HEALTH AND WELLBEING BOARD

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

Date: **Wednesday 27 September 2023**

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. Appointment of Councillor Foster
   The Board to consider the appointment of Councillor Foster as an observer to the Board

7. Communications

8. Minutes of the previous meeting (Pages 3 - 22)

For Discussion

9. Aim 2 Update by Board Sponsors
   Board sponsors to provide an update on Aim 2 of the Health and Wellbeing Strategy

10. Loneliness Action Plan (Pages 23 - 74)
    Ruth Fletcher-Brown, Public Health Specialist, to present an update on the loneliness action plan

11. NHSE funded pilot to support frequent attenders to ED with complex Alcohol and Mental Health needs (Pages 75 - 80)
    Amanda Marklew, TRFT, to report on the successful pilot supporting frequent attenders to ED with complex Alcohol and Mental Health needs with outreach team

12. Outcomes from the co-production work to deliver on the Carers Strategic Framework (Pages 81 - 88)
Katy Lewis, Carers Strategy Manager, RMBC, to present an update on progress against the Carers Strategic Framework

13. The Rotherham Place Digital Inclusion Strategy (Pages 89 - 115)
Helen Barker, RMBC, and Andrew Clayton, ICB, to share the recently finalised Digital Inclusion Strategy
(Appendix 1 is included in the "For Information" document pack

14. Rotherham Place Partnership Health and Care Plan 2023-25 (Pages 117 - 157)
Lydia George/Claire Smith to present the refreshed Place Plan

15. Launch of Safe Place to Sleep
Chris Edwards to provide a verbal update on the launch of the ICP Safe Place to Sleep Programme

16. Update on Health and Wellbeing Board Strategy Action Plan (Pages 159 - 205)
Ben Anderson, Director of Public Health, and Leonie Weiser, Policy Officer, to present

For Information

17. Items escalated from the Place Board
Sharon Kemp, Chief Executive RMBC, and Chris Edwards, Place Director NHS South Yorkshire Integrated Place Board, to present

18. Better Care Fund (Pages 207 - 247)
BCF Call-Off Partnership / Work Order 2023/24

19. ICB Joint Forward Plan
The documents relating to this item is included within the "For Information" document pack

20. Public Rotherham Place Board Minutes (Pages 249 - 259)

21. Rotherham Place Board - ICB Business (Pages 261 - 268)

22. Date and time of next meeting
Wednesday, 22nd November 2023, commencing at 9.00 a.m. venue to be confirmed

HEALTH AND WELLBEING BOARD
Wednesday 28 June 2023

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

Resolved: That the matters considered were under the categories suggestion 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.

There were no urgent item.

3. APOLOGIES FOR ABSENCE

Present:-

Councillor Roche	Cabinet Member, Adult Social Care and Health In the Chair
Ben Anderson	Director of Public Health
Chris Edwards	Executive Place Director, NHS South Yorkshire Integrated Care Board
Shafiq Hussain	Voluntary Action Rotherham
Scott Matthewman	Interim Assistant Director, Strategic Commissioning, Rotherham MBC (representing Ian Spicer)
Dr Jason Page	Medical Director, NHS South Yorkshire Integrated Care Board
Eldho Rajan	Healthwatch Manager
Clair Smith	Deputy Place Director (Rotherham Place)
Helen Sweaton	Assistant Director, Commissioning, Performance and Quality (representing Nicola Curley)
Andrew Turvey	Consultant in Public Health, Rotherham NHS Foundation Trust & Rotherham MBC (representing Michael Wright)
Sharon Wood	Chief Inspector, South Yorkshire Police (representing Laura Koscikiewicz)

Report Presenters:-

Kelsey Broomhead	Public Health Practitioner (Apprentice)
Ruth Fletcher-Brown	Public Health Specialist (Mental Health, Suicide Prevention and Loneliness)
Denise Littlewood	Health Protection Principal
Sam Longley	Public Health Specialist

Lorna Quinn	Public Health Intelligence Manager

Also Present:-

Leonie Wieser	Policy Officer
Caroline Webb	Senior Governance Advisor

Apologies for absence were received from Cllr Victoria Cusworth, Dr Richard Jenkins, Sharon Kemp, Neil Thorman and Paul Woodcock.

4. DECLARATIONS OF INTEREST

There were no declarations of interest.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no questions from members of the public or press.

6. COMMUNICATIONS

There were no items of communications.

7. MINUTES OF THE PREVIOUS MEETING

Resolved: That the minutes of the meeting held on 29 March 2023 be agreed as a true and correct record.

8. BREASTFEEDING-FRIENDLY BOROUGH

Consideration was given to paper presented by Sam Longley, Public Health Specialist in respect of Rotherham Breastfeeding Friendly Borough.

Rotherham Council formally adopted the Local Authority Declaration on Healthy Weight in January 2020. A key action within the declaration referred to creating supportive environments for all children, young people and parents by:

- promoting good relationships with food and physical activity from an early age, through childhood and into teenage years
- promoting healthy eating and activity during pregnancy
- creating supportive environments to help normalise breastfeeding

In pursuit of that ambition, in June 2022 a briefing paper was presented to the Health and Wellbeing Board proposing adoption of a Rotherham Metropolitan Borough Council Breastfeeding Friendly Borough Declaration. This was agreed in principle by the Board.

The declaration articulated the commitment of the Council, the Health and Wellbeing Board and key partner organisations to support ongoing

change to enable families to make the right choice for them, with appropriate support.

The briefing set out the progress made over the last year in respect of the following:

Breast feeding rates: whilst demonstrating an improvement from 34.2% in 2020/21 to 37.5%. The current breastfeeding prevalence at 6-8 weeks was significantly worse than the England average of 49.2%, although relative performance against its comparator group had improved.

Informed and supported choice: Rotherham was promoting a compassionate approach to health behaviour choice to ensure that infant feeding choices were well informed and supported without stigma or blame.

Breastfeeding and climate change: it was outlined that increases to breastfeeding rate also had the potential to reduce environmental costs that arise from infant formula production and administration.

Breastfeeding and the cost of living: it was estimated that bottle feeding cost on average between £50 and £100 per month, meaning that exclusive breastfeeding for the UNICEF recommended six months was likely to offer considerable financial savings.

Actions since June 2022

- Creation of the Rotherham Breastfeeding Borough Forum, with membership from a variety of stakeholders in Rotherham which includes VCS, 0-19 service, midwifery, RMBC HR, RMBC public health team and RMBC Children and Young Peoples Service.
- The refresh of the RMBC HR Infant Feeding Policy.
- RMBC premises had been identified to enable staff and/or public to be supported to breast feed.
- A plan had been developed for RMBC staff to receive training regarding Making Every Contact Count and Breastfeeding. This would be shared to all Health and Well-being Board partner organisations and wider business in Rotherham.
- Resources developed with TRFT infant feeding team to support wider Rotherham businesses to become Breastfeeding Friendly.
- Specialist Community Public Health team for 0-19 years (25 SEND) comprising of Health Visitors (HV), School Nurses (SN) delivering the Healthy Child Programme have been recommissioned.
- A “Rotherham backs breastfeeding” campaign had been designed by the Community Infant Feeding team. A launch event was planned for Summer 2023.
- Children’s Centres/ Family Hubs were to begin the process of UNICEF Baby Friendly Initiative accreditation.
- Additional funding received via the Family Hub specific for an Infant Feeding Co-ordinator to enhance the support offer to families for

Infant feeding.
- LA communication plan completed.
- Public Health was also pursuing this agenda at ICB level, as part of the Local Maternity Network and System (LMNS), which included recent work on breastfeeding and climate change and the cost of living.

Next steps included
- delivery of MEC infant feeding sessions,
- creation and distribution of a business pack created alongside the 'Rotherham Backs Breastfeeding' campaign to identify breastfeeding friendly business and venues in Rotherham,
- family hub development and
- enhanced offer of peer support volunteers, opportunities to promote the Rotherham Breastfeeding Friendly Borough will be sought at community events such as Rotherham Show and via the Start For Life Offer.

Resolved:

That the Health and Wellbeing Board:

1. Notes the 3.27% increase in Rotherham's 6-8 week Breastfeeding rate and the progress made during the last year to become a Breastfeeding Friendly Borough
2. Reaffirms its support for the ambition for Rotherham to become a breastfeeding friendly borough by signing the declaration on behalf of its member organisations.
3. Agrees a 12-month period for update.

9. HEALTH PROTECTION ANNUAL REPORT

The Chair invited Denise Littlewood, Health Protection Principal to introduce the report.

It was noted that the Health Protection Assurance Report was the first published since the pandemic. The accompanying presentation outlined the following issues:

Covid Response
- 2045 Outbreaks
- Things we did exceptionally well
    - Contact Tracing – Local 0
    - Workplace Support
- Living with Covid – supporting Care homes in particular and the most vulnerable – Infection Control Support
- Decommissioning Covid Stores

Screening
- All screening programmes suffered with Impact of Covid

- Action Plans and improvement plans in place for all services affected by COVID
- Most Screening programmes back on Target, although breast screening was still below pre-pandemic levels.

Immunisation

- All immunisation programmes affected by COVID vaccination programme.
- Primary Childhood Immunisations – working with a number of practices to increase uptake – MMR intervention planned.
- Linking Flu and Covid Vaccination programmes going forward to increase uptake.

Further Health Protection links

- Links between Emergency Planning and Env Health need to be strengthened to provide further assurance.
- Emergency Planning
    - Weather Health Alerts
    - Plans e.g. update Major Outbreak Plan
- Environmental Health
    - Air quality
    - Infectious Disease investigations

Upcoming Priorities

- Focus on new and emerging concerns – working alongside UKHSA to ensure competent surveillance systems.
- Effective incident and outbreak response – explore options to address Rotherham's deficit in Community IPC.
- Tuberculosis
- Air quality
- Adverse Weather
- Sexual Health
- Anti-Microbial Resistance

Ms Littlewood referred to the framework document highlighting priorities and risks.

The Director of Public Health added that there were concerns nationally that ‘anti-vax’ sentiments may influence take-up rates of measles vaccinations although there appeared to be a higher level of compliance locally. It was highlighted that clinicians may not be familiar with a measles outbreak so may be slower to identify trends.

It was noted that teams were utilising data to identify any emerging issues or trends within communities, applying the learning from covid tracking. It was outlined that there were existing networks and good partnership working. It was highlighted that NHS England has developed an inclusion strategy to work with communities.

Resolved: That the report be noted.

10. DPH ANNUAL REPORT

The Chair invited Ben Anderson, Director of Public Health to speak to the report.

Following on from the 2022 DPH Annual Report on the impact of Covid-19 in Rotherham, this year's Report considered the wider impacts of the pandemic and some of the longer-term changes in Rotherham from pre1pandemic through to March 2023. The report focused on the impact of the pandemic on people, health behaviours, community and neighbourhoods, the environment, and wider socio-economic factors. It looked at the immediate impact of the pandemic during the first wave, how Rotherham adapted to deal with the challenges presented, and the long-term effects on people and the essential services they used.

Rotherham is 35th most deprived of the 151 upper-tier local authorities in England. The pandemic highlighted how Rotherham's deprivation coupled with the unequal distribution of social determinants of health impacted resilience to Covid-19 and the outcomes for the population. These inequalities included exposure to risk factors, education, housing, employment, and led to associated inequalities in physical and mental health. The pandemic exposed these inequalities with people living in the poorest 10% of areas more likely to die from Covid-19, and left sections of society vulnerable to financial insecurity, employment loss, missing education, and unmet mental and physical health needs.

The report had been produced using both RMBC service data and community intelligence from Rotherham residents, or those who work in Rotherham. Data was analysed and contextual intelligence gathered through discussion. This information was coupled with significant public engagement.

The DPH gave a presentation, highlighting key issues for the Health and Wellbeing Board, including details of the recommendations:

Education:

- Attainment for KS2 indicated there may have been impact following periods of lockdown and home-schooling with a lower percentage of pupils performing as expected in Reading, Writing and Maths in 2022 compared to 2019.
- Many children, particularly in transition cohorts, were presenting with social and emotional needs, lack of self-regulation, speech and language issues and generally not being school-ready.
- Since before the pandemic, there had been an increase in year 7 & 10 pupils reporting their mental health as poor, and 35% of this cohort had reported some deterioration in their mental health in the past two years.
- Some focus group members found workload for children difficult, there were issues with the internet, and some parents, who couldn't

read or write themselves, were unable to support their children with home-schooling.

Education - Special Educational Needs and Disabilities (SEND) and Social, Emotional and Mental Health (SEMH)

- Following the pandemic there has been increases in pupils registered with SEND support needs, and applications for Education, Health and Care Plans (EHCP).
- More children, and more very young children, were being identified as having social, emotional, and mental health needs.
- Greater numbers of children were seen to have SEMH needs who did not present with these needs before the pandemic.
- Difficulties recruiting in the post pandemic labour market for support staff positions and within Special Schools meant there may be a lack of support available for pupils.

Primary care

- 151,000 fewer primary care appointments were booked between April 2020 and March 2021 compared to the previous 12 months; the fall in appointment number was most evident in April and May 2020.
- Despite the number of total appointments decreasing from 2019/20 to 2020/21, the increased number in 2021/22 and 2022/23 had increased by almost double the number that were lost with the decrease indicating a higher level of demand post-pandemic.
- The reasons for this were not fully understood but may include the impact of lost pro-active care, changes in lifestyle habits during and since the pandemic amongst other factors.
- Focus group reflections were overwhelmingly negative predominately around the ability to get a GP appointment, and many struggled, and continue to struggle, with this.

Secondary care

- At the start of the covid-19 outbreak, total A&E attendances sharply decreased reaching the lowest value in April 2020.
- Reductions in visits predate lockdown suggesting that the initial decrease in attendances were as a result of covid-19 awareness, and not lockdown itself.
- Although we might expect lockdown and subsequent social distancing measures to present reductions in infectious diseases and certain types of injuries, we expect that prevalence of other illnesses, such as long-term conditions, will remain constant. However, concern about infection risk in health and social care workers, may have driven demand for patients to seek care elsewhere.

Adult care

Number of adults in care

- There was a substantial decrease in the total number of people in Residential and Nursing care due to excess mortality at the start of

the pandemic.
- Overall number of contacts for adult care show no overall trend over the course of the pandemic and has remained between 1,500 to 2,200 per month.

Integrated discharge team
- Since the pandemic, there has been an increased number of requests for support from social care to facilitate safe hospital discharge.
- These included frailty and complex needs demonstrating the rising level of need at this stage in the patient pathway.

Transitions
- Transitions saw scaling back of service visits, and the closure of day services placing an additional strain on carers.
- Some service used limited contact due to infection risk so had little external contact and reduced socialising with others.

Local picture
- Social isolation and anxiety around catching Covid were reported as the main concerns from service users.
- Vaccination offered a level of reassurance, but people were still mindful of Covid and continue to take precautions which themselves may be having wider impacts on lifestyles, care access and quality of life.
- Focus group members reflected on negative feelings around providing care or receiving care during the pandemic.

Housing

Income and financial inclusion
- Tenancy support saw a rise in support calls following the withdrawal of the £20 uplift in UC with tenants finding paying rent more difficult.
- Longer term, the team have seen financial and emotional struggles among tenants who lost family members due to Covid-19; those who weren't main earners, those who found themselves under occupying a property having to pay penalties or downsize, and provision for those who needed support maximising their income.

Homelessness
- The service saw a rise in people presenting as homeless with increased vulnerability and multiple support needs e.g., substance abuse and mental health needs

Housing advice and assessment
- Demand for social housing continued to rise since the pandemic ended, although other factors such as cost of living rises were likely to be influencing this.
- Homelessness and temporary accommodation demand created additional demand in lettings, with more people placed into Band 1

(highest priority for social housing) and extended wait times for people in Band 2 and below

Income and employment

- There was a significant increase in claimant levels in 2020/2021 for Jobseeker's Allowance and those who claim Universal Credit (both in, and out of work).
- The claimant count has not yet returned to pre-pandemic levels in any area and the post pandemic cost of living crisis and change in economy has resulted in more people in work in poverty.
- There were significant differences throughout the pandemic between those who were out of work or unable to work due to restrictions in their sectors, and those whose employment continued. Some sectors saw rising demands creating opportunities while others were unable to operate or limited in their operation.
- Staffing issues impacted education and adult care particularly during the time of the pandemic.

Smoking, sexual health, and weight

- Self-reporting current smokers in Rotherham increased in 2021 to 16.9% of adults.
- Data indicates that smoking amongst females increased faster than for males in 2021, bringing smoking rates between sexes into parity.
- The move to digital services and the retention of staff during the pandemic allowed the sexual health service to continue to operate throughout the pandemic in Rotherham.
- Contraceptive services, specifically LARC, were hampered by a lack of in-person appointments and experienced a decrease in 2020.
- There was moderate reduction in the percentage of adults classified as overweight or obese in Rotherham in 2020/21.
- Year 6 (10-11 years) overweight and obesity prevalence has shown an upward trend for several years and was significantly higher than prevalence in reception.
- Post lockdown, there was an increase in self-referrals for weight management services in early 2022.

Substance misuse, alcohol and mental wellbeing

- There was no large influx of alcohol related presentations during 2020/21 as may have been anticipated and numbers dropped compared to 2019/20.
- Reduced number, and a smaller proportion, of patients referred by self, family, or friends in 2020/21 compared to previous years.
- Opiate treatment saw no major changes over the last two years and trends from pre-pandemic continued.
- Growing numbers in treatment as a result of exits not keeping pace with new presentations.
- Data for 2020/21 showed a shift towards more patients classified

as unemployed or economically inactive presenting for alcohol treatment, which may be explained by changes to the labour market during the pandemic.
- People have struggled with loneliness, anxiety and other issues with mental health worsening during the pandemic
- Lasting impacts were still experienced by some people who were afraid to go out of the house and were living with persistent anxiety.

Language, communication, and digital
- Most groups reflected that the guidance and rules were unclear to confirm if they were being adhered to.
- Amendments were suggested to make the messaging easier to understand in the future.
- Although there have been benefits to a shift to a digital first approach, barriers still existed for some members of the community that required consideration moving forward.

The report outlined a series of recommendation; in summary:

1. That the population health management operational group work to develop further understanding of health and social care demand and service access underpinned by data sharing agreements and mechanisms for reporting.
2. Areas of concern and post pandemic trends should continue to be monitored.
3. For future major incidents, that the importance of good communications nationally, regionally, and locally should be recognised by partners.
4. Recruitment and career pathways within these key sectors that were attractive within the post pandemic economy should be developed by partners.
5. That people should be supported to regain the confidence to interact normally and achieve full integration with society.
6. That consideration was given to how digital first approaches were rolled out and those excluded by this were considered and able to maintain access.
7. That work to recover services to pre-pandemic positions be monitored and the impact on health inequalities and inequalities considered.
8. That actions to mitigate poverty locally through the provision of poverty friendly services should be considered.

It was outlined that the recommendations had been positively received and progress was being made.

The Chair invited comments from the Board and the following issues were raised:
- It was difficult to ascertain if tolerance levels of anti-social behaviour had changed since the pandemic.
- Primary care had been transformed; however public perception of

access to primary care had worsened.
- There had an increase in numbers experiencing poor mental health.
- Whilst Rotherham was meeting local targets for operations, there was a backlog sub-regionally and nationally.
- There was an increase in length of stay in hospitals.
- Speech and language therapy were experiencing additional demands which were challenging to meet.

The Chair invited the Board to submit additional comments to the DPH for consideration.

Resolved: That the recommendations (as set out on page 40 of the DPH Report) be agreed.

11. JOINT STRATEGIC NEEDS ASSESSMENT

The Chair invited Lorna Quinn, Public Health Intelligence Manager to give a presentation of the Joint Strategic Needs Assessment summary of key findings (May 2023).

The JSNA summary provides key headlines structured into the key domains:
- People
- Health behaviours
- Community and neighbourhoods
- Environment
- Socioeconomic

New data in the 2023 refresh included:
- A refresh of IMD data and supporting narrative
- 2021 Census dashboard with supporting narrative
- Addition of a deprivation dashboard displaying data on the 20% most deprived communities
- Life course view (C&YP and the lifestyle survey, working-aged adults, older adults, and end of life care)
- Public health additions include 1,001 days, child mortality, NCMP, Physical activity, food, and loneliness (list not exhaustive).

Key findings were drawn from the report to illustrate issues relating to health behaviours; life expectancy; community and neighbourhoods; environment and socio-economic factors.

The Chair invited comments from the Board and the following issues were raised:

- Partners would be consulted to ascertain if the JSNA could be better utilised.
- The publication of the JSNA was a statutory requirement.
- It was outlined that dental extraction for children remained broadly

at the same level; however more children were requiring mass extraction. It was estimated that approximately 10% of attendances at Accident and Emergency were for dental care.

- Numbers of looked after children accessing dental assessment was improving.
- The feasibility of options to fluoridate water supplies were being explored in South Yorkshire.
- The Integrated Care Board would have greater influence on dental care locally.
- Number of children with Education, Health and Care plans and access to timely assessment.

The Chair referred the presentation to the Health Select Commission for information.

Resolved: That the presentation be noted.

12. SUICIDE PREVENTION

The Chair invited Ruth Fletcher-Brown, Public Health Specialist to give a presentation and update on suicide prevention.

It was outlined that responsibility for suicide prevention action plans sits with local government (in England) but this cannot be achieved without working with partners.

At Place RMBC work with:

- People with living experience
- South Yorkshire Police
- NHS SY ICB (Rotherham)
- Rotherham NHS Foundation Trust
- RDASH
- Rotherham Samaritans & other Voluntary and Community Sector organisations
- Rotherham United Community Trust

South Yorkshire ICB

- People with living experience
- Public Health Leads for all 4 Local Authorities
- NHS SY ICB
- Acute Trusts
- Mental Health Trusts
- SYP & British Transport Police
- Yorkshire Ambulance Service
- Office of Health Improvement and Disparities (OHID)
- Primary Care

Further details were given in the slides of the rates of suicide (standardised per 100,000) from 2001-03 to 2019-21 for Rotherham

compared with England; disaggregated on the basis of male:female; and comparators against CIPFA nearest neighbours.

What's working well- Rotherham

- New Be the One film launched September 2022
- Continued promotion of Place Guidance document for staff and volunteers on responding to people at risk of suicide
- 309 frontline staff and volunteers have attended suicide prevention, self harm and mental health awareness training in 22/23
- Suicide Awareness session delivered for primary care in March 2023
- Suicide Awareness session in Safeguarding Awareness week, November 2022
- Distribution of 'Walk with Us' resource to all schools (124) , colleges, early years, cyp services, voluntary and community organisations (70) and all childcare providers
- Early Help delivery of self harm awareness sessions for parents and carers
- Early Intervention and prevention work- as evidenced in the Prevention Concordat application
- Joint working with domestic abuse colleagues
- Peer to peer support groups (Survivors of Bereavement by Suicide, Andy's Man Club and ASK)
- ICB Rotherham commissioning Qwell, the online mental health platform for adults

What's working well- South Yorkshire

- Strong partnership working- all 4 LAs, SYP, NHS and Voluntary and Community Sector
- Second memorial event for families bereaved by suicide in December 2022
- Survivors of Bereavement by Suicide groups (SOBS) in all 4 LA areas
- Real Time Surveillance including work with Yorkshire Ambulance Service
- Reducing access to means
- Joint working on themes and addressing the needs of vulnerable and at risk groups.
- Launch of 'Walk with Us' toolkit. Winner in the LGC Award Public/Public Partnership category.

What are we worried about

- Increasing pressure on individuals and families
- Support for people who had attempted suicide
- Yorkshire Ambulance Data for SY data shows that the anxiety was the highest presenting final working impression
- Rotherham's response to the NICE guidance in relation to self harm
- Capacity for comms and engagement activity

- Support for peer-to-peer support groups going forwards
- Changes to the SY Real Time Surveillance System meant that the onus is on staff from across the partnership to promote Amparo
- Launch of the Attempted Suicide Prevention service

What needs to happen next and when

- Partners to review the Traumatic Bereavement Pathway for children and young people- May 2023
- Further specific actions to address needs of vulnerable and at risk groups- specifically transitions
- Launch of the Attempted Suicide Prevention service- Autumn 2023
- There have been 412 referrals to the ZSA training through the Be the One website to date. Further promotion of Zero Suicide Alliance Training- ongoing
- Targeted work on themes and vulnerable groups identified through real time data- ongoing
- Promotion of mental health support to children, young people and adults in Rotherham- ongoing
- Targeted Comms campaigns as part of Be the One- summer 2023
- Review action plan in light of the anticipated national strategy- Summer/Autumn 2023

The Chair offered his congratulations on behalf of the Board for the recent LGC Award in the Public/Public Partnership category for its 'Walk with Us' toolkit.

Resolved: That the update be received.

13. PREVENTION CONCORDAT ON BETTER MENTAL HEALTH

The Chair invited Ruth Fletcher-Brown, Public Health Specialist and Kelsey Broomhead, Public Health Practitioner to present the briefing.

The briefing sought approval of the draft application form and a commitment to an annual prevention and promotion action plan, with the health and well-being Board receiving an annual update on progress.

The Concordat was launched by Public Health England in 2017 (now Office of Health Improvement and Disparities, OHID) and refreshed in December 2020. It is supported by a number of public bodies including the Association of Directors of Public Health, the Local Government Association and the Centre for Mental Health. The Prevention Concordat drew on the evidence base including of cost effectiveness for public mental health interventions.

The Prevention Concordat focused on the wider determinants of health. It was a whole population approach, supporting joint cross-sectoral action locally. It encouraged collaborative working to address local needs and identify local assets to prevent mental ill health.

The Prevention Concordat welcomed Health and Wellbeing Boards and Integrated Care Systems, as anchor institutions to become signatories. Becoming a signatory was also a condition of the Better Mental Health Find expression form.

The draft application form was completed with support from the Better Mental Health for All Group, which represents partners of the Health and Wellbeing Board. This group met to consider each of the domain areas and provide evidence of activity across the partnership. The domains were as followed:

- Understanding local needs and assets
- Working together
- Taking action on the prevention/promotion of mental health
- Taking action to reduce mental health inequalities
- Defining success/measuring outcomes
- Leadership and Direction

The application form once approved by the Health and Wellbeing Board would be assessed by a national panel who will give feedback. If successful, the Board will receive signatory certificate and social media promotion. Ongoing support would be provided by a specialist regional team and there would be a follow-up after 12 months.

An action plan had been developed to outline proposed work and timeline for completion.

Resolved: That the following recommendations be approved.

That:

1. The Health and Well-Being Board approves the draft application form.
2. The Chair and DPH attend Regional Panel meetings.
3. The Health and Well-Being Board commits to an annual prevention and promotion action plan.
4. The Health and Well-Being Board receives annual update.

14. HEALTH AND WELLBEING BOARD ANNUAL REPORT

The Chair introduced the Health and Well-Being Board's Annual Report 2022/23. He began by thanking all the partners for their commitment to delivering Rotherham's health and well-being strategy and working together to improve outcomes for local people.

The four aims of the Health and Wellbeing Strategy were:

- All children get the best start in life and go on to achieve their potential
- All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life

- All Rotherham people live well for longer
- All Rotherham people live in healthy, safe and resilient communities

While these aims remained the same since inception of the strategy in 2018, the strategic priorities underpinning each aim were refreshed in summer 2021. The strategy was updated to reflect these priorities in 2022 and the Health and Wellbeing Board agreed the revised strategy in September 2022.

The report detailed key achievements against each of these aims.

It was noted that he Health and Wellbeing Board was a statutory sub-committee of the Council and an integral part of Rotherham's wider strategic partnership structures that sat under the Rotherham Together Partnership. Following the changes to Integrated Care Systems in July 2022, Rotherham became one of the four constitutive Places in the South Yorkshire Integrated Care System, with some Health and Wellbeing Board members providing representation at the South Yorkshire Integrated Care Partnership. The Rotherham Place Board continued to report into the Health and Wellbeing Board and took strategic direction from the Health and Wellbeing Strategy.

The timeline outlining these changes were as follows.

- July 2022 -Rotherham Clinical Commissioning Group became South Yorkshire Integrated Care Board
- September 2022 the Board approved refreshed health and well-being strategy and action plan. Board agreed nominations for the South Yorkshire Integrated Care Partnership
- March 2023 -South Yorkshire Integrated Care Strategy was agreed and launched. The memorandum of understanding formalising the role of Board sponsors was signed off.

The Chair gave details of the Health Inequalities Event held in February 2023. Supported by the Local Government Association, the South Yorkshire event explored opportunities for collaboration through the newly established South Yorkshire Integrated Care Board to discuss inequalities across a range of health outcomes. Key partners, were brought together to:

- Explore how partners can work together at place level to deliver on tackling health inequalities
- Identify opportunities to work on a South Yorkshire footprint around this agenda
- Hear examples of current work happening across the patch and feed into ICP and ICB strategy on health inequalities

The workshops informed development of the NHS Joint Forward Plan and locally, learning from the event is taken forward through Rotherham's Prevention and Health Inequalities Group

Details were given of the Board's annual feedback survey; the following points were highlighted:

- Good response rate (8/15 members and 4/8 organisations)
- Average rating of 8.38/10 for overall working of the board over the past year (responses ranging from 6-10)
- Positive feedback on partnership working and commitment, range of agenda items
- Continuing with the progress and development of the Board:
  - Developing ambition in plans, developing new initiatives and approaches
  - Wider determinants work: breadth of items could be developed (importance of housing, more items from outside of core health and care partners)
- Importance of board sponsors having oversight of their strands
- Points raised will be addressed in board sponsor meetings and through board development meeting in November.

It was outlined that reducing health inequalities and prevention and early intervention would continue to be key to the Health and Wellbeing Board over the next year.

The Board would also oversee delivery through partnerships and partners, monitored through the Health and Wellbeing Strategy action plan. Other priorities included:

- Signing the OHID Prevention Concordat for Better Mental Health.
- Developiong relationships within the new South Yorkshire Integrated Care System.
- Alignment of aims with the South Yorkshire Integrated Care Strategy.
- Reducing health inequalities between our most and least deprived communities was continued.
- Addressing the wider determinants of health to embed health equity in all policies.

The Chair thanked Leonie Weiser, Policy Officer, for her work in compiling the report.

Resolved: That the Annual Report 2022/23 be approved.

15. HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

Leonie Weiser, Policy Officer, presented the Board's terms of reference for its annual report.

The report detailed:

- The role of the Health and Well-Being Board
- Responsibilities

- Expectations of the Health and Well-Being Board Member
- Membership
- Governance
- Quorum
- Meeting arrangements
- Engaging with the public and providers

It was noted that subject to sign off at this committee, the next formal review was due in May 2024.

Further details were provided of the governance arrangements and the Memorandum of Understanding between the Rotherham Health and Well-Being Board and Board Sponsors for Health and well-Being Strategy Aims.

The MoU detailed the role of sponsors as follows:

- To have strategic oversight and ownership of their respective aim, this includes:
    - Monitoring progress against aims and removing blockages
    - Providing strategic steer and identifying opportunities to develop their aim, including action to reduce health inequalities and actions that support integration of delivery
- To be champions for their aim within the Board and Board activities
- To be champions for health and wellbeing priorities in their organisations

It was noted that since its last iteration, a paragraph had been added outlining the responsibilities of the Board in relation to the Better Care Fund (BCF). A Better Care Fund Executive group existed as a sub-group of the Health and Well Being Board and reports into this group.

Resolved:

1) That the revised Terms of Reference be approved.
2) That a formal review takes place in May 2024.

16. UPDATE ON HEALTH AND WELLBEING STRATEGY ACTION PLAN

The Chair invited Leonie Weiser, Policy Officer, to present the update on the Health and Well-Being Board Strategy Action Plan (June 2023).

The plan outlined progress against agreed priorities, highlighting where actions were completed, on track, at risk of not meeting milestones or off track. It was noted that the majority of priorities were completed or on track and mitigations were in place for those at risk of not meeting their milestones.

Details were also provided of new priorities added to the plan. Further updates would be provided to future meetings.

Resolved: That the update be approved.

17. ITEMS ESCALATED FROM THE PLACE BOARD

Chris Edwards, Place Director NHS, South Yorkshire Integrated Care Board gave an update. It was noted that the Place Board – Place Strategy would be presented to the next meeting of the Health and Well-Being Board.

Resolved: That the update be noted.

(a) NON SURGICAL ONCOLOGY (BREAST) - VERBAL REPORT

Chris Edwards, Place Director NHS, South Yorkshire Integrated Care Board gave a verbal report on non-surgical breast oncology. A temporary service model was in place for breast oncology services. Sheffield Teaching Hospital Foundation Trust continued to work to provide an insourcing solution to provide additional capacity. In addition, existing staff were undertaking additional clinics. This meant all priority 1 and 2 patients were currently being seen with 2 weeks.

Longer term, the Out-Patient model was still developing model with extensive staff and public/patient engagement to explore options.

18. BETTER CARE FUND - BCF PLAN 23-25

The Chair introduced the briefing to give the Board an overview of the Better Care Fund Plan for 2023/24.

The BCF Planning Template and Narrative Plan including capacity and demand for intermediate care services was in line with the Better Care Fund Policy Framework 2023-25 and the Better Care Fund Planning Requirements 2023-25.

The Better Care Fund (BCF) Policy Framework outlined the Government's priorities for 2023-25, including improving discharge, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care, unpaid carers and housing adaptations. The BCF planning template (Appendix 1) detailed that the planning requirements which are set out in the BCF Policy Framework 2023-25 were fully met.

The Better Care Fund (BCF) for 2023/24 was £50.681m, an increase of £1.425m from 2022/23. This increase was due to a combination of underspends in 2022/23 on the Improved BCF and Disabled Facilities Grants (DFG) carried forward, plus additional investment and the removal of non-recurrent funds from the previous year. Spending Plans were allocated to the 6 themes plus Improved Better Care Fund and Discharge grant funding. The plans were managed within 2 separate pooled funds,

both the South Yorkshire ICB (Rotherham Place) and RMBC managing one pool fund each.

Priorities for 2023-25 were as follows:

- Workstream 1: Sustaining People at Home, Prevention and Avoidance
- Workstream 2: Integrating a Sustainable Discharge to Assess Model (Priority 4)
- Workstream 3: Digital Whole System Flow

The report highlighted the major changes since the last BCF plan was issued. It also detailed the relevant timelines for the approval process, with the final planning submission to NHS England scheduled for 28 June 2023 and all Section 75 Agreements to be signed and in place by 31 October 2023.

Resolved: That the documentation for submission to NHS England (NHSE) on 28 June 2023 be approved.

19. BETTER CARE FUND - 2022-23 YEAR END TEMPLATE

Resolved: That the report be noted.

20. PLACE PLAN PRIORITIES CLOSE DOWN REPORT

Resolved: That the report be noted.

21. BEST START AND BEYOND QUARTERLY REPORT

Resolved: That the report be noted.

22. ROTHERHAM PLACE BOARD

Resolved: That the minutes of the Rotherham Place Board Partnership Business Meeting be noted.

23. ROTHERHAM PLACE BOARD ICB BUSINESS

Resolved: That the minutes of the Rotherham Place Board: ICB Business be noted.

24. DATE AND TIME OF NEXT MEETING

Resolved: The next meeting of the Health and Well-Being Board will be held on Wednesday 27 September 2023 commencing at 9.00am at Rotherham Town Hall.

Rotherham Loneliness Action Plan 2023 – 2025

Working together to ensure people of all ages in Rotherham feel more connected to others and loneliness is reduced.

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. In 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'. [1]

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 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 how we now live, work, and interact. 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. Feeling connected to others 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.

Rotherham Loneliness Action Plan 2023-2025

"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[1]:

[1] Events that trigger loneliness across the lifecourse - What Works Wellbeing

Other factors which operate at community and societal levels contribute to loneliness, these include transport, neighbourhood safety, access to services, financial hardship, insular communities, stigma and discrimination, digital technology, and work-life balance. 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.[2] The Marmalade Trust (Insert ref, https://www.marmaladetrust.org/loneliness-guide) states that it is the language around loneliness needs to change, 'admitting' to and 'suffering' from, could unintentionally add to the belief that something is wrong with the person. There is a case to make that conversation about it should be normalised.

Loneliness was brought into sharper focus during the first couple of years of the pandemic, particularly during the months of the severe restrictions. *'National levels of loneliness increased during the coronavirus pandemic. Those that were at greater risk of loneliness before the pandemic were more affected by loneliness during it.*' (Mental Health Foundation, 2022, 'All the lonely people', https://www.mentalhealth.org.uk/sites/default/files/2022-06/MHAW22-Loneliness-UK-Report.pdf).

Jones, Jopling and Kharicha (2021) (Loneliness beyond Covid-19: Learning the lessons of the pandemic for a less lonely future https://www.campaigntoendloneliness.org/wp-content/uploads/Loneliness-beyond-Covid-19-July-2021.pdf), call for more than just the ongoing direct support for loneliness. Alongside this there needs to be a building up of infrastructure to facilitate connection, with investment into strengthening community capacity, green spaces, high streets, and meeting places, as well as transport and digital connectivity, to ensure a connected recovery. (*Chronically lonely refers to people feeling lonely more often or always).

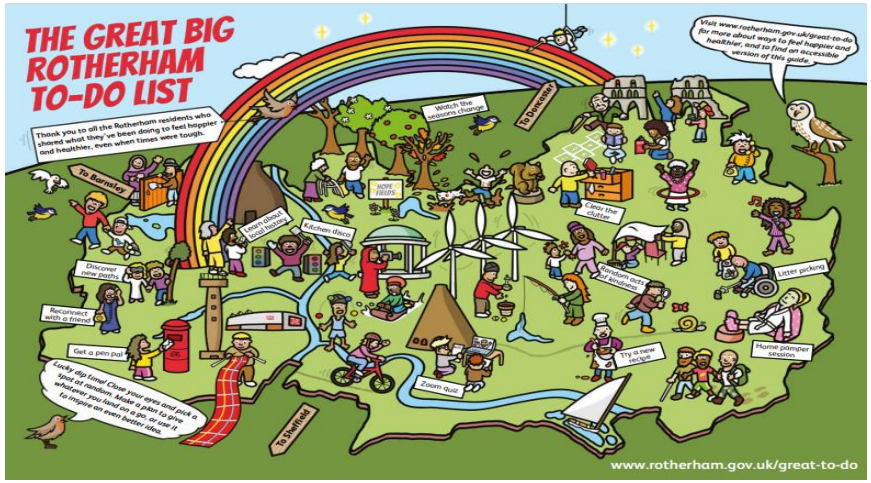
It is because loneliness presents as an issue wider than the individual, that a whole system response is required in Rotherham. In Rotherham actions to address loneliness are referenced in the Health and Wellbeing Board Strategy (Aim 4) and the refreshed Place Plan. This important public health issue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

This action plan will ensure that links are made to other supporting strategies and action plans, for example, Thriving Neighbourhoods, Rotherham Carers Strategy and the Rotherham Suicide Prevention and Self-Harm action plan.

Progress on the 2020-2022 Loneliness Action Plan

The first Rotherham Loneliness Action plan was signed off by the Health and Wellbeing Board ready for a launch date in March 2020, when the national restrictions commenced due to the pandemic. The start of the pandemic saw an increase in activity to address loneliness and isolation. These are just a few actions which took place, with many more happening at a community, neighbourhood, and household level:

- The introduction of the Rotherham Community Hub which saw local people volunteer to become Rotherham Heroes to collect prescriptions, shop for food and provide telephone befriending support. Telephone befrienders signposted to Rotherfed & befriending services network.
- Communications across the Partnership highlighted actions to address loneliness and included; promotion of Five Ways to Wellbeing messages (https://www.rotherham.gov.uk/homepage/91/five-ways-to-wellbeing), a film to encourage people to take action themselves to help people who might be lonely, The Great Big Rotherham To Do List (https://www.rotherham.gov.uk/great-to-do)



- The Befriending Network formed during the pandemic and had a real impact, not least of all the delivery of the Better Mental Health for All Befriending Project through a group of VCS partners from the Network.
- Delivery of the Better Mental Health Befriending Project which was funded from the Department of Health and Social Care (DHSC) Mental Health Fund in response to the impact of the COVID 19 pandemic on mental health. This project was managed by Rotherham Federation and delivery for the befriending part of the project was from 5 voluntary sector organisations and commenced September/October 2021 finishing in May 2022. These organisations worked with adults, older people, carers, people living in deprived areas of the borough, people living with disabilities and long-term conditions and those from different minority ethnic groups. The sixth VCS organisation, Voluntary Action Rotherham (VAR), worked with Theory Media Productions to produce some short films all about being a 'good neighbour'. This project supported:
    - 835 residents who were lonely and isolated were supported through the Befriending project.
    - 34% of beneficiaries for the Befriending project were from BAME communities.525 residents who accessed the Befriending project.
    - (63%) live in the most deprived 30% LSOAs in England.
      28% of beneficiaries of the Befriending project were living with a disability.

  The Befriending project used the full 14 questions of the Warwick-Edinburgh Mental Wellbeing Scale (https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/about/wemwbsvsswemwbs/). Volunteers collated this information from the individual's pre and post support. The mean score at first assessment was 40.22, at second assessment 49.38. This increased by 9.22 and is classed as "significant" change.
  This project collected case stories of people's journeys. The full stories can be found here: https://www.rotherhamfederation.org/better mental-health-fund/.To view the films please visit: https://www.varotherham.org.uk/befriending.

Refresh of the Rotherham Loneliness Action Plan

This refresh has been informed by a call for evidence from stakeholders and a dedicated meeting of the Better Mental Health for All group. Partners were asked:

What's working well?
What are We Worried About?

What Needs to Happen Next?

These are some of the responses from the stakeholder engagement:

What's working well?

- **Speakup** has lots of experience developing friendship circles. Prior to the pandemic in 2016, Speakup were successful with a People Health Trust grant and used this money to combat loneliness by creating 25 circles varying in size from 2-3 people up to groups of 8-10. This ran for over 18 months supporting, encouraging, and facilitating friendships to grow and flourish. Throughout the pandemic, many of these friendships survived and during this time worked with universities looking at the effects of Covid-19 and how this impacted on social isolation and loneliness. Presently, there are over 14 active circles which are working well without the support of inclusion workers, but with the support of peer support workers who are people with learning disabilities or autistic people.
- Being able to go to different meeting places, such as Socialise, Speakup and RANSS and other Social Enterprises that give people activities to do and allow people to meet new people with similar interests and connect /reconnect with new and old friends.
- The creation of activities such as walking bubbles, the Speakup quiz, yoga, pamper and 'Girls Can' these activities also help people to keep fit and healthy.
- More organised social events involving our peer support workers or inclusion workers to places like the theatre, music festivals, meals out, the Euros and various birthday meals. A holiday to America is now being planned. Speakup for autism regularly meeting at weekends for a meal or drink.
- Advice on hand from peer supporters and people with lived experience. This helps people to keep safe when out and about and can help people to live a more independent and social life.
- **Rotherham VCS Befriending Network**- The Befriending Network that formed during Covid has had a real impact, not least of all the delivery of the BMHF Befriending Project through a group of VCS partners from the Network. Getting together, sharing best practice, and ultimately reaching as many local people as possible has been a key success of the network.
- South Yorkshire ICB) commissioned Rotherham parent carers forum to develop RANNS: RANSS is a support service for neurodiverse adults (18+) with a Rotherham GP. They offer person-centred **post-diagnostic** support from Peer Support Workers with lived experience of autism or ADHD alongside group workshops. We also facilitate meetups, activities, and focused group discussions on neurodiversity-related topics for adults with a new or historic diagnosis of autism or ADHD*. Adults with a new autism or ADHD diagnosis can access a limited number of peer support sessions, counselling sessions and a 4-week group workshop to help them explore their diagnosis, and what it means for them as an individual.

- Partnership working – Rotherham prides itself on this across the voluntary sector.
- Multi-agency working – established during COVID, identified gaps/issues/resources.
- Rother Rise – café groups available.
- Rotherham Gismo – a way to find out about groups in the local community (inputting postcode).

What are We Worried About?

- **Speakup-** Even with our friendship circles some people remain isolated (some through choice, but not many) and this has had an impact on people's lives. Some people are still afraid to go out into social situations such as the pub, cinema etc. Another fear is the cost-of-living crisis and the rise of energy prices as this is already beginning to prevent people from socialising with friends and family as they may have to choose between loneliness and friendship.
- Sometimes bullying and harassment of people with learning disabilities and autistic people: members of Speakup and other groups have faced this in the past and continue to face this.
- This can lead to people being too scared to go out due to being too afraid of what people will do or say to them, which once again can cause isolation and loneliness. People need to know more widely about how to report Hate Crime.
- People not having the right support when bad things happen in their life, such as grief, abandonment, and neglect.
- **Rotherham VCS Befriending Network-** Funding will always be a concern. We and other providers have been able to access grants for befriending support for the last couple of years, that are now either no longer available or they have a short term deliver period left. Some of this work, makes such a difference and really demonstrates that early intervention and prevention impact. Focus has turned towards the cost-of-living crisis.
- Research suggests that autistic people are more likely to experience feelings of loneliness compared to non-autistic people. This can be due to a lack of acceptance and understanding by society, making them feel excluded.
- Specific barriers to social opportunities include unwelcoming sensory environments (such as noisy pubs or restaurants), social anxiety, fear of rejection, experiences of bullying and lack of formal support (in education or as an adult).
- Many autistic people enjoy spending time alone and consider it important for their wellbeing. Loneliness is different though. Autistic people might feel lonely if they don't have opportunities to socialise or find this difficult. Autistic people might have friends/colleagues but feel misunderstood or feel they cannot be themselves around them. Many autistic people describe feeling lonely even when they are in company.
- Rotherham supports the preparation for adult outcomes that children have meaningful friendships and for this to happen requires all partners to ensure that they are open and welcoming.

- Investment – a lot of the projects run on time limited grants, which is not sustainable.
- Capacity – Staff and volunteer recruitment.

What Needs to Happen Next?

- Further consultation with the voluntary and community sector about needs to happen.
- Concerns about capacity and recruitment of volunteers.
- **Speakup**- many of the people we know can have complex issues and anxiety, which needs the support of an inclusion worker or paid peer support worker to enable people to feel comfortable, develop and maintain friendships and thrive.
- Accessible Information about support services should be available in lots of different places and media platforms and regularly updated.
- When someone moves into a new area it would be good to be told about available support within their community.
- Funding for loneliness and isolation support is an ongoing issue. Could there be a way of mainstreaming some of the key services that have delivered so well during the last couple of years, to prevent the "come and go" local projects that we had seen previously?
- **Befriending Network**- The peer support model really works and demonstrates good value for money, targeting early help and support. This can be achieved by the recruitment and training of volunteer befrienders, who provide peer support and give confidence to our beneficiaries, being there to support them every step of the way. It's the peer support given by our volunteers that can really make a difference in successful engagement.
- Being able to get additional support to people once friendships through peer support have been made, has had a significant impact on people's lives. The access to other support services with the befriending work as a catalyst, such as advice and guidance relating to debt, home energy, employment support, training etc. are all examples of how we have supported the progression and development of our beneficiaries, all stemming from an initial welfare call.
- It would be good to maintain the Befriending Network but perhaps some consultation with partners/providers who attend on how this can be taken forward for everyone's benefit? Perhaps we proactively introduce some other elements into the meetings, such as cost of living updates and other health related services/updates?
- Would the production of a monthly or bi-monthly e-newsletter help, to raise awareness of the support that is out there and how people can get involved? Could include a beneficiary case study in each edition that helps to demonstrate the impact of how becoming more involved in community life can be of real benefit.
- For social groups/youth groups to be more accessible – consider sensory differences and communication
- Invite autistic friends and family to social events, but without any pressure on them to attend.

- Allow autistic people to socialise on their own terms.
- Societal change, including acceptance of autistic people's differences, and welcoming sensory environments, is needed to reduce social exclusion of autistic people.
- Promote the following resources: How To Deal With Loneliness And Autism (coping strategies and advice for dealing with loneliness) - YouTube
- Vulnerable groups identified clearly – Domestic abuse victims, Migrants, Ukraine refugees.
- Community meet spaces – to get projects initially off the ground.
- Kindness – Inclusive training to move away from a professional 'us' and 'them' approach
- Employer/Employee wellbeing – loneliness is an issue that has crept up especially from COVID – can be lonely in a big group such as a workforce
- 'Not just one thing' – needs to be a continued and consistent approach/support
- Library service – be aware of what the service can provide and facilitate/signposting, there are 15 library area/services. They are offering as a warm space over the winter months – could this be tied into the loneliness actions?
- Loneliness after life changes – particularly bereavement.
- Promoting of Safe Spaces – culturally competent, off up to 13 spaces a night, running 6pm -12am, Leeds have a good response so potential to share good practice?
- Frontline case studies within the voluntary sector to gain feedback around what they personally feel went well and what areas need improvement.
- Autism friendship groups – a real need and a great interest with regards to research.

Governance

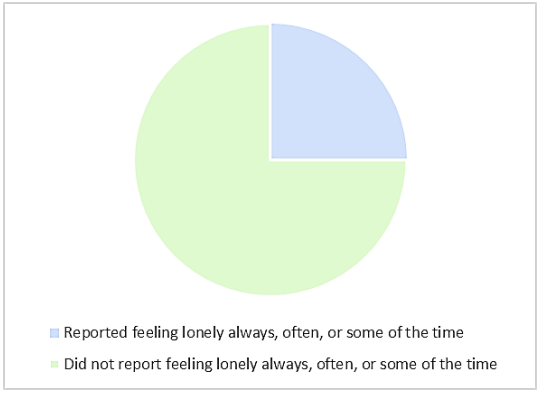
The implementation of the Rotherham Loneliness Action Plan 2023 – 2025, will be overseen by the Better Mental Health for All Group. These meetings are chaired by Public Health and have representation from HWB partners. The multi-agency group meets bimonthly and is tasked to implement this plan and the Better Mental Health for All Action Plan. 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.

The Partners represented on the Better Mental Health for All Group include:

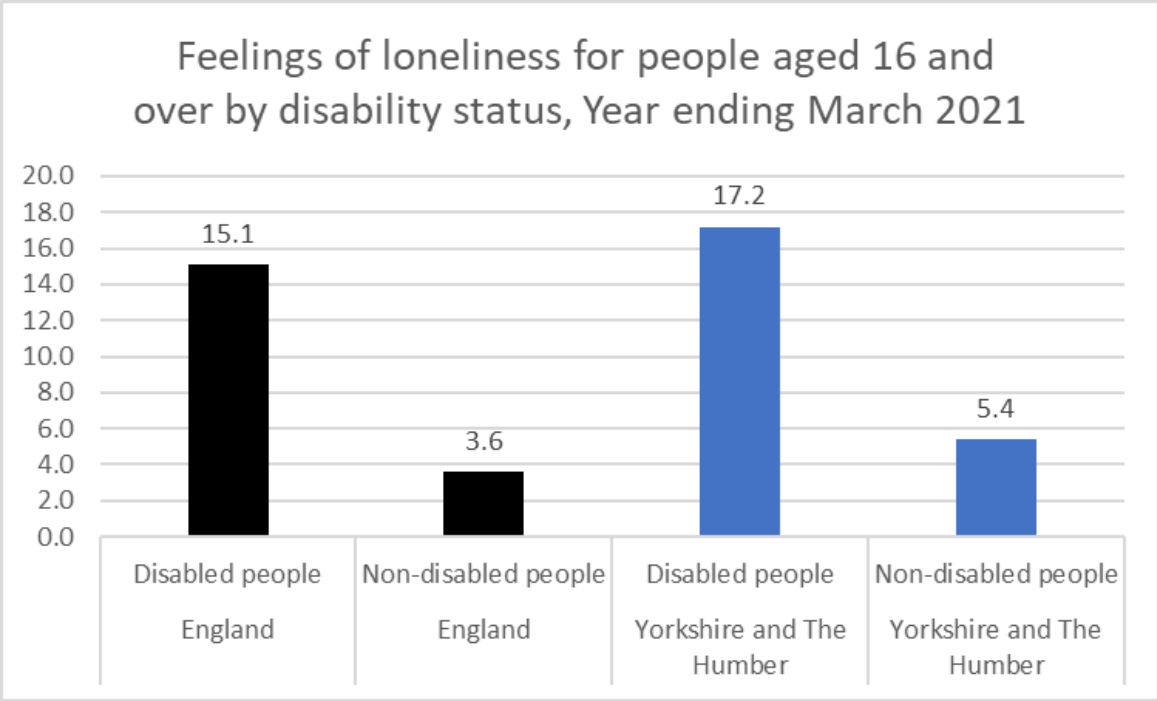
- Children, Young People and Families Consortium
- Crossroads
- Healthwatch Rotherham
- NHS South Yorkshire
- RDaSH (mental health provider)
- Rotherham NHS Foundation Hospital Trust
- RMBC- Adult Care, Housing and Public Health (including Neighbourhoods)
- RMBC Children and Young People's Services
- RMBC Communications
- RMBC Culture, Sport and Tourism Service, Regeneration and Environment
- Rotherham Federation
- Rotherham United Community Sports Trust (RUCST)
- South Yorkshire Police

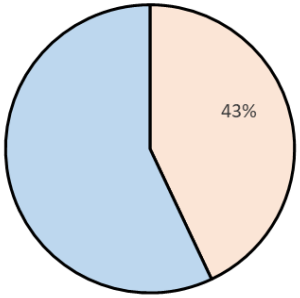
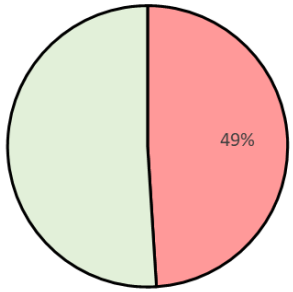
National Picture

- The Office for National Statistics (ONS) public opinions and social trends, Great Britain bulletin, September 2022, shows one-quarter of adults (25%) reported feeling lonely always, often, or some of the time in the latest period (26% in the previous period).



- Feelings of loneliness for people aged 16 and over by disability status and region, ONS, year ending March 2021, show that in Yorkshire and the Humber, 17.2 % of people living with a disability experience feeling of loneliness often or always. This compares to 5.4% for non-disabled people. For England, this value is 15.1% and 3.6% respectively.



		
43% of 17 – 25-year-olds used Action for Children services experienced problems with loneliness.	1 in 10 men says they are lonely but would not admit it to anyone[2].	49% of people aged 65+ say their main form of company is either the TV or a pet[3]
	33.3%	
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[4].	More than 1 in 3 people aged 75 and over say that feelings of loneliness are out of their control[5].	Loneliness costs UK employers £2.5 billion per year[6].

[2] Millions of men are hiding their loneliness | Campaign to End Loneliness
[3] rb_june15_lonelines_in_later_life_evidence_review.pdf (ageuk.org.uk)
[4] Lonely visits to the GP | Campaign to End Loneliness
[5] One-third of older people say feelings of loneliness are out of their control (independentage.org)
[6] cost-of-loneliness-2017.pdf (campaigntoendloneliness.org)

The need for tackling loneliness is shown by every £1 invested in tackling loneliness, you can save £3 in health costs[7], with an overall 81% of people agreeing that there are lots of actions everyone can take in their daily lives to help those feeling lonely.

The latest annual report for tackling loneliness (February 2022) is still following 3 overarching objectives:

1. Reduce stigma by building a national conversation on loneliness, so that people feel able to talk about loneliness and reach out for help.
2. Drive a lasting shift so that relationships and loneliness are considered in policymaking and delivery by organisations across society, supporting and amplifying the impact of organisations that are connecting people.
3. Play our part in improving the evidence base on loneliness, making a compelling case for action, and ensuring everyone have the information they need to make informed decisions through challenging times.

The strong message from the report is that tackling loneliness will require a response from public sector staff, employers and businesses, communities, and individuals. These organisations working together as one will lead to a more connected society.

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.[3] 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 multicultural communities can be met.[4]

Covid-19 Impact

After a year of lockdowns, social distancing, and restrictions on travel and gatherings, some groups of people have reported high rates of loneliness and poorer well-being in recent months. In the midst of Covid-19, lockdowns and social restrictions made the loneliest of people even more lonely with 1 in 18 people in the UK felt a reduction in social contact during lockdowns made their life harder[8]. A recent study found that 9 different characteristics would put you at a greater risk of feeling lonely during the pandemic (see table[9] below).

Important risk factors for adult loneliness	Other characteristics carry a small increase in the risk of being lonely, both before and during the pandemic.
• Being young (18-30) • Living alone • Having a low income • Being unemployed • Having a mental health condition	• Non-white ethnicity • Low educational attainment • Being female • Living in urban areas

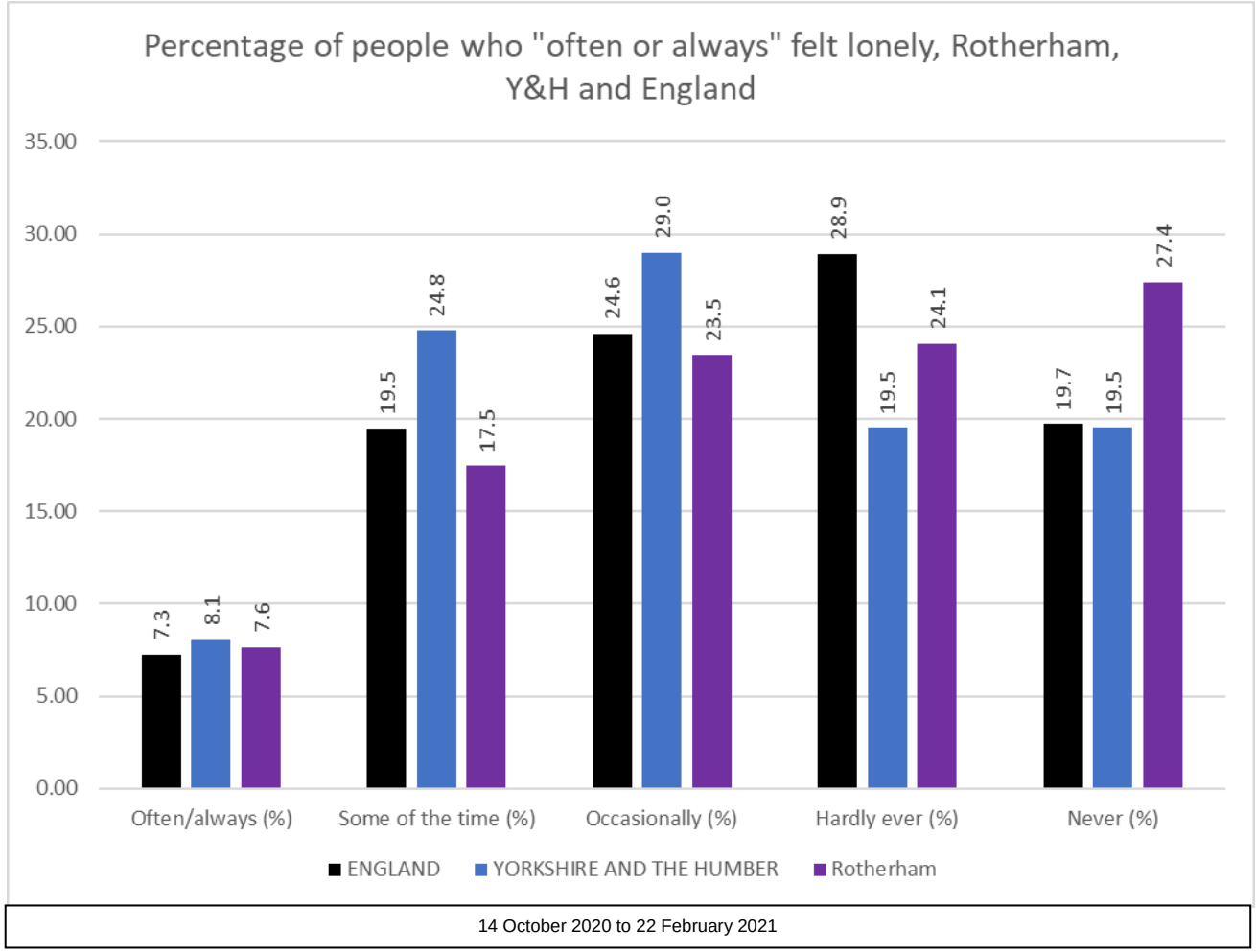
During the Covid lockdowns, young people alone were 5 times more likely to feel lonely due to their social connections being restricted. Therefore, there is a real need nationally and locally for the loneliness action plan.

SOUTH YORKSHIRE INTEGRATED CARE PARTNERSHIP

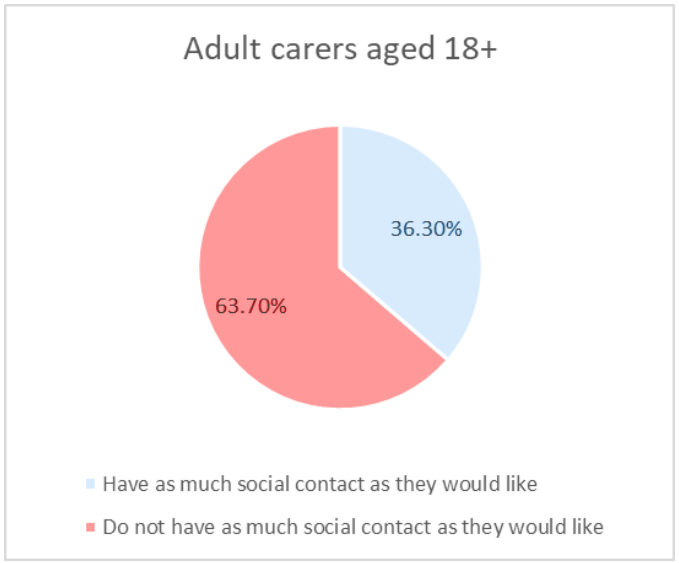
The approach it is taking is in line with the guidance building on existing work in South Yorkshire and each of its place communities and priorities for this initial strategy. There is an expectation that during 2022/23 the South Yorkshire Integrated Care Partnership develops an Integrated Care Strategy for South Yorkshire. Significant engagement and work have been undertaken to date by ICP partners to develop Health and Wellbeing Strategies, Place Plans and the South Yorkshire NHS Strategic Plan and it is upon these that the South Yorkshire Integrated Care Strategy will build.

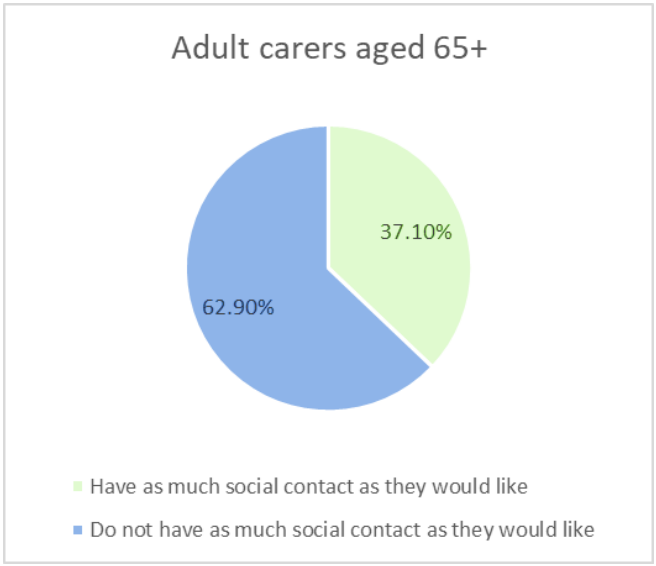
Local picture– What loneliness looks like in Rotherham

The ONS estimates of loneliness and personal well-being during the coronavirus (COVID-19) pandemic by showed that 7.6% of Rotherham residents felt lonely often or always and 43% of Rotherham residents felt lonely in the previous 7 days.



In 2018/19 only 36.3% of adult carers aged 18+ had as much social contact as they would like and for those aged 65+ this was 37.1%





The Office of Health Improvement and Disparities (OHID) plan to include loneliness indicators in the Public Health Outcomes Framework this year, which will give a more detailed picture for Rotherham. However, there has been some focused work with specific communities of interest in Rotherham to establish how loneliness affects them.

Vulnerable Groups identified in Rotherham are*:

- Young people
- Domestic abuse victims
- Migrants
- Ukraine refugees
- People with learning difficulties (such as autism)

**These groups were identified in the refresh loneliness action plan meeting with stakeholders*

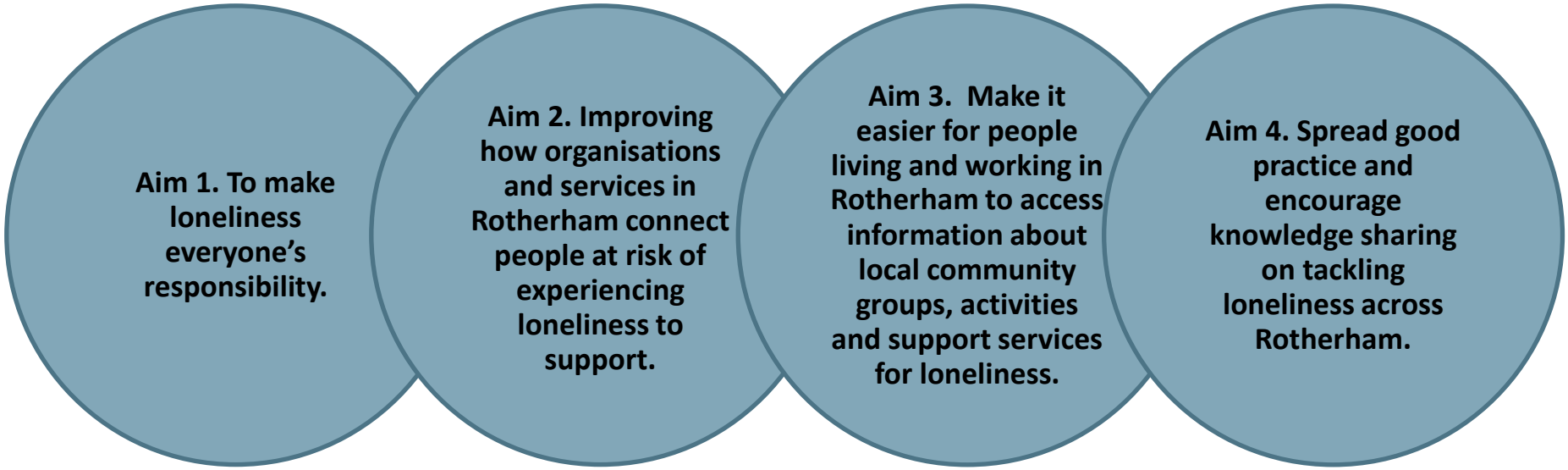
Helpful resources on loneliness

- 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
- Campaign to End Loneliness (2021), Loneliness beyond Covid-19 Learning the lessons of the pandemic for a less lonely future Loneliness-beyond-Covid-19-July-2021.pdf (campaigntoendloneliness.org)
- 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
- Government refresh of Loneliness report Tackling Loneliness annual report February 2022: the third year - GOV.UK (www.gov.uk)
- 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
- Local Government Association Combating loneliness: A guide for local authorities https://www.local.gov.uk/sites/default/files/documents/combating-loneliness-guid-24e_march_2018.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

Action Plan Framework

Considering national and local evidence, the framework for the action plan will cover the whole life course and will aim to tackle loneliness as early as possible and throughout a person's life as circumstances change. Addressing loneliness is a complex and will require support from all sectors within Rotherham; Partners of the HWB, local communities, people with lived experience, private sector, and voluntary and community groups. Evidence and actions will be added as more information is available from working with Partners and the public. The action plan will follow four aims when addressing the issues of tackling loneliness. The four aims are as followed:



Rotherham Loneliness Action Plan 2023-2025

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 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 response to	• To develop clear and consistent messages in relation to loneliness, the affects and impact on people across the whole life course. • Partners of the HWB to use agreed messages in communications to their workforce and 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: To be Active To Connect To Give To keep Learning To Take Notice. • To develop clear messages about how	Communication Leads and identified champions from all HWB partners.	Starting November 2023	• Consistent messages about loneliness which are supported and communicated by all HWB 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 connected and supported by the	August 2023 Distribution of Five Way to Wellbeing resources to community groups and via training for staff, for example suicide prevention training to Adult Care and RDASH. Partners are promoting Five Ways to Wellbeing, inclusion on RotherHive. Through Mental Health campaigns like MH Awareness week in April 2023. Befriending video, Be a Good Neighbourhood, has been promoted, further promotion to follow. SY Student Welfare Guide includes as section on mh wellbeing

Rotherham Loneliness Action Plan 2023-2025

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
address loneliness.	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.			people they live and work with.	and signposting to local resources. Gaps Comms and engagement plan
Utilise local assets to address loneliness and improve opportunities for people to connect.	• HWB partners to understand how local assets can be used as community hubs. • Actions in place to use local assets as places for people to connect.	HWB partners		• Creation of more community hubs/opportunities for people to connect.	Promotion of local assets/buildings/activities regularly taking place via monthly ward e-bulletins and other more traditional channels, particularly in the wards that have specifically identified loneliness within their priorities. Details of community events and meetings circulated to partner agencies so that they can link in their services, particularly those that are

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
					providing support and advice to tackle the cost-of-living crisis. Warm Welcome sites promoted during the Winter months.
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. • VAR to lead on workshops with VCS organisations to explore solutions. Spring 2023 • Development of the Befriending Providers	Neighbourhoods, RMBC working with Elected Members Local community Communities of interest- CYPS, AC, H & PH, VAR, VCS, and partners of the HWB.	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.	Refreshed ward priorities published in June 2023. Strengths-based approaches – e-learning for council staff to be launched in September 2023. This will include identification and building on local assets. Place-based working – mapping of assets taking place as part of the Early Intervention and Prevention work in the North Locality.

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
	Network – capacity building, standardised measuring/approach/.				
Promote and increase the use of neighbourhood centres	• Promote the use of neighbourhood centres for tenants. • To install WIFI to designated centres to promote digital inclusion for tenants	Housing Operations Manager	September 2023	• Tenants feeling less isolated and connected to the local	Rotherfed undertook a piece of work with residents at a number of centres, to build capacity and interest in using centres more actively for social activity. Whilst this initially increased usage and activity, this was not sustained. It is planned that the next edition of Home matters, which will be sent to Council tenants and leaseholders in November, will showcase a neighbourhood centre such as Peregrine Way, which is well used and the type of activity that is delivered there. It is hoped that this will stimulate interest amongst tenants who

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
					have access to neighbourhood centres in other locations. In the meantime, the service and Rotherfed continue to provide supports to residents and groups to make the best use of their centres. This includes working with resident's groups to improve those spaces, through for example redecoration and new furnishings and promoting active use of external as well as internal areas. Whilst the use of centres remains generally low, there are some great examples where centres are actively used and a real community hub for residents. With regard to Wi-Fi, public access wifi similar to the offer in local libraries will be installed to a further 11

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
					neighbourhood centres during this financial year. it is the intention to undertake an evaluation exercise of the impact and outcomes of installation prior to taking decisions on wider rollout to the remaining centres. This is prudent, given the levels of centre usage.
For partners to mitigate against loneliness in the planning, commissioning, and development of services/policies.	• To agree a set of measures to ensure social connectivity is considered in place-based initiatives such as planning, commissioning of services, housing, and transport.	Champions from HWB.		• Evidence of social connections being considered in place-based initiatives such as planning, commissioning of services, housing, and transport.	Meeting in September to draft set of measures using JSNA information and Local Government Association 'Combating loneliness- A guide for local authorities'

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

Rotherham Loneliness Action Plan 2023-2025

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
To understand the needs of specific groups/communities who are more at risk of loneliness and use this to address to issues leading to loneliness, improve support and connect people to local offers. (examples include children and young people, adults with Learning Disabilities and autism, new parents, carers)	• To work with organisations and people with lived experience to do some detailed work to understand the issues which are leading to loneliness. • Develop specific actions to address this. • Ensure information is shared in training like MECC. • Promote opportunities for these groups/communities to connect with others.	Public Health, Speak Up, CYPS, HWB Partners, VCS	Working with specific communities to understand the issues to commence January 2023 MECC training to incorporate information gleaned from January 2023	• Specific actions to address loneliness for vulnerable groups. • Informed workforce • People feeling connected where they live and work.	August Open Arms Update **Outputs** Number of drop-in sessions delivered – 75 (June target 60) Number of people dropping into a centre – 436 (June target – 400) Number of Community leaders Trained & developed – 17 (June target 20) **Outcomes** Number of people with better awareness of services and venues - 334 Number of people stating they have found the information, advice and support at the session helpful – 361 Number of people received/receiving ongoing 1-2-1 support from a service – 181 (RotherFed – 58. CARD – 113. Laser – 10) Number of people stating the session

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
					has had a positive impact on their health & wellbeing, i.e., adopting new habits, feeling less stress & worried - 145 Befriending Network remains an ongoing feature, with cost-of-living impact being on each agenda now. MECC and Loneliness training will feature in 2023/24 plan
Mapping services/organisations which are available to support Rotherham residents	• Working with Council and VCS to capture local information on centres, groups, Libraries, events. • Information will be stored on a map which the public will have access to- JSNA	Public Health Intelligence, VAR, Adult Care, Housing and Neighbourhoods, RMBC	First draft December 2022	• Interactive map that the public can use to find out what is available in their local community.	The mapping is also complete and is being shared with the Link Workers at VAR to trial the use and double check the guide makes sense. It will be added to the JSNA in September.
Promote health, wellbeing and connectedness through arts and cultural initiatives.	• Co-design Children's capital of culture with children and young people, with focus on improving their mental health and wellbeing	Head of Creative Programming & Engagement Culture, Sport and Tourism Service	March 2025	• Improved mental health and wellbeing of children and young people.	Year 1 Engagement Programme completed. Manifesto for Year 2&3 Design and Development phase launched in Jan 23

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
	and promoting connectedness			• Children and young people feeling connected.	To date the programme has attracted in excess of £3m in revenue investment and achieved: Supporting 75 young people employed part-time as Trainee Creative Producers, 14 of these trainees were care experienced Three months after the traineeships were completed, over 70% of the young people had gone into further work or education. Supported 10 Young Artists in Residence to develop creative skills in areas including music, dance, poetry and graphic design and build freelance portfolios. Delivered 124,029 participations by children, young people, and their

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
					parents and carers in Children's Capital of Culture activities. Worked with 582 artists and organisations, 36% of which have been Rotherham based, and a further 40% were from the wider South Yorkshire region. Featured in 86 positive stories in media titles including ITV Calendar News, Yorkshire Post, BBC Look North, Rotherham Advertiser, Sheffield Star and BBC Radio Sheffield
RMBC Library service will actively seek to reduce social isolation and loneliness through the Library Strategy 2020-2022 and the RMBC	• Continue to make improvements to library buildings to make them more accessible, to create a warmer welcome and provide more	All Libraries and Neighbourhood Hubs Team Leaders.	Ongoing	• Libraries functioning as friendly and welcoming community hubs, freely accessible to all. • Libraries as spaces for people to share	-Libraries have partnered with Rotherfed to deliver Energy Know How sessions at Greasbrough, Riverside and

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
Culture, Sport & Tourism service plan 2022/23	advice and support services being delivered through libraries. • Training for staff on 'Making Every Contact Count' and 'Loneliness Training'. • Organise reading groups and activities in which people can come together, both face to face and digitally e.g., 'Cuppa and chat' sessions, death cafes, menopause cafes etc. • Work with the community hub to identify additional customers who would benefit from the Booklink and Home Library Service.			experiences and spaces that respond to specific health issues, including death, menopause, and dementia, and improve community resilience. • Library staff to be able to identify individuals requiring support as first points of contact. Offer a service to those who are potentially lonely and vulnerable.	Mowbray Gardens Libraries. **-Open Arms Community Support Hubs -** working with Rotherfed as part of a VCS partnership project for the UK Shared Prosperity Fund. The support delivered will have a strong focus on financial and social inclusion. -Booklink service and Home Library Service currently reviewing locations for resurrection of walk-on service aiming to start in June 23. -Shared reading group started at Dinnington in January 23. Plan to advertise a group to run at Swinton library as there have been some expressions of interest. -Death café – trialled at Dinnington 12th December but no participants attended.

Rotherham Loneliness Action Plan 2023-2025

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
					Planning bi-monthly cafes at Mowbray with partners. -Staff training courses on going. Volunteers for Shared Reading training to take place so that another group can be established. -Menopause Café running monthly at Maltby. Plans for partnership work with RUFC who have received funding for a project linked to activity and social time for women affected by Menopause in September 23. 3x sessions still taking place within Rotherham libraries for gentle exercise linked to the Women's Euro 22 Legacy. Funding is being explored for a 4th session via Active Regen.

Rotherham Loneliness Action Plan 2023-2025

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. • Partners of the HWB 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.	Neighbourhoods, PH with support from partners of the HWB.	March 2023	• 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.	Loneliness section is complete, but there has been a delay getting it onto the JSNA website (due to website updates). When published this will be promoted to Partners.

Rotherham Loneliness Action Plan 2023-2025

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
To continue to apply the principles of Making Every Contact Count (MECC), to enable practioners across Place to spot the signs of loneliness have meaningful conversations.	• To roll out MECC and loneliness training across Rotherham.	PH working with HWB partner organisations including VAR.	Ongoing	• Number of staff trained in MECC and loneliness. • Case studies showing how people have been identified and signposted.	Rotherfed worked with Public Health to contribute to the content of the MECC training for Cost-of-Living sessions. Currently updating the training PPT. Looking at offering monthly MECC sessions through HR portal at RMBC form October 2023, some of which will be on Loneliness, these sessions will also be offered to partner organisations. Will be looking to offer this training to organisations are working on the Bewell@work scheme.

Rotherham Loneliness Action Plan 2023-2025

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
Raise awareness amongst public sector, local businesses and communities of the causes, triggers, and impact of loneliness, using training and local campaigns.	• 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 campaign to promote the importance of good social connections.	PH working with HWB partner organisations	Ongoing	• Frontline staff aware of at-risk groups and trigger points for loneliness. • Increased knowledge used to identify people and signpost to appropriate support and give tailored self-help self-care information.	Be a good neighbour campaign and video created. Befriending Network keeps partners updated on services available and gets support to those who need it the most through partner comms, referrals/signposting etc. MECC training covers causes and triggers of loneliness.
Work with Primary Care Network (PCN) to raise awareness of loneliness.	• To assist PCNs in understanding their local communities and the assets available which support good social connections.	PCN, PH and Voluntary Action Rotherham and HWB partners, Link Workers.		• Reduction clinician time spent supporting people whose main issue is loneliness. • Improved wellbeing of people experiencing loneliness.	Changes to the GP contract 23/24 have shifted focus onto patient access to appointments and patient experience - PCN Link Workers play a key role in delivering both - offering appointments to

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
					support with non-clinical needs and providing personalised care planning as link workers are able to dedicate more time to wider wellbeing conversations with patients as well as follow up phone calls to review their progress and outcomes. The link workers receive 1500+ referrals each year, helping patients with a wide range of issues including loneliness and social isolation and outcome measures record patients' feelings on life satisfaction, feeling life is worthwhile, happiness and anxiety. Engaging in any number of

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
					social groups across the borough from crafting to boxing, is known to improve social isolation and we see significant benefits for the patient (demonstrated in monthly case studies). The PCN Link Worker patient satisfaction surveys also demonstrate the helpfulness of the service from patients own perspective.
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. (For example; allowing community groups use of premises, staff trained to	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 workforce and to the wider community.	This will be considered in a reviewed of the scheme in April 2024.

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
	identify people at risk, staff time to have conversations with vulnerable people).			• Shared examples of good practice.	
Employers of the HWB to consider what actions they can take to encourage staff to have good social connections both in and out of work.	• To work with HR in HWB partner organisations to develop policies and working practices which outline responsibilities for employers, managers, and staff in maintaining good social connections. • HWB partners to consider the following: allowing community groups use of premises, staff trained to identify people at risk, staff time to have conversations with vulnerable people). • Explore the potential for Potential ESV (employer supported volunteering) and development of developing bespoke	HR Leads from HWB organisations working (linking into the Be Well @ Work) & VAR		• 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.	Some evidence that Partners are doing this. Organisations of the HWB promote RotherHive, Gismo and Five Ways to Wellbeing. Further actions needed to progress volunteering.

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
	volunteering opportunities, linking in with Befriender Network.				
Program of tenant health check to identify tenants suffering from loneliness	• Routine checks (once every 4 years) • Signposting and referring on	Head of Housing and Estate services	Ongoing	• Tenants receiving support and relevant signposting. • Tenants feeling settled and belonging within the local community.	The annual programme of Tenancy Health Checks is continuing, which includes a focus on loneliness and isolation and better connecting residents to their local community and appropriate services. This year in addition to continuing to focus on older and more vulnerable tenants, we have been including tenants who have not reported repairs within a 12-month period, to ensure that they are

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
					managing well and there are no hidden issues or support needs that we are unaware of. In August, Rotherfed had 22 Open Arms drop-in sessions across their target areas in 5 libraries and 5 venues. Open Arms is a partnership in collaboration with Voluntary Action Rotherham, Citizens Advice and LASER Credit Union. In addition to their usual Hubs, Rotherfed also organised Community Get Togethers throughout August. These themed events were aimed at families, enabling them to get an insight into what

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
					Rotherfed offer at community events. The sessions ran from 11am and 2pm across our5 non library venues. Over the month Rotherfed have welcomed over 103 new individuals and have seen an amazing 204 children come along to enjoy various events. The More Energy Know How team are continuing to engage with partners and supporters to provide energy advice to community groups and individual Rotherham residents. They have provided

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
					information to several clients on a one-to-one basis who have contacted the group through friends, family, or recommendation.
Recognise how loneliness and isolation contributes to vulnerability to crime and exploitation	• Raising awareness with partners and the public around the signs of vulnerability in crime and exploitation.	Safer Rotherham Partnership – Protecting vulnerable Adults and protecting vulnerable children.	SRP priority until 2025	• Loneliness and isolation are considered as part of the vulnerability risk assessment process. • Make appropriate referrals through individual support plans.	'Spot The Signs' campaigns and awareness raising is taking the place with public and professionals and front line workers in relation to Child Criminal Exploitation (CCE), Child Sexual Exploitation (CSE), Modern Slavery, Cuckooing and radicalisation through the Protecting Vulnerable Children, Protecting Vulnerable Adults, Prevent (counter terrorism) and Organised Crime

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
					priorities within the SRP Plan 2022-25. Appropriate referrals are made through children's and adults safeguarding procedures and there is further identification and case management through the multi-agency Area Tasking, Community MARAC, and Channel processes.
To work in partnership with others to embed tackling loneliness into local policies and practices.	• To work with Mayoral Combined Authority to explore opportunities that transport can contribute to tackling loneliness.	Consultant in Public Health- Healthy Communities	July 2023	• Evidence of partner policies taking actions to address loneliness.	Public Health have raised awareness of social connectedness (tackling loneliness) as part of strategic conversations on the bus network and wider public realm; including both accessibility of services and perceptions of

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
					safety which can contribute to isolation. Healthy public realm, including safe space for social contact in communities remains an active discussion in strategic conversations.

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 public and practitioners to access. (GISMO)	• Partners of the HWB to agree to use and promote one directory of services in Rotherham- GISMO. • To ensure that this one directory is maintained.	VAR working with HWB partners.	Ongoing	• One directory of services which is used by all HWB partners. • Website advertised and promoted widely across the borough. • Directory updated regularly.	Gizmo update is taking place. Gismo information has been incorporated into mental health service mapping.
Increase awareness amongst the public of opportunities to access free and affordable activities.	• Promoting the one directory (GISMO) and Rotherham council website to people who live and work in Rotherham. • All HWB partners to promote the activities/initiatives they deliver using the Five Ways to Wellbeing branding. • To ensure that organisations who	VAR, Comms Leads from HWB partners.	Ongoing	• People living and working in Rotherham know where to access information on local activities.	See earlier comments on asset mapping and signposting. Gismo and Rotherham council websites are promoted on MECC loneliness training

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
	engage with the public have access to update and relevant information for signposting.				
Support and empower community groups	• Deliver the tenant federation contract to support and empower community groups to deliver services within their local neighbourhoods. • Community development and capacity building for VCS- opportunity to map and do some targeted work	Housing Operations Manager VAR	March 2024 Ongoing	• Supported individuals and increased activity provision.	Continuing to work with Rotherfed to strengthen and sustain existing capacity and activity in our communities and continually look for opportunities to grow further engagement capacity. The current Tenant Federation Contract expires at the end of March 2024 and the service is currently in the process of progressing the necessary procurement exercise to secure a further

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
					contract from April 24.

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 HWB partners.		• Better communication about what works amongst partner organisations. • Better use of resources. • Strong local evidence base on which to build upon.	Good practice examples and learning from the Better Mental Health Befriending project have been shared via Network. Examples of good practice will feature on the JSNA Loneliness page.
Evaluation from COVID funded projects for the over 55s	• Complete evaluation of over 55s programme to provide recommendations for future programming for this audience and reduce social isolation	March 2023	Head of Creative Programming & Engagement Culture, Sport and Tourism Service	• Evidence from programme being used in future planning.	Evaluation completed; final evaluation film due by end March 2023 Meeting planned with Public Health DLT to share findings.

Rotherham Loneliness Action Plan 2023-2025

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
Encourage communities/businesses to engage with national based initiatives.	• Support local communities/employers to take part in national initiatives like The Jo Cox Great Get Together	Neighbourhoods, PH, HWB partner leads working with local communities, schools, colleges, universities, and local businesses.		• Reduction in stigma surrounding loneliness. • Greater community cohesion. • Examples of national initiatives being implemented in Rotherham. • Positive media coverage.	Promotion of MECC Loneliness Sessions and resources to employers.
Counter the narratives that drive hate, division, and exclusion in communities	• Implement a programme of community engagement, working with partners, to promote dialogue and understanding, and challenge prejudice, stereotypes, and hateful narratives. • Engage with schools and young people to develop and deliver a range of educational activities and interventions on the Harms of Hate.	Community Safety Team, RMBC – Chris Gaynor, Community Safety Officer (Safer Stronger Communities)	3-year priority to 31 March 2025	• Build safer stronger communities by tackling the drivers of hate that can cause division and tension in communities that potentially could lead to social isolation.	Holding Difficult Conversations training was delivered to frontline partners 6th Oct 22 to help them tackle the drivers of hate. Work was undertaken with three community groups over summer 2022 (young people to 70+) to talk

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
	• Raise public awareness of hate crime and sources of support.				about the issues they see as facing Rotherham; to tease out their views and engage in meaningful dialogue about these. Work with schools resulted in a significant rise in the number of them adopting Rotherham Youth Cabinet's Hate Charter and a broader understanding of hate crime and its impact. Local media coverage of our projects with schools has enabled positive messages to reach a large number (46k+) of people not

Objectives	Actions	Who will lead?	By when?	What do we want to see as a result?	Progress to date
					connected with the schools. An event at Magna on 9th February saw us successfully engage with 200 pupils from five primaries to work alongside each other on the harms and risks they face. The number of hate crime reporting centres in the borough has more than doubled, allowing quicker, easier reporting. 6th March, Y7 hate crime assembly to 200 pupils at Wingfield Academy

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

References

[1] Perlman, D. and Peplau, 1981, cited in HM (2018), 'A connected society: a strategy for tackling loneliness' https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750909/6.4882_DCMS_Loneliness_Strategy_web_Update.pdf Accessed 02/03/2020

[2] Jo Griffin, Mental Health Foundation (2010) The lonely society. https://www.mentalhealth.org.uk/sites/default/files/the_lonely_society_report.pdf Accessed 02/03/2020

[3] Local Government Association (LGA), ref code 22.28. https://www.local.gov.uk/sites/default/files/documents/22.28%20-%20Loneliness%20Must%20Know_02.pdf. Accessed 02/03/2020

[4] NHS England, 2019, PAN 000581. https://www.england.nhs.uk/wp-content/uploads/2019/07/pcn-reference-guide-social-prescribing.pdf Accessed 02/03/2020

COAST

The Community Outreach and Alcohol Team 2023

Amanda Marklew
Lead Transformation Nurse
Alcohol Liaison Service
Acute & Outreach

Identifying Patients

Rotherham was identified as an national optimum treatment site:

1 out of 4 sites

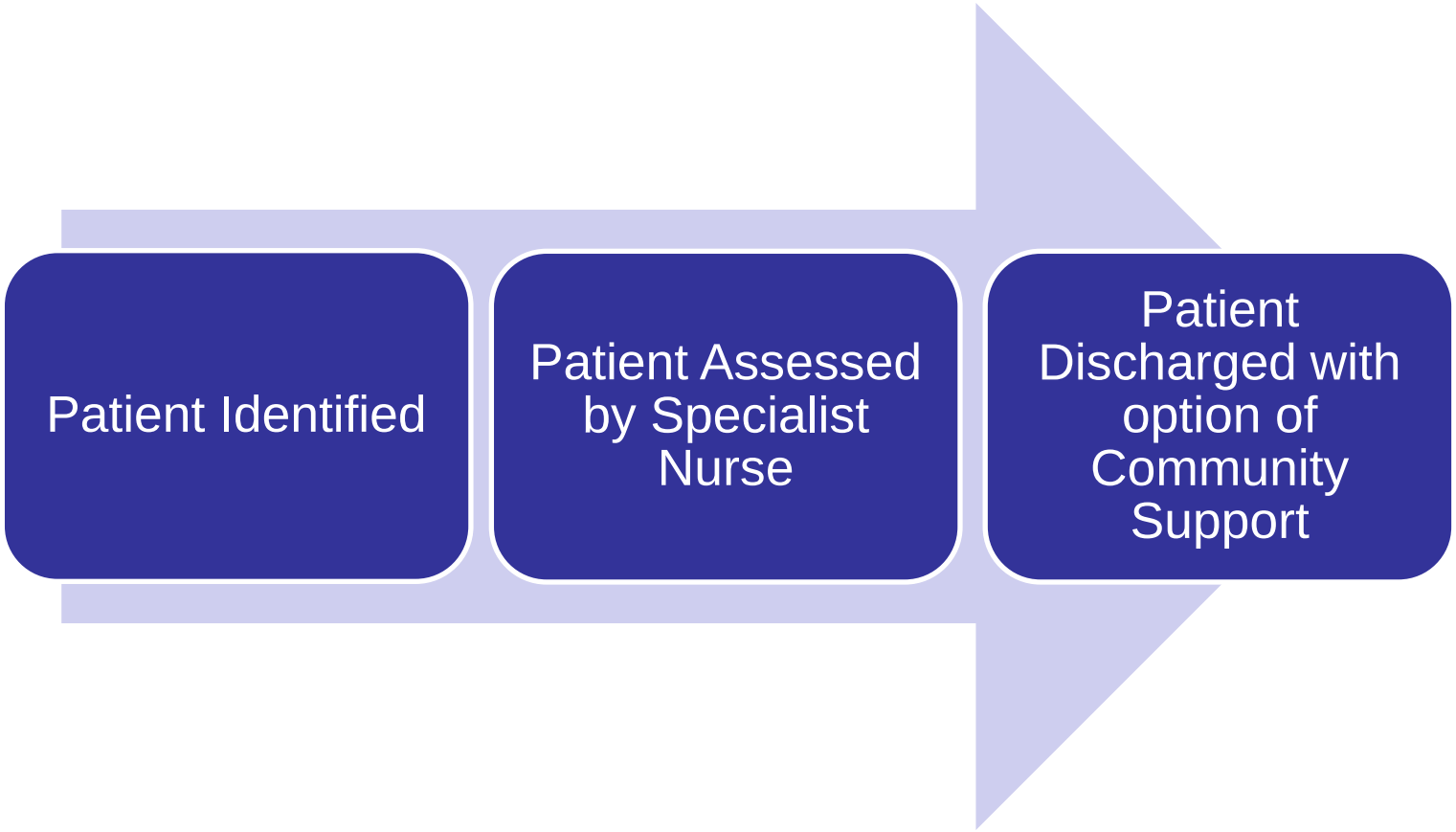
Eligible to apply for NHSE funding

Brief

a) Non –nursing
b) Specified patient group would have Alcohol & Mental Health problems.
c) Model to evidence some positive patient outcomes & showcase same

- All patients would consent when offered the extended care option
- Identified current patients known to be high users of services and Frequent attenders to A&E
- Patients in crisis
- In-patients as assessed for need

Community Based Approach



Community Outreach and Support Team for Alcohol and Mental Health

Acute Alcohol Care and Mental Health Services

Identify Caseload via HIUG and FF Forums

COAST

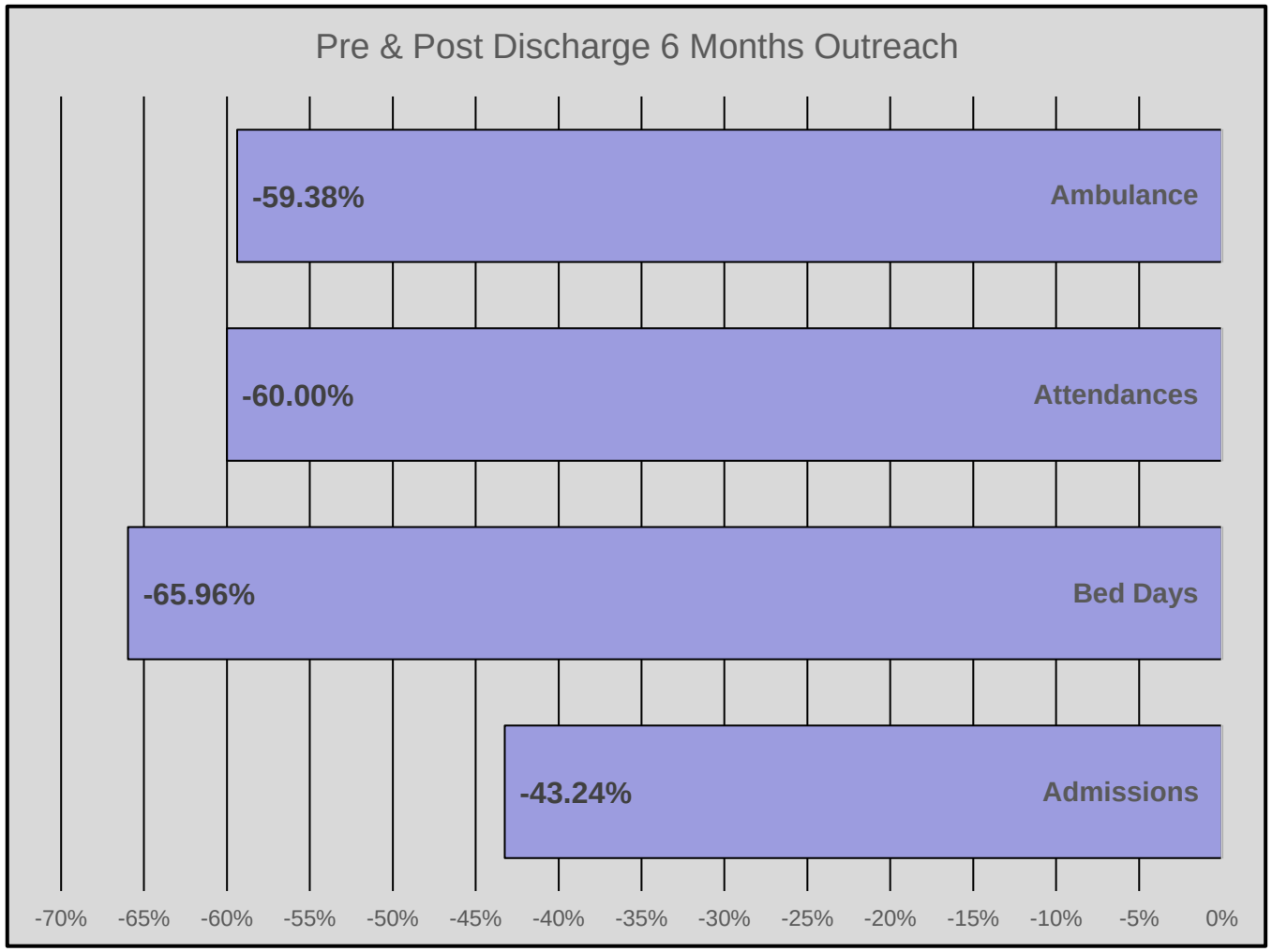
x 4 Non Nursing Community & Life Skills Mentors

MDT approach out into Community

All relevant services involved in Care planned approach

- Community Substance Treatment Providers
- Social Care
- Safer Policing Teams
- Community Mental Health Teams
- Housing
- Citizens Advice
- Social Prescribing
- Inpatient Detox Facilities
- Voluntary Organisations e.g. Age UK
- Named GP & Community Pharmacist
- DWP / Benefits

Results for Rotherham Patients who engaged with Outreach Team



- 29 Patients have completed care under the Outreach Team during this time period
- 2 Patients (7%) had no admissions or attendances in the 6 month period before discharge
- Ambulance use 64 pre / 26 post
- UECC Attendances 85 pre / 34 post
- Bed Days 188 pre / 64 post
- Admissions 37 pre / 21 post

Improved Outcomes

- Community Partnership Approach
- Joint initiatives and a shared vision…no longer stand alone Inc. commissioning

Shared investment and collaborative MDT working

Consideration to Improvements within the wider Community

- Greater Understanding of the ‘bigger picture’

‘Living well for Longer’-Harm to Hope & Suicide prevention

The Borough That Cares Strategic Framework 2022-2025

Creating a Carer friendly Rotherham

Achievements October 2022 - September 2023

Katy Lewis
katy.lewis@rotherham.gov.uk
Carers Strategy Manager

Achievements
October 2022 to September 2023

Contents

- Carers Strategy Manager Post Update
- Achievements against the strategic framework
    - Focus 1 Carers Cornerstones
    - Focus 2 Creating Communities of Support

Carers Strategy Manager

- Interim Carers Strategy Manager in post from March 2023 to end of June 2023
- Permanent Carers Strategy Manager in post from July 2023

Initial Focus has been on:

- Networking/Identifying stakeholders
  - Joined the Yorkshire & Humber Carers Lead Group
  - Joined the South Yorkshire Integrated Care Partnership Commitment to Carers Group

- Securing provision of the current carers emergency service until end March 2024
- Undertaking a programme of carers workshops during August/September - 'Carers Conversations' to be completed in October
- Updating the RMBC Website Carers Information pages – further work ongoing

Focus 1 - Carer Cornerstones

- Better Care Fund underspend of £100,000 allocated to the provision of small grants, of up to £5,000 each, to small VCS organisations for projects to improve the health and wellbeing of carers

  - 19 grants awarded
  - Carers to be supported include those caring for people with dementia, mental ill health, parent carers and carers from minority communities
  - Projects funded include physical activity, art therapy, mindfulness and creative craft skills
  - Projects funded will run from August 2023 to end of March 2024

Focus 1 - Carer Cornerstones cont.

- Borough That Cares Strategic Group
    - Borough That Cares Strategic Group continued to meet regularly to share best practice and information
- Advice and Information
    - First Carers Newsletter published in Spring 2023
    - Electronic version available on RMBC website Carers pages
    - Intelligence gathering on user experience of existing advice and information offering
    - Programme of events delivered for Carers Week across the Borough

Focus 2 - Creating Communities of Support

Worked collaboratively with South Yorkshire Integrated Care Partnership

- Contributed to version 2 of the Practitioners Guide to Carers Support

Worked with RMBC digital inclusion strategy group to reduce digital exclusion for carers

- Included carer webpages in RMBC's customer portal design

Carers Conversations Co-Production Programme (August to October 2023)

- 14 co-production events (as at Sept 2023) completed in partnership with locality based support groups
- Focus on the themes of accessing advice and information and support services, and improved health and wellbeing
- Outcomes will inform future commissioning decisions

Next Steps

- November 2023, Produce report on the outcomes and commissioning proposals following the engagement work being undertaken, to include:
  - Results of Survey undertaken by Healthwatch, due October 2023
  - Outcomes of the Carers Conversations
  - Feedback gathered at the Rotherham Show
  - Feedback from social care and health professionals
  - Proposals for the ongoing provision of a carers emergency service

- Encourage unpaid carers in Rotherham to take part in the national Survey of Adult Carers in England, 2023-24, administered by NHS England

- Agree terms of reference and commence the Borough That Cares Network Group

Any Questions?

BRIEFING TO:	Health and Wellbeing Board
DATE:	27th September 2023
TITLE	Rotherham Place Digital Inclusion Programme

Programme Leads
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Report Summary
To brief and obtain the continued support of the Health and Wellbeing Board on the progress of the Rotherham Place Digital Inclusion Programme, detailing work undertaken to date, future actions and associated costs.

List of Appendices Included

Appendix 1 Digital Inclusion Review – Rotherham Place
Appendix 2 Rotherham Digital Inclusion Strategy
Appendix 3 Digital Inclusion Action Plan
Appendix 4 Digital Inclusion Action Plan on a page
Appendix 5 Communication & Engagement Plan
Appendix 6 Equality Impact Assessment
Appendix 7 Risk Register

1.	**Background**
1.1	Digital inclusion remains a challenge for some people in Rotherham and a lack of digital access can have a detrimental impact on residents. The associated problems can be significant for citizens and families contributing to educational and economic disadvantage, health inequalities and increased social isolation.
1.2	The shared view across the Council, Health, and third sector organisations is that whilst Covid-19 created increased digital engagement, it had also widened the gap between those who are digitally included and those who are digitally excluded; leaving some members of the community at risk of missing out on opportunities to find jobs, save money, learn new skills and socially engage from the comfort of their home.
1.3	Whilst national research already supported this view, the degree to which this was happening in the local area was unknown.
1.4	Talking to both residents and service providers was the best way to gain a better understanding of the level and quality of the "digital offer" of services within the Rotherham Place, the local appetite for digital inclusion and the identification of any barriers that prevent the people of Rotherham accessing and benefiting from online services and digital channels.
1.5	In 2021 Rotherham Health and Rotherham Council therefore jointly proposed establishing a Rotherham Place Digital Inclusion Programme. The programme funding was secured through the NHS Digital Aspirant Programme grant (£200,000), RMBC Capital Digital Strategy (£200,000) and 2021/22 Council revenue budget (£50,000).
1.6	The programme's overarching objective is to deliver strategies, governance, and operational practices that maximise access to technology, training and support for the people, small businesses, and organisations across the Rotherham borough.
1.7	A key focus of the Digital Inclusion programme is on working collaboratively and co-productively. As such a cross organisational stakeholder working group was established to jointly input into and shape the aims and outcome of the Digital Inclusion programme; ensuring the needs of all customers and communities within the Rotherham place are fully considered and represented in all digital inclusion activities and reflected within a future co-designed Digital Inclusion strategy.
1.8	The Digital Inclusion Stakeholder group currently consists of representation from different organisations within the Rotherham Place including AGE UK Rotherham, Rotherfed, VAR, REMA, NHS, RNN Colleges, Rotherham Council; although membership invitations are likely to be extended as the delivery of the programme progresses.
1.9	Each member of the group is expected to contribute to the delivery of the programme objectives which were grouped into four delivery phases: **Phase 1**: Information gathering **Phase 2**: Develop evidence-based intervention strategies and programme governance

	Phase 3: Delivery **Phase 4:** Develop a sustainability and ongoing financial model
1.10	The purpose of this paper is to provide an update on progress to date and to gain the continued support of members of the Rotherham Place Partnership Board and Rotherham Together Partnership board in terms of the planned approach/priorities.
2.	**Programme Phases**

2.1	**<u>Phase 1 - Information gathering (completed)</u>**
	
	Objective
	
	A third-party organisation with a proven track record of assessing and analysing digital inclusion/exclusion, be commissioned to:
	
	• Identify and profile the target group within the Rotherham Place. For example, adults, children and businesses who are offline and/or lack basic digital skills/confidence to engage online
	• Understand the local barriers to digital inclusion at an individual and Rotherham Place level
	• Identify existing digital inclusion activity (and the gaps) across the Rotherham Place
	• Identify best practice Digital Inclusion activities and programmes at a local and national level to inform the type of digital inclusion activities that best respond to the brough wide needs and aspirations.
	
	Approach and Actions
	
	i) A specification document outlining the objectives and intended outcomes of the knowledge gathering phase was created and signed off by members of the Digital Inclusion Stakeholder group.
	
	• An independent consultancy was appointed (Attain) to produce a Rotherham place baseline review which involved:
	  • National and Rotherham population level analysis
	  • Consultation with residents:
	  ○ 454 online surveys received
	  ○ 67 postal surveys returned (500 sent out)
	  ○ 9 focus group sessions held across the borough in areas with high levels of deprivation and groups where English isn't the first language
	
	ii) An assessment of the digital maturity of Rotherham provider organisations was undertaken. Participants were asked to complete a self-assessment across seven key areas using the 'What Good Looks Like' (WGLL) framework which organisations can choose to use to accelerate digital and data transformation.

Providers who contributed included VAR, Rotherfed, Clifton Learning Partnership, RMBC, AGE UK Rotherham, and three NHS trusts.

Objective Outcomes
The findings of the Digital Inclusion Rotherham Place Review identified:

i) Groups most at high-risk groups of digital inclusion:

- Older People
- Deprivation
- LTC / Learning Disability
- Disadvantaged Young People

ii) The combination of deprivation and poor internet infrastructure puts some populations at particularly high-risk of digital exclusion, with following areas considered to be most high risk:

- East Herringthorpe
- Rotherham Central
- Thrybergh
- Maltby East

iii) Common barriers to digital inclusion:

- Internet availability in venues such as sheltered housing.
- Language
- Residents wanting more 'one to one' support to help them use their own devices and be more aware of internet safely.
- Age –increasing age increases the need for digital support, but there are also pockets of younger people who are at risk of being digitally excluded
- Based on the survey responses around 54% of residents need some form of digital support

iv) Organisational digital maturity:

- 'Empower Citizens' Place score was the lowest in the WGLL framework which indicates that organisational focus moving forward needs to be on the resident offer.
- There are some established digital support offers across Rotherham, mostly delivered through groups in libraries or courses provided by Rotherham College
- Other community digital support offers have now ceased (e.g., Digital Dan, Rotherfed).

Appendix 1 provides a full copy of the 'Digital Inclusion Review – Rotherham Place.' (April 2022)

2.2 **Phase 2 – Develop evidence-based intervention strategies and programme governance (Complete)**

2.2.1 **Objective 1**

Establish a governance framework that ensures accountability to the Rotherham Together Partnership and partner working arrangements reporting and decision-making boards.

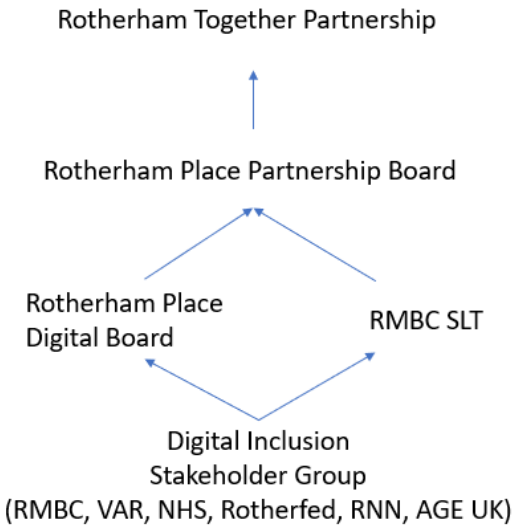
Approach and Actions

- Created Terms of Reference for Digital Inclusion Stakeholder Group
- Established regular meetings with key stakeholders
- Provided regular financial updates with key programme leads
- Created programme highlight report and risk register

Objective Outcome

Governance Structure in Place:

Rotherham Digital Inclusion Governance Structure



2.2.2 **Objective 2**

Develop a Digital Inclusion strategy, the outcomes of which can be delivered by a range of projects and initiatives that target Rotherham's most digitally excluded using the most appropriate method of delivery within the budget available.

Approach and Actions
Members of the Digital Inclusion Stakeholder group have worked collaboratively with both organisations and members of the public to create the Rotherham Place Digital Inclusion strategy. **(Appendix 2).**

The key criteria for the shaping of this document are:

- It aligns with the 'Rotherham Together Partnership' and Place Board priorities
- It is person centric:
    - Focuses on the things that matter to people who live, work and do business in Rotherham
    - Anyone who reads it can identify with something in the strategy
    - Accessible and understandable – using simple, plain and meaningful language with no 'jargon'

    In November a workshop was held with over 22 representatives from different organisations[1] across Rotherham inputting into the creation of a Digital Inclusion Action Plan (A**ppendix 3**) which sets out a range of projects and initiatives aimed at supporting Rotherham's most digitally excluded communities (as identified from the *Digital Inclusion Review – Rotherham Place'*).

Objective Outcomes
- Creation of a Place Based Digital Inclusion Strategy
- Action Plan on a page – easy reference document for general circulation/promotion (**Appendix 4**)

2.2.3 **Objective 3**
Agree target priority areas and communities in terms of geography and demographics to maximise impact and fully exploit organisational presence in the community.

Approach and Actions
The baseline report 'Digital Inclusion Review – Rotherham Place' provided the information needed to identify High-Risk groups and Wards (Page 14):

High-Risk Groups
- Older People
- Deprivation
- LTC / Learning Disability
- Disadvantaged Young People

High-Risk Wards
- East Herringthorpe
- Rotherham Central

[1] AGE UK Rotherham, RotherFed, Rotherham Older Peoples Forum, RNN Group, RDASH, NHS, Rotherham Council

	• Thrybergh • Maltby East **Objective Outcome** The priority activities and actions agreed by the Digital Inclusion Stakeholder group will be initially focused on the high-risk groups in the high-risk wards. For example, the creation of 'digital surgeries' in libraries and community centres in East Herringthorpe, Rotherham Central, Thrybergh, and Maltby East.

2.2.4	**Objective 4**
	
	Establish a process for evaluating the Rotherham Digital Inclusion Programme and provide a robust and transparent measurement framework.
	
	Approach and Actions
	• Through discussion with stakeholder group members it was accepted that there are numerous initiatives expected to help improve digital inclusion; but none are likely to be the single solution. It will therefore be critically important to review and evaluate the work we are doing regularly and continuously.
	• The stakeholder group agree that the programme's fundamental approach should be based on a test and learn methodology; making best use of resident stories and case studies to highlight successes. This will be achieved by:
	  ○ Maintaining constant dialogue with all delivery partners, and more importantly through conversations with those who are directly receiving help.
	  ○ Consistent and frequent user consultation
	  ○ Capturing evidence of how initiatives and activities are helping residents and enabling them to become more digitally included and active.
	  ○ Being confident and decisive as a group
	  ○ Listening to feedback so that we can quickly change or amend anything that isn't working and refocus our energies.
	  ○ Keeping residents updated about the programme
	  ○ Re-visiting the groups that took part in the initial baseline report research to share progress and find out from them how the programme is making a difference.
	
	Objective Outcome
	A robust and transparent measurement framework has been implemented and adopted, providing the evidence source for continuous evaluation of the Rotherham Digital Inclusion Programme and the impact it is having on the lives of local people.

2.3	**<u>Phase 3: Delivery (in progress)</u>**
2.3.1	**Objective:** *Following the completion of phases 1 and 2, identify the different delivery mechanisms that can add most value to the communities of Rotherham.*

Approach and Actions

The Digital Inclusion workshop held in November was used to debate, identify, and agree a range of priority projects, activities and initiatives to support Rotherham's most digitally excluded communities.

i) ***Activities already underway****:*

RNN Digital Champions

A volunteer programme has been jointly developed with the RNN group. Students attending Rotherham college who are undertaking a digital qualification are encouraged to volunteer as 'digital champions' to gain experience of working with local people and help them make better use of technology.

- 10 community groups have signed up to be involved in the initial pilot.
- There are 18 Student volunteers; who have each been matched to a group that is local to where they live to help limit travelling distances.
- Sessions held to date include:
  - Bramley Coffee Morning, Bill Chafer Centre.
  - Catchup Café, Rotherham Minster
  - Mindfulness & Wellbeing, Kimberworth Park
  - The Salvation Army, Maltby

Feedback has been overwhelmingly positive.

- Students say they have felt accepted and welcomed, increasing their communication skills and confidence
- Community groups have said how extremely useful they found it
- Students have told us that since volunteering, they now feel less nervous going out on placements outside of college
- RNN feel this work has helped them further strengthen their link with the community which has also led to requests for assistance with other activities unrelated to digital inclusion.

The initiative is set to continue when the college reopens in September.

Good Things Databank Pilot with the libraries

Good Things Foundation offer free sim cards to organisations through their Databank programme.

This is a national programme designed to support people on low income who have limited/no access to online services.

Rotherham Council are piloting the scheme which was launched in May from Riverside House library; enabling local people who might otherwise be unable to afford to communicate/engage digitally to benefit from a free mobile data, calls and texts.

A phased roll out of the free sim card initiative to other Library & Neighbourhood sites will commence in September (Maltby, Rawmarsh, Dinnington and Swinton).

Subject to the success of the initial pilot, it is anticipated that other Stakeholder organisations will sign up to the scheme. In addition, the Digital Support Officers, once in post, will have the ability to offer sim cards directly through their work in the community.

ICT Classes and Employability classes for residents

Free training courses on specifics subjects for individuals like Excel and Word are important for individuals to upskill themselves ready for employment. These are available across Rotherham, and we will work with the deliverers to ensure what they offer is fit for purpose and to help them be advertised throughout Rotherham.

ii) ***Activities and initiatives that are planned*** *to deliver the priorities in the Baseline review and help communities/people become more digitally included, active, and confident. Delivery of these actions requires:*

Resource

All members of the Digital Inclusion Stakeholder group are unanimously agreed that the success of this programme is reliant on resource that is dedicated to place-based digital inclusion related activities.

A Digital Inclusion 'team' managed by a single organisation is required to ensure the 'place based' approach remains fully intact with the focus of any activity/time dedicated to the delivery of the priorities agreed by the Digital Inclusion Stakeholder group.

To deliver the agreed activities set out in the Action Plan, the following posts are required:

- 1 FTE Digital Inclusion Delivery Manager (Currently in post until November 30th, 2023. Contract to be extended to 31st March 2025) – To oversee the programme as a whole and manage the Digital Support Officers to ensure the agreed action plan is being delivered as agreed and to timescales

- 2 FTE Digital Support Officers (until minimum 31st March 2025) - To undertake the activities identified in the action plan and deliver interventions across Rotherham Place. These post holders will spend most of their time working within the communities of Rotherham.

It is proposed that the employment/management of these roles be established with Rotherham Council as they are the budget holder. The advertised roles closed 10th September with interviews expected to take place w/c 25th September

Devices

	The findings of the report indicate that device ownership is a real barrier to being digitally included. As indicated on pages 35,52,53 and 56 of the baseline report a device loaning scheme would help reduce this barrier to digital inclusion. There are various best practice examples in other authorities that highlight successes with schemes such as device lending services and 'gifting' using previously owned donated devices. The action plan therefore includes the need to further explore the feasibility of offering one or both schemes, or anything similar, which would be initially introduced as a proof of concept to deliver on one of the identified priorities. **Community engagement across Rotherham** A key part of the success of this programme is reaching as many people as possible from different demographics within Rotherham; particularly those groups that are harder to reach. A Communication Plan has been created and signed off by members of the Rotherham Digital Inclusion Stakeholder Group (Appendix 5); a small budget for which has been included for various activities including things like a presence at events, and costs for pitches, promotional material etc. **'Rotherham Digital' Website** A website will be created as a focal point for the Rotherham Digital Inclusion programme and related activities, and information; publicly accessible and inclusively designed to encourage and inform residents, communities, and businesses. This will be a galaxy site hosted by Rotherham Council designed with an independent look and feel and using a previously acquired 'Rotherham Digital' domain name (URL). **Programme Funding** Section 3 (Financial) of this report sets out in detail how the available budget will be used to support the delivery of the agreed actions. Please note, not all activities on the action plan require funding from the programme as some represent initiatives/approaches already in situ that are already aimed at increasing digital inclusion and will continue. **Objective Outcome** The different delivery mechanisms that can add most value to the communities of Rotherham have been identified, with some already underway and others set to be delivered subject to the dependencies referenced above.
2.4	**Phase 4: Develop a sustainability and ongoing financial model (not yet started)**

Objectives

- *Agree a programme of continued support for all partner organisations to establish digital inclusion activities as a core component of service offerings.*
- *Explore options for additional funding and pool potential match funding to support the programme and future sustainability.*
- *Evaluate the effectiveness of digital inclusion interventions to demonstrate how the programme has added value; the evidence from which can be used to inform "what future delivery would look like."*

Approach and Actions

To be formed over the course of the next 12-18 months.

3. Financial

3.1 As referenced in 1.5, the programme funding has been secured through the NHS Digital Aspirant Programme grant (£200,000), RMBC Capital Digital Strategy (£200,000) and 2021/22 Council revenue budget (£50,000).

3.2 Spend to date as follows:

Costs Incurred to date	Funding Amount	2021/22	2022/23	Total Costs	Balance Carried Forward
Funding Stream		**Costs**	**Costs**		
RMBC Revenue Budget	**50,000**				
Digital Inclusion Delivery Manager (Band I)		16,440	33,560	50,000	0
DAP - Revenue	**200,000**				
Digital Inclusion Delivery Manager (Band I)			10,383		
Digital Inclusion Baseline review - Attain			55,080	65,463	134,537
RMBC Capital Digital Strategy	**200,000**				
		0	0	0	200,000
	450,000	**16,440**	**99,022**	**115,463**	**334,537**

3.3 To deliver the priorities listed in the Digital Inclusion Action Plan, it is expected that the available funding will be allocated as follows:

Digital Aspirant Programme	2023/24	2024/25	Total Expected Costs	Budgets Available
Funding Stream	**Expected Costs**	**Expected Costs**		
DAP - Revenue & Capital				
Project Management: Digital Inclusion Manager - 2 years	45,893	48,188		

	Year 1 - Creating digital infrastructure (RDASH capital)	40,000			
	Travel	250	206		
		86,143	**48,394**	**134,537**	134,537
	Funding Stream	**Expected Costs**	**Expected Costs**		
	Digital Inclusion Project - Capital				
	Creating programme and digital inclusion delivery model – Support Officer 2 FTE Band F 2 years	69,542	73,019		
	Website Development	17,400	3,406		
	Marketing Materials	1,500	1,500		
	Year 2 Creating digital infrastructure		21,951		
	Contingency	7,000	4,682		
		95,442	**104,558**	**200,000**	200,000

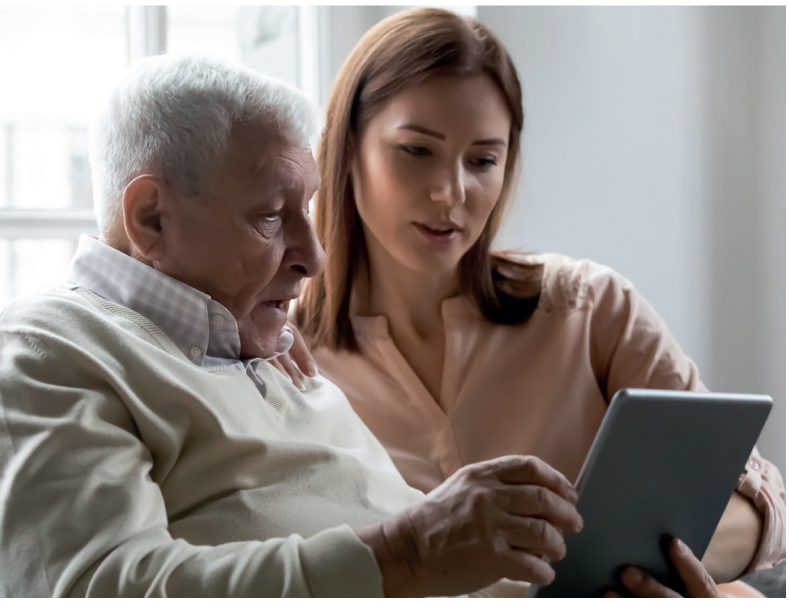
2023/24 salary costs have been calculated based on an assumption that current 22/23 local government pay scales could increase by 5.5% for Band I and 7.8% for Band F.

2024/25 salary costs have then been calculated on the estimated 23/24 cost shown plus a further percentage increase of 4% and 7% respectively.

4.	**Equality & Diversity**
4.1	An Equality Impact Assessment (Appendix 6) has been completed and signed off by the Rotherham Digital Inclusion Stakeholder group members.
4.2	This will be reviewed every six months.
5.	**Risks and Mitigation**
5.1	Please see Appendix 7
6.	**Recommendations**
6.1	That the Health and Wellbeing board: • Note the progress of the Rotherham Digital Inclusion Programme to date • Continue to support the programme and the approach being taken to improve digital inclusion across the borough of Rotherham • Note the intention of the Rotherham Digital Inclusion Stakeholder group to deliver the actions outlined in the Action Plan • Note the intention of the Rotherham Digital Inclusion Stakeholder group to keep the Health and Wellbeing Board, Place Board and Rotherham Together Partnership Board informed of progress on a periodic basis

This report is published on the Rotherham Digital Inclusion website (once established)

Rotherham Digital Inclusion Strategy



Voluntary Action Rotherham

Rotherham Federation
Strengthening Communities

Rotherham ageUK

RNN GROUP

NHS

Rotherham Metropolitan Borough Council

What is digital inclusion?

Making sure that people are given the opportunity to use and access technology to do things that benefit them everyday.

What are the benefits of being online?

Finding a job

- More jobs now are only advertised online and the process to apply is often online only
- More employers require some level of digital skills

Keeping in touch

- Talk to friends and family through video or telephone calls, messages, or emails

Shopping

- It can be cheaper and more convenient to buy things online
- Find better deals for the things you need using comparison sites to find an energy supplier, mobile phone package and makes it easier to switch

Knowledge and learning

- The internet can help you find information, learn new skills, learn a new language, or keep up to date with news and events from around Rotherham and the world

Health

- Book and manage health appointments online 24/7
- View and manage your personal health information
- Improved access to health services and information

Entertainment and lifestyle

- Watching online TV services for your favourite box sets
- Tips and tricks for your hobbies, including finding recipes
- Buy tickets to events

Financial

- Online banking, apply for and access Council/Government services (including Benefits)

Travel

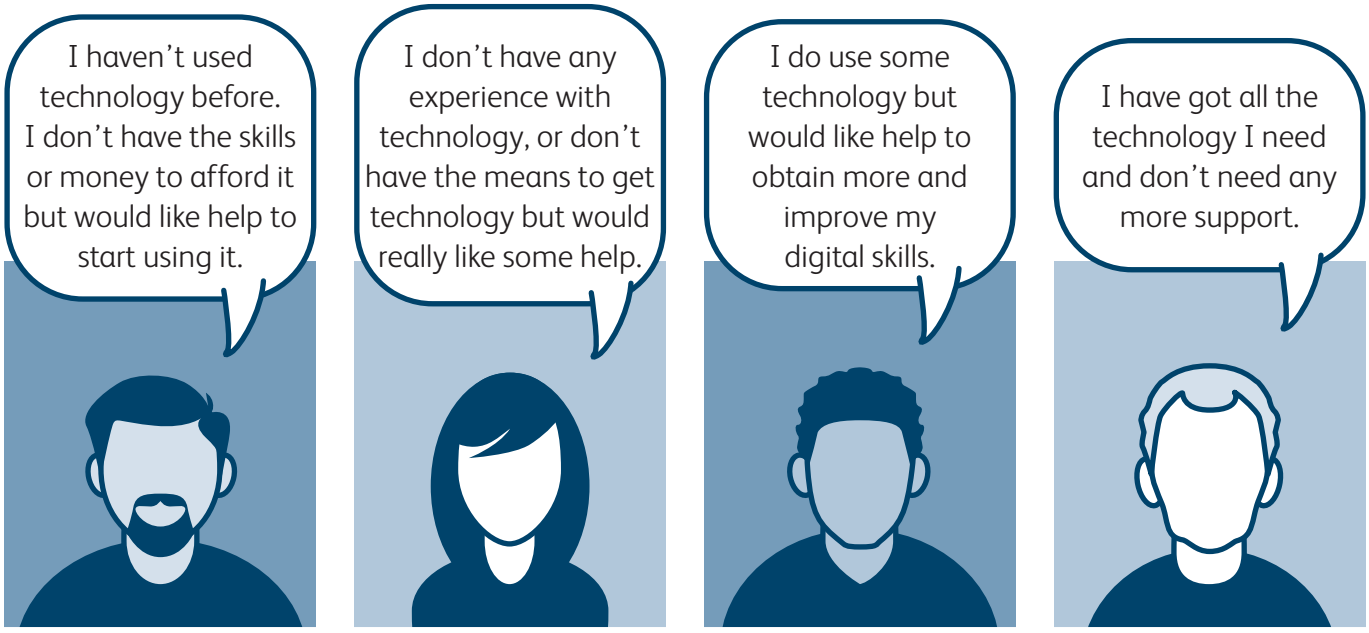
- Book holidays, check-in at the airport and get your NHS Covid Pass
- Travel around using a Sat Nav or online map

Why do we need a Digital Inclusion Strategy?

We want every resident in Rotherham to be able to enjoy the benefits of getting online.

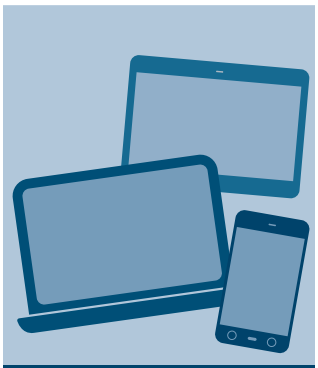
We asked people who live and work in Rotherham about their views and experiences of using technology and their worries and concerns.

This is what they told us…



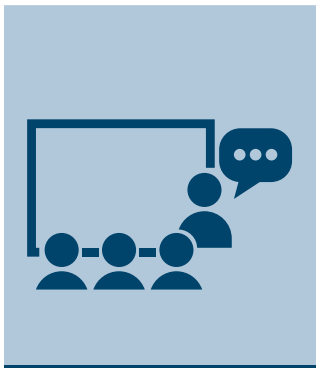
Everyone is different, but there is something for everyone

If technology isn't for you, that's fine but if you change your mind, help and support is available and we'd love to talk to you about it.



We want to help you learn about digital, as well as how to use and access devices.

We want to help improve your digital skills in a way that's flexible to your needs.

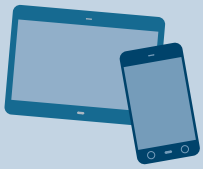


Can you help?
We can support you to share your knowledge with others.

We want to help you get online and feel more confident about using technology so you can do the things you want to do.

Based on what you told us we will:

Help you get online



Help you with phones, tablets and sim cards.

Increase the number of places where free Wifi can be accessed across Rotherham.

Help you learn

Show you how to use the internet and devices including computers, tablets and phone.

We want to offer flexible learning in your community and ensure schools and employers are improving the digital literacy of their students or workers.

Help keep you safe

We know how important it is for people to feel safe online and will provide you with advice and guidance.

Help through volunteering

We will help people who want to volunteer by putting them in touch with organisations across Rotherham who are providing support within the community where people need it.

Why we want to help you become more digitally included

- Some organisations only provide services or reduced costs online
- You can talk to organisations online, which is quicker than sending a letter
- Accessing help online will give your more choices and give you the information you need to make important decisions in your life when you need to make them.

Find out more

This document will be reviewed annually, and we welcome your feedback. If you need this information in another format or language, please contact us to discuss how we can best meet your needs.

Email: rotherhamdigital@rotherham.gov.uk
Website: www.rotherhamdigital.co.uk/

/RotherhamDigital
@RothDig

Digital Inclusion Rotherham Action Plan April 2023 to September 2025

Phase 1 - Information gathering (Completed)

i) Objective:

A third-party organisation with a proven track record of assessing and analysing digital inclusion/exclusion, be commissioned to:

- Identify and profile the target group within the Rotherham Place.
- Understand the local barriers to digital inclusion at an individual and Rotherham Place level.
- Identify existing digital inclusion activity (and the gaps) across the Rotherham Place.
- Identify best practice Digital Inclusion activities and programmes at a local and national level to inform the type of digital inclusion activities that best respond to the brough wide needs and aspirations.

Ref	Outcome	Actions	Lead / Org	Timescales	Progress	Baseline Ref / Priority
1.1	Robust and effective programme governance in place	• Form a Digital Inclusion Stakeholder group with a diverse set of members from organisations across Rotherham to help form the strategy and action plan. This group will meet monthly • Appoint Digital Delivery Manager • Establish a governance framework that ensures accountability to the Rotherham Place Partnership Board and the Rotherham Together Partnership	H. Barker RMBC A. Clayton NHS	Complete November 2021		

1.2	Digital Inclusion Baseline report provides place-based evidence of digital inclusion/exclusion in Rotherham	• Create and sign off a specification document.
		
		• Appoint an independent research specialist to produce a Rotherham place baseline review to include:
		  • National and Rotherham population level analysis
		  • Consultation with residents across all channels, with particular focus on groups most likely at risk of digital inclusion.
		  • An indication of the digital maturity of organisations in Rotherham
		
		• Review report to ensure meets requirements specified
			Digital Inclusion Stakeholder group	Complete November 2021
				
				Complete November 2021
				
				Report completed and published April 22		

Phase 2 - Develop evidence-based intervention strategies and programme governance (Complete)

i) Objective (based on the findings derived from Phase 1)

- *Develop a Digital Inclusion strategy, the outcomes of which can be delivered by a range of projects and initiatives that target Rotherham's most digitally excluded using the most appropriate method of delivery within the budget available.*

Ref	Outcome	Actions	Lead / Org	Timescales	Progress	Baseline Ref / Priority

2.1	Digital Inclusion Strategy and Action Plan created in response to priorities identified in Baseline review	• Workshop with representatives from different organisations across Rotherham inputting into the creation of a Digital Inclusion Action Plan. • Financial Plan completed and signed off by budget holder (RMBC) • Work up a one-page visual document to highlight the work intended in 2023	Digital Inclusion Stakeholder group P Rushton/L Williams RMBC P Woodhouse RMBC	April 23 March 23 March 23	Drafts in progress Drafts in progress Drafts in progress	
2.2	Strategy and Action Plan supported by all organisations represented at the stakeholder group, Place Board and Rotherham Together Partnership Board	• Sign off final version of strategy and action plan by respective organisations/people • Presentation to Place Board • Presentation to Rotherham Together Partnership Board	Digital Inclusion Stakeholder group H Barker RMBC/ A Clayton NHS H Barker RMBC/ A Clayton NHS	March 23 April 23 May 23		
2.3	Publication of a Place Based Digital Inclusion Strategy	• Stakeholder group to make the agreed Digital Inclusion strategy publicly available	Digital Inclusion Stakeholder group	TBC	launched when the website goes live – Scheduled for September	
2.4	Communication Strategy in place	• Develop a communications plan for the programme	W Wilcock RMBC	February 23 - Ongoing	This is a live document; subject to frequent review	
2.5	Action plan visual document	• Create a visual one-page action plan for purposes of sharing externally. It will follow the same visual style of as the strategy	P Woodhouse RMBC W Wilcock RMBC	Completed March 23		

Phase 3 - Delivery (In Progress)

i) Objective

- *Following the completion of phases 1 and two, identify the different delivery mechanisms that can add most value to the communities of Rotherham.*

Ref	Outcome	Actions	Lead / Org	Timescales	Progress	Baseline Ref / Priority
3.1	Key roles in place to focus on delivering the Digital Inclusion Action Plan in Rotherham	• Recruit a small team to work on delivering the action plan and Digital interventions in the community 1 FTE Digital Inclusion Delivery Manager 2 FTE Digital Support Officers	H Barker RMBC A. Clayton NHS	Oct 23	Job advert closed 10th September, interviews w/c 25th September	Page 5, 55,63
3.2	Residents of Rotherham to have increased access to technology including Wi-Fi, Devices and sim cards	• Map 'free Wi-Fi' locations Publish this information both on the website and using offline methods	Digital Inclusion Team	Sept 23	This links to Website launch	
3.3		• Launch a National Databank pilot in RMBC libraries starting initially in Riverside House to offer free sim cards to residents.	A Heggie RMBC	Launched April 23 - Onwards	Launched 9th May from Riverside only. To be expanded to 4 more libraries in September	
3.4		• Explore the feasibility of installing free Wi-Fi in community settings: • Identify pilot location – to be based in one of the following high priority areas: East Herringthorpe, Rotherham Central, Thrybergh or Maltby East	Digital Inclusion Team	May 23 Onwards	Initial research phase with Sky and BT to determine a out personal v business. Will work with the stakeholder group to eventually identify a pilot location from one of the high priority areas,	Page 28 - Feedback from residents

		• Implement • Measure impact and outcomes • Determine whether model can/should be rolled out more widely • Create model that can be sustained moving forward				
3.5		• Work with the assisted technology teams in RMBC to make sure activities/priorities are aligned • Promote technology that helps people with their health. • Engage and link up with various departments and boards within Public Health • Engage and Link into mental health organisations / networks as the cost-of-living crisis is having a huge impact in this area • Engage and Link into the Rotherham Prevention and Health Inequalities group	P Woodhouse RMBC P Woodhouse RMBC P Woodhouse RMBC P Woodhouse RMBC P Woodhouse RMBC A Clayton NHS	April 23 Onwards April 23 Onwards Sept 23 Ongoing Ongoing	Engaging with Sandra Whiting and the Assisted Tech team Included on website Presentation to Health and Wellbeing board by Helen Barker is scheduled for September PW has presented to the Health and Inequalities group	
3.6		• Collaborate with the NHS to on their Virtual Wards programme	P Woodhouse RMBC	Ongoing	PW is part of the Digital Board for Virtual Wards	

3.7		• Research and explore the feasibility of offering a device loaning or gifting scheme.
		  • Create a proof of concept
		  • Implement
		  • Measure impact and outcomes
		  • Determine whether model can/should be rolled out more widely
		  • Create model that can be sustained moving forward
			Digital Inclusion Team/ Digital Inclusion Stakeholder group	May 23 Onwards	PW has spoken to a number of other towns / cities who have successful schemes, and this is still in the research phase. Will be a priority of the team once new roles in post.
					
					The employment hub have a set of 10 tablets that they are happy could be used for this pilot.
					
					The libraries have expressed interest in being the base for these, but further discussions to be had with the stakeholder group to determine its scope
						Page 52,56

3.8	Provide information that gives people more confidence in being safe online	• Identify local organisations to engage with to deliver safety talks into their community • Engage with Safer Rotherham Partnership	Digital Inclusion Team	March 23 Onwards	Agreed with RMBC Community Safety team to do some in the community safety talks. Would also be part of the Digital Support Officer roles. Can also engage with other organisations, have a contact at the police to speak to.	

3.9		• Signpost to existing online safety information
		  • Identify and make use of already published good practice safety guidelines
		  • Promote using online methods (website, YouTube etc) but also when out in the community
		  • Work with organisations to help support young people
			CS Web team RMBC
			
			Digital Inclusion Team/CS web Team
			
			Digital Inclusion Stakeholder group
			
			Digital Inclusion team
				April 23 Onwards	Awaiting Website launch	Page 36, 56

		with information about being safer using social media • Promote safety information to parents/carers to help them feel better informed as to the different types of social media out there, their uses and risks.	Digital Inclusion Stakeholder group / W.Wilcock (RMBC)			
3.10	Help residents across Rotherham increase their Digital Skills: Activities and actions to be initially focused on the high-risk groups (Older People, Deprivation, LTC / Learning Disability, Disadvantaged Young People) living in the high risk wards (East Herringthorpe, Rotherham Central, Thrybergh, Maltby East)	• Identify organisations across Rotherham currently offering free digital skills training. • Promote and share these opportunities via Rotherham digital website, partner websites, social media and whilst out in the community.	Digital Inclusion team All	Ongoing	Part of the website content	
3.11		• Create 'digital surgeries' in libraries and community centres in East Herringthorpe, Rotherham Central, Thrybergh, Maltby East) (where people can drop in to learn more about digital and how to do things online)	A Clayton NHS Digital Inclusion Team	May 23 Onwards	Focus for the new Digital Support Officers once in post. Initial site would be Maltby Community Hub which houses the library but also the Manor Field GP Surgery.	
3.12		• Establish volunteer programme with RNN whereby Digital students go into community groups to help residents with their use of technology	P Woodhouse RMBC D Smith RNN	March 23 Onwards	First phase was very successful with great feedback. Will start again in September when the students return to college	Page 28, 63

3.13		• Develop a longer term plan of community-based activities linking in with existing and established outreach programmes eg. Warm welcome, poverty & financial inclusion • Create activities that focus on helping residents with their digital skills • Provide and promote an easy way for residents to seek help if unsure how to do something online	Digital Inclusion Team	May 23 Onwards	Will be a main focus of the new Digital Support Officer Roles once in post	Page 55
3.14	Residents use and develop their digital skills working in the voluntary sector to help others	• Create a digital champion model that compliments existing volunteer programmes across Rotherham	Stakeholder group members	Ongoing		Page 56,63
3.15		• Work with community groups to encourage people to become involved in volunteering so they can support other people in their local area	Digital Inclusion team/ Digital Inclusion Stakeholder group	Ongoing		Page 56,63
3.16	Opportunities seized to learn from the best practice of others	• Continue dialogue and learning from all the current work happening in other parts of the country to learn from best practice and identify opportunities for shared benefit.	P Woodhouse RMBC	Ongoing	Continued communication, for eg ,recently with Barnsley to talk about their Databank and their digital champion roles, and Stockport to talk about their device gifting service	
3.17	A robust and effective Communication Strategy is in place to ensure the Digital inclusion programme is communicated across Rotherham using both online and offline methods	• Publish the Digital Inclusion Strategy in different formats so people can find out more about the programme aims and support available	W Wilcock RMBC CS Web Team RMBC	Sept 23	Starts with launch of website	
3.18		• Launch the 'Rotherham Digital' website:	W Wilcock RMBC	Sept 23		

		• Website that captures all Digital Inclusion information, case studies, best practice, and activity in Rotherham, • Promote the website through social media and other available messaging to encourage and inform residents, communities, and businesses.				
3.19		• Promote digital inclusion work using all available offline and online communication channels so people are aware of what's happening, how they can get involved, and how they can access the help and support they may need • Plan attendance at events across Rotherham like the Rotherham Show and various roadshows. • Create easy way for organisations to make contact to share information about their Digital Inclusion activity and/or request support/help.	W Wilcock RMBC Digital Inclusion Stakeholder group Digital Inclusion team Digital Inclusion team	Ongoing Start of each financial year June 2023		

Phase 4: Develop a sustainability and ongoing financial model (longer term)

I) Objective

- *Evaluate the effectiveness of digital inclusion interventions to demonstrate how the programme has added value; the evidence from which can be used to inform "what future delivery would look like."*
- *Agree a programme of continued support for all partner organisations to establish digital inclusion activities as a core component of service offerings.*
- *Explore options for additional funding and pool potential match funding to support the programme and future sustainability.*

Ref	Outcome	Actions	Lead / Org	Timescales	Progress	Baseline Ref / Priority
4.1	The effectiveness of the programme is fully evaluated to inform what future delivery would look like	• Establish measurement mechanisms that are designed to evaluate the impact of actions taken; to both residents and organisations/businesses within the Rotherham Place	Digital Inclusion Stakeholder group	July 2023	Measuring Impact draft produced. Will form part of the new Digital Support Officers induction to ensure they understand its importance.	
4.2		• Through established programme governance, ensure the Digital Inclusion programme continues to focus on agreed priorities and is being delivered to timescale within budget	Digital Inclusion Stakeholder group	Ongoing		
4.3		• Constantly review the membership of the group to identify any gaps in representation and look to address this by inviting new members to join	P Woodhouse RMBC	Ongoing		
4.4		• Share case studies involving local people and community groups to inspire others onto the website and through regular updates to our partners	P Woodhouse RMBC	Ongoing		
4.5		• Keep a track of national, regional digital inclusion levels and compare against the baseline review	P Woodhouse RMBC	Ongoing		
4.6	Partner organisations have each established digital inclusion activities as a core	• Identify activities/best practice that should/could be absorbed by all organizations	Digital Inclusion Stakeholder group	Ongoing		

	component of their service deliver/approach	• Review the digital maturity findings of the baseline report to identify organisational gaps • Create a library of best practice guidance that all organisations can access when undertaking any work with a digital inclusion aspect				
4.7	Activities/actions required to further increase digital inclusion have been identified	• Identify any actions that have not been completed due to timescales/budget • Assess the impact of any work not undertaken and likely risks if not completed • Identify critical actions/activities and deliverables that should be considered as key to the continued reduction of digital exclusion	Digital Inclusion Stakeholder group	Ongoing		
4.8	Options for the future sustainability of the programme have been fully considered	• Briefing paper created setting out activities undertaken, impact on the Rotherham Place and recommendations/risks of continuing/ending the programme	Digital Inclusion Stakeholder group	To be completed by July 2024		

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BRIEFING	TO:	Health and Wellbeing Board
	DATE:	27 September 2023
	LEAD OFFICER	Claire Smith, Deputy Place Director, SYICB (Rotherham Place)
	TITLE:	**Rotherham Place Partnership Health and Care Plan 2023-25**

Background

1.1 Rotherham's first Integrated Health and Social Care Place Plan (Place Plan) was published in November 2016, it detailed the joined-up approach to delivering key initiatives that would support achievement of the health and wellbeing strategic aims.

The Place Plan was then refreshed in 2018 to ensure clear alignment with the revised Health and Wellbeing (H&WB) Strategy. The H&WB Strategy sets the overall strategic direction for health and social care in Rotherham, the 'Place Plan' is the delivery mechanism for the health and social care elements of the H&WB Strategy.

The NHS Long Term Plan (LTP) was published in January 2019, as a result place partners took the decision to refresh the Place Plan to ensure it addressed the requirements of the NHS LTP. The third Place Plan was approved in February 2020, on the cusp of the covid-19 pandemic.

As a consequence of the pandemic there was acknowledgement that the system had significantly changed, in September 2020, in response to this and the Governments planning requirements all partners across the Rotherham place engaged in assessing the impact of covid on the revised Place Plan. The updated priorities document produced supplemented the 2020-22 Place Plan and reconfirmed place priorities and the key actions associated.

1.2 The updated priorities document has been regularly reviewed and received at Place Board and H&WB Board since September 2020 enabling members to be assured on progress. A 'close down' version of the priorities document was received at April Confidential Place Board, May Public Place Board and June H&WB Board. It identifies the actions that have been completed and the actions that roll over to the refreshed Place Plan.

1.3 This fourth edition of the Place Plan 2023-25 has been refreshed taking account of the changed landscape following the Health and Care Act 2022 and the establishment of a statutory Integrated Care System (ICS) from 1 July 2022. The Place Plan also continues to align with the Rotherham H&WB Strategy which was refreshed in 2022.

1.4 The final draft was received at the May 2023 confidential Place Board where members approved the plan in principle subject to the plan receiving approval through partners own governance arrangements.

The final version, incorporating partner comments, was received at public place board in July, where it received approval subject to any minor amendments. It was agreed that the H&WB Board would receive both the full Place Plan and the summary version in September.

Key Issues

2.1 ***Alignment across NHS South Yorkshire ICB and Rotherham Place***

At a **local level,** the Rotherham Place Plan continues to align with the Rotherham H&WB Strategy for delivery on the health and social care elements of the strategy. The Rotherham Prevention and Health Inequalities Strategy is also a key local driver for the Place Plan.

The 2023-25 Place Plan builds on the previous plans and takes into account the expectations set out in the NHS Long Term Plan, but also the new NHS landscape, and so aligns with the South Yorkshire Joint Forward Plan and, through the H&WB Strategy, aligns to the South Yorkshire Integrated Care Strategy.

In line with the expectations of the Joint Forward Plan, the Place Plan also sets out local priorities and is coherent with operational planning returns.

2.2 ***Key Changes from the previous Plan***

Members are receiving the final version of the Place Plan, which has been designed so that the chapters reflect the Joint Forward Plan whilst maintaining close alignment with the Rotherham H&WB Strategy.

The following chapters were within the previous Plan and remain in this version:

- Best Start in Life (maternity / children & young people)
- Improving mental health and wellbeing
- Support people with learning disabilities & autism
- Urgent, emergency and community care

The following are new chapters, this has been influenced by recent guidance and importantly, as a result of the outcomes from the Place Board development session in January:

- Live Well for Longer (prevention, self-care & long-term conditions)
- Palliative and End of Life Care

2.3 The first draft of the Place Plan was received at confidential Place Board in April, members gave two key areas of feedback:

1. Consider how the plan could be produced in different formats suitable for a variety of audiences, how we communicate with the public and how to bring the plan to life in more innovative ways than before.
    - *This will be taken forward once the final version has been agreed.*
2. The plan is quite lengthy.
    - *In response the attached final version has been significantly reduced*.

A number of comments and amendments have been received from partners and have been incorporated into this final version. These include changes to the plan on a page, governance diagram and points of clarity across a number the workstream sections.

Key feedback, particularly from RMBC, is that expected impact from the key priorities needs to be more visible. This is something that we will aim to address through an interactive website version.

2.4

Final Steps

2.5	Once the final version of the place plan has received approval, a designed version will be produced using the place branding and will become the platform for an interactive online version, including creation of infographics to make the content easier to digest. This will be embedded within the 'your health' website which will also include the summary version and a printable version. This should address the feedback around producing the plan in different formats; bringing it to life in more innovative ways; and making some of the expected impacts of our priorities more visible. As with previous Place Plans, a performance report will be developed to enable members to be assured on delivery against the priorities and actions within the Plan.

Key Actions and Relevant Timelines

3.1 ***Patient, Public and Partner Engagement***

All 'place' partners have been involved in the development of the Place Plan and comments received have been incorporated into the final version.

Timeline

Date	Meeting	Version of Place Plan
November 2022	Place Leadership Team and Place Board (confidential)	Draft Framework and timescales
January 2023	Place Board Development Session	Focussed session on the priorities
April 2023	Place Board (confidential)	Draft Place Plan version 1.0
May 2023	Place Leadership Team	Draft Place Plan version 2.0
May – July 2023	Partners respective governance groups	Draft Place Plan version 2.1
July 2023	Public Place Board	Final version of Place Plan

Implications for Health Inequalities

4.1 A key input into the development of the Place Plan was Rotherham's Prevention and Health Inequalities (P&HI) Strategy. The P&HI Strategy aims to drive delivery against South Yorkshire's Joint Forward Plan in Rotherham and local ambitions around improving the health of the local population.

The P&HI Strategy is driven by the P&HI Group which is a key group within the place delivery structure and is committed to building understanding of health inequalities in Rotherham, which will include analysis of disparities in access, outcomes, and experience for ethnic minority communities. This will inform the delivery of the entirety of the Place Plan, with all workstreams contributing towards narrowing the gap.

Recommendations

5.1 The Rotherham Health and Wellbeing board are asked to consider and endorse the final version of the refreshed Rotherham Partnership Health and Care Place Plan 2023–25 and the accompanying Summary Version.

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Rotherham Partners' Commitment

Rotherham's Health and Social Care Community has been working in a collaborative way for many years to transform the way it cares for and achieves a positive change for its population.

We are passionate about providing the best possible services and outcomes and are committed to a whole system approach. By working together to make decisions on a best for Rotherham basis, we can provide sustainable services over the long term that aim to help all Rotherham people **live well for longer**.

To realise our ambition and the necessary scale of transformation, we need to act as one voice with a single vision and a single Plan to deliver the best for Rotherham.

We want everyone who works or lives in Rotherham – patients, people, families – to work together to establish an individual and collective widespread aspiration for improved health and social care.

Rotherham Place Partnership was established since 2018, and the 2023-25 Place Plan is the 4th edition since then. The 2023-25 Place Plan continues to deliver on the health and social care elements of the Rotherham Health and Wellbeing Strategy but also aligns to the South Yorkshire Integrated Care Strategy and the NHS South Yorkshire Joint Forward Plan.

Our shared vision is: ***'Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery'***

The Rotherham Culture

Rotherham Place has a strong, experienced and cohesive executive leadership team who have set clear expectations and the spirit of collaboration and inclusiveness across the Rotherham Place with the key aim of driving forward the transformation set out within the Place Plan.

A high standard of integrity is set amongst all leaders and a culture of empowering and engaging with all staff. This means that staff are confident to challenge and change things that are not right to improve services for people. A key strength in Rotherham is the trust and openness between partners and their shared vision and shared principles by which we work to achieve our vision for Rotherham.

We can create a first-class strategy, but the hard part is implementation and achieving the goals it sets, this can only be done by winning the hearts and minds of our staff, through adapting to diverse approaches and styles and building mutual benefit.

In July 2022 there was significant change to the landscape which included the formation of the South Yorkshire Integrated Care System. Rotherham partners recognise the significant opportunities to be gained by working together across South Yorkshire, and as such are committed to supporting and playing their role in the delivery of the South Yorkshire Integrated Care Strategy and the NHS South Yorkshire Joint Forward

The Rotherham Place Plan closely aligns to the Rotherham Health and Wellbeing Strategy

The **Place Plan does not** replace partners' individual plans but builds upon them identifying areas where we can do more together. It uses insights from the Health and Wellbeing Strategy and the Joint Strategic Needs Assessment, and takes into account other relevant key documents:

- The Rotherham Plan
- The Rotherham Prevention and Health Inequalities Strategy
- The South Yorkshire Integrated Care Strategy
- The NHS South Yorkshire Joint Forward Plan

ROTHERHAM PLACE PARTNERS

NHS South Yorkshire Integrated Care Board

Rotherham, Doncaster and South Humber NHS Foundation Trust

The Rotherham NHS Foundation Trust

Rotherham Metropolitan Borough Council

Voluntary Action Rotherham

CONECT HEALTHCARE ROTHERHAM CIC

What we know about our population

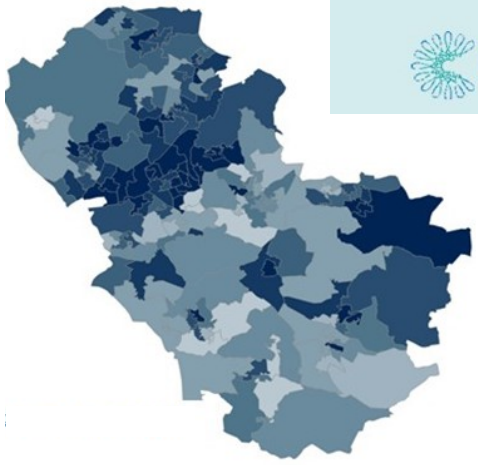
The health of people in Rotherham is generally poorer than the England average, and people are living shorter lives than they should and in poorer health for longer than they should.

A high proportion of Rotherham residents live in the 20% most deprived communities of England. Inequalities in access to the wide range of determinants (and protective factors) of health have led to inequalities in health outcomes.

A range of factors impact on individual and population level health, such as the environment we live, the opportunities we have as well as the health care we receive.

To improve the health of Rotherham people we need to work collaboratively with all Rotherham partners and across South Yorkshire. And we need to pay particular attention to certain population groups such as those who live in the most deprived areas or those from ethnic minority populations as they are more likely to experience higher inequalities in health.

- Rotherham ranks as the 35th most deprived upper tier local authority in England our of a total of 151
- 35% of Rotherham's neighbourhoods live in the 20% most deprived in England, and 22% live in the 10% most deprived
- No neighbourhoods in Rotherham are in the least deprived 10%
- People in the most deprived areas spend around a third of their lives in poor health, twice the proportion spent by those in the least deprived areas.



Summary of transformation, enabling, cross-cutting workstreams and key priorities

Rotherham Place Partnership Shared Vision	***'Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery'***					
Transformation Workstreams	**Ensuring Best Start in Life**	**Improving Mental Health & Wellbeing**	**Support People with Learning Disabilities & Autism**	**Urgent, Emergency & Community Care**	**Palliative & End of Life Care**	**Live Well for Longer**
Key Priorities (key projects to deliver the transformations)	• Best Start in Life • Mental Health & Emotional Wellbeing • Special Educational Needs and/ or Disabilities	• Adult Severe Mental Illnesses in Community • Mental Health Crisis & Liaison • Suicide Prevention	• Uptake of enhanced health checks • Benefits & independence of employment	• Prevention & Alternative Pathways to Admission • Sustainable Discharge • Whole System Command Centre Model	• Review Palliative and End of Life Care Medicine • Personalised Palliative and End of Life Care	• Anticipatory Care • Personalised Care • Medicines Optimisation
Enabling Workstreams	**Communication & Engagement**	**Workforce & Organisational Development**	**Digital**	**Estate & Housing**	**Finance & Use of Resources**	
Cross-cutting	**Prevention and Health Inequalities** *(priorities below)*					
	Strengthen our understanding of health inequalities	Develop the healthy lifestyles prevention pathway	Support prevention and early diagnosis of chronic conditions	Tackle clinical variation and promote equity of access & care	Harness partners' roles as anchor institutions	
	Primary Care		**Planned Care**		**Finance**	

What we have delivered in 2020-22

Progress in delivering on the 2020-22 Place Plan is documented within the refreshed Place Plan for 2023-25. Further information on our delivery against priorities and examples of key achievements can be seen in the following documents, all can be accessed as part of the Place Board papers at the link below:

- Place Partnership Updates
- Achievements,
- Close Down Report for Priorities in the 2020-22 Plan

https://yourhealthrotherham.co.uk/public-meetings/

Examples of what will be delivered over the course of the 2023-25 Plan

Children & Young People

Family hubs including the Start for Life offer, parent-infant mental health support and infant-feeding support services will ensure joined up, accessible and timely support to mitigate the impact of poverty and increase the number of children under 5 **achieving a good level of development.**

40% of Children and Young People in Rotherham wait longer than 18 weeks to access **mental health assessment and intervention**, we will improve this and ensure children receive timely access when the need has been identified.

Looked After Children and young people in care are more likely to experience poor outcomes, a key priority for Rotherham is to **recruit, retain and grow the best inhouse foster carers locally** so that the needs of children and young people can be met effectively in an environment that provides high quality care and support.

Mental Health and Wellbeing.

To ensure that people have access the right care and support at their earliest point of need and closer to home so they can live as healthy and fulfilling lives as possible in their community, we will **Transform adult mental health** services; including integrated primary care hubs, improved access to physical health checks, employment support and targeted work on adult eating disorders, personality disorders and community rehabilitation.

Strengthen the mental health crisis pathway to improve the journey and outcomes for people with mental ill-health. We will redesign pathways to embed principles and practices that prevent, reduce and delay people's need for care and support, including embedding a 24/7 'Making Safe' and reablement model, focussed on community-based recovery.

Loneliness can fluctuate over the life course and causes are difficult to pinpoint. We will continue to take action to tackle the known trigger factors at an individual, community and societal level.

Learning Disabilities & Autism

Everyone over the age of 14 who is on their doctor's learning disability register should have an **annual health check**. Often people with a learning disability have poorer physical and mental health than other people, this does not need to be the case

Provide specialist support to **access sustainable employment** for our residents with a learning disability and/or autism. Partners will work together to increase the number of young people accessing supported internships and other opportunities for employment, utilising such as the Supported Internships Grant; Employment is for Everyone projects and the RMBC Supported Employment team.

Ongoing commitment to the **Transformation of Learning Disability Services** including a new service model focussed on day opportunities for people with high support needs. This includes a new day centre facility replacing the existing day service, providing a modern, state of the art facility in a calming and exciting purpose-built environment.

Urgent, Emergency and Community Care

Based on the principle '**prevention is better than cure**', we aim to help support people to live independently for longer. This will in turn support their own and their family/carer's health and wellbeing and reduce avoidable reliance on services. We will do this by:

- Proactive (Anticipatory) care to identify and engage people living with frailty, multiple long-term conditions and/or complex needs to help them stay independent and healthy at home, for longer
- Identify alternative pathways to emergency care and admission
- Implement virtual ward and urgent community response to support more people at home who would otherwise be in an acute bed or at risk of admission
- Improve frailty services, embed same day emergency care offer and review falls services

Create a coherent **multi-disciplinary discharge to assess model** with an integrated Transfer of Care hub. This will enable referral and triage assessment of the level of risk that can be safely supported at home and in community beds with assessments carried out at home and resource to be allocated flexibly

Link admission avoidance activity and discharge to inform decision making to improve whole system flow, including the development of a whole system command centre and performance dashboard.

Palliative and End of Life Care

Review palliative and end of life care across Rotherham, to get a comprehensive understanding, focussing on access to specialist palliative care services, bereavement services, pharmacy services, equipment, spiritual care and access to information.

Implement the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) across Rotherham . The ReSPECT process creates a summary of **personalised recommendations** for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.

Proactive (Anticipatory) Care

Develop our proactive care model, and identify registered practice populations who have complex needs and are **at high risk of unwarranted health outcomes;** understand those who would benefit from proactive care, and deliver comprehensive support for those individuals

Personalised Care

Support people to have **choice and control** over the way their care is planned and delivered, based on **'what matters'** to them and their individual strengths, needs and preferences by continuing to embed the personalised care ethos across place and by a focus on workforce development.

Medicines Optimisation

Continue to deliver the comprehensive work plan including;

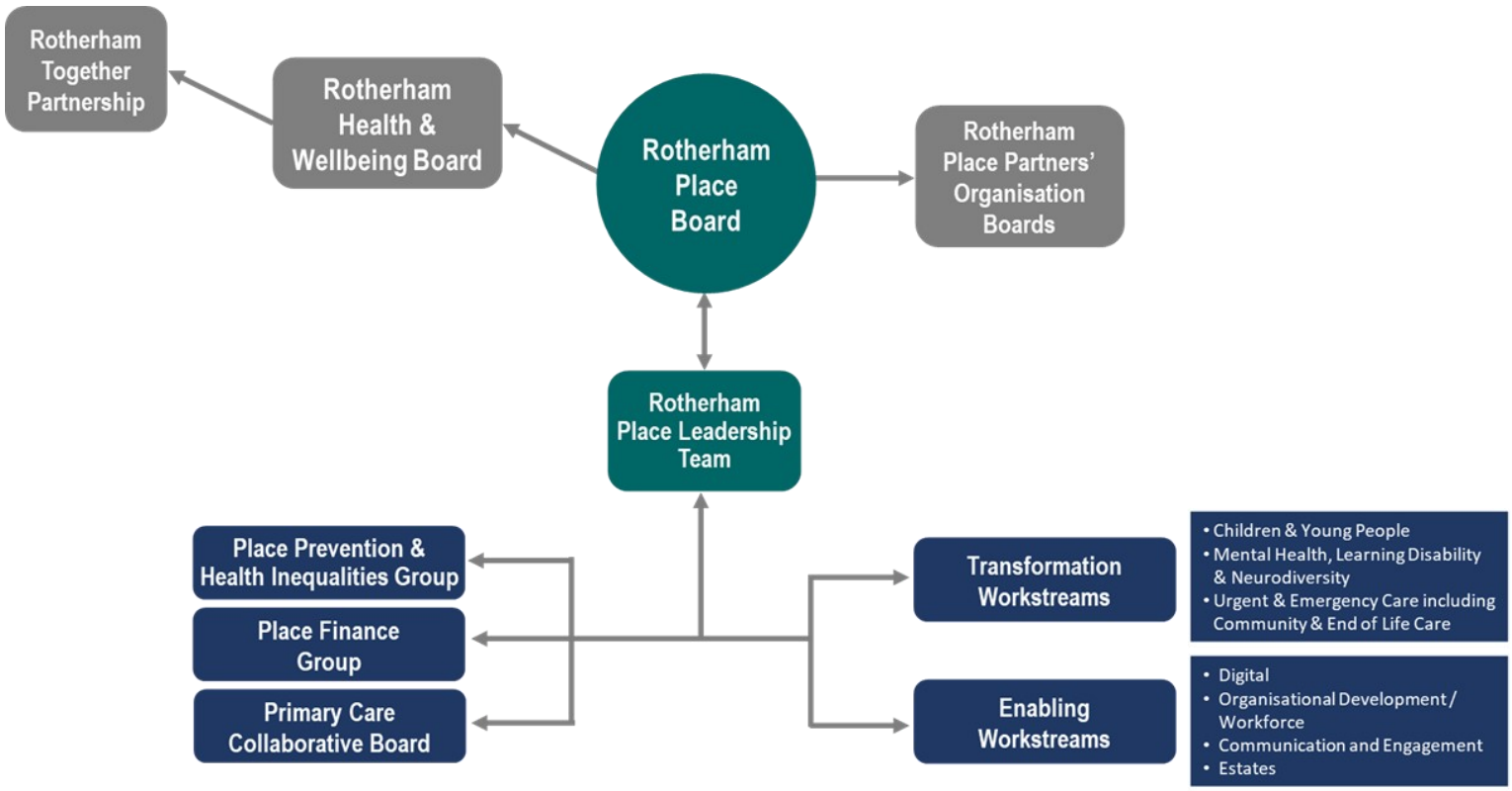
- Implementation of plans for **diabetes, hypertension**, and antibiotic prescribing
- **Antidepressant** review programme
- Care home hydration project
- Continued improvement of diabetes management
- Establish **chronic pain management** pilot

Rotherham Health and Care Place Plan: 'Plan on a Page'

Rotherham Place Partnership Shared Vision	*'Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery'*						
South Yorkshire Integrated Care System Key Purpose	Improving outcomes in population health and health care		Tackling inequalities in outcomes, experience and access		Helping the NHS to support broader social and economic development		Enhancing productivity and value for money	
Rotherham Place Key Challenges	The health of people in Rotherham is generally poorer than the England average	People living in our most deprived areas have both shorter lives and are living those years in poorer health	35% of Rotherham's neighbourhoods live in the 20% most deprived in England, and 22% live in the 10% most deprived.	Increasing numbers of people with long term conditions and people living longer in poorer health	One in four adults experience a diagnosable mental health problem in any given year	Significantly more children affected by income deprivation, particularly in the most deprived areas	Half of people aged 75 years and over live alone and most experience loneliness	Significant joint financial challenge
Transformation Workstreams	**Best Start in Life** Maternity, Children & Young People	**Improve Mental Health & Wellbeing**	**Supporting People with Learning Disabilities & Autism**		**Urgent, Emergency & Community Care**	**Palliative & End of Life Care**	**Live Well for Longer** Prevention, early identification & Long Terms Conditions	
Enabling Workstreams	**Digital** (including Information Technology)		**Workforce Development** (including Organisational Development)		**Communications** (Including Engagement)		**Estates** (including Housing)	
Cross Cutting Workstreams	**Finance & Best Use of Resources**				**Prevention & Health Inequalities**			
Rotherham Place Principles	Focus on people and places	Encourage prevention, self-management, and early intervention	Design pathways together	Strive for best quality services based on best outcomes	Be Innovative	Be financially sustainable	Jointly buy health, care, and support services once for a place	Work together to reduce health inequalities
Rotherham Place Partners	Voluntary Action Rotherham (VAR)	Rotherham Metropolitan Borough Council (RMBC)	Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)		Connect Healthcare Rotherham CIC	The Rotherham NHS Foundation Trust (TRFT)	South Yorkshire Integrated Care Board (Rotherham Place)	

Read left to Right

Rotherham Place Governance Structure



ROTHERHAM

PLACE PARTNERSHIP | HEALTH AND CARE

HEALTH AND CARE PLACE PLAN 2023-25

Table of Contents

ROTHERHAM PLACE PARTNERS

NHS

South Yorkshire
Integrated Care Board

Rotherham, Doncaster and South Humber
NHS Foundation Trust

The Rotherham
NHS Foundation Trust

Rotherham Metropolitan Borough Council

VoluntaryAction Rotherham

CONNECT HEALTHCARE ROTHERHAM CIC

1 Introduction

1.1 Rotherham Partners Commitment and Vision

Rotherham's Health and Social Care Community has been working in a collaborative way for many years to transform the way it cares for and achieves a positive change for its population of 267,000. Our successful track record in developing and delivering new solutions makes Rotherham the perfect test bed for new innovations. We are passionate about providing the best possible services and outcomes for our population and are committed to a whole system partnership approach. Only through working together can we provide sustainable services over the long term that aim to help all Rotherham people live well for longer.

Rotherham Partners' recognise that to realise our ambition and the necessary scale of transformation, we need to act as one voice with a single vision and a single Plan to deliver the best for Rotherham. Our **shared vision** is:

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

The first Rotherham Integrated Health and Social Care Place Plan was developed in November 2016. The Plan was refreshed in 2018, to ensure close alignment with the Rotherham Health and Wellbeing Strategy. The 2020-22 Plan described achievements to date, future strategic intent and how relationships between the health and social care community continued to mature to move us forward at pace. The plan was approved in the month before the Covid-19 pandemic, following the first wave and in line with the Governments approach, the priorities within the plan were re-affirmed acknowledging that the system had changed significantly and would continue to do for the foreseeable future as we adjusted to delivering services in the context of Covid 19.

In July 2022 there was significant change to the landscape with the dissolution of CCGs and the formation of the South Yorkshire Integrated Care System. The 2023-25 Plan, this plan, continues to be the delivery plan for the health and social care elements of the Rotherham Health and Wellbeing Strategy, but also aligns to the South Yorkshire Integrated Care Strategy and the NHS South Yorkshire Joint Forward Plan. The Plan is intended to work as a catalyst to deliver sustainable, effective, and efficient health and care support and community services with significant improvements underpinned by collaborative working through the continue development of the Rotherham Place Partnership.

Partners are fully committed to working together to make decisions on a best for Rotherham basis to achieve the transformations set out in this Plan. This is underpinned by robust governance arrangements, including the Rotherham Agreement, a document that captures how we work together. Rotherham Place has a strong, experienced, and cohesive executive leadership team who have set clear expectations and the spirit of collaboration and inclusiveness across the Rotherham Place with the key aim of driving forward the transformation set out within this Plan. It sets a high standard of integrity amongst leaders across all partners, and a culture of empowering and engaging with all staff. As well as a shared vision, Rotherham partners have agreed a shared set of principles by which we work to achieve our vision for Rotherham, these can be found in the Rotherham Agreement or terms of reference for the Place Board.

To realise our vision, we want everyone who works or lives in Rotherham– patients, people, families – to work together for a better Rotherham, to establish an individual and collective widespread aspiration for improved health and social care. The Rotherham culture means that staff are confident to challenge and change things to improve services for people, aligning to the vision and principles within this plan. A key strength in Rotherham is the trust and openness between partners and their commitment to the shared vision. We can create a first-class strategy, but the hard part is implementation and achieving the goals it sets, this can only be done by winning the hearts and minds of our staff, through adapting to diverse approaches and styles and building mutual benefit.

Rotherham partners recognise the significant opportunities to be gained by working together across South Yorkshire, and as such are committed to supporting and playing their role in the delivery of the South Yorkshire Joint Forward Plan. This Plan sets out the additionality at Rotherham Place, but the priorities and actions within the South Yorkshire Joint Forward Plan and the role of Rotherham partners in its delivery should simultaneously be acknowledged.

1.2 Summary of transformation, enabling and cross-cutting workstreams

Rotherham Place Partnership Shared Vision	***'Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery'***					
Transformation Workstreams	**Best Start in Life** (maternity / children & young people)	**Improving Mental Health & Wellbeing**	**Support People with Learning Disabilities & Autism**	**Urgent, Emergency & Community Care**	**Palliative & End of Life Care**	**Live Well for Longer** (prevention, self-care & long-term conditions)
Key Priorities (key (projects to deliver the transformations)	1. Best Start in Life 2. Mental Health & Emotional Wellbeing 3. Special Educational Needs and/ or Disabilities	1. Adult Severe Mental Illnesses in Community 2. Mental Health Crisis & Liaison 3. Suicide Prevention	1. Uptake of enhanced health checks 2. Benefits & independence of employment	1. Prevention & Alternative Pathways to Admission 2. Sustainable Discharge 3. Whole System Command Centre Model	1. Review Palliative and End of Life Care Medicine 2. Personalised Palliative and End of Life Care	1. Anticipatory Care 2. Personalised Care 3. Medicines Optimisation
Enabling workstreams	**Communication & Engagement**	**Workforce & Organisational Development**	**Digital**	**Estate & Housing**	**Finance & Use of Resources**	
Cross-cutting	**Prevention and Health Inequalities** *(priorities below)*					
	Strengthen our understanding of health inequalities	Develop the healthy lifestyles prevention pathway	Support the prevention and early diagnosis of chronic conditions	Tackle clinical variation and promote equity of access & care	Harness partners' roles as anchor institutions	
	Primary Care *Including, for example, Rotherham Health App, primary care estates developments, centralised spirometry*					
	Planned Care *Including diagnostics, elective recovery, waiting times*					
Business as Usual	There are other workstreams / projects supporting Business as Usual AND there are further priorities, projects and actions beneath our transformation, enabling and cross-cutting workstreams					

1.3 Plan on a Page

Rotherham Place Partnership Shared Vision	***'Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery'***						
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Read from left to Right.

2 How we work together in Rotherham Place and across South Yorkshire

2.1 How we are organised

The first South Yorkshire Sustainability and Transformation Partnership was established in 2016, this then became one of the first non-statutory Integrated Care Systems in England in 2018. Following the Health and Care Act 2022 a statutory **Integrated Care System (ICS)** has come together from July 1st 2022.

New statutory Integrated Care Systems have been set up to bring local authorities, NHS organisations, combined authorities and the Voluntary, Community and Social Enterprise Sector together with local communities to take collective responsibility for planning services, improving health and wellbeing, and reducing inequalities.

Integrated Care Systems have four key purposes:

- Improving outcomes in population health and health care
- Enhancing productivity and value for money
- Tackling inequalities in outcomes, experience, and access
- Helping the NHS to support broader social and economic development

An Integrated Care Board, which is an NHS organisation responsible for planning and funding NHS services, in our case NHS South Yorkshire established in July 2022. NHS South Yorkshire has been established with Partner Board Members, including Healthwatch, Mental Health and the Voluntary Care Sector representation.

The Integrated Care Partnership is statutory committee jointly convened by Local Government and the Integrated Care Board, to bring together the NHS with Local Authorities, Combined Authorities, the Voluntary, Community and Social Enterprise Sector and other partners.

In South Yorkshire the membership of our Integrated Care Partnership (ICP) was proposed by the Health and Wellbeing Boards in the four local authority areas, Barnsley, Doncaster, Rotherham and Sheffield and NHS South Yorkshire. Oliver Coppard, Mayor of South Yorkshire Combined Mayoral Authority became Chair of the South Yorkshire Integrated Care Partnership in September 2022 and Pearse Butler the Chair of NHS South Yorkshire is vice chair.

Place, Provider Collaboratives and Alliances

South Yorkshire continues to build on the **collaborative working arrangements**. A key priority for the development of the South Yorkshire Integrated Care System is maturing ways of working across the system including provider collaboratives, alliances, and place-based partnership arrangements. It is through these arrangements that enables delivery of the NHS SY Joint Forward Plan and will require delegating and sharing responsibility with our Places and Provider Collaboratives.

In each of the South Yorkshire communities of Barnsley, Doncaster, Rotherham, and Sheffield there is a well-established **place-based health and care partnership** already working well together to provide joined up integrated health and social care, support, and services. These are the cornerstone of our health and care system and will have delegated authority from NHS South Yorkshire to deliver plans that meet the needs of local communities. As our key delivery vehicles, they each have an integrated health and care delivery plan.

Rotherham Partners have a long and successful history of working together, the Rotherham Place governance was developed by all place partners, through a series of development sessions. The first Rotherham Place Board was held in June 2017, and has met in public since May 2018. As a result of the establishment of the Integrated Care Systems in July 2022, Rotherham Place Partners built on the existing governance arrangements to reflect the new statutory guidance, but the ethos of how we work together to deliver the best for Rotherham remains the guiding principle for all partners.

2.2 What influenced our place plan

The first **Integrated Care Strategy for South Yorkshire** was created by the newly formed Integrated Care Partnership and was launched in March 2023. The vision in the SY Integrated Care Strategy is that

'Everyone in our diverse communities lives a happy, healthier life for longer'

It is in line with the Mayor's Manifesto, for South Yorkshire to become the healthiest region in the UK and underpinned by three overarching goals to see the people in all our communities:

1. live healthier and longer
2. have fairer outcomes for all
3. timely, equitable access to quality health and care services and support.

The vision and goals are supported by four shared outcomes. Which are reflected in all our Health and Wellbeing Strategies and support the transition through the life courses of starting well, living well, and aging well.

- Children and young people have the best start in life
- People in South Yorkshire live longer and healthier lives AND the physical and mental health and wellbeing of those with the greatest need improves the fastest
- People are supported to live in safe, strong, and vibrant communities
- People are equipped with the skills and resources they need to thrive

The **NHS Five Year Joint Forward Plan for South Yorkshire** was developed in collaboration with all NHS Trusts that operate in the South Yorkshire Integrated Care System. The JFP guidance was published alongside the annual NHS England Operational Planning Guidance for 2023/24 with a clear expectation of alignment. The 2023/24 Operational Planning guidance asks for a particular focus in 2023/24 on; prioritising recovering core services and productivity, return to delivery of the key ambitions in the NHS Long Term Plan (LTP); and continue transforming the NHS for the future and detailed plans and trajectories to deliver against each of the 32 specific national objectives as set out in the Operational Guidance.

The JFP sets out plans to deliver operational requirements, the NHS universal commitments, contribute to the four core purposes of an Integrated Care System (ICS) and dispatch statutory duties/legal requirements.

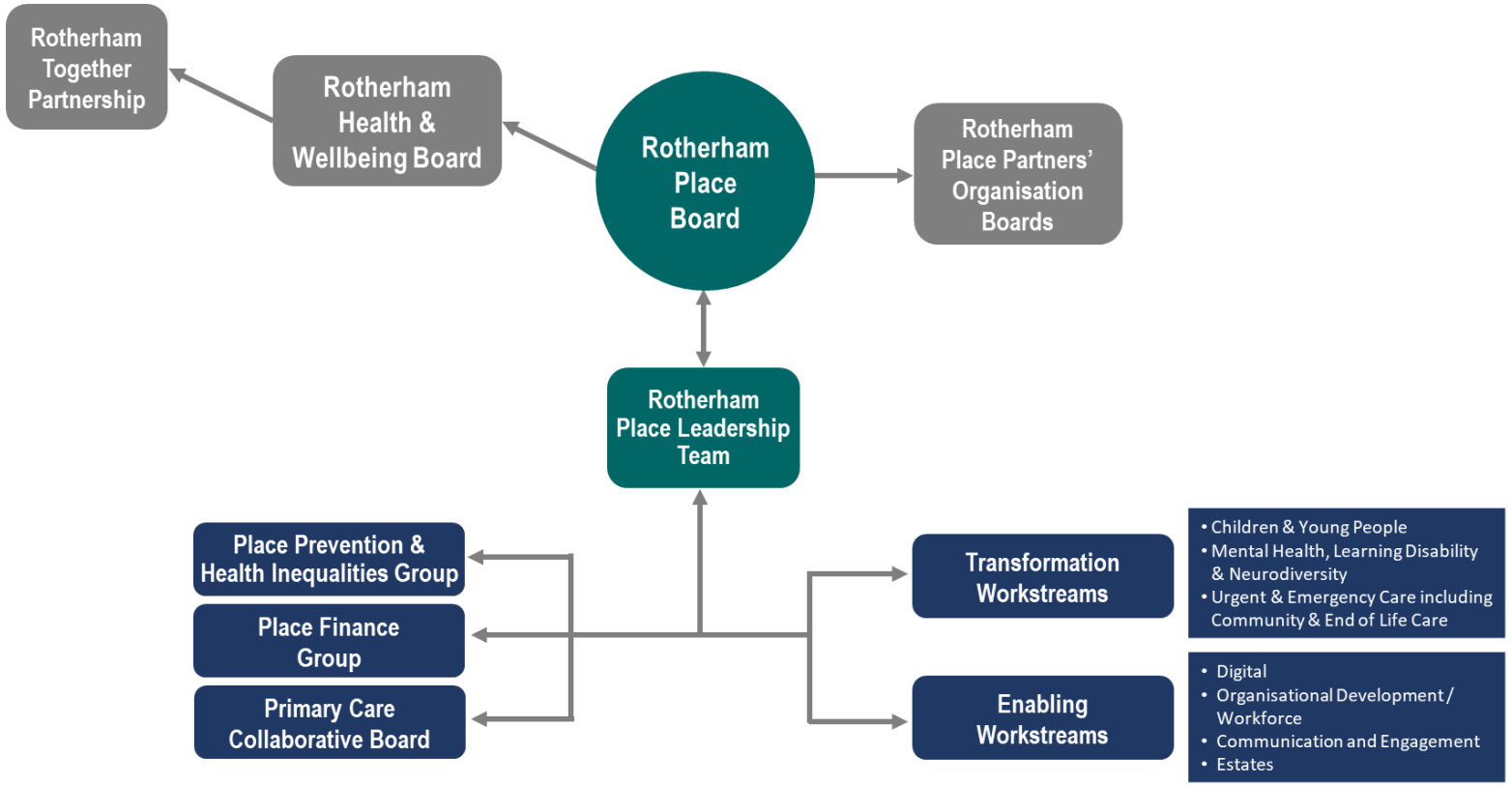
The Rotherham Plan 2025 - The Rotherham Together Partnership provides a framework for partners' collective efforts to create a borough that is better for everyone who wants to live, work, invest or visit. The Health and Wellbeing Board and Strategy contribute to achieving the vision of the Rotherham Plan, particularly in relation to integrating health and social care and improving health and wellbeing outcomes for local people. The wider partnership also provides an opportunity to explore where better outcomes could be achieved in relation to the wider determinants of health, for example, the environment people live in, education, employment, financial inclusion, and transport. All of which contribute to the aims and priorities within the H&WB Strategy.

Rotherham Health and Wellbeing Board is a statutory sub-committee of Rotherham Metropolitan Borough Council (RMBC). Locally, it is the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health, and other services directly related to health and wellbeing.

The H&WB Strategy for Rotherham sets the strategic vision for health and social care and improving health and wellbeing outcomes for local people. The H&WB Strategy includes four aims which the H&WB Board have agreed are the most important things to focus on to improve health and wellbeing outcomes for all Rotherham people, and that can be best tackled by a 'whole system' approach:

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

2.3 Rotherham Place Delivery



Rotherham Place Plan 2023-25, this plan, is the fourth in the series. It closely aligns to the H&WB Strategy and is the delivery mechanism for the health and social care elements of the H&WB Strategy. The Place Plan builds on the previous plans and takes into account the expectations set out in the NHS Long Term Plan, but also the new NHS landscape, and so aligns with the SY Joint Forward Plan and, through the H&WB Strategy, aligns to the SY Integrated Care Strategy.

Progress in delivering the 2020-22 Place Plan is documented within this refreshed Plan. For further information on our delivery against priorities and for examples of key achievements please view the following documents:

- Place Partnership Updates (bi-monthly)
- Achievements (monthly as provided)
- Close Down Report for Priorities (for 2020-22 Plan)

https://yourhealthrotherham.co.uk/public-meetings/

Monthly Place Board Papers are also available at the above link.

Rotherham Partners' collective approach to delivery allows a 'Golden Thread' from our 'Health and Well Being' strategy aims through to the priorities within the Place Plan.

Partners have developed and agreed a Rotherham Place Agreement for how we will work together, based on a Memorandum of Understanding approach to provide an overarching arrangement which governs the development of integrated multi-party solutions for health, care, and support across the geographical area of Rotherham. First agreed in 2018, it has been updated to reflect the new NHS architecture from 1 July 2022. The Agreement is not intended to be legally binding except for specific elements but encompasses the spirit by which the Place partners have and will continue to collaborate in supporting work towards the transformation set out in the plan.

Collectively partners have worked towards an agreed governance structure and have agreed a shared vision and a set of principles by which the Rotherham Place Board, and sub-groups will adhere to. The structure can be seen above, setting out the relationship to the H&WB Board. All place partners are represented at each of the groups, along with other partners as appropriate.

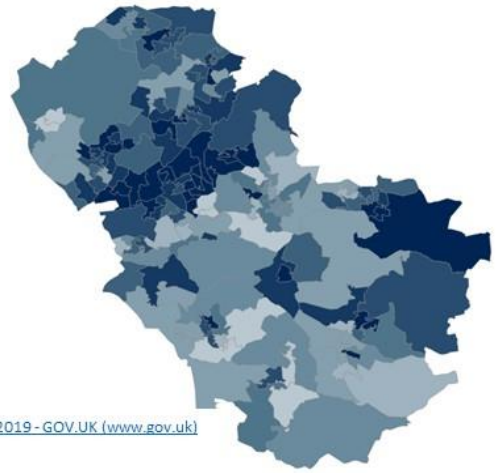
A quarterly performance report is produced on the delivery of the Place Plan so that the Place Board can be assured on its delivery and can be sighted on any potential opportunities or risks to delivery. The Performance Report includes key milestones and key performance indicators (KPIs) for each of the priorities beneath the areas of transformation. The milestones provide a way of measuring that the actions and pace set for each of the priorities is being met. The KPIs have been chosen from existing metrics that are already collected and where there is baseline information and associated targets.

3 Rotherham – an overview

3.1 What we know about our population

20% Most Deprived Communities

- Rotherham ranks as the 35th most deprived upper tier local authority in England out of a total of 151 upper-tier local authorities.
- 35% of Rotherham's neighbourhoods live in the 20% most deprived in England, and 22% live in the 10% most deprived.
- No neighbourhoods in Rotherham are in the least deprived 10%.
- People in the most deprived areas spend around a third of their lives in poor health, twice the proportion spent by those in the least deprived areas.



Source: Index of multiple deprivation, English indices of deprivation 2019 - GOV.UK (www.gov.uk)

The health of people in Rotherham is generally poorer than the England average. People are living shorter lives than they should and are living in poorer health for longer than they should.

A high proportion of Rotherham residents live in the 20% most deprived communities of England. Inequalities in access to the wide range of determinants (and protective factors) of health have led to inequalities in health outcomes.

A range of factors impact on individual and population level health, such as the environment we live, the opportunities we have as well as the health care we receive.

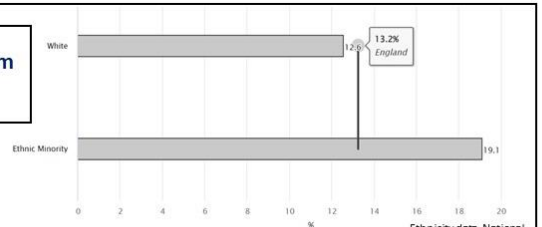
To improve the health of Rotherham people we need to work collaboratively with all Rotherham partners and across South Yorkshire. And we need to pay particular attention to certain population groups such as those who live in the most deprived areas or those from ethnic minority populations as they are more likely to experience higher inequalities in health.

- In primary care (2020/21), 15.9% recorded **prevalence of depression** (aged 18+), a total of 33,251 persons, this is higher than the England value of 12.3% and has been increasing since 2013/14.
- Data from 2018/19, show 12% of Rotherham residents reported a **long-term mental health problem**, which is significantly higher than the England value of 9.9%
- Deaths from **drug misuse** in Rotherham, 2018-20, were 6.4 per 100,000 compared to the England value of 5.0 per 100,000.
- Half of people aged 75 years and over live alone and most **experience loneliness**.

Wider Determinants

The estimated number of households in fuel poverty, 2020, is greater than the England average and expected to increase significantly with the rising fuel prices. Those from ethnic minorities are more likely to be in fuel poverty compared to white counterparts.

17.9% Rotherham
13.2% England



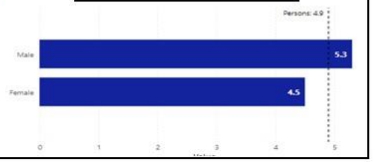
Being in work is good for both physical and mental health/wellbeing. The employment rate (16-64yrs) is 73% in Rotherham, 2021/22

73.0% Rotherham
75.4% England

16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known, 2021.

Young people who are not in education, employment or training are at greater risk of a range of negative outcomes, including poor health or depression

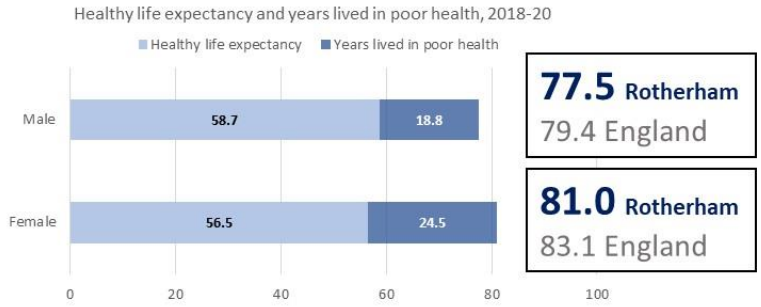
4.9% Rotherham
4.7% England



Source: OHID, Public Health Profiles, Public Health Outcomes Framework - OHID (phe.org.uk)

Life Expectancy and Healthy Life Expectancy

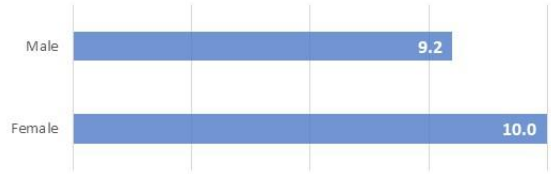
Life expectancy at birth is significantly lower for both males and females in Rotherham compared to England, 2018-20.



77.5 Rotherham
79.4 England

81.0 Rotherham
83.1 England

Life expectancy gap by deprivation (slope index of inequality).



9.7 England

7.9 England

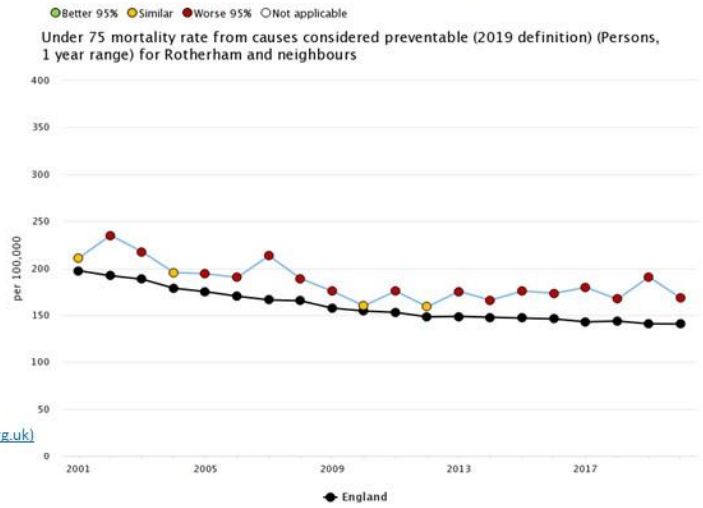
Source: OHID, Public Health Profiles, Public Health Outcomes Framework - OHID (phe.org.uk)

Preventable Early Mortality

Under 75 mortality rate from causes considered preventable (2019 definition)

The under 75 mortality rate from causes considered preventable, in Rotherham, has remained statistically worse then England for 8 years.

All or most deaths from the underlying cause (subject to age limits if appropriate) could mainly be avoided through effective public health and primary prevention interventions.



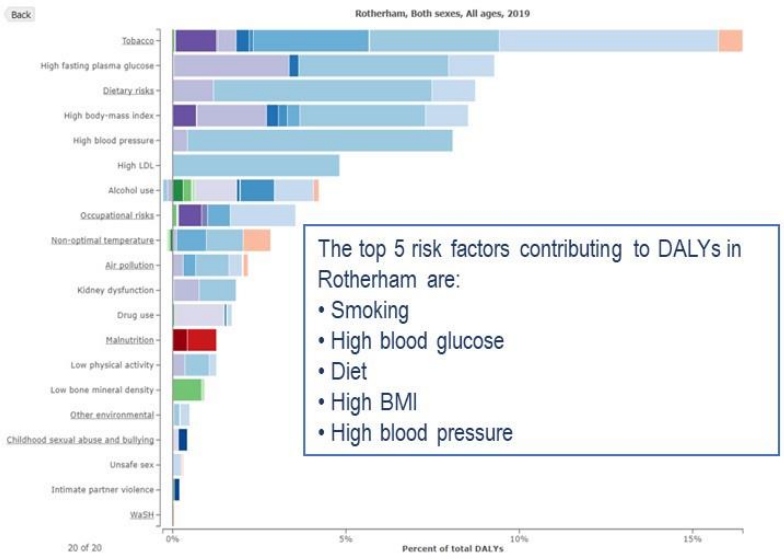
Source: OHID, Public Health Profiles, Public Health Outcomes Framework - OHID (phe.org.uk)

Improving the population's health and preventing illness and disease is key to reducing health inequalities and is at the heart of the NHS Long Term Plan.

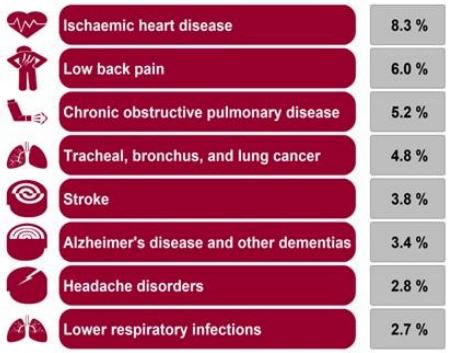
Tackling health inequalities is a core priority for NHS England because people from more deprived backgrounds are more likely to have long term health conditions and suffer poor health. The NHSE prevention programme specifically looks at the early detection of disease and support for people taking their own action to better health through supported self-management.

Global Burden of Disease, Rotherham 2019

Risk factors affecting DALYs (Disability Adjusted Life Years)



Causes ranked by percentage of total disability-adjusted life years



Source: Global Burden of Disease, Global Burden of Disease (GBD 2019) | Institute for Health Metrics and Evaluation (healthdata.org)

Rotherham is similar to the rest of South Yorkshire; the Joint Forward Plan tells us that:

- The biggest underlying causes of deaths in South Yorkshire were heart disease, COVID19, Dementia, lung cancer, Stroke and lower respiratory disease.
- The biggest causes of living in poor health were attributable to musculoskeletal disease, Mental disorders (including depression and anxiety), CVD and diabetes and neurological conditions.
- Impact of Covid-19 pandemic had a significant impact on our elective admission rates as well as our waiting times for interventions.
- We also observed that there was an increase in the referrals to children's mental health services.

Rotherham has a high prevalence of behaviours likely to cause harm. But many of the risk factors associated with our main diseases are modifiable and we can have impact on these early deaths by focussing on our role in prevention, these are picked through our prevention and health inequalities work, see section 5.1:

- 16.9% of the Rotherham population smoke
- 68.3% of Rotherham residents are overweight or obese
- 26.6% of reception age **children were overweight or obese** (2019/20) compared to 23.0% nationally; 37.9% of Year 6 children were overweight or obese in 2019/20, compared to 35.2% nationally
- Deaths from **drug misuse** in Rotherham, 2018-20, were 6.4 per 100,000 compared to the England value of 5.0 per 100,000.
- Rotherham's **breastfeeding initiation** rate is amongst the lowest in the region at 62.5%, contributing to levels of childhood obesity and paediatric hospital admissions
- 12.8% of mothers were **smokers during pregnancy** in 2021/22 (whilst this is significantly improved on the previous rate of 17.1%, it is still above the national rate of 9.4% nationally for the same period). Smoking in pregnancy contributes to increased risk of stillbirth, low birthweight, and neonatal deaths
- 69% of residents in Rotherham indicated they used natural environment for health and exercise purposes compared to 82% for England (2017).

Health Behaviours and Disease Prevention

Smoking prevalence in adults (18+), 2021

16.9% Rotherham
13.0% England

Percentage of adults drinking over 14 units of alcohol a week (2015-18)

31.1% Rotherham
22.8% England

Percentage of physically inactive adults, 2020/21

25.2% Rotherham
23.4% England

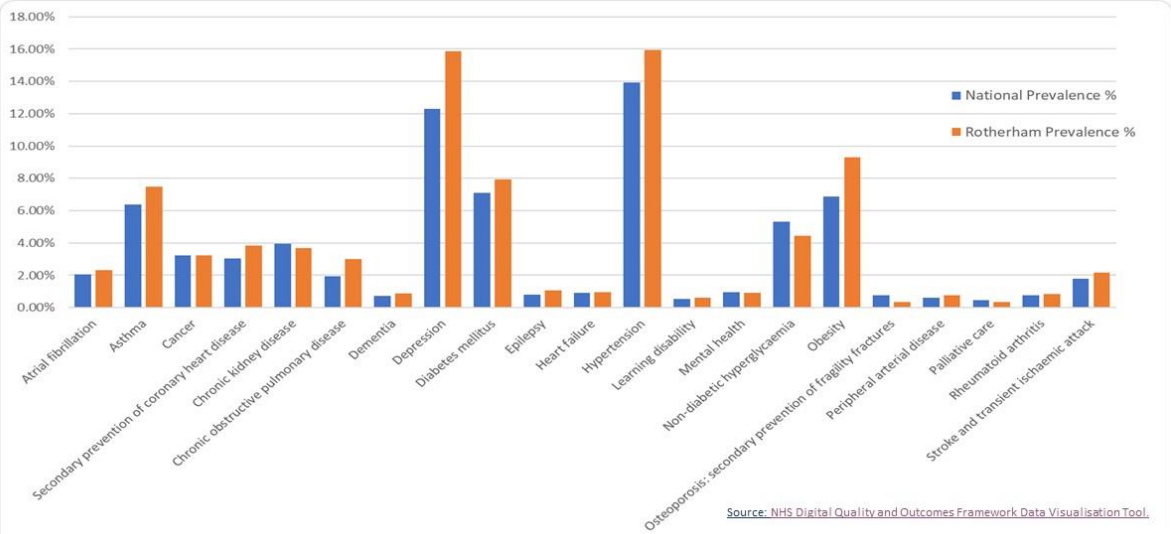
Percentage of adults (18+) classified as overweight or obese, 2020/21

68.3% Rotherham
63.5% England

Source: OHID, Public Health Profiles, Public Health Outcomes Framework - OHID (phe.org.uk)

Long Term Conditions

Rotherham has a higher prevalence of many long-term conditions than nationally.



The number of people experiencing more than one long term condition (multi-morbidity) is increasing and the age at which this happens in getting lower, especially for those living in the most deprived parts of Rotherham.

For further information about Rotherham, its population and key challenges visit the JSNA website:
JSNA website

For further information about our actions on prevention and health inequalities please see pages 25 – 27 of this plan and the **Rotherham Place Prevention and Health Inequalities Strategy** here

Inclusion Health

Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.

People belonging to inclusion groups, tend to have very poor health outcomes, often much worse than the general population and a lower average age of death. This contributes considerably to increasing health inequalities.

Poor access to health and care services and negative experiences can also be commonplace for inclusion health groups due to multiple barriers, often related to the way healthcare services are delivered.

Access to the internet: 21.2% (38 LSOAs) in Rotherham are classified as e-withdrawn and have least engagement with the internet, with one measure associated with the classification being the highest ratio of people with no broadband access.

21.2% Rotherham

This group have;

- The highest ratio of people that don't have access, or have access but never engage with the internet
- The lowest rates of engagement in terms of information seeking and financial services.

Homelessness: households owed a duty under the Homelessness Reduction Act, 2020/21

13.6% Rotherham
11.3% England

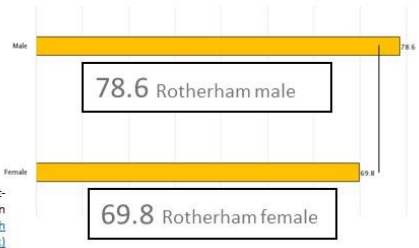
Homelessness is associated with poor health, education and social outcomes, particularly for children.

Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate, 2020/21.

Employment rates amongst disabled people reveal one of the most significant inequalities in the UK. Rotherham is significantly worse than England.

74.0% Rotherham
70.0% England

Source:: https://data.cdrc.ac.uk/dataset/internet-user-classification
OHID, Public Health Profiles, Public Health Outcomes Framework - OHID (phe.org.uk)



4 Transformation Workstreams

4.1 Ensuring the Best Start in Life: Maternity, Children & Young People

Rotherham has 57,453 children aged under 18 representing 21.7% of the local population (ONS, mid 2020), 23% of children live in low-income families (England 18%). Our Free School Meals (FSM) entitlement rate is above the English national average (23.8% compared to 21.6% at Primary, 21.4% compared to 18.9% at Secondary – DfE 2020/21). 19.4% of Rotherham's school age population is from ethnic minorities background (England 35.1%) (DfE 2020/21). 34.6% of Rotherham children were living in poverty in 2020, based on research from End Child Poverty. 64.5% of children under 5 are achieving a "good" level of development, compared to 65.2% nationally (DfE 2020/21).

Significant progress has been achieved through delivery of the previous plan with:

- The development and implementation of the Best Start and Beyond Framework which now provides a context for priorities for all commissioning and delivery, ensuring all activity aligns to our ambition for children to have a better start in life.
- Successful realignment and recommissioning of the 0-19 children's public health service, a key outcome for the recommissioning was to align with the reviewed and updated Healthy Child Programme and the High Impact Changes.
- The launch of a re-developed and co-produced Local Offer website providing children and young people with Special Educational Needs and Disabilities (SEND) and their families with relevant, up to date information in an easily accessible way.
- Delivery of training and support to health practitioners to ensure good quality, timely information is submitted to inform Education, Health, and Care Planning
- Improved dental registration and attendance at appointments for Looked After Children to above 80% from 53% last year.
- The development of good practice guidance for protocols of effective transitions

All this has been achieved against a backdrop of; increased demand post-pandemic, delivering post pandemic recovery plans, the impact of the pandemic with higher levels of acuity, dependency and complexity, unprecedented and sustained system pressures, in particular for children with complex needs, recruitment, and retention issues, particularly. relating to some professional roles and low paid roles. These factors have a disproportionate impact on our most deprived individuals, families, and communities which. make up over 20% of our population.

Our Key priorities are:

1. **Best Start for Life**
2. **Mental Health and Emotional Wellbeing**
3. **Special Educational Needs and Disabilities**
4. Looked After Children
5. Preparation for Adulthood

Aim: All children get the best start in life and go on to achieve their potential

Pathway design	• Children's Community Nursing and Community Paediatrics • Child Development Centre • Looked After Children • Neurodevelopmental • Sensory Support
Enablers	**Information Sharing** • Develop shared information tool across health and care. **Digital Solutions:** • Health Passport for Transitions • Digital Assessment - Neuro **Workforce** • OD • Training and Development • Employer of choice • Place recruitment and retention **Comms and engagement** • Children/ Young People • Parent/ Carer Inc. Panel • Impacted staff. • Providers • Partners **Review of funding streams** • Joint strategic commissioning • Transforming Care

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

1. Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injuries.
2. Increase fill rates against funded establishment for maternity staff.

Priorities and how they will address the key issues.

1. Best Start for life

Partners in Rotherham are passionate about children getting the best start in life and going on to achieve their potential, this is reflected as an aim of the Health and Wellbeing Strategy, however over 35% of children under 5 do not achieve "good" level of development. The importance of giving children in Rotherham the best possible start in life was identified in the Government's Best start for life report (2021).

Both education and the family and social support networks available to people have a huge impact on health and wellbeing. The Development of family hubs including publication of the Start for Life offer, Parent-infant mental health support and infant-feeding support service will ensure that people have integrated, accessible support when and where they need it which is vital to mitigate the impact of poverty and increase the number of children under 5 achieving a good level of development.

Delivery Milestones during the period of this plan include:

- Develop and implement the "Start for Life Pack" for all families taking a proportionate universalism approach to targeted engagement
- Embed the Breastfeeding friendly Borough Declaration through the delivery of Breastfeeding Friendly initiatives
- Review the Child Development Centre to ensure children in Rotherham will have timely access to an assessment and intervention when developmental needs are identified

2. Children and young people's mental health and emotional wellbeing

The impact of the pandemic on mental health has been significant and has made it more difficult for professionals to identify problems at an earlier stage. More people are seeking assessment, diagnosis, and support for children's mental health, learning and developmental needs. 40% of Children and Young People in Rotherham wait longer than 18 weeks to access mental health assessment and intervention. Timely diagnosis of Autism is a high priority nationally and a key strand within The NHS Long-term plan, Rotherham's Autism Strategy and Rotherham Partnership's special educational needs and disabilities strategy.

Sleep issues are a common phenomenon in children and young people. Additional to the physical and psychological issues linked with sleep deprivation, there is a significant financial cost in prescribing sleep medication to children in Rotherham. £400,000 was spent on Melatonin prescribing in 21/22. It has been reported that 40% of all children and young people will experience sleep disorders at some time in their early lives. This percentage rises in children with Special needs particularly children on the autism spectrum and in Looked after Children. 80% of children in the portage service have sleep disorders of some sort. A high number of children and young people are prescribed melatonin to manage their sleep disorder. Earlier identification and improved access to assessment and intervention will support children's emotional wellbeing, mental health, neurodevelopment, and sleep hygiene.

Delivery Milestones during the period of this plan include:

- Children in Rotherham will have timely access to an assessment and intervention for neurodevelopment disorders when a need has been identified
- Development of a framework to support consistent aspirations for children and young people's social emotional and mental health (SEMH) across the continuum with appropriate support identified, a workforce competency framework and workforce development framework and a communications plan
- Re-develop, implement, and embed a tiered sleep pathway

3. Looked After Children

Looked-after children and young people in care are a vulnerable group; their issues feature prominently in the United Nations Convention on the Rights of the Child (UNCRC). Looked after children are statistically more likely to experience poor outcomes, to address this NICE set quality standards for the health and wellbeing of looked-after children and young people. One of the key priorities for Rotherham, and a key ambition as corporate parents, is to recruit, retain and grow the best inhouse foster carers locally. It is well understood that the needs of children and young people can only be met effectively if they live in an environment that provides a high quality of care and support. In general, this is achieved within a family home setting within their own community. Targeted, high-quality support will ensure Looked-after children and young people in care achieve their potential.

Delivery Milestones during the period of this plan include:

- Embed the Looked After Children pathway into child and adolescent mental health services (CAMHs)
- Redevelop and implement our therapeutic offer to looked after children, in-house foster carers/ residential care providers
- Actively engage in recruitment activity to increase the number of foster carers

4. Children and Young People with Special Educational Needs and/ or Disabilities

The Special Educational Needs Code of Practice (2015) sets out the requirements for the NHS to identify children with additional needs at the earliest possible opportunity and work with Local Authorities to plan to meet their needs. Disability Living Allowance (DLA) is claimed for 5.3% of children aged under 16 years in the local authority area compared with 3.8% in England as a whole. Learning Difficulties affect 55% of DLA claimants under 16 years in Rotherham. (DWP 2018). Increasing numbers of children and young people with SEND need a local offer to meet their needs to support them to achieve their potential.

Delivery Milestones during the period of this plan include:

- Ensure children and young people with special educational needs and disabilities (SEND) and their families have access to accurate and relevant information on the Local Offer
- Develop, implement, and embed the accessibility strategy including the policy for funding equipment
- Review joint decision making for children with complex needs, including those with complex health and medical needs

5. Preparation for adulthood

Improving communication and addressing barriers will help to ensure young people and their families feel supported as they transition to Adulthood.

Delivery Milestones during the period of this plan include:

- Produce a mental health transition pathway to support effective transition for looked after children and care leavers with social emotional and mental health (SEMH) needs
- Maximise the use of the Rotherham Health Record to provide a 'health passport' to support transition from paediatric to adult
- Implement and embed preparation for adulthood guidance, including involving families in transition planning

4.2 Enjoying the best possible Mental Health and Wellbeing

The Rotherham Adult Mental Health priorities are aligned with the national and regional drivers as outlined in the Operational Planning, Mental Health Long-term Plan and Core20PLUS5 documents, and reflects the priorities of South Yorkshire ICB, South Yorkshire MHLDA Provider Collaborative and South Yorkshire Specialist Commissioning MHLDA Provider Collaborative priority programmes.

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

3. Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
4. Increase the number of adults and older adults accessing Talking Therapies (IAPT) treatment.
5. Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services.
6. Work towards eliminating inappropriate adult acute out of area placements.
7. Recover the dementia diagnosis rate to 66.7%
8. Improve access to perinatal mental health services.

Since the publication of the previous plan significant progress has been made in the development and enhancement of mental health provision across Rotherham.

- Transformation of the dementia care pathway, including the implementation of a new computed tomography (CT) scan pathway and transfer of 320 to primary care to receive their ongoing dementia monitoring.
- Achievement of the Long-term Mental health Ambitions for Early Intervention in Psychosis, which has consistently achieved its 60% access target, as well as achieving a Level 4 rating of 'top performing' (national ambition level 3).
- Working with colleagues from across SY ICB, Rotherham has successful commissioned and mobilised the Individual Placement Support (IPS) service delivered by South Yorkshire Housing.
- Developed and launch of several new services, including a new expanded Community Adult Eating disorder service delivered by SYEDA, Rotherham Safe Space Service, delivered by Touchstone in September 2022, which has supported 118 people since its launch; and Rotherham Samaritan's Wellness Check Pathway as a follow-up from a crisis call in April 2022, to date has supported 178 people.
- The continued development and expansion of the mental health communication programme across the borough, examples are the development and delivery of the Be the One 22/23 Campaign; and ongoing development of the Rotherhive digital platform, which received over 3.6 million hits since its launch in May 2020.

All of this will be achieved against a backdrop of' an increasing demand for mental health and emotional wellbeing support across the VCSE, Health and Social care system, people presenting with greater complexity and acuity, a need to ensure the successful delivery of post pandemic recovery plans, workforce recruitment and retention challenges across the whole of the mental health pathway, and a cost-of-living crisis and the impact of this on people mental health and emotional wellbeing.

Successful delivery of these priorities will require; partnership working across wider Place organisations supporting the delivery of acute, neurodivergent, children and young peoples' provision; consideration of the cost cutting themes of enabling digitalisation, address inequalities and disparities; that the voice of those with living Experience and their families / carers is central to the transformation undertaken.

Our Key Priorities are:

1. **Delivery of the Adult Severe Mental Illness in Community Health transformation plan.**
2. **Delivery of the Mental Health Crisis & Liaison programme**
3. **Suicide-prevention programme**
4. Dementia pathway transformation
5. Delivery of the Better Mental Health for All Plan (note this also includes the loneliness delivery plan).

Summary of priorities:

1. Delivery of the Adult Severe Mental Illness (SMI) in Community Health Transformation Plan.

Additional funding has enabled the increase in the mental health workforce within the primary care setting; and expansion of the RDaSH community mental health workforce to support the mental health needs across the primary / secondary care pathway. This has supported the increase of psychological support in the pathway provision.

The aim of which is to ensure that people with SMI access the right care and support at their earliest point of need and have wide ranging support closer to home and can live as healthy and fulfilling lives as possible in their community. Delivery of this priority will require Rotherham Place partners to work with the wider South Yorkshire ICB groups. Next steps will be to work together to continue the transformation of adult mental health services for those with SMI, this includes implementation of the integrated primary care hubs, enhance support for people by improving access to SMI physical Health Checks and employment Support; develop new personalised models of care by moving away from 'traditional' CPA and undertake targeted work on Adult Eating Disorders, Personality Disorder and Community Rehabilitation. For the past two years partners across Rotherham have been working together to support the transformation of the community mental health pathway across community, primary and secondary care.

Delivery Milestones during the period of this plan include:

- Implementation of Mental health ARRs roles in Primary Care in line with year 3 ambition
- Launch Primary care integrated Mental Health Hubs
- Community Mental Health Transformation pathways in place (targeted work on Community rehabilitation, complex needs/Personality & eating disorders)

2. Delivery of the Mental Health Crisis & Liaison programme

In recent years, the demand for crisis support across the whole of the mental health pathway has increased. The combination of the pandemic and cost-living crisis are undoubtedly having an impact on people's mental health and emotional wellbeing. This is reflected in not only the increasing demand for mental health support but also the complexity and acuity of presentation. This will provide an opportunity for partners to collectively strengthen the mental health crisis pathway (including prevention and intervention, alternatives to crisis, crisis, reablement and post crisis support) to improve the journey and outcomes for people with mental ill-health. It will be achieved by redesigning the pathway, to embed principles and practices that prevent, reduce and delay people's need for care and support, including embedding a 24/7 'Making Safe' and reablement model, focussed on community-based recovery.

Delivery of this priority will require Rotherham Place partners to work with the wider South Yorkshire ICB groups

Delivery Milestones during the period of this plan include:

- Rotherham Crisis Care Concordat established
- Place Crisis pathway Health and Social Care delivery action plan agreed and considered at RMBC Cabinet
- Development of a Place Crisis Service specification
- Expansion of the alternative to crisis offer
- Implementation of a new Health and Social Care Crisis Pathway
- 111 'option 2' live for patients to have the option to press 2 for mental health in Rotherham
- 111 option 2 reporting in place via strategic data collection service (SDCS)

2. Suicide-prevention programme

Suicide prevention is a high priority for Rotherham. Males (18.2) have seen a decrease and we are now statistically similar to the England average (15.9). (Y&H 18.8) However, females have increased to 8.5 compared to England at 5.2 which is statistically higher (Y&H 6.5). For All Persons- Rotherham is 13.2 compared to 10.4 (England) and Y&H 12.5. statistically higher. Rotherham has a partnership suicide prevention group which oversees the implementation of the local action plan. The action plan reflects the national strategy and local priorities as outlined in the real time surveillance data. Rotherham works closely with colleagues across the ICB to deliver elements of suicide prevention, for example postvention support for all those bereaved and affected by suicide.

Delivery Milestones during the period of this plan include:

- Mobilisation and launch of the attempted suicide Prevention Pilot
- Refresh of the suicide prevention and self-harm action plan in line with the National strategy

3. Dementia pathway transformation

Rotherham has consistently performed well against the national diagnosis prevalence target. During the last year work has also been undertaken to support the transfer the ongoing monitoring of some people with dementia from secondary care to primary care, develop and mobilisation a new CT scan pathway and develop Admiral Nurses in each of the PCNs. More recently, a dementia partnership group has been established to consider how partners can work together to increase awareness of dementia and the support available. It is the work of this partnership group which will be one of the keys the focuses of this priority.

Delivery Milestones during the period of this plan include:

- Dementia Partnership Plan to be developed and approved

4. Delivery of the Better Mental Health for All Plan (note this also includes the loneliness delivery plan)

In 2019, Rotherham was ranked 44th most deprived authority in England, making the borough amongst the 14% most deprived local authorities in England. Even before covid, the estimated Rotherham prevalence for common mental health disorders was high in the over 65 age group (11.6% compared to 10.2% nationally) and 16+ population (18.6% compared to 16.9% nationally).

The ONS estimates of loneliness and personal well-being during the COVID-19 pandemic by showed that 7.6% of Rotherham residents felt lonely often or always and 43% of Rotherham residents felt lonely in the previous 7 days. (14 October 2020 to 22 February 2021). 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. The Rotherham Place Better Mental Health for All Group, looks at early intervention and prevention in relation to mental health and oversees the development and implementation of the Rotherham Loneliness Action plan.

Delivery Milestones during the period of this plan include:

- Health and Wellbeing Board to sign up to Prevention Concordat for Mental Health
- Develop and mobilise action plan in response to application
- To increase the number of practitioners receiving Making Every Contact Count (MECC) training

4.3 Supporting people with Learning Disabilities & Autism

The Rotherham Learning Disability and Autism priorities are aligned to national and regional drivers. It is also aligned to the Rotherham Plan of:

- Building an inclusive economy – ensuring people with a learning disability and autistic people enjoy the benefits and independence that employment brings.
- Building better health and wellbeing - to improve access for people with a learning disability and autistic people to better health and wellbeing.
- Building stronger communities - people with a learning disability and autistic people are partners in developing services.

Significant progress has been achieved through delivery of the previous plan with:

- Rotherham has been relatively successful in preventing admissions of people with a learning disability under the Mental Health Act. This is evidenced by the fact that Rotherham reported the lowest number of people with learning disability detained in hospitals under the Mental Health Act than any of the South Yorkshire partners.
- Up to 72% of people with a learning disability have accessed enhanced health checks.

There have been significant challenges due to the pandemic, the current cost of living and housing emergencies and staffing in health and social care issues. The learning disability mortality review (LeDeR) summarises the lives and deaths of people with a learning disability and autistic people who died in England in annual reports. In Rotherham the mean age at death in 2021/2022 in Rotherham was 56 years, with all notified deaths being in respect of adults with a learning disability.

Rotherham Place and Rotherham Council Adult Care has seen an increase in autistic people presenting in crises. The need to develop place plans to prevent autistic people from escalating into crises (defined in this case as mental health crises, suicide risk, forensic risks, or placement breakdown) is also highlighted.

With this in mind, the overarching theme is improving access. The focus of work over the next 2 years will be to improve access to health and improve well-being.

Rotherham Place and Rotherham are working to Develop proposals for day opportunities for people with high support needs through a redesigned new build specialist day support provision at Castle View and a £2.1m capital investment.

Our Key priorities are:

1. **Increase the uptake of enhanced health checks for people with a learning disability aged 14 upwards**
2. **Ensure people with a learning disability and autistic people have better access to employment opportunities**
3. Support the development of South Yorkshire pathways to reduce the need for inappropriate admissions into mental health services
4. To further develop accommodation with support options
5. Refresh the Vision and Strategy for people with a learning disability through coproduction and codesign
6. Develop a new service model for day opportunities for people with high support needs

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

9. Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
10. Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit.

Brief summary of each priority

1. Increase the uptake of enhanced health checks for people with a learning disability aged 14 upwards

People with a learning disability often have poorer physical and mental health than other people. This does not need to be the case. It is important that everyone over the age of 14 who is on their doctor's learning disability register has an annual health check. RDaSH offer support to GP practices to offer enhanced health checks.

Delivery Milestones during the period of this plan include:

- Additional support will be offered to GP Practices to undertake enhanced health checks
- Peer Support offered to people with a learning disability to access enhanced health checks
- Focus on increasing the numbers of eligible young people to access GP enhanced health checks

2. Support the development of South Yorkshire pathways to reduce the need for inappropriate admissions into mental health services.

The proposal is to commission 4 safe place beds across South Yorkshire to prevent unnecessary hospital admissions, with clear protocols and a robust memorandum of understanding between health and social care to further the South Yorkshire Memorandum of Understanding for Ordinary residence with cross-authority supported living services, to ensure the beds are used appropriately as a system resource, with ongoing specialist team input and a clearly defined pathway. Due to the low numbers of admissions, it is not cost-effective to develop these solely at place level, so it is suggested that an ICS joint commissioned resource will be more achievable.

Delivery Milestones during the period of this plan include:

- SY ICB to source a suitable provider who has the skills, knowledge and values who can provide this service (SY ICB led)

3. Ensure people with a learning disability and autistic people have better access to employment opportunities

RMBC successfully bid for the Department for Education Supported Internships Grant. Over a three-year period, Rotherham will work with partners (Rotherham Opportunities College, Rotherham College and Dearne College) to increase the number of young people accessing supported internships for young people with SEND needs. Employment is for Everyone aims to bring together all partners, projects and opportunities relating to employment across South Yorkshire for people with learning disabilities and autistic people and will support the engagement with employers. In addition to Supported Internships RMBC have established a Supported Employment team that will provide specialist support to access sustainable employment for our residents with a learning disability and or autism. The project is commissioned for a two-year initial period with delivery expected from late June 2023, it can be accessed through the RMBC Employment hub.

Delivery Milestones during the period of this plan include:

- Develop a special educational needs and disabilities (SEND) supported internships action plan

4. To further develop accommodation with support options

RMBC has a strong commitment to expanding supported living for people with a learning disability and autistic people through the My Front Door Project, this enables better outcomes for people and is more cost-effective than traditional forms of housing. Rotherham's population of people with a learning disability and autistic people is changing, both in complexity and with an ageing population. As an example, some young people with SEND needs often require a home that is specially adapted and includes support which will enable them to be more independent. Speaking to people with a learning disability and autistic people across all communities, people told us that they want good quality homes that are close to friendship circles and their families. People want homes that offer flexibility and choice and are places "where we can relax, unwind and work off that stress". Cabinet approved the creation of a Flexible Purchasing System (FPS) to ensure that for the development of future Supported Living contracts, providers are aligned to Rotherham's vision of providing housing for people with learning disabilities and autistic people. These developments will be based on the principles contained in 'Building the Right Home'. In addition, the peer support system via key ring has been expanded.

Delivery Milestones during the period of this plan include:

- To launch Rotherham's supporting living Flexible Purchasing System (FPS)
- To build an agreed number of supported living units each year

5. Refresh the Vision and Strategy for people with a learning disability through coproduction and codesign

To deliver on this the Council and Rotherham Place needs to refresh the vision and strategy for people with a learning disability from 2023 and beyond. The approach will be co-produced with people with a learning disability, young adults and their families, parents, and carers, as well as partners and providers who are delivering services and supporting people with a learning disability. Rotherham will also refresh its autism strategy. This will be coproduced with autistic people, young people and their families, parents, and carers.

Delivery Milestones during the period of this plan include:

- Refresh the Vision and Strategy for people with a Learning Disability and Autism Strategy

5. Develop a new service model for day opportunities for people with high support needs

The ongoing commitment to the transformation of Learning Disability Services includes a new service model focussed on day opportunities for people with high support needs. This includes the construction of a new day centre facility in Canklow replacing the existing Learning Disability Day Service, providing a modern, state of the art facility whilst providing a welcoming, calming, and exciting purpose-built environment. The new service will:

- Offer modern accessible day opportunities with multifunctional fit for purpose facilities within the heart of the community, promoting independence, wellbeing, and social inclusion and supporting a focus on community connectivity
- Welcome support and involvement from local businesses, community groups and voluntary sector organisations.
- Act as bespoke day support for those with the most complex needs delivered in a person-centred manner, but also be a hub for wider activity, learning and skill development. The hub will also act as a place for anyone with a learning disability to access general support with getting on with their lives', therefore reducing the need for formal contact with adult care for low level support and dealing with the small issues thus supporting a prevention and early intervention model.
- Consider extended opening times and also enable the use of the facilities during evenings and weekend for events and social gatherings
- Support young adults in transition to achieve a life of their own.
- Support an outcome focused strength-based approach in accordance with good practice and the principles of the Care Act 2014.

Delivery Milestones during the period of this plan include:

- Opening of new facilities for people with learning disabilities, autism and complex needs

4.4 Urgent, Emergency and Community Care

The Rotherham Urgent and Emergency priorities are aligned to national and regional drivers for out of hospital care including the Urgent and Emergency Action Plan. The approach continues to build on Rotherham's strategic vision of supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery. Significant progress has been achieved through delivery of the previous plan with:

- the implementation of a virtual ward and urgent community response to support admission avoidance
- development of an integrated discharge service, with over 90% of people being discharged home.
- the launch of a multi-disciplinary referral and triage hub to provide the right level of care, at the right time and place according to patient need including improving 111/999 referral processes.
- improved multi-disciplinary working to enhance health in care homes.

All this has been achieved against a backdrop of; an increasingly aging population, delivering post pandemic recovery plans, the impact of the pandemic with higher levels of acuity, dependency and complexity, unprecedented and sustained system pressures impacting on attendances in the emergency department and pressure on acute beds, recruitment, and retention issues, particularly relating to some professional roles and low paid roles.

These factors have a disproportionate impact on our most deprived individuals, families and communities which make up over 20% of our population. Whilst Rotherham is performing comparatively well on national discharge indicators there is still work to do to reduce the number of people remaining in our acute and community bed base with no right to reside and we still have a heavier reliance on our community bed base than comparative Places.

Against this backdrop and significant financial challenges across the system the aim of this work steam is to work collaboratively together to enable more people to be cared for at home, with the right care, at the right time and in the right place. Leading to improved patient and carer outcomes and reduced avoidable conveyances and admissions. To achieve the priorities, we will:

- take stock of our current provision and impact of out of hospital services in order to prioritise the areas which have the greatest impact and relieve pressure points.
- re-introduce the 4-hour A&E response standard, including reviewing the patient experience, pathways, ways of working and workforce.
- develop alternative pathways to ED and acute admissions to reduce unnecessary conveyances and avoidable admissions. Most of our service users tell us that they want to be cared for at home. National evidence shows that patient outcomes are better for people who are cared for at home. This is particularly the case for the frail elderly and people with dementia who are at higher risk of harm through deconditioning and infection following an acute admission.
- Further develop and embed a sustainable whole system approach to patient flow to relieve the pressure on ED, ensure acute beds are available for those who need them and ensure people who do require admission are discharged in a timely way with the right support for them.
- We will utilise technology for direct patient care and business management wherever possible and draw on support from our enabler groups for workforce, communications, finance, and digital expertise. Where appropriate, and of benefit, we will work with colleagues from other Places and the South Yorkshire footprint to benefit from good practice, lessons learned and economies of scale.

Working Together for Whole System Flow

Aim: to work collaboratively to enable more people to be cared for at home, with the right care, the right time and in the right place – leading to improved patient and carer outcomes and reduced avoidable conveyances and admissions

Pathway design	**Prevention** • 111/999 including push model. • Front door deflection • Proactive (Anticipatory) care • SDEC • Grown virtual wards and UCR. • Falls review	**Discharge** • Develop a discharge to assess model • Establish an integrated Transfer of Care Hub for referral and Triage
System command centre	**Transfer of Care Framework & Delivery Model (avoidance & discharge)** • Develop and improve access to 7 day/integrated hub with out of hours offer. • Capacity and demand: community @ home; acute & community bedded offer (IC & complex commissioning of bed offer	
	Digital Solutions: • Practitioner: remote tech, assistive tech • Whole system community and acute digital command centre and performance dashboard	
Enablers	**Workforce** • OD • Training and Development • Employer of choice • Place recruitment and retention	**Comms and engagement** • Patients/carers • Impacted staff. • Providers • partners
		Review of funding streams • Joint strategic commissioning • BCF/winter monies • Discharge/UEC monies

Our Key priorities are:

1. Prevention and alternative pathways to admission
2. Sustainable Discharge
3. Whole System Command Centre Model

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

11. Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
12. Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
13. Reduce adult general and acute (G&A) bed occupancy to 92% or below.
14. Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard.

Each of our priorities will work together to create an overall step change in delivery. There are interdependencies with the mental health work stream and services particularly in relation to crisis. At South Yorkshire level there are interdependencies with the virtual ward (including a joint procurement of remote technology), proactive (anticipatory) care including roll out of respect and potentially a digital risk stratification tool, work to review end of life care and digital solutions for record keeping in care homes.

Brief summary of each priority

1. Prevention and alternative pathways to admission

This priority is based on the principle 'prevention is better than cure', that is it is better to help maintain people to live independently for longer for their own and family/carer's health and wellbeing and thereby reduce avoidable reliance on services. The priority will bring together a number of work streams in order to take a cross system strategic overview whilst progressing areas of national/local priority. These include:

- Proactive (Anticipatory) care which is an approach which identifies and engages people living with frailty, multiple long-term conditions and/or complex needs to help them stay independent and healthy at home, for as long as possible.
- Develop alternative pathways to ED and admission working with 111/999 to grow referrals and develop and embed the PUSH model.
- Grow the virtual ward and urgent community response to support more people at home who would otherwise be in an acute bed or at risk of admission.
- Review deflection at the front door streamlining avoidance and frailty services and developing and embedding our Same Day Emergency Care offer as an alternative to ED and admission.
- Review of falls services to develop a fit for purpose, affordable, multi-disciplinary falls pathway.

Delivery Milestones during the period of this plan include:

- Grow the Virtual Ward and Urgent Community response according to agreed trajectories
- Implement Virtual Ward remote monitoring
- Review Falls offer and deliver revised model
- Scope and develop the Proactive (Anticipatory) care model with phased implementation including delivery of a risk stratification tool
- Review Services which deflect admission at the front door

2. Discharge

Rotherham has carried out extensive incremental change to facilitate timely discharge. C93% of our patients are discharged home. We have invested in home-based services with some excellent examples of good practice. Whilst we believe we have all the constituent parts to deliver a timely discharge to assess model these parts need to be bought together into a coherent multi-disciplinary discharge to assess model with an integrated Transfer of Care hub for referral and triage which

- enables community expertise to assess the level of risk that can be safely supported at home and in the community bed base.
- enables assessment to be carried out at home.
- enables resource to be allocated flexibly across pathways to meet demand and acuity across 7 days

Delivery Milestones during the period of this plan include:

- Implement integrated transfer of care hub and discharge to assess model
- Review and streamline discharge pathways
- Review community home and bed base care in line with demand
- Capacity and demand modelling of intermediate care and discharge provision

3. Whole System Command Centre

This priority is the link which brings together admission avoidance activity and discharge to inform strategic and operational decision making to improve whole system flow:

- Capacity and demand modelling of domiciliary and rehabilitation intermediate home based and commissioned bed services and discharge provision.
- Commissioning of community bed offer
- Development of a whole system command centre and performance dashboard

Delivery Milestones during the period of this plan include:

Development of a whole system digitised Command Centre and performance dashboard:

- Community escalation wheel
- Community dashboards and performance reports

4.5 Palliative and End of Life Care

We believe that people approaching the end of their life are entitled to high quality care, wherever that care is delivered. Good end of life care should be planned with the individual and the people close to them to ensure it is tailored to their needs and wishes and including management of symptoms, as well as provision of psychological, social, spiritual, and practical support. More people in Rotherham should be able to exercise choice over their end of life care and the place of their death. Rotherham partners will play an active role in delivering the ICB ambitions. At a place level we want earlier identification of people at the end of life, to improve the care and support they receive, make sure people are able to voice their preferences and that more people die in the place of their choice and that we reduce the number of hospital admissions for people in the last months of life.

Our Key Priorities are:

1. **Complete a review of PEOLC Medicine**
2. **Enhance personalised palliative and end of life care.**
3. Implementation of ReSPECT across Rotherham
4. Benchmark against the Ambitions Framework
5. Inform future commissioning through patient and carer experience.

Actions we will take are:

- We will carry out a review of PEOLC Medicine across Rotherham, to obtain a comprehensive understanding of the PEOLC pathway across Rotherham, paying particular attention to access to specialist palliative care services, bereavement services, pharmacy services, equipment, spiritual care (as part of mental health and wellbeing support) and access to information.
- Enhance personalised PEOLC by undertaking work to identify Rotherham patients and carers experience to inform future commissioning and introduce co-production opportunities.
- The ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process creates a personalised recommendation for clinical care in emergency situations where patients are not able to make decisions or express their wishes. Rotherham partners will work together to implement ReSPECT, ensuring that all partners are involved, and that training and communication is carried out effectively.
- The Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026, sets out the vision to improve end of life care through partnership and collaborative action between organisations at Place level. During May/June 2023 we will undertake the benchmarking against the Ambitions Framework using the self-assessment tool, following which a SY wide event will take place and we will contribute to the development of a full PEOLC SY ICB action plan.
- We will start the development of a Rotherham PEOLC Data Dashboard to feed into a SY wide dashboard.
- ECHO is an online learning and support methodology. It supports knowledge sharing between staff from across health and social care and facilitates the exchange of specialist knowledge and best practice. Rotherham and Doncaster have joined up to provide an ECHO training programme across the two Places. During Q1 of 2023/4 the ECHO PEOLC training plan for Care Home staff and Community Nursing will be developed further and will be expanded to other community and primary care teams.
- The Palliative and End of Life Care Statutory Guidance for Integrated Care Boards (Sept 2022) has been developed by NHSE to support ICBs with our duty to commission PEOLC services within the ICS and ensure that people can receive high quality personalised care and support. We will work collaboratively across the ICB to implement the requirements of guidance.

Delivery Milestones during the period of this plan include:

- Review of Palliative and End of Life Care (PEOLC) Medicine across Rotherham
- Undertake work to identify Rotherham patients and Carers experience to inform future commissioning
- Implement Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) across Rotherham, including relevant training
- Benchmark against the ambitions for PEOLC framework
- Develop an action plan to address the outcomes
- Develop Rotherham PEOLC Dashboard

4.6 Enabling People to Live Well for Longer (prevention, early identification, self-care and improve management of long terms conditions)

Life expectancy and health life expectancy in Rotherham are both lower than average for men and women and this is significantly worse in the most deprived areas of the borough compared to the most affluent. This inequality in health leads to around 6,500 years of life being lost each year in Rotherham (2023-2024 average) through causes considered amenable to healthcare, this is almost 1,400 years more than might be expected based on the England average.

The impact of a long-term condition or disability may mean that a person may not have 'good' health, but they should still be able to live well through the right support and by keeping mentally, physically, and socially active. Making sure people get the right care when they need it is important, but importantly we need to understand and make sure that **what matters most to people** is considered, not just looking at what is the matter with them (their presenting needs/issue), in line with the Rotherham Health and Wellbeing Strategy key aims for ensuring people live well for longer include:

Our key priorities are:

1. **Proactive Care (formerly Anticipatory Care)**
2. **Personalised Care**
3. **Medicines Optimisation**
4. Social Prescribing
5. Address the Major Health Conditions Strategy
6. Prevention and High impact Interventions

1. **Proactive (Anticipatory) Care**

Proactive Care Planning (previously referred to as Anticipatory Care) is a person-centred, proactive "thinking ahead" approach whereby health and social care professionals support and encourage individuals, their families, and carers to plan ahead of any changes in their health or care needs. It is targeted at people of all ages living with frailty, multiple long-term conditions and/or complex needs to help them stay independent and healthy for as long as possible at home, in the place they call home or in their local community. It focuses on providing the support based on what is important to the individual, improving health inequalities and health outcomes. Proactive Care reduces the risk of long-term health conditions worsening that would result in an individual needing a hospital stay or visit.

Proactive Care aims to increase peoples' healthy years by up to 5 more years, typically it involves structured proactive care and support from multidisciplinary teams within the system and focuses on groups of patients with similar characteristics, such as living with multimorbidity, frailty and/or complex needs. Patients are often identified through risk stratification and population health management tools alongside clinical judgement. **During 2023/24 we will work as a system to develop our proactive care model based on the following components:**

- Identification of specified key segments of PCNs registered practice populations who have complex needs and are at high risk of unwarranted health outcomes.
- Maintenance of a comprehensive and dynamic list of individuals who would benefit from proactive care, based on the outcome of the population segmentation approach.
- The delivery of a comprehensive set of support for those individuals identified as eligible through the proactive care list, through an MDT based across health and social care providers.

2. Personalised Care

Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences. This happens within a system that supports people to stay well for longer and makes the most of the expertise, capacity and potential of people, families, and communities in delivering better health and wellbeing outcomes and experiences. The NHS LTP makes personalised care business as usual across the health and care system, as one of the 5 major practical changes to the NHS service model. Personalised care takes a system-wide approach, integrating services around the person including health, social care, public health, and wider services. It provides an all-age approach from maternity and childhood right through to end of life, encompassing both mental and physical health and recognises the role and voice of carers, and the contribution of communities and the voluntary and community sector to support people and build resilience. There are several national documents on the personalisation, with outline strategic aims, priority areas, enablers, comprehensive models of care, to universal models of care with targeted approaches and it is easy to become lost in the complexity and scale of the ask. The thread running through all the documentation is that **places should work together to**:

- Embed a personalised care ethos across the place.
- Reduce health inequalities.
- Enrich personalised care approaches across health care.
- Focus on workforce development – so teams focus on the patient and what matters to them most, involving them in decisions about their care to get the best outcomes for that individual.

3. Medicines Optimisation

Prescribing is the second largest area of expenditure for Place and the South Yorkshire Integrated Care Board (ICB). Prescribing costs are influenced by a wide range of factors that are often outside of the individual clinician's control such as: National guidance (NICE etc), new clinical evidence, drug shortages – resulting in having to prescribe less cost-effective alternatives and drugs not available at drug tariff price (NHS contract price). Drugs are global commodities and supply chains into the UK are international. The ever-increasing number of drug shortages/supply problems and the inability to obtain drugs at drug tariff prices, will all impact on prescribing costs. The Rotherham medicines management team engages with prescribers to get them to accept ownership of the financial impact of their prescribing, even though increased prescribing costs will have little direct impact on the clinician. The team, in conjunction with the primary care team, monitors performance across three GP local enhance services: anticoagulant monitoring, Palliative Care End of Life care drugs and Transgender prescribing. The team also designs and monitor two prescribing incentive schemes, where practices are rewarded for their performance against these two schemes. **The 2022-23 Work plan includes:**

- Implementation of the agreed strategies for Diabetes, Hypertension, and antibiotic prescribing
- Launch of the new Prescribing Incentive scheme
- Care home hydration project to be relaunched capitalising on the national funding.
- Continued improvement of diabetes management, with particular focus on patients receiving high doses of insulin and poor HbA1c control.
- Eclipse Live a risk stratification tool will be introduced.
- The antidepressant review programme will be continued.
- Aim to establish a chronic pain management service pilot.
- Work is underway to build a system utilising AccWeb to maximise the potential of the community pharmacy BP monitoring service commissioned by NHSE.

4. Social Prescribing

Rotherham has an award-winning Social Prescribing programme. From the original two schemes, (one for people with long term conditions who are referred through their GP to Voluntary Action Rotherham (VAR), and one to help patients under the care of RDaSH with a mental health diagnosis to be supported out of long term statutory mental health services). Both of these Social Prescribing Programmes are funded through the Integrated Better Care Fund.

The Rotherham Social Prescribing work has expanded in a number of ways. This includes working with a number of Rotherham PCNs, through the GP Federation, to host social prescribing link workers, supporting patients who are able to benefit from non-clinical interventions. The 'link workers' complement the existing social prescribing work by supporting patients who otherwise would miss out. Social Prescribing has, very successfully, for well over a year now, also been part of the 'Long Covid Pathway'. A Social Prescribing pilot is also underway, as part of the UECC offer; working with TRFT colleagues to enable patients to have their wider support needs met. Rotherham is also part of a South Yorkshire programme of implementing social prescribing to be part of the Stoke Service/s pathway; where social prescribing link workers, will work along a multi-disciplinary team to ensure Stroke patients' needs are met holistically. The Rotherham Social Prescribing work recognises that as well as the Advisors and Link Workers, that resources are made available to support the voluntary and community sector to develop, grow and sustainably provide the 'social prescriptions and related interventions.

5. Major Health Conditions

The Department of Health and Social Care is developing a **Major Conditions Strategy** in consultation with NHS England which is due to be published later in 2023. The strategy will seek to shift the policy agenda towards a whole-person care approach, setting out patient standards in the short term and over a five-year timeframe. It focuses on major conditions including Cancers, Cardiovascular diseases, including stroke and diabetes, Chronic respiratory diseases, Dementia, Mental ill health, Musculoskeletal disorders

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

15. Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
16. Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.
17. Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
18. Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
19. Continue to address health inequalities and deliver on the Core20PLUS5 approach.

The Strategy aims to alleviate pressure on the health system, reduce economic inactivity caused by ill-health, support the Government's manifesto commitment of gaining five extra years of Healthy Life Expectancy by 2035, and fulfil its levelling up mission to narrow the gap in Healthy Life Expectancy by 2030. It also seeks to cater to patients with increasingly complex needs and with multiple long-term conditions. Preserving good health, early detection and treatment of diseases have been highlighted by the Strategy, as has the need for joint working between health and care services, local government, NHS bodies, and others. We will work with partners across SY ICB to deliver the plans against the National and Local Requirements, in addition examples of work at a **Rotherham Place are:**

- Implement Targeted Lung Health Checks
- Increase promotion/awareness of cancer screening programmes (breast, bowel and Cervical)
- Improve CVD Prevention and Diagnosis in primary care
- Pilot centralised spirometry across primary care to inform commissioning Pulmonary rehab
- Identify overuse of SABA inhalers, to improve management/reduce admission
- Phase 1 development of the CDC – focused on respiratory
- Greater input from PCN pharmacist into diabetes & heart failure management
- Community Diabetes Specialist Nursing Service in place, joint dietetic and nursing clinics
- Increase referrals to all weight management programmes
- Targeted management of heart failure in the community

6. Prevention and High Impact Interventions

Improving the population's health and preventing illness and disease is key to reducing health inequalities and is at the heart of the NHS Long Term Plan. Tackling health inequalities is a core priority for NHS England because people from more deprived backgrounds are more likely to have long term health conditions and suffer poor health. The NHSE prevention programme specifically looks at the early detection of disease and support for people taking their own action to better health through supported self-management. In December 2022 NHS England published range of **prevention and high impact interventions** for: modifiable risk factors, diabetes, cardiovascular disease, and diabetes. During 2023/24 we will:

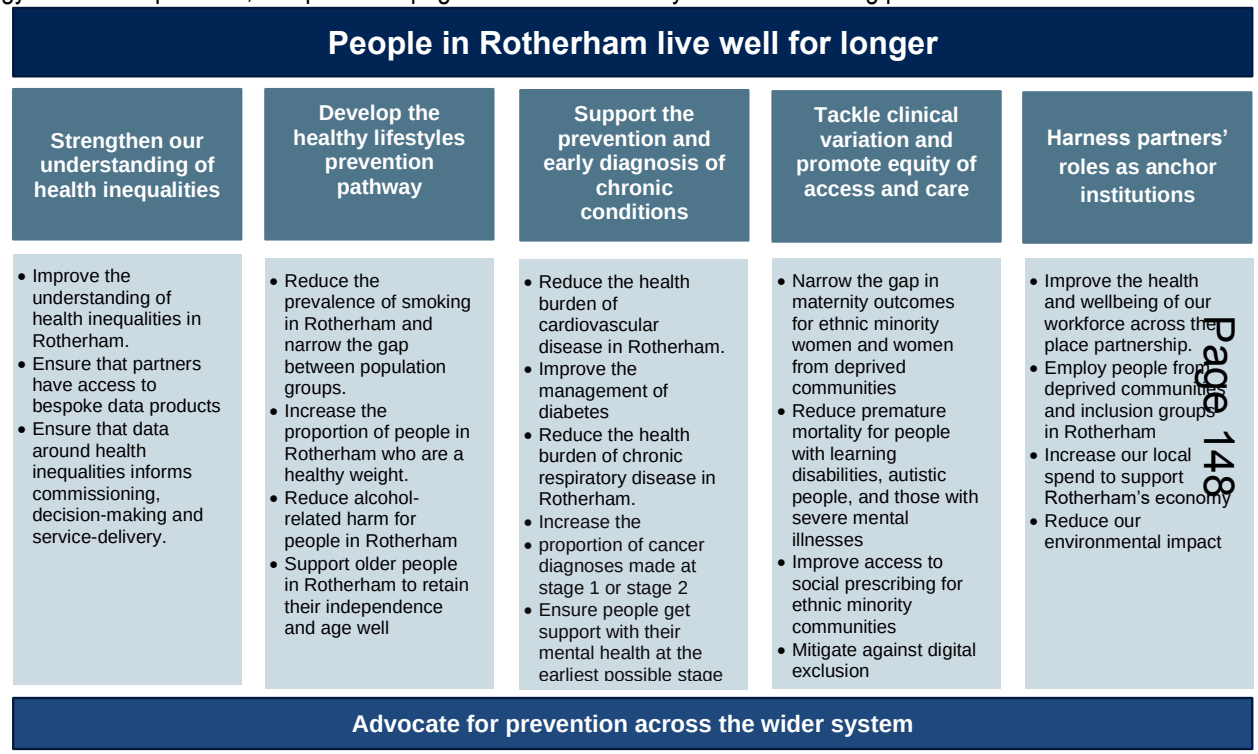
- undertake a piece of work baselining where we are in Rotherham against the published prevention and high impact interventions and including the Core20Plus5 clinical areas for adults and children and young people.
- use the outcomes to inform and update the prevention and health inequalities action plan.

5 Cross-cutting Workstreams

5.1 Prevention and Health Inequalities

To drive delivery against South Yorkshire's Joint Forward Plan in Rotherham and our ambitions around improving the health of the local population, Rotherham's Prevention and Health Inequalities Strategy was adopted in 2022. As a Place partnership, we want more people in Rotherham to experience better health and wellbeing. Focussing on preventing problems from arising in the first place and intervening early will not only lead to better health outcomes for local people but is also vital to ensure a sustainable future for our services. Where problems do arise, we want to focus on preventing them from escalating further, so that people can live happy, healthy, and fulfilling lives for as long as possible.

There are also significant health inequalities between different groups in Rotherham, which means we need to support communities at a level that is proportionate to the degree of need – taking a universal approach where appropriate whilst also providing targeted support to those who most need it. To effectively address health inequalities, this principle of 'proportionate universalism' should be embedded within everything we do. Our Prevention and Health Inequalities Strategy identifies 5 priorities, see plan on a page below is a summary of the work taking place:



1. ***Strengthen our understanding of health inequalities***
   To make a compelling impact on health inequalities, we must act based on a strong understanding of the needs and experiences of our communities. This includes having a clear understanding of who our target groups are, to enable us to take a proactive approach and make the biggest difference to population health. Work to build our understanding of health inequalities will inform our approach to tackling health inequalities; the intention is that our local Prevention and Health Inequalities Strategy will evolve as we build our understanding of the data and intelligence, ensuring we are responsive to the best evidence available and emerging needs. We will also share the data and intelligence we collate more widely to influence across the wider system. Integral to this work will be the inclusion of community intelligence and the voice of local people. Listening to and acting on what people tell us is essential to addressing inequalities in our communities, including identifying any barriers to accessing care and disparities in the experiences and outcomes of different groups.
2. ***Develop the healthy lifestyles prevention pathway***
   Modifiable risk factors, such as smoking, alcohol, and obesity are all associated with disability adjusted life-years and are key drivers of poor health. Rotherham has higher rates of smoking, obesity and alcohol-related harm when compared with the England average and there are also significant disparities in the prevalence of these issues between the most and least affluent communities and for specific communities. This means that focussing on these preventable risk factors is an important part of addressing inequalities within the borough, as well as between Rotherham and the national average. Working in partnership, we will aim to ensure that our services operate within a person-centred, joined-up and effective pathway. We will aim to support and empower local people by taking a compassionate approach, which means promoting health gains for all people, without stigma or judgement, and taking into account the wider context of their lives.
3. ***Support the prevention and early diagnosis of chronic conditions***
   It is estimated that two thirds of premature deaths could be avoided through improved prevention, early detection, and better treatment, meaning that focussing on the prevention and early diagnosis of long-term conditions has the potential to have a significant impact on mortality in Rotherham. Early detection and effective treatment are also vital to ensure that people with long-term conditions experience a good quality of life. Additionally, having one long-term condition can increase the risk of developing another, and multimorbidity is higher in the most deprived communities.

To provide the best treatment and care, we will take a person-centred and holistic approach, rather than focussing on individual diseases. We will also ensure that a focus on sustainable behaviour change, such as integrating physical activity as treatment within clinical pathways, is part of our approach to supporting people with LTCs.

4. ***Tackle clinical variation and promote equity of access and care***
   The COVID-19 pandemic and the cost-of-living crisis have shone a harsh light on some of the health and wider inequalities that persist in our society, and we know that people do not receive services or support on an equal footing. This includes disparity in both access to services and the experience and outcomes from treatment. Ensuring that every person in Rotherham has access to quality care is a key component to addressing health inequalities across the borough. This will often require a tailored and targeted approach to meet the needs of specific communities.
5. ***Harness partners' roles as anchor institutions***
   The term 'anchor institutions' is used to refer to organisations which have an important presence in a place, usually through a combination of being largescale employers; the largest purchasers of goods and services in the locality; controlling large areas of land; and/or having relatively fixed assets. Being such large institutions within Rotherham means that Rotherham Place partners have the potential to improve population health by addressing the socioeconomic and environmental conditions that influence health outcomes. By working collectively on joint commitments, we have the potential to have a significant influence on these determinants, making Rotherham a healthier place to live and work.

In addition, we will ***advocate for prevention across the wider system -*** Evidence shows that the wider determinants of health – (the conditions in which people are born, grow, live, work, and age) – are more influential in shaping people's health and wellbeing than the healthcare that people receive. Whilst the Place Plan and Prevention and Health Inequalities Strategy are focussed on the health and social care system, it will be important to use partners' collective influence and the intelligence we gather to shape action to address the wider determinants of health.

To support this, Place partners will provide evidence to key stakeholders and partnership forums such as the Health and Wellbeing Board to influence action on the wider determinants of health and will also advocate for prevention within each of our own organisations. Over 2022/23, work started to deliver on the strategy, some of the key achievements include:

- Development of a prevention campaign to support engagement with local people around their health and wellbeing.
- Expansion of the RotherHive website to incorporate sections on smoking, food, and physical activity.
- Embedding of the QUIT programme across TRFT and RDaSH.
- Relaunch of the NHS Health Checks programme, with a focus on areas of high deprivation in line with proportionate universalism.
- Rollout of the lung health checks programme in Rotherham.
- Delivery of OHID-funded projects to support people with their mental health, which included an award-winning befriending project delivered by voluntary sector partners.
- Launch of the continuity of care model within maternity services in TRFT.
- Engagement in the national Place Development Programme, which provided insights around multimorbidity.
- Development of an interactive health inequalities tool, which includes an assurance framework to measure delivery
- Engagement with local ethnic minority communities on mental health to support the development of cultural competency training for GPs and other clinicians.

The Rotherham Place Prevention and Health Inequalities Group is committed to building our understanding of health inequalities in Rotherham, which will include analysis of disparities in access, outcomes and experience for ethnic minority communities. This will inform the delivery of the entirety of the Place Plan, with all workstreams contributing towards narrowing the gap.

The NHS Long Term Plan requirements set out action relating to prevention and health inequalities, such as:

- Providing more personalised care and giving people more control over their own health.
- Taking action to address the key drivers of ill-health such as smoking, obesity, alcohol, air pollution and antimicrobial resistance.
- Supporting a strong start in life for children and young people, including a focus on maternity and neonatal services, children, and young people's
- Providing better care for major health conditions, including cancer, cardiovascular disease, strokes, diabetes, respiratory disease, mental health.
- Deploying population health management solutions to understand the areas of greatest health need and match services to meet them.

The Operational Planning Guidance includes 32 national objectives covering 12 areas of the NHS, some of the key objectives relating to prevention and health inequalities include:

- Making it easier for people to contact a GP practice and delivering 50 million more appointments by the end of March 2024.
- Continuing to recruit Additional Roles Reimbursement Scheme (ARRS) roles.
- Recovering dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels.
- Focussing on cancer diagnosis, including meeting the cancer faster diagnosis standard, and increasing the percentage of cancers diagnosed at stages 1 and 2.
- Increasing the percentage of patients that receive a diagnostic test within six weeks and delivering diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition.
- Improving access to mental health support for children and young people.
- Increasing the number of adults and older adults accessing Talking Therapies (IAPT) treatment and achieving a year-on-year increase in the number of adults and older adults supported by community mental health services.
- Recovering the dementia diagnosis rate.
- Improving access to perinatal mental health services.
- Ensuring people aged over 14 on GP learning disabilities registers received an annual health check and health action plan.
- Reducing the reliance on inpatient care for people with learning disabilities and autistic people, whilst improving the quality of inpatient care.
- Increasing the percentage of patients with hypertension treated to NICE guidance.
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies.

The Core20Plus5 framework for adults and for children and young people is the national NHS framework for tackling healthcare inequalities. This framework sets out a focus on the 20% most deprived communities nationally according to the Index of Multiple Deprivation (IMD), 'plus' inclusion health groups, which are identified locally and a number of priority clinical areas. Rotherham's Place Plan and the Prevention and Health Inequalities Strategy both draw from and seek to deliver against this national framework. This means a commitment to focussing on:

The **20**% most deprived of the national population according to the Indices of Multiple Deprivation.	According to the IMD (2019), 36% of the Rotherham population live in the 20% most deprived areas of England. There are significant inequalities in health outcomes for the most and least deprived communities in Rotherham, and we know that deprivation also influences the way that people access and experience our services.
Plus, any locally identified priority groups. Several inclusion groups for Rotherham have been identified as it shown in the box to the side. It should be noted that this list is far from comprehensive, and other inclusion groups will be of particular import for certain pathways and health concerns. Moreover, the identification of 'plus' inclusion groups for Rotherham will be an iterative and ongoing process which will inform the delivery of Rotherham's Place Plan on an ongoing basis.	• Ethnic minority communities • Gypsy, Roma, and traveller communities • People with severe mental illnesses (SMIs) • People with learning disabilities and autistic people • Carers • Asylum seekers and refugees As well as facing structural inequalities, many of the inclusion groups within this list are more likely to also live in Rotherham's 20% most deprived communities, leading to multiple disadvantages. A focus on these cohorts will inform the delivery of Rotherham's Place Plan.

Delivery across **5** key clinical areas for adults and **5** for children and young people. These areas are outlined in the table to the right.

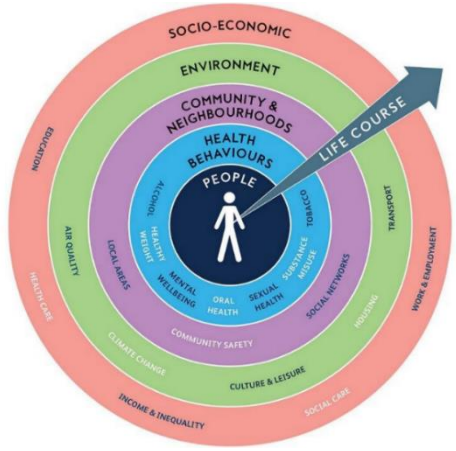
All of these clinical areas have been factored into the workstreams within this plan.

Adults	Children and young people
• **Maternity** – Continuity of care within maternity services for women from Black, Asian and minority ethnic communities and from the most deprived groups. • **SMI** – Annual health checks for those living with SMI. • **Respiratory** – A clear focus on Chronic Obstructive Pulmonary Disease (COPD) and driving uptake of COVID, flu and pneumonia vaccines. • **Cancer** – Early cancer diagnosis. • **Hypertension and lipid management** – Hypertension case-finding and optimal management and lipid optimal management.	• **Asthma** – Reduce reliance on reliever medications for asthma and decrease the number of asthma attacks. • **Diabetes** – Increase access to Real-Time Continuous Glucose Monitors and insulin pumps in the most deprived communities and from ethnic minority backgrounds and increase the proportion of young people with Type 2 Diabetes experiencing annual health checks. • **Epilepsy** – Increase access to specialist nurses and ensure access in the first year of care for those with a learning disability or autism. • **Oral health** – Address the backlog for tooth extractions in hospital for under 10s • **Mental health** – Improve access rates to children and young people's mental health

The wider determinants of health and the cost-of-living crisis.

Health is influenced by a broad range of factors. The wider determinants of health include socioeconomic factors, environmental conditions, and the social and community networks people have access to. Evidence indicates that these wider determinants have a greater influence on health than the healthcare people receive. As a health and social care system, it is therefore vital that partners work in a way that takes into account these wider factors.

A pressing example of this is the cost-of-living crisis. Struggling to afford essential items, like food, rent, heating, or transport has wide-ranging negative impacts on mental and physical health and wellbeing. Working within this context makes it even more critical that Rotherham's Place Partnership remains focussed on tackling health inequalities as part of everything we do. Tackling the cost-of-living crisis requires a twofold approach; mitigating against the immediate effects within our population and seeking to address the underlying inequalities which make certain groups more vulnerable to such crises. Locally, action has been taken to support local people through the cost-of-living crisis.



5.2 Primary Care

The challenges and actions for primary care are consistent across South Yorkshire and there are significant gains by working at scale. Our key aim is to provide high quality healthcare for all through equitable access, excellent experience and optimal outcomes and the development of new service models.

We have strong, well connected Primary Care leadership across place and at South Yorkshire level. The Primary Care Collaborative Board provides strategic leadership across all Rotherham primary care, at all levels. It is embedded within the Rotherham Place Delivery Structure and has the ability to interact and influence on behalf of the wider primary care community. The GP federation provides strategic leadership and a strong voice for primary care provision. There are six well-established Primary Care Networks (PCNs), with Clinical Directors meeting regularly and connected into the broader system discussions and decisions.

We recognise that primary care is critical to our integrated health and care system and in our vision to improve population health. Key priorities across South Yorkshire are improve access, workforce, and integration. Rotherham will support at South Yorkshire level but also has additional actions that are being taken forward:

Workforce is the key risk as it is difficult to recruit and then retain staff within primary care it also poses a risk to other services e.g., appointment of paramedics and pharmacists is taking them away from other sectors, other risks include continued increase in demand which is in excess of capacity and sustainability of the Federation if PCNs take on services directly.

Our Key priorities are:

- Workforce; recruitment (ARRS), new roles development
- Pilot of centralised spirometry across primary care to inform commissioning of respiratory services
- Development of primary care to support personalisation.
- Continued development and roll out of the Rotherham health app to support patient to take control of their health Primary Care Estates development:
- Virtual Wards see section 4.4 and for Proactive (Anticipatory) Care see section 4.6
- Development of a Primary Care Medicines Dashboard
- Increase primary care referrals to the NHS Diabetes Prevention Programme
- Work with primary care to deliver the early diagnosis DES, embed CtheSigns, promote FIT and tele dermatology.
- Integrate adult community mental health services for those with SMI with Primary care with a focus on Early Intervention for Psychosis
- Continue PCN development with layers of scale as outlined in the SY Primary Care Strategy

Primary Care Estate developments include:

- New medical centre at Olive Lane (Waverley) delivered in partnership across Rotherham
- Extension to Broom Lane Medical Centre to deliver 11 additional clinical rooms
- Extension of the Greasbrough practice to support pressure on space for PCN posts and planned housing developments
- Continued work on the Wickersley roundabout as all practice premises are no longer fit for purpose

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

20. Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.
21. Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.
22. Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
23. Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
24. Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels.

Delivery Milestones during the period of this plan include:

- Continue the trajectory to deliver 50 million more appointments in general
- Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS)
- Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels.

5.3 Planned Care (Elective and Diagnostics)

The delivery of high-quality and sustainable elective care continues to be a key priority across Rotherham Place. Historically, Rotherham has performed well in regard to planned care delivery, however covid brought about significant challenges to the way we work and deliver. Rotherham partners will continue to work together to build on our success to transform how we deliver planned care, how we share and roll out good practice and how we develop our care pathways to be as effective as possible, managed through our Rotherham Place clinical referral management committee.

Recovery of diagnostics has been extremely good in Rotherham. Phase 1 of the Community Diagnostic Centre is currently underway which will bring together all respiratory diagnostics into a community setting, this is really important as these are some of our most vulnerable patients who feel nervous attending hospitals for tests.

Whist significant progress has been made all partners recognise that there is further work required as we continue to develop and transform our planned care services. The implementation of clinical protocols across Rotherham will allow for a further reduction in unnecessary follow up appointments which will be supported by our ambition to improve clinical triage of referrals, helping to make sure the right patients get the right treatment at the right time. Work will also take place with specific services where a step change reduction in face-to-face outpatient consultations can take place while improving the quality of service offered. Initially this will include Dermatology and Ophthalmology.

We will continue to make improvements to our surgical pathways to enable an increasing number of patients to be treated as day cases. We will also continue to work collaboratively across partners to expand access, through initiatives such as direct access to Musculo Skeletal First Contact Practitioners and our integrated community approach using the principle of every contact matters, to offer better access to services closer to, or even in, the patient home. All partners in Rotherham accept that to continue to deliver high quality, safe and sustainable planned care across Rotherham we must continue to work together with an increasing focus on proactive and preventative care, a move of activity out of the acute setting and an increasing use of digital technologies. Rotherham will support at South Yorkshire level but also has additional actions that are being taken forward at Rotherham Place.

Workforce is the key risk to elective care, along with the continuing impact of covid and other illnesses increasing non-elective activity impinging on elective beds

Key Priorities are:

- Recovery of waiting lists
- Maintain electives and referrals within affordable levels.
- Reduce follow ups to national follow up ratios.
- Audits Projects / Schemes
- iRefer
- Advice and Guidance
- Review of Pathways and PIFU
- Patient portal
- Implementation of a breast pain pathway to de-medicalise breast pain and ensure patients receive full support to manage their pain.
- Implementation of a menopause pathway to ensure patients are directed to the most appropriately experienced clinician.
- Transforming outpatient services to ensure patients not requiring tests or physical examination can have a virtual appointment and patients who are appropriate for patient initiated follow up are able

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

25. Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
26. Deliver the system- specific activity target (agreed through the operational planning process)
27. Continue to reduce the number of patients waiting over 62 days
28. Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
29. Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition.

Delivery Milestones during the period of this plan include:

- Diagnostic Centre
- Increasing day case and theatre utilisation to 85% at
- No waits over 65 weeks
- GP Direct Access for Brain MRI

6 Enabling Workstreams

6.1 Digitally Enabling Our System

The Rotherham Place Partnership Digital Group has been operating for many years, it has representation from all key partners and has supported the development of strong working partnerships between the digital teams across Rotherham, which helps to drive forward our joined up digital initiatives. Our first place-wide digital strategy was co-produced in 2019, it supported us in our bid for funding from the national Digital Aspirant Programme (DAP) in 2020, which in turn supported the significant acceleration in delivery of the strategy over the period 2020 – 2022. Our inclusive partnership approach to working together enabled us to use the DAP funds to support the delivery of digital transformation across the place including in health, care, and voluntary services.

In 2022 we updated and refreshed our place digital strategy, acknowledging that much has changed for the health and social care organisations in the place because of the Covid-19 pandemic. This unprecedented period of demand for public services dramatically changed the preconceptions of both citizens and the health and social care workforce about how those services should be provided, with a surge to digital and remote delivery. We need to take stock of the ongoing ramifications of the pandemic, updated strategy elaborates on the following five overarching objectives. We will:

1. ensure that place partners build integrated digitally supported care pathways in a way that involves the wider health community (e.g., community pharmacy and ambulance), puts citizens and their needs at the centre of service design, and gives staff the skills they need to manage these services effectively.
2. keep digital innovation at the heart of our service commissioning and delivery planning.
3. continue to work towards ever closer alignment of our individual organisations' digital programmes and increase the information that is shared for patient care.
4. continue be full partners in the development of NHS South Yorkshire's digital strategy and plans and contribute to ICS wide initiatives.
5. continue to leverage the power of our collective data to design and commission services to meet the needs of the population.

These objectives are then augmented by specific actions set out in four themed sections, which reflect on Rotherham's ambitions in those areas, the challenges experienced, and the steps required to achieve them: The themes and associated actions are detailed in the following sections:

1. Digital infrastructure

Acknowledging that many new digital technologies have been implemented across Rotherham to support the Place-wide Covid-19 response, we commit to a review programme that will consolidate and optimise them and develop and document use cases and standard operating procedures, we will:

- ensure that all digital solutions implemented are fully compliant with mandated standards and staff are fully trained to use them.
- Build on the implementation of remote patient monitoring technologies in Rotherham, we will develop service models that harness the potential to support patients in their own homes, intervene when patients' health deteriorates, and reduce unnecessary face-to-face attendance.
- ensure that care homes and PODAC providers have robust and secure digital infrastructure, and access to key systems, building on the pharmacy integration work started between TRFT and community pharmacies to implement the NHS Discharge Medicines Service.
- continue our programme of reviewing and improving GP network performance.
- support our NHS partners and care homes to meet required bandwidth capacities

2. **Shared care records** - we will:

- assess the long-term role of the Rotherham Health app in the context of:
  - the 2022-23 Priorities and Operation Planning Guidance requirement to raise NHS app registrations to 60% of GP adult lists size.
  - potential to secure NHS Digital's support for integration of the Rotherham Health app into the NHS app.
- review, and if required develop and communicate a set of use cases for the Rotherham Health Record.
- work with partners across the ICS and Yorkshire and Humber region to build the availability of data and number of people using the Yorkshire Humber Care Record.

will continue with work to improve the datasets available in Rotherham Health Record.

3. **The digital citizen -** we will:

- review the impact of the Covid-19 pandemic on the digital maturity of the voluntary sector, recognising the significant contribution that the sector makes to the lives of Rotherham citizens.
- when we procure or design digital tools for public use, we will engage citizens or citizen groups in co-design and testing, to ensure ease of use is built in.
- continue to work with GP surgeries to align their website to those of their PCN.
- continue to develop Gismo as a tool to signpost citizens to voluntary organisations, by increasing its functionality and driving higher usage.
- support the work of the Digital Inclusion Team and look for opportunities to share learning across the place partners.

4. **Intelligence and analytics -** we will:

- continue to develop the sustainable analytical resources that we need to support the delivery of population health management across the Place, from data analysis tools techniques to skilled analysts and general data skills in the workforce.
- contribute to better population health management at ICS-level by developing and improving data links with health and social care organisations outside Rotherham.
- create information products in collaboration with all of the ICP partners, ensuring that they provide insights from which commissioning and service redesign decisions can be made.
- maintain a forward view of innovative data analysis techniques and technologies, e.g., artificial intelligence and machine learning.

The table below show some of the key ongoing projects from our digital strategy mapped to the strategic aims for the Rotherham Place that are detailed in this plan:

Prevention and Health Inequalities	Ensuring the Best Start in Life	Enjoying the Best possible Mental Health and Wellbeing	Enabling people to Live Well for Longer	Improving care for Life-limiting illnesses and End of Life Care	Transforming Healthcare Delivery
Dedicated digital inclusion programme underway in Rotherham Closely linked with work to reduce health inequalities and response to cost of living crisis • Flexible digital support arrangements planned to complement formal digital skills courses already available • Established strong links with communications teams to improve how we shared information and guidance with our local populations • Partnership with local colleges and voluntary groups are under discussion • Plans for access to devices, mobile data packages, free wi-fi sites. Training and support in development Work to support deliver of the proactive (anticipatory) care programme is ongoing. Initiatives include: • Providing appropriate digital solution to support the identification of people for anticipator care support • Providing the MDT with the necessary information to fully support proactive care delivery in a joined-up way • Enabling the sharing of care plans with the patient and across the MDT	• Supporting the development of a joined up digital offer for the Family Hubs that will be developed in Rotherham • Integration of data from RMBC Children and Young Peoples Service (CYPS) into the Rotherham health Record, starting with inclusion of a SEND data set • Onboarding staff from CYPS as users of the Rotherham Health Record	• Working with place partners to ensure digital is embedded within mental health transformation projects • Supporting community mental health reporting requirements (MHDS specification) for ARRS identifiable activity • Scoping the use of eReferrals for mental health services • Development of the Community Mental health Transformation Hubs • Reconciliation of SMY registers across the place • Development of the Bluebox devises for outreach SMI health checks	• Further development of the Rotherham Health App functionality to provide people with the information and tools to support management of their long-term condition • Widening use of the Rotherham Health App functionality through integration that will enable direct access via the App	• Digital transformation for Enhanced Health in Care Homes: • Rolling out secure access to the Rotherham Health Record in care homes to improve information sharing between settings • Enabling key documentation to be uploaded to the Rotherham Health Record, enabling detailed plans and information to be shared more effectively across care settings • Working with the ICB wide programme to increase the uptake of digital care record systems and falls detection systems in our care homes	Primary care digital plan for FY 23/24 developed to continue optimised use of core systems and tools to support primary care colleagues to: • Improve access and personalised care • Increasing and optimising capacity • Addressing variation and encouraging good practice • Improving communications with the public Urgent, Emergency and Community Care: Virtual Wards – understanding gaps in information sharing across the end to end pathway to help ensure patients get the best outcomes and can avoid unnecessary hospital (re) admissions and get the care they require in their usual place of residence Improving information sharing – linking our place shared records with the wider Regional record (Yorkshire and Humber Care Record)

6.2 Workforce and Organisational Development

To achieve the ambitions, we have as a Health and Social Care partnership, and bring our Place Plan to life, will require the dedication, understanding and commitment from across our collective workforce at all levels. We are committed to investing in our workforce; ensuring that there is a skilled, experienced, and motivated workforce working within the right environment and demonstrating the right behaviours that are vital for delivery. As partners we will continue to build on our existing partnership strengths, encouraging and supporting our workforce to think creatively and adopt new ways of working to further enhance service provision that puts the Rotherham people at the very heart of everything we do. This includes engaging with residents and communities to support them to proactively maintain their physical, mental, and social health, and ensure they know how to access health and support services at the right time to meet their needs.

The approach we are taking to workforce and organisational development is based on the Burke-Litwin model (see diagram below) which provides a framework that is adopted across all partners. The model identifies that change is influenced from environmental factors not just organisational factors and by embracing these concepts within the 'Rotherham Place' we can develop and deliver positive change across all partner organisations.

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

30. Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise

To support this approach the partnership has agreed on four key areas to focus our current and future activities around:

- Place as an Employer of Choice
- Culture, Values and Ways of Working
- Equality, Diversity, and Inclusion
- Health and Wellbeing

Workforce challenges - Rotherham as a Place aspires to be an employer of choice, and a key enabler of this aspiration is firmly grounded in ensuring that recruitment and retention is effective, streamlined and provides a positive user experience in a very competitive employment market. In addition, activity is taking place to ensure that all the key benefits of working within health and social care are promoted. This includes being a flexible employer, identifying and promoting career pathways and opportunities and having an inclusive and compassionate culture where everyone can thrive.

The workforce shortages and recruitment challenges should not be underestimated with vacancies and a lack of stability across several key professions within the system. There is a definitive need to ensure that as a Place we develop a talent pipeline that feeds the workforce. This needs to be sustainable and meet the demands of the changing population. This will include engaging and enthusing the next workforce generation by working with academic partners, connecting the existing workforce with the purpose of Place, identifying opportunities to truly transform and being open and honest about the capacity and resourcing pressures and identifying key skills for the future.

Rotherham has a diverse and active voluntary and community sector (VCS), underpinned by thousands of volunteers which supplements our workforce. It is recognised that the VCS plays a crucial role in prevention and early intervention, enabling self-help, and supporting community resilience. As a Place there is acknowledgement that a VCS offer of workforce support does not mean zero cost and that appropriate investment is required to support delivery of our plans.

	OD Area		Organisation Development Area
1.	**Mission and Strategy**	→	• Create a collective vision to enable improved communication with our staff and communities • Ensure that safety, quality, and efficiency underpin our vision. • Collaboratively develop a collective brand for the Rotherham Place
2.	**Leadership**	→	• Create a multidisciplinary leadership programme, which has the vision of ICP plan embedded within it. • Commitment to lead change together
3.	**Culture**	→	• Change culture and behaviour to take a Rotherham Place first approach. • Develop opportunities to co-produce initiatives such as staff well- being and resilience building
4.	**Structure**	→	• Develop mechanisms that allow cross organisational recruitment and retention, using values-based recruitment. • Where appropriate create opportunities to introduce cross organisational posts
5.	**Management Practice**	→	• Create Rotherham Place 'talent' management opportunities. • Introduce Rotherham Place apprenticeship / intern opportunities – including levy sharing
6.	**Systems**	→	• Align induction processes to ensure place and organisation is covered. • Create an accredited training programme that supports transferable skills and ensures cross working across partner organisations
7.	**Tasks & individual values & behaviours**	→	• Agree a set of cross organisations "Place Based" staff values • Have a collaborative approach to identifying good and problematic areas of joint working. • Develop an accepted approach to use of language in our Rotherham Place
8.	**Engagement & motivation**	→	• Undertake across organisation engagement events - 'The Best solutions come from staff themselves.' • Engage staff on 'what matters to them'

6.3 Best Use of Our Estate & Housing

If we are to be successful in the delivery of our place ambition, we need to ensure that our available housing and estates act as an enabler to our strategic transformation workstreams. Partners recognise the value of working together and taking a strategic approach to asset management and getting the most from our collective assets. As well as buildings, this includes community assets: the skills and knowledge of local people; community groups; informal networks; and public spaces. Key priorities will be primary care estate, the green agenda and better utilisation.
Our established Strategic Estates Group continues to work constructively, identifying available estate across the system, ensuring it is fit for purpose and identifying disposals where possible. It will continue to respond to the changing needs of services and the population. Rotherham place is also working with the ICS Strategic Estates Board in developing and delivering the ICS Estates Strategy and with the Sheffield City Region's Public Asset Development Group to develop their Estates Transformation Strategy, to ensure estates strategies work beyond the Rotherham boundary. System leaders are clear that our approach to utilising estate needs to be driven by our Place Plan transformation.

It is important that people have access to local, well managed services but the type of housing they live in also has a huge impact on health. Good quality, affordable housing provides the basis for people to live healthy, independent, and fulfilling lives. The population continues to age and pressures on the health services to support individuals is increasing. Therefore, it is important that we plan for housing that is care and support ready so that people can live in their home for as long as they are able, whilst reducing reliance on public services and encouraging independence.

The role of housing goes beyond bricks and mortar; providing investment in council stock, encouraging improvements in private housing provision, development of new homes, and engagement with tenants and residents all contribute to creating healthy, stronger, and more resilient communities. Getting people in the right housing and building community resilience can lead to improved health outcomes, financial wellbeing and reduced social isolation.

6.4 Best Use of Our Financial Resources

System partners recognise the challenges of delivering improvements and transforming health and care services at a time of increased demand and lower growth in resources and understand the importance of working collaboratively to address these challenges. To help facilitate this, the Place Finance group was established in May 2019, membership consists of Chief Finance Officers and Directors of Finance representing all Rotherham Place partners.

Its role is to support delivery of the Place Plan by providing specialist financial advice; this includes assessing and advising on financial matters linked to or arising from the Place Plan and its underpinning initiatives and schemes. Importantly, the group provides a forum for the Place Board to refer financial matters to and a forum for individual system finance leaders to refer financial matters to. Key deliverables include:

- developing a joint understanding of the financial impact of place initiatives on individual partner organisations and on the place as a whole.
- developing appropriate financial strategy and governance arrangements to support delivery of place and partnership working.
- observing and documenting the financial impact on individual organisations of Place Plan initiatives.
- developing a Place based financial framework including any transitional funding arrangements.

Which of the 31 NHS National Objectives that we will be measured by in this workstream:
31. Deliver a balanced net system financial position for 2023/24

The Finance group works to the place principles, but in addition has specific aims to; ensure the best possible use of the Rotherham pound; be open and honest, fostering an open book approach to disclosing and sharing of financial information; observe and respect the financial sustainability of partner organisations by ensuring financial impact is jointly acknowledged and made transparent.

Whilst system partners acknowledge the joint responsibility for the effective use of the available financial resource within the Rotherham place, each partner also has its own challenges and mitigations. Our aspiration is to better direct financial resources to deliver more impact on health outcomes.

6.5 Communication & Engagement

The approach and direction for communications and engagement will focus on informing, sharing, listening, and responding to the people of Rotherham and how we can work together collaboratively to improve both services and lives. We know that real and meaningful engagement with the people that are using or may use our services is fundamental in ensuring that plans will be effective and practical. Specific target activity will take place, with a variety of stakeholders, for each of our workstreams and we will continue to develop meaningful communication, in a simple and easy to understand way that meets their needs. We will consider the most effective ways of communicating and engaging with local people, including those who are seldom heard, which includes residents whom English is not their first language.

Our Inclusive Approach will:

- proactively and effectively communicating our vision, transformational priorities, and achievements
- develop two-way communication opportunities; where we share news, we listen and respond and are visible to local people. Where appropriate, we will look to use new and innovative ways to engage and communicate with our local communities in an ever-growing digital environment, whilst considering the needs of individuals with limited digital access or knowledge
- implement relevant and effective communication and engagement tactics with key audiences and stakeholders
- encourage people of Rotherham to take care of themselves, making healthy choices with a focus on prevention and self-management. We want people to be active, happy, and comfortable in their own homes where possible
- use an asset-based approach; making the most of our joint resources; avoiding duplication of activity, and building on the skills and knowledge of Rotherham people
- use a variety of mechanisms for communication and engagement, utilising skills, resources, and contacts in a manner proportionate and appropriate to the issue; with opportunities covering the spectrum from seeking feedback to co-creation

We will aim to bring the plan to life, focussing on what it means for children, young people, and adults in Rotherham, making the plans more tangible and encouraging participation and involvement. As the work continues to develop, we will share the impact and success through stories and case studies. As a core part of the Rotherham Together Partnership, we will ensure that health and care communications activity reflects and enhances the profile of the partnership by using the Rotherham brand identity within campaigns and resources that support this plan. Planning and delivery of our communication and engagement in Rotherham will be co-ordinated with the activity at an overarching South Yorkshire level.

We recognise our staff as one of our biggest assets in the development and transformation of health and care. We will develop co-ordinated and timely staff activity across all partner organisations, allowing them to shape and support the transformation of health and care.

We are committed to the active participation of local people in the development of health and social care services and as partners in their own health and health care. Local people will have an important voice in how services are planned, delivered, and reviewed. We need local people in Rotherham to influence change that will improve services, health outcomes and their experience of care. We will build on information gathered from views shared by our people as part of the engagement exercise for the South Yorkshire Integrated Care Partnership Strategy and Joint Forward Plan where residents told us what matters most to them about their health and wellbeing. This feedback has informed the place plan and will also be reflected in our communications and engagement activity.

The successful delivery of the place plan is dependent upon collaboration between health, social care, and voluntary sector, and to a degree, a level of understanding from a wider set of stakeholders from across Rotherham. The place plan has been jointly developed by health and social care partners in Rotherham and, in doing so, we have engaged views from a range of local partners by presenting the plan at the Health and Wellbeing Board, Rotherham Together Partnership, Primary Care Networks, Health Select Committee, and through each partners' governance structure

Glossary

A&E	Accident and Emergency
BCF	Better Care Fund
BME	Black Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CCC	Care Co-ordination Centre
CHR CIC	Connect Healthcare Rotherham CIC
CT	Computed Tomography
C&YP	Children and Young People
DTOC	Delayed Transfers of Care
FSM	Free School Meals
H&WB	Health and Wellbeing
ICP	Integrated Care Partnership
ICS	Integrated Care System
IH&SC	Integrated Health and Social Care
IRR	Integrated Rapid Response
IT	Information technology
IDT	Integrated Discharge Team
JFP	Joint Forward Plan
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LAC	Looked After Children
LMC	Local Medical Committee
LOS	Length of Stay
MOU	Memorandum of Understanding
NHS LTP	NHS Long Term Plan
PCN	Primary Care Network
RDaSH	Rotherham Doncaster and South Humber NHS Foundation Trust
RHR	Rotherham Health Record
SDCS	Strategic Data Collection Service
RMBC	Rotherham Metropolitan Borough Council
SEMH	Social Emotional and Mental Health
SEND	Special Educational Needs and Disabilities
SY&B	South Yorkshire and Bassetlaw
STP	Sustainability and Transformation Plan
TRFT	The Rotherham NHS Foundation Trust
UEC	Urgent and Emergency Centre
VAR	Voluntary Action Rotherham
VCS	Voluntary and community sector

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Health and Wellbeing Strategy Action Plan: September 2023 update

Key:

Completed
On track
At risk of not meeting milestone
Off track
Not started

Aim 1: All children get the best start in life and go on to achieve their full potential

Board sponsors: Nicola Curley, Strategic Director of Children and Young People's Services, Rotherham Metropolitan Borough Council and Dr Jason Page, Medical Director for Rotherham Place, South Yorkshire Integrated Care Board

Priority	#	Milestones	Timescale	Lead(s)	BRAG rating	Progress update
Cross-cutting	1.1	Implement 'Best Start and Beyond' framework.	Ongoing (up to March 2025)	Alex Hawley, RMBC Helen Sweaton, ICB/RMBC		The terms of reference of the group will be revised at the next meeting (25th September), to take account of the decision to add the oversight for the Family Hubs funded workstreams to the group's remit. This fits very well in particular with the focus on the first 1001 days. Meeting frequency is likely to change to monthly.
	1.2	Mobilise and launch 0-19 service with a universal offer to support all children and young people and their families, with an enhanced offer for those that need it, ensuring that there is equality across the service.	April 2023	Michael Ng, RMBC		The service was mobilised and launched successfully in April 2023 with no issues. Rotherham's Best Start and Beyond Public Health Nursing service will lead, coordinate, and deliver the Healthy Child Programme. The Service forms a part of the Children and Young

						People's (C&YP) system. It will contribute to improving and reducing inequalities between health and wellbeing outcomes, identifying additional needs early, building resilience and reducing health inequalities by providing preventive universal and targeted interventions.
Develop our approach to give every child the best start in life.	1.3	Building on gap analysis, develop a local action plan to deliver on the first 1001 days through the Best Start and Beyond Framework.	March 2023	Alex Hawley, RMBC		A collated action plan was presented to the Best Start and Beyond Steering Group. Subgroups are now taking forward delivery of the 1001 Days aspects. Initial maternity analysis was undertaken by a task and finish group. Development of the Start for Life offer is now underway.
	1.4	Work towards formal ratification of 'Breastfeeding Borough' declaration, including BF friendly places, BF policy, comms plan	June 2023	Sam Longley, RMBC		The Rotherham BFFB declaration was given further endorsement by the Health and Wellbeing Board in June. In August the declaration was signed by representatives of the Council, the Trust and Public Health at a launch event, which was combined with the launch of the Trust's

						'Rotherham Backs Breastfeeding" campaign.
	1.5	Developing and publishing the Start for Life Offer (first 1001 days), through implementation of Best Start and Beyond Framework.	September 2023	Alex Hawley		The start for life offer was published at the end of July - Start for Life – Rotherham Metropolitan Borough Council, following a very well-attended stakeholder workshop in mid-July, where feedback on the draft version of the website was received. The workshop also looked at next steps, which will be Phase 2, where the form and content of the resource will be developed. This will be the development of a more mature web entity, integrated into the suite of pages within the fully branded Family Hubs digital offer. Phase 2 would also ultimately lead to a hard copy version.
	1.6	Work with the LMS to ensure continuity of carer is the default model by March 2024.	March 2024	Sarah Petty, Head of Midwifery, TRFT		The target for continuity has been removed by NHS England on the 21st September 2022.

						TRFT are currently working on workforce Transformation plan with the Rotherham Maternity Voice Partnership to improve the COC offer women antenatally and postnatally whilst maintaining safe staffing in the acute service on every shift. The development of the Maternity workforce transformation plan is enabling the team to develop this plan to get the model right for the local population. The model has commenced on the 5th Dec 2022.
Support children and young people to develop well.	1.7	Develop and agree prevention-led approach to children and young people's healthy weight with partners, building on childhood obesity pathway review and evidence from compassionate approach	January 2024	Sue Turner, RMBC		Compassionate approach working group, has met, well represented by health, including from Healthwave, and school nursing. Adapting action plan from this workshop. A comms resource is being developed. Trained operational staff from school catering.

	1.8	Develop proposals for multi-agency Family Hub model of service delivery	November 2022	David McWilliams, RMBC		Sign up paperwork was completed, approved and submitted to government DfE and DHSC in October 22. Task & Finish groups were established to cover the different funded strands of the programme and the groups have contributed to early delivery planning. In January 23 there will be two workshops to develop delivery planning further.
	1.9	Continue to support children and young people's Mental Health and wellbeing, along with schools, health and voluntary sector	Ongoing (up to March 2025)	Helen Sweaton, ICB		Smiles for Miles (2-year National Lottery funded) increased youth provision and support for Children and Young People aged 9-19 / up to 25 with SEND in Rotherham. DfE Wellbeing for Education Return has been rolled out Two cohorts for the Anna Freud Link Programme delivered using the Cascade framework to map whole system provision.

						CAMHs Getting Advice pathway is operational The SEMH toolkit has been developed and available to schools which supports the graduated response Autism Education Trust training has been rolled out to learning providers. Approval has been sought for this to be rolled out to Early Years.
	1.10	Continue to jointly deliver the SEND Written Statement of Action, jointly led by LA and ICB and with local area partners.	Ongoing	AD Education and Inclusion, RMBC Helen Sweaton, ICB		The most recent support and challenge meeting was held on the 5th of June. Comments from the draft note of visit following support and challenge 5 suggested that Rotherham has made considerable progress in its focus on 'impact'. Following support and challenge meeting 5 it was confirmed that Rotherham wouldn't be subject to a re-visit based on progress against the Written Statement of Action, instead any re-

						inspection would form part of the timetable under the new framework. Ongoing monitoring of our Written Statement of Action will form part of business as usual monitoring linking to the SEND Development Plan for Rotherham.
	1.11	Continue to focus on improving early years take-up in targeted areas of Rotherham (Central) to have wider holistic benefit on key development measures	July 2023 July 2024	AD Education and Inclusion, RMBC		In Summer term, 85.6% of eligible 2 year olds are taking up their entitlement. Pockets of slightly lower takeup have been identified at Canklow North, Rockingham West, Brinsworth West, Munsbrough, Ferham and Eastwood. Demand is greatest in the Summer term and action taken to understand the lower take-up has highlighted a lack of available places at some provision with some parents waiting to join in September. Alternative places are available locally. Early Years continue to use Golden Ticket and translated marketing to promote take up in harder to reach communities. 'Not in a place' ring rounds are carried out by FIS. Work continues

						with Early Help colleagues to promote takeup.

Aim 2: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life

Board Sponsors: Claire Smith, Deputy Director Rotherham Place, South Yorkshire Integrated Care Board and Toby Lewis, Chief Executive, Rotherham Doncaster and South Humber NHS Foundation Trust

Priority	#	Milestones	Timescale	Lead(s)	BRAG Rating	Progress update
Promote better mental health and wellbeing for all Rotherham people.	2.1	Work towards signing up to the OHID prevention concordat for better mental health as a Health and Wellbeing Board.	March 2023	Ruth Fletcher-Brown, RMBC		The Prevention Concordat application was signed by HWB Partners and submitted in August. Health and Wellbeing Board chair, DPH and officers will attend the panel meeting on the 20th September.
	2.2	New action: Progress formal sign up to the OHID prevention concordat for better mental health as a Health and Wellbeing Board	September 2023	Ruth Fletcher-Brown, RMBC		Formal sign up subject to panel meeting outcome on 20th September
	2.3	Develop and deliver partnership communications activity focussed on mental health, building on successful campaigns and resources • Rotherhive	Delivery to March 2025	Comms lead, RMBC Gordon Laidlaw, ICB		Social media messages promoting Rotherhive and Five Ways to Wellbeing are scheduled at least once every four weeks at the moment – this is reviewed quarterly as part of the Council's overall communications plan. Regular messaging is also going out via

		• Five Ways to Wellbeing • Great Big Rotherham To Do List				neighbourhoods ebulletins aligned to local ward priorities.
	2.4	Refresh and deliver Better Mental Health For All action plan, focused on early intervention and prevention, developed in line with national 10-year Mental Health Plan	December 2022 Delivery to March 2025	Ruth Fletcher-Brown, RMBC		Delay is due to policy change on National 10 Year Mental Health Plan (The update of the local plan was to be aligned to this national plan). The actions within the Prevention Concordat application will form the basis of the new Better Mental Health for All action plan. Once the Prevention Concordat has been approved by OHID at the September panel meeting, the action plan will be developed with Partners.
Take action to prevent suicide and self-harm.	2.5	Promote suicide and self-harm awareness training to practitioners across the partnership and members of the public through internal and external communications	March 2025	Ruth Fletcher-Brown, RMBC		A second training session held with RDASH, which looked at suicide prevention activity in Rotherham, sharing findings from the Real Time Surveillance system and postvention support. 3 training sessions delivered to SYP Sergeants in September. This covered suicide prevention activity in Rotherham, sharing findings from the Real Time Surveillance system, postvention support for CYP and adults and an input with a

						family member who had been bereaved by suicide. The Zero Suicide Alliance Training is being promoted as part of World Suicide Prevention Day.
	2.6	Deliver the Be the One campaign with annual targeted messages based on local need with support from all partners' comms and engagement leads.	Annual delivery up to September 2025	Ruth Fletcher-Brown, RMBC Gordon Laidlaw, ICB		Targeted messages being promoted for World Suicide Prevention Day, 10 September 2023.
	2.7	To promote postvention support for adults, children and young people bereaved, affected and exposed to suicide and monitor referrals to services, including staff affected	March 2024	Ruth Fletcher-Brown, RMBC		CYP Sudden and Traumatic Bereavement pathway has been finalised. Work is progressing on the third Memorial Day for people in SY bereaved by suicide. Amparo promoted at staff training and on World Suicide Prevention Day social media posts. Chilypep is working on an easy read version of 'Walk with Us'. ICB NHS Rotherham is working with PH Leads on the procurement of the SY suicide liaison service. The contract with the current provider expires early 2024.

Promote positive workplace wellbeing for staff across the partnership.	2.8	Promote the Be Well @ Work award to Health and Wellbeing Board partners and support sign up	Ongoing	Colin Ellis, RMBC		We are still wanting partners to come forward and sign up to the award scheme. TRFT have agreed to renew their award and we will be working together on this. Still not a very good response from partners who are not signed up to the award.
	2.9	Ensure partners are engaged in Employment is for everyone programme, promoting employment opportunities to those with SEND, and improving wellbeing at work	March 2024	Colin Ellis, RMBC		Rotherham has launched employment for everyone. employment is for everyone is a project that four organisations have created in Rotherham (Speakup, Dexx, Art Works, EDLounge) supported by RMBC, Community Catalysts and the South Yorkshire Integrated Care System Rotherham as part of a joint SY bid to the DWP has been successful and this will bring additional resource to the employment is for everyone initiative. This is going from strength to strength and is linked in with various partners across the region. We are linked into all four regional SEND forums and are working with a number of regional employers to promote the benefits of employing people with SEND.

Enhance access to mental health services.	2.10	Ensure partners are engaged in the development and mobilisation of the integrated primary/secondary care mental health transformation. This will include: • Implementation of MH ARRS roles • Long term plan eating disorders, IPS and EIP targets by March 2024 • Implementation of Community Mental Health Integrated primary / secondary care transformation programme by March 2024	March 2024	Kate Tufnell, ICB-Rotherham Julie Thornton, RDaSH		• 8/9 B7 Mental Health Specialist Practitioners in post (ARRS) • 8/8 Health & Wellbeing Triage Coaches in post (ARRS) – 2 due to leave post September 2023 – recruitment in progress • Primary Care Mental Health Team Manager in post • Primary Care Mental Health Team Clinical Lead in post • Primary Care Mental Health Team Service Manager – vacant until November 2023 • Transformation Lead – resignation – review of requirement Early intervention in psychosis – this service now well established and continue to deliver the required targets, as identified in the Mental Health Long-term plan by March 2024. IPS service continue to work with partners to increase the number of people accessing the service. RDaSH / SYHA have recently established a joint steering group. Primary care hub development underway. Initial discussions held with RMBC regarding estates. Exploring opportunities to co-locate, following a HUB and Spoke model.

	2.11	To work in partnership to enhance the Mental Health Crisis Pathway (early intervention, prevention, social care & crisis). This will require: • Partnership working to ensure an early intervention and crisis prevention model is developed • Mobilisation of the Touchstone Safe Space (alternative to crisis) provision • Mobilisation of social care pathways	March 2024	Andrew Wells, RMBC Julie Thornton, RDaSH Kate Tufnell, ICB – Rotherham Ruth Fletcher-Brown, Public Health		Mobilisation of a pilot service in Rotherham which will support people who have attempted suicide due to a life event, where their physical and mental health needs have been met. This will commence end of October 2023. Partnership working to ensure an early intervention and crisis prevention Meeting arranged for 12th September 2023 to agree the 'to be' model of crisis service delivery. New crisis pathways for RMBC model to go through their internal Governance process in October 2023. Soft launch of the National NHS 111 programme across Rotherham from 1st September 2023. Touchstone mobilisation The number of people accessing the Rotherham Safe Space service continues to grow month on month. Currently operating 3 nights a week work is underway to expand this to 4 nights a week from November 2023.

Aim 3: All Rotherham people live well for longer

Board sponsors: Sharon Kemp, Chief Executive, Rotherham Metropolitan Borough Council and Michael Wright, Deputy Chief Executive, The Rotherham NHS Foundation Trust

Priority	#	Milestones	Timescale	Lead(s)	BRAG rating	Progress update
Ensure support is in place for carers.	3.1	Refresh the information, advice and guidance available to carers, including the launch of the carers newsletter	March 2023	AD Strategic Commissioning, RMBC		The first edition of the Carers Newsletter published and launched in Carers Week 2023, June 2023: https://www.rotherham.gov.uk/downloads/file/3270/carers-newsletter However, more work is needed to refresh information, advice and guidance. Carers Conversations are now underway and outcomes will further inform the refresh of our advice and information offer. Carers Conversations (co-production workshops) have been

						held in August and more planned for Sept/Oct: Beacon, Crossroads, Making Space Dementia Café, RFT, Headway, Carers Forum, online internal & external. Initial findings indicate a preference for one place to find information that can be logically searched. RMBC webpages will be redesigned as an outcome. Planning activity for Carers Rights Day on 23.11.23 underway.
	3.2	Take an integrated approach to identifying and supporting carer health and wellbeing through working with partners to develop a carer health and wellbeing action plan.	April 2023 – March 2024 (as part of delivery of area of focus	AD Strategic Commissioning, RMBC		Permanent Carers Strategy Manager took up post 24.07.23. Information pack produced by RMBC Community Connectors and user opinion sought during carers week and

			2 of strategic framework)			during carers conversations – very positively received and users requested handbook be printed and available to them at carers needs assessment and at support groups/events. Health and Wellbeing Checks undertaken during carers week with partners – Beacon, Reach, Community Connectors, IDT and Carers Assurance Lead. 19 small grant applications (up to £5000 each) for carer wellbeing activity evaluated in partnership with Engagement Manager, SYICB and approved. Funds currently being distributed. Outcomes from these projects will inform

						priorities for health and wellbeing action plan and strengthen local communities. Carers Strategy Manager attending Unpaid/Working Unpaid Carers System Leads – (Integrated Care System) and Yorks & Humber ICB Carers Leads group to continue partnership working. ICB Rotherham Place carers information pack is near completion for use by primary care to identify unpaid carers - updates via SYICB meeting. Planning for Nov Carers Rights Day and 2024 Carers Week in collaboration with SYICB, HR & community providers.

	3.3	Establish locality specific carer partnership / network groups	April 2023 – March 2024 (as part of delivery of area of focus 2 of strategic framework)	AD Strategic Commissioning, RMBC		Terms of reference for a network group to be developed with members of the Borough That Cares Strategic Group. The above mentioned grant recipients will be invited to join, if not already attending.
	3.4	Introduce co-production programme with communities to build our carer friendly Borough	April 2023 – March 2024 (as part of delivery of area of focus 2 of strategic framework)	AD Strategic Commissioning, RMBC		Carers Strategy Manager now in post – to progress the setup of a panel of Experts by Experience. People engaging in the projects run by the small grant recipients will be encouraged to participate to build wider community based offer. Carers Conversations co-production workshops unfortunately

						postponed from June/July now being held through Aug/Sept and Oct. Healthwatch survey results due early Nov.
	3.5	Introduce an assurance process for all published Information, Advice and Guidance to ensure the relevance, accuracy and accessibility	April 2023 – March 2024 (as part of delivery of area of focus 2 of strategic framework)	AD Strategic Commissioning, RMBC		Desktop review of information standards completed. Partners to form working group to redesign webpage to ensure information meets required standard and will contain links to national providers whose information has been through a quality assurance process.
	3.6	Ensure carers feel their role is understood and valued by their community • Develop Carer friendly communities action pack • Empowerment Plan – align carers reps (navigators) to key strategic meetings • Pull community generated content through to The Borough that Cares virtual platform	April 2024 – March 2025 (as part of delivery of area	AD Strategic Commissioning, RMBC		This will be taken forward as part of the medium-term delivery of the strategic framework.

			of focus 3 of strategic framework)			
	3.7	Ensure Carers are supported when they have a breakdown in care through delivery of Carers emergency services	Sept 2023	AD Strategic Commissioning, RMBC		Approval was granted and the current contract end term has been extended to 31st March 2024. Carers Assurance Lead reviewing how the directorate records the details of people that are signed up to the service. Carers Strategy Manager undertaking a telephone survey to gather the views of people that have used the service in the last twelve months to aid future commissioning decisions. The route to market to be decided by the end

						September 2023 to allow a service to be secured post April 2024; should this be required.

Priority 2 – new actions

					Why is this important?	What impact will this have?'
Support local people to lead healthy lifestyles, including reducing the health burden from tobacco, obesity and drugs	Develop the healthy lifestyles prevention offer/pathway					
	3.9	Deliver the communications and engagement prevention campaign 'Say Yes' and evaluate the impact and reach.	April 2024	Becky Woolley	The campaign fills a gap in easily accessible information for local residents regarding how they can improve their health and links them into existing resources and services.	• Increased self-management • Improved take-up of services for our most underserved communities (e.g., targeted promotion of screening)

and alcohol.	3.10	Review the current service specification for social prescribing and recommission the service	March 2024	SY ICB Deputy Place Director	Social prescribing is a key element of the prevention pathway and the service ensures residents are referred to a range of local, non-clinical services to support their health and wellbeing. An integrated pathway will ensure that residents have access to a consistent and joined up social prescribing offer.	• Improvement in levels of patient activation • Improvement in self-reported levels of wellbeing
	3.11	Review Rotherham Place offer for social prescribing and implement an integrated pathway (with consideration of a Lead Provider Social Prescribing Partnership Model):		SY ICB Deputy Place Director	Social prescribing is a key element of the prevention pathway and	• Improvement in levels of patient activation

		• Review services and roles across health and social care that contribute to prevention through social prescribing i.e. ARRS roles, Community Connectors and Social Prescribing service	Septem ber 2024		the service ensures residents are referred to a range of local, non-clinical services to support their health and wellbeing. An integrated pathway will ensure that residents have access to a consistent and joined up social prescribing offer.	• Improve ment in self-reported levels of wellbeing
	Strengthen understanding of health behaviours and health inequalities					
	3.12	Engage local people in target areas to inform a proposal around self-management and holistic support for people living with physical health conditions and poor mental wellbeing.	Engage ment by Novem ber 2023	Becky Woolley (Preventio n & Health Inequalitie s Group)	Local intelligence and engagement has supported the need to embed more holistic	• Improve the understandin g of health inequalities in Rotherham.

			Proposal tbc	Andrew Turvey (Population Health Management group)	approach to supporting people with long-term conditions, taking into account both their mental and physical health. This engagement will help partners to understand how to tailor this approach in areas of high deprivation.	
	3.13	Explore options to coordinate community engagement activities around health at Place and develop approach to share findings, • Proposal to Health and Wellbeing Board	March 2023	Hannah Hall, TRFT	Engagement is increasingly a focus at South Yorkshire level and in the South Yorkshire Integrated Care Strategy and developing a	• Improve the understanding of health inequalities in Rotherham. • Improved engagement and trust with the public.

					coordinated approach at Rotherham level is necessary to improve planning of engagement activity and avoid duplication	• Improve the use of insights to inform service-delivery.
	Ensure effective partnership working on key strategic projects					
	3.14	Ensure partners are engaged in implementation of Drug and Alcohol Related Death (DARD) review process including • Establishment of quarterly DARD panel meetings • Analysis and review to inform upstream activity, prevention and understanding of issues to improve service delivery.	Dec 2023 Annual review by Dec 2024	Jessica Brooks, RMBC	The review process is central to understanding the local population and how drugs and alcohol are causing harm in local areas and collaboratively identifying challenges in the system and the changes	• Reduction in drug and alcohol related deaths

					needed to address them	
	3.15	Deliver NHSE funded pilot to support frequent attenders to ED with complex Alcohol and Mental Health needs through an outreach team providing holistic support offer.	March 2024	Amanda Marklew, TRFT		Final Peer-to-Peer review April 23 NHSE complimentary of TRFT ambitions and exceptional outcomes. Invited to speak with national team to discuss moving forward. Local discussions to be arranged to build up a business case. Extension to March 2024 agreed in Feb 2023. Presenting to Health and Wellbeing Board September 2023

Aim 4: All Rotherham people live in healthy, safe, and resilient communities

Board sponsors: Laura Koscikiewicz, Chief Superintendent, South Yorkshire Police and Paul Woodcock, Strategic Director of Regeneration and Environment, Rotherham Metropolitan Borough Council

Priority	#	Milestones	Timescale	Lead(s)	BRAG rating	Progress update
Deliver a loneliness plan for Rotherham	4.1	Deliver dissemination opportunities from OHID Better Mental Health Fund Befriender project, look to integrate learning into pathways and loneliness action plan and develop legacy opportunities.	March 2023	Ruth Fletcher-Brown, RMBC and VCS leads		Befriending project has presented at various meeting with a presentation at the Health and Wellbeing Board 23rd Nov, it has been cited as good practice within the refreshed Loneliness Action Plan.
	4.2	Promote existing resources on loneliness and befriending (including VAR film: Be a good neighbour and Five Ways to Wellbeing)	March 2024	Comms lead tbc, RMBC, Gordon Laidlaw ICB Kerry McGrath, VAR		Messaging around loneliness and befriending are scheduled at least once every four weeks at the moment – this is reviewed quarterly as part of the Council's overall communications plan. Regular messaging is also going out via neighbourhoods ebulletins aligned to local ward priorities.
	4.3	Update and deliver loneliness action plan	Update November 2022	Ruth Fletcher-Brown, RMBC		The Loneliness Action plan has been updated by Partners and an update will be presented to the HWB at the September

			Delivery to March 2025			meeting. Some highlights include: Refreshed ward priorities published in June 2023. Place-based working – mapping of assets taking place as part of the Early Intervention and Prevention work in the North Locality. Age UK participated in national pilot for MECC and loneliness. Smiles for Miles project (Children, Young People and Families Consortium Project) has supported 1800+ young people. Crossroads funding bid was successful in supporting carers which includes therapy in people's homes. Three sessions within Rotherham libraries for gentle exercise linked to the Women's Euro 22 Legacy.

						The Rotherham 10k took in May raising awareness and funds for Age UK Rotherham. Year 1 Engagement Programme of Childrens Capital of Culture completed. One outcome to date has been 75 young people employed part-time as Trainee Creative Producers, 14 of these trainees were care experienced.
	4.4	Promote volunteering opportunities	March 2024	Kerry McGrath, VAR		We currently have 73 volunteer opportunities advertised on our website.
Promote health and wellbeing through arts and cultural initiatives.	4.5	Annual delivery of Rotherham Show, creating opportunities for communities to come together and be outdoors	September 2022 September 2023 September 2024 September 2025	Leanne Buchan, RMBC		Rotherham Show 2023 has been successfully delivered for 2023. New for this year's show was the Festival Village, curated by Flux Rotherham. In this new space, visitors were treated to music from Rotherham Drummers United and The Bewonderment Machine, poetry from Ray Hearne, a wonderful workshop from artist and designer Ellie Way, plus traditional dance by Wath Morris Minors. Visitors also had

						the opportunity to see popular attractions, including the Vintage Vehicle Rally, Strongmen competitions, Let's Circus, the Chuckle Tent and, of course, the much loved Made in Rotherham horticultural show. Throughout the weekend the show celebrated the spirit of the borough and gave people the chance to enjoy an amazing free festival of culture, entertainment, and family fun.
	4.6	Complete evaluation of over 55s programme to provide recommendations for future programming for this audience and reduce social isolation	March 2023	Leanne Buchan, RMBC		A programme of activities supporting audiences aged 55+ to reconnect following Covid-19 launched in October 2021 and completed in September 2022. The programme included a series of events, exhibitions and performances, and the creation of a new Care Home Choir and of a new circus school. An evaluation of the programme was completed in December 2022 and found that: • 45% of participants said that they were more physically active

						• 55% of participants said that they were thinking more clearly • 50% of participants said that they were feeling more optimistic about the future • 90% of participants had not tried the activity before • 89% of participants would recommend the activities to a friend or family member • 60% of participants said their wellbeing had improved as a result of attending.
	4.7	Co-design Children's capital of culture with children and young people, with focus on improving their mental health and wellbeing	March 2025	Leanne Buchan, RMBC		Children's Capital of Culture launched in February 2022. Children's Capital of Culture occupied its own area at Rotherham Show 2023, reserved exclusively for families and young adventurers.
	4.8	Deliver a series of activities in libraries for people of all ages to connect, be active and learn new skills, and widen the accessibility of library services, through: • Pop-up libraries • Reading gardens • Makerspaces • Authors' visits and performances • Fun palaces	March 2025	Zoe Oxley, RMBC		22nd June 2023 awards ceremony for the Rotherham Loves Writing competition. 53 attended & feedback was positive. 15th July the winners' workshop took place at Wentworth Woodhouse. -4 events with author Ray Matthews. Riverside poorly attended but more participants signed up at Wath, Wickersley and Mowbray Gardens.

						-Shared Reading at Swinton every Tuesday. The Reader are funding training for two new reading volunteers in Rotherham. -The FLUX funded poetry project, 'Spread the Word', began in June at Rawmarsh, Mowbray Gardens and Dinnington. Work produced is fantastic and participants are finding it a valuable space. -5th July pop up at Rotherham Minster to share information about library services and promote the Summer Reading Challenge. 15 adults and 5 children attended. -6th July libraries Teddy Bear's Picnic event at Wentworth Woodhouse Gardens to raise funds for the Master Cutler's Challenge & promote the Summer Reading Challenge through storytelling. - 6th July mobile library van visited Bramley Sunnyside Junior School to issue 15 children with new library cards for Wickersley library. -On 12th July colleagues visited St. Ann's Infant &Junior School to consult with parents about what facilities they would like to see at the new Central Library.

						Consultations also took place at Coleridge Primary School on Friday 14th July and at Ferham Primary School on 20th July. -Riverside House hosted Utopia Theatre, on 24th & 25th July, who performed Anna Hibiscus. Over the 4 performances there were over 150 visitors in the gallery. - Saturday 5th August, pop-up event for Yorkshire Day, promoting libraries. STEM related activities delivered by Work-wise and live music by Children's Capital of Culture Young Musician in Residence. -Thursday mornings, throughout August, pop up events at the Civic Theatre to promote the Summer Reading Challenge (SRC) with Granny Norbag. -26th July, 9th & 23rd August pop up events at Keble Martin Green, with FLUX Rotherham, to promote library events, SRC & carry out story sessions. -Saturday 2nd and Sunday 3rd September Rotherham Show to promote library services and sign people to become library members, promote volunteering in libraries and Fun Palaces. Brightbox hosted a Makerspace & author, Salma Zaman,

						engaged families with a story telling session followed by Bollywood dance. -Maker{Story} sessions were piloted for 4 weeks at Maltby & Rawmarsh during August funded by Maker Futures (University of Sheffield) running in partnership with the Direct Education Business Partnership. -The ambassador attended the Fun Palace national conference at Gateshead to share ideas, good practice and attend training. S62 group- in Rawmarsh, who provide mental health peer-to-peer support and other groups-will be holding their own Fun Palace! The Ambassador is supporting the group to build the confidence of members, so they feel able to share their skills & open up the venue to the local community to enhance community connections and reduce stigma. Some members are also going to display their work in the Fun Palaces Mental Health exhibition.
	4.9	Utilise libraries as death positive spaces, where the public can have conversations	March 2023	Zoe Oxley, RMBC		Death cafes are taking place at Mowbray on a bi-monthly basis

		around loss, grief, end of life planning and legacy. Explore legacy opportunities for programme, building on positive public response	March 2024			on the 3rd Thursday of the month. The June meeting has taken place – attendance was low. The next meeting will be in October.
	4.10	Utilise and promote libraries as spaces for people to share experiences and response to specific health issues, including menopause and dementia, and improve community resilience	March 2025	Zoe Oxley, RMBC		Maltby Menopause Café now running monthly, on Monday evenings, from 5.45pm – 6.45pm. Attendance ranges from 1-4 customers. Partnership work is being explored with RUFC who have received funding for a project. A representative has been asked to attend an event on Wednesday 18th October for World Menopause Day at Mexborough Montagu Hospital.
Ensure Rotherham people are kept safe from harm.	4.11	Embed referral pathways with key partners in Rotherham through the Home Safety Partnership Referral Scheme and Safe and Well checks.	July 2023	Shayne Tottie and Toni Tranter, South Yorkshire Fire and Rescue		Training has continued with LA Adult Social Care and is proving to have appositive impact on the referrals being received by SYFR. The team at SYFR continues to engage with key stakeholders working within the Rotherham area.

	4.12	Work with other partnership boards on crosscutting issues relating to safety and safeguarding.	Ongoing for the duration of the plan	Board chairs, RTP		Safeguarding Board Chairs meetings are now established to maintain the relationship between the safeguarding boards and work on crosscutting issues. The safeguarding protocol has been updated. Meetings will take place bi-annually and boards' annual reports will be shared for the group to consider and for cross-cutting issues to be discussed.
	4.13	Establish a Combatting Drugs Partnership for Rotherham	October 2022	Jessica Brooks, RMBC		4th Combatting Drugs Partnership meeting held 02/02/23.
	4.14	Conduct joint needs assessment for the Combatting Drugs Partnership for Rotherham and agree local drug strategy delivery plan	December 2022	Jessica Brooks, RMBC		The needs assessment was compiled from existing HNA and additional contributions from partners, a high-level version was presented at the action planning workshop held on 05/12/23. The action plan is complete and was formally signed off at the 14/09/23 CDP. It will be shared at future HWBB meeting.

	4.15	Delivery of vaccination programme for Covid-19 and flu	Annual target	Denise Littlewood, RMBC		560 082 Covid Vaccinations have been given in Rotherham in total . In line with Living with Covid, data is no longer being published for the number of 1st and 2nd vaccinations received. The Spring Booster Campaign was completed with a 74% uptake. The winter Flu and Covid vaccination programme starts on 18th September 2023.
Develop a borough that supports a healthy lifestyle.	4.16	Progress strategic approach to physical activity in Rotherham, through four key areas: • Active workforce • Social movements • Front line workers signposting • Local social prescribing structures	Nov 2022 (Action plan developed) March 2025 (Delivery)	Gilly Brenner, RMBC, with Norsheen Akhtar, Yorkshire Sport Foundation		Action plan continues to be implemented and delivered on track. Moving Rotherham Board established, and meeting held. Wider physical activity and health subgroup established and has now met twice. Momentum is positive.
	4.17	Develop a borough-wide MECC training offer on physical activity	March 2023	Gilly Brenner, with Norsheen Akhtar, Yorkshire Sport Foundation		New training offer agreed from Yorkshire Sport to be rolled out in train-the trainer model to social prescribers / link workers (Oct 23), health care assistants (Feb 24) and care homes (Apr 24) to support wider understanding of benefits and

						opportunities for physical activity for all.
	4.18	Deliver a range of programmes to welcome women and girls into football, focussing on under-represented groups.	July 2023	Chris Siddall, RMBC		Legacy provision across the borough continues in three main guises- RUCT, Adult and Recreation Officer post via The FA and School provision. Presentation at Wembley for "1 year on" went well with Rotherham highlighting good practice that was commended.
	4.19	Use football to encourage more women and girls to adopt and maintain a healthier lifestyle.	July 2023	Chris Siddall, RMBC		Adult recreation programme continues throughout the community venues in Rotherham. Still awaiting new KPI's have yet to be agreed.
	4.20	Conduct research and engagement with priority groups on the development of inclusive and accessible outdoor sports facilities, through the PlayZone initiative	Sept 2023	Chris Siddall, RMBC		Funding applications have been submitted seeking match funding on 2 schemes. Locations are yet to be determined, and subject to consultation being complete. Additional work is being conducted with partners to seek wider offer.

	4.21	Finalise delivery plan for the approved cycling strategy.	March 2023	Andrew Moss, RMBC		Final Delivery Plan approved 30 March ’23.
	4.22	Rotherham Food Network to develop an action plan and response based on the framework of the Sustainable Food Places Bronze Award	April 2023	Gilly Brenner, RMBC		Rotherham Food Network established, though still growing membership, and actions on track. Further detail including action plan scheduled to be shared with H&WbB in Nov 23.
	4.23	Enable all partner staff to support neighbourhoods and communities to thrive, through exploring options on a partnership offer on training on strength-based approaches	March 2024	Martin Hughes, Neighbourhoods, and Lily Hall, OD		The General Awareness training (Level 1) will be delivered via an e-learning package. It will be available to all IT enabled council staff by the end of September 2023. Work is ongoing to commission an outside organisation to deliver the Enhanced Awareness (Level 2) and Practitioner (Level 3) training for council staff that have been nominated by their Directorate Leadership Teams.

Cross-cutting priorities

Priority	#	Milestones	Timescale	Lead(s)	BRAG rating	Progress update
Work in partnership to maximise the positive impact of anchor institutions across all 4 priorities	5.1	Undertake a baselining assessment regarding social value and map trend annually through the Rotherham Anchor Network.	March 2023 (baselining assessment) March annual target (trend mapping)	Karen Middlebrook, RMBC		The Council has been working with partners and local spending profile data has now been provided by the Council and NHS Rotherham Foundation Trust for financial years 2020/21 and 2021/22. This has enabled some baselining and trend analysis activity to take place between the two organisations. Work will continue to encourage other partners to participate.
	5.2	Agree our partnership approach to act as anchor institutions to reduce health inequalities in Rotherham	March 2023	Place Board (Becky Woolley, RMBC)		Following a series of workshops in January and February, a proposed approach to take this agenda forward has been developed with various partnership subgroups.

						An action plan has been developed and was formally supported at Place Board.
Support safe and equitable recovery from the Covid pandemic	5.3	Building on the VAR annual survey, explore options to assess the current position of the voluntary and community sector in partnership with stakeholders and report relevant learning to the board.	March 2023	Shafiq Hussain, VAR		The Centre for Regional Economic and Social Research (Sheffield Hallam University) has been formally engaged to conduct State of the Sector research for South Yorkshire, including a place approach. The survey questions are currently being finalised. Rotherham State of The Sector Report (2023) details to be shared with Health and Wellbeing Board in January 2024.
	5.4	Conduct strategic impact assessment of Covid-19 on residents and Council services	May 2023	Lorna Quinn		The assessment is complete with the report being circulated through appropriate channels and to be presented at the Health and Wellbeing Board in June. Findings are included in the 2023 DPH report.

	5.5	Consider further service developments to ensure differentials in access for certain patient cohorts are removed, for example by segmenting our waiting list based on wider patient needs.	March 2023 Continuing to November 2023	Michael Wright, TRFT		• A pilot to support the most deprived patients in booking and attending appointments has proved successful, reducing the rate of 'did not attend' appointment outcomes within the target population. • The waiting well web portal has now launched, linking to other Place resources, such as Rotherhive, and represents a step towards joining up support for wider patient needs while waiting for treatment. • An exploratory piece of work has begun to examine options and appetite for adopting a clinical prioritisation algorithm to support an equalities-based approach to managing waiting lists.

						• The trust is working with colleagues across Doncaster and Barnsley to identify, monitor and respond to any emerging health inequalities impacts of the Mexborough Montagu elective orthopaedic pathway • The TRFT health inequalities operational group has initiated work to improve data quality and reporting on patient characteristics to afford greater insight into differences in cohort access and outcomes.
Develop the Pharmaceutical Needs Assessment.	5.6	Host stakeholder consultation to support needs assessment	January 2025	Lorna Quinn, RMBC		Annual steering group meetings will be held; next one will be 2023.
	5.7	Publish updated Rotherham Pharmaceutical Needs Assessment	September 2025	Lorna Quinn, RMBC		Not yet started but will commence in 2025.

						The PNA annual steering group is taking place in October 2023.
Work in partnership to further develop the Rotherham Data Hub and assess population health.	5.8	Work with partnership steering group on annual refresh and development of the JSNA.	April 2023 April 2024 April 2025	Lorna Quinn, RMBC		The JSNA refresh is complete and has been published for 2023. Updates will be provided through the mailing list and the steering group.
	5.9	Launch annual training and promotion of the JSNA across the partnership	October 2022 October 2023 October 2024	Lorna Quinn, RMBC		Training has been conducted for 2023 including with RMBC colleagues and Voluntary Community Sector colleagues. Further training is set to be scheduled for 2023.
	5.10	Monitor population health through Outcomes Framework and report any emerging issues to the board	Ongoing	Becky Woolley, RMBC		The assurance framework has been developed as part of a wider interactive health inequalities tool. Regular reporting arrangements are now in place through to the Prevention and Health Inequalities Enabler Group and Place Board. The next step is to profile the inclusion groups

						identified within the strategy, building on the work that has taken place to build a profile of local people living in the 20% most deprived communities.

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BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	27th September 2023
	LEAD OFFICER	Steph Watt Joint Head of Adult Commissioning (Rotherham Place) E-mail: steph.watt@nhs.net
	TITLE:	Better Care Fund (BCF) Call-Off Partnership / Work Order 2023/24

Background

1.1 The purpose of this report is to confirm that Rotherham Metropolitan Council (RMBC) and South Yorkshire Integrated Care Board (Rotherham Place) have jointly developed a new BCF Call-Off Partnership/Work Order in 2023/24, which reflects local need and priorities.

1.2 The Department of Health and Social Care (DHSC) and Department for Levelling Up, Housing and Communities (DLUHC) have published a BCF Policy Framework for the implementation of the Better Care Fund (BCF) for 2023-25.

1.3 As set out in the BCF Policy Framework, the delivery of the BCF will support two key priorities for the health and care system that align with the two existing BCF objectives:

- Improving overall quality of life for people, and reducing pressure on UEC, acute and social care services through investing in preventative services
- Tackling delayed discharge and bringing about sustained improvements in discharge outcomes and wider system flow, as set out in the BCF objectives and priorities for 2023-25

1.4 NHS England and the Government have published the BCF Planning Requirements for 2023/25, the vision for the BCF is to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by the two core BCF objectives:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

1.5 The use of BCF mandatory funding streams (including NHS minimum contribution, Improved Better Care Fund (iBCF) grant, Disabled Facilities Grant (DFG) and Discharge Funding must be jointly agreed by Integrated Care Boards (ICBs) and Local Authorities to reflect local health and care priorities, with plans signed off by Health and Wellbeing Boards (HWBs).

1.6 The Discharge Funding needs to be used to reduce flow pressure on hospitals, including mental health inpatient settings by enabling more people to be discharged to an appropriate setting, with adequate and timely health and social care support.

Key Issues

2.1 The Better Care Fund will continue to provide a mechanism for personalised, integrated approaches to health, social care and housing 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.

2.2 The BCF Plan for Rotherham has been developed to promote and implement integration, and these schemes are set out in the BCF Call-Off Partnership / Work Order 2023/24 (Appendix 1)

2.3 The BCF Planning Requirements 2023-25 illustrates that a formal agreement needs to be established in each local area to enable the Council and the SYICB (Rotherham Place) to work

	collaboratively in delivering the services. The BCF Call-Off Partnership / Work Order 2023/24 needs to be fully signed by both partner organisations and in place by 31st October 2023.
2.4	The BCF Call-Off Partnership/ Work Order 2023/24 has established two Better Care fund pooled budgets. With each organisation hosting one fund, the proposal allows both the Council and SYICB (Rotherham Place) to maximise the benefits of hosting a pooled budget.
2.5	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.
2.6	The BCF Executive Group is the body which has strategic oversight of the whole BCF plan. The BCF Operational Group will gather reviews and interprets performance data, and ensures targets are monitored and met. The officer groups will be held accountable across the system and have key representatives from both RMBC and SYICB (Rotherham Place). Terms of Reference for each of these groups are set out in BCF Call-Off Partnership / Work Order.
2.7	This partnership will work across all Partners to ensure effective delivery of the ambitions set out in the BCF metric plans. The SYICB (Rotherham Place) 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.
2.8	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 £50.681m BCF Plan for 2023/24. One fund, hosted by the SYICB (Rotherham Place), is valued at £13.756m and the other fund, hosted by the Council, is valued at £36.925m. Both funds sit under the same Section 75 Framework Agreement which provides governance for the BCF plan.
2.9	The BCF mandatory funding includes the minimum NHS contribution of £24.188m, Improved Better Care Fund (IBCF) £14.481m and DFG £3.064m for 2023/24 which amounts to a total of £41.733 million.
2.10	In line with previous years the BCF Risk Pool will be utilised to contribute to the increase in demand and to support discharges from hospital.
2.11	Risk sharing agreements have been agreed to protect both parties from areas of overspend and financial risk.
2.12	**Feedback from Better Care Team** The Better Care national team provided informal feedback on 15th June 2023, confirming that Rotherham's draft BCF plan was excellent and met the majority of the Key Lines of Enquiry (KLOE). The BCF draft plan gave a comprehensive overview on how a joined-up approach to the integration of health, social care and housing services is implemented, the approach to joint commissioning, and demonstrates how services support people to remain independent for longer and support them to remain in their own home.
2.13	The draft plan also gave a good description of how the plan will contribute to reducing health inequalities and disparities for the local population, and how services, including BCF funded services, support unpaid carers, in particular the use of census data to set the context and the involvement of carers in developing the Carers Strategy. The draft plan gave an excellent description of how services support people to receive the right care, in the right place, at the right time.
2.14	The BCF planning template in relation to capacity and demand now shows variance over the year in relation to rehabilitation / reablement and urgent community services. Further detail has been added in relation to providing examples of BCF schemes which achieves the ambitions of the plan.

2.15	The final versions of the BCF planning and narrative templates were agreed at the Health and Wellbeing Board and submitted to the BCF National team on 28th June 2023.
2.16	The BCF national team have provided further feedback on 18th July 2023, confirming that the Yorkshire and Humber BCF Assurance Panel has put forward Rotherham's BCF Plan for 2023/24 for approval.

Key Actions and Relevant Timelines

3.1 The BCF planning templates and BCF Call Off Partnership / Work Order 2023/25 are going through the approval process as follows:

BCF Planning templates for 2023-25 – signed off by the Health and Wellbeing Board	28th June 2023
Approval letters issued by NHS England giving formal permission to spend (NHS minimum)	Week commencing 11th Sept 2023
BCF Call Off Partnership Work Order 2023/25 (Appendix 1) to Health and Wellbeing Board	27th Sept 2023
All Section 75 Agreements to be signed and in place	31st October 2023

Implications for Health Inequalities

4.1 Addressing health inequalities is integral to the allocation of BCF resource and funded schemes. This includes contributing to achieving the strategic aims of developing healthy lifestyles and prevention pathways, supporting prevention and early diagnosis of chronic conditions and targeting variation.

BCF funded schemes which reduce health inequalities include social prescribing, Breathing Space and project support for the implementation of Population Health Management (PHM) priorities.

Recommendations

5.1 **That the Health and Wellbeing Board approves the:**

(i) Better Care Fund (BCF) Call-Off Partnership / Work Order for 2023/24.

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Appendix 1

Better Care Fund (BCF) –

Call Off Partnership Agreement / Work Order

1. OBJECTIVES OF THE SCHEME

The Department of Health and Social Care (DHSC) and NHS England have specifically requested in the BCF Planning Requirements (2023-25) that all funding is transferred into one or more pooled funds, established under Section 75 of the NHS Act (2006) and agreed through the Health and Wellbeing Board.

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 Planning Requirements, Vision and Local Objectives. It is a requirement of the Better Care Fund that the South Yorkshire Integrated Care Board (Rotherham Place) 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 Planning Requirements 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 (RMBC and SYICB Rotherham Place), Directorate Leadership Team, BCF Executive Group and Rotherham Health and Wellbeing Board have agreed the establishment of the following pooled arrangements:

Pool 1; Hosted by RMBC; Value of **£36.925m** for Theme 2 Rehabilitation, Reablement and to include the Improved Better Care Fund (iBCF). This includes adults revenue base budget as well as specific grants (Improved Better Care Fund, Disabled Facilities Grant and Adult Social Care Discharge Funding).

Pool 2; Hosted by the SYICB (Rotherham Place); Value of **£13.756m** for all Themes excluding Theme 2 Rehabilitation, Reablement and Intermediate Care, including a Risk Pool and the SYICB (Rotherham Place) Discharge Funding.

4. FUNCTIONS

The SYICB (Rotherham Place) and the 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 SYICB (Rotherham Place) shall be commissioned for the benefit of individuals for whom in relation to that service the SYICB (Rotherham Place) 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 SYICB (Rotherham Place) and the Council shall each liaise with any relevant neighbouring authority or SYICB (Rotherham Place) in respect of individuals who are the responsibility of either the SYICB (Rotherham Place) 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 SYICB (Rotherham Place)'s base contribution for 2023/24 will be **£25.944m** and the Council's base contribution, including the Improved Better Care Fund (iBCF), will be **£24.737m** as per the table below:

Better Care Fund 2023/24 Budget	2023/24 INVESTMENT			2023/24 SPLIT BY POOL	
BCF Investment	SYICB SHARE	RMBC SHARE	Total	Pool 1 RMBC Hosted	Pool 2 SYICB Hosted
	£000	£000	£000	£000	£000
THEME 1 - Mental Health Services	1,464		1,464		1,464
THEME 2 - Rehabilitation & Reablement	12,188	6,759	18,947	18,947	
THEME 3 - Supporting Social Care	4,144		4,144		4,144
THEME 4 - Care Mgt & Integrated Care Planning	5,090		5,090		5,090
THEME 5 - Supporting Carers	791		791		791
THEME 6 - Infrastructure	242		242		242
Risk Pool	500		500		500
Improved Better Care Fund		15,948	15,948	15,948	
Discharge Funding	1,525	2,030	3,555	2,030	1,525
TOTAL BUDGET	25,944	24,737	50,681	36,925	13,756

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 SYICB (Rotherham Place) and the Strategic Director of Finance and Customer Services of the Council prior to any additional expenditure being incurred.

6.4 Any over or underspend in the pooled funds shall be subject to the risk share agreement (Section 8) in the first instance.

6.5 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 SYICB (Rotherham Place) and RMBC.

6.6 The BCF includes the Improved Better Care Funding (iBCF) of £14.481m for 2023/24 which are subject to the following grant conditions:

- Meeting adult social care needs
- Reducing pressures on the NHS including seasonal winter pressures
- Supporting people to be discharged from hospital when they are ready
- Ensuring that the social care provider market is supported

There is no requirement to spend across all four purposes, or to spend a set proportion on each. However, the grant determination requires the Council and the SYICB (Rotherham Place) and providers to meet the National Condition 4 (Implementing the BCF Policy Objectives) in the 2023-25 Better Care Fund Policy Framework and Planning Requirements.

National Conditions 2 and 3 requires that local partners should have an agreed approach to implementing the two policy objectives for the BCF, set out in the Policy Framework. This includes:

- Enable people to stay well, safe and independent at home for longer.
- Provide the right care in the right place at the right time.

6.7 Included within the iBCF is funding for Winter Pressures 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.

6.8 In September 2022, the Government announced a commitment of £500 million to support timely and safe discharge from hospital into the community by reducing the number of people delayed in hospital awaiting social care over the winter period. The main focus is on, although not limited to, a 'home first' approach and discharge to assess (D2A).

6.9 On 4th April 2023, the Government confirmed that a total allocation of £7.705 million has been provided to NHS South Yorkshire ICB and Rotherham Place will receive £1.525 million of this funding. Rotherham Council has also been allocated £2.030 million of the fund. Therefore, this amounts to a total of £3.555 million of funding for Rotherham Place partners for 2023/24. These funds are required to be pooled into the local Better Care Fund (BCF) plans and Section 75 agreements.

6.10 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 South Yorkshire Integrated Care Board (Rotherham Place) in arrears one quarter of the estimated annual costs of the schemes.

7.2 The SYICB (Rotherham Place) 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 SYICB (Rotherham Place) meet their specific financial reporting deadlines.

7.4 The Council and the SYICB (Rotherham Place) 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 pro rata to the proportion of that scheme commissioned by each partner organisation. 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 each partners contribution, subject to the maximum level of funding each partner contributes to the scheme unless agreed by the Chief Finance Officer of the SYICB (Rotherham Place) and the Strategic Director of Finance and Customer Services of the Council prior to any additional expenditure being incurred (paragraph 6.3).

8.5 **Overspends and Underspends**

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 to be proposed in year which can utilise the resources in year.
- Underspends may be carried forward to meet ongoing financial pressures subject to each organisation's own governance arrangements. Allocation of funding will be subject to agreement of the pooled fund partners as part of the BCF governance.

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 SYICB (Rotherham Place) 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 BCF Executive group exists as a sub-group of the Health and Well Being Board and reports into this group. The BCF Executive is primarily the strategic group who set the criteria, parameters, and priorities of the BCF funds, and at a high level monitors the progress of the BCF fund and spending plan. The BCF Operational group creates the plan, but it is signed off firstly by the BCF Executive group and finally by the HWBB.

10.2 For the purpose of the BCF Plan for 2023-24, a review of the BCF Executive Group and BCF Operational Group governance arrangements has taken place to ensure that they are fit for purpose and robust in light of the newly formed SY ICB (Rotherham Place). The purpose of the review is to enhance transparency.

10.3 The BCF Operational group will present proposals to the BCF Executive group to agree appropriate use of the fund in line with the objectives of the scheme, and ensure the scheme is appropriately transacted.

10.4 Using the governance framework set out below, all partners will monitor the BCF plan effectively ensuring plans are delivered through each scheme.

10.5 The SYICB (Rotherham Place) 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.

10.6 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.

10.7 **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 HWBB chair and including senior representatives from both the Council and SYICB (Rotherham Place).

The BCF Executive Group is supported by the BCF Operational Group, which is made up of the identified lead officers at the Service Head level for each of the BCF actions within the plan, plus other supporting officers from the Council and SYICB (Rotherham Place). The BCF Operational Group meets on a quarterly basis and reports directly to the BCF Executive Group. Only the co-chairs of the BCF Operational group will also attend meetings of the BCF Executive group in view of the scrutiny role of the Executive.

10.8 **BCF Executive Support**

The BCF Executive Group and BCF Operational Group will be supported by officers from the Partners as required.

10.9 **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. These meetings to be so arranged that the HWBB is able to sign off the quarterly report before it is sent off to the BCF Assurance group.

The meetings will take place face to face as the default position, with options made available where face to face is not possible by exception for members to join on-line through Microsoft Teams.

Taking into consideration that timelines are set by NHS England guidance and policy framework that can often be delayed in year, the plan is for BCF Executive Group meetings to take place before the Health and Wellbeing Board to ensure the sign off process is followed.

The quorum for meetings of the BCF Executive Group shall be a minimum of three representative from each of the Partner organisations with a minimum of six members of the group present.

The minutes of the BCF Operational Group will be a standard agenda item for the BCF Executive Group for information and discussion where appropriate.

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. Unless agreed by the Chair in advance, substitutions will not be permitted

Minutes of all decisions shall be kept and copied to the Authorised Officers within seven (7) days of every meeting.

10.10 **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 any Pooled Fund subject to the agreement of a quorate of the Executive; and

- authorise a Lead Commissioner to enter into any contract for services necessary for the provision of Services under an Individual Scheme

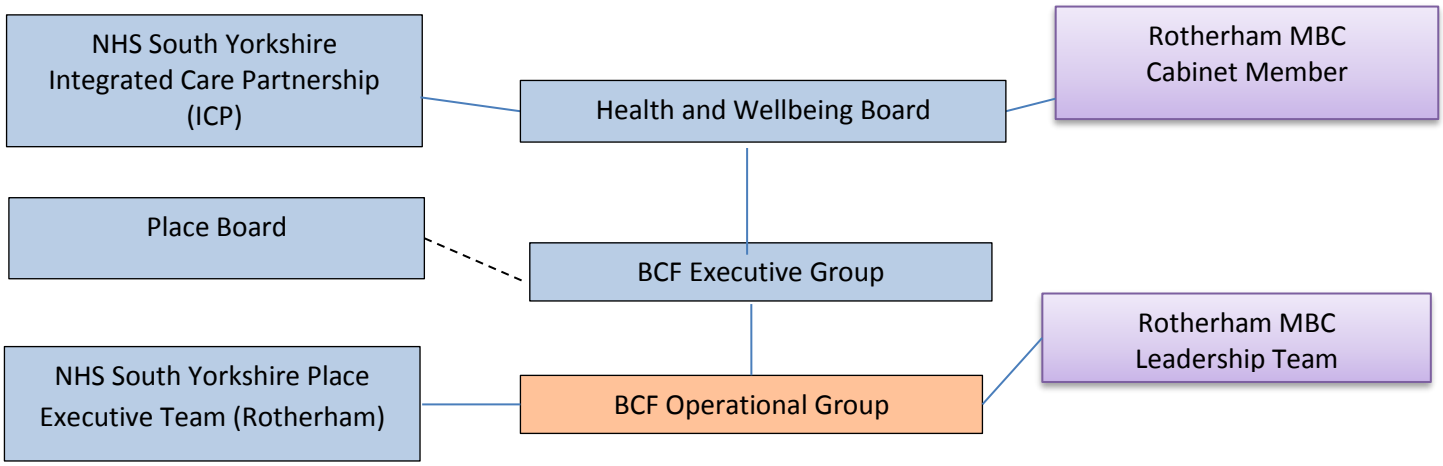
10.11 **Information and Reports**

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. In addition, in terms of RMBC, BCF spending in a particular Directorate will be part of the standard monthly agenda item on Finance. In essence this will apply to Public Health, Adult Social Care and CYPS.

10.12 **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.

10.13 **BCF Governance - Reporting Structure**



ROTHERHAM METROPOLITAN BOROUGH COUNCIL

ADULT CARE, HOUSING AND PUBLIC HEALTH

NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD (ROTHERHAM PLACE)

BETTER CARE FUND (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; setting up the strategy, parameters, criteria, priorities, framework and to make recommendations for the strategic direction and management of the Better Care Fund to the Health and Wellbeing Board (HWBB). The group is set up as a sub-group of the HWBB

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, None 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 HWBB, and • Take responsibility for any corporate issues associated with the fund. • Monitor spending plans 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 chaired by the Cabinet Member chairing the HWBB, with the SYICB Rotherham Place Lead as co-chair.

Membership of the Executive Group
Elected Member/Chair of HWBB
SYICB (Rotherham Place) Executive Place Director Rotherham
SYICB (Rotherham Place) Deputy Place Director
SYICB (Rotherham Place) Chief Finance Officer
SYICB (Rotherham Place / RMBC Head of Adult Commissioning (Joint Commissioning)
RMBC / SYICB (Rotherham Place Strategic Commissioning Manager (Joint Commissioning)
RMBC Strategic Director of Adult Care, Housing and Public Health (DASS)
RMBC Director of Public Health
RMBC Assistant Director, Strategic Commissioning or Assistant Director, Adult Care and Integration
RMBC Head of Finance (Adult Care, Housing and Public Health)
Both parties will call in relevant officers such as RMBC Finance Manager (Adult Care and Public Health) for specific topics where required and a standing invitation will be made to Public Health Director to attend.

Quorate
3 representatives from each of the organisations, with a minimum of 6 members present

Frequency of Meetings
Quarterly

Co-ordination of Meetings
Strategic Commissioning Manager, RMBC / SYICB (Rotherham Place) will co-ordinate following liaison with the Chair.

Governance
The group will report to the Health and Wellbeing Board (HWBB)

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 HWBB, LGA and NHSE.

ROTHERHAM METROPOLITAN BOROUGH COUNCIL

ADULT CARE, HOUSING AND PUBLIC HEALTH

NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD (ROTHERHAM PLACE)

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 create the funding plan to be then signed off by the Executive group • 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 quarterly basis and to circulate to the Executive. 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 SYICB (Rotherham Place) Deputy Head of Financial Management and the RMBC Assistant Director, Strategic Commissioning.

Membership of Group
SYICB (Rotherham Place) Chief Finance Officer (co Chair)
SYICB (Rotherham Place) Deputy Head of Financial Management
SYICB (Rotherham Place) Performance and Intelligence Manager
SYICB (Rotherham Place) / RMBC Head of Adult Commissioning (Joint Commissioning)
RMBC/SYICB (Rotherham Place) Strategic Commissioning Manager (Joint Commissioning)
RMBC Finance Manager (Adult Social Care and Public Health)
RMBC Head of Service - Access
RMBC Assistant Director, Strategic Commissioning (co Chair)
RMBC Performance and Improvement Manager
RMBC Consultant in Public Health
Both parties will call in relevant officers for specific topics where required

Quoracy
Three representatives from each of the organisations

Frequency of Meetings
Quarterly

Co-ordination of Meetings
Strategic Commissioning Manager, RMBC / SYICB (Rotherham Place) 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 2023/24
- 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
- South Yorkshire Integrated Care 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.

11.11 SYICB (Rotherham Place) / RMBC BCF Metrics:

As part of the Better Care Fund plan, the national metrics will be monitored by Rotherham MBC and South Yorkshire ICB (Rotherham Place). The national metrics include some changes for 2023/24. The metrics included for 2023/24 are as follows.

- Indirectly standardised rate (ISR) of avoidable admissions per 100,000 population, for chronic ambulatory sensitive conditions

- Falls – Emergency hospital admissions due to falls in people aged 65 years and over directly age standardised rate per 100,000 population – ***New Indicator***
- Percentage of people who are discharged from acute hospital to their normal place of residence.
- Long-term support needs of older people (aged 65 years and over) met by admission to residential and nursing care homes, per 100,000 population
- Proportion of older people (65 years and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

The metrics relating to percentage of inpatients who have been an inpatient in an acute hospital for 14 days or more and 21 days or more and delayed transfers of care are no longer included.

Metric descriptions are below.

Table 4 – BCF Metrics Definitions

	Metric	Numerator	Denominator
1	Indirectly standardised rate (ISR) of avoidable admissions per 100,000 population, for chronic ambulatory care sensitive conditions	Unplanned hospitalisation episodes taken from SUS (Secondary Uses Service).	Mid-year population estimates for England published by the Office for National Statistics (ONS)
2	Falls – Emergency hospital admissions due to falls in people aged 65 years and over directly age standardised rate per 100,000 population	Emergency hospital admissions due to falls in people aged 65 years	Mid-year population estimates for England published by the Office for National Statistics (ONS)
3	Percentage of people who are discharged from	Total Number of people discharged from hospital (taken from SUS)	Total Number of people discharged to their normal

	Metric	Numerator	Denominator
	acute hospital to their normal place of residence.		place of residence (taken from SUS)
4	Long-term support needs of older people (aged 65 years and over) met by admission to residential and nursing care homes, per 100,000 population	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
5	Proportion of older people (65 years and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	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.

Indirectly standardised rate (ISR) of admissions per 100,000 population

ACS admissions have been more challenging than expected in 2022/23, particularly in Q3 and Q4. This is thought to be linked to high winter pressures particularly in primary care, linked to areas such as Children's respiratory conditions. The average of last 3 available quarters has been used for Q1 and Q2 plan as some stabilisation expected. Q3 currently assumes a less challenging winter than 2022/23 and assumes a level more in line with previous years. Q4 plan remains an estimate until final data available. 2024/25 is expected to be a key year in terms of same day emergency care and anticipatory care, which will be factored into 2024/25 plans. Key areas of work linked to this plan to stabilise and support an improved Q3 include anticipatory care development, growing the use of the virtual ward and increasing the

volume of urgent community response activity. Consideration of alternative ambulance pathways such as the PUSH model may also support this.

Falls – Emergency hospital admissions due to falls in people aged 65 years and over directly age standardised rate per 100,000 population

This is a new indicator for 2023-24. The rate per 100,000 population of emergency admissions due to falls in people aged over 65, has shown a small decrease in the last few years. Falls is recognised as an area for review in 2023-24, to streamline services and develop a more integrated pathway. This work is expected to impact this indicator with the impact expected to be clearer once the review is completed. A small decrease in admissions due to falls in people aged over 65 years has been planned, as previous years trend expected to continue.

Percentage of people who are discharged from acute hospital to their normal place of residence

Rotherham is currently above national % discharged to usual place of residence. Performance over last 3 months is 93.4%, with 94% being upper level of achievement. As performance is above national levels, trajectory has been set to maintain for Q1 and achieve higher level of 94% in Q2 and Q4, based on previous upper levels of performance. A slight dip is profiled in for Q3 to account for winter challenges. Key areas of work expected to impact this indicator include moving to a discharge to assess model and development of a more integrated approach across health, social care and voluntary sector partners to support right care, right time, right place.

Long-term support needs of older people (aged 65 years and over) met by admission to residential and nursing care homes, per 100,000 population

In 2022-23 Rotherham had 341 new admissions, (population rate 650.91), which was within the limits of the 2022-23 BCF target of 360 admissions, (population rate 688.25).

The 2023-24 BCF target has been reduced to a population rate of 571.7, which equates to 317 admissions over the year. The first quarter of 2023-24 has already seen 107 admissions and the Council acknowledges that further work is required to achieve a stepped reduction and BCF, Commissioning and Service joint working and quality plans will be monitored in year to support delivery of improvement.

Proportion of older people (65 years and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

This is an annual measure calculated from a sample of people aged 65 and over, who commenced a reablement service during the October to December period 91 days after discharge from hospital. Rotherham Indicator has seen small decreases over the last couple of years following changes in service pathway which resulted in an increase in the number of people commencing the service and a broadening of the cohort to include more complex needs. The 2022/23 year end position was 72.5% compared to a 78.1% target and an outturn of 75.1% in the previous year.

The BCF target set for 2023/24 recognises that the challenges of the supporting a wider system whilst improving current performance would be challenging and an interim midpoint 'step' improvement target of 75.4% has been set.

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.

14. POOLED FUND MANAGER DETAILS

Partner	Lead Officer	Address	Tel. No.	Email Address
SYICB (Rotherham Place)	Chief Finance Officer	Oak House Moorhead Way Rotherham S66 1YY	01709 302025	wendy.allott@nhs.net
RMBC	Head of Finance – (Adults, Public Health and Housing)	Riverside House Main Street Rotherham S60 1AE	01709 822098	Gioia.morrison@rotherham.gov.uk

15. 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.

16. OTHER PROVISIONS

No other provisions.

17. AUTHORISATION

	Rotherham MBC	SYICB (Rotherham Place)
Signature		
Date of signature		
Name of signatory (print)	Sharon Kemp	Christopher Edwards
Title or role of signatory (print)	Chief Executive	Executive Place Director Rotherham/ Deputy Chief Executive

Appendix 2A – Detailed BCF Schemes

Better Care Fund Budget 2023-24	Budget 2022-23	Investment /Disinvestment	Budget 2023-24
	£'000	£'000	£'000
THEME 1 - Mental Health Services			
Adult Mental Health Liaison	1,367	97	**1,464**
THEME 2 - Rehabilitation & Reablement			
Falls Service	494	25	**519**
Home Enabling Services :			
Reablement	1,087		**1,087**
Pressures on Domiciliary Care Budgets	758		**758**
Community Stroke Service	553	28	**581**
Community Neuro Rehab	170	9	**179**
Breathing Space	1,933	98	**2,031**
Otago	20		**20**
Mediquip (Wheelchairs & Equipment)	1,947	(38)	**1,909**
Community Occupational Therapy	862	41	**903**
Disabled Facilities Grant (including underspend c/fwd)	5,547	(987)	**4,560**
Age UK Hospital Discharge	161	7	**168**
Stroke Association Service	51	6	**57**
Intermediate Care Pool:			
Intermediate Care Therapy (TRFT)	409		**409**
Therapy & Nursing cover to support vulnerable patients and Fast Response team	113	6	**119**
Intermediate Care (LH/DC)	1,620	159	**1,779**
Intermediate Care beds (30) - Davies Court	1,039		**1,039**
Home first	820	42	**862**
Intermediate Care 24 Beds - Althorpe	1,396	71	**1,467**
RDASH Therapies	97		**97**
GP Support - medical cover	36		**36**
Other Intermediate care (TRFT)	349	18	**367**
THEME 3 - Supporting Social Care			
Direct Payments:			
Direct Payments/ Personal Budgets (Physical Disabilities)	396		**396**
Direct Payments (Older People)	526		**526**
LD Supported Living	410		**410**
Direct Payments (Learning Disabilities)	315		**315**
Direct Payment Support	46		**46**
Residential Care			
Mental Health rehabilitation services	209		**209**
Learning Disability Services:			
Learning Disabilities independent sector residential care/Transitional Placements	984		**984**
Learning Disabilities Domiciliary Care	37		**37**
Free Nursing Care		520	**520**
Care Act - Older People Direct Payments	501		**501**
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**

Better Care Fund Budget 2023-24	Budget 2022-23	Investment /Disinvestment	Budget 2023-24
	£'000	£'000	£'000
THEME 4 - Care Mgt & intergrated Care Planning			
GP Case Management	1,480	(340)	**1,140**
Care Home Support Service	297	15	**312**
Hospice - End of Life care	881	86	**967**
Social Prescribing	777	79	**856**
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	433		**433**
Early Planning Team	230		**230**
Mental Health Crisis Team	36		**36**
Care Co-ordination Centre	853	43	**896**
THEME 5 - Supporting Carers			
Carers Support Service:			
Carers Strategy	237	230	**467**
Carers Emergency Service	23		**23**
Direct Payments (Older People)	251		**251**
Crossroads	50		**50**
THEME 6 - Infrastructure			
Joint Commissioning Team	49	1	**50**
IT to support Comm Trans	192		**192**
RISK POOL			
Risk pool	500		**500**
Improved Better Care Fund			
Adaptation of Liquid Logic to support care pathways	60		**60**
Rotherham Place DTOC Project Manager, to manage and oversee implementation of the agreed DToC action Plan	85		**85**
Health Inequalities	90		**90**
Trusted Assessor	70		**70**
Social Care Sustainability	7,244		**7,244**
Engagement with the independent sector providers in respect of fee increases due to increase in NLW	4,225		**4,225**
Changes to HMRC in relation to sleep in arrangements - impact on LD provider fees	553		**553**
External Shared Lives support/Supporting LD transformation	200		**200**
Advice and Guidance VCS support - SPA	50		**50**
Speak up	55		**55**
Additional Legal Support Costs	20	(20)	**0**
Perform Plus	48		**48**
Digital Lead Project Manager	64	(64)	**0**
Reablement - 2 posts	87		**87**
Spot purchase reablement beds	107		**107**
Double Handling - IMC beds at Davies Court	100	(100)	**0**
Contingency 22/23	77	(77)	**0**
Mediquip (RMBC contribution)	0	92	**92**
Escalation Wheel	0	12	**12**
ibcf Contingency 23/24 (Capacity Demand Community services)	0	157	**157**

Better Care Fund Budget 2023-24	Budget 2022-23	Investment /Disinvestment	Budget 2023-24
	£'000	£'000	£'000
Winter Pressures/Other Grant Income			
Tactical Brokerage	110		**110**
Resource for Winter Bed Capacity	500		**500**
Integrated Discharge Team	225		**225**
Early Planning Team	237		**237**
Additional Winter Capacity	273		**273**
IBCF Balance b/fwd 22/23	1,041	427	**1,468**
Adults Discharge Funding (RMBC)			
22/23 approved schemes:			
COT Independent Sector	45	-45	**0**
Mental Health Agency Social Workers	153	-153	**0**
Befriending Service	15	-15	**0**
Care Broker Service	12	-12	**0**
Step-down beds at Lord Hardy Court	128	-128	**0**
Trusted Assessor to support Integrated Discharge Team	104	-104	**0**
Home Care Bridging Service	255	-255	**0**
LD Discharges (Specialist Agency)	21	-21	**0**
Supporting Unpaid Carers	59	-59	**0**
Housing Support	12	-12	**0**
Administration support	11	29	**40**
Short Stay Placements	87	-87	**0**
Incentive Payments for Home Care and Residential Care	219	-219	**0**
23/24 approved schemes:			
IDT staffing resources	0	120	**120**
Reablement expansion	0	200	**200**
Davies Court IMC	0	500	**500**
Rothercare - installer	0	30	**30**
Housing Officer	0	50	**50**
CHC assessors	0	150	**150**
MH Discharge	0	100	**100**
Althorpe Lodge Community Beds	0	93	**93**
Incentive payment - Fees for Nursing EMI Beds	0	138	**138**
Trusted Assessor for Care Homes (over 7 days)	0	100	**100**
Fast Response - Additional capacity	0	130	**130**
Home Care - Temporary block capacity	0	379	**379**

Better Care Fund Budget 2023-24	Budget 2022-23	Investment /Disinvestment	Budget 2023-24
	£'000	£'000	£'000
ICB (Rotherham Place) Discharge Funding			
Voluntary Sector - AGE UK	30	-30	**0**
TRFT Place escalation wheel	61	-61	**0**
CHC: Home care provider	67	-67	**0**
CHC: Care home provider	137	-137	**0**
Provision of Crisis Beds	61	-61	**0**
S136 cost pressures	63	-63	**0**
SYHA Discharge Support	15	43	**58**
Discharge Coordinator	11	-11	**0**
Administration support	16	-16	**0**
CHC – assessments	30	0	**30**
CHC – interim funded beds for complex patients to expediate discharge	711	-711	**0**
Community Equipment and transport - Medequip/TRFT	124	26	**150**
Discharge Lounge support and Co-ordinators	218	-218	**0**
Pharmacy Cover - weekend (2 hours sat&sun)	29	-29	**0**
Voluntary Sector - VAR	29	-29	**0**
Hospice - Clinical Nurse Specialist	20	45	**65**
Hospice - Hospice at Home	5	-5	**0**
Hospice - Care Support Worker	10	-10	**0**
Hospice - Increased Inpatient Unit costs	15	45	**60**
Home Care/Care Home sustainability	0	1012	**1,012**
Alternative to Admission	0	150	**150**
Grand Total	**49,256**	**1,425**	**50,681**

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BRIEFING		
	TO:	Health and Wellbeing Board
	DATE:	27th September 2023
	LEAD OFFICER	Steph Watt Joint Head of Adult Commissioning (Rotherham Place) E-mail: steph.watt@nhs.net
	TITLE:	BCF Finance and Risk Monitoring 2023/24

Background

1.1 The purpose of this report is to confirm to the Health and Wellbeing Board that the financial framework is agreed as part of the BCF governance processes which includes the in-year assessment of expenditure against the schemes and highlights risks emerging in year as set out in the risk share section of the Section 75 agreement.

Key Issues

2.1 **Position to Date and Forecast Outturn**

2.2 **Table 1 below** sets out a summary of the source of funding for the 2023/24 Better Care Fund, the Annual Plan for each Pool, the year-to-date position as at the end of June 2023 and the forecast Outturn. The latest forecast Outturn position based on quarter 1 is an overall underspend of £1.179m mainly in respect of the forecast underspend on the Disabled Facilities Grant, due to the carry forward of unspent funding due to the delays in implementing the approved schemes as a result of the Covid pandemic.

2.3 **The total Better Care Fund (BCF) for 2023/24 is £50.681m an increase of £1.425m from 2022/23, this relates to additional LA Discharge funding, an increase in minimum contribution from health and a further underspend in 2022/23 on the iBCF and Carers support funding carried forward into this years' Better Care fund.**

(i) Red figures in brackets indicate overspends and positive figures indicate an underspend to potentially be used to fund areas of risk.

(ii) The risk share agreement requires each party to fund its own pressures in the first instance. Where this is not possible it is possible to utilise other underspends or the risk pool. The suggested approach is to utilise the risk pool to support discharges from hospital.

2.4 **Table 1**

Financial Monitoring 2023/24 : April - June 2023	2023/24 INVESTMENT		2023/24 SPLIT BY POOL		YEAR TO DATE EXPENDITURE AS AT 30th June 2023		Quarter 1 OUTTURN VARIANCE (OVERSPEND) / UNDERSPEND			
BCF Investment	**RICB SHARE**	**RMBC SHARE**	**Pool 1 RMBC Hosted**	**Pool 2 RICB Hosted**	**Pool 1 RMBC Hosted**	**Pool 2 RICB Hosted**	**Pool 1 RMBC Hosted**	**Pool 2 RICB Hosted**	**TOTAL**	
THEME 1 - Mental Health Services	1,464			1,464		366		0	0	
THEME 2 - Rehabilitation & Reablement	12,188	6,759	18,947		4,350		1,045		1,045	Note 1
THEME 3 - Supporting Social Care	4,144			4,144		1,024		47	47	Note 2
THEME 4 - Care Mgt & Integrated Care Planning	5,090			5,090		1,265		30	30	Note 3
THEME 5 - Supporting Carers	791			791		183		57	57	Note 4
THEME 6 - Infrastructure	242			242		60		0	0	
Risk Pool	500			500		125		0	0	Note 5
Improved Better Care Fund		15,948	15,948		3,552		0		0	Note 6
LA Discharge Funding		2,030	2,030		0		0		0	Note 7
ICB Discharge Funding	1,525			1,525		465		0	0	Note 7
TOTAL	25,944	24,737	36,925	13,756	7,902	3,489	1,045	134	1,179	
TOTAL (OVERSPEND) / UNDERSPEND BEFORE RE-INVESTING IN BCF SERVICES									1,179	
RE-INVESTMENT OF UNDERSPENDS IN BCF ACTIVITIES									0	
TOTAL (OVERSPEND) / UNDERSPEND AFTER RE-INVESTING IN BCF SERVICES (will be the figure in the Annual Accounts of both organisations)									1,179	
RE-INVESTMENT OF UNDERSPENDS IN NON BCF ACTIVITIES										

2.5 **Notes**

(i) Note 1 – there is significant forecast underspend within Theme 2 mainly in respect of the Disabled Facilities Grant due to accumulated underspends from previous years due to the impact of Covid and vacancies in Occupational Therapists resulting in delays in the assessment and completion of aids and adaptations. Further investment was made in 2022/23 to procure additional support from the independent sector to carry out assessments to help reduce the waiting list.

(ii) Note 2 – there is an overall forecast underspend within Theme 3. An overspend in residential care is offset by an underspend in direct payments.

(iii) Note 3 - the forecast underspend within Theme 4 relates to staff vacancies within social work teams.

(iv) **Note 4 –** Theme 5 forecast underspend relates to the cost of providing direct payments. This theme also includes a non-recurrent underspend on the Carers Strategy carried forward from 2022/23 which is forecast to fully spend.

(v) Note 5 - it is proposed in line with the previous years the BCF Risk Pool is utilised to contribute to the increase in demand and to support discharges from hospital.

(vi) Note 6 - the improved Better Care grant funding has been allocated towards meeting Adult Social Care pressures and service transformation, reducing delayed transfers of care from hospital including meeting pressures during the winter period and maintaining market sustainability within social care. The current forecast is to fully spend by the year end. The budget also includes a non-recurrent £1.468m underspend carried forward from 2022/23.

(vii) **Note 7 -** The extension of the Discharge Funding into 2023/24 has provided £3.6m (RMBC £2.030m and the ICB £1.525m) to support hospital discharges over the full financial year. Both elements of the funding are forecast to fully spend and in accordance with the grant conditions are subject to separate fortnightly

	reporting requirements. Any underspends on these grants must be repaid back to DHSC and cannot be carried forward.
Key Actions and Relevant Timelines	
3.1	The BCF Executive Group on 5th September 2023: (i) Noted the areas of risks, underspends and explanations; and (ii) Accepted the report as the Quarter 1 position. (iii) Agreed in principle to carry over any underspend to 2024/25 in respect of capital expenditure against the Disabled Facilities Grant.
Implications for Health Inequalities	
4.1	Addressing health inequalities is integral to the allocation of BCF resource and funded schemes. This includes contributing to achieving the strategic aims of developing healthy lifestyles and prevention pathways, supporting prevention and early diagnosis of chronic conditions and targeting variation. BCF funded schemes which reduce health inequalities include social prescribing, Breathing Space and project support for the implementation of Population Health Management (PHM) priorities.
Recommendations	
5.1	**That the Health and Wellbeing Board:** **(i) Note the areas of risks, underspends and explanations; and** **(ii) Accept the report as the Quarter 1 position.** **(iii) Agree in principle to carry over any underspend to 2024/25 in respect of capital expenditure against the Disabled Facilities Grant.**

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Rotherham Metropolitan Borough Council

NHS South Yorkshire Integrated Care Board

Better Care Fund provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life. Below is a Dashboard to support Rotherham's Better Care Fund for 2023/25.

		Apr 2023	May 2023	Jun 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Avoidable admissions – indirectly standardised rate (ISR) of admissions per 100,000 population	**Actual**	296	292	257									
	Target	245	245	245									
		Apr 2023	**May 2023**	**Jun 2023**	**July 2023**	**Aug 2023**	**Sep 2023**	**Oct 2023**	**Nov 2023**	**Dec 2023**	**Jan 2024**	**Feb 2024**	**Mar 2024**
Falls – emergency hospital admissions due to falls in people aged 65 years and over directly age standardised per 100,000 population	**Actual**	Please see narrative.											
	Target												
		Apr 2023	**May 2023**	**Jun 2023**	**July 2023**	**Aug 2023**	**Sep 2023**	**Oct 2023**	**Nov 2023**	**Dec 2023**	**Jan 2024**	**Feb 2024**	**Mar 2024**
% of People who are discharged from acute hospital to their Normal Place of Residence	**Actual**	94.5%	94.7%	95.4%									
	Target	93.5%	93.5%	93.5%									
		Apr 2023	**May 2023**	**Jun 2023**	**July 2023**	**Aug 2023**	**Sep 2023**	**Oct 2023**	**Nov 2023**	**Dec 2023**	**Jan 2024**	**Feb 2024**	**Mar 2024**
Long-term support needs of older people (65 and over) met by admission to residential and nursing care homes, per 100,000 population	**Actual () indicates no of admissions**	78.26 (41)	53.45 (28)	72.54 (38)									
	Target rate 100k per pop (Number of Admissions)	57.27 (30)	57.27 (30)	57.27 (30)	57.27 (30)	57.27 (30)	57.27 (30)	57.27 (30)	57.27 (30)	57.27 (30)	57.27 (30)	57.27 (30)	57.27 (30)
	Actual (YTD) () indicates no of admissions	78.26 (41)	131.71 (69)	204.25 (107)									
	Target rate 100k per pop (Number of Admissions)	57.27 (30)	114.63 (60)	171.99 (90)	229.35 (120)	286.71 (150)	344.08 (180)	401.44 (210)	458.8 (240)	516.16 (270)	573.53 (300)	630.89 (330)	688.25 (360)

		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement/rehabilitation services	**Actual**	82.8% (144/174)	85.6% (113/132)	72.34% (136/188)	70.0% (119/170)	75.1% (154/205)	72.5% (153/211)	
	Target	88%	89%	86% (123/143)	83%	78%	78.1%	75.4%

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BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	27th September 2023
	LEAD OFFICER	Steph Watt Joint Head of Adult Commissioning (Rotherham Place) E-mail: steph.watt@nhs.net
	TITLE:	Better Care Fund (BCF) Metrics Report Q1 2023-24

Background

1.1 The Better Care Fund (BCF) Policy Framework sets out the Government's priorities for 2023-25, including improving discharge, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care, unpaid carers and housing adaptations.

1.2 The vision for the BCF plan in 2023-25 is to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by the two core BCF objectives:

- Enable people to stay well, safe and independent at home for longer.
- Provide the right care in the right place at the right time.

1.3 As part of the BCF plan for 2023/24, measures have been agreed to monitor the success of the BCF schemes. This report provides an update on national measures which have been identified at year end as on target or where there are areas for concern.

Key Issues

2.1 The Better Care Fund for 2023/24 consists of 5 Key National Performance Indicators which includes one new indicator in relation to falls. The BCF Metrics Scorecard is attached at Appendix 2.

2.2 ***Avoidable admissions – indirectly standardised rate (ISR) of admissions per 100,000 population***

This indicator measures the number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. This includes conditions such as: acute bronchitis, angina, ischaemic heart disease, heart failure, dementia, emphysema, epilepsy, hypertension, diabetes, COPD and pulmonary oedema. It should be noted that not all the admissions included in this indicator are necessarily "avoidable". The data extracted is based purely on coding of conditions and does not necessarily reflect wider factors that may require a patient to be admitted.

ACS admissions were more challenging than expected in 2022/23, particularly in Q3 and Q4. This is thought to be linked to high winter pressures particularly in primary care, linked to areas such as Children's respiratory conditions. The average of last 3 available quarters was used for Q1 and Q2 plan as some stabilisation was expected. Q3 currently assumes a less challenging winter than 2022/23 and assumes a level more in line with previous years. Q4 plan remains an estimate until final data available. 2024/25 is expected to be a key year in terms of same day emergency care and anticipatory care, which will be factored into 24/25 plans.

The national indicator is represented as an indirectly standardised rate. The indicator is presented on the scorecard however as actual admissions for easier interpretation.

ACS admission levels have been above plan for the first quarter of the year but have seen a decrease in June.

2.3 ***Falls – Emergency hospital admissions due to falls in people aged 65 years and over directly age standardised rate per 100,000 – New Indicator***

This is a new indicator for 2023-24. The rate per 100,000 population of emergency admissions due to falls in people aged over 65, has shown a small decrease in the last few years. Falls is recognised as an area for review in 2023-24, to streamline services and develop a more integrated pathway. This work is expected to impact this indicator with the impact expected to be clearer once the review is completed. A small decrease in admissions due to falls in people aged over 65 years has been planned, as previous years trend expected to continue.

We are currently reviewing the data available for monitoring this indicator as the data within the nationally published BCF pack, does not fully align with that provided nationally to inform the plan. We have reviewed locally extracted provisional data. Initial indication from this data is that we are above plan for Q1.

2.4 ***% of People who are discharged from acute hospital to their Normal Place of Residence***

Rotherham was above national % discharged to usual place of residence when the plan was set. Performance over last 3 months, when the plan was set was 93.4%, with 94% being upper level of achievement. As performance is above national levels, the trajectory has been set to maintain for Q1 and achieve the higher level of 94% in Q2 and Q4, based on previous upper levels of performance. A slight dip is profiled in for Q3 to account for winter challenges.

Performance has been positive in Q1, being above target.

It should be noted national data does show around a 0.5% lower performance compared to local data. National data however has historically experienced issues with refreshing, so local data has been used.

2.5 ***Long-term support needs of older people (aged 65 years and over) met by admission to residential and nursing care homes (per 100,000 population)***

In 2022-23 Rotherham had 341 new admissions, (population rate 650.91), which was within the limits of the 2022-23 BCF target of 360 admissions, (population rate 688.25).

The 2023-24 BCF target has been reduced to a population rate of 571.7, which equates to 317 admissions over the year.

The first quarter of 2023-24 has already seen 107 admissions which is 28 above the target at this point in the year. If admissions continue at this rate the year end position could reach 428 (rate: 771.90), 109 above the BCF target. This has been due to a higher number of crisis issues for adults with complex needs which has led to increased admissions.

The Council acknowledges that further focussed work is required to achieve a stepped reduction and BCF, Commissioning and Service joint working and quality plans will be monitored in year to support delivery of improvement.

2.6 ***Proportion of older people (65 years and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services***

This is an annual measure calculated from a sample of people aged 65 and over, who commenced a reablement service during the October to December period 91 days after discharge from hospital. Rotherham Indicator has seen small decreases over the last couple of years following changes in service pathway which resulted in an increase in the number of people commencing the service and a broadening of the cohort to include more complex needs. The 2022/23 year end position was 72.5% compared to a 78.1% target and an outturn of 75.1% in the previous year.

2.7 The BCF target set for 2023/24 recognises that the challenges of the supporting a wider system whilst improving current performance would be challenging and an interim midpoint ‘step’ improvement target of 75.4% has been set.

Key Actions and Relevant Timelines	
3.1	The BCF Executive Group on 5th September 2023: (i) Noted the contents of the report and performance for 2023/24
Implications for Health Inequalities	
4.1	Addressing health inequalities is integral to the allocation of BCF resource and funded schemes. This includes contributing to achieving the strategic aims of developing healthy lifestyles and prevention pathways, supporting prevention and early diagnosis of chronic conditions and targeting variation. BCF funded schemes which reduce health inequalities include social prescribing, Breathing Space and project support for the implementation of Population Health Management (PHM) priorities.
Recommendations	
5.1	**That the Health and Wellbeing Board:** **(i) Notes the contents of the report and performance for 2023/24.**

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Minutes	
Title of Meeting:	**PUBLIC** Rotherham Place Board: Partnership Business
Time of Meeting:	9.00am – 10.00am
Date of Meeting:	Wednesday 19 April 2023
Venue:	Elm Room, Oak House, Bramley, S66 1YY
Chair:	Chris Edwards
Contact for Meeting:	Lydia George: lydia.george@nhs.net/ Wendy Commons: wcommons@nhs.net
Apologies:	Richard Jenkins, Chief Executive, The Rotherham Foundation Trust Sharon Kemp, Chief Executive, Rotherham Metropolitan Borough Council Dr Neil Thorman, Executive GP Lead, RPCCB Shafiq Hussain, Chief Executive, Voluntary Action Rotherham Wendy Allott, Chief Financial Officer - Rotherham, NHS SY ICB Sally Kilgariff, Chief Operating Officer, The Rotherham Foundation Trust Ian Spicer, Strategic Director of Adult Care, Rotherham Metropolitan Borough Council Cllr David Roche, Joint Chair, Health and Wellbeing Board, Rotherham Metropolitan Dr Jason Page, Medical Director, NHS SY ICB Leonie Wieser, Policy Officer, Rotherham MBC
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.
Quoracy:	Confirmed as quorate.

Members Present:
Chris Edwards (**CE**), Chairing, Executive Place Director, NHS South Yorkshire ICB
Claire Smith (**CS**), Deputy Place Director – Rotherham, NHS South Yorkshire ICB
Michael Wright (**MW**), Deputy Chief Executive, The Rotherham NHS Foundation Trust
Dr Anand Barmade (**AB**), Medical Director, Connect Healthcare Rotherham
Julie Thornton (**JT**), Care Group Director (Roth), Rotherham, Doncaster & South Humber Foundation Trust

Participants:
Ben Anderson (**BA**), Director of Public Health, Rotherham Metropolitan Borough Council (left meeting after Item 2)
Sue Cassin (**SC**), Chief Nurse - Rotherham, NHS South Yorkshire ICB
Lydia George (**LG**), Strategy & Delivery Lead - Rotherham, NHS South Yorkshire ICB
Gordon Laidlaw (**GL**), Head of Communications (Roth), NHS SY ICB
Borough Council
Shahida Siddique (**SS**), Independent Non-Executive Member, NHS South Yorkshire ICB
Helen Barker (**HB**), Head of Customer Service, Rotherham Metropolitan Borough Council (left after Item 3)
Rebecca Woolley (**RW**), Public Health Specialist, Rotherham Metropolitan Borough Council

In Attendance:
Wendy Commons, Support Officer, Rotherham Place, NHS SY ICB
Fiona Flinders, Rotherham Place Support Officer, NHS SY ICB

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Item Number	Discussion Items
01/04/23	**Public & Patient Questions**
There were no questions.	
02/04/23	**Public Health Update: by exception**
BA advised that the ONS had ceased the Coronavirus Infection Survey and the reporting of the infection rates from 1 April 2023. The decision has therefore been taken to discontinue providing regular COVID-19 briefings. Living with Covid means that there will be a background infection rate of between 1% and 4% of the population that will continue to rise and fall in waves every 2-3 months. This shows that the vaccination programme has worked and had a huge impact. We will however still see care homes and hospital having a number of patients with Covid. Testing will only be carried out on symptomatic patients and outbreaks will still need to be managed. The booster vaccines continue to be important and the spring campaign is commencing this week for the elderly and immuno-compromised. BA explained that due to Strep A arriving earlier this year, we are not now seeing the usual peak at this time and cases have reduced. It was noted that there had been better take up of flu vaccinations than pre-pandemic. Going forward flu vaccinations will be aligned with covid for those who are eligible for both. Members noted the position.	
03/04/23	**Digital Inclusion Strategy**
Helen Barker, Head of Customer Services at RMBC gave an update on the Rotherham Digital Inclusion Programme that had been established since June 2021. It was noted that a digital inclusion review had taken place and the strategy produced in late 2022 followed by engagement and an action plan produced early this year. Helen outlined the groups and areas in the borough that were most at high-risk of digital exclusion. These were as expected older people, those with learning disability or long-term conditions, disadvantaged young people and those living in areas of deprivation ie Maltby East, Thrybergh, Rotherham central and East Herringthorpe. The strategy has been developed with the purpose of delivering outcomes to those most digitally excluded. HB went on to outline some of the activities already underway from the action plan including Digital Champions, a Rotherham Digital website, ICT and employability classes for residents. Going forward it is intended to appoint two digital inclusion support officers, create digital surgeries in libraries and community centres and expand resident access to technology including wi-fi devices and assistive technology. Discussion followed and it was acknowledged that further work is required around the wi-fi function and accessibility across Rotherham and members were assured that the strategy also aligns with the ambitions of the Joint Strategic Needs Assessment. Place Board thanked HB for the update, welcomed the approach being taken, offered support with promoting initiatives associated with the strategy and looked forward to receiving future progress updates through Place Board and Rotherham Together Partnership.	

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04/04/23	Anchor Institution Action Plan

RW gave an update on the work undertaken by the Prevention and Health Inequalities Group around anchor institutions, one of the five priorities in its strategy. A structured approach had been undertaken to scope opportunities by way of self-assessments using the Joseph Rowntree framework. The findings had been shared and used to draft an action plan on a small number of deliverables. The areas for action included the dimensions of employer, procurer, bricks and mortar, service delivery and corporate and civic. The action plan is on page 8 of the report.

One of the main findings in the employer section had been around paying the living wage. Although this was already achieved by most partners, it was agreed as an aspiration for all to pay the living wage to their employees.

It was noted that at the time the self-assessment was undertaken, the timing hadn't been right for primary care services to take part, work will take place retrospectively with PCNs to ensure a contribution can be included.

GL suggested that the terminology for the diagnostic centre under the bricks and mortar section be amended to reflect that health services with high footfall will be delivered in the town centre or considered if appropriate for the town centre as best for local people, eg smoking cessation.

To achieve the ambition of 'one plan' it was felt that Rotherham Together Partnership Chief Executive's Group should discuss and agree the governance route for this work.

Place Board thanked RW for the update, supported the action plan and encouraged Rotherham Together Partnership to consider further.

Action: RW(BA)

05/04/23	South Yorkshire Integrated Care Partnership Strategy

CE reported that the Strategy had been launched as planned w/c 20 March. It is an overarching strategy, co-owned by Rotherham with six Rotherham Place Partners as members on the ICP Board. The Strategy was signed off and agreed by all partners. Place Board Members are encouraged to circulate within their respective organisations including An animation which has previously been shared with partners as part of the toolkit of resources.

06/04/23	Feedback from South Yorkshire Integrated Care Partnership Board

CE confirmed that, as well as signing off the South Yorkshire Integrated Care Partnership Strategy, the partnership had adopted and launched a safe place to sleep for South Yorkshire and received early feedback on children's work.

07/04/23	Communication to Partners

The digital inclusion strategy will be shared via the communications group who will be key in the communications and engagement taking place in a variety of ways to progress the action plan.

08/04/23	Draft Minutes and Action Log from Public Place Board – 15 March 2023

The minutes from the March meeting were agreed as a true and accurate record.

The action log was reviewed and up to date.

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10/04/23	Risks and Items for Escalation to Health and Wellbeing Board

The final version of the refreshed Rotherham Place Plan will go to H&WB Board.

The Place Priorities Close-down Report for 2022-23, Digital Inclusion and Anchor Institutions items to be considered for H&WB Board. LG to discuss with the Cllr Roche.

Action: LG

11/04/23	Future Agenda Items:

- Town Centre Development Update (June)
- Update on Strategic Estates Group (July)
- OD and Workforce Update (May)
- Refreshed Place Plan – Final (May)

Standing Items

- Bi-Monthly Place Partnership Briefing
- Feedback from SY ICP Meetings
- Place Achievements

12/04/23	Date of Next Meeting

The next meeting will take place on ***Wednesday 17 May 2023*** in Elm Room, Oak House from 9.00am – 10.00am.

Membership

Chris Edwards (Joint Chair)	Executive Place Director/ICB Deputy Chief Executive	NHS South Yorkshire Integrated Care Board
Sharon Kemp (Joint Chair)	Chief Executive	Rotherham Metropolitan Borough Council
Ben Anderson	Director of Public Health	Rotherham Metropolitan Borough Council
Richard Jenkins	Chief Executive	The Rotherham NHS Foundation Trust
Shafiq Hussain	Chief Executive	Voluntary Action Rotherham
Toby Lewis	Chief Executive	Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)
Dr Anand Barmade	Medial Director	Connect Healthcare Rotherham (GP Federation)
Dr Neil Thorman	Primary Care Representative	Rotherham Primary Care Collaborative Group

Participants

Cllr David Roche	Joint Chair	Rotherham Health and Wellbeing Board
Claire Smith	Deputy Place Director, Rotherham Place	NHS South Yorkshire Integrated Care Board
Sue Cassin	Chief Nurse, Rotherham Place	NHS South Yorkshire Integrated Care Board
Dr Jason Page	Medical Director, Rotherham Place	NHS South Yorkshire Integrated Care Board
Wendy Allott	Chief Finance Officer, Rotherham Place	NHS South Yorkshire Integrated Care Board
Shahida Siddique	Independent Non-Executive Member	NHS South Yorkshire Integrated Care Board

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Ian Spicer	Strategic Director, Adult Care, Housing and Public Health	Rotherham Metropolitan Borough Council
Suzanne Joyner	Director of Children's Services, RMBC	Rotherham Metropolitan Borough Council
Lydia George	Strategy and Delivery Lead	NHS South Yorkshire Integrated Care Board
Gordon Laidlaw	Head of Communications	NHS South Yorkshire Integrated Care Board
Michael Wright	Deputy Chief Executive	The Rotherham NHS Foundation Trust
Sally Kilgariff	Chief Operating Officer	The Rotherham NHS Foundation Trust
Julie Thornton	Care Group Director	Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)

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Minutes	
Title of Meeting:	**PUBLIC** Rotherham Place Board: Partnership Business
Time of Meeting:	9.00am – 10.00am
Date of Meeting:	Wednesday 17 May 2023
Venue:	Elm Room, Oak House, Bramley, S66 1YY
Chair:	Chris Edwards
Contact for Meeting:	Lydia George: lydia.george@nhs.net/ Wendy Commons: wcommons@nhs.net
Apologies:	Richard Jenkins, Chief Executive, The Rotherham Foundation Trust Dr Neil Thorman, Executive GP Lead, RPCCB Lydia George, Strategy & Delivery Lead (Rotherham) NHS SYICB Toby Lewis, 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.
Quoracy:	Confirmed as quorate.

Members Present:
Chris Edwards (**CE**), Chairing, Executive Place Director, NHS South Yorkshire ICB
Ben Anderson (**BA**), Director of Public Health, RMBC
Dr Anand Barmade (**AB**), Medical Director, Connect Healthcare Rotherham
Shafiq Hussain (**SH**), Chief Executive, Voluntary Action Rotherham
Sharon Kemp (**SK**), Chief Executive, Rotherham Metropolitan Borough Council (RMBC)
Julie Thornton (**JT**), Care Group Director (Roth), Rotherham, Doncaster & South Humber Foundation Trust (Deputising for Toby Lewis)
Michael Wright (**MW**), Deputy Chief Executive, The Rotherham NHS Foundation Trust

Participants:
Sue Cassin (**SC**), Chief Nurse - Rotherham, NHS South Yorkshire ICB
Gordon Laidlaw (**GL**), Head of Communications (Roth), NHS SY ICB
Dr Jason Page (**JP**), Medical Director, NHS SY ICB
Cllr David Roche (**DR**), Joint Chair, Health and Wellbeing Board, RMBC
Shahida Siddique (**SS**), Independent Non-Executive Member, NHS SY ICB
Claire Smith (**CS**), Deputy Place Director – Rotherham, NHS SY ICB
Ian Spicer (**IS**), Strategic Director of Adult Care, RMBC
Leanne Dudhill (**LD**), Place Workforce Lead (Rotherham), RMBC

In Attendance:
Fiona Flinders, Rotherham Place Support Officer, NHS SY ICB

Item Number	Discussion Items
13/05/23	**Public & Patient Questions**
No members of the public were present.	
14/05/23	**Workforce & Organisational Development Update**
Leanne Dudhill gave an update on progress following on from September of last year. She advised that the Place Workforce and Organisational Development group continues to meet monthly with the main focus of the group is how to do things better. Partnership agreement was reached and a Place Based Lead has been funded for 3 years, on a full-time basis. Recruitment is being led by TRFT. Appointment of the Place based role is a key action and will support/drive the overarching workstream review and refresh of the Workforce/OD action plan, which will align with the anchor institution action plan. Working collaboratively to embed a range of employability initiatives across the partnership. Working with the SYICB Schools Engagement lead to build an ambassador scheme in social care for school engagement work. Working collaboratively allows partner capacity to maintain traction and to transform ways of working whilst carrying on with business as usual. A vast amount of work has been progressing around working with SY ICB colleagues in relation to school/college engagement and employability agenda and will work with the SY ICB Schools engagement lead to build an ambassador scheme into care for school engagement work. Plans are being looked at around an appropriate matrix moving forward. LD gave an overview of upcoming activities in the next months. MW to meet WA outside the meeting regarding funding for place-based lead. IS added that work has been taken forward in the town centre regarding housing. GL has had discussions regarding people who go to other towns to study querying how do we get them to come back to Rotherham to study. LD advised there are now lots of opportunities and pathways for young people to get them into apprenticeships. SS reflected that we should all celebrate the transformation process Rotherham has gone through.	
15/05/23	**Communications & Engagement Update**
GL advised that he has worked with other workstreams/groups, including digital inclusion, Primary Care Network (PCN) websites, which will link in with the digital group, SEND Local Offer website redevelopment, Rotherham Health App, Prevention and inequalities. Linking in with all these different workstreams will enable Place to thrive and deliver. Other areas that are working well are the mental health campaigns, which include a national rebrand of Talking Therapies; an emphasis on re-energising Rotherham as being a good place to live, suicide prevention and Rotherhive. Rotherhive is continuing to evolve and adapt and has recently been noted to have had 4 million hits to the app. The app has been running for 4 years, which coincides with	

Mental Health week. This app looks at the physical element as well as mental health and wellbeing, with advice on weight management and health lifestyle issues.

Working with children workstreams have been co-designed with parents at parent forums.Prevention and equality will be coming taken to PLT.

Spring and autumn vaccination boosters are being promoted with the importance of the public undertaking the option of these.

System pressures and industrial action briefings and messages are continuing to be related to the public.

GL spoke about the priorities for the next 12 months and will develop an action plan to focus on these and advised that these are to align with the national, regional and place priorities, which will include the review and update the Terms of Reference, including membership/attendance. Momentum has slowed down a little with transformation of communications and engagement activity.

It was agreed that celebrating success and achievement would be a standing item in the meeting, including case studies and stories across our partner organisations,

SK advised that she had recently attended a meeting and got quite a critical report on how we think collectively as partners about Rotherham. How do we get together and think about what is important and what do we want from Rotherham. This will be supported by the communications group who will aim to bring back a proposal in 3-4 months' time.

JT informed members that with it being mental health week, 'wear it green' day will be promoted in Rotherham town centre which will include raising awareness of Rotherhive.

DR will also be promoting Rotherhive with the local schools and all partners agreed to continue to raise the platform's profile when/where possible.

16/05/23	**Place Plan Priorities Close Down Report**

CS advised that the Place plan had been taken to confidential meeting and had been brought to public today.

Final assessment of the end of the year 22-23 enables us to have insight on what areas have been completed, and what areas need to be transferred across to this year

In summary, 2022-23 positive progress had been made, members noted the close down report.

It was agreed for all Partners to share with own organisations.

17/05/23	**Care Quality Commission Assurance of Local Authorities**

IS advised that as from April 2023, local authorities and integrated care systems (ICS) will be assessed by the Care Quality Commission (CQC).

CQC will assess local authorities against four domains, working with people, providing support, how the local authority ensures safety and leadership.

SS advised that she has been previously involved in a CQC working group. There is an underlying element looking at how partnership working is happening. She advised that there was a distinct change in CQC framework of questions being asked and the focus is about demonstrating joined up working, partnership and collaboration.

CE advised that the ICB will also be CQC assessed therefore all documents are to be collated in libraries and are to be shared with all partnerships. The recommendations of the paper (Enc 5) were agreed, and future progress and outcomes will be added to the forward agenda for PLT.	
18/05/23	**Rotherham Place Partnership Update**
Members noted the update and discussed how best to promote, it was agreed to take back into partner organisations for inclusion at Boards and in staff newsletters.	
19/05/23	**Feedback from Integrated Care Partnership Meeting**
DR advised that as the meeting had not taken place this month there was no update. The item will be added to next month's agenda.	
20/05/23	**Communications to Partners**
GL advised that Rotherhive and CQC changes are to be shared, and the Rotherham Place Update. No further feedback	
21/05/23	**Draft Minutes and Action Log from Public Place Board – 19 April 2023**
The minutes from the April meeting were agreed as a true and accurate record. The action log was reviewed and up to date.	
22/05/23	**Risks and Items for Escalation to Health and Wellbeing Board**
Joint Forward Plan (Jun) Rotherham Place Plan (Sept) DR to mention Rotherhive with a query as to whether to ask Rotherham Advertiser to promote.	
23/05/23	**Future Agenda Items:**
– Town Centre Development Update (June) – Update on Strategic Estates Group (July) – Prevention and Health Inequalities Update (June) Standing Items – Bi-Monthly Place Partnership Briefing – Feedback from SY ICP Meetings – Place Achievements – Transformation & Enabling Groups Updates	
24/05/23	**Date of Next Meeting**
The next meeting will take place on ***Wednesday 21 June 2023*** in Elm Room, Oak House from 9.00am – 10.00am.	

Membership

Chris Edwards (Joint Chair)	Executive Place Director/ICB Deputy Chief Executive	NHS South Yorkshire Integrated Care Board
Sharon Kemp (Joint Chair)	Chief Executive	Rotherham Metropolitan Borough Council
Ben Anderson	Director of Public Health	Rotherham Metropolitan Borough Council
Richard Jenkins	Chief Executive	The Rotherham NHS Foundation Trust
Shafiq Hussain	Chief Executive	Voluntary Action Rotherham
Toby Lewis	Chief Executive	Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)
Dr Anand Barmade	Medial Director	Connect Healthcare Rotherham (GP Federation)
Dr Neil Thorman	Primary Care Representative	Rotherham Primary Care Collaborative Group

Participants

Cllr David Roche	Joint Chair	Rotherham Health and Wellbeing Board
Claire Smith	Deputy Place Director, Rotherham Place	NHS South Yorkshire Integrated Care Board
Sue Cassin	Chief Nurse, Rotherham Place	NHS South Yorkshire Integrated Care Board
Dr Jason Page	Medical Director, Rotherham Place	NHS South Yorkshire Integrated Care Board
Wendy Allott	Chief Finance Officer, Rotherham Place	NHS South Yorkshire Integrated Care Board
Shahida Siddique	Independent Non-Executive Member	NHS South Yorkshire Integrated Care Board
Ian Spicer	Strategic Director, Adult Care, Housing and Public Health	Rotherham Metropolitan Borough Council
Suzanne Joyner	Director of Children's Services, RMBC	Rotherham Metropolitan Borough Council
Lydia George	Strategy and Delivery Lead	NHS South Yorkshire Integrated Care Board
Gordon Laidlaw	Head of Communications	NHS South Yorkshire Integrated Care Board
Michael Wright	Deputy Chief Executive	The Rotherham NHS Foundation Trust
Sally Kilgariff	Chief Operating Officer	The Rotherham NHS Foundation Trust
Julie Thornton	Care Group Director	Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)

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Minutes	
Title of Meeting:	Rotherham Place Board: **ICB Business**
Time of Meeting:	10.15 – 11.00am
Date of Meeting:	Wednesday 19 April 2023
Venue:	Elm Room, Oak House, Bramley, S66 1YY
Chair:	Chris Edwards
Contact for Meeting:	Lydia George: lydia.george@nhs.net/ Wendy Commons: wcommons@nhs.net

Apologies:	Wendy Allott, Chief Finance Officer – (Roth), NHS SY ICB Ben Anderson, Director of Public Health, RMBC Shafiq Hussain, Chief Executive, VAR Richard Jenkins, Chief Executive, TRFT Sharon Kemp, Chief Executive, RMBC Toby Lewis, Chief Executive, RDaSH Dr Jason Page, Medical Director, NHS SY ICB Cllr David Roche, Health & Wellbeing Board Chair, RMBC Ian Spicer, Strategic Director of Adult Care, RMBC Dr Neil Thorman, Primary Care Representative, RPCCG
Conflicts of Interest:	General declarations were acknowledged for Members as providers/commissioners of services.
Quoracy:	No business shall be transacted unless at least 60% of the membership (which equates to 3 individuals) and including the following are present: (1) Executive Place Director and (2) Independent Non-Executive Member

Members Present:
Chris Edwards (**CE**), Chairing, Executive Place Director - Rotherham, NHS South Yorkshire Integrated Care Board (ICB)
Sue Cassin (**SC**), Chief Nurse - Rotherham, NHS South Yorkshire ICB
Shahida Siddique (**SS**), Independent Non-Exec Member, NHS South Yorkshire, ICB
Claire Smith (**CS**), Deputy Place Director – Rotherham, NHS South Yorkshire ICB

Participants:
Dr Anand Barmade (**AB**), Medical Director, Connect Healthcare Rotherham
Nicola Curley (**NC**), Director of Children's Services, Rotherham MBC
Lydia George (**LG**), Strategy & Delivery Lead - Rotherham, NHS South Yorkshire ICB
Gordon Laidlaw (**GL**), Head of Communications (Roth), NHS SY ICB
Michael Wright (**MW**), Deputy Chief Executive, The Rotherham NHS Foundation Trust
Ruth Nutbrown (**RN**), Head of Governance and Risk, NHS South Yorkshire ICB (Item 2)
Alison Hague (**AH**), Corporate Services Manager, NHS South Yorkshire ICB (Item 2)
Sheila Lloyd (**SL**), Deputy Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust

In Attendance:
Wendy Commons, Rotherham Place Board Support Officer, NHS South Yorkshire ICB
Fiona Flinders, Rotherham Place Support Officer, NHS South Yorkshire ICB

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Item Number	Discussion Items
i1/04/23	**Place Performance Report: April 2023**

CS gave highlights from this month's performance report.

- IAPT waits are in a strong position and currently exceeding national targets with good self-referrals into the service. Although it was noted that IAPT access continues to be challenging and predicted to not meet target. Significant actions are being taken.
- Cancer continues to be an issue. Patients seen for radiotherapy treatment within 31 days has dipped to 41.4% in January from 95%. Discussions will take place outside this meeting to check these figures and better understand the detail.
- The referral to treatment position is slightly more challenged than it has been but remains above the national position.
- The Diagnostics position is positive and although it worsened in December has come back with further improvement.
- There had been one breach in January for mixed sex accommodation.
- There had been a further increase in the position with cancelled operations not re-booked within 28 days but it was acknowledged that this may have been due to the recent strikes.
- Ambulance handovers had further improved in March from 48.1 to 62.8% with 15 minutes and a decrease in the over 60 minutes from 202 to 95. It was acknowledged that sustaining this position will be key.
- GP appointments continue to be offered above the baseline with 70% being face to face.
- There had been a dip in performance on early intervention for psychosis which will be monitored.
- There has been an increase in Learning Disabilities health checks in the quarter,
- The 2-hour community response has consistently been above the 70% target and discharge is back on track to meet target.

SL advised that it was important to review and reflect on the position with IAPT and investigate whether there is an issue with the data. Once this has been completed Place Board will be updated and receive clear narrative along with any actions that need to be progressed.

Place Board noted that the data within the performance relates to January and this could highlight a differential. However, it was noted that due to the Easter break, time had not allowed for the usual checks and investigation that usually take place prior to Place Board presentation to be undertaken. CS will undertake the checks retrospectively this month and highlight any continued exceptions in May.

i2/04/23	**Review of ICB Risk Register**

Members reviewed the ICB risk register in detail to confirm the risks and score ratings for Rotherham Place. RN highlighted that Place Board is not expected to resolve risks.

Members considered all the relevant risks and scored as felt appropriate for RN to report back through the ICB risk management process.

Some (but not all) of the revisions included:

- Raising the risk relative to efficiency savings and the 30% reduction in running costs

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- Adding an issue relating to breast oncology
- Increasing the risk score relating to eating disorders
- Querying whether the Covid inquiry should be removed as it has been responded to
- Moving the risk for LeDeR to the South Yorkshire LeDeR team.

Detail of all risks will be reflected in more detail on the risk register and issues log.

However, it was agreed that the process of undertaking this task during the meeting did take a lot of time for comprehensive assessment. CE/RN will look at alternative options including the possibility of it being undertaken by a separate group and the outcome being reported through the ICB Business session of Place Board to confirm assurance once a baseline has been ascertained.

Action: CE/RN

i3/04/23	**Minutes and Action Log from 15 March 2023 Meeting**

The minutes from the March meeting were accepted as a true and accurate record.

The action log was reviewed and up to date.

i4/04/23	**Communication to Partners**

None.

i5/04/23	**Risks and Items for Escalation**

The current process will be reviewed and an alternative proposal brought here.

i6/04/23	**Future Agenda Items:**

- Targeted Lung Health Checks (May)
- Finance Update after planning round (possibly June)

Standing Items

- Rotherham Place Performance Report
- Place Prescribing Report
- Risk Register (Monthly)

i7/04/23	**Date of Next Meeting**

The next meeting will take place on **Wednesday 17 May 2023** from 10.15am – 11am in Elm Room, Oak House, Bramley, Rotherham S66 1WB.

Membership

Chris Edwards (Chair)	Executive Place Director/Deputy Chief Executive, ICB	NHS South Yorkshire Integrated Care Board
Claire Smith	Deputy Place Director, Rotherham Place	NHS South Yorkshire Integrated Care Board
Wendy Allott	Chief Finance Officer, Rotherham Place	NHS South Yorkshire Integrated Care Board
Sue Cassin	Chief Nurse, Rotherham Place	NHS South Yorkshire Integrated Care Board
Dr Jason Page	Medical Director, Rotherham Place	NHS South Yorkshire Integrated Care Board
Shahida Siddique	Independent Non-Executive Member	NHS South Yorkshire Integrated Care Board

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Participants

Ben Anderson	Director of Public Health	Rotherham Metropolitan Borough Council
Shafiq Hussain	Chief Executive	Voluntary Action Rotherham
Richard Jenkins	Chief Executive	The Rotherham NHS Foundation Trust (TRFT)
Sharon Kemp	Chief Executive	Rotherham Metropolitan Borough Council
Toby Lewis	Chief Executive	Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)
Cllr David Roche	Joint Chair	Rotherham Health and Wellbeing Board
Dr Neil Thorman	Primary Care Representative	Rotherham Primary Care Collaborative Group
Dr Anand Barmade	Medical Director	Connect Healthcare Rotherham
Michael Wright	Deputy Chief Executive	The Rotherham NHS Foundation Trust
Sally Kilgariff	Chief Operating Officer	The Rotherham NHS Foundation Trust
Lydia George	Strategy & Delivery Lead	NHS South Yorkshire Integrated Care Board
Suzanne Joyner	Director of Children's Services	Rotherham Metropolitan Borough Council
Gordon Laidlaw	Head of Communications	NHS South Yorkshire Integrated Care Board
Ian Spicer	Strategic Director, Adult Care	Rotherham Metropolitan Borough Council
Julie Thornton	Care Group Director	Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)

Minutes	
Title of Meeting:	Rotherham Place Board: **ICB Business**
Time of Meeting:	10.15 – 11.00am
Date of Meeting:	Wednesday 17 May 2023
Venue:	Elm Room, Oak House, Bramley, S66 1YY
Chair:	Chris Edwards
Contact for Meeting:	Lydia George: lydia.george@nhs.net/ Wendy Commons: wcommons@nhs.net

Apologies:	Richard Jenkins, Chief Executive, TRFT Ben Anderson, Director of Public Health, RMBC Toby Lewis, Chief Executive, RDaSH Lydia George, Strategy & Delivery Lead (Roth), NHS SYICB Sharon Kemp, Chief Executive - RMBC
Conflicts of Interest:	General declarations were acknowledged for Members as providers/commissioners of services.
Quoracy:	No business shall be transacted unless at least 60% of the membership (which equates to 3 individuals) and including the following are present: (1) Executive Place Director and (2) Independent Non-Executive Member

Members Present:
Chris Edwards (**CE**), Chairing, Executive Place Director - Rotherham, NHS South Yorkshire Integrated Care Board (ICB)
Wendy Allott (**WA**), Chief Finance Officer – (Roth), NHS SY ICB
Sue Cassin (**SC**), Chief Nurse - Rotherham, NHS South Yorkshire ICB
Shahida Siddique (**SS**), Independent Non-Exec Member, NHS South Yorkshire, ICB
Dr Jason Page (**JP**), Medical Director, NHS SY ICB
Claire Smith (**CS**), Deputy Place Director – Rotherham, NHS South Yorkshire ICB

Participants:
Ben Anderson **(BA)**, Director of Public Health, RMBC
Dr Anand Barmade (**AB**), Medical Director, Connect Healthcare Rotherham
Shafiq Hussain (**SH**), Chief Executive, VAR
Ian Spicer (**IS**), Strategic Director of Adult Care, RMBC
Gordon Laidlaw (**GL**), Head of Communications (Roth), NHS SY ICB
Michael Wright (**MW**), Deputy Chief Executive, The Rotherham NHS Foundation Trust
Leanne Dudhill (**LD),** Place Workforce Lead, RMBC
Stuart Lakin **(SL),** Head of Prescribing, NHS SY ICB

In Attendance:
Fiona Flinders, Rotherham Place Support Officer, NHS South Yorkshire ICB

Item Number	Discussion Items
i8/05/23	**Place Performance Report: May 2023**

CS gave highlights from this month's performance report including:

- IAPT access is improving and performing well with 6-week wait being at 96%, just above the national target.
- Cancer 2 week waits remain challenging with the 28-day cancer diagnosis dipping from 98.4 to 90%.
- Referral to treatment has shown a small improvement at 67% being 15 out of 106 nationally.
- There continues to be a couple of challenging areas in diagnostics with a slight increase in terms of cancelled operations and system pressures due to recent strikes.
- A&E has now changed to reporting on 4hr targets, which has been discussed at the Urgent and Emergency Care meeting.
- Ambulance hand overs remain relatively positive, we have had a challenging winter but we are now coming out of this.
- GP appointments remain higher in Rotherham than before the pandemic, which is positive.
- The urgent community response is really performing well against the 2-hr target, but there are challenges with a slight increase around ambulatory admissions but should now start to see an improvement.

CE suggested that partners may wish to share the report within their organisations.

i9/05/23	**Quality, Patient Safety and Experience Dashboard**

SC presented the May 2023 report for information. The report highlights key issues in the first part and more detailed information in the second section. As requested previously, it also now included a map of the borough identifying care homes.

Members complimented the content and level of information contained which has been developed over recent months.

Key areas highlighted by SC were around learning disability mortality reviews, the new serious incident framework, infection prevention and safeguarding information shared with GP practices, details can be found within the report.

i10/05/23	**Place Prescribing Report (Quarter 3)**

SL advised that the report covers from April 2022 to December 2022 but there was no data available for the final quarter at the time of writing the report.

Cost growth is 4.82% adding £1,540,206, to Rotherham's prescribing costs, this is below the cost growth for England (5.48%) but slightly above the average cost growth for Yorkshire & Humber (4.72%). Cost growth is to some extent being driven by item growth (Volume). Rotherham is showing strong item growth at 3.02% which is above that for England (2.83%) and Y & H (2.81%). Prescribing costs have increased mainly due to No Cheaper Stock Obtainable (NCSO), contributing 70% to Rotherham's cost growth, with no signs of abating.

The cost efficiency programme has delivered savings of £454k over 2022/23, but it is proving more difficult to find areas to target. Pilot projects around diabetes and weight loss are being developed as well as developing interventions throughout pathways to look at inequity across practices. Dieticians are now prescribing nutritional products for those on the infant feeding pathway requiring specialist infant formula feeds and this is service model is being extended to include the management of infant reflux issues, which will also prevent endoscopies. Members discussed how to promote this good practice, whether by a case study to sell the benefits to other areas. BA to discuss with SL. SL to return on a quarterly basis.	
i11/05/23	**Joint Capital Resource Use Plan**
Circulated without narrative to the local authorities. It shows that Doncaster and Sheffield have more capital than Rotherham and Barnsley. All areas received the capital requested.	
i12/05/23	**ICB Board Assurance Framework, Risk Register and Issue Log**
The risk register was shared for information with partners, it will be received monthly.	
i13/05/23	**Minutes and Action Log from 19 April 2023 Meeting**
The minutes from the April meeting were accepted as a true and accurate record. The action log was reviewed and up to date.	
i14/05/23	**Communication to Partners**
None.	
i15/05/23	**Risks and Items for Escalation**
None.	
i16/05/23	**Future Agenda Items:**
– Targeted Lung Health Checks (tba - JP) Standing Items – Rotherham Place Performance Report – Place Prescribing Report – Risk Register (Monthly)	
i15/05/23	**Date of Next Meeting**
The next meeting will take place on **Wednesday 21 June 2023** from 10.15am – 11am in Elm Room, Oak House, Bramley, Rotherham S66 1WB.	

Membership

Chris Edwards (Chair)	Executive Place Director/Deputy Chief Executive, ICB	NHS South Yorkshire Integrated Care Board
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