-off Partnership referring to a particular remedy in a particular circumstance	It does not in itself exclude the availability of any other remedy in that circumstance (unless otherwise clearly indicated).
64.2	Whether available remedies are cumulative	Yes.
64.3	Consequence if a person with rights under this Framework Agreement and/or the contractual terms of a particular Call-off Partnership pursues a particular remedy in a particular circumstance	That shall not in itself constitute a waiver of that person's right to pursue other available remedies in those circumstances (whether under common law, equity, statute or otherwise).
64.4	Rights of a person with rights under this Framework Agreement to seek **remedies other than damages** against a Participant	• The Participants acknowledge that damages may not always be an adequate remedy of that person in particular circumstances. • Accordingly, that person may (without being required to prove special damage) obtain other remedies available to that person (whether arising under common law, equity, statute or otherwise), including without limitation, injunctions and/or specific performance.

65. Severance

65.1	Application of this section 65	It applies where any section, item or other part of this Framework Agreement and/or the contractual terms of a particular Call-off Partnership is held by any court (or equivalent body) to be invalid or unenforceable for any reason.
65.2	First step	• If possible, the relevant provision shall be modified by removing or altering those parts of that provision that create the invalidity or unenforceability. • Such removal or alteration shall be to the minimum extent necessary to allow the provision to be held to be valid and enforceable, having regard to the purpose of the relevant provision.

65.3	Second step (if the action required in item 0 is not reasonably possible)	The entire provision shall be severed from this Framework Agreement unless it alters the fundamental nature of this Framework Agreement and/or the contractual terms of a particular Call-off Partnership or is otherwise against public policy.
65.4	Remaining provisions	The remaining provisions shall remain in full force and effect.

66. Waivers

66.1	Strict requirements for a waiver of a Participant's rights or powers in connection with this Framework Agreement and/or a particular Call-off Partnership to be binding on that Participant	Only if all of the following apply to the waiver (and not otherwise): • It is clearly indicated to be a waiver of the relevant right or power. • It is in writing. • It is properly authorised by that Participant.
66.2	Other rules regarding waiver of any Participant's right or power in connection with this Framework Agreement and/or a particular Call-off Partnership	• Delay or failure to exercise that right or power shall not in itself be a valid waiver of it. • A waiver of that right or power on one occasion does not (except to the extent otherwise indicated in that waiver) in itself constitute a waiver of the same right or power on a later occasion and does not affect any other right or power.

67. Governing law and jurisdiction

67.1	Law under which this Framework Agreement is to be interpreted and generally governed	English law.
67.2	Jurisdiction to exclusively apply to disputes arising in connection with this Framework Agreement. This is subject to the dispute resolution arrangements in section 56	English courts.

68. Definitions

Except to the extent the context otherwise requires (and except to the extent otherwise indicated elsewhere in this Framework Agreement), the following words and expressions shall have the following meaning when used in this Framework Agreement

Defined term	Definition
2006 Act	National Health Service Act 2006.
Affiliate	• In relation to a person, any other entity which controls that person, is controlled by that person or is under the same common underlying control as of that person. • For this purpose, a person (**'X'**) will be regarded as having control over another person (**'Y'**) if X alone (and without being subject to the further direction of any other person) directly or indirectly possesses the power (whether by the direct or indirect holding of voting shares or otherwise) to direct the management and policies of Y on all matters.
Call-off Partnership	Each partnership which the Participants enter from time to time under (and according to) this Framework Agreement.

Defined term	Definition
CCG Function	Any function of the CCG which it delegates from time to time to the Council under a Call-Off Partnership, to the extent permitted by Law (particularly the Regulations) to do so.
Centre	The Centre for Effective Dispute Resolution or a successor body.
Claim	A claim, proceedings, action, prosecution (or the like of any of these) which a third party threatens or makes against a Participant in connection with the Partnership.
Commissioned Contract	Any contract • For the purchase of goods, services or works • To which at least one Participant is a party in its capacity as client, commissioner or equivalent. • Which is place for the purposes of a particular Call-off Partnership.
Confidential Information	In relation to a Discloser, as indicated in section 43.
Council Function	Any health related function of the Council which it delegates from time to time to the CCG under a Call-Off Partnership, to the extent permitted by Law (particularly the Regulations) to do so.
Data Protection Legislation	• The GDPR and the Law Enforcement Directive (Directive (EU) 2016/680). • The Data Protection Act 2018 (when given Royal Assent) • In any case, any additional or replacement Law from time to time relating to the processing and protection of personal data or the like of individuals and privacy.
Deadlock	As indicated in item 37.1.
Deliberate Default	Any act of the following by a Participant • A breach of the Law. • A breach of this Framework Agreement (including any act by the Host Participant in excess of its Individual Authority under section 35). • A breach of any duty it separately owes a third party (whether in tort, contract or otherwise) • Other misconduct Where that act is done with the knowledge of any of the following • Any elected member of that Participant. • Any officer of that Participant at the Assistant Director (or equivalent) level or higher.
Discloser	A Participant (and its relevant Affiliate where indicated) in relation to its respective Confidential Information.
Escalated Person	In relation to a Participant, its director responsible for the relevant service at the time, or his/her delegate.
FOI Act	See section 44.
Function	Either a Council Function or CCG Function, or both, as the context indicates.
GDPR	General Data Protection Regulation (Regulation (EU) 2016/679)
Host Participant	In relation to a particular Call-off Partnership, as indicated in section **Error! Reference source not found.**.
Host Participant Remuneration	The remuneration payable to the Host Participant by the other Participants according to item 28.2(b).
Individual Authority	See item 35.1.

Defined term	Definition
Intellectual Property	Copyright, trademarks (whether registered or otherwise), service marks (whether registered or otherwise), patents, design rights (whether capable of registration or otherwise), registered designs, domain names, know how rights, rights in relation to databases, trade secrets, rights to take action for passing off, and all other relevant intellectual property rights as ordinarily recognised as such throughout and in any parts of the world, and in relation to the questions so listed in this definition, all registrations, pending registrations, reversions, extensions and renewals of such rights.
Law	Any of the following applicable to a Participant from time to time (to be read independently) • Any statute, regulation or other subordinate legislation. • Any directive or other European instrument (to the extent it is binding on the Participant) • Any treaty • Any judgement, rule of common law or equity • Any order of a competent court, tribunal, arbitrator or the like of any of these • Any permit, permission (e.g. planning permission) consent, licence, statutory agreement and authorisation (or the like of any of these) required by Law and affecting the relevant person and its activities in connection with this Framework Agreement from time to time. • Any guidance or the like issued by authorised government bodies (whether legally binding or not) • Anything else imposed by any governmental body (in its capacity as such) having a legally binding effect on the respective activities of any Participant in connection with this Framework Agreement from time to time.
Losses	• All losses, damages, costs, charges and expenses incurred by the relevant Participant in the relevant circumstances to which the context refers, whether in tort, contract, by Law or otherwise including, where relevant, third party claims, liabilities, demands, proceedings, interest, penalties and fines, damage to property, death or personal injury, and full legal costs charged on a solicitor-client basis. • **Exception:** to the extent any of these are capped or excluded in this Framework Agreement.
Non-Pooled Fund	Any budget of a Call-Off Partnership indicating the financial contributions of the Participants to the Call-Off Partnership, but where that budget is separate from a Pooled Fund in relation to that Call-Off Partnership.
Overspend	See item 22.3(a).
Partnership	The collaboration which the Participants establish under this Framework Agreement.
Partnership Board	The board of the Partnership established and conducted according to this Framework Agreement.
Partnership Record	See item 39.1.
Personnel	In relation to a Participant or other organisation (as the context indicates), any individual who at the time is one of its genuinely appointed officers, employees, workers, consultants, trustees, elected members, agents, interns, seconded persons, volunteers, advisers or contractors.
Pool Manager	The relevant individual in that position from time to time according to item 18.2.
Pooled Fund	Any pooled fund maintained from time to time in connection with a particular Call-Off Partnership according to the Regulations.
Recipient	A Participant in relation to the Confidential Information of a relevant Discloser.
Regulations	The NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617.

Defined term	Definition
Relevant Dispute	See item 56.1.
Relevant Provider	Any person firm or organisation supplying goods, services and/or works under a Commissioned Contract.
Representative	In relation to a Participant, the current person (and if more than one, each of them individually) who holds that role according to this Framework Agreement or his/her replacement from time to time including: • **Where the relevant individual is absent from time to time:** any other individual deputising for him/her, as decided by the relevant Participant. • **Where the position is vacant from time to time:** the Escalated Person of the relevant.
Reserved Matter	See section 36.
Services	The services in relation to which a Call-off Partnership relates according to item 10.1.
Uncontrollable Circumstances	See item 50.1.

69. Interpretation

Except to the extent the context otherwise requires (and except to the extent otherwise indicated elsewhere in this Framework Agreement), this Framework Agreement shall be interpreted as follows

69.1	Headings	Headings do not affect the interpretation of this Framework Agreement.
69.2	Reference to a Participant	Reference to any Participant includes reference to that Participants' successors in title and permitted assignees.
69.3	Consents, approvals	• Where consent, approval, permission or the like of a person is not to be unreasonably refused, also cannot be unreasonably delayed or subject to unreasonable conditions. • Where consent, approval, permission or the like of a person is to be at that person's discretion, that person - Shall not be obliged to respond to a request for it; and - Shall not be obliged to give reasons for its decision (including any decision not to respond); and - Excludes (to the fullest extent permitted by Law) that person's liability to any person for any reason given for that decision (including any decision not to respond).
69.4	Definitions	If a word or phrase is defined in this Framework Agreement, its other grammatical forms have a corresponding meaning.
69.5	Statutes, codes etc.	Reference in this Framework Agreement to any statute, code or the like includes reference to any amending, replacing, modifying or consolidating statute, code or the like on substantially similar subject matter.

69.6	‘In writing’	• Use of the expression ‘in writing’ (or a similar word) includes (but is not limited to) an e-mail or facsimile message. • It does not include communication by telephone text messages or communication via a social media site (or the like of any of these).
69.7	‘Including’	• Use of the word ‘including’, ‘in particular’, ‘for example’ (or a similar word) at the commencement of a list to illustrate a particular concept does not limit that concept in any way. • Use of the abbreviation ‘etc.’ at the end of a list to illustrate a particular concept does not limit that concept in any way.
69.8	Other references	• Reference to one gender refers to all genders • Reference to the singular includes the plural and vice versa • Reference to any particular type of body, firm or other entity includes reference to any other type of body, firm or other entity.

Appendix 2

Better Care Fund (BCF) – Call Off Partnership Agreement/ Work Order

1. OBJECTIVES OF THE SCHEME

Department of Health and Social Care, Ministry of Housing, Communities and Local Government and NHS England have specifically requested in the BCF Planning Requirements (2019-20) that BCF plans will be approved, subject to the agreement that all funding is transferred into one or more pooled funds, established under Section 75 of the NHS Act (2006).

The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose. Partners may wish to extend the use of pooled funds to include funding streams from outside of the Better Care Fund.

2. AIMS AND OUTCOMES

The aims and benefits of the Partners in entering into this agreement are to:

- Improve the quality and efficiency of the services;
- Meet the National Conditions and Local Objectives;
- Drive integration between the Health and Social Care Economy;
- Make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the services.

3. THE ARRANGEMENTS

In meeting its duties and responsibilities to develop a pooled arrangement to support the BCF Plan, the Partners and Rotherham Health and Wellbeing Board have agreed the establishment of the following pooled arrangements:

Pool 1; Hosted by RMBC; Value of **£29.300m** for Theme 2 Rehabilitation, Reablement and to include the Improved Better Care Fund (iBCF) and Winter Pressures funding.

Pool 2; Hosted by the CCG; Value of **£11.070m** for all Themes excluding Theme 2 Rehabilitation, Reablement and Intermediate Care and to include a Risk Pool.

4. FUNCTIONS

The CCG and Council shall utilise funds to deliver against agreed objectives set out within the BCF Plan.

5. SERVICES WTIHIN THE SCHEME

5.1 Persons Eligible to Benefit

5.1.1 Services commissioned by the CCG shall be commissioned for the benefit of individuals for whom in relation to that service the CCG is the responsible commissioner; for services commissioned by the Council, the services shall be commissioned for the benefit of individuals who are ordinarily resident in the Borough of Rotherham.

5.1.2 The CCG and the Council shall each liaise with any relevant neighbouring authority or CCG in respect of individuals who are the responsibility of either the CCG or the Council but not both.

5.2 Commissioning Arrangements

Each partner organisation will manage the commissioning of specific services for which it is identified as the responsible organisation, in line with its own internal processes.

5.3 Contracting Arrangements:

Each partner organisation will manage the contracting of specific services for which it is identified as the responsible organisation, in line with its own internal processes

6. FINANCIAL CONTRIBUTIONS

6.1 The CCG's base contribution for 2019/20 will be **£21.833m** and the Council's base contribution, including the Improved Better Care Fund (iBCF) and Winter Pressures funding, will be **£18.538m** as per the table below:

Budget 2019-20	2019/20 INVESTMENT			2019/20 SPLIT BY POOL	
BCF Investment	**RCCG SHARE**	**RMBC SHARE**	**Total**	**Pool 1 RMBC Hosted**	**Pool 2 RCCG Hosted**
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**	**40,370**	**29,300**	**11,070**

Appendix 2A provides a list of detailed schemes under each theme.

6.2 In the event that the partners agree to extend this agreement, there will be no automatic annual uplift to the amounts stated in this agreement for any subsequent year. Any uplift to these figures in future years will be determined by both partners as part of their budget setting process.

6.3 It is expected that the Pool Fund Managers will manage the Agreement within the approved budget for the financial year. Any proposed expenditure over and above the approved budget must be agreed in writing by the Chief Finance Officer of the CCG and the Strategic Director of Finance and Customer Services of the Council prior to any additional expenditure being incurred.

6.4 Any overspend in the pooled funds shall be subject to the risk share agreement (Section 8) in the first instance. If all appropriate options in this agreement have been explored it will need to be jointly agreed with the Chief Finance Officer of the CCG and the Strategic Director of Finance and Customer Services of the Council that the overspend be borne in equal shares and may, subject to any national conditions applying in any subsequent year, be deducted from the following year's contribution of both the CCG and the Council to the Pooled Fund.

6.5 Any underspending in one year will be refunded to each partner based on percentage contribution to the pooled budget, subject always to the powers of the parties to make grants to each other outside the terms of this agreement.

6.6 Separate to any base contribution, further contributions may be agreed between parties in year or removal/alteration of services may be agreed through the scheme governance arrangements. Any base or subsequent contribution will be agreed and notified between the joint fund managers of the CCG and RMBC.

6.7 The BCF includes the Improved Better Care Funding of £12.710m for 2019/20 which are subject to the following grant conditions:

- Meeting adult social care needs
- Reducing pressures on the NHS – including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local care provider market is supported

There is no requirement to spend across all three purposes, or to spend a set proportion on each. However, the grant determination requires the Council and the CCG and providers to meet the National Condition 4 (Managing Transfers of care) in the 2019-20 Better Care Fund Policy Framework and Planning Requirements.

6.8 Also included within the BCF is Winter Pressures revenue grant funding of £1.345m which must be used for the purposes of supporting the local health and care system to manage demand pressures on the NHS with particular reference to seasonal winter pressures including on interventions which support people to be discharged from hospital, who would otherwise by delayed, with the appropriate social care support in place, and which help promote people's independence

6.9 Where capital expenditure forms part of the Pooled Fund it shall be identified and accounted for separately from revenue expenditure and treated in accordance with any specified grant funding conditions. Capital funding cannot be used to finance revenue expenditure, however, revenue funding may be used to fund capital expenditure if in agreement with the BCF Executive Group and is in compliance with Financial Regulations and Standing Orders and recommended accounting codes of practice of the lead commissioner. Any capital asset acquired from the Pooled Funds shall be the property of the Council, who shall be responsible for it.

7. PAYMENT TERMS

7.1 The Council will invoice the Rotherham Clinical Commissioning Group in arrears one quarter of the estimated annual costs of the schemes.

7.2 The CCG will invoice the council in arrears one quarter of the estimated annual costs of the IBCF schemes.

7.3 Each party shall provide such accounting information as may be required for the preparation of accounts and audit as may be required both during and at the end of each financial year recognising the need to ensure that both the Council and the CCG meet their specific financial reporting deadlines.

7.4 The Council and the CCG will pay invoices within 30 days of receipt.

8. RISK SHARE ARRANGEMENTS

8.1 The areas of risk are under or overspending of budgets within Better Care Fund budget lines and exceeding affordable levels of care outside the Better Care Fund.

8.2 As part of the initial development of the BCF pooled budget a number of risks were identified where the individual schemes would potentially result in additional demand for services and/or additional costs, or the required efficiencies and reductions do not materialise to the extent planned. The pooled budget in total includes an amount of £0.5m as a risk pool. In applying the risk pool funding it is important to have a jointly agreed approach.

8.3 It is proposed that the BCF Executive Group is the forum where decisions on the application of risk pool funding for either pool is made.

8.4 Risk is attributable to the scheme commissioner pro rata to the proportion of that scheme commissioned. This is to reflect where the levers for change and control sit. Similarly, where the scheme is joint and there is one lead commissioner, the risk should be shared pro-rata to the proportion of that scheme commissioned, subject to the maximum level of funding each partner contributes to the pool unless agreed by the Chief Finance Officer of the CCG and the Strategic Director of Finance and Customer Services of the Council prior to any additional expenditure being incurred (paragraph 6.3).

8.5 <u>Over and Underspends</u>

If an overspend is identified the following approach will be taken:

- Seek to cover the overspend from areas of underspend identified within either pool;
- Utilise the risk pool funding;
- Reduce uncommitted scheme allocations;
- Cover from resources outside the pool.

If an underspend is identified the following approach will be taken:

- Underspends remain within the pooled arrangement to support overspends elsewhere in the pool;
- Further joint schemes within budget lines to be proposed in year which can utilise the resources in year.

In all of these scenarios the BCF Executive Group is the forum where decisions would be made.

8.6 The use of the BCF pooled budget is anticipated to deliver greater outcomes for patients and the public, as well as anticipated reductions in non-elective spend. In the event that demand for acute non-elective care exceeds affordable levels it is proposed that the approach suggested above is taken.

8.7 Where issues arise under this category the Partners shall meet and discuss the appropriate means of addressing the problem through the Health and Wellbeing Board or such other forum as the Partners may decide.

9. FINANCIAL MANAGEMENT AND YEAR END ARRANGEMENTS

9.1 Except by prior agreement between the CCG and the Council, expenditure to be made from the scheme otherwise than in respect of the performance of the services identified above is not permitted.

9.2 Both parties will keep proper accounts in relation to the use of the funds for which it is responsible under the agreement. Accounts will be open to inspection at any reasonable time together with all invoices, receipts and any other related documents.

9.3 Both parties will arrange for the funding and related expenditure to be audited by its respective external auditors as part of the accounts process of each organisation.

9.4 Monitoring information, financial or otherwise, will be provided as required and in accordance with the agreed format.

9.5 All utilisation of the budget and day to day management of services delivery will be subject to each Partner's scheme of reservation and delegation.

9.6 The budget will be governed by any regulatory requirements of each Partner as necessary.

9.7 Funds will be provided to each organisation in line with its delegated commissioning responsibilities net of VAT implications. Utilisation of funds delegated will then be subject to each partners' relevant VAT regime.

9.8 To meet requirements in relation to the preparation of annual accounts SI 2000/617 paragraph 7(6) the host must prepare and publish a full statement of

spending signed by the accountable officer or section 151 officer, to provide assurance to all other parties to the pooled budget. This is required to meet the specified timescales for the publication of accounts and should include:

- Contributions to the pooled budget, cash or kind;
- Expenditure from the pooled budget;
- The difference between expenditure and contributions;
- The treatment of the difference;
- Any other agreed information.

10. GOVERNANCE ARRANGEMENTS

10.1 The joint Fund Managers for the scheme shall be the CCG Chief Finance Officer and the Head of Finance - Adult Social Care, Housing and Public Health for RMBC, working in collaboration.

10.2 The fund managers shall jointly agree appropriate use of the fund in line with the objectives of the scheme, and ensure the scheme is appropriately transacted.

10.3 Using the governance framework set out below, all partners will monitor the BCF plan effectively ensuring plans are delivered through each scheme.

10.4 The CCG and RMBC have co-terminus boundaries which supports the delivery of good governance. The BCF plan was produced through effective governance mechanisms which have been reviewed and updated to facilitate the implementation and delivery of the BCF plan.

10.5 These mechanisms are known and agreed with all partners within the health and social care sector in Rotherham, and there is a commitment from all, including TRFT and RDaSH to work within the governance framework.

10.6 **Governance Framework**

The Health and Wellbeing Board will have overall accountability for the delivery of BCF plan, and for the operation of the delivery of this Section 75 Partnership Framework Agreement they will:

- monitor performance against the BCF Metrics (National/Local) and receive exception reports on the BCF action plan;
- agree the Better Care Fund Commissioning Plan;
- agree decisions on commissioning or decommissioning of services, in relation to the BCF.

The framework below demonstrates the decision making structure and how the BCF plan will be delivered.

The management and oversight of the delivery of the BCF plan has been delegated to the BCF Executive Group, chaired by the HWB chair and including senior representatives from both the council and CCG.

The BCF Executive Group is supported by the BCF Operational Group, which is made up of the identified lead officers for each of the BCF actions within the plan, plus other supporting officers from the Council and CCG. The BCF Operational Group meets on a quarterly basis and reports directly to the BCF Executive Group.

10.7 **BCF Executive Support**

The BCF Executive Group and BCF Operational Group will be supported by officers from the Partners from time to time.

10.8 **Meetings**

The BCF Executive Group will meet quarterly at a time to be agreed within 30 days following receipt of each quarterly report from each Pooled Fund Manager.

The quorum for meetings of the BCF Executive Group shall be a minimum of one representative from each of the Partner organisations with a minimum of two members of the group present.

The BCF Operational Group meets on a quarterly basis. Quorum for these meetings will be a minimum of four representatives from each of the schemes with at least two representatives from each organisation present

Where a Partner is not present and has not given prior written notification of its intended position on a matter to be discussed, then those present may not make or record commitments on behalf of that Partner in any way.

Minutes of all decisions shall be kept and copied to the Authorised Officers within seven (7) days of every meeting.

10.9 **Delegated Authority**

The BCF Executive Group is authorised within the limits of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:

- authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Partners to the aggregate contributions of the Partners to any Pooled Fund subject to the agreement of the Chief Finance Officer of the CCG and the Strategic Director of Finance and Customer Services of the Council; and

- authorise a Lead Commissioner to enter into any contract for services necessary for the provision of Services under an Individual Scheme

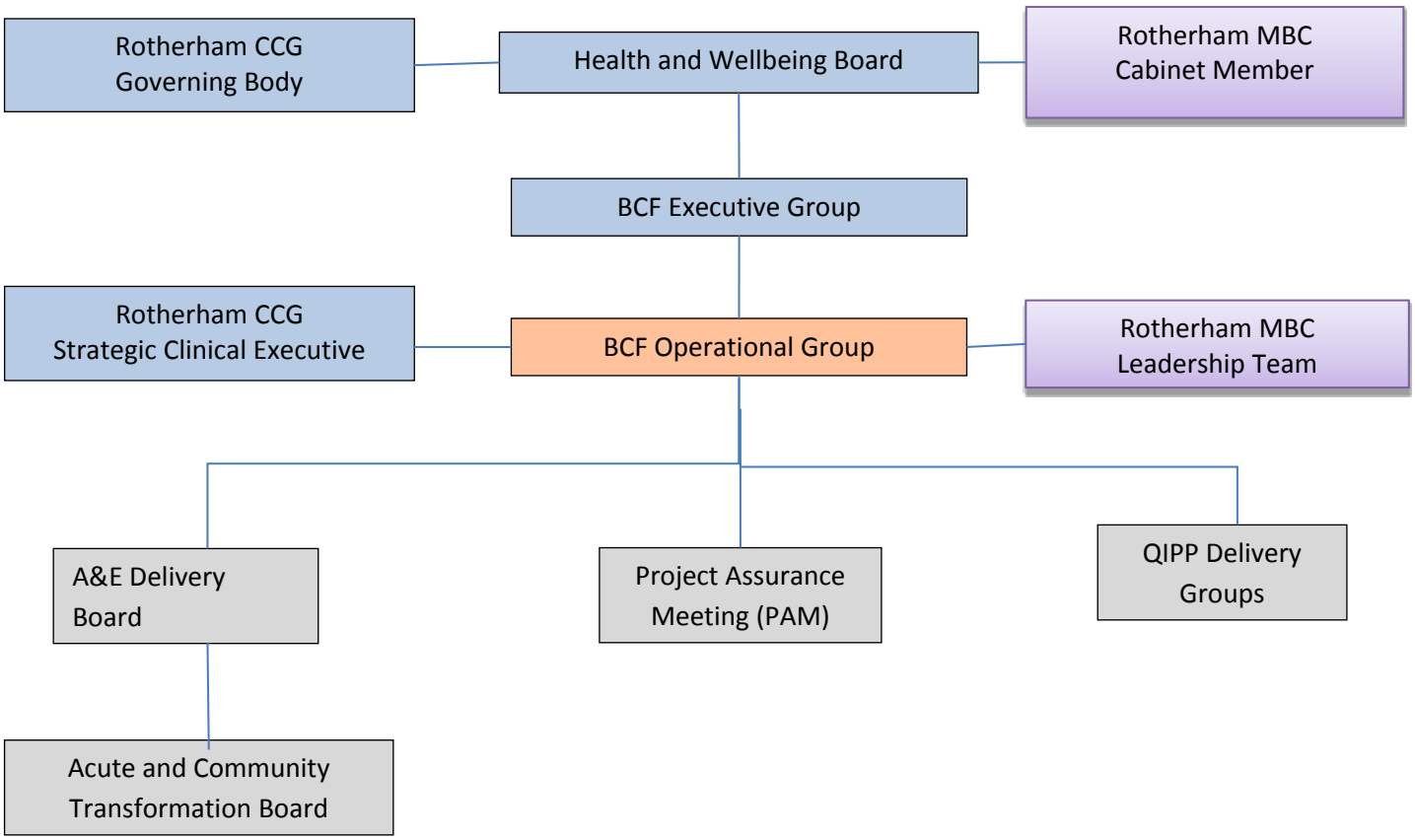
10.10 **Information and Reports**

Each Pooled Fund Manager shall supply to the BCF Executive Group on a Quarterly basis the financial and activity information as required under the Agreement.

10.11 **Post-Termination**

The BCF Executive Group shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

10.12 **BCF Governance - Reporting Structure**



ROTHERHAM METROPOLITAN BOROUGH COUNCIL ADULT CARE, HOUSING AND PUBLIC HEALTH

ROTHERHAM CLINICAL COMMISSIONING GROUP BETTER CARE FUND (BCF)

BCF EXECUTIVE GROUP

Purpose of the Executive Group
The purpose of the BCF Executive Group is to take responsibility for the delivery of the Better Care Fund plan for Rotherham; the strategic operation and delivery of the Framework Partnership Agreement; and to make recommendations for the strategic direction and management of the Better Care Fund to the Health and Wellbeing Board (HWB).

Functions of the Executive Group

- Take responsibility for the fund's feasibility, business plan and achievement of outcomes;
- Defining and realising benefits and budgetary strategy
- Monitor delivery of the Better Care Plan through quarterly meetings
- Ensure performance targets are being met
- Ensure schemes are being delivered and additional action put in place where the plan results in unintended consequences
- Undertake an annual review ("**Annual Review**") of the operation of this Agreement
- Undertake or arrange to be undertaken a review of each Pooled Fund, Non Pooled Fund and Aligned Fund and the provision of the Services within 3 Months of the end of each Financial Year.
- Arrange or oversee the production of a joint annual report- to be presented to the Executive Group within 20 Working Days of the presentation of the annual review ensure the fund's scope aligns with the requirements of the stakeholder groups;
- Address any issue that has major implications for the fund;
- Keep the fund scope under control as emergent issues force changes to be considered;
- Reconcile differences in opinion and approach, and resolve disputes arising from them;
- Report quarterly to HWB, and
- Take responsibility for any corporate issues associated with the fund.

In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

The role of the individual members of the BCF Executive Group Fund Board includes:

- Understand the strategic implications and outcomes of initiatives being pursued through fund outputs;
- Appreciate the significance of the fund for stakeholders and ensure the requirements of stakeholders are met by the fund's outputs;
- Be an advocate for the fund's outcomes;
- Have a broad understanding of fund management issues and the approach being adopted;
- Help balance conflicting priorities and resources;
- Review the progress of the fund;
- Check adherence of fund activities to standards of best practice, both within the organisation and in a wider context.
- To ensure the customer journeys/experience are delivering increased customer satisfaction as shown by the delivery of the measures, i-statements and the plan.

Chair
The meeting will be co-chaired by the respective Accountable Officers.

Membership of the Executive Group
Elected Member
CCG Chief Officer
CCG Chief Finance Officer
CCG Deputy Chief Officer
CCG Assistant Chief Officer
RCCG/RMBC (Joint) Head of Adult Commissioning
RMBC/RCCG (Joint) Strategic Commissioning Manager
RMBC Chief Executive
RMBC Head of Finance (Adult Social Care, housing and Public Health)

RMBC Director of Adult Care, Housing and Public Health (DASS)

RMBC Assistant Director, Strategic Commissioning

RMBC Director of Public Health

Both parties will call in relevant officers for specific topics where required and a standing invitation will be made to Public Health Director to attend.

Quorate
One representative from each of the organisations, with a minimum of two members present

Frequency of Meetings
Quarterly

Co-ordination of Meetings
Strategic Commissioning Manager, RMBC/RCCG will co-ordinate.

Governance
The group will report to the HWB.

Key Deliverables
• Ensure that the financial reporting framework is adhered to. • To be responsible for maintaining the risk register and ensuring risk mitigation plans are in place. • Recommend actions and deliver reports to the HWB, LGA and NHSE.

ROTHERHAM METROPOLITAN BOROUGH COUNCIL ADULT CARE, HOUSING AND PUBLIC HEALTH

ROTHERHAM CLINICAL COMMISSIONING GROUP

BETTER CARE FUND (BCF) OPERATIONAL GROUP

Purpose of the Group
To oversee the delivery of the Better Care Fund Plan for Rotherham, making recommendations to the Better Care Fund Executive Group to ensure effective action and implementation of the plan

Functions of the Group
• To provide the forum for BCF accountable operational leads to co-ordinate the delivery of the BCF Performance Measures and BCF Action Plan. • To ensure that effective performance management of the BCF Performance Measures takes place and where performance is not meeting targets appropriate and timely action is taken. • To ensure the effective delivery of the BCF action plan at operational level and allow for necessary operational partnership discussions to take place to meet the outcomes of the plan. • To ensure that the accountable leads of the BCF performance measures and the BCF action plan are collectively discussing their progress and key actions. • To identify the areas which need to be reported on progress and performance by exception to the BCF Executive Group. • To ensure the BCF conditions are met. • To co-ordinate partner activity within the BCF Plan, ensuring that all elements of the plan are linked together to deliver positive outcomes. • To ensure the Rotherham BCF Scorecard is updated on a monthly basis. To review risk and to oversee the implementation of mitigating action plans. • To ensure the customer journeys/experience are delivering increased customer satisfaction as shown by the delivery of the measures, i-statements and the plan.
Chair
The meeting will be co-chaired by the CCG Chief Finance Officer and the Strategic Director of Adult Care, Housing and Public Health

Membership of Group
RCCG Chief Finance Officer
RCCG Assistant Chief Officer
RCCG Performance and Intelligence Manager
RCCG/RMBC (Joint) Head of Adult Commissioning
RMBC/RCCG (Joint) Strategic Commissioning Manager
RMBC Public Health Principal
RMBC Finance Manager (Adult Social Care, Housing and Public Health)
RMBC Assistant Director, Independent Living and Support
RMBC Assistant Director, Strategic Commissioning
RMBC Performance Manager
Both parties will call in relevant officers for specific topics where required

Quoracy
Two representatives from each of the organisations

Frequency of Meetings
Quarterly

Co-ordination of Meetings
Strategic Commissioning Manager, RMBC/RCCG will coordinate.

Governance
Each organisation maintains accountability for service specific operational delivery. The group will report to the BCF Executive Group. This does not replace existing performance management and accountability mechanisms, but will provide a specific focus and bring coordination to the BCF targets and actions.

Key Deliverables
• Maintain financial reporting framework. • Maintain a risk register appropriate to the level of group operation. • Coordinate the completion of reports for the Health and Wellbeing Board and the Department of Health

11. INTEGRATED PROVIDER PERFORMANCE MANAGEMENT FRAMEWORK

11.1 Purpose

To ensure that Partners adopt an integrated performance management framework in order to plan, deliver, review and act on relevant information to commission improved outcomes for the people of Rotherham. It is the expectation that the Lead for each BCF Scheme will be responsible for ensuring this framework will be completed for each scheme.

The BCF Executive, supported by the BCF Operational Group will be responsible for ensuring the performance management framework for the BCF programme is in place, updates produced, and reports compiled for NHS England and the Health and Well Being Board.

11.2 Definition

For the purposes of this Schedule, “performance management” shall mean the overall process that integrates planning, action, monitoring and review and shall incorporate the following:

- Identifying the aim, (e.g. purpose, mission, corporate aims, strategic goals etc.) and the action required to meet the aim (e.g. business plan, project plan, etc.);
- Identifying priorities and ensuring there are sufficient resources to meet them;
- Monitoring performance of any commissioned provider or voluntary organisation;
- Reviewing progress, detecting problems and taking action to ensure the aim is achieved;
- Determining which services should be delivered; benchmarking performance against an agreed and transparent set of measures.

11.3 Outline Framework

The performance management framework should incorporate three processes in relation to joint commissioning, i.e. Business Planning, Reporting and Review and Performance Improvement.

11.4 Commissioning Business Planning Process

This process consists of integrated commissioning plans, which should set out:

- strategic objectives and key performance measures for 17/18
- the commissioning intentions for the strategic objectives and
- the timescales for achievement.

Contracts with service providers that state how performance shall be monitored, reported and reviewed will also be required.

11.5 Reporting and Review Process

This will involve monitoring overall progress against:

- delivery of the strategic objectives in the integrated commissioning plans,
- delivery of the contracts as detailed in Schedule 4
- identifying the reasons for any under-performance of service providers.

11.6 Performance Improvement Process

To ensure action is taken where the continuation of current performance would lead to an outcome/target not being met.

The application of a range of tools and techniques to improve overall performance.

11.7 Commissioning Plan

The Partners shall agree an Integrated Commissioning Plan for each Service by 1 April each year. This will set out the “direction of travel” and the shared commissioning intentions for the development of the Services The plans shall be agreed by the Partners.

11.8 Contracts with Service Providers

The lead commissioner shall be required to agree a contract with each third party provider regarding the outcomes they are to deliver.

Contracts with third party providers should:

- Take account of the requirements of the relevant current plans of the respective partners and the actions agreed in response to external review;
- Include a requirement that the service provider develop a detailed service plan, which covers how the provider intends to achieve the said outcomes and the risk associated with not achieving them.
- Require the provider to regularly measure progress against achieving the outcomes and to report this to the Host Partner at a frequency to be agreed

- Require the provider to provide an improvement plan in the case of significant under or over performance.
- Include a process whereby outcomes may be added/removed as a result of changing needs.

11.9 Reporting and Review Process

Regular meetings should be held between the Host Partner and the service provider to review the latter's performance.

The Host Partner shall monitor services having regard to national, regional and local key performance indicators, including:

- Performance assessment framework indicators
- National performance indicators
- Audit and inspection recommendations
- Self-assessment Statement actions
- Relevant operational plan indicators
- NHS clinical commissioning board targets
- Relevant core and Care Quality Commission standards
- Patient and Customer feedback

11.10 Performance Reporting and Review of the Section 75 Agreement

The pooled fund manager will be responsible for producing quarterly reports to the BCF Executive Group and Health and Wellbeing Board on a quarterly basis.

The pooled fund manager will be responsible for producing an annual report to the BCF Executive Group and Health and Wellbeing Board.

The BCF Executive Group will be responsible for ensuring the timeline to ensure the data is collected, reported, authorised by the health and wellbeing Board, and submitted to the NHS England on their specified reporting dates, these being one day after the dates specified in section 9.1.

11.11Rotherham CCG / RMBC BCF Metrics:

Rotherham CCG / RMBC BCF Metrics:

As part of the Better Care Fund Plan we will measure against the national metrics and Rotherham's agreed local metrics. The BCF Policy Framework establishes that the national metrics will continue as they were set out for 2019/20. In summary these are:

- Non-elective admissions (General and Acute)
- Admissions to residential and care homes
- Effectiveness of reablement

- Delayed transfers of care

The detailed definition of the non-elective admissions (NEA) metric is set out in the Planning Round Technical Definitions. The level of non-elective activity which BCF plans seek to avoid, in addition to reductions already included within the calculation of CCG operating plan figures, are clearly identified in the BCF planning return. The detailed definitions of the other three metrics are set out in Table 4

Table 4 – BCF Metrics Definitions

	Metric	Numerator	Denominator
2	Admissions to residential and care homes	The sum of the number of council-supported people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year. Data from Short- and Long-Term Support (SALT) collected by HSCIC	Size of the older people population in area (aged 65 and over). This should be the appropriate ONS mid-year population estimate or projection
3	Effectiveness of reablement	Number of older people discharged from acute or community hospitals to their own home or to a residential home for rehabilitation, with a clear intention that they will move on/back to their own home who are at home 91 days after the date of their discharge from hospital.	Number of older people discharged from acute or community hospitals to their own home or to a residential home for rehabilitation, with a clear intention that they will move back to their own home.
4	Delayed transfers of care	The total number of delayed bed days (for patients aged 18 and over)	Number of days in period

Non-elective hospital admissions – The plan illustrated (within the BCF planning template) is the affordable level of non-elective admissions reflected in CCG contracts. The plan is a composite of shares of all the CCG's plans covered by the HWB area. The definitions and shares used for this target are set nationally by the BCF programme.

The Rotherham CCG plan for non-elective admissions is built up from growth assumptions produced by analysing local data on previous trends and from the planned impact of relevant quality improvement and targeted intervention programmes which are all established.

Key schemes for 2019/20 include the on-going implementation of an integrated urgent and emergency care centre, interventions in mental health liaison, ambulatory care, social prescribing, case management in risk stratified patients, integrated locality working and Hospice at Home services.

Non-elective activity and the impact of these schemes are monitored through a number of contractual processes and meetings.

No additional reductions have been planned in as part of BCF as the broader non elective plan already encompasses the key schemes impacting non elective admissions.

Delayed Transfers of Care (DTOC)

The Delayed Transfers of Care (DTOC) targets have been set nationally and the definitions for this indictor have also been set nationally.

The national expectations for Delayed Transfers of Care (DTOCs) have been presented as daily delayed bed days at a Health and Wellbeing Board level (18 Years+). Delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed.

The targets for Rotherham are:

- 11.1 average daily delayed bed days for NHS delays
- 4.2 average daily delayed bed days for Social Care delays
- 0.8 average daily delayed bed days for Joint delays

Rotherham is currently routinely achieving the NHS delays target but not the Social Care delays target. The Joint delays target is generally achieved but occasionally missed. As at September 2019, the Rotherham DTOC position was:

- 9.3 average daily delayed bed days for NHS delays
- 16.4 average daily delayed bed days for Social Care delays
- 1.1 average daily delayed bed days for Joint delays

DTOC performance is being addressed by all partners (including health and social care providers), underpinned by an action plan, focusing on a universal home first approach and a more integrated discharge model. DTOCs are a key issue for the Urgent and Community Transformation Board and a cross partner operational group is in place to work through individual DTOCs.

National Condition 4 - Managing Transfers of Care of the Better Care Fund (BCF) sets out the requirement to ensure people's care transfers smoothly between services and settings. This requires all local areas to implement the high impact change model which is also a condition of the Improved Better Care Fund (IBCF).

Rotherham used the High Impact Change Model to self-assess the local position in 2017-18 developed a Delayed Transfer of Care (DToC) action plan. This self-assessment was completed by the Rotherham health and social care system partners and is reported through to our local Urgent and Community Transformation Board (when appropriate).

Permanent admissions of older people to residential and nursing care homes (per 100,000)

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. Final year end admissions data in 2018-19 demonstrated continued improvement with 292 admissions in year (or a rate of 572), compared with previous year admissions of 303 (or a rate of 608) in 2017-18.

A target of 264 admissions (or a rate of 511) has been agreed for 2019/20.

The service continues mitigating the short stay risk by ensuring that officers explore alternative options and that these are only used in exceptional circumstances. The application of the *Home First* principles underpinning discharge, maximise opportunities for people to return to their homes and community where appropriate. The target takes account of recent trend analysis and is realistic when considering demographic pressures.

Proportion of older people still at home 91 days after discharge from hospital into rehabilitation and reablement services

This is an annual measure and collation of data is undertaken during January to March period each year, to track service users who have been 'offered' (i.e. commenced) the service during the previous October to December period, to identify those who were still at home 91 days following discharge from hospital.

Performance for 2018/19 has seen an improvement on the previous year (2017-18, 82.8%) to 85.6% against a target of 89%. Although proportion at home at 91 days improved, the service recognises that 2019/20 changes to the reablement cohort

(offering service to people with more complex needs and younger than 65 years) and operating pathways, whilst likely to increase the number of individuals offered the service, the overall improvement in those still at home after 91 days may be moderate (estimate 10 still at home for every 11 offered service).

A target of 86% has been agreed for 2019/20 and data will be collected using the same criteria adopted in previous years.

12. NON FINANCIAL RESOURCES

Non-financial contributions to the Schemes are confined to current support for joint and integrated commissioning arrangements and will continue with no charges being made to the pooled fund.

13. ASSURANCE AND MONITORING

The Fund Managers will make financial information available quarterly to the BCF Executive and Operational Groups, reporting on performance against the BCF metrics and in each of the 6 Themes listed above.

13. POOLED FUND MANAGER DETAILS

Partner	Lead Officer	Address	Telephone Number	Email Address
CCG	Chief Finance Officer	Oak House, Moorhead Way, Rotherham S66 1YY	01709 302025	Wendy.allott@nhs.net
RMBC	Head of Finance - Adult Social Care, Housing and Public Health	Riverside House, Main Street, Rotherham S60 1AE	01709 382121	Owen.campbell@rotherham.gov.uk

14. DURATION AND EXIT STRATEGY

There is no requirement for an exit strategy, over and above each organisation's own strategies.

Responsibility for any debts, liabilities, record-keeping, equipment and contractual arrangements will remain with the relevant Partner.

15. OTHER PROVISIONS

No other provisions.

16. AUTHORISATION

	Rotherham MBC	Rotherham CCG
Signature		
Date of signature		
Name of signatory (print)		
Title or role of signatory (print)		

Appendix 2A – Detailed BCF Schemes

Better Care Fund Budget 2019-20	Budget 2018-19	Additional Investment	Budget 2019-20
	£'000	£'000	£'000
THEME 1 - Mental Health Services			
Adult Mental Health Liaison	791	378	**1,169**
THEME 2 - Rehabilitation & Reablement			
Home Improvement Agency	75		**75**
Falls Service	444	18	**462**
Home Enabling Services :			
Reablement	1,120	(35)	**1,085**
Pressures on Domiciliary Care Budgets	756		**756**
Community Stroke Service	182	10	**192**
Community Neuro Rehab	156	3	**159**
Breathing Space	2,348	92	**2,440**
Self Management	50		**50**
Otago	20		**20**
Medequip	1,675	40	**1,715**
Community OT	746	29	**775**
Disabled Facilities Grant	2,502	198	**2,700**
Age UK Hospital Discharge	158		**158**
Stroke Association Service	50		**50**
Intermediate Care Pool:			
Intermediate Care Therapy(TRFT)	374		**374**
Therapy & Nursing cover to support vulnerable patients and Fast Response team	274	11	**285**
Increase residential capacity by 8 beds (Lord Hardy Court)	228		**228**
Intermediate Care Independent spot beds	30		**30**
Further Investment into Intermediate Care(LH/DC)	560		**560**
Intermediate Care(LH/DC/RICC)	2,916		**2,916**
Interim Care beds (Lord Hardy Court)	100		**100**
Short Term Residential/ Respite care for older people to avoid hospital admission or speed up discharge (Davies Court).	115		**115**
THEME 3 - Supporting Social Care			
Direct Payments:			
Direct Payments/ Personal Budgets (Physical Disabilities)	395		**395**
Direct Payments (Older People)	525		**525**
LD Supported Living	409		**409**
Direct Payments (Learning Disabilities)	314		**314**
Direct Payment Support	46		**46**
Residential Care			
Mental Health rehabilitation services	209		**209**

Better Care Fund Budget 2019-20	Budget 2018-19	Additional Investment	Budget 2019-20
	£'000	£'000	£'000
Learning Disability Services:			
Learning Disabilities independent sector residential care/Transitional Placements	982		**982**
Learning Disabilities Domiciliary Care	37		**37**
Care Act - Older People Direct Payments	500		**500**
Care Act - IT (Liquid Logic)	60		**60**
Care Act - LD Domiciliary Care	30		**30**
Care Act - PD Domiciliary Care	60		**60**
Care Act - OP Domiciliary Care	10		**10**
Care Act - DoLs	40		**40**
THEME 4 - Care Mgt & intergrated Care Planning			
GP Case Management	1,316	36	**1,352**
Care Home Support Service	267	10	**277**
Hospice - End of Life care	789		**789**
Social Prescribing	760		**760**
Social Work Support (A&E, Case management, Supported Discharge):			
Single Point of Access	100		**100**
Fast Response Twilight Service (TRFT)	60		**60**
Fast response Nursing team(TRFT)	60		**60**
Supported Discharge Pathways Team	432		**432**
Early Planning Team	230		**230**
Mental Health Crisis Team	36		**36**
Care Co-ordination Centre	767	30	**797**
THEME 5 - Supporting Carers			
Carers Support Service:			
Early Planning Team	237		**237**
Carers Emergency Service	78		**78**
Direct Payments (Older People)	250		**250**
Carers Centre	35		**35**
Crossroads	50		**50**
THEME 6 - Infrastructure			
Joint Commissioning Team	49		**49**
Rotherham Health Record	192		**192**
RISK POOL			
Risk pool	500		**500**

Better Care Fund Budget 2019-20	Budget 2018-19	Additional Investment	Budget 2019-20
	£'000	£'000	£'000
Improved Better Care Fund			
Sustainability/mitigation of service reduction/transformation	6,954	27	**6,981**
Information Sharing/System Development	185	(27)	**158**
Leadership Capacity for system transformation	135	45	**180**
Discharge Pathways and Patient Flow	1,580	(45)	**1,535**
Market Capacity/sustainability	1,200	2,596	**3,796**
Prevention and Early Intervention	50	10	**60**
Winter Pressures	0	1,345	**1,345**
GRAND TOTAL	***35,599***	***4,771***	***40,370***

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

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

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	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

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	
Remaining Word Limit:	0

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 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 and an enhanced quality of life. This will also result in a stronger understanding of what care is currently being provided, with increased reviews and oversight, specifically with a recovery/reablement model that requires close working with providers 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 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 DTOC rates.

4 key themes of the new pathways include:

1. Prevention – ensuring right information is available in all formats, that a range of options promote healthy lifestyles and increased use of digital channels.
2. Integration – future models for integrated health/social care teams, including hospital discharge team and mental health services, role and reconfiguration of intermediate care/reablement services, 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 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 patients 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/recovery service, Multi-Disciplinary Teams, 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 CHC 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/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/older people; and to ensure that they are fully engaged in the commissioning process

Rotherham CCG has developed an IT strategy to ensure that the CCG and partners have the 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. This remains the cornerstone of the CCG's strategic direction available at http://www.rotherhamccg.nhs.uk/our-plan.htm.

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/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 in terms of health, wellbeing, self-care, independence, Increase resilience of individuals and communities, support dependence to independence and reduce social isolation.
A new Rotherham Health and Wellbeing Strategy ("A Healthier Rotherham by 2025") sets out Rotherham's overarching vision to improve the health and well-being of its population, for people to continue to live fulfilling lives, 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, 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. Work across the partnership to look at ways to improve/enhance the use of evidence-based programmes to reduce health inequalities, including: parenting programmes, sleep programmes, weaning, oral health programmes for both people living in the community and care homes and smoking cessation projects. The focus is on those children/young people who are most vulnerable: those who are looked after or on edge of care, adults with mental health conditions/physical/learning disabilities and those from the most deprived communities. BCF funded schemes contribute to reducing health inequalities through the provision of intermediate care/reablement type services, extension of social care prescribing service for people with mental health conditions, Community Occupational Therapy provides assessments for children/adults with complex needs, use of Assistive Technology/aids/adaptations which are accessible to all with a range of disabilities/health conditions. The Council also assists people from the most deprived communities to access support, including welfare benefit advice, through a number of voluntary sector organisations including Citizens Advice Bureau, Advice Centres, Age UK and Rotherham Ethnic Minority Alliance, which collaboratively work together as an "Advice in Rotherham Partnership" to deliver a "Single Advice Model" to help vulnerable residents. The BCF Plan contributes to priorities within the HWB Strategy: all people enjoy the best possible mental health and wellbeing, have a good quality of life, live well for longer and live in healthy, safe, resilient communities.
Rotherham ICP has formed a system wide steering group to examine the requirements for the development of a 'Rotherham Segmentation Tool'. Robust data is currently being collected across the partnership to support the development of the tool. Once achieved, analysis of the data will support how community provision identifies cohorts requiring care and support and deals with them in a multi-disciplinary approach.

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)

^^ Link back to top

Remaining Word Limit:	0

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 (2017-19) 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 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 works 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 been recognised nationally, with Social prescribing 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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Rotherham Council is a Housing Authority, so we can confirm that the use of the DFG has been agreed with Housing Services. 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 DFG provides funding for the provision of aids/adaptations to disabled people's homes to enable them to live independently and to improve their quality of life. Services work collaboratively together in responding to the Care Act requirements in order to prevent, reduce or delay care/support needs.

The DFG has provided funding for aids/adaptations for 252 people with physical disabilities, 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 DFG also supports people being disharged from hospital with our indepenent sector housing contractors supplying minor fixings such as key safes, grab rails and stair-rails. 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/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/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 an independent sector provider to implement and deliver an assistive technology pilot with a group of around 60 individuals. The DFG 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/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 SIM card, Amazon Alexa, sensors, video calling device and other add-ons eg epilepsy monitor.

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 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 develop 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 1 year period to support around 800 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 service aims are 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	
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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 a 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

Sche me 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	Communit y 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/ domiciliary 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	Increase capacity/ sustainability for care packages	Personalised Budgeting and Commissioning	Direct Payments				Medium	High	High	Medium	Social Care		LA

	transformation														
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

Scheme ID	Scheme Name	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1.	Adult Mental Health Liaison			NHS Mental Health Provider	Minimum CCG Contribution	£1,169,000	Existing
2.	Home Improvement Agency			Charity / Voluntary Sector	Minimum CCG Contribution	£60,000	Existing
2.	Home Improvement Agency			Charity / Voluntary Sector	Additional LA Contribution	£15,000	Existing
3.	Falls Service			NHS Community Provider	Minimum CCG Contribution	£462,000	Existing
4.	Reablement			Local Authority	Minimum CCG Contribution	£1,085,000	Existing
5.	Domiciliary Care			Private Sector	Minimum CCG Contribution	£756,000	Existing
6.	Community Stroke Service			NHS Community Provider	Minimum CCG Contribution	£192,000	Existing
7.	Community Neurological Rehabilitation			NHS Community Provider	Minimum CCG Contribution	£159,000	Existing
8.	Breathing Space			NHS Community Provider	Minimum CCG Contribution	£2,439,894	Existing
9.	Expert Patient Programme			Private Sector	Minimum CCG Contribution	£50,000	Existing
10.	Otago Exercise Programme			Local Authority	Minimum CCG Contribution	£20,000	Existing
11.	Rotherham Equipment and Wheelchair Service			Private Sector	Minimum CCG Contribution	£1,623,000	Existing

12.	Community Occupational Therapy Services			Private Sector	Additional LA Contribution	£92,000	Existing
12.	Community Occupational Therapy Services			NHS Acute Provider	Minimum CCG Contribution	£388,000	Existing
13.	Disabled Facilities Grant			NHS Acute Provider	Additional LA Contribution	£388,000	Existing
13.	Disabled Facilities Grant			Local Authority	DFG	£1,730,150	Existing
14.	Age UK Hospital Discharge			Local Authority	DFG	£970,000	Existing
15.	Stroke Association Service			Charity / Voluntary Sector	Minimum CCG Contribution	£158,000	Existing
16.	Intermediate Care Pooled Budget			Charity / Voluntary Sector	Minimum CCG Contribution	£50,000	Existing
16.	Intermediate Care Pooled Budget			Local Authority	Additional LA Contribution	£1,238,000	Existing
16.	Intermediate Care Pooled Budget			Local Authority	Additional CCG Contribution	£1,677,000	Existing
17.	Direct Payments			Local Authority	Minimum CCG Contribution	£1,003,000	Existing
18.	Supported Living			NHS Acute Provider	Minimum CCG Contribution	£689,000	Existing
19.	Mental Health rehabilitation services			Private Sector	Minimum CCG Contribution	£1,280,000	Existing
20.	Learning Disability Service			Private Sector	Minimum CCG Contribution	£409,000	Existing
21.	Care Act			Private Sector	Minimum CCG Contribution	£209,000	Existing

21.	Care Act			Private Sector	Minimum CCG Contribution	£1,019,000	Existing
22.	GP Case Management			Private Sector	Additional CCG Contribution	£40,000	Existing
23.	Care Home Support Service			Private Sector	Minimum CCG Contribution	£660,000	Existing
24.	Hospital End of Live Care			NHS Community Provider	Minimum CCG Contribution	£1,352,000	Existing
25.	Social Prescribing			NHS Community Provider	Minimum CCG Contribution	£277,000	Existing
26.	Social Work Support (A&E, Case Management			Charity / Voluntary Sector	Minimum CCG Contribution	£789,000	Existing
27.	Care Co-ordination Centre			Charity / Voluntary Sector	Minimum CCG Contribution	£760,000	Existing
28.	Carers Support Service			Local Authority	Minimum CCG Contribution	£918,000	Existing
28.	Carers Support Service			NHS Acute Provider	Minimum CCG Contribution	£797,000	Existing
28.	Carers Support Service			Local Authority	Minimum CCG Contribution	£237,000	Existing
29.	Joint Commissioning Team			Charity / Voluntary Sector	Additional LA Contribution	£50,000	Existing
30.	IT to Support Community Transformation			Charity / Voluntary Sector	Minimum CCG Contribution	£363,000	Existing
31.	BCF Risk Pool			Local Authority	Minimum CCG Contribution	£49,000	Existing
32.	Sustainability and migration of service			CCG	Minimum CCG Contribution	£192,000	Existing

32.	Sustainability and migration of service			NHS Acute Provider	Additional CCG Contribution	£500,000	Existing
32.	Sustainability and migration of service			Private Sector	iBCF	£2,777,283	Existing
32.	Sustainability and migration of service			Private Sector	iBCF	£1,000,000	Existing
32.	Sustainability and migration of service			Private Sector	iBCF	£1,527,000	Existing
32.	Sustainability and migration of service			Private Sector	iBCF	£700,000	Existing
33.	Information sharing and system development			Local Authority	iBCF	£875,000	Existing
33.	Information sharing and system development			Charity / Voluntary Sector	iBCF	£100,000	Existing
34.	Leadership Capacity for System			Local Authority	iBCF	£88,896	Existing
35.	Discharge Pathways and Patient Flow			NHS Acute Provider	iBCF	£70,000	Existing
35.	Discharge Pathways and Patient Flow			Local Authority	iBCF	£120,000	Existing
35.	Discharge Pathways and Patient Flow			NHS Acute Provider	iBCF	£60,000	Existing
35.	Discharge Pathways and Patient Flow			Private Sector	iBCF	£835,000	Existing
35.	Discharge Pathways and Patient Flow			Private Sector	iBCF	£500,000	Existing
36.	Market Capacity and Sustainability			Charity / Voluntary Sector	iBCF	£90,000	Existing
36.	Market Capacity and Sustainability			Local Authority	iBCF	£110,000	Existing

36.	Market Capacity and Sustainability			Private Sector	iBCF	£990,000	Existing
37.	Prevention and Early Intervention			Private Sector	iBCF	£1,368,000	New
37.	Prevention and Early Intervention			Private Sector	iBCF	£200,000	Existing
32.	Sustainability & migration of service			Charity / Voluntary Sector	iBCF	£50,000	Existing
38.	Implementation of new staff operating			Charity / Voluntary Sector	iBCF	£10,000	New
38.	Market Capacity and Sustainability			Private Sector	iBCF	£1,238,308	New
38.	Integrated Discharge Team			Private Sector	Winter Pressures Grant	£300,000	New
38.	Intermediate Care and Reablement			Private Sector	Winter Pressures Grant	£151,000	New
38.	Intermediate Care Occupational			Local Authority	Winter Pressures Grant	£157,070	New
38.	Mental Health Diversion			Local Authority	Winter Pressures Grant	£272,947	New
				NHS Acute Provider	Winter Pressures Grant	£264,270	New
				Private Sector	Winter Pressures Grant	£200,000	New

^^ Link back up

Scheme Type	Description	Sub Type
Assistive Technologies and Equipment	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	Telecare Wellness Services Digital Participation Services Community Based Equipment Other
Care Act Implementation Related Duties	Funding planned towards the implementation of Care Act related duties.	Deprivation of Liberty Safeguards (DoLS) Other
Carers Services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	Carer Advice and Support Respite Services Other
Community Based Schemes	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood level (eg: Integrated Neighbourhood Teams)	
DFG Related Schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.	Adaptations Other
Enablers for Integration	Schemes that build and develop the enabling foundations of health and social care integration encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.	
High Impact Change Model for Managing Transfer of Care	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM as such, is included in this section.	Chg 1. Early Discharge Planning Chg 2. Systems to Monitor Patient Flow Chg 3. Multi-Disciplinary/Multi-Agency Discharge Teams Chg 4. Home First / Discharge to Access Chg 5. Seven-Day Services Chg 6. Trusted Assessors Chg 7. Focus on Choice Chg 8. Enhancing Health in Care Homes Other - 'Red Bag' scheme Other approaches

Home Care or Domiciliary Care	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.	
Housing Related Schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	
Integrated Care Planning and Navigation	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches like Single Point of Access (SPoA) and linking people to community assets. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams and the HICM for managing discharges, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.	Care Coordination Single Point of Access Care Planning, Assessment and Review Other
Intermediate Care Services	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.	Bed Based - Step Up/Down Rapid / Crisis Response Reablement/Rehabilitation Services Other
Personalised Budgeting and Commissioning	Various person centred approaches to commissioning and budgeting.	Personal Health Budgets Integrated Personalised Commissioning Direct Payments Other

Personalised Care at Home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.	
Prevention / Early Intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.	Social Prescribing Risk Stratification Choice Policy Other
Residential Placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.	Supported Living Learning Disability Extra Care Care Home Nursing Home Other
Other	Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.	

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 High Impact Change Model (HICM) project was established to develop integrated health working between health and social care, to reduce DTOC rates and bring in line within the national average. This was incorporated into the Rotherham Integrated Health and Social Care Place Plan to ensure strategic commitment and cross organisation governance. The project reported into the Urgent and Community Transformation Group on a monthly basis and Rotherham Place Board which are held every 6 weeks. The project report is also submitted to monthly Foundation Trust's transformation group and is now regularly monitored through the Foundation Trust's performance team and is built into the Meditech system which is received weekly. 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	The Foundation Trust is implementing the Safer Patient Flow Bundle and Red2Green principles across all ward areas. Rotherham has participated in the next cohort of the SAFER/Red2Green collaborative run by NHS Improvement (NHSI). A dashboard is being developed to support this with key metrics included. These focus on pre-noon discharges, % of patients with an expected discharge date (EDD) and length of stay.

Chg 2	**Systems to monitor patient flow**	Mature	Mature	All length of stays over 21 days are reviewed through a weekly cross system Multi-Disciplinary Team, based on Emergency Care Intensive Support Team (ECIST) model. Follow up escalation meetings are also held on a weekly basis and are chaired by the Deputy Chief Operating Officer. Delayed Transfers of Care are monitored through the Hospital Trust's performance meeting.
Chg 3	**Multi-disciplinary/Multi-agency discharge teams**	Exemplary	Exemplary	Phase 1 is now completed which includes the establishment of an Integrated Discharge Team (IDT) which includes nurses, therapists and, social workers and the role of trusted assessor. End of project evaluation has been conducted by the CCG. Phase 2 is now underway. The intermediate care and reablement project will review how acute and community discharges are integrated into 3 integrated health and social care pathways where home is the default pathway. Where a community bed is unavoidable, IDT with in-reach from locality teams for people that are already known to the service will be responsible for timely discharges, thereby managing the whole of the end to end process for the first time.
Chg 4	**Home first / discharge to assess**	Mature	Mature	This is a Key Performance Indicator for the IDT which is based on the ethos of Why Not Home, Why Not Today? This is monitored by the Hospital Trust's performance team and a performance measure which is monitored by the Urgent and Community Transformation Group and Place Board. This will form part of the divisional quality performance management system and also contributes to the BCF metrics of % of older people discharged home from hospital who are still 91 days.
Chg 5	**Seven-day service**	Established	Mature	The IDT including therapy, nursing and social work staff who takes charge of discharge planning for those patients with complex needs who require co-ordinated care and support to return home. The team provide a 7 day service.
Chg 6	**Trusted assessors**	Mature	Mature	A trusted assessor model has now been embedded within the IDT, which will be further developed through the new Intermediare Care and Reablement project and will be monitored by the Urgent and Community Transformation Group.
Chg 7	**Focus on choice**	Established	Mature	A new Patient Choice policy has been drafted and will be circulated in October 2019. This procedure will be implemented once agreement has been reached by all key stakeholders.
Chg 8	**Enhancing health in care homes**	Mature	Mature	Achievements in Enhanced Health Care framework narrative is included in Tab 7 – HICM, Row 11.

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. The Health and Wellbeing Board (HWB) level plan is calculated nationally incorporating a percentage of the RCCG plan (97.9%) and a percentage (6.2%) of other SYB CCG's plans. This reflects patients who live in Rotherham but are registered with a GP practice in other localities such as Sheffield and vice versa. The HWB plan is 29582 admissions in 2019-20. 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. We are spending the winter pressures grant on increasing capacity of the Integrated Discharge Team to carry out assessments, increasing capacity to deliver Intermediate Care and reablement including additional OT capacity, provision of winter beds and additional resources to increase capacity of Age UK hospital discharge service and mental health liaison worker. A new tender for domiciliary care will ensure that joint assessments are carried out, using the trusted assessor model.	**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 Adult Social Care (ASC) Pathway, 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 (the 2018/19 actual figures reported were 113/132 = 85.6%). 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 unforeseen 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. The 86% target has been agreed as part of the Adult Social Care Key Performance Indicator suite for 2019/20, which has been approved locally and formally reported via the Council's ASC Directorate Leadership Team and joint agency Better Care Fund governance arrangements. Achievement of 86% (123/143) 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 ASC Pathway. 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, , 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.

Rotherham

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 in place towards meeting the requirement**	**Where the Planning requirement is not met, please note the anticipated timeframe for meeting it**
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 Planning Template agreed at BCF Operational Group on 2.9.19, BCF Executive Group on 3.9.19 and Health and Wellbeing Board on 18.9.19 which includes LA, CCG, VCS representatives and providers. Governance arrangements described under Tab 4 - Strategic Narrative - Item C. Rotherham's plan covers one HWB area.		
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	The Narrative plan for the Health and Wellbeing Board is descriibed under Tab 4 - Strategic Narrative, Items A, B(i) and C. This also describes how we contribute to reducing health inequalities and any key achievements and lessons learnt since Rotherham's BCF Plan 2017-19.		
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	The narrative plan sets out our strategic approach to using housing support, including DFG under Tab 4 - Strategic Narrative, Item B(ii). The DFG funding is also listed under Tab 5 Income - Row 9 and Tab 6 Expenditure - Row 37 and 38.		
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 Tab 6 - Expenditure Row 18 which shows that the total spend from the CCG minimum contribution on social care exceeds the minimimum required 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 Tab 6 - Expenditure Row 17 which shows that the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceeds the minimum ringfence requirements.		
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	The BCF plan shows there is a continued plan in place for implementing the High Impact Change Model within Tab 7 HICM, Changes 1 to 7, Row 15 to 22. Change 8 includes the work completed over last 12 months with the Enhanced Health Care in Care Homes framework.		
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	The planned schemes have been assigned to BCF metrics and there is confirmation tha the use of grant funding is in line with grant conditions. This is described under Tab 6 - Expenditure.		
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	The outputs are illustrated in Tab 6 - Expenditure, Columns H and I.		
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	Clear narrative on metrics including stretch targets are described in Tab 8 - Metrics.		

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%

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