# HEALTH AND WELLBEING BOARD

**Date and Time:-** **Wednesday 26 November 2025 at 9.15 a.m.**

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

The items which will be discussed are described on the agenda below and there are reports attached which give more details**.**

Rotherham Council advocates openness and transparency as part of its democratic processes. Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair or Governance Advisor of their intentions prior to the meeting.

## AGENDA

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 Chair 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. **Communications**

7. **Minutes of the previous meeting (Pages 5 - 25)**

8. **2025/26 Winter Plan (Pages 27 - 40)**

   Steph Watt, Portfolio Lead – Urgent and Community Care, ICB, to present the 2025/26 Winter Plan.

9. **Working with the Voluntary and Community Sector to provide a more Integrated Approach to Care (Pages 41 - 58)**

   Hannah Thornton, Director of Services (Projects) Voluntary Action Rotherham, to

present the work with the voluntary and community sector to provide a more integrated approach to care.

**10. School Survey Analysis (Pages 59 - 132)**

Lorna Quinn, Public Health Intelligence Specialist, to present an analysis of health and wellbeing related questions of the Rotherham School Survey and trend analysis.

**11. Health and Wellbeing Priorities Update (Pages 133 - 142)**

Oscar Holden, Corporate Improvement Officer, and Emily Parry-Harries, Director of Public Health, to provide an update on the Health and Wellbeing Strategy action plan.

**12. Health Protection Annual Report (Pages 143 - 190)**

Alex Hawley, Public Health Consultant, to present the Health Protection Annual Report.

**13. Rotherham Food Network (Pages 191 - 211)**

Alexandra Hart, Public Health Practitioner/Gilly Brenner, Public Health Consultant, to provide an overview of the Rotherham Food Network including vision and action plan.

**14. Neighbourhood Working (Pages 213 - 241)**

Joanne Martin to present an update on the Neighbourhood Working programme.

**For Information**

**15. Items escalated from the Place Board**

**16. Better Care Fund (Pages 243 - 297)**

(a)
BCF Covering Report and 2025/26 Quarter 1 Reporting Template
BCF Call-Off Partnership Work Order 2025-26 (and appendix)

(b)
BCF Covering Report and Quarter 2 Template

**17. Rotherham Place Board ICB Business (Pages 299 - 303)**

Minutes of meeting held on 16th July, 2025.

**18. Rotherham Place Board Minutes - Partnership Business (Pages 305 - 310)**

Minutes of meeting held on 16th July 2025.

**The next meeting of the Health and Wellbeing Board will be held on Wednesday 28 January 2026 commencing at 9.00 a.m. in Rotherham Town Hall**.

JOHN EDWARDS,
**Chief Executive**.

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**HEALTH AND WELLBEING BOARD**
**24th September, 2025**

**Present:-**

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|---|---|
| Councillor Baker-Rogers | Cabinet Member, Adult Social Care and Health<br>**In the Chair** |
| Chief Insp. Kevin Bradley | South Yorkshire Police<br>(representing Chief Supt Andy Wright) |
| Nicola Curley | Strategic Director, Children and Young People's Services |
| Chris Edwards | Executive Place Director, NHS SYICB |
| Kym Gleeson | Healthwatch Rotherham |
| Alex Hawley | Public Health Consultant, Public Health<br>(representing Emily Parry-Harris, Director of Public Health) |
| Shafiq Hussain | Chief Executive, Voluntary Action Rotherham |
| Bob Kirton | Managing Director, The Rotherham Foundation Trust |
| Jason Page | Medical Director, Rotherham Place, NHS SY ICB |
| Ian Spicer | Strategic Director, Adults, Housing and Social Care |

**Report Presenters:-**

| | |
|---|---|
| Matthew Blomefield | Public Health Intelligence Analyst, RMBC |
| Rachel Copley | Public Health Practitioner, RMBC |
| Gilly Brenner | Public Health Consultant, RMBC |
| Lorna Quinn | Public Health Intelligence Principal, RMBC |
| Jean Summerfield | Lead Nurse, Child Death Review |
| Amelia Thorp | Public Health Specialist, RMBC |

**Also Present:-**

| | |
|---|---|
| The Mayor (Councillor Ismail) | |
| Councillor Brent | |
| Paul Benson | Private Sector Housing Co-ordinator |
| Oscar Holden | Corporate Improvement Officer, RMBC |
| Sue Panesar | Public Health Specialist, RMBC |
| Alicia Sansome | South Yorkshire CYP Alliance |
| Sarah Bond | ICB |

Apologies for absence were received from Councillor Cusworth, Gavin Boyle (NHS England), Andrew Bramidge (RMBC), Helen Dobson (TRFT), John Edwards (RMBC), Jo McDonough (RDaSH), Emily Parry-Harris (RMBC) and Claire Smith (ICB).

**14. DECLARATIONS OF INTEREST**

There were no Declarations of Interest made at the meeting.

**15. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS**

No questions had been received in advance of the meeting and there were no members of the public or press in attendance at the meeting.

## 16. COMMUNICATIONS

There were no communications to bring to the Board's attention.

## 17. MINUTES OF THE PREVIOUS MEETING HELD ON 25TH JUNE, 2025

Arising from Minute No. 11 (Better Care Fund), Bob Kirton raised the issue of how the TRFT could become involved in the discussions for the allocation of funds for the next financial year.

Chris Edwards replied that it would be the annual budget setting process where partners could help in the check and challenge.

Resolved:- That the minutes of the previous meeting held on 25th June, 2025, be approved as a true record.

## 18. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

Alex Hawley, Public Health Consultant, Public Health, presented the Director of Public Health 2025 annual report which had focussed on creative health within the Borough and how arts, creativity and culture could be used to improve the health and wellbeing of children and young people in Rotherham.

The following powerpoint presentation was also shown in conjunction with the report:-

Background

- In 2025 Rotherham became the world's first Children's Capital of Culture (CCoC) holding a year long festival of celebration
- The journey to this celebration year started in 2017 with the Embassy for Reimagining Rotherham where young people created a vision for Rotherham's future
- CCoC was not only about increasing engagement with the arts, culture and creativity but harnessing the engagement to improve the life chances of Rotherham's children and young people
- Building on the momentum of this celebration year, the Director of Public Health's annual report had explored the role that culture and creativity could play in the health and wellbeing of children and young people

Why is art, culture and creativity important for children and young people's health

- Children and young people aged 19 and under made up 23.5% of Rotherham's population
- Creative health meant working with creativity, arts and/or culture to support health and wellbeing. This could include lots of activities such as drama, art, film or writing
- For children and young people, doing cultural and creative things could help with social skills, physical health and mental health

- Teenagers who did art activities outside of school were less likely to do things which could harm their health such as smoke, drink alcohol or use drugs
- Lots of children and young people struggled with their mental health; creative health could help if included as part of mental health support

What matters to young people in Rotherham?

- Children and young people have said
  - They want to feel proud of where they lived
  - They wanted more fun things to do in Rotherham
  - There were quite a few different things that young people worried about including education, mental health, social media and body image
  - Some young people did not feel happy with more Year 10s than Year 7s saying their mental was fair or poor
  - Spending time with friends and family was very important to children and young people with many saying this was the most important thing to them
- The DPH report was therefore split into the 4 CCoC themes which encompassed the above

You're not from New York City you're from Rov'rum

- Feeling like you belong helped you to feel happier and could make you healthier
- Being involved in arts and creative pursuits could help young people to get better grades even in subjects that were not related to arts or culture

Who we are, where we come from

- Health in Rotherham was generally worse than the average for England and this was partly due to some people in Rotherham eating unhealthily, smoking and drinking alcohol. For many people they started doing these things from childhood or being a teenager
- Arts and culture could help reduce negativity, lift mood, calm and increase proactivity providing a positive impact on mental health

Plug In and Play

- Some people were concerned about the impact social media was having on young people
- Creative content online may offer an alternative to social media that was better for young people's mental health
- Creative activities like drama clubs, music groups, writing circles or book clubs helped to bring children and young people together and feel less lonely

The world beneath our feet

- Access to green space was one of the many neighbourhood-specific characteristics that affected health and neighbourhoods with greater access to green space tended to have greater life expectancy

- Some young people in Rotherham were worried about the impact of climate change but opportunities to spend time in nature and look after the environment could help

Recommendations

1. A comprehensive evaluation of the Children's Capital of Culture programme to be completed including consideration of the role of the programme in supporting the health and wellbeing of Rotherham's children and young people

2. A legacy programme to be delivered, building on the learning from the year-long festival of celebration, the evidence of the benefits of cultural and creative arts activities to health and wellbeing and linking up with wider initiatives such as the SYMCA Year of Reading.

3. Cultural and creative activities in Rotherham to strive to be welcoming and inclusive for families and to tackle inequalities in access.

4. Partners and stakeholders across the local education sector to value and champion arts and culture and work to increase access and reduce inequalities to arts education.

5. Long-term and sustainable funding to be identified to support work to engage children and young people in the arts, culture and creativity.

6. Partners and organisations to learn from the success of genuine co-production as a means for children and young people to be empowered to work with us on more of the things that matter most to them.

7. Physical activity to remain embedded when the Rotherham Cultural Strategy was refreshed, acknowledging the role it plays in culture and creative activity and the benefits to health and wellbeing and wider outcomes.

8. Opportunities for local research to be explored that built on some of the gaps identified through the report, including the role of creativity in supporting positive health behaviours and to better understand the impact of school on young people and their mental wellbeing.

9. The valuable contribution of the arts, culture and creativity to children and young people's mental health to be harnessed acknowledging that mental health was an area of increasing need and system-wide partnership working was vital to ensuring enough support for children and young people.

10. The preferred communication methods of children and young people to be used to ensure that they were aware of fun things to do and places to go locally.

It was noted that the report was published annually in September/October with the steering group meeting in late 2025 to discuss the topic of the 2026 report.

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

- It was a statutory requirement that every local authority Director of Public Health produced an independent annual report
- The report contained 10 recommendations but could not mandate any action on them. They would be discussed by the Director of Public Health Annual Report Steering Group and the report disseminated as widely as possible
- It was suggested that the report should be submitted to the Rotherham Together Partnership
- Work was ongoing but the full evaluation of activity would include numbers, health outcomes etc.
- Voluntary Action Rotherham had drawn down £1M National Lottery funding for social, emotional and mental health support for children. It was an opportunity to showcase that work
- The learning gained from CCoC would be used to inform the processes and procedures to improve/reduce the inequalities that children experienced across the Borough. The quantitative information i.e. the numbers of people coming through doors were known; it was the qualitative information i.e. focus groups, legacy and relationship building that was needed. Any differences in equalities would be highlighted in recommendations going forward
- The level of funding secured for the CCoC was a one off, however, an element of the events that had taken place had been embedded through existing funding streams

It was emphasised that it was not the official CCoC report; it was the Director of Public Health's report with the theme of creativity and health and there would be opportunities to highlight further the opportunities mentioned. It would also be referred to in the CCoC evaluation.

Resolved:- (1) That the 2025 Director of Public Health report be noted.

(2) That the conclusions of the report be supported.

## 19. HEALTHY HOMES PLAN

Rachel Copley, Public Health Practitioner, presented a briefing on the Healthy Homes Plan which sat within Aim 4 of the Health and Wellbeing Strategy.

The proposed Plan would be an annually refreshed document outlining the significance of poor housing on health and wellbeing in Rotherham and the key steps being taken to improve the housing sector.

The following powerpoint presentation illustrated the purpose of the Plan:-

What is the Healthy Homes Plan?

- Collaboration between Housing and Health Directorates using data that indicates the impact of poor housing on health and outlines the importance of cross-sector action to tackle this issue

Main sections of the Plan

- Current Housing and Health Strategies
- Local demographic and housing data
- Health risks in housing
- Available support
- The action plan

Plan Content: Current Housing and Health Data in Rotherham

- Rotherham housing data – total dwellings 122,000 (approximately)
  15.30% private rented
  64% owner-occupied
  20.70% Council housing
- Rotherham Demographics
  Population – 270,000
  Deprivation – 35th most deprived local authority
  Life expectancy has decreased
  Rotherham has higher rates of Asthma, Heart Disease, Stroke, Lung Cancer and MSK issues

Action Plan – split into 3 themes

1. Intelligence and evidence gathering
2. Reducing fuel poverty in Rotherham
3. Increasing support and assistance to tackle housing related health risks

The full version of the document and action plan was attached as an appendix to the report submitted and would be published on the Rotherham Joint Strategic Needs Assessment (JSNA) Housing page.

The action plan would be a regular agenda item on the Rotherham Energy Network meetings which were held every 6 weeks with any major changes to the action plan or full document submitted to the Public Health and Housing Strategic Management Teams.

Discussion ensued with the following issues highlighted/raised:-

- The plan was refreshed annually and hosted on the Joint Strategic Needs Assessment website
- A paragraph could be added to the report with regard to poverty, overcrowded housing and increasing levels of children in poverty
- Housing was the one area that the Health Service's portfolio and the wider determinants had the less impact. Was there anything the NHS could do to change this?

- In discussions regarding the neighbourhood pilot, Housing had expressed potential interest in the Health Hub
- South Yorkshire Children and Young People Alliance was doing a lot of work in terms of children with Asthma. Was there an opportunity to link that up?
- TRFT to evaluate what could be delivered in people's homes with the aim of the traditional hospital work being conducted within the home setting as well as in the hospital
- A range of respiratory conditions contributed to the low age expectation in the Borough. Working with the Fire Service and other agencies around health and wealth checks and checking on the domestic environment would be a good showcase of neighbourhood working
- The Housing Strategy should be shared widely to give the opportunity for an understanding of the challenge within Rotherham around housing and what that meant on the ground for delivery of care and support. The Strategy looked at the broader challenge and might be helpful for partners to have an understanding of it
- In order for people to access the help they needed for their homes they needed to know what help was available. The Rotherham Winter Health Being event was to be held on 8th October in Riverside House. Partners across Public Health, the Community Energy Team etc. would be present with information available for any members of public to take away or discuss with staff
- The Housing Strategy was aligned with the Healthy Homes Plan
- Housing Services were engaging with Public Health, the Climate Change Team and in particular the Community Energy Officer who had events planned throughout the year using all forms of engagement such as social media

Resolved:- That the Healthy Homes Plan and its action plan be noted.

## 20. TOBACCO CONTROL UPDATE

Amelia Thorp, Public Health Specialist, provided an update on measures being taken locally to improve tobacco control with the aid of the following powerpoint presentation:-

Why prioritise tobacco control

- Smoking was the leading cause of preventable and early deaths in the UK and Rotherham
- Smoking was the greatest contributor to the total burden of disease in Rotherham
- Smoking rates in Rotherham > all England (14.5% vs 11.6%)
- Smoking was the single largest driver of health inequalities locally and nationally

National Timeline

- Government Commitment
  In 2019 the Government made a commitment to make England Smokefree by 2030
  Smokefree defined as <5% prevalence
- The Khan Review
  Published 2022
  Independent review into the Government's smokefree ambition
  Recommendations:-
  - Increase investment
  - Increase age of sale
  - Offer vapes as a substitute for smoking
  - Prioritise prevention in the NHS
- Stopping the Start
  Government plan to create a smokefree generation
  Launched 2023
  Aimed to address Khan review recommendations
  Included launch of Swap to Stop and Smoking in Pregnancy Incentives Schemes
- Tobacco and Vapes Bill
  Introduced to House of Commons in 2024
  Proposes:
  - Increasing age of sale of tobacco products
  - Ban on display and advertising of vapes
  - Expand smokefree measures to some outdoor settings
  - Strengthen enforcement activity

Local Timeline

- An Internal Audit and Health Needs Assessment was undertaken in 2022 resulting in the establishment of the Rotherham Tobacco Control Steering Group and development of a 3 year multi-partner tobacco control workplan

Local Achievements

- Launch of a new Community Stop Smoking Service in October 2023
- Implementation of national schemes including Swap to Stop and Smoking in Pregnancy Incentives
- Embedded hospital provision of specialist stop smoking services for patients at TRFT and RDaSH
- Expansion of tobacco treatment services to all staff at TRFT and RDaSH
- The development of a dashboard of indicators to enable meaningful tracking of progress against the strategy and work plan
- The development of a Rotherham Position Statement on Vapes

Local Stop Smoking Services and Support Grant (LSSSSG)

- Launched alongside the Government's plan in 2023 with ringfenced funding to support an additional 360,000 people to quit smoking nationally

- Rotherham was allocated £384,845 for 2024/25, similar amount (to be confirmed annually) each year through to 2028/29

Local Impact

- Supported the delivery of a Local Enhanced Service (LES) including training of staff in primary care to identify, triage and offer stop smoking interventions
- Initially targeted to focus on high-prevalence and high risk groups with capacity to expand in future
- Funding also set aside to support additional capacity in the Community Stop Smoking Service

South Yorkshire Tobacco Control Alliance (SYTCA)

- Collaborative partnership between the four local authorities within South Yorkshire and the ICB and wider partners from the public, private and voluntary sector aiming to collectively accelerate our efforts in eliminating smoking across our region and contribute to the achievement of making South Yorkshire Smokefree by 2030

South Yorkshire Campaign

- Development of the South Yorkshire Brand “Smokefree Starts” in 2023 with the first campaign focusing on Smoking and Mental Health launched in March 2024
- Campaign materials included:
  Smokefree Starts website
  TV and radio advertising
  Information resources for professionals
  Information leaflets and posters for the public
  Social media content
- Follow-up campaign launched in November 2024

South Yorkshire Contribution to Yorkshire and the Humber

- Mass media campaign
  8 week mass media campaign launched in March 2025 including TV and radio advertising, OOH advertising, digital and social media advertising, search engine optimisation and launch of campaign website signposting to local services
  Campaign evaluation found that 30% of smokers cut down the amount they smoked and 15% made a quit attempt following seeing the campaign
- Training programme
  Developed in partnership with all 15 Yorkshire and Humber local authorities and the National Centre for Smoking Cessation and Training (NCSCT). It was a 5 year programme aiming to advance the knowledge and skills of those involved in commissioning, managing and delivering tobacco dependency treatment services across Yorkshire and the Humber

Work Plan 2025-2029 – Ambition – for Rotherham to become smokefree by 2030 (<5% prevalence)

A. Strategy and Co-ordination. Deliver a co-ordinated tobacco control policy, strategy, governance and monitoring system
    1. Create a shared vision, plan, governance structure and set of policies for effective tobacco control across Rotherham
    2. Improve the availability and use of local data on tobacco use, exposure and related health outcomes

B. Quit for good. Encourage and support smokers to quit for good
    3. Provide high quality community-based smoking cessation support
    4. Deliver a smoke free NHS
    5. Eliminate tobacco dependence in pregnant women
    6. Work with local employers to help staff to quit

C. Enforcement. Tackle suppliers of cheap, counterfeit and illicit tobacco and nicotine-containing products through delivery of effective enforcement
    7. Create a hostile environment for tobacco fraud and underage sales through intelligence sharing
    8. Tackle illegal activity including sales of counterfeit and illegal nicotine containing products
    9. Change perceptions about illegal tobacco sales and the harms of buying and using illegal vape products

D. Reduce variation in smoking rates by tackling inequalities
    10. Deliver targeted and tailored smoking cessation services and communications to reach groups with highest prevalence of smoking.

E. Stop the start. Reduce the number of people taking up smoking particularly young people
    11. Support schools to minimise uptake of smoking and e-cigarette use amongst Rotherham children and young people
    12. Reduce exposure to second-hand smoke and de-normalise smoking by expanding and enforcing smokefree place policies
    13. Use targeted and mass communication to change attitudes and social norms around smoking and increase quit attempts

Vaping in Children

- Recent local data shows that most students (74%) report never trying vaping, however, the overall number regularly vaping has been increasing since 2017
- A Vaping Harms Action Plan was being developed in response

Rotherham Position Paper on Vapes

- Vapes are significantly safer than cigarettes and were a valuable harm reduction tool and quitting aid for adults
- Young people should be discouraged from vaping

- Vaping amongst pregnant people was safer than tobacco smoking but was not risk free
- A better balance was needed between minimising promotion of vapes to young people whilst allowing promotion to adults who smoked
- We do not have all the answers now but on balance there was sufficient evidence to take action to improve the health of local people

Discussion ensued with the following issues raised/clarified:-

- The data on vapes was not as strong as that on tobacco; there was a need to understand the prevalence of vapes
- The South Yorkshire Tobacco Alliance had contributed to the delivery of a Joint Yorkshire and Humber mass media campaign launched in March 2025. It was well received but difficult to ascertain if that translated into quit attempts
- The difficulties of enforcement with regard to illicit tobacco. There were wider networks of Trading Standards that were in communication on a national level as well as sharing intelligence but it was ongoing work
- There was a Trading Standard representative on the Tobacco Control Steering Group who fed into the action plan
- Should there be stronger wording than “young people should be discouraged from vaping”
- 86% of the people in Rotherham did not smoke; when speaking to the remaining 14% it was the one joy in their lives whilst acknowledging that they knew they had to quit
- The TRFT had been part of the successful quit programme screening just under 2,000 people a month, 90% of which received advice as well 50% getting support with nicotine replacement therapy as well
- The Maternity Service had supported people to reduce the rate of smoking at time of delivery. It was well below 10% and in that last month had reduced further to 5%. That had been delivered at cost pressure at the Trust because of decisions that had been made and trying to work through that as partners. A lot of the work would be recognised as a key part but was not something that was always commissioned so it was a challenge
- Agencies were all trying to do the right things but were members of the public being given an overview of all the different interventions available and what success they were having
- The Stop Smoking Services in England was celebrating 25 years of service. A series of events was to be hosted in Rotherham to celebrate the number of people who had managed to quit in Rotherham over the 25 years. There was also to be a local event for the professionals to give thanks to them as part of the annual Stoptober campaign

- Was it better to promote what vapes should be used for i.e. a smoking cessation tool rather than a negative message? Young people tended not to see the link between smoking tobacco and vaping so consideration needed to be given as to how it should/could be promoted

Resolved:- (1) That the Tobacco Control Work Plan, developed by the Rotherham Tobacco Control Steering Group be approved and that Board members seek to provide the leadership, support and resources required to enable effective implementation of the priority actions within the organisations they represent.

(2) That further discussion take place between the Strategic Director of Children and Young People's Services and Public Health with regard to the way forward relating to vaping.

(3) That the development of the Vaping Harms Action Plan, developed with key local stakeholders, be supported.

## 21. CHILD DEATH OVERVIEW PANEL ANNUAL REPORT 2024-25

Alex Hawley, Child Death Overview Panel (CDOP) Chair, and Jean Summerfield, Lead Nurse Child Death Review, presented the CDOP annual report 1st April, 2024 to 31st March, 2025.

The powerpoint presentation highlighted:-

Foreword and Context

- First standalone Rotherham CDOP report
- Transitioned oversight from Safeguarding Children Partnership to Health and Wellbeing Board
- Administrative support now provided by Rotherham NHS Foundation Trust
- Tribute to Sharon Pagin and welcome to Jean Summerfield
- South Yorkshire CDOP having less frequent meetings
- Backlog of cases reduced despite organisational changes

CDOP Purpose and Structure

- The Panel included RMBC – Public Health and Social Care; TRFT – Safeguarding, Paediatrics, Midwifery; South Yorkshire Police; RDaSH; ICB; Children's Hospice
- Statutory function to review deaths of children (under 18 years) excluding stillbirths and planned terminations
- To categorise cause of death
- To consider the importance/relevance of factors present within 4 key domains – factors intrinsic to the child; factors in social environment including family and parenting capacity; factors in the physical environment and factors in service provision

- To identify modifiable factors and prevent opportunities
- To update the National Child Mortality Database
- To share learning and take whatever improvement actions were identified within the system to prevent future deaths or reduce vulnerabilities

South Yorkshire CDOP Network
- Covered Barnsley, Doncaster, Rotherham and Sheffield
- Enabled identification of regional themes and trends
- Pragmatic shift in 2024 and was now a community of interest with less frequent meetings
- Still valuable for shared learning and data comparison

Rotherham CDOP 2024-25
- 8 meetings held (2 additional to reduce backlog)
- 29 cases reviewed (20 deaths in 2024/25)
- 22 active cases ongoing (delays due to inquests, reports, investigations)
- Age distribution – highest in neonates (0-27 days)
- Place of death – mostly hospital-based
- Ethnicity – majority white; some Asian, Black, Mixed
- Collaboration with agencies to improve timeliness

Modifiable Factors
- 4 cases (14%) had modifiable factors
- National average 43% of cases had modifiable factors
- Issues included – seatbelt use in modified vehicles, tracheostomy management in babies and inter-professional communication
- National common factors – parental smoking, high maternal BMI, supervision issues, poor inter-agency communication

Learning and Actions
- Themes/actions identified at CDOP inform local practice
  - Safe Sleep campaign enhancement planned
  - Task and Finish Group reviewed neonatal deaths (2021/22)
  - Most deaths linked to deprivation and chronic conditions
  - Learning shared with professionals and networks e.g. swimming lessons partnership for children with learning disabilities
- Task and Finish Group reviewed infant/neonatal deaths. Findings:
  - Most deaths due to prematurity/immaturity
  - Some avoidable deaths due to care delays
  - No evidence of a single factor explaining increase in numbers

National Trends

- 3,577 child deaths in England 2023/24 (down 4% vs previous year)
- Child deaths at 29.8 per 199k children
  - Black children: 55.4 deaths/100k
  - Asian children: 46.8 deaths/100k
  - White children: 25.5 deaths/100k
- Children in most deprived areas >2x death rate of least deprived. Deprivation strongly linked to mortality
- Infant deaths (within 1st year of life) = 61% of total child deaths
- Neonatal deaths (within 28 days of birth) = 42% of total child deaths
- Infant mortality rate (under 1 year): 3.9 per 1,000 live births – a slight increase from the previous year

Next Steps

- Thematic review of modifiable factors
- Strengthen multi-agency collaboration
- Focus on health equity and early intervention
- Continue to work to improve the Sale Sleep offer
- Targeted interventions for high risk groups
- Continue backlog reduction and monitoring delays
- Thematic review of modifiability factors
- Influence training, service delivery and policy
- Aim – reduce inequalities and prevent child deaths

Conclusion

- CDOP delivered statutory responsibilities effectively
- CDOP maintained rigorous review standards
- Continued to strive towards timely and thorough reviews
- Identified modifiable factors and learning points
- Continued commitment to learning, prevention and family support
- Focus on reducing inequalities and improving child outcomes
- Persistent challenges: deprivation and inequalities
- Commitment to prevent, partnership and family voice
- Ongoing work to improve outcomes for children and families in Rotherham

Discussions ensued with the following issues raised/clarified:-

- It was a statutory requirement under the Working Together to Safeguard Children guidance in England to have a CDOP and every child that died was required to have their history looked at by a Panel
- The CDOP was in a very strong position now having processed the backlog and transitioned to the HWBB
- The report was to be considered at the Rotherham Safeguarding Board Executive
- The CDOP review would be focussing quite specifically on ethnicity and correlation with deprivation

- Stillbirths were not included in DCOP reviews. Legally a stillbirth was not defined as the death of a person. Under UK law, a Coroner or CDOP could not review a death unless there was an independent life to begin with, however, Maternity Services within the TRFT, reviewed every stillbirth

Resolved:- (1) That the Child Death Overview Annual Report be noted.

(2) That the report be approved for publication.

## 22. PHARMACEUTICAL NEEDS ASSESSMENT

Lorna Quinn, Public Health Intelligence Specialist, together with Matthew Blomefield, Public Health Intelligence Analyst, presented the Pharmaceutical Needs Assessment for the period 2025-28 with the aid of the following powerpoint presentation:-

Process

- Legislation required that Health and Wellbeing Boards produce an assessment of the need for pharmaceutical services. The assessments (Pharmaceutical Needs Assessments (PNAs)) were due every 3 years
- A steering group met annually (or as frequently as required) to provide supplementary updates and to refresh the full document each year
- The previous PNA covered 2022-2025; this document covered 2025-28
- The draft document was shared for 60 days consultation on 14th July 2025
- The PNA would be published September 2025 and would be reviewed as necessary following any changes in provision

Regulation Requirements

- A map of current provision
- A summary of local health need
- Conclusions
  - If there was sufficient choice with regard to obtaining pharmaceutical services in Rotherham
  - Pharmaceutical services that were necessary to meet the health needs of the population
    - ❖ All essential services
    - ❖ Advance Services (Pharmacy First; Hypertension case-finding, Flu Vaccination)
    - ❖ Locally commissioned services (needle exchange, supervised consumption and emergency hormonal contraception)
  - If there were identified future need for pharmaceutical services e.g. new housing developments
  - If there were any other NHS services that affected pharmaceutical service needs

Main Findings

- Overall access to pharmaceutical services in Rotherham was good. Most of the population lived within easy access of a pharmacy and good physical access was supplemented by increasing growth in national online service provision
- As of January 2025, there were 65 pharmaceutical service providers for the area of Rotherham Health and Wellbeing Board. This included:-
  - 61 pharmacies
  - 1 dispensing appliance contractor (DAC)
  - 3 dispensing GP practices
- A local population of 268,267 (mid-2022 – most recent estimate for local areas) indicates 22.7 pharmacies per population head in Rotherham
- As there was no set definition for 'need', access, resident choice and current use of pharmacies had been reviewed

Access

- In Rotherham 23% of the population did not have access to a car or van in their household, therefore, access had been reviewed to include walking time and walking distance alongside drive time:
  - 83.4% of the population of Rotherham lived within a 15 minute walk of a Rotherham-based pharmaceutical service provider
  - 93.2% of the 20% most deprived population lived within a 15 minute walk of a Rotherham-based pharmaceutical service provider
  - 98.9% of the population lived within 15 minutes on public transport on a weekday morning
  - 100% of Rotherham-based residents lived within a 10 minute drive of a Rotherham-based pharmaceutical services provider during rush hour
  - Including cross-border pharmacies had a marginal impact on the proportion of Rotherham residents within 15 minutes walk or 1.6 km (1 mile) of a pharmaceutical services provider

Resident Choice

- In a resident survey conducted with Healthwatch Rotherham, residents fed back that access and convenience were the biggest influencers of pharmacy choice
- The most common method of access was driving although this was slightly less likely for participants living in the 2 most deprived deciles than those living in less deprived areas
- Participants living in the 2 most deprived deciles were as likely to rely on delivery from a pharmacy as those in less deprived areas
- Participants living in the 2 most deprived deciles were slightly more likely to cycle or take public transport to a pharmacy than those in less deprived areas
- Residents also commented on their preferred days and times which had been incorporated into the recommendations

Pharmacy Use

- Essential services were offered by all pharmacy contractors but not all services register to provide advanced or locally commissioned services
- For Essential and Advanced Services, the number of pharmacies providing each service was calculated based on the number of pharmacies that had provided that service once or more in 2024
- Locally Commissioned Services data was provided by contractors and the Strategic Commissioning Team in Adult Care, Housing and Public Health at RMBC
- Service provision of these had been detailed within the document including at Ward level and findings considered in the document

Conclusions – Necessary Services

- Based on the information available at the time of developing this Pharmaceutical Needs Assessment, no current gaps in the provision of essential services within or outside normal working hours had been identified
- However, if one of the 100-hour pharmacies reduced their hours or there was a loss of weekend or evening hours, there would be a need

Conclusions – Advanced Services

- This Pharmaceutical Needs Assessment had detailed the distribution of these within Rotherham and Wards. Based on the data available the Health and Wellbeing Board was satisfied that there was sufficient capacity to meet the demand for these advanced services
- However, if one of the 100-hour pharmacies reduced their hours or there was a loss of weekend or evening hours, there would be a need

Conclusions – Future Need

- The document had reviewed population growth in line with forecasts and housing developments that would deliver new homes within the timeframe of the document
- There were no new housing developments of significant size during the lifetime of the document and the population projections were not predicted to increase to sufficient size to create unmet pharmaceutical need providing services remained as they were at the time of writing

Conclusions – Other Services

- The document notes the number of pharmacies that had signed up to provide and were providing the advanced and enhanced services listed below:-
  - Lateral Flow Device Tests Supply Service
  - New Medicine Service
  - Emergency Hormonal Contraception
  - Needle and Syringe Provision Needle Exchange
  - Palliative Care
  - Over the counter medication Labelling Scheme

- It was satisfied that the current demand could and would be met by the existing providers

Next Steps
- Publication of the 2025-28 PNHA
- The Steering Group continue to meet annually
- Further analysis in the Public Health Team to look at access to provision by public transport, walking and car use. This will be hosted on the Joint Strategic Needs Assessment

Discussion ensued with the following issues raised/clarified:-

- It was not expected that there would be sufficient home owners moving onto the Waverley estate during the lifetime of this PNA for enhanced provision and similarly at Bassingthorpe Farm. However, this would be monitored by the Steering Group
- In such areas as Waverley, that were very near to a bordering local authority, consideration was given to Rotherham's provision plus a one mile buffer
- Any changes in pharmacy provision would be monitored including any closures and out of hours
- More analysis would be undertaken on the number of members of public who did not have access to a car
- The PNA looked specifically at the time it took to get to a pharmacy or the distance to a pharmacy; it did not take into consideration whether there was a "safe" walking route. The data was quite limited in terms of safety but it was something that could be picked up in the analysis as part of the wider consultation on public transport and access to transport
- The timing of public transport was also not included but could be fed into the wider analysis

Resolved:- That the findings of the 2025-2028 Pharmaceutical Needs Assessment be noted.

## 23. EVALUATION OF THE 3-4 MONTHS HEALTH VISIT CHECK

Lorna Quinn, Public Health Intelligence Principal, presented the initial findings from the implementation of an additional visit within the Healthy Child Programme (HCP).

The following powerpoint presentation was also shown in conjunction with the report:-

Background
- Successful application to work with the National Institute for Health and Care Research (NIHR) Public Health Intervention Responsive Studies Teams (PHIRST) based at Nottingham University

- The aim was to evaluate the impact of the 3-4 month health visit, an additional visit which was previously available to only families requiring enhanced support but offered to all parents through Family Hubs funding until March 2026
- Practitioners review child development, provide guidance on breastfeeding and safe weaning and support parental mental health

Methods

- Qualitative
  - 15 individual interviews with parents
  - 2 focus groups with parents (including one with parents who had not taken up the visit)
  - Focus groups with 7 nursery nurses, 4 Public Health staff and commissioners
  - Factors associated with delivery and uptake of the visit were examined
- Quantitative
  - Tracking month-by-month how many eligible babies received it and whether it happened on time. Visit completion was described by demographic factors including socio-economic deprivation, ethnicity, maternal age and parity and developmental scores at 3-4 months
  - The children's 12 month development scores were compared before and after the review controlling the demographic factors

Reach

- The 3-4 month visit began in September 2023 but was targeted
- General rollout to the entire population began from January 2024
- On average just under 200 babies and their families received a 3-4 month visit each month

Qualitative Key Findings

- Parents valued having an additional visit between the 6-8 week and 9-12 month reviews and the visit was positively supported
- There were positive opinions of the service and family hubs
- Community groups, such as those delivered at a local mosque, provided an important way of delivering information and support to diverse communities
- Parents felt the visit was more developmentally focused than other visits, aligning with nursery nurse skills in developmental screening
- The visit supports parents' knowledge and preparedness for upcoming developmental milestones, providing parental reassurance

Quantitative Findings - Demographic

- 3-4 month visit rates stabilised at around 80%
- Before adjusting for potential confounders, 3-4 month visit rates were lower for older mothers, those who already had a child and those in IMD deciles 5 and 6

Quantitative Findings - ASQ

- Of those who received the visit, the ASQ completion was around 80%

Quantitative Key Findings

- The 3-4 month visit uptake was equitable across socio-economic deprivation, ethnicity and maternal age group but families with more than one child were around 70% less likely to receive a visit
- Maternal mood recording rates were consistent across deprivation quintiles and ethnic groups
- At the 9-12 month visit, children eligible for a universal 3-4 month visit had higher likelihood of scoring above the close-monitoring cutoff in the ASQ domain of problem solving

Next Steps

- These findings provided evidence for Rotherham stakeholders to consider when deciding on the future of the review and may contribute to the wider national debate on delivery of the Healthy Child Programme
- A detailed report would be published by November describing the findings further
- Meetings with Public Health Senior Management Team and Family Hubs Operational Group would share the detailed report and to discuss the future commissioning options

Conclusion

- Overall the evaluation indicated that the 3-4 month review was a valued addition to the Healthy Child Programme, offering a point of contact between the 6-8 week and 9-12 month visits and supporting families during a period of rapid developmental change
- The visit appeared feasible to deliver, culturally adaptable and acceptable to parents
- Work remained for ongoing data collection to monitor outcomes and to discuss future commissioning options

Discussion ensued with the following issues raised/clarified:-

- The term ‘parent’ was used to refer to the parents, carers and guardians eligible for a 3-4 month visit
- Parents were suggesting that that the additional visit would be more beneficial (5-6 months), however, the 3-4 months visit was in line with the national Child Programme
- No studies since 2015 had specifically assessed adding a universal 3-4 month review. The review was not nationally mandated; the Council was evaluating its impact to assess the case for retaining it locally and to influence wider national debate on delivery of the Healthy Child Programme

Resolved:- That the findings from the 3-4 visit within the Healthy Child Programme be noted.

## 24. ITEMS ESCALATED FROM PLACE BOARD

Chris Edwards, Executive Place Director, NHS SYICB, reported Rotherham had been selected as a Neighbourhood Pioneer Pilot. There had been 42 national pilots identified in South Yorkshire and Rotherham, Doncaster and Barnsley had been successful. Workshops were to be held to work out how to bring Acute Services into neighbourhoods.

Resolved:- That, when appropriate, a report be submitted to a future meeting of the Board.

## 25. BETTER CARE FUND

Chris Edwards, Executive Place Director, NHS SYICB, reported that the BCF plan would be shared with TRFT.

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| **BRIEFING** | **TO:** | Health and Wellbeing Board |
| | **DATE:** | 26th November 2025 |
| | **LEAD OFFICER** | Steph Watt, Portfolio Lead Urgent and Community Care |
| | **TITLE:** | Rotherham Winter Plan |

**Background**

| | |
|---|---|
| **1.1** | It is an NHS England requirement to produce an annual Winter Plan in to prepare for and manage higher levels of demand and acuity for health and care urgent and emergency services associated with seasonal pressures. The plan has been co-ordinated by the ICB and developed with Place partners including The Rotherham Foundation Trust (TRFT), Rotherham Council, Rotherham Doncaster and South Humber NHS Foundation Trust, Primary Care, The GP Federation and Voluntary Action Rotherham.<br>Assurance stress tests of the plan have been held regionally and locally.<br>Rotherham's Plan has been assured through the Urgent and Emergency Care Group and signed off by both the Rotherham Place Board and TRFT Board. The Plan forms part of a wider South Yorkshire plan which has been signed off by the ICB Board and submitted to NHS England.<br>The Plan is aligned to the national urgent and emergency care metrics which are monitored through the NHSE regional team and nationally. |

**Key Issues**

| | |
|---|---|
| **2.1** | Rotherham's demographic and associated health inequalities alongside an aging population is resulting in increased demand for health and care services, including urgent and emergency care.<br>Significant time and resource have been invested in developing out of hospital services to support more people to be cared for at home, which is better for the individual and reduces avoidable conveyances and admissions.<br>Where possible successful schemes developed for previous winters have been incorporated into business as usual, as higher levels of demand throughout the year have become the new normal.<br>Despite these efforts we have seen record levels of demand in presentations to the Emergency Department. This results in increased waiting times for people with the associated risks and pressure on acute beds and discharge pathways.<br>There appears to be vaccination fatigue within the population, therefore there is a drive to increase uptake for eligible vulnerable groups and health and care staff.<br>The plan has included planning for industrial action based on learning from previous action. |

**Key Actions and Relevant Timelines**

| | |
|---|---|
| | For planning purposes winter is deemed to be the period between November to March. There is a pre-winter period from September when children return to school and respiratory cases start to rise. The impact of flu varies, cases usually rise in December and peak in January / February. Last year there was a long tail into March, impacting into April. This year flu has come early and is already impacting. As a result, our Acute Respiratory Infection Hub has been bought forward and the majority of our schemes are |

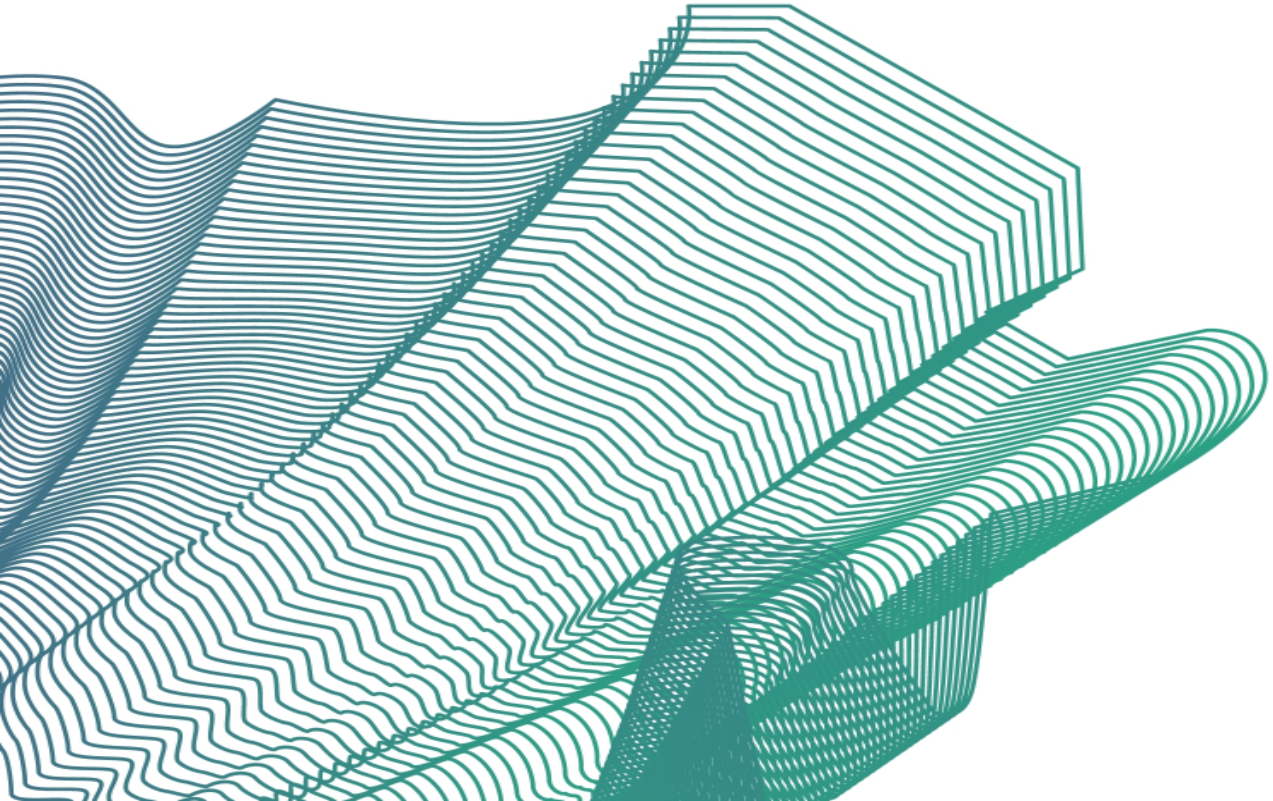
| | |
|---|---|
| | operational. Staffing rotas are carefully planned to minimise the impact of school holidays and the winter holiday period.<br>Additional funding has been provided from the Better Care Fund and Section 75 monies and TRFT and the Council have also invested to improve flow.<br>Initiatives include:<br>**i.** **Prevention** including new ways of working in TRFT and the Council's redesign of services supporting flow. Funding for an Acute Respiratory Infection Hub for primary care, additional GP appointments and improved access. Expansion of the virtual ward and PUSH/PULL models with Yorkshire Ambulance Services and a comprehensive Place vaccination scheme.<br>**ii.** **Flow through the Acute Hospital** The opening of the new medical SDEC, additional medical, clinical, pharmacy and portering resource, extended operating hours for patient transport and the Community Ready Unit and Age UK delivery of medications.<br>**iii.** **Discharge** further development of the multi-disciplinary Transfer of Care Hub to co-ordinate urgent and emergency community referrals which could otherwise result in a conveyance/admission and support timely discharge, development of the Discharge to Assess pathway and additional resource for enablement and social workers<br>**iv.** **Children's and mental health services** including whole family approach to support the most vulnerable, targeted crisis support including extension of the safe space provision and enhanced online support<br>The plan is underpinned by a communication and engagement campaign aligned to the national campaign and adapted for local need. |
| **Implications for Health Inequalities** | |
| **4.1** | Deprivation factors play out in health presentations, which are heightened in winter due to cold weather and greater prevalence of infectious diseases. At individual level the plan supports the need, and there is a focus on improving mulit-disciplinary working, particularly across organisations for those with more complex conditions. At system level we are reviewing demand in the emergency department and working to identify and target under or over-represented groups and high intensity users to inform how we provide care. |
| **Recommendations** | |
| **5.1** | For information. |

ROTHERHAM
INTEGRATED CARE PARTNERSHIP | HEALTH AND SOCIAL CARE

# Rotherham Winter Plan 2025-6

## Health and Wellbeing Board

## November 2025



NHS
Rotherham
Clinical Commissioning Group

Rotherham, Doncaster and South Humber
NHS Foundation Trust

The Rotherham
NHS Foundation Trust

Rotherham
Metropolitan
Borough Council

VoluntaryAction
Rotherham

CONNECT
HEALTHCARE
ROTHERHAM CIC

# Winter 2024-25

- Urgent and Emergency Care programme focussed on increasing out of hospital pathways as alternatives to avoidable conveyances and admissions and reducing discharge delays
- Additional monies were invested across Place to support system flow over winter utilising Section 75 Better Care monies and the national discharge fund
- Plus organisation investment by TRFT and RMBC

# Winter Schemes 2024-5

Included

- Comprehensive vaccination programme co-ordinated across primary care, TRFT and the Council supporting vulnerable citizens, care homes and health and care staff
- Increased GP appointments including acute respiratory hub
- 'PUSH' community health and social care teams responding to non-critical 999 calls to reduce ambulance conveyances, including new respiratory and mental health pathways
- Increased capacity on the virtual ward
- Additional staffing resource including Consultant and resident doctor medical cover, therapy, social worker, enablement and portering resource
- Extended opening hours for Community Ready Unit with support to ensure timely medicines
- Extension of patient transport
- Home from hospital pathway to reduce waiting times
- Priority services identified for children with plans for temporary reductions elsewhere to support peak pressures
- Plans to ensure routine and emergency support for vulnerable children and family oversight
- Reduction in out of area mental health placements
- Robust mental health digital offer
- Rotherham safe space provided additional out of hours support for individuals in crisis
- Voluntary sector support through Age UK Hospital Aftercare Service, Urgent and Emergency Social Prescribers and NHS Responders providing post discharge medicine delivery service

# Going into Winter 2025-26

## Post winter/summer period

- Successful winter schemes embedded into business as usual
- £7M investment in new medical SDEC and ways of working
- Transfer of Care Hub co-located in the community setting
- High impact work/proactive care
- Increased capacity virtual ward, including remote tech
- Enablement waiting lists reduced from high of 66 to record low of 9, 13 Aug 25
- Impact of system flow roles
- 4 hour performance improving – 70%+
- NCTR metric improved, Metrics for 7, 14 and 21 day delays and discharges pre 5pm all compare favourably with the region and those with lower NCTR
- Understanding ED demand work to target and promote alternative pathways

## Challenges

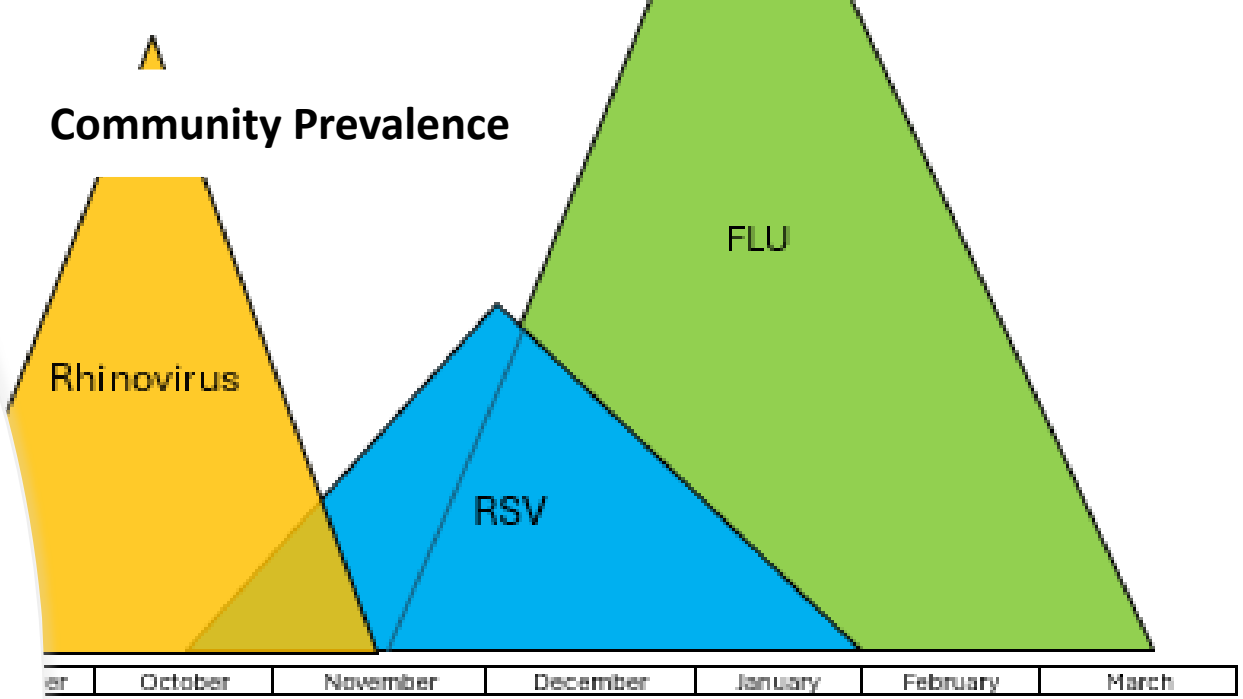
- Demand still high in community and ED
- High levels of acuity and complexity, reflecting Rotherham's aging population and demographic
- New ED attendance normal 300+, compared to c270s previously
- Playing out through system flow and pressure on discharge care co-ordination and community pathways
- Record high of 391 attendances 20 Oct 25
- Escalation beds remained open over the summer
- 30 surge beds open in October
- High levels of scrutiny
- Still work to do ….

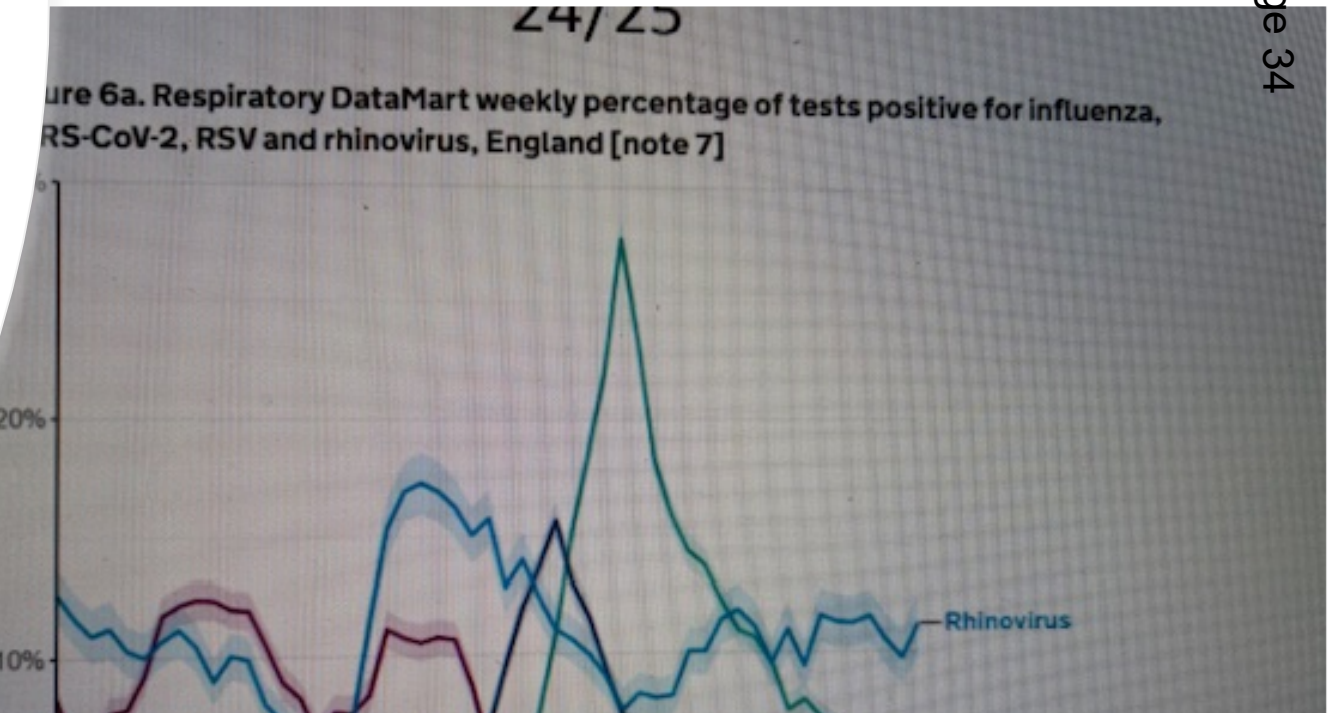
# National Performance Metrics 2025-6

- Reduce ambulance wait times for Cat 2 (stroke, heart attack, sepsis and major trauma) from 35 minutes to 30
- Eradicate ambulance handover delays, max 45 minutes
- Ensure 78% of people who attend ED are admitted, transferred or discharged within 4 hours
- Reduce number of patients waiting over 12 hours for admission or discharge
- Reduce the number of people waiting over 24 hours in ED for mental health care
- Tackle discharge delays initially focussing on those over 21 days (14 and 7 days). Aim for complex discharge within 48 hours
- Increase the number of children seen within 4 hours

# National Learning re Vaccinations 2024-5

- Importance of vaccination uptake to reduce attendances/staff sickness
- Plan for peaks based on southern hemisphere and monitor actual impact, with flexibility to adapt plans
- Need to build annual leave/staff sickness into plans
- Review IPC what has and hasn't worked and how connects with overarching plan
- Consider how staff vaccination programme can be incentivised



| National priorities for 2025-6 | Rotherham Plans |
|---|---|
| Improve vaccination uptake and reduce sickness | Targeted plans to increase citizen/staff vaccination rates in primary care, public health and TRFT. TRFT aiming for 5% increase<br>Joint working to target areas of high foot fall for over 75s/immunosuppressed.<br>Staffing/resources based on Southern Hemisphere – peak from New year /Feb and national data.<br>Staff wellbeing support and targeted rotas to cover annual leave/sickness |
| Improve access to primary care | Additional primary care appointment including Acute Respiratory Infection Hub – early opening<br>Improved booking including on-line/app booking<br>Additional local winter monies for PCNS |
| Increase the number of people receiving urgent care in primary, community and mental health settings including UCR and virtual ward | High impact respiratory, diabetes and proactive care pathways including highly complex frail patients<br>Community based multi-disciplinary co-located Transfer of Care Hub to reduce avoidable conveyances, admissions and discharge delays through referral, triage and allocation to community pathways<br>Investment in enablement to embed D2A pathway and release capacity for UCR and virtual ward<br>Expansion of the virtual ward including remote tech to support 'amber' acuity including SDEC hypertension<br>Community X Ray pilot for care homes<br>Enhanced mental health offer – safe space, crisis support, on-line/text support |
| Meet the 45 minute ambulance handover standard | W45 live from September |
| Improve flow through hospitals including meeting 4 hour performance and ambulances standards, reduce 12 hour and discharge waits | ACT/RMBC service re-design service improvements – releasing capacity<br>Additional medical, clinical staff and porters to support periods of high demand<br>Increased capacity for care co-ordination /timely decision making via TOCH<br>New single referral form to streamline processes and reduce delays<br>Improved process for out of area discharges<br>Extended transport hours<br>Reduced TTOs and Age UK TTO delivery service |
| Set local targets to improve discharge times | Discharge trajectory across pathways. Review of system flow in community bed base. New dashboard and system escalation process. |
| Reduce lengths of stay for those requiring overnight emergency admissions | Understanding demand in ED targeted action plan<br>Medical SDEC opened July 2025 reducing need for overnight admission, new paperless processing<br>Extended/consistent SDEC opening |

# New Roles Supporting Patients, Families and System Flow

## Flow capacity manager

Mrs T wanted to go home after a spell in hospital, but ward staff raised concerns regarding her safety at home due to her declining mobility, refusal to accept an increased care package, and preference to sleep on a recliner sofa instead of a profiling bed.

A Mental Capacity Assessment (MCA) determined that Mrs T lacked capacity to fully understand her own needs and the risks associated with returning home without additional support.

The System Flow Capacity Manager arranged and chaired two Best Interest Meetings to ensure effective multi-agency collaboration. Attendees included Mrs T's daughter, the Occupational Therapist, Ward Staff, Therapy Team, Mental Health Social Worker.

A home assessment was completed, and the property was deemed suitable, with recommendations for equipment to support discharge and Mrs T's future independence. Mrs T's GP practice agreed to provide ongoing medical and well-being input.

Recognising the wider impact on the family, the System Flow Capacity Manager acknowledged the daughter's stresses and arranged community support through Age UK and Social Prescribing to offer emotional and practical assistance.

Mrs T is continuing to make good progress with the support of therapy and other services

## Care Home Trusted Assessment

### Patient Story

Mr TD admitted on medical grounds. Has dementia and safeguarding issues. Although he had displayed challenging behaviours, he had become introverted whilst his wife, newly diagnosed with dementia, was becoming increasingly violent and aggressive towards him. She had refused to accept him back home.

The TA carried out an assessment liaising with the wider family including providing advice for support in relation to the mother's escalating care needs and 24 hour care was agreed. The TA liaised with Byron Lodge who accepted the referral without visiting. Discharged the next day with an estimated saving of £690 from bed days saved.

# Organisation Development, Communications and Engagement

- Whole system working together to support right care, time, place and reduce pressure on individuals/teams
- Targeted organisational development work
- Champion roles
- Comms and engagement plan with national, SY ICB and local plans aligned
- Local comms informed by understanding ED demand analysis

# Governance and Assurance

- Urgent and Emergency Care Group
- RPET/RMBC & TRFT assurance
- Place Board
- Health and Wellbeing Board
- ICB Board Assurance: NHSE Requirement
- Health Select Committee
- National KLOEs
- Winter resilience scenario testing

ROTHERHAM
INTEGRATED CARE PARTNERSHIP | HEALTH AND SOCIAL CARE

# Risks and Issues

| Area | Risk Description | Anticipated Impact | Mitigation Plan |
|---|---|---|---|
| A&E Attendance | Following unprecedented levels of demand in 2024-25 attendances continue to increase at the current rate. | ED overwhelmed, increased waiting time, patient harm and breaches.<br>Staff burnout. Increased admissions due to poor decision making. | Development of alternative pathways to ED eg x-ray pilot, virtual ward, prevention, enablement, improved access to primary care, seasonal ARI hub.<br>Expanded SDEC offer. Additional medical and clinical staffing including twilight shifts and porters; |
| Ambulance handovers | Failure to meet handover targets | Crews delayed, reducing response capacity | YAS co-located in ToCH for alternative pathways, project Chronos, PUSH acceptances<br>45 minute protocol implemented from 2 September. |
| Acute Bed Occupancy | Insufficient capacity to meet demand. | Patients backed up in ED/SDECs and short stay outliers, corridor care, patient harm. | Increased capacity/extended operating hours in SDECs. |
| Primary Care Access | There is a perceived, or real, lack of primary care appointments | Patients present at ED | Investment in additional GP appointments and ARI hub, (with flexible start/end dates)<br>Understanding ED demand project: analysis of attendances targeted action plan. |
| Community Services | Process and system changes due to implementation of the ToCH leads to unintended consequences.<br><br>Insufficient capacity in the required pathways, particularly P1<br><br>Community commissioned bed base does not meet length of stay KPIs. | Patients are not tracked through into the community | Phased implementation, OD and training sessions, comms and engagement plan<br>Follow up checks on a risk basis<br>Assurance dashboard to oversee delays by pathway<br><br>Streamlined MDTs with full partner membership. Improved referral form for complex discharges also used for enablement referrals. More flexible resource in ToCH to allocate according to need.<br>Investment to support D2A.<br><br>UEC priority project to review community system flow. streamlined process, deep dive into delays by bed base. Targets for reduced length of stay. |
| Adult Social Care | The adult social care re-design is delayed.<br>Insufficient capacity in the required pathways. | Delays to the implementation of ToCH<br>Delays to the discharge of patients or capacity to remain in community settings. | Re-design implemented.<br>ToCH co-location August 2025 completed. |
| Industrial Action | On-going Resident Doctor action with potential for others to take action | Reduced capacity. Increased delays/risk of patient harm<br>Increased work load for those not taking IA | Contingency planning based on previous experience/national requirements |
| ICB re-organisation | National guidance has indicated ICBs to continue to be system co-ordinator for UEC plans in 2025-6<br>Reduced capacity /loss of skills/knowledge may impact on ICB's ability to deliver | System co-ordination at Place and SY level<br>Decisions regarding funding may cause delay | Support for UEC /winter planning has continued<br>National guidance is that ICBs will continue to be responsible for this in 2025-6<br>In year impact to be reviewed when structure/timing confirmed with appropriate contingencies put in place including prioritisation of work loads |

| | | |
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| **BRIEFING** | **TO:** | Health and Wellbeing Board |
| | **DATE:** | 26/11/25 |
| | **LEAD OFFICER** | Hannah Thornton – Director of Services – Voluntary Action Rotherham |
| | **TITLE:** | Rotherham VCSE & Health – Partnerships, Integration & Developments |

**Background**

**1.1** The Rotherham Health and Wellbeing Board is looking to further understand the role of the Voluntary Community and Social Enterprise Sector (VCSE) sector in contributing to health, wellbeing and care across the borough.

**1.2** Therefore, and item outlining the broad details of the wider VCSE role, offers and provision has been included on the Health and Wellbeing Forward Plan for an information only update.

**1.3** This item is being presented on behalf of the VCSE sector by a representative of Voluntary Action Rotherham (VAR) as representatives of the organisation attend the Heath and Wellbeing Board regularly and have been identified as an appropriate conduit between the sector and the Board.

**Key Issues**

**2.1** This presentation provides an update on current work in the VCSE in Rotherham. It will summarise:

- The current 'state of the sector' of Rotherham VCSE.
- Outline the ways in which VCSE organisations support the health & wellbeing of the Rotherham population
- Give examples of where VCSE partners are integrated into Health services and programme delivery, for adults, children and young people.
- Explore some of the VAR-led infrastructure work that directly contributes to the strength of the VCSE in relation to supporting health & wellbeing across Rotherham.

**Key Actions and Relevant Timelines**

**3.1** Due to this presentation being an update on the current contributions of the wider VCSE sector towards health and wellbeing in Rotherham there are not specific key actions recommended for this item.

**3.2** Each of the examples included in this presentation have their respective timelines and key deliverables which will be individually documented.

**Implications for Health Inequalities**

**4.1** As this presentation is giving a general update on the contributions of the VCSE sector it will not specifically address the implications for health inequalities.

| | |
|---|---|
| **4.2** | All examples references within the presentation have considered health inequalities respectively and will have individually documented their aims and impact towards reducing health inequalities in Rotherham. |
| **Recommendations** | |
| **5.1** | To note the current examples of partnership, integration and VCSE infrastructure. |

# Voluntary Action Rotherham

## Rotherham VCSE & Health

November 2025

Hannah Thornton, Director of Services (Projects)

# Rotherham VCSE - State of the sector 2024

**1,399 Organisations**

The majority are small (£10k - £100k) or micro (under 10k income)

**3,388** **employees** work in charities in Rotherham

**£120 million** estimated contribution of **employees to the economy** per annum

**6,017** people **volunteer** in charities in Rotherham

**£17 million** estimated contribution of **volunteers to the economy** per annum

**1,774** people are **trustees** in charities in Rotherham

Overall income of charities in Rotherham: **£97 million**


Many organisations have a focus on **diversity, equity and inclusion.** Some are specifically dedicated to serving particular groups, including:

- **older people** (26%)
- **disabled people** (21%)
- people who are **educationally or economically disadvantaged** (14%)
- communities experiencing **racial inequity** (13%)
- **young people** (13%)

# Rotherham VCSE - Connecting with people's health

## Specialist & Condition-Specific

- Condition-specific Peer Support
- Domiciliary care
- Specialist carers support
- Palliative care
- Counselling & Therapy

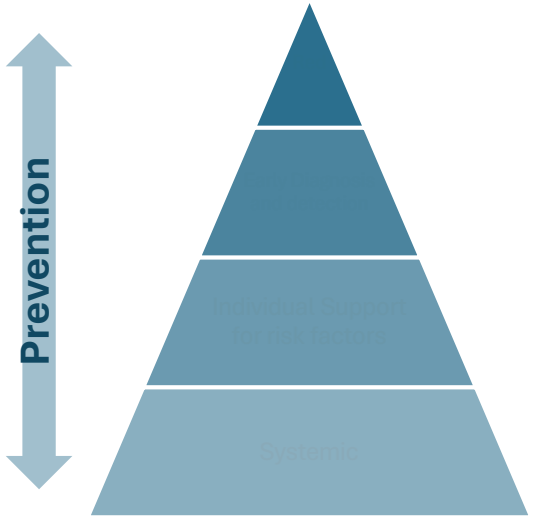
## Health Creation and Maintenance

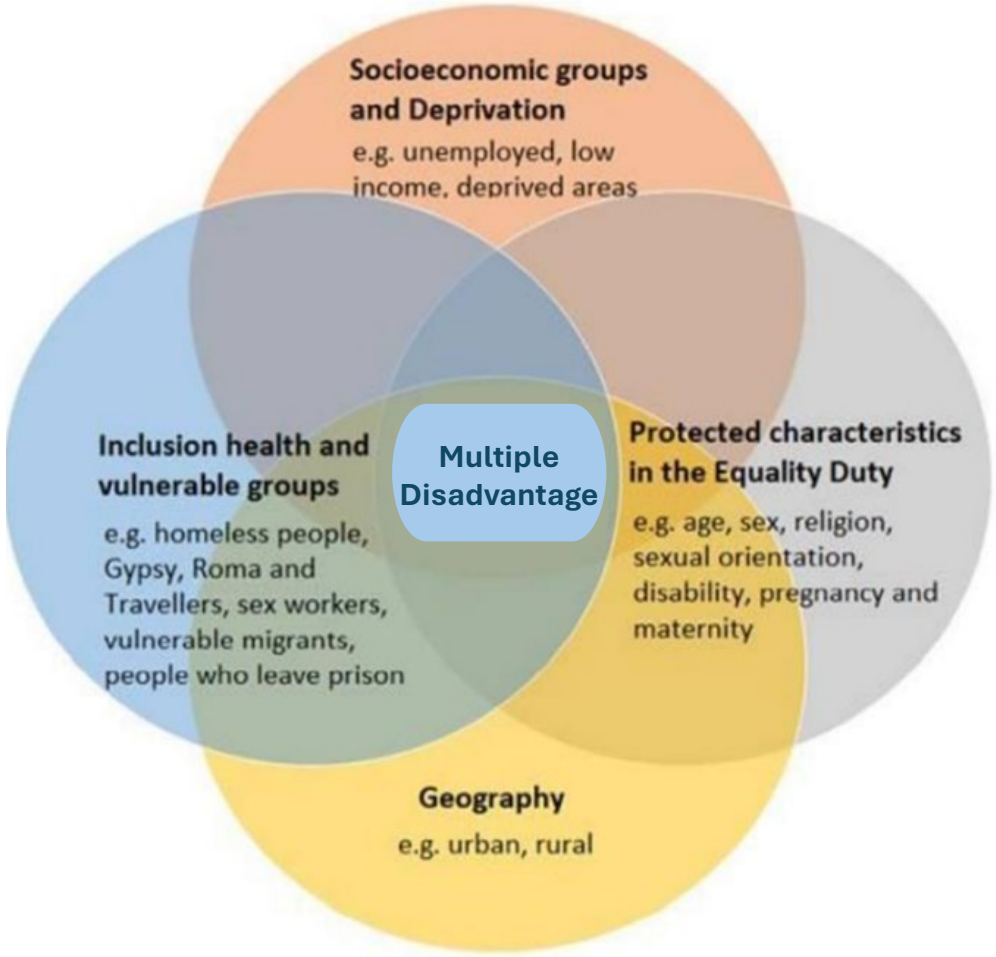
- Physical & Mental Wellbeing
- Faith and Spirituality
- Nature Connection
- Social Connection & Fun !
- Family Support
- Creative Health
- Support for Older People
- Local Community Hubs

## Addressing wider Determinants

- Learning, skills & Digital Inclusion
- Information, Advocacy and Benefits Advice

# Rotherham VCSE - Connecting with people where they are






**Rotherham VCSE organisations receive funding from a range of sources with the highest levels coming from:**

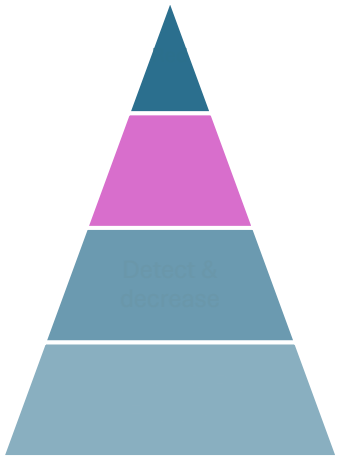
- Grants from trust and foundations (31%)
- Fees and earned income (22%)
- Grants from the public sector (18%)
- Contracts of service agreements (11%)

South Yorkshire VCSE: Understading Value and Impact Sept 2024

# Primary Care - Proactive Care

**Risk Stratification of patients:**

- moderate to severe frailty patients with 2+ hospital admissions in the last 12 months
- Diabetes + high risk of admission
- Respiratory + high risk of admission




Multi-Sector PCN MDT

Non-MDT direct referrals

## Rotherham Social Prescribing Service

- Holistic Social Prescribing Assessment - what matters to you?
- Onward supported referral to specialised support
- Liaison with RMBC Housing/SPA/ASC as req'd

## Dementia Carers Resilience Service

- Holistic Carers Wellbeing assessment
- Information & Guidance
- Onwards supported referral for specialist support

## Micro-Commissioned Support:

- Befriending & Enablement
- Benefit info, advice & advocacy
- Specialist advocacy
- Carers respite
- Dementia Enablement
- Education & Training – digital inclusion
- Counselling
- Complementary therapies
- Activity pathway groups
- Physical Activity

**8 Social Prescribing Community Hubs**

Active Independence

Wider VCS

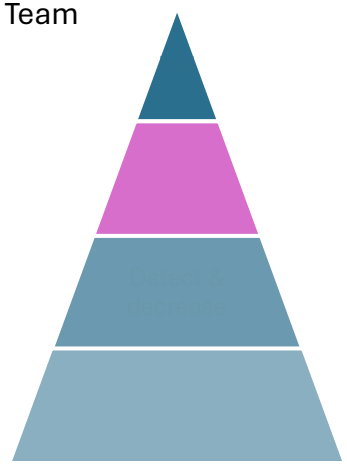


Voluntary Action Rotherham

# Urgent & Emergency Care Centre

**Identification of patients on/awaiting discharge:**

- Integrated Discharge Team
- Urgent Therapy Team
- Reablement Team
- Healthy Hospitals Programme
- Community Hospital Admission Avoidance Team



Transfer of Care Hub MDT

Non-TOCH direct referrals

## Rotherham Social Prescribing Service

- Holistic Social Prescribing Assessment - what matters to you?
- Onward supported referral to specialised support
- Liaison with RMBC Housing/SPA/ASC as req'd

## Hospital Aftercare Service

- Transport & settle within 3 hrs of referral
- Home visit and basic safe & well check
- Up to 30 days on going support

## Micro-Commissioned Support:

- Befriending & Enablement
- Benefit info, advice & advocacy
- Specialist advocacy
- Carers respite
- Dementia Enablement
- Education & Training – digital inclusion
- Counselling
- Complementary therapies
- Activity pathway groups
- Physical Activity

**8 Social Prescribing Community Hubs**

Wider VCS



Voluntary Action Rotherham

# Rotherham Social Prescribing Service - Patient Case Study

Patient was referred for help to be more **socially connected**. He has hearing and sight loss, his magnifier was broken and was feeling very isolated. Patient was worried about accessing community groups as he struggles with his bowels. Patient and his partner were living in a rented house that didn't fit their needs as they had a broken stair lift and rusty grab rails, the patient was also concerned about mould. They required the heating on most of the time; this meant they were struggling financially as they were also paying for Carer.

- A referral to **Rotherham Sight and Sound** was made for a full review on the patient's home equipment. Advisor made a call to Sight & Sound to understand the accessibility of their groups (building layout and toilet access). Transport to get to the groups was arranged through a referral to Door2Door.
- A call was made to both **Blind Veterans** regarding replacing broken home equipment and a referral to **RSPS-Commissioned Digital Inclusion** delivered by **The Learning Community** to support the Patient to relearn his skills with his magnifier and continue communication with the Blind Veterans.
- RMBC were contacted regarding home equipment and reducing the cost of carers.
- A referral to **RSPS-Commissioned Advocacy** delivered by **You Ask We Responded** to support with a benefits check and to continue supporting with KeyChoices.
- A referral to **Green Doctor** was made for mould prevention and guidance of reducing bills.

As a result of RSPS support and the RSPS-Commissioned services, the patient now has a new flashing doorbell, new loudspeaker phone so he can use the telephone, new additional aid to support his hearing aids and he is awaiting piece of equipment to support with hearing the television. The patient has started walking outside of his home to build his confidence to eventually be able to access community groups. The patient has new grab rails in place and is now confidently using his magnifier 2-3 times per day and him and his partner have now been given a bungalow; they are awaiting an Occupational Therapy assessment prior to moving in.

# Social Prescribing Community Hub Network

- Cortonwood Comeback Centre
- High St Centre, Rawmarsh
- Unity Centre, town centre
- Kimberworth Park Community Partnership
- Dinnington Area Regeneration Trust
- The Learning Community, Dinnington
- Treeton Village Community & Resource Centre
- Kiveton Community Hub

- Rawmarsh Social Prescribing Hub

**50+ Staff employed**

**2,000+ People per week**

**75+ Volunteers**




Voluntary Action Rotherham

Voluntary Action Rotherham

NHS Property Services

# Social Prescribing Hub Rawmarsh Timetable

Rotherham Social Prescribing Hub
(Next to health centre & library)
Barbers Ave,
Parkgate,
Rotherham S62 6AA

| | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| Morning | Rotherham Parent Carers Forum (RPCF) 9.30am - 11.30am Weekly SEND Connect Group | Impressive Expression 10am - 4pm Weekly | Pen & Purpose 10am - 1pm Weekly | Age UK Rotherham Coffee Morning 10am - 12pm Weekly | Memory Clinic RDaSH Peer Support Group for Lewy Body Dementia 10am-12noon 2nd Friday of Every Month |
| Afternoon | You Asked We Responded (YAWR) 1pm- 3pm Weekly | Impressive Expression 10am - 4pm Weekly | Headway 1.15pm-3pm Weekly | Live Inclusive 12.30pm - 3pm Weekly | Nayi Zindagi session currently not running |
| Evening | Empowering Men Initiative 7pm - 9pm Every 2nd & 4th Monday of Month | Available contact VAR for more details | Women A.S.K 7pm - 9pm Weekly | The Rainbow Project 6.30pm - 8.30pm Weekly | Available contact VAR for more details |

Live Inclusive - www.liveinclusive.org.uk
07769039614
catherine@liveinclusive.co.uk

RANSS - www.ranss.co.uk
01709 296262 mike@rpcf.co.uk

Nayi Zindagi
www.nayizindagi-newlife.org.uk
07542383655 rziahmj786@hotmail.co.uk

The Rainbow Project - www.trpr.co.uk
07729418490
tony@therainbowprojectrotherham.com

Headway - www.headwayrotherham.org.uk
07925224461
info@headwayrotherham.org.uk

Women A.S.K - www.womenask.co.uk
07581396306 alisonhiggs@hotmail.co.uk

Pen and Purpose - 07541 991265
hellopenandpurpose@gmail.com

Age UK Coffee Morning - 07988638355
madeleine.leaper@ageukrotherham.org

RCPF - www.rpcf.co.uk - 01709 296262
sharon.foster@rpcf.co.uk

Impressive Expression - 07769185804
impressive.expression3@gmail.com

YAWR Services - www.yawrservices.org
07512306827 makhmur@yawrservices.org

Empowering Men Initiative -
info@emicio.org
www.facebook.com/EmpoweringMenInitiative 07823422444

Memory Clinic Sessions - 03000 15100
rdash.rotherham-memory-service@nhs.net

Voluntary Action Rotherham, The Spectrum, Coke Hill
Rotherham S60 2HX
01709 829821 admin@varotherham.org.uk
www.varotherham.org.uk
Registered Charity Number: 1075895 - Limited Company Number: 2222190

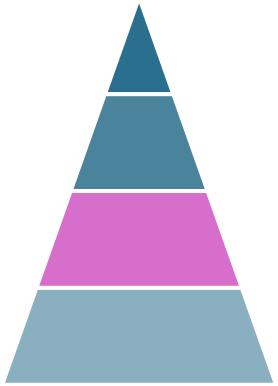
Please contact individual organisations for session info, group times and referral routes

# Primary Care – Integrated Mental Health Hubs

**Care provision for people living with SMI**

In the context of the CMHT this includes:

- psychosis, bipolar disorder, personality disorder diagnosis, eating disorders, severe depression and mental health rehabilitation needs
- May be co-existing with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use



Multi-Sector PCN MDT

Non-MDT direct referrals

**Mental Health Community Connector Service**

- Holistic Social Prescribing Assessment - what matters to you?
- Onward supported referral to physical health support
- Liaison with RMBC Housing/SPA/ASC as req'd
- Enablement to attend apts – Health check, Vaccinations, Dental

**Peer Support Service**

- Wellness Recovery Action Plan
- 1:1 Peer Support
- Group Peer Support

**Micro-Commissioned Support:**

- Walking Groups
- Community Gyms
- Leisure Ctr Induction
- Gardening groups
- Cooking & nutrition
- Walking Football
- Bat & Chat
- Women's Football
- Swimming

**8 Social Prescribing Community Hubs**

**Wider VCS**



Voluntary Action Rotherham

# Social Prescribing - Return on investment

Sheffield Hallam University's 4-year evaluation of the Rotherham Social Prescribing Service (published Aug 2024) identified:

- **Reduced in-patient admissions** for all patients who had been admitted to hospital more than twice in the 12months prior to RSPS support.
- **Reduced attendances at A&E** for patients below the age of 80 during the 12 months following RSPS support.

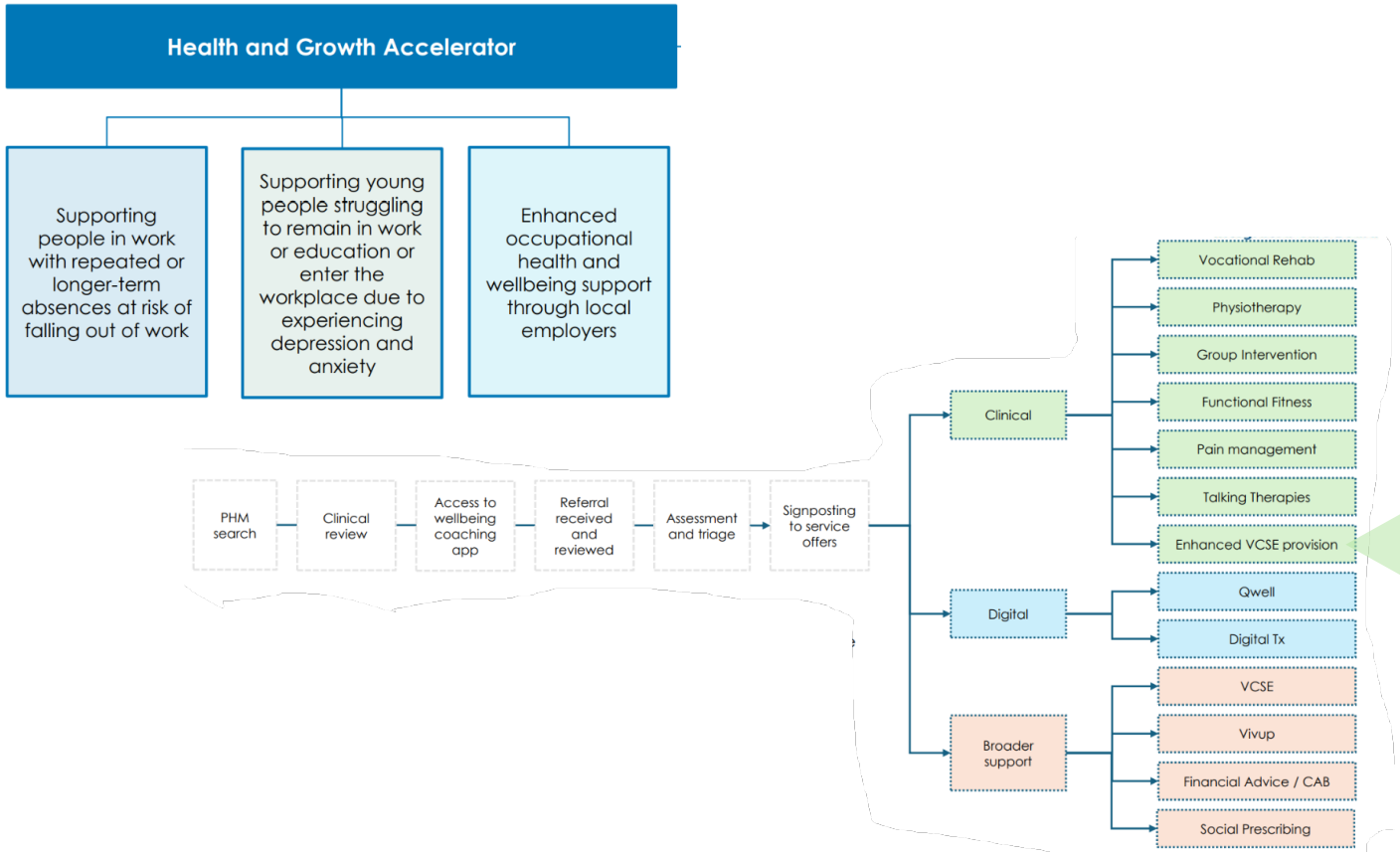
**2024/25 the service helped individuals secure £1.3m in additional benefits**

## National Evaluation of the Preventing and Tackling Mental Ill Health through Green Social Prescribing Project

The social return on investment from funding for natured-based voluntary, community and social enterprise (VCSE) providers, was £11.49 for each £1 invested.

The national evaluation used the **HM Treasury WELLBY methodology** – a form of social return on investment (SROI) to measure the **value for money of wellbeing improvements** for participants in nature-based activities.

# SY Health & Growth Accelerator – Enhanced VCSE provision




## Priority 1 - Provision for adults:

- Neurodiverse wellbeing walks and community allotment
- Gym based exercise and education
- Counselling, resilience workshops and talk and train sessions
- Cooking, allotment, sports, soft skills, weight mgt, addiction support
- Community gym, yoga, pilates, walking and strength training
- Boxing, fitness, soft skills, goal setting
- Nature-connection wellbeing walks, heritage sessions, gardening

Autism and ADHD Peer Support Service

ACTIVE FOR LIFE SOLUTIONS

mind Rotherham & Barnsley

ROTHERHAM UNITED COMMUNITY TRUST

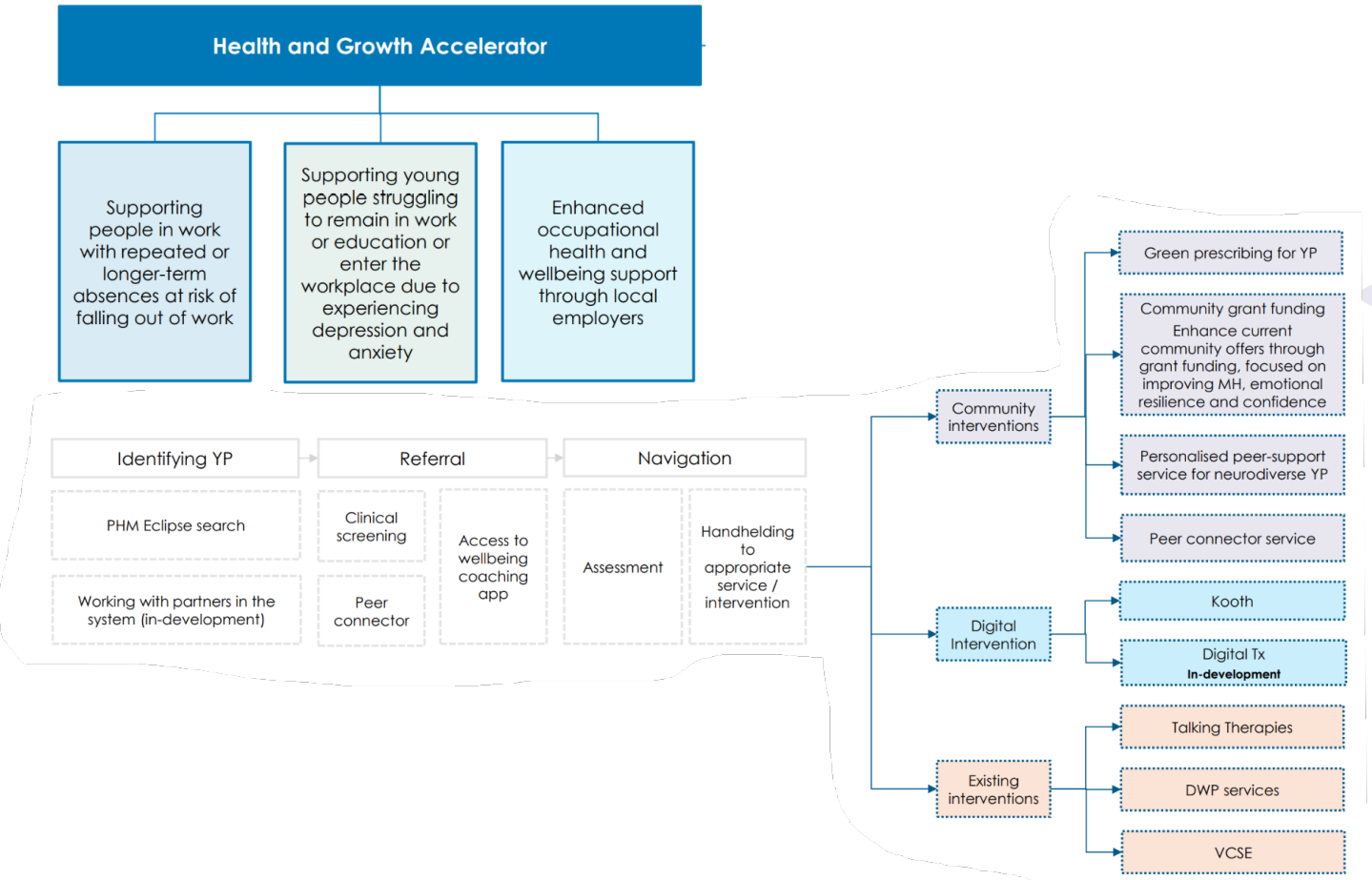
PIVOTAL

WITTER'S BOXING CLUB

Sheffield & Rotherham Wildlife Trust

YAWR Services You Asked : We Responded

# SY Health & Growth Accelerator – Enhanced VCSE provision




## Priority 2 Provision for
**Young People aged 16-24yrs:**

- Art, creative writing and group reflection
- Women & girls only creative therapies, walking & talking, trauma stabilisation
- Outdoor team building, digital, creative arts, gardening
- Online & in-person creative writing
- Neurodiverse wellbeing walks and community allotment



Voluntary Action Rotherham

# Children, Young People and Families' Consortium

STRONGER TOGETHER IN CHANGING LIVES

## 1) platform for vcs collaboration

We **facilitate collaboration** and promote excellent delivery standards by **uniting diverse organisations**, exchanging **skills, knowledge and learning**, sharing best practice and **enhancing community and service connections** in Rotherham.

## 2) joint-consortia projects

We **co-design** and **lead collaborative service models** to address local needs and strategic priorities, **empowering members** to deliver high-impact services more sustainably through **shared funding, pooled skills and expertise,** infrastructure support and **coordination.**

## 3) representation and Partnerships

We **represent our members** and the communities they service **strategically** and **promote partnership working** across sectors to ensure that members, children, young people and families have a **voice** to **influence** policy and **change** things for the better.

SMILES FOR MILES

TRFT Youth Worker Pilot Project

SY ICB Health Growth Accelerator Peer Connector Service

# SMILES FOR MILES

CYPF CONSORTIUM
EST. 03'
ROTHERHAM VCS

**FREE** open access youth groups, activities and support for children and young people aged 8-19 or up to 25 with SEND.

Led by the CYPF Consortium and delivered by 10 member organisations, the project began in 2021 and will run until 2027.

## The project so far...

4578 participants

6523 activities

36090 Attendances

# Voluntary Action Rotherham - VCS Health & Care Infrastructure

Rotherham Gismo

Community And Leisure

Health And Wellbeing

Information And Advice

rotherhamgismo.org.uk

Rotherham VCS Adult Health & Care Network

Growing connections, strengthening communities

RAMBLERS WELLBEING WALKS Rotherham

## Rotherham Social Prescribing Network

| | | |
|---|---|---|
| **BRIEFING** | **TO:** | Health and Wellbeing Board |
| | **DATE:** | Wednesday 26th November 2025 |
| | **LEAD OFFICER** | Lorna Quinn, Public Health Intelligence Principal |
| | **TITLE:** | Rotherham School survey |

**Background**

| | |
|---|---|
| **1.1** | In 2025, all 16 secondary schools in Rotherham participated in the survey along with 1 pupil referral unit, and students who are elective home educated. |
| **1.2** | The survey was open to all Students in Year 7 (ages 11 to 12) and Year 10 (ages 14 to 15) at secondary schools, pupil referral units, and those who are elective home educated. |
| **1.3** | Following consultation with young people, in 2024, several questions were made optional enabling young people to opt out if they feel the question is not relevant to them. |
| **1.4** | Where possible, the survey analyses trend data from previous surveys (including 2017, 2018, 2019, 2022, 2023 and 2024 – please note the survey was not undertaken in 2020 and 2021). However, response rates differ due to questions being optional and as such, it is not possible to assess trends for all questions. |
| **1.5** | To prevent any misinterpretation of findings, the report notes the findings as both a proportion of total respondents to a question, and as a proportion of total number of children in the year. |
| **1.6** | Inequalities have been considered throughout the report with each topic area reviewing data differences with gender, ethnicity, age, and health condition. |
| **1.7** | Findings from this report should be viewed alongside wider population data for the 0-25 population available on the Rotherham Joint Strategic Needs Assessment. |

**Key Issues**

| | |
|---|---|
| **2.1** | A report has been attached alongside this and the presentation delivered alongside this paper will consider the topics of mental health and wellbeing, health behaviours, and protective factors. |
| **2.2** | Areas that highlight an overall positive trend include a decrease in alcohol consumption, a decrease in regular smoking, a decrease in 'poor' physical health, and a decrease in students who do not eat breakfast. |
| **2.3** | Areas that highlight an overall worsening trend include an increase of year 10's regularly vaping, a decrease of oral health quantified by brushing more than once per day, an increase in poor mental health, and an increase in bullying. |

**Key Actions and Relevant Timelines**

| | |
|---|---|
| **3.1** | The survey is conducted each year and analysis conducted September-November. |
| **3.2** | The survey will move to the new consultation software in 2026. |
| **3.3** | Findings will be shared at Health and Wellbeing Board alongside other strategic meetings and with partners. |
| **Implications for Health Inequalities** | |
| **4.1** | This report considers findings across a range of characteristics including age (year 7 and year 10), ethnicity, gender, and whether people are living with a health condition. |
| **Recommendations** | |
| **5.1** | To note the findings of the School Survey Report for 2025. |

# Rotherham School Survey, 2025

## Summary of findings for Health and Wellbeing Board



This is a joint piece of work between Performance & Quality, Children and Young People's Services, and Public Health.

## Contents

# Acknowledgements

We would like to express our thanks to all the head teachers and staff at schools who coordinated the completion of the School Student Survey for 2025.

In 2025, all 16 secondary schools in Rotherham participated in the survey along with 1 pupil referral unit, and students who are elective home educated. This is the second year in which all 16 secondary schools have participated in the survey, after 2024. Schools participating in the survey gave their commitment to enable students to participate in the survey to have their voices be heard and to share their views on health, well-being, and safety in Rotherham and their local communities.

A small number of students said the school they attended was Swinton Lock, however this is an activity centre. It is unclear which school these students attended as a result.

We would like to thank the 4,602 students who participated and shared their views by participating in this year's survey:

- Year 7 – 2,519
- Year 10 – 2,083

The school numbers on roll taken from the spring census 2025 are below:

- Year 7 – 3,724
- Year 10 – 3,650

As such, the survey had a 62.4% participation rate, consistent with the participation rate of the 2024 survey of 62.7%.

# Background information

This report summarises the findings from the 2025 Rotherham School Student Survey for Year 7 and Year 10 pupils.

The survey was open to all students in Year 7 (ages 11 to 12) and Year 10 (ages 14 to 15) at secondary schools, pupil referral units, and those who are elective home educated.

The School Student Survey allows opportunity for young people in Rotherham to have their say about their health and wellbeing, and the things that impact on their lives; and it gives the council and their partners an insight into the experiences of children and young people living in the borough.

Responses to the survey provide important feedback to partners in relation to the services they provide to young people and are a rich source of information, which they can use to measure and monitor performance against their targets and objectives.

Schools receive an individual school report from the survey to assist them in gauging how well they are meeting their own health and wellbeing objectives, and to help shape their PSHE curriculum. This is considered outstanding practice and provides evidence in relation to Ofsted grade descriptors.

Information about the completion of the School Student Survey and the content of the survey are shared with parents and carers, and they are given the opportunity to ask their respective school any questions about the survey. Schools are encouraged to share their results with students, parents, and carers.

All questions, with the exception of several demographic questions, were made optional, enabling young people to opt out if they felt the question was not relevant to them. This follows from several questions being made optional in the 2024 survey. Therefore, please note, it is possible that total number of responses for each question will not always equal the total number of participants. Two sets of proportions will be shown in these results – the proportion of respondents who answered out of the total respondents, and the proportion of respondents who answered out of the total participants.

Where possible, the survey analyses trend data from previous surveys (including 2017, 2018, 2019, 2022, 2023 and 2024 – please note the survey was not undertaken in 2020 and 2021). However, the number of total participants differ due to questions being optional and as such, it is not possible to assess trends for all questions.

For the 2024 survey, there were additional updates to a number of questions to align with the National Health Behaviours in School Children (HBSC) survey 2021-22. This

is to allow for comparison of Rotherham data to national data, which may alter how the results compare to previous years. It should be noted that, as the most recent version of the national survey was completed in 2021-22, the gap in time may impact the comparisons with Rotherham data.

In the 2024 iteration of this survey, a system error meant students were not provided with all intended answer choices for six questions. For example, where they should have been provided five answer choices from 'Strongly Agree' to 'Strongly Disagree' they were only provided three choices from 'Agree' to 'Disagree'. This was fixed in this year's survey.

Skip logic has also been added, meaning that if a student answered 'no' to a particular question, they were not asked further questions about it. For instance, if a student was asked 'have you ever drunk alcohol?' and they answered 'no', they were not asked further questions about experiences with alcohol.

Colours within charts are done so that green means 'better' and red means 'worse'.

# Rotherham context

## 0-19 Population

Where possible, data is representative of the 0-19 population, however select information is only available below the age of 24.

The 2023 mid-year (30 June) estimates of population showed there are 63,673 0-19-year-olds living in Rotherham of which 30,919 are female and 32,754 are male.

| Age Group | Female | Male | All Persons | Total in the age group as a proportion of 0 - 19 population (%) |
|---|---|---|---|---|
| Aged 4 years and under | 7,185 | 7,708 | 14,893 | 23.4% |
| Aged 5 to 9 years | 7,992 | 8,244 | 16,236 | 25.5% |
| Aged 10 to 15 years | 8,362 | 8,696 | 17,058 | 26.8% |
| Aged 16 to 19 years | 7,380 | 8,106 | 15,486 | 24.3% |
| Total 0 to 19 years | 30,919 | 32,754 | 63,673 | 23.4% (of total population) |

Table 1: 0-19 population in Rotherham by age group and gender.

There are 29,914 single-family households with dependent children in Rotherham. The household composition of all families with dependent children are shown in table 2, below.

| Household Composition | Number of Families |
|---|---|
| Single family household: Married or civil partnership couple: Dependent children | 14,150 |
| Single family household: Cohabitating couple family: With dependent children | 7,151 |
| Single family household: Lone parent family: With dependent children | 8,613 |
| Multiple-family household: With dependent children | 2,401 |

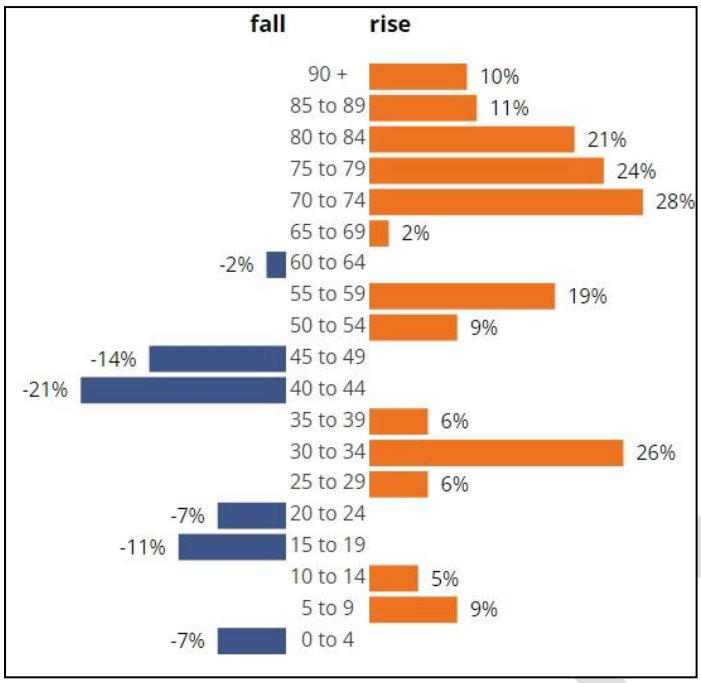
Table 2: Number of families in Rotherham by household composition.

More than 1 in 4 (28.8%) of the single-family households listed above are with a lone parent. This is close to the national rate of 2021-22 where 27.0% of single-family households with dependent children are with a lone parent.

## Change in population

Overall, the size of the 0 to 19 population in Rotherham has decreased from the 2011 Census. In 2021, there were approximately 700 fewer people in this age group (61,600 in 2021 compared to 62,300 in 2011). However, the age groups of those aged 5 to 9 and 10 to 14 have seen an overall increase.

The figure below shows the population difference across all age groups in Rotherham. The population size has increased by 3.3%, from around 257,300 in 2011 to 265,800 in 2021. Projections from the Office to National Statistics (ONS) suggest the 0-19 population will increase to 63,673 in 2031.




# Rotherham School Student Survey Demographics

## Academic Year

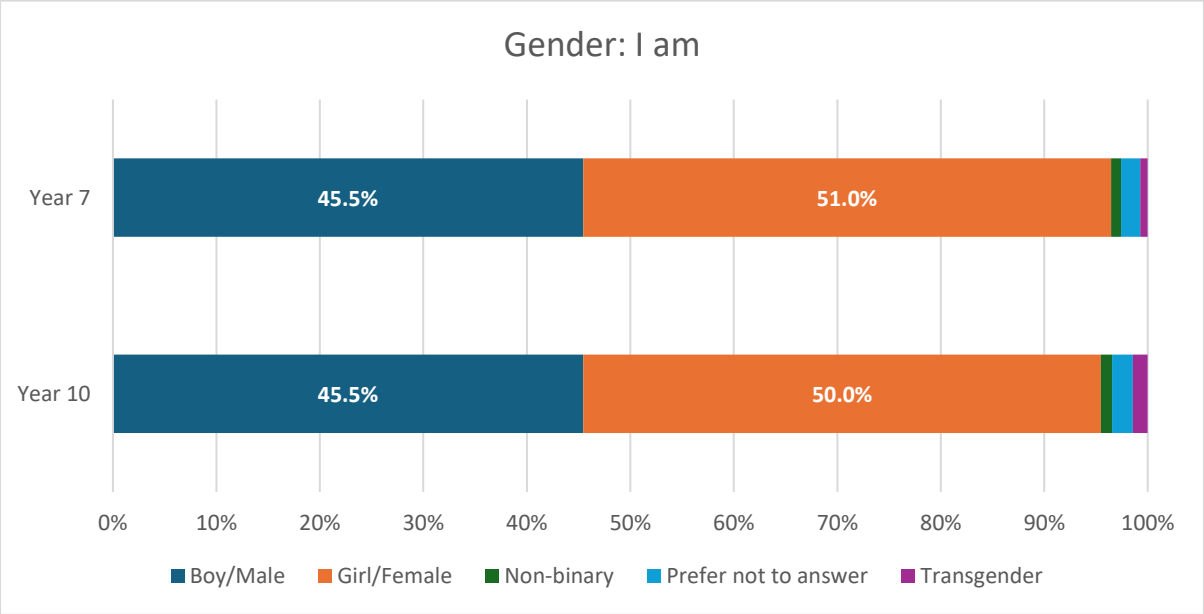
Out of the registered school population of 7,374 for those eligible, a total of 4,602 students completed the 2025 survey. By academic year, 2,519 (67.6%) of the 3,724 students in Year 7 and 2,083 (57.1%) of the 3,650 students in Year 10 participated in the 2025 survey. This is a 62.4% participation rate for the school survey, consistent with the participation rate of 62.7% in 2024.

## Gender

Overall, 50.6% of respondents identified as female, 45.5% identified as male, 1.0% identified as transgender, 1.0% identified as non-binary, and 1.9% preferred not to answer.

In the Year 7 cohort, 1,285 (51.0%) participants identified as female, 1,145 (45.5%) identified as male, 24 (1.0%) identified as non-binary, 18 (0.7%) identified as transgender, and 47 (1.9%) preferred not to answer.

In the Year 10 cohort, 1,042 (50.0%) participants identified as female, 947 (45.5%) identified as male, 22 (1.1%) identified as non-binary, 30 (1.4%) identified as transgender, and 42 (2.0%) preferred not to answer.




## Ethnicity

Altogether, 3,434 (75%) students stated they were White British. This is an increase from 72-73% of students for the previous surveys most recently (2022-2024).

A total of 993 (22%) described themselves as other ethnic groups, a decrease from 25% in 2024. 175 (4%) chose not to provide their ethnicity. Ethnicity proportions of students who responded are detailed in table 3, below.

| How would you describe your ethnicity? | Proportion of participants | Ethnicity of the under 24 population in Rotherham (2021 census) | Ethnicity of total population in Rotherham (2021 census) |
|---|---|---|---|
| White British | 74.6% | 82.4% | 88.3% |
| Pakistani | 6.8% | 6.1% | 3.8% |
| Prefer not to answer | 3.8% | | |
| Other White Background | 3.3% | 2.3% | 2.2% |
| African | 2.4% | 1.1% | 0.8% |
| Other Mixed Background | 2.1% | 0.6% | 0.3% |
| White and Asian | 1.3% | 1.2% | 0.5% |
| Other Asian Background | 0.9% | 1% | 0.7% |
| Indian | 0.7% | 0.6% | 0.5% |
| White and Black Caribbean | 0.7% | 1% | 0.4% |
| Gypsy/Roma | 0.6% | 0.5% | 0.3% |
| Arab | 0.5% | 0.5% | 0.3% |
| White and Black African | 0.5% | 0.6% | 0.2% |
| Chinese | 0.5% | 0.3% | 0.3% |
| Other Black Background | 0.4% | 0.4% | 0.2% |
| Bangladeshi | 0.2% | 0.1% | 0.05% |
| Caribbean | 0.2% | 0.1% | 0.1% |
| Traveller of Irish Heritage | 0.2% | 0.1% | 0.1% |

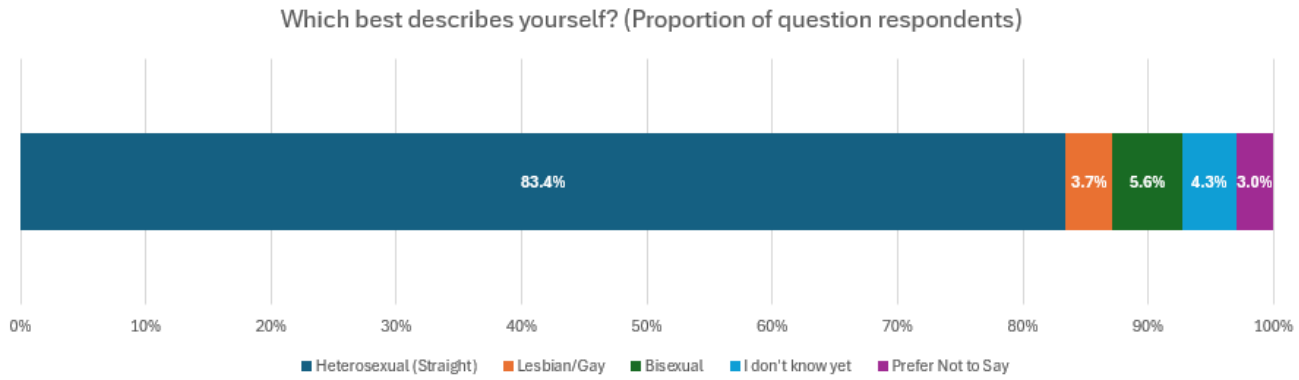
Table 3: Proportion of participants by ethnic group in the 2025 School Survey, compared with 2021 Census results.

## Sexuality

Only Year 10 students were asked about their sexuality, in contrast to previous survey years where both year groups were asked. A total of 2,062 students responded, 99.0% of total participants in Year 10:

- 1,720 (83.4%) respondents described themselves as heterosexual,
- 150 (7.3%) respondents preferred not to answer (62) or did not yet know (88)

- 115 (5.6%) respondents as bisexual,
- 77 (3.7%) respondents described themselves as lesbian or gay.

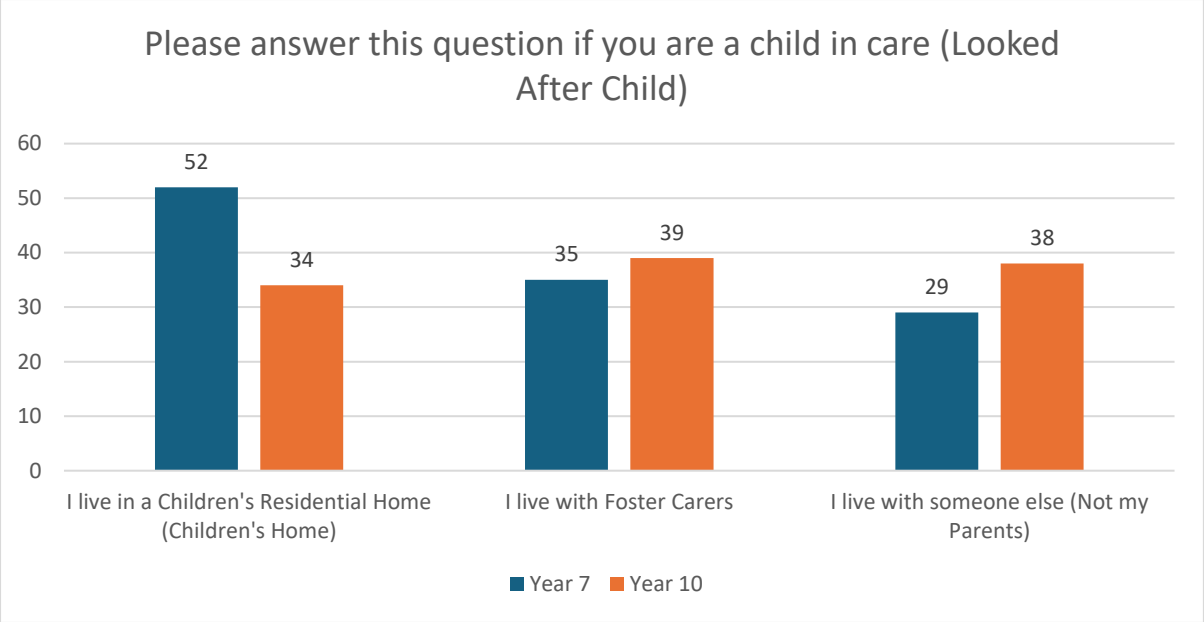



Similar results are seen globally in the Ipsos LGBT+ Pride 2021 Global Survey, where it was reported that on average 11% of people identified as a sexuality other than heterosexual, excluding those who said I don't know/Prefer not to say. This included lesbian/gay/homosexual, bisexual, pansexual/omnisexual and asexual. The global average was 9%.

## Children in Care

227 children stated they either live in a Children's Residential Home, with someone else (not their parents), or with Foster Carers; 116 in Year 7 and 111 in Year 10. This equates to 4.9% of the 4,602 participants, a slight decrease from 5.7% of participants in 2024.

Comparatively, Children in Care Data from Insight (internal RMBC system) shows 128 Children in Care from Years 7 and 10. In the survey, 86 students reported living in a Children's Residential home, 67 with someone else (not their parents), and 74 with Foster Carers.




| Looked After Children Data from Insight July 2025 | |
|---|---|
| **Year 7 Ages 11/12** | **Year 10 Ages 14/15** |
| 56 Children in Care | 72 Children in Care |

# Background

## Personal, Social, Health and Economic education (PSHE)

PHSE a statutory requirement for all state funded secondary schools in the UK to deliver relationships and sex education (RSE) and health education. National guidance states that the following topics are expected to be taught:

- families;
- respectful relationships (including friendships);
- online and media;
- being safe;
- intimate and sexual relationships (including sexual health);
- the laws around sex, relationships and young people;
- mental wellbeing;

- internet harms and safety;
- physical health and fitness;
- healthy eating; drugs, alcohol and tobacco;
- health and prevention;
- basic first aid;
- and the changing adolescent body.[1]

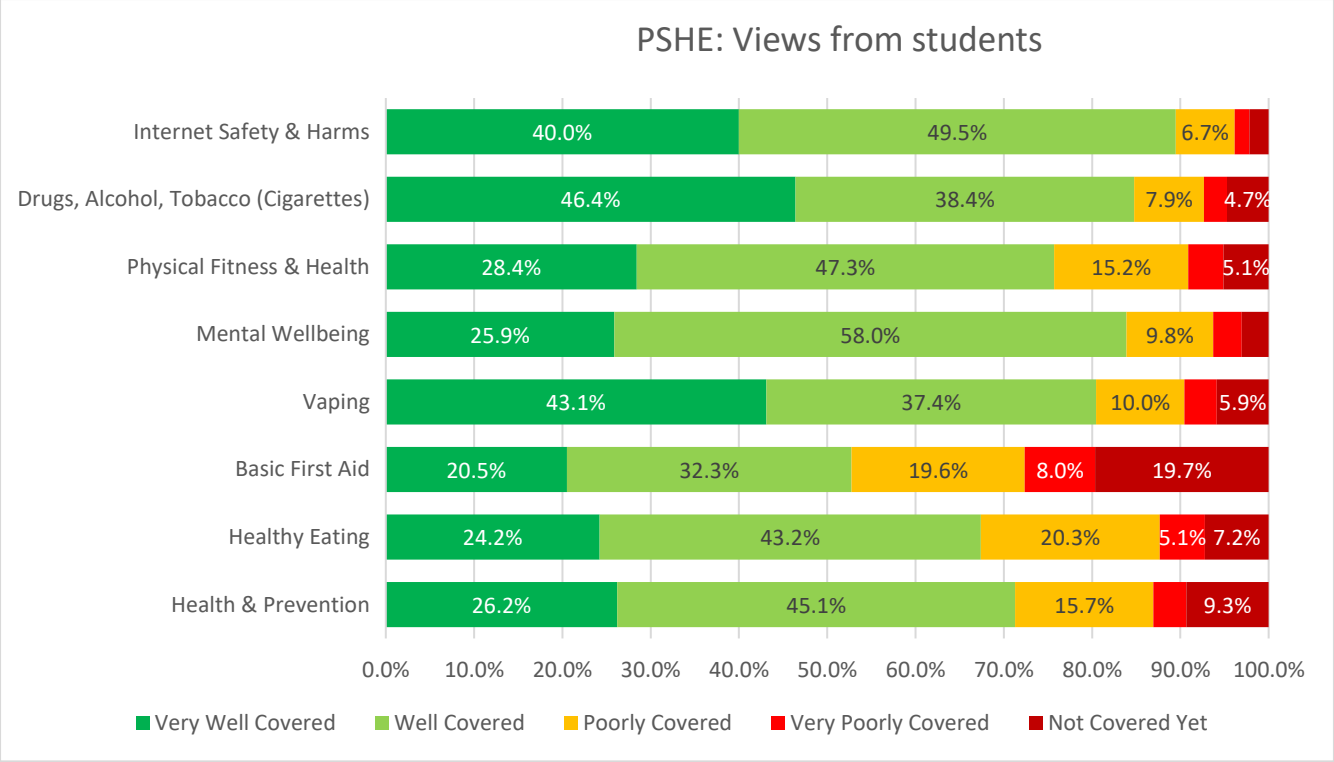
There are currently no standardised frameworks or programmes of study for state-funded secondary school's provision of PSHE education.[2] While some schools in Rotherham outline their PSHE curriculum, it is unclear how different schools teach certain subjects, especially when taking into account religious influence, parental pressure, external providers, or teacher and student availability.

The Government funds the PSHE Association to offer support for PSHE delivery, but there is freedom for schools to decide how best to deliver the content to avoid duplication in other subjects and to best meet the needs of their students. It is expected that RSE and health education content is taught across statutory subjects (for example, through the sciences, computing, PE, etc.) and may also be covered in dedicated PSHE lessons, assemblies, full day sessions, or tutor time to support and supplement statutory content. However, the frequency of PSHE and RSE lessons varies from school to school and from year to year; this can range from 30 minutes a week, to one 100-minute lesson a fortnight, to two lessons weekly.

It is also important to note that while RSE is compulsory, parents have the right to withdraw their child from sex education topics.[3]

Students were asked how well they thought Personal, Social, Health and Economic topics have been covered in school. A different number of students responded to each subject, ranging from 4,229 to 4,287 (91.9-93.2% of the total participants).

[1] Relationships and Sex Education (RSE) (Secondary) - GOV.UK
[2] Personal, social, health and economic (PSHE) education - GOV.UK
[3] Introduction to requirements - GOV.UK




- 83.9% (3,578) of respondents (4,265) felt mental wellbeing was well covered or very well covered. Overall, this was 77.7% of all participants in 2025.
- 89.5% (3,836) of respondents (4,287) felt internet safety and harms was well covered or very well covered. Overall, this was 83.4% of all participants in 2025.
- 75.7% (3,229) of respondents (4,266) felt physical fitness & health was well covered or very well covered. Overall, this was 70.2% of all participants in 2025.
- 67.4% (2,864) of respondents (4,249) felt healthy eating was well covered or very well covered. Overall, this was 62.2% of all participants in 2025.
- 84.8% (3,626) of respondents (4,277) felt the topics of Drugs, Alcohol, Tobacco (Cigarettes) were well covered or very well covered. Overall, this was 78.8% of all participants in 2025.
- 80.5% (3,431) of respondents (4,264) felt vaping was well covered or very well covered. Overall, this was 74.6% of all participants in 2025.

- 71.3% (3,015) of respondents (4,229) felt health & prevention was well covered or very well covered. Overall, this was 65.5% of all participants in 2025.
- 52.8% (2,249) of respondents (4,262) felt basic first aid was well covered or very well covered. Overall, this was 48.9% of all participants in 2025.

Across the eight subjects, on average 76% of respondents felt that PSHE topics were well covered, compared with 66% nationally as of 2021-22. Basic First Aid had the lowest proportion of respondents saying the subject was well covered, by 52.8% students compared with 51% nationally.

A higher proportion of Year 7 respondents than those in Year 10 reported to the eight subjects being 'Well Covered' or 'Very Well Covered' – 78.6% compared to 72.4% of respondents.

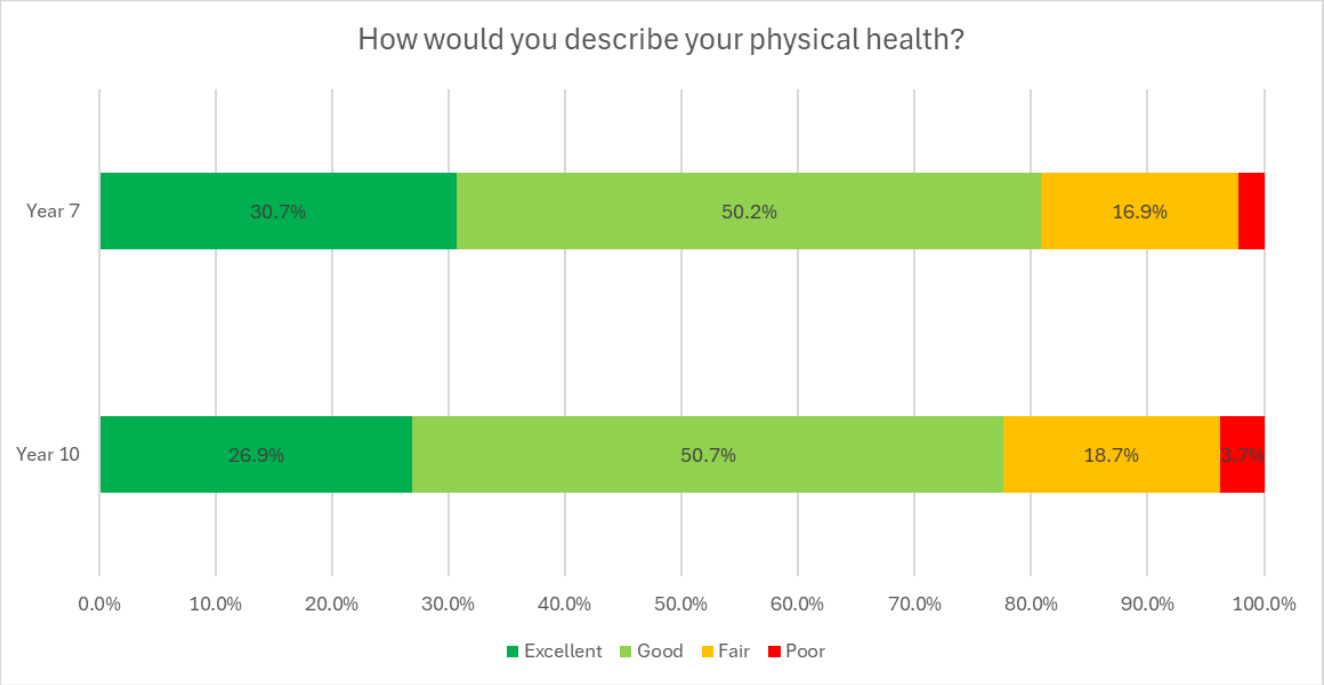
# Physical health

## Description of physical health

Students were asked 'How would you describe your physical health?' Overall, 4,320 students responded, 93.9% of total participants:

- 29.0% (1,251) of respondents described their physical health as 'excellent' (27.2% of total participants).
- 50.4% (2,178) of respondents described their physical health as 'good' (47.3% of total participants).
- 17.7% (765) of respondents described their physical health as 'fair' (16.6% of total participants).
- 2.9% (128) of respondents described their physical health as 'poor' (2.7% of total participants).

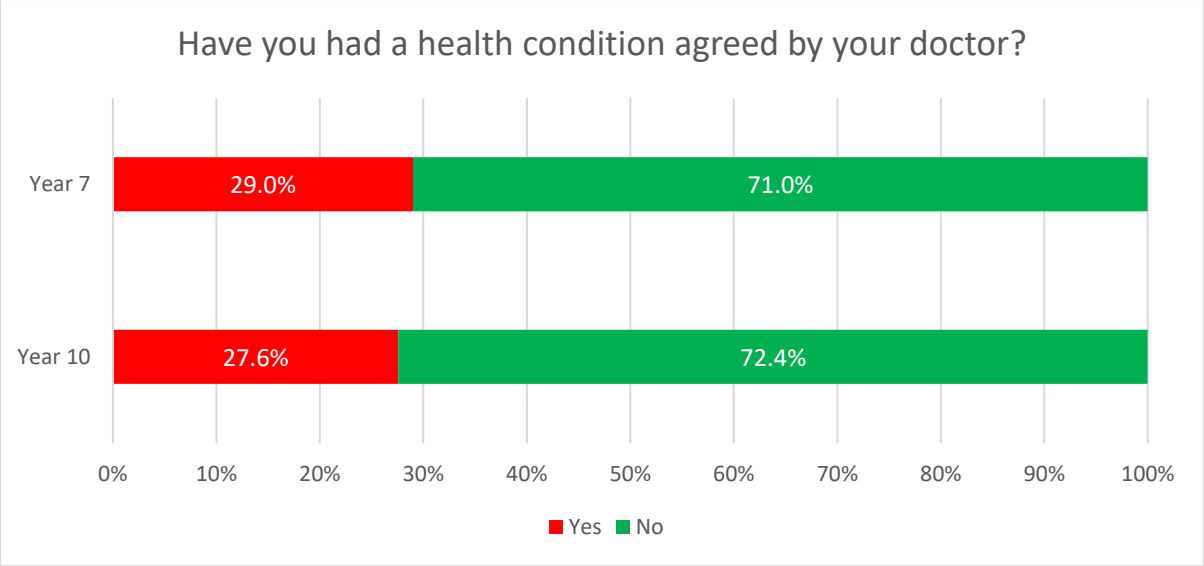
A higher proportion of Year 10 respondents rated their physical health as 'fair' or 'poor' compared to Year 7 respondents (22.4% for Year 10 and 19.1% for Year 7). This equates to 21.3% and 17.8% of total participants respectively.




## Health conditions

Students were asked, 'Have you had a health condition agreed by your doctor – these may include diabetes, asthma, allergies, epilepsy etc.' 4,249 students responded (92.3% of the total participants).

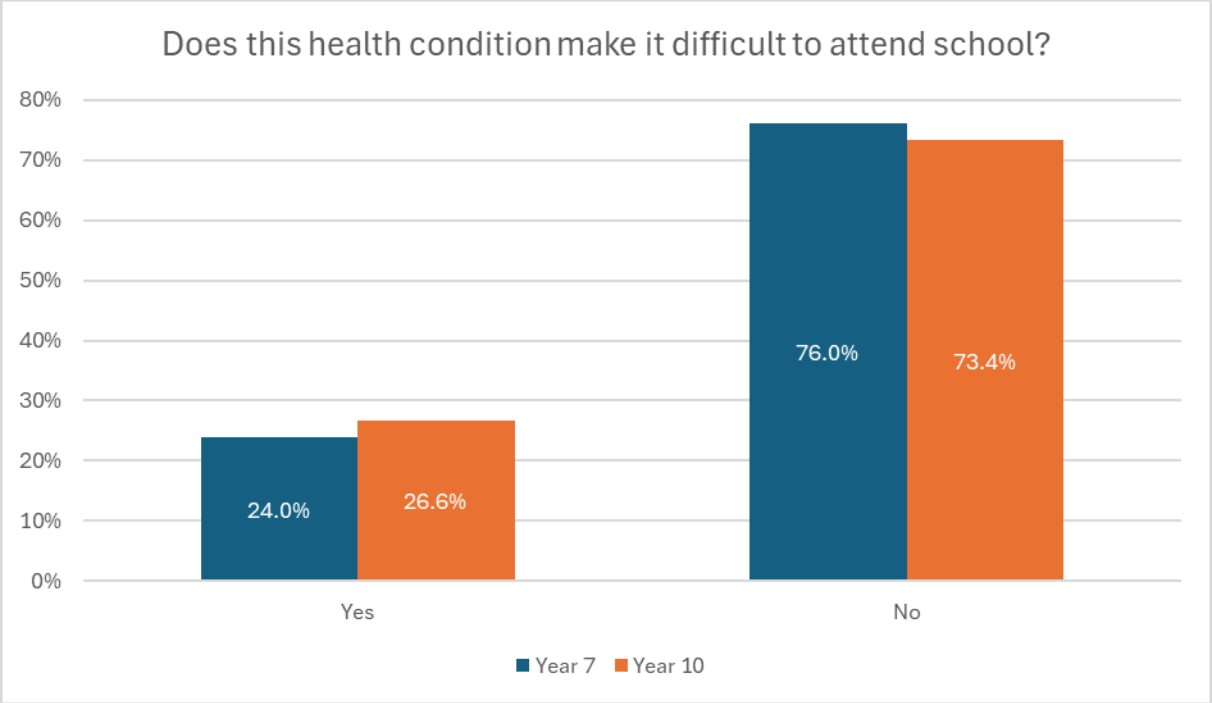
- 28.3% (1,204) respondents said they had a diagnosed health condition (26.2% of total participants).
- 71.7% (3,045) of respondents said 'no' (66.2% of total participants).
- This equates to 666 students in Year 7 and 538 students in Year 10.

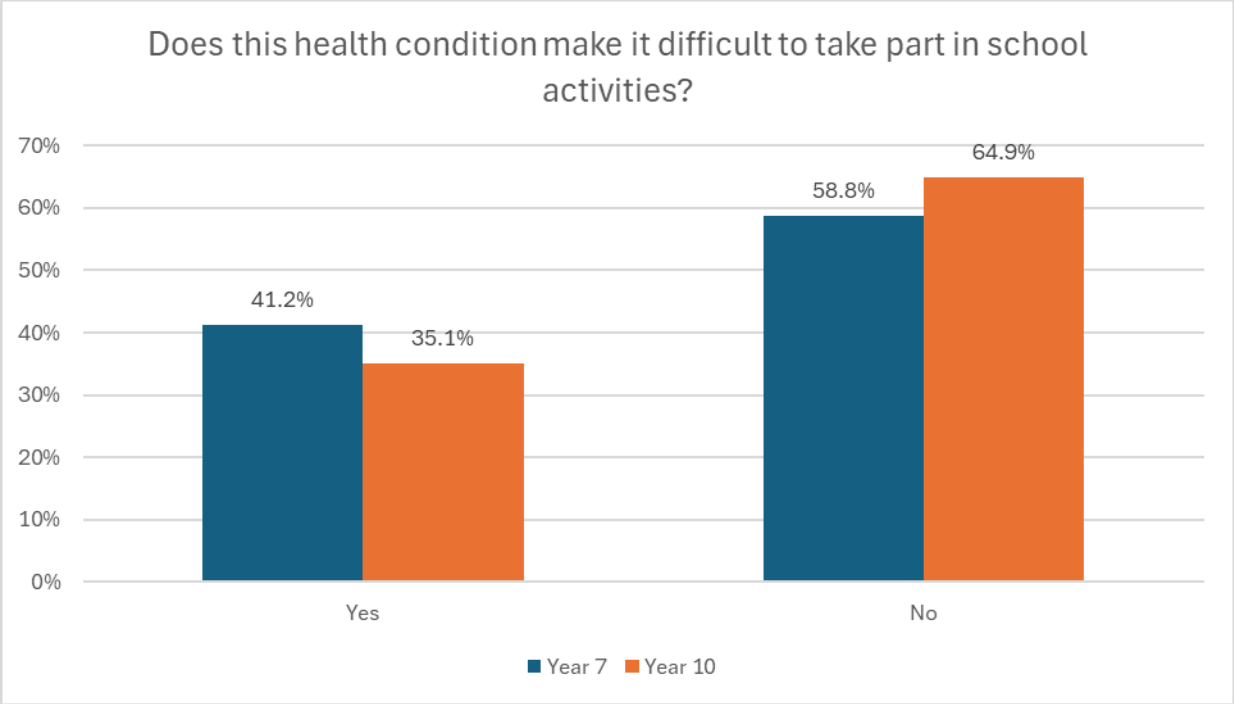



Students were then asked, 'Does this health condition make it difficult to attend school and/or take part in school activities?' They were able to answer separately for school attendance and for activities/participation. 1,209 students responded about the impact of their health condition on their school attendance, 5 more people than the number who said they had a health condition (26.3% of total participants). Meanwhile, 1,210 students responded about the impact of their health condition on participating in school activities. 1,169 students responded to both questions (25.4% of total participants):

- 304 (25.1%) respondents said their health condition impacts their school attendance (6.6% of total participants).
- A substantially larger proportion of respondents said their health condition impacts their participation in school activities (38.5%, 466, equating to 10.1% of total participants).

The proportion of girls who reported their health condition impacts their attendance at school was 27.4% and was 21.5% for boys.



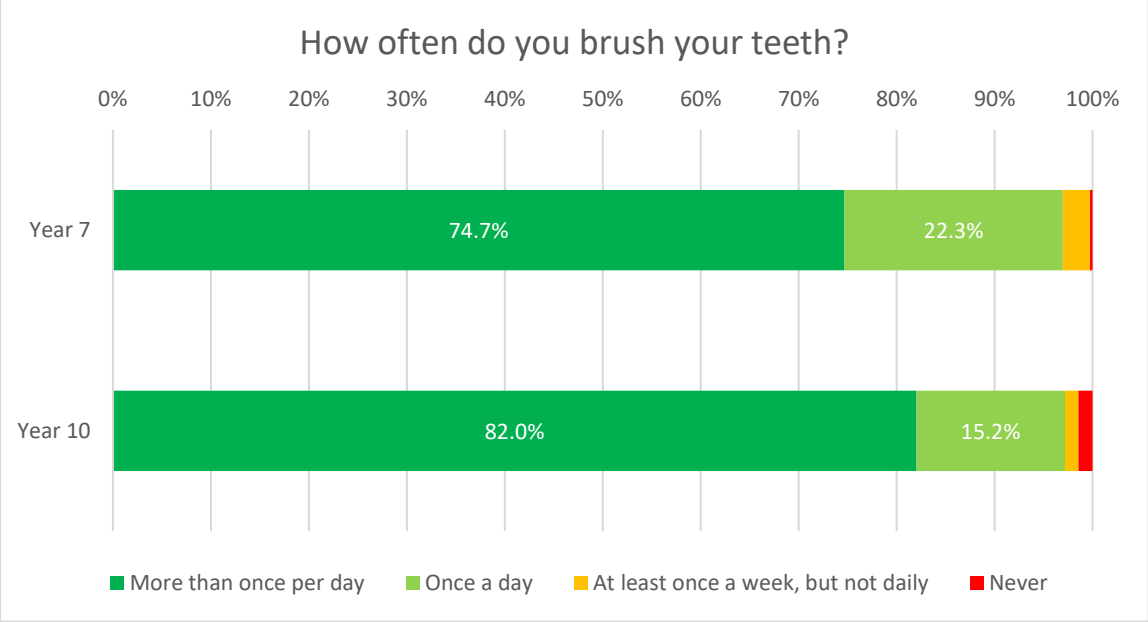

## Oral Health

When asked about whether they had been to a dentist in the last 12 months, 93.2% of total participants responded.

- 89.6% (3,845) of respondents reported that they had been to a dentist within the last 12 months (83.5% of total participants)
- There was little difference between older and younger students; 90.3% (2099) of Year 7 respondents said they 88.9% (1746) of those in Year 10 (83.3% and 83.8% of total participants respectively).

92.8% (4,269) of total participants responded when asked how often they brushed their teeth.

- Overall, 78.0% (3,331) of respondents reported that they brush their teeth more than once a day (72.4% of total survey participants).
- By academic year, a higher proportion of older students said they brush their teeth more than once a day:
    - 74.7% (1,730) of Year 7 respondents said they had compared to 82.0% (1,601) of those in Year 10 (68.7% and 76.9% of total participants respectively).
- 125 (2.9%) respondents reported they do not brush their teeth on a daily basis (2.7% of total participants).




By gender:

- 71.5% (1389) of boys who responded and 84.9% (1839) of girls who responded in Rotherham reported brushing their teeth more than once a day.

- Of total participants, this equates to 66.4% of boys and 79.0% of girls in Rotherham in 2025.

4,168 participants responded when asked if they had experienced toothache or other problems with their teeth in the last 12 months (90.6% of total participants):

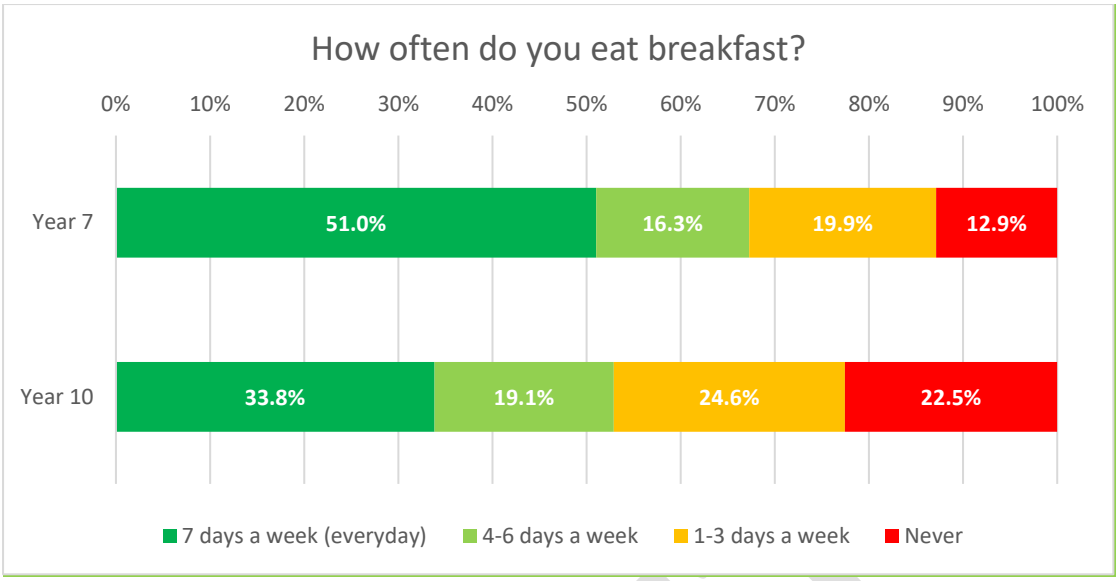
- 1,160 (27.8%) respondents said they had (25.2% of total participants)
- A similar proportion of boys who responded reported having toothache or other problems to girls – 27.5% and 27.8% of respondents.

## Eating Habits

Students were asked about their eating habits, including how often they ate breakfast and how many times per week they ate specific types of food and beverages.

4,109 students reported how often they eat breakfast during the week, 89.3% of total respondents:

- 43.1% (1,771) of respondents reported that they eat breakfast 7 days a week (38.5% of total participants).
- 17.5% (721) of respondents reported they eat 4-6 days a week (15.7% of total participants).
- 22.0% (905) reporting they eat breakfast 1-3 days a week (19.7% of total participants).
- 17.3% (712) of students reported that they never eat breakfast (15.5% of total participants).




By gender:

- A higher proportion of girls than boys who responded said they never eat breakfast; 20.4% (427) of girls compared to 12.4% (227) of boys:
    - Of total participants, this equates to 18.4% of girls and 10.9% of boys.
- A higher proportion of boys than girls who responded said they eat breakfast every day; 52.0% (961) of boys compared to 35.9% (754) of girls:

## Food Consumption

Students were asked about their food consumption across a number of categories. The top results are seen below:

- 1,978 (46.9%) respondents reported eating fruit and vegetables more than once a day (22.2% of total participants).
- 1,737 (41.6%) respondents reported eating meat at least once a day (37.7% of total participants).
- 1,220 (30.9%) respondents reported eating fish less than once per week, and 1,016 (25.7%) reporting that they never eat fish (24.3% and 22.1% of total participants).

- 1,344 (32.0%) respondents reported eating food high in fat and sugary snacks such as cakes and chocolates at least once per day (29.2% of total participants).
- 1,227 (29.3%) respondents reported eating foods high in salt such as crisps and ready meals 2-4 days per week (26.7% of total participants).
- 2,411 (58.3%) respondents reported eating takeaway meals less than once per week or never (52.4% of total participants).

### Fizzy drinks

Students were asked about their drink consumptions over a week. Survey responses can be seen in the figure below. Please note that last year, this question only had three drink categories: high energy drinks, regular sugary drinks and sugar-free drinks. This has changed this year to include water and remove the phrase fizzy from the categories.

- Water – 3,903 students responded (84.8% of total participants):
    - 3,127 (80.1%) respondents said they never drink water (67.9% of total participants).
    - 114 (2.9%) respondents said they never drink water (2.5% of total participants).
- Sugar-free drinks such as Coke Zero and other zero sugar drinks – 4,162 students responded (90.4% of total participants):
    - 597 (14.3%) respondents said they drink sugar-free drinks at least once a day (13.0% of total participants).
- Drinks that contain sugar, such as regular Coke, Pepsi, or Dr. Pepper – 4,212 students responded (91.5% of total participants):
    - 542 (12.9%) respondents said they drink drinks that contain sugar at least once a day (11.8% of total participants).

### High-energy drinks

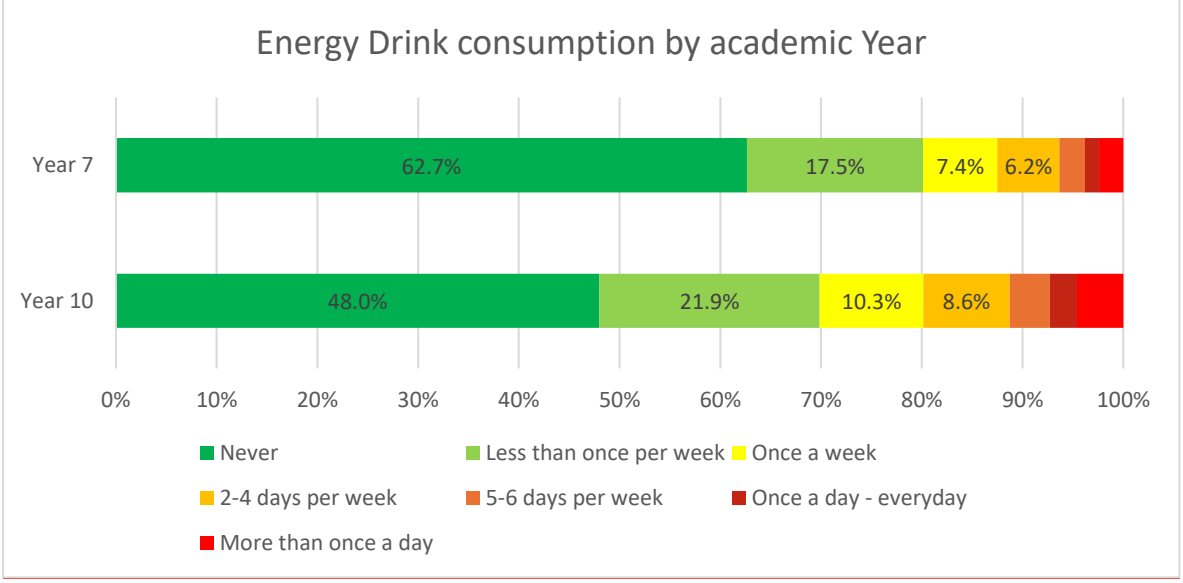
Students were asked about high-energy drink consumption, with 4,073 students responding (88.5% of total respondents). The figure below shows the high-energy drink consumption by academic year.

- 2,364 (56.0%) respondents said they never drink high energy drinks (51.4% of total participants)

- 1,191 (28.2%) drink one or less high energy drinks per week (25.9% of total participants)
- 307 (7.3%) drink high energy drinks per 2-4 days per week (6.7% of total participants),
- 135 (3.2%) drink high energy drinks per 5-6 days per week (2.9% of total participants),
- 228 (5.4%) drink high energy drinks at least once per day (5.0% of total participants),

Older students were more likely to drink energy drink than younger students, and more regularly:

- 62.7% of Year 7 respondents reported they never drink energy drinks, compared to 48.0% of Year 10 respondents (57.0% and 44.6% of total participants respectively).
- 3.8% of Year 7 respondents reported drinking energy drinks at least once a day, compared to 7.3% of Year 10 respondents (3.5% and 6.8% of total participants respectively).



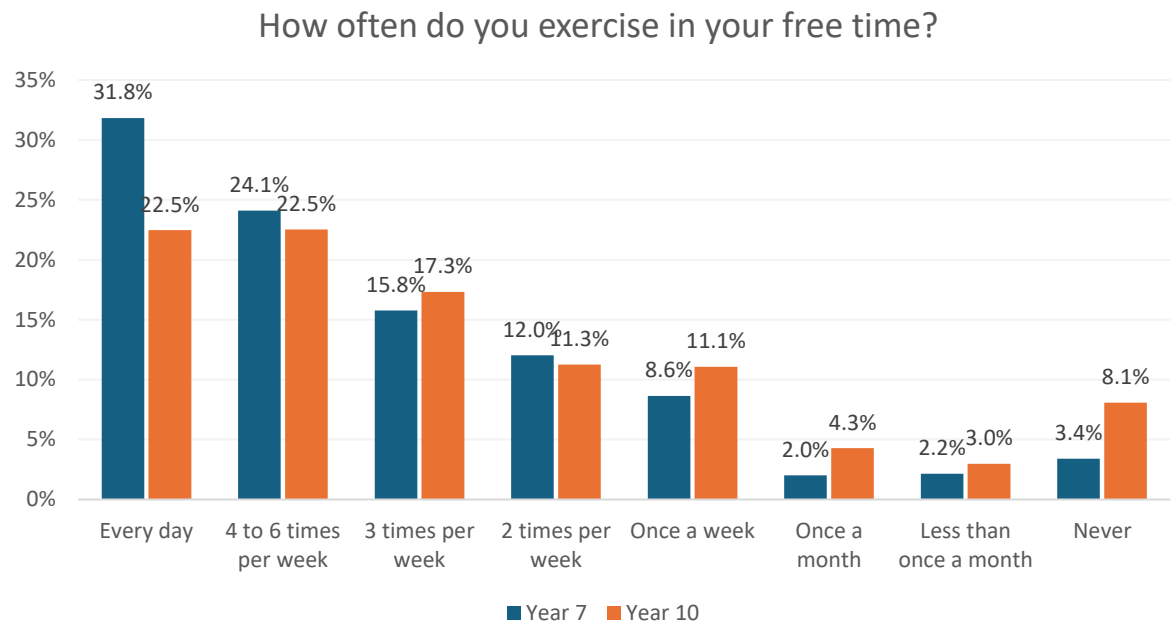
# Physical Activity and Body Image

## Physical Activity

Students were asked how often they exercise in their free time. 4,186 students responded, 90.9% of total participants.

The results are listed below and shown in the figure below:

- 232 (5.5%) respondents said they never take part in physical activity (5.0% of total participants)
- 106 (2.5%) respondents said they exercise less than once a month (2.3% of total participants)
- 128 (3.2%) respondents said they exercise once a month (2.8% of total participants)
- 408 (9.7%) respondents said they exercise once a week (8.9% of total participants)
- 489 (11.7%) respondents said they exercise 2 times per week (10.6% of total participants)
- 690 (16.5%) respondents said they exercise 3 times per week (15.0% of total participants)
- 979 (23.4%) respondents said they exercise 4 to 6 times per week (21.3% of total participants)
- 1,153 (27.6%) respondents said they exercise every day (25.1% of total participants)




## Active Travel

Students were asked how they travel to and from school. 4,176 students responded, 90.7% of total participants.

- 2,014 (48.2%) respondents said they walk (43.8% of total participants).
- 1,340 (32.1%) respondents said they travel by car (29.1% of total participants).
- 745 (17.8%) respondents said they take the bus (16.2% of total participants).
- 43 (1.0%) respondents said they cycle (0.9% of total participants).
- 15 (0.4%) respondents said they use an electric scooter (0.3% of total participants).
- 11 (0.3%) respondents said they take a train or tram (0.2% of total participants).
- 8 (0.2%) respondents said they use a manual scooter (0.2% of total participants).

## Body Image

Students were given statements to answer to around how feel about their body. For all statements, a higher proportion of girls than boys disagreed with positive

statements about their body image and agreed with negative statements about their body image.

In total, 4,165 participants responded to the statement “I am comfortable with my body” (90.5% of total participants).

Students were also asked if they had taken action to change the shape of their body during last 12 months. 4,095 people responded to the question (89.0% of total respondents). 2,118 (51.7%) respondents stated that they had (46.0% of total participants).

The most common changes reported were related to physical activity (exercise, gym/working out, and walking) reported by around 1 in 3 respondents (33.2%). Generic weight change was mentioned by around 1 in 4 respondents (25.8%) and changes to eating habits reported by around 1 in 10 (11.1%).

## Sexual Health

Questions on sexual health are only asked to Year 10 students except the school topics question.

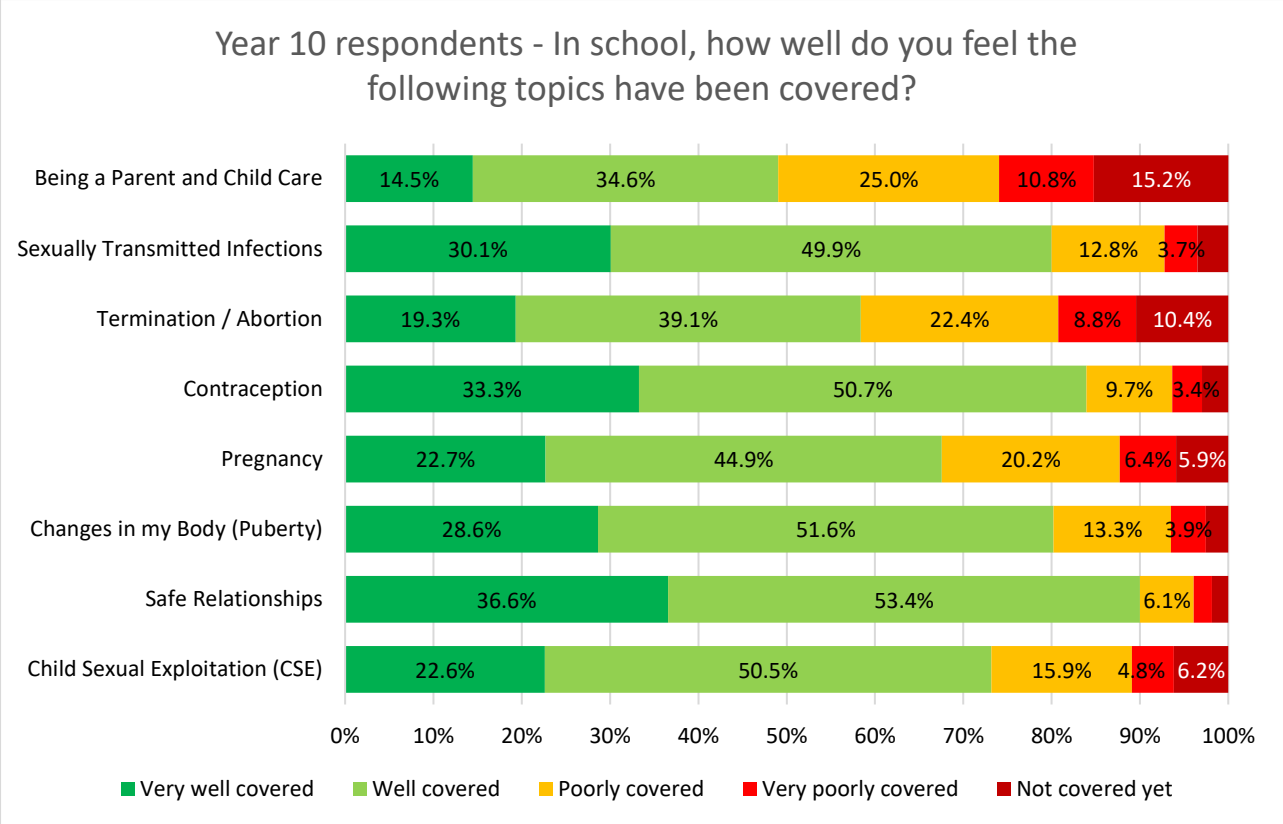
The first question aims to assess how well covered sexual health topics are on the school curriculum. The topic of Safe Relationships includes Anti-Bullying, Hate-Crime, Healthy Relationships, Respect, Consent in a Relationship, Relationship Abuse. The number of respondents for each topic ranged between 3,941 and 4,067 (85.6-88.4% of total participants).

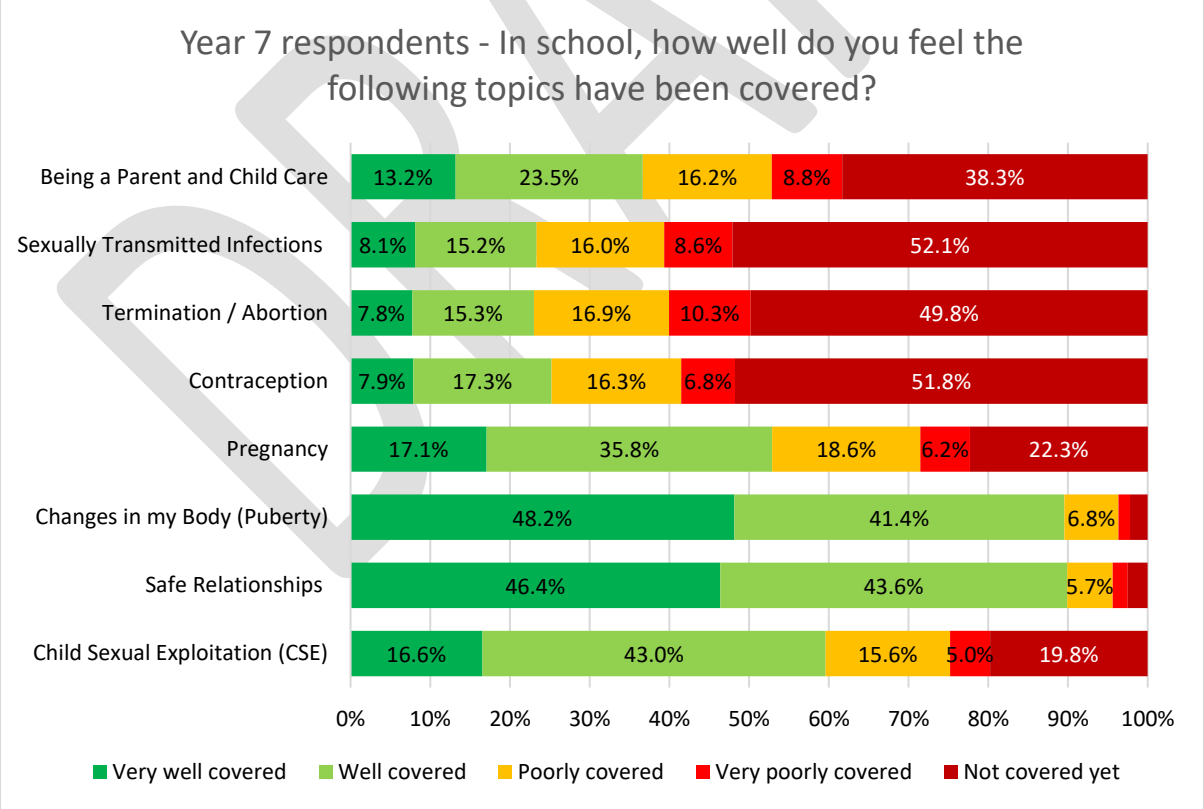
- Being a Parent and Child Care – 1,701 (42.3%) respondents reported this was very well covered or well covered:
    - Overall, this was 37.0% of all participants in 2025.
- Changes in my Body (Puberty) – 3,469 (85.3%) respondents reported this was very well covered or well covered:
    - Overall, this was 75.4% of all participants in 2025.
- Child Sexual Exploitation (CSE) – 2,665 (65.8%) respondents reported this was very well covered or well covered:
    - Overall, this was 57.9% of all participants in 2025.

- Contraception – 2,065 (52.4%) respondents reported this was very well covered or well covered:
    - Overall, this was 44.9% of all participants in 2025.
- Pregnancy – 2,406 (59.6%) respondents reported this was very well covered or well covered:
    - Overall, this was 52.3% of all participants in 2025.
- Safe Relationships – 3,652 (90.0%) respondents reported this was very well covered or well covered:
    - Overall, this was 79.4% of all participants in 2025.
- Sexually Transmitted Infections – 1,987 (49.2%) respondents reported this was very well covered or well covered:
    - Overall, this was 43.2% of all participants in 2025.
- Termination / Abortion – 1,576 (39.2%) respondents reported this was very well covered or well covered:
    - Overall, this was 34.2% of all participants in 2025.

In Year 10, the responses show that the most well covered topics are safe relationships, contraception, puberty and Sexually Transmitted Infections (STIs). The least well covered topic is Being a Parent and Child Care, with 15.2% of respondents not being taught about it and another 35.7% saying this topic was been poorly or very poorly covered (13.3% and 31.4% of total participants).

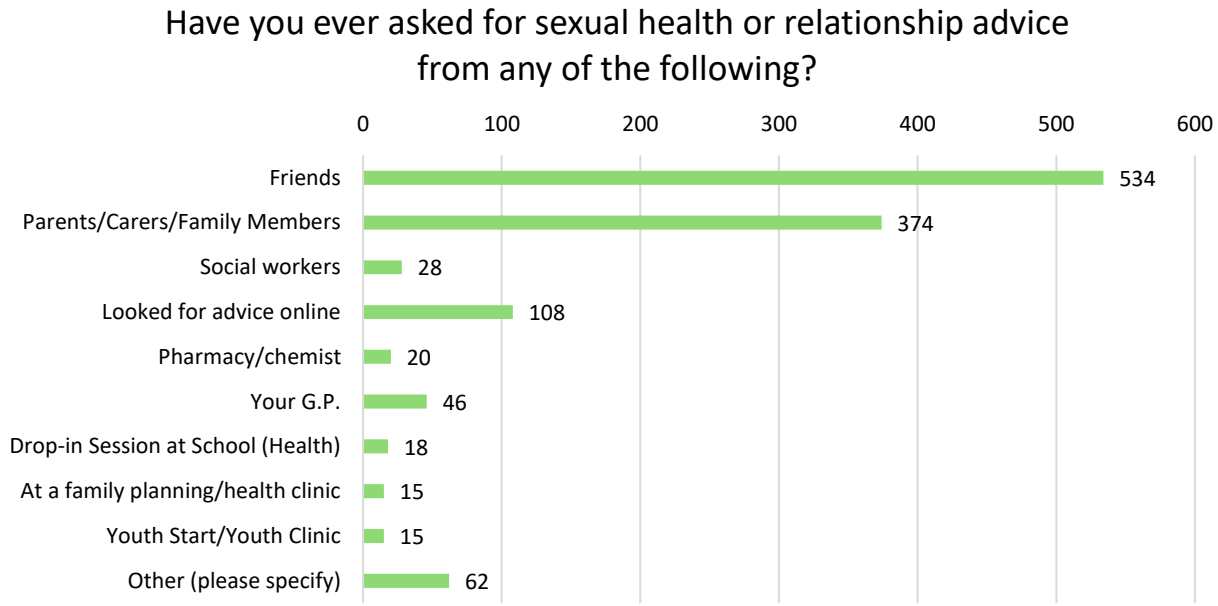
In Year 7, the best covered topics are safe relationships and puberty, and the least well covered topics are contraception, abortion and STIs. It is worth noting that some of these topics are not on the Year 7 curriculum currently so students would not be expected to have good coverage of these topics yet.


Year 10 respondents - In school, how well do you feel the following topics have been covered?
Being a Parent and Child Care
14.5%
34.6%
25.0%
10.8%
15.2%
Sexually Transmitted Infections
30.1%
49.9%
12.8%
3.7%
Termination / Abortion
19.3%
39.1%
22.4%
8.8%
10.4%
Contraception
33.3%
50.7%
9.7%
3.4%
Pregnancy
22.7%
44.9%
20.2%
6.4%
5.9%
Changes in my Body (Puberty)
28.6%
51.6%
13.3%
3.9%
Safe Relationships
36.6%
53.4%
6.1%
Child Sexual Exploitation (CSE)
22.6%
50.5%
15.9%
4.8%
6.2%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Very well covered
Well covered
Poorly covered
Very poorly covered
Not covered yet


Year 7 respondents - In school, how well do you feel the following topics have been covered?
Being a Parent and Child Care
13.2%
23.5%
16.2%
8.8%
38.3%
Sexually Transmitted Infections
8.1%
15.2%
16.0%
8.6%
52.1%
Termination / Abortion
7.8%
15.3%
16.9%
10.3%
49.8%
Contraception
7.9%
17.3%
16.3%
6.8%
51.8%
Pregnancy
17.1%
35.8%
18.6%
6.2%
22.3%
Changes in my Body (Puberty)
48.2%
41.4%
6.8%
Safe Relationships
46.4%
43.6%
5.7%
Child Sexual Exploitation (CSE)
16.6%
43.0%
15.6%
5.0%
19.8%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Very well covered
Well covered
Poorly covered
Very poorly covered
Not covered yet

Year 10 students were then asked if they have ever asked for sexual health advice and if so, who from. 1,666 students answered this question, 80.0% of total Year 10 participants.

- 988 responded that they have not needed to ask for any sexual health advice (59.3% of respondents, 47.4% of total participants).
- The most popular people/places to ask for advice is from friends and family, with many students asking more than one source.
    - Friends – 534 (32.1%) respondents, 25.6% of total participants.
    - Family (Parents/Carers/Family Members) – 374 (22.5%) respondents, 18.0% of total participants.




# Mental Wellbeing

## How would you describe your mental health?

Students were asked how they would describe their mental health on a scale of 'Excellent' to 'Poor'. 4,011 students responded, 87.2% of total participants.

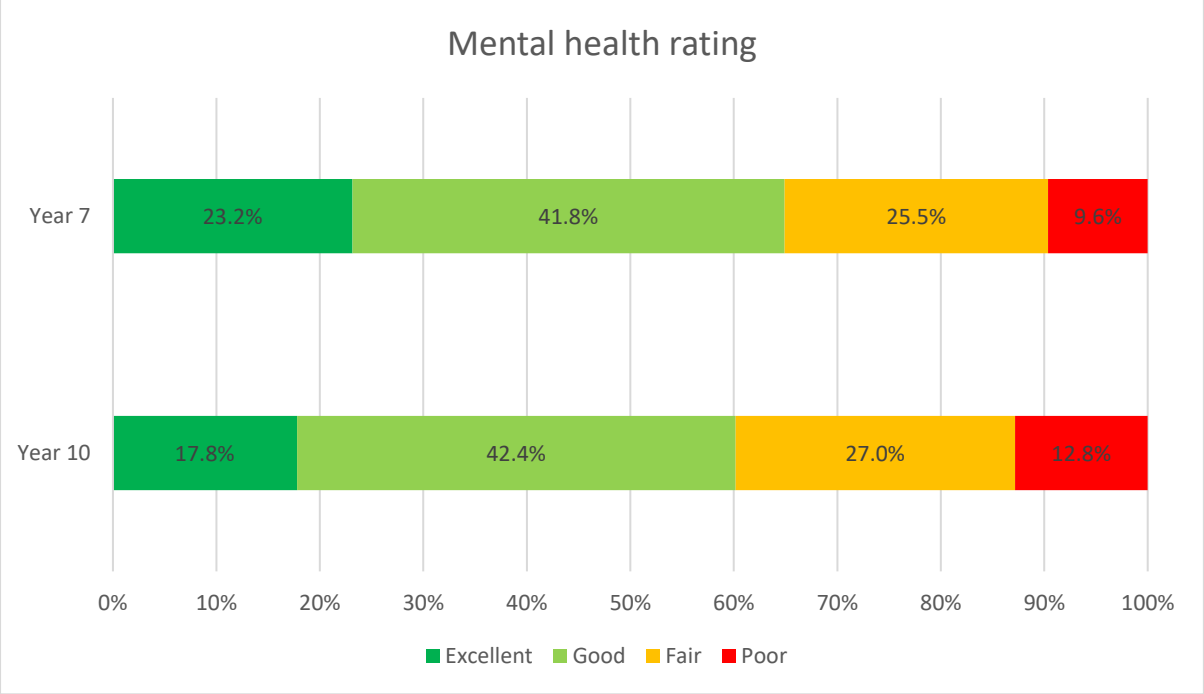
Overall:

- 62.8% of respondents rated their mental health as either good or excellent (2,513, 54.6% of total participants).

- 37.2% of respondents rated their mental health as either fair or poor (2,513, 54.6% of total participants).
    - 11.1% of respondents rated their mental health as poor (443, 9.6% of total participants).

By academic year:

- Year 7
    - 64.9% of Year 7 respondents rated their mental health as either good or excellent (56.5% of total participants).
- Year 10
    - 60.2% of respondents in Year 10 rated their mental health as good or excellent (52.3% of total participants).



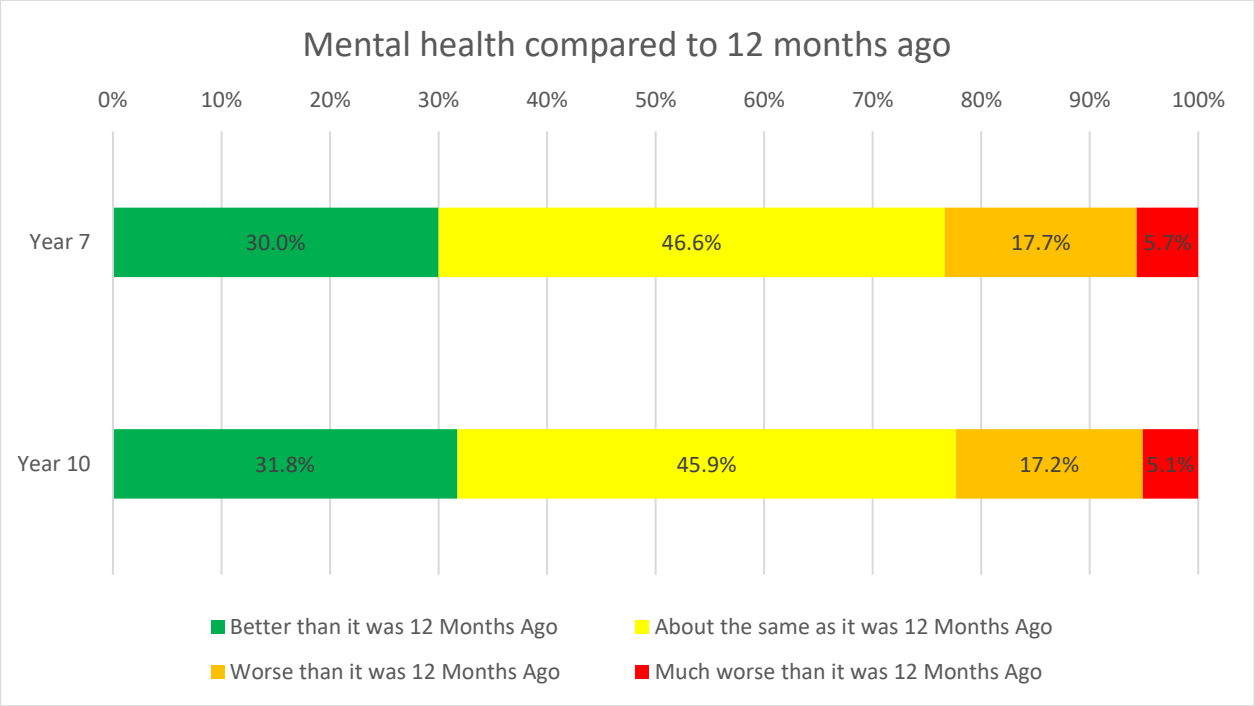

## Change in Mental Health Over the Last 12 Months

When asked about the change in their mental health over the past 12 months, 4,026 students responded (87.5% of total participants).

- 1,240 (30.8%) respondents said their mental health was better than it was 12 months ago (26.9% of total participants).

- 1,864 (46.3%) respondents said their mental health was about the same as it was 12 months ago (40.5% of total participants).
- 922 (22.9%) respondents said their mental health was worse or much worse than it was 12 months ago (20.0% of total participants).
    - 702 said it was worse.
    - 218 said it was much worse.

There was relatively little difference between older and younger respondents. These results indicate that younger and older students share similar support needs and reinforce the importance of accessible and age-appropriate mental health support across both year groups.




Alongside having a higher proportion who described their mental health as being ‘fair’ or ‘poor’, a substantially higher proportion of girls who responded to the question about a change in their mental health said that it had gotten worse or much worse in the last 12 months than boys (28.2% compared to 15.2%). Of total

participants, this equates to 24.7% of girls and 13.4% of boys. Additionally, a higher proportion of respondents with a diagnosed health condition said their mental health had gotten worse or much worse in the last 12 months than boys (26.0% compared to 22.9%). Of total participants, this equates to 24.4% of those with a health condition and 20.0% of all participants.

## Strategies Used to Support Mental Health

Students were asked to select what support strategies they used for their mental health and were able to select multiple activities. There was a low response rate to this question, with only 1,247 students responding (27.1% of participants).

- A substantial proportion of respondents said they used physical activities:
    - 819 (65.7%) respondents reported to being active and starting a new activity (17.8% of total participants).
    - 476 (38.2%) respondents reported to trying a new sport (10.3% of total participants).
    - 279 (22.4%) respondents reported to trying a new sport (6.1% of total participants).
    - 117 (9.4%) of respondents reported to doing yoga or meditating (2.5% of total participants).
- A number of respondents said they had talked to people they knew or made contact with professionals:
    - 636 (51.0%) respondents reported to setting aside time to talk with family and/or friends (13.8% of total participants).
    - 442 (35.4%) respondents reported to talking with staff at school (9.6% of total participants).
    - 265 (21.3%) respondents reported they had made contact with professional support (5.8% of total participants).
- A number of respondents said they took part in creative activities:
    - 453 (36.3%) respondents reported to learning a new skill (9.8% of total participants).
    - 340 (27.3%) respondents reported to reading books they like (7.4% of total participants).
    - 104 (8.3%) respondents reported to taking part in a local event, such as the Children Capital of Culture (2.3% of total participants).

- A number of respondents said they engaged in routines, sought information, or volunteered:
    - 461 (37.0%) respondents reported to setting a daily routine for themselves (10.0% of total participants).
    - 285 (22.9%) respondents reported to using information on social media, 239 (19.2%) searched for information on the internet, and 192 (15.4%) used apps for advice (6.2%, 5.2% and 4.2% of total participants respectively).
    - 98 (7.9%) respondents reported to volunteering in their local community (2.1% of total participants).
    - 74 (5.9%) respondents reported to reading self-help books (1.6% of total participants).

By academic year:

- Year 7:
    - A higher proportion of Year 7 respondents were more likely than those in Year 10 to engage in active and creative coping strategies, such as trying new sports and learning new skills.
    - The most reported strategies were physical activity and social support, indicating a strong preference for informal methods of coping.
- Year 10
    - A higher proportion of Year 10 respondents reported engagement with school staff and professional support compared to Year 7. However, informal strategies—particularly physical activity and social support—remained dominant.

| Strategy to support MH | Total % | Year 7 | Year 10 |
|---|---|---|---|
| Being active - Started a new activity e.g. Riding a bike, walking etc | 65.7% | 71.6% | 56.9% |
| Set aside time to talk with family and/or friends | 51.0% | 53.8% | 46.9% |
| Tried a new sport | 38.2% | 49.9% | 20.8% |
| Set myself a daily routine | 37.0% | 40.9% | 31.1% |
| Learned a new skill | 36.3% | 47.5% | 19.8% |
| Talked with staff at school | 35.4% | 34.9% | 36.3% |
| Read books I like | 27.3% | 30.2% | 23.0% |
| Used information on social media | 22.9% | 24.3% | 20.8% |

| | | | |
|---|---|---|---|
| Signed up to the gym or exercise group | 22.4% | 20.8% | 24.8% |
| Made contact - with professional support (GP, Mental Health Service, Voluntary Support) | 21.3% | 16.2% | 28.7% |
| Searched for information on the internet | 19.2% | 22.0% | 15.0% |
| Used Apps for support advice | 15.4% | 14.7% | 16.4% |
| Meditation or Yoga | 9.4% | 10.9% | 7.2% |
| Took part in a local event (Children Capital of Culture, Rotherham Show etc.) | 8.3% | 11.0% | 4.4% |
| Given my time - volunteered in the local community | 7.9% | 8.4% | 7.0% |
| Read self-help books | 5.9% | 7.1% | 4.2% |
| Other - Please say if you did something different | 24.8% | 31.2% | 15.2% |

Of the students that responded to the question about strategies to support their mental health, 309 students responded ‘other’ (24.8% of respondents). Of the 309 students that responded 'other’, 283 responses could be analysed. This equates to 22.7% of respondents.

Themes included:

- Hobbies – 145 respondents
    - This including physical activities, such as exercise, sports and walking.
    - This also included creative activities, including writing, drawing and singing.
    - Listening to music.
    - Physical activity – 73 respondents
        - Group activities such as dancing and football.
        - Solo activities, primarily exercise and going to the gym.
    - Creative activities – 39 respondents
        - This included group activities, such as dancing, singing and acting.
        - Respondents also talking about activities they did on their own, such as baking, writing and drawing.
- Family and friends – 58 respondents.
    - Friends were mentioned more often than family; friends were mentioned 42 times, whilst family was mentioned 20 times.
- General self-soothing techniques – 38 respondents
    - Including sleeping, writing about feelings and spending time with pets.
- Support from professionals – 36 respondents

- This was primarily therapy and counselling.

## What Support is Most Important for Improving Mental Health?

Across both year groups, safe spaces to chat were identified as the most valued form of support. 3,704 students responded, 80.5% of total participants:

- 1,229 (33.2%) respondents said safe spaces to be able to chat with other young people either in person or online were most important (26.7% of total participants).
- 507 (13.7%) respondents said online support was most important (11.0% of total participants).
- 444 (12.0%) respondents said their school sharing information of where support can be accessed was most important (9.6% of total participants).
- 350 (9.4%) respondents said a wellbeing guide for young people was most important (7.6% of total participants).
- 140 (3.8%) respondents said more information being available on social media was most important (3.0% of total participants).
- 82 (2.2%) respondents said telephone support was most important (1.8% of total participants).
- 74 (2.0%) respondents said online lessons or programmes on TV was most important (1.6% of total participants).

These preferences are consistent with 2024 findings, which highlighted a continued preference for informal and peer-based support among younger students.

872 students responded ‘other’, 23.5% of respondents. However, this decreased to 826 students when excluding participants who said that they were not lonely 'most of the time' or 'always', misunderstood the question or gave an inappropriate response. This equates to 22.3% of respondents. Themes included:

- Talking to others - 249 respondents
  - Several respondents specified the importance of this being someone that they trusted.
- Family - 222 respondents
- Friends - 151 respondents

- Therapy or counselling - 80 respondents
    - Several mentioned they wanted this in a face-to-face setting.
    - Some wanted this support to be in school, whilst some said they wanted it out of school.
- Benefits of physical activities and sports - 68 respondents
    - This included group sports like football or going to the gym.
    - It also included going outside and going for a walk, such as walking the dog.
    - Several respondents specified doing these activities with others or on their own.
- The need for support from their school or issues with school that needed to be addressed - 50 respondents
    - This included taking actions to prevent bullying or check on students' mental health.
    - People expressed a desire to talk to teachers or a trained counsellor.
    - 15 of these mentioned issues with school, including wanting less pressure on them
- A small number of students talked about their mental health being bad, such as crying.
- A small number of students mentioned explicitly the need for a safe space, including a safe environment in which to talk about their feelings.
- 62 respondents said they didn't know.

| What support do you think is most important for improving mental health? | Total % | Year 7 % | Year 10 % |
|---|---|---|---|
| Safe spaces to be able to chat with other young people either in person or online | 33.2% | 33.1% | 33.3% |
| Online support | 13.7% | 12.2% | 15.5% |
| School sharing information of where support can be accessed | 12.0% | 12.7% | 11.1% |
| A Wellbeing Guide for Young People | 9.4% | 9.8% | 9.0% |
| More information available on social media | 3.8% | 2.3% | 5.6% |
| Telephone support | 2.2% | 2.3% | 2.1% |
| Online lessons or programmes on TV | 2.0% | 1.7% | 2.3% |
| Other - Please add any ideas you may have on how to support young people with their mental health | 23.7% | 25.8% | 21.0% |

## What support would you like to see more of?

This was a free-text question, allowing respondents to say what support they would like to see more of in their own words. Overall, 2,346 students responded to this question, 50.1% of total participants.

Excluding responses who said "nothing" or that they didn't know resulted in 1635 responses (35.5% of total participants).

- Mental Health Support – 544 respondents
- One-to-One and Trusted Conversations – 354 respondents
- Support in school – 323 respondents
- Physical Health and Activities – 250 respondents
- Peer and Family Support – 202 respondents
- Online and Anonymous Support – 149 respondents
- Safe Spaces and Environment – 96 respondents
- Education and Life Skills – 79 respondents
- Bullying – 33 respondents
- Other – 518 respondents

## Awareness and Use of Mental Health Support

Students were asked a range of questions about mental health support, and the number of respondents for all but one of the questions ranged from 3,869-3,915 respondents (84.1-85.1% of total participants). For the question 'If you have had contact with With Me In Mind, would you recommend this service to a friend?', 3,542 students responded (77.0% of total participants).

Participants were asked several questions about the service With Me In Mind, a mental health support team that supports children and young people aged 5 to 19. While general awareness was moderate, actual usage and understanding of access routes remained low, reinforcing the need for better promotion and clearer pathways to support:

- 1,950 (49.8%) respondents said they had heard of the service (42.4% of total participants).

- 1,200 (30.8%) respondents said they knew how to access the service (26.1% of total participants).
- 471 (12.1%) respondents said they knew how to access the service (10.2% of total participants).
- 548 (14.1%) respondents said they had joined in an activity supported by With Me In Mind (11.9% of total participants).
- 925 (26.1%) respondents said would recommend With Me In Mind to a friend (20.1% of total participants).

Participation in 'With Me in Mind' activities is slightly higher among Year 7 respondents, suggesting stronger engagement at younger ages.

Students were also asked if they knew who the Mental Health Lead at their school was. Schools have a Mental Health Lead, who is responsible for developing and overseeing the school's approach to mental health and wellbeing.[4] 1,389 (35.9%) respondents said they knew who their Mental Health Lead was at their school (30.2% of all participants in 2025.

## Kooth Awareness and Usage

Students were asked about their awareness of and use of Kooth, an anonymous, online mental health platform for young people. 3,872 people responded when asked if they had heard of Kooth, and 3,841 people responded when asked if they had ever used Kooth (84.1% and 83.5% of total participants):

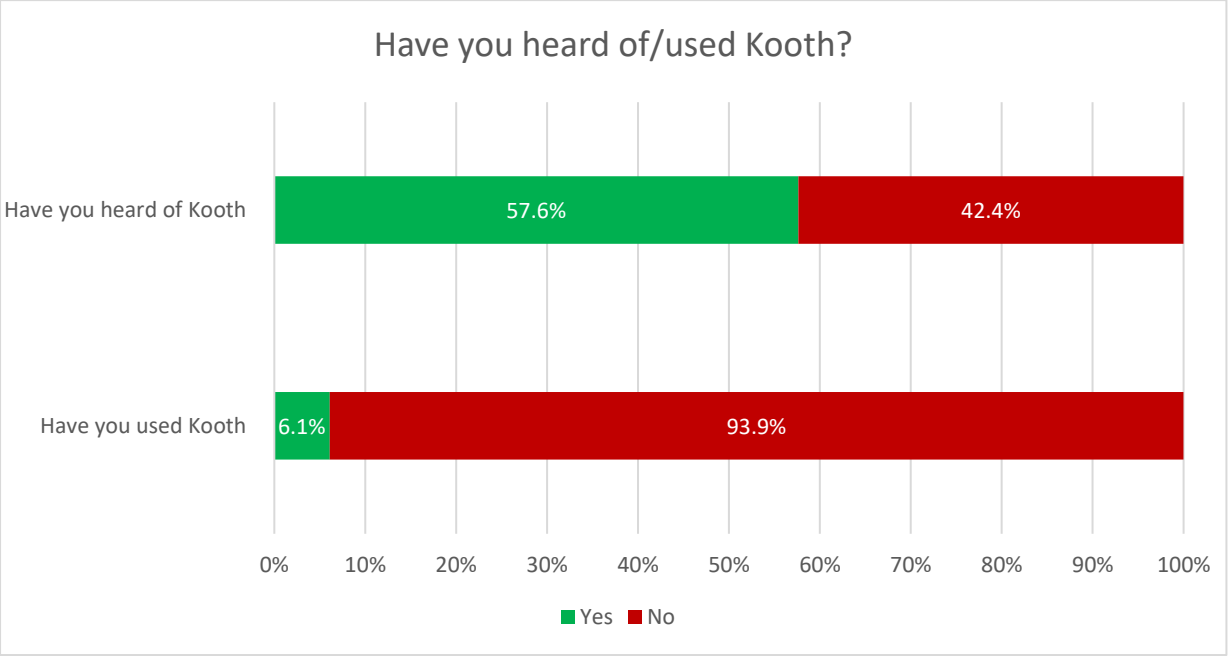
- 2,232 (57.6%) respondents said they had heard of Kooth
    - This an increase from 51.7% of respondents in 2024.
    - This equates to 48.5% of all participants in 2025.
- 234 (6.1%) respondents said they used Kooth
    - This equates to 5.1% of total participants.

Awareness of Kooth, the online mental health support platform, has increased slightly since 2024, however actual usage remains low across both year groups,

[4] Promoting and supporting mental health and wellbeing in schools and colleges - GOV.UK

indicating a gap between awareness and meaningful engagement. By academic year:

- Awareness of Kooth
    - A substantially higher proportion of older students were aware of Kooth than younger students.
    - 49.5% of Year 7 respondents said they had heard of Kooth (41.7% of total participants).
    - 67.5% of Year 10 respondents said they had heard of Kooth (56.7% of total participants).
- Usage of Kooth
    - A substantially higher proportion of older students reported using Kooth than younger students.
    - 4.0% of Year 7 respondents reported using Kooth (3.3% of total participants).
    - 8.6% of Year 10 respondents reported using Kooth (7.2% of total respondents).



Participants were then asked ‘If you have used Kooth - what did you think about the service? Has it helped you?’

690 students responded to this question, 15.0% of total participants. However, this decreased to 182 students when including only participants who had said ‘yes’ to whether they had used the service. Another four responses were excluded as they were non-responses, such as NA, resulting in 178 responses. This equates to 4.0% of total participants. Of these:

- 77 respondents were positive (43.3%)
- 24 respondents were neutral (13.5%)
- 77 respondents were negative (43.3%).

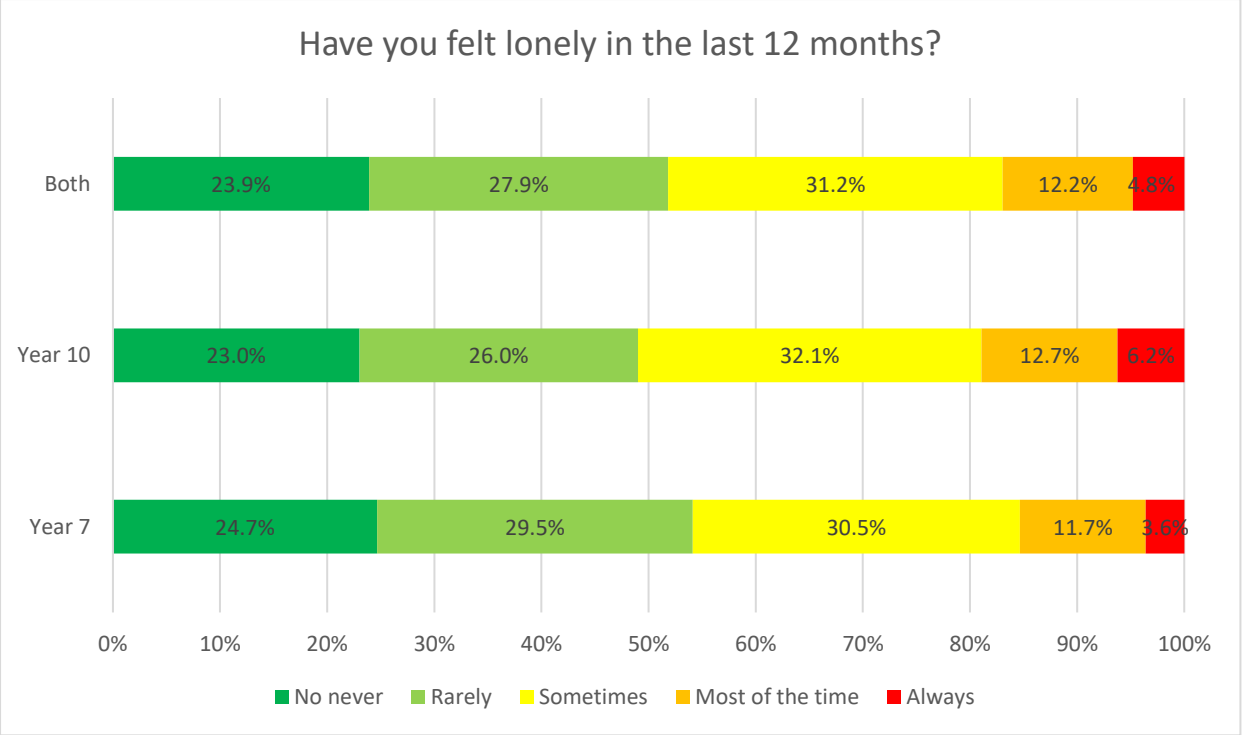
## Feelings of Loneliness in the Last 12 Months

Loneliness remains a significant emotional wellbeing concern among students. When asked if they had felt lonely in the last 12 months, 3,930 students responded (85.4% of total participants).

- 16.9% (666) of respondents reported feeling lonely most of the time or always within the last 12 months (14.5% of total participants):
- 31.2%% (1,227) of respondents reported feeling sometimes within the last 12 months (26.7% of total participants).
- 27.9% (1,097) of respondents reported rarely feeling lonely within the last 12 months (23.8% of total participants).
- 23.9% (940) of respondents reported never feeling lonely within the last 12 months (20.4% of total participants).

By academic year:

- In Year 7, 15.3% of respondents reported feeling lonely either most of the time or always.
    - This equates to 13.2% of participants.
- In Year 10, 18.9% of respondents reported feeling lonely either most of the time or always.
    - This equates to 16.0% of participants.




A substantially higher proportion of girls who responded to the question about a change in their mental health said that it had gotten worse or much worse in the last 12 months than boys (22.7% compared to 8.6%). Of total participants, this equates to 19.5% of girls and 7.4% of boys. Additionally, a higher proportion of respondents with a diagnosed health condition said their mental health had gotten worse or much worse in the last 12 months than boys (26.0% compared to 22.9%). Of total participants, this equates to 24.4% of those with a health condition and 20.0% of all participants.

Participants were then asked, ‘If you have responded 'most of the time' or 'always', what would help when you are feeling lonely?’. 614 students responded to this question, 15.6% of the respondents. However, this decreased to 481 students when excluding participants who said that they were not lonely 'most of the time' or 'always', misunderstood the question or gave an inappropriate response. This equates to 12.2% of the respondents.

- 295 respondents said it helped to be around other people, or that it would help to be around other people more often.
- 142 respondents mentioned being with their friends.

- 102 respondents mentioned having someone to talk to:
    - This included talking to someone about their feelings, but also simply being able to talk to another person.
- 60 respondents said doing something helped them:
    - This included activities with others, such as playing games at home and sports such as football.
    - This also included activities for people to do alone, such as reading, listening to music and going for a walk.
- 46 respondents mentioned being with their family.
    - Many specified this was a friend who they are comfortable around.
- 39 respondents said they didn't know what would help when they were feeling lonely.
- 20 said being with their pet(s) helped.
- 23 people mentioned doing something creative.
- 10 people mentioned physical activities

A number of respondents misunderstood the question and expanded on how they feel lonely and why. People who responded this way said they often felt left out or excluded by others.

## Hopes when leaving school

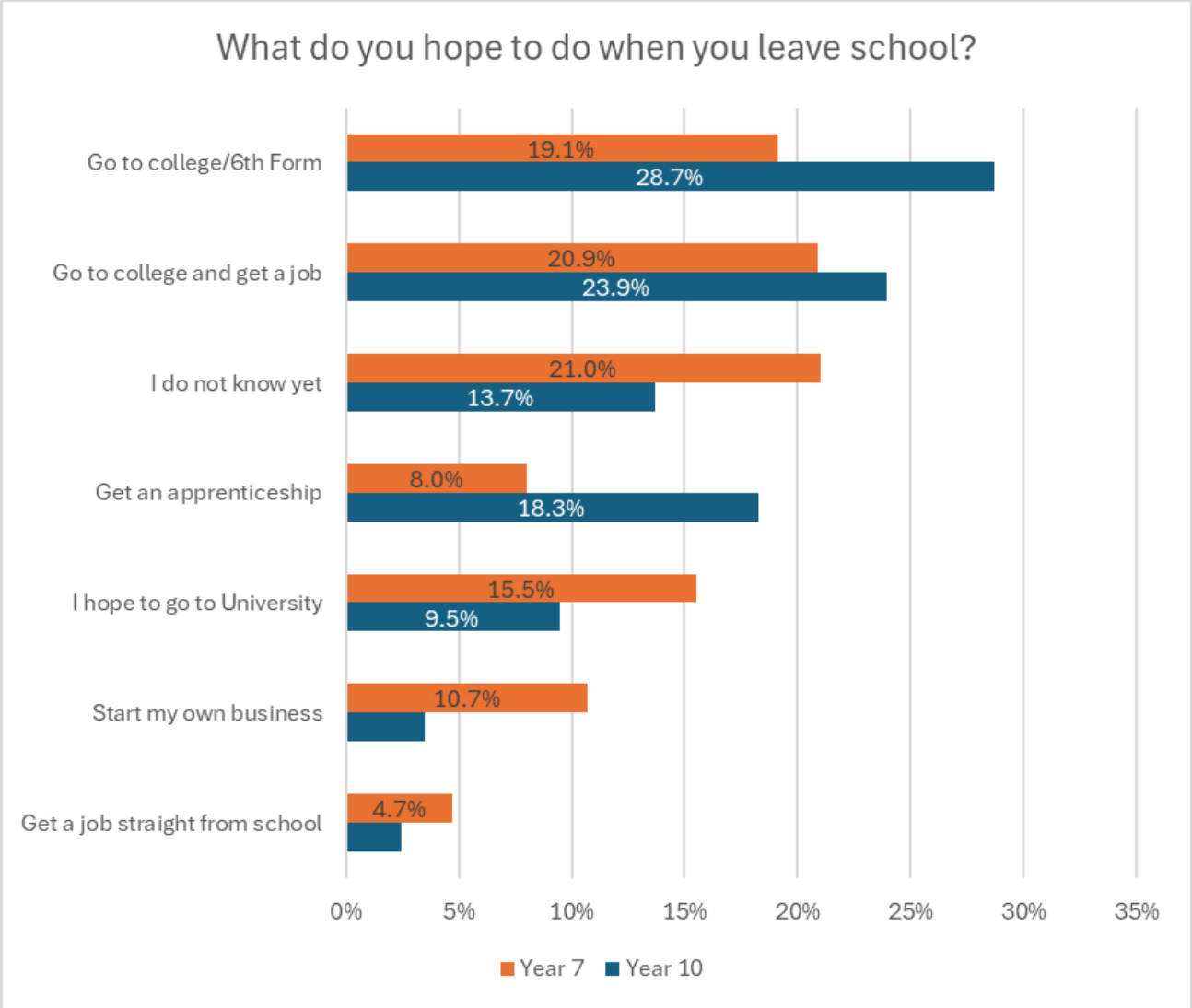
Participants were asked about their hopes when leaving school at the end of Year 11. The option 'Go to college and then university' in previous surveys has been replaced by the options 'Go to college/sixth form' and 'I hope to go to university'. 3,945 students responded to this question (85.7% of total participants):

- 45.8% (1,706) of respondents said they wanted to go to college or sixth form, or to go to college and get and job (37.1% of total participants):
    - 23.5% (876) of respondents said they wanted to go to college or sixth form (19.0% of total participants).
    - 22.3% (830) of respondents said they wanted to go to college and get a job (18.0% of total participants).
- 17.6% (657) of respondents said they didn't know what they wanted to do yet (14.3% of total participants).

- 12.8% (475) of respondents said they wanted to get an apprenticeship (10.3% of total participants).
- 12.7% (474) of respondents said they wanted to go to university (10.3% of total participants).
- 7.4% (275) of respondents said they wanted to start their own business (6.0% of total participants).
- 3.7% (137) of respondents said they wanted to get a job straight from school (3.0% of total participants).

12.3% (484) of respondents responded ‘Other’ and were able to provide a free-text response (10.5% of total participants). 226 respondents provided ‘Other’ as a response in addition to selecting one of the options, whilst 221 respondents who answered ‘Other’ only.

- However, this decreases to 442 when excluding non-responses (442 is 11.2% of respondents)
- Several participants said they wanted to do multiple things – for instance, specifying the job they wanted to do as well as going to college or university.
- The responses have been themed to provide an indication of how people responded. Of those who responded other:
    - 128 respondents said they wanted to go to college/university.
    - 99 respondents said they wanted to go to college.
    - 108 respondents said they wanted to go be a professional sportsperson, most commonly a footballer.
    - 44 respondents said they wanted to start their own business.
    - 33 respondents said they wanted to do a practical job - hairdressing, nail technician, plumbing, electrician.
    - 28 respondents said they wanted to do an apprenticeship.
    - 20 respondents said they wanted to go into the armed forces, most commonly the army.




## Young Carers

Students were asked if they ever have to do any extra work around their home because someone is disabled or sick or 'can't do things', to establish whether they were a young carer. 3,765 students responded, 81.8% of total participants:

- 760 students said yes (20.2% of respondents, 16.5% of total participants).
- A higher proportion of younger students reported to being young carers than older students:
    - In Year 7, 23.5% of respondents said ‘yes’ (19.5% of total participants).
    - In Year 10, 16.1% of respondents said ‘yes’ (13.1% of total participants).

A greater number of participants responded to all other questions related to young carers, suggesting that the wording of the question about whether people were carers or not did not represent the experiences of everyone with caring responsibilities. Some students may have caring responsibilities outside the home, such as taking siblings to school, filling out forms or calling organisations on behalf of someone else in the house, which they may not have identified with the question.

Students were asked whether caring for someone affects their school day. 835 students responded, 18.1% of total participants, and 75 more students than the number reporting to being carers in the initial question. 248 reported an impact on their school day as a result of caring responsibilities.

Students were asked if they had heard of a service in Rotherham that supported young carers. 840 students responded, 18.3% of total participants, and 80 more students than the number reporting to being carers in the initial question. 200 respondents had heard of a service in Rotherham supporting young carers.

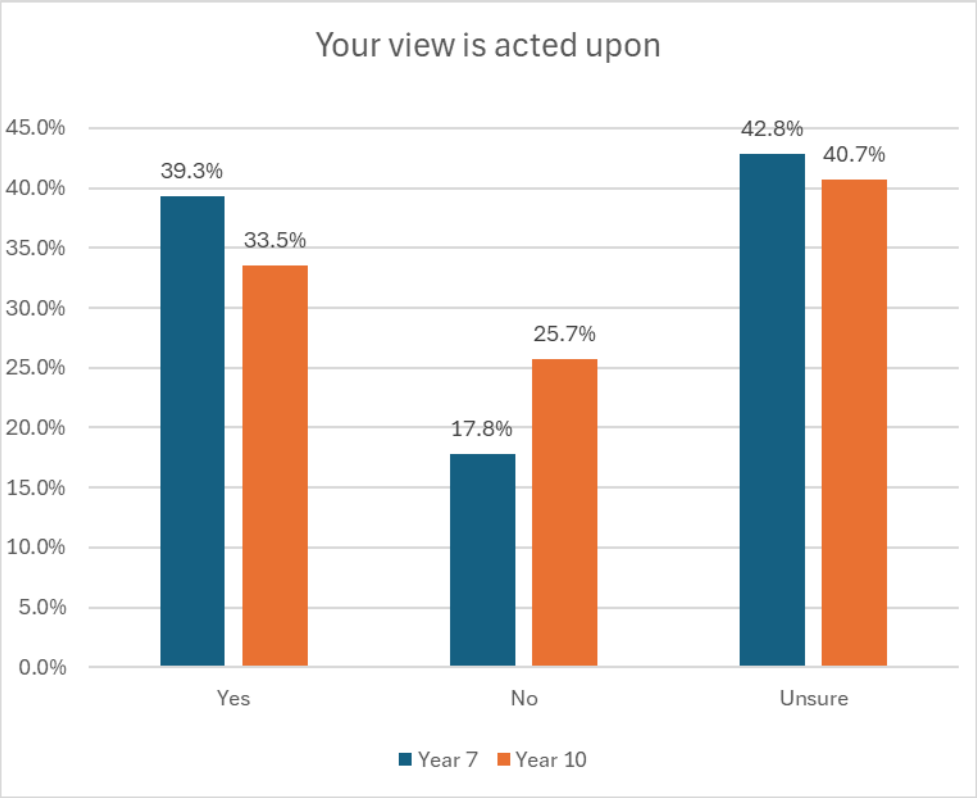
Students were then asked if they would make contact with a service if they felt they needed to. 832 students responded, 18.1% of total participants, and 72 more students than the number reporting to being carers in the initial question.

- Just under a third of respondents saying that they would (32.8%, 273, 5.9% of total participants).
- Respondents were just as likely to say they didn't know if they would (32.9%, 274), or that they would not (34.3%, 285) – 6.0% and 6.2% of total participants.
- Younger students were more likely to say they would make contact with a service if they felt they needed to (37.1% of Year 7 respondents compared to 25.4% of those in Year 10).

## Views and Voice

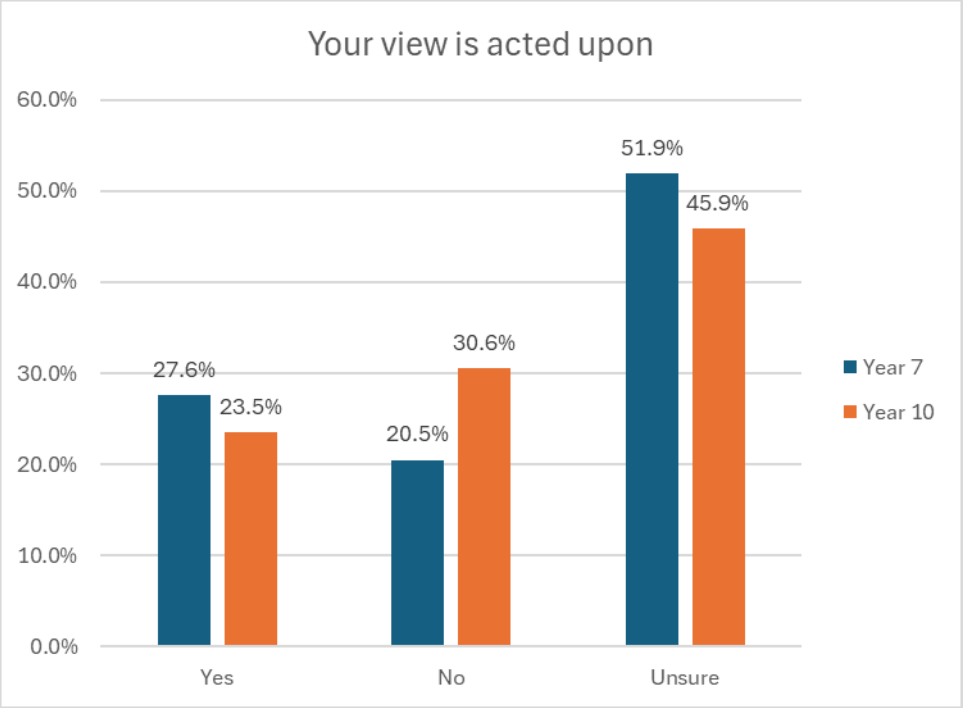
Students were asked to respond to the statement 'Your view and your voice is listened to and taken seriously'. 3,809 participants responded, 82.8% of total participants:

- The largest proportion of respondents were unsure (1,595, 41.9% of respondents and 34.7% total participants participants).
- 1,399 (36.7%) respondents said yes (30.4% of total participants).
- 815 (21.4%) respondents said no (17.7% of total participants).




Students were asked to whether they felt that their view was acted upon. 3,809 participants responded, 82.8% of total participants:

- The largest proportion of respondents were unsure (1,847, 49.2% of respondents and 40.1% total participants participants).
- A similar number of respondents said they felt their voice was acted upon to the number that felt it was not:
    - 968 (25.8%) respondents said yes (21.0% of total participants).
    - 942 (25.1%) respondents said no (20.5% of total participants).




# Community Safety & Belonging and Town Safety

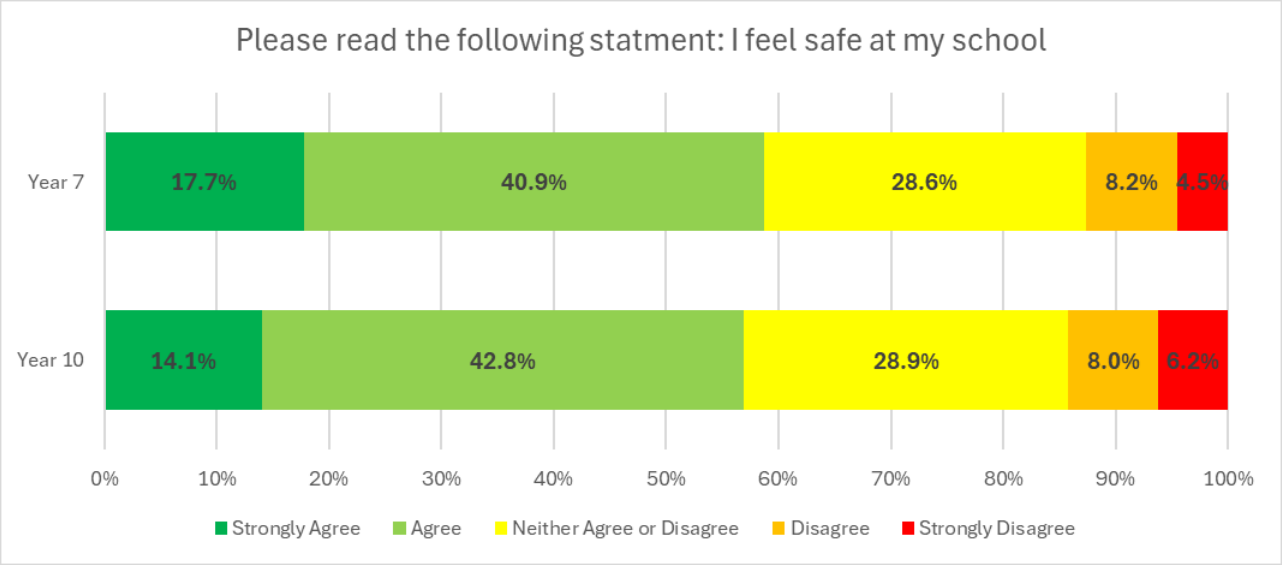
## School perceptions

Students were asked about how they felt about the following statements: 'I feel safe at my school' and 'I feel like I belong at my school'.

3,852 students responded to the prompt 'I feel safe at my school' (83.7% of total participants). 57.9% (2,229) of respondents said they feel safe at their school (48.4% of total participants). This was also very similar to the national proportion of 58% as of 2021-22:

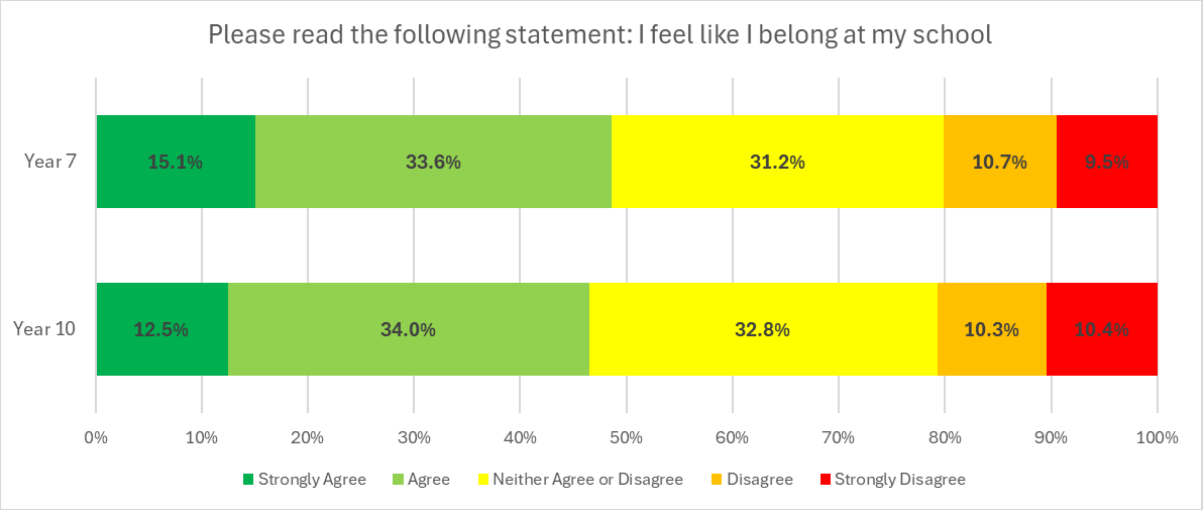
- 16.1% (620) of respondents said they 'Strongly Agree' (13.5% of total participants).
- 41.8% (1,609) of respondents said they 'Agree' (35% of total participants).
- 28.8% (1,108) of respondents said they 'Neither Agree or Disagree' (24.1% of total participants).
- 8.1% (313) of respondents said they 'Disagree' (6.8% of total participants).
- 5.2% (202) of respondents said they 'Strongly Disagree' (4.1% of total participants).

- 57.9% (2,229) of respondents said they feel safe at their school (48.4% of total participants).




3,826 students responded to the prompt 'I feel like I belong at my school' (83.1% of total participants). 47.7% (1,824) of respondents said they feel like they belong at their school (39.6% of total participants).

- 13.9% (532) of respondents said they 'Strongly Agree' (11.6% of total participants).
- 33.8% (1292) of respondents said they 'Agree' (28.1% of total participants).
- 31.9% (1221) of respondents said they 'Neither Agree or Disagree' (26.5% of total participants).
- 10.5% (103) of respondents said they 'Disagree' (8.8% of total participants).
- 9.9% (378) of respondents said they 'Strongly Disagree' (8.2% of total participants).




## Neighbourhood belonging

Students were asked to answer statements about where they live to get a sense of neighbourhood belonging. A different number of students responded to each statement, ranging from 3,626 to 3,661 (78.8-79.6% of the total participants).

Overall:

- 55.8% (2,031) of respondents felt they could trust people in the area they lived (44.1% of total participants).
- 69.1% (2,518) of respondents felt they could ask for help from their neighbours (54.7% of total participants).
- 68.9% (2,522) of respondents felt safe in the area they lived (554.8% of total participants).
- 63.8% (2,325) of respondents said it was safe for younger children to play outside during the day (50.5% of total participants).
- 68.9% (2,523) of respondents said there were good places to spend their free time (54.8% of total participants).

A new statement was added to the 2025 survey, ‘Some people cannot be trusted in the area where I live’. Overall, just over half (50.7%, 1,835) of the respondents said some people in the areas they lived could not be trusted (40.0% of total participants). Year 10 respondents were more likely than Year 7 respondents to feel that some people in their areas could not be trusted (54.9% compared to 47.0%).

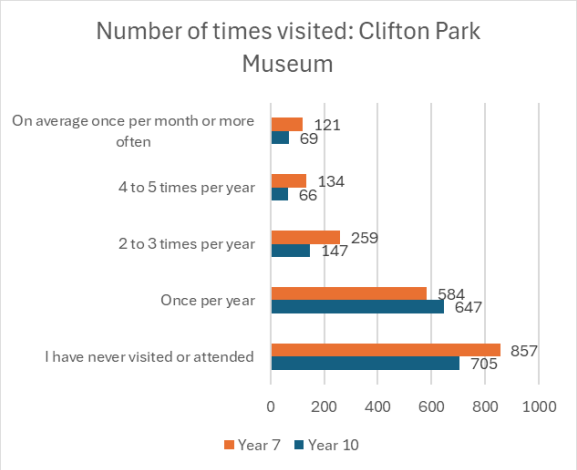
## Local Culture

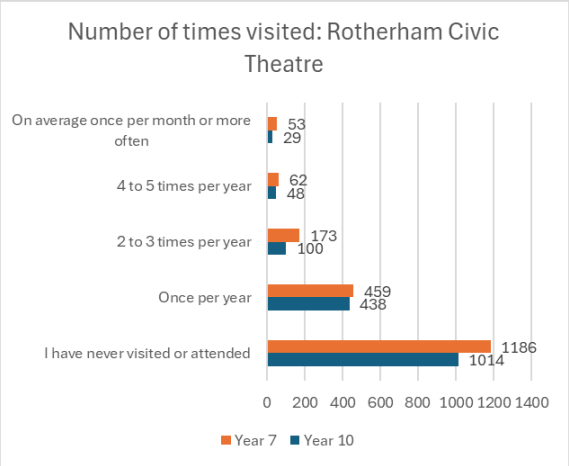
### Places visited

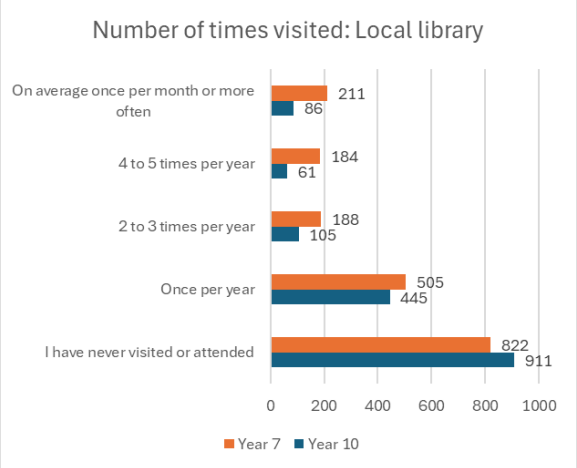
Students were asked how often they visited locations in Rotherham including a library, a leisure centre, a park, Clifton Park Museum, the theatre, and events such as the Christmas light switch on and the Rotherham show.

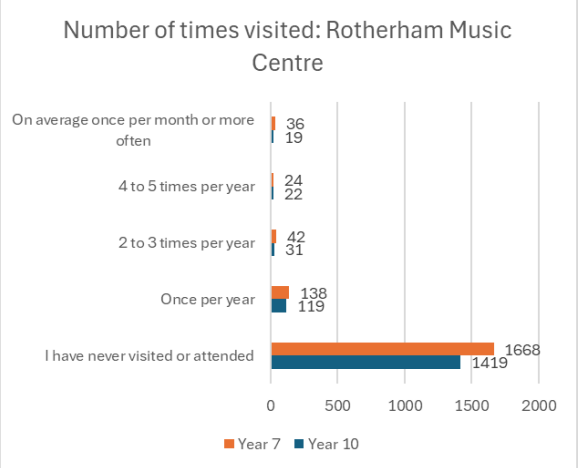
- Clifton Park Museum
    - 2,027 respondents (56.5%) said they visited once per year or more often.
    - This equates to 44.0% of total participants.
- Rotherham Civic Theatre
    - 1,362 respondents (38.2%) said they visited once per year or more often.
    - This equates to 29.6% of total participants.
- Local library
    - 1,785 respondents (50.7%) said they visited once per year or more often.
    - This equates to 38.8% of total participants.
- Rotherham Music Centre
    - 431 respondents (12.3%) said they visited once per year or more often.
    - This equates to 9.4% of total participants.
- Urban park or green space
    - 1,472 respondents (42.2%) said they visited once per year or more often.
    - This equates to 32.0% of total participants.
- Arc Cinema
    - 1,803 respondents (51.1%) said they visited once per year or more often.
    - This equates to 39.2% of total participants.
- Gulliver's

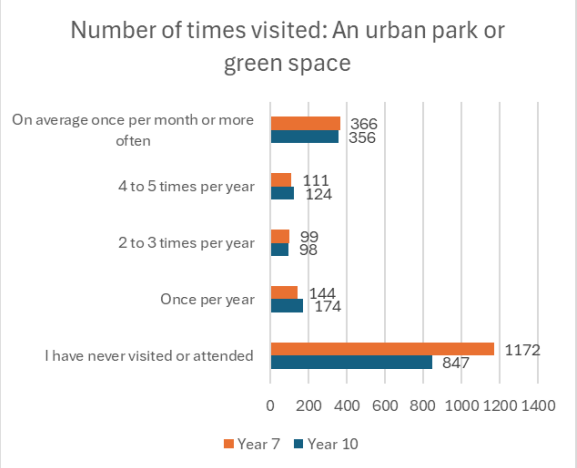
    - 2,146 respondents (61.1%%) said they visited once per year or more often.
    - This equates to 46.6% of total participants.
- Wentworth Woodhouse
    - 1,589 respondents (45.1%) said they visited once per year or more often.
    - This equates to 34.5% of total participants.
- Grimm and Co
    - 687 (19.9%) respondents said they visited once per year or more often.
    - This equates to 14.9% of total participants.
- Rotherham United Football Club
    - 1,352 respondents (38.5%) said they visited once per year or more often.
    - This equates to 29.4% of total participants.
- Magna
    - 2,359 respondents (66.9%) said they visited once per year or more often.
    - This equates to 51.2% of total participants.
- Rotherham Country Park (Thrybergh; Rother Valley; Ulley; Waleswood Campsite)
    - 2,360 respondents (66.4%) said they visited once per year or more often.
    - This equates to 51.2% of total participants.
- A leisure centre
    - 2,654 respondents (74.9%) said they visited once per year or more often.
    - This equates to 57.7% of total participants.

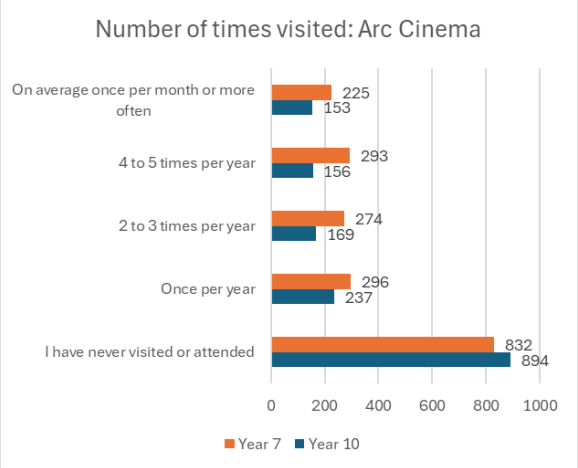

Number of times visited: Clifton Park Museum
On average once per month or more often
121
69
4 to 5 times per year
134
66
2 to 3 times per year
259
147
Once per year
584
647
I have never visited or attended
857
705
0 200 400 600 800 1000
Year 7 Year 10

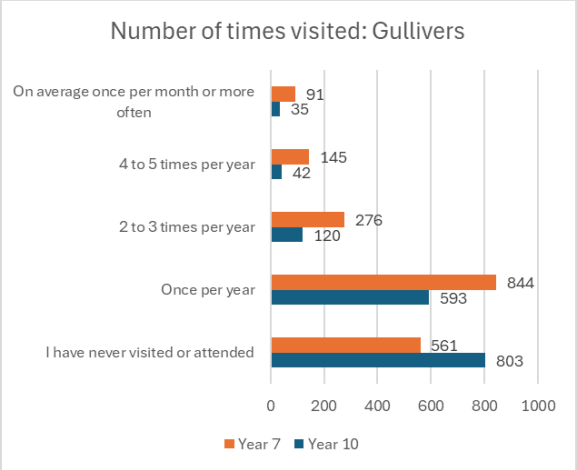

Number of times visited: Rotherham Civic Theatre
On average once per month or more often
53
29
4 to 5 times per year
62
48
2 to 3 times per year
173
100
Once per year
459
438
I have never visited or attended
1186
1014
0 200 400 600 800 1000 1200 1400
Year 7 Year 10

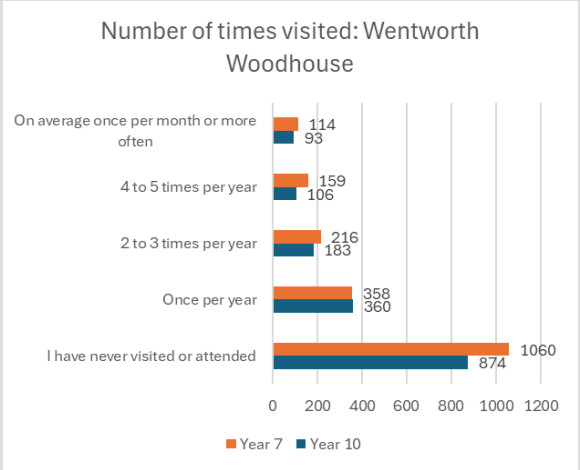

Number of times visited: Local library
On average once per month or more often
211
86
4 to 5 times per year
184
61
2 to 3 times per year
188
105
Once per year
505
445
I have never visited or attended
822
911
0 200 400 600 800 1000
Year 7 Year 10

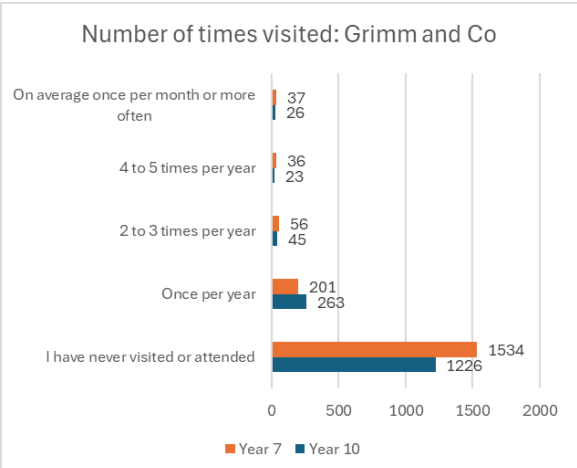

Number of times visited: Rotherham Music Centre
On average once per month or more often
36
19
4 to 5 times per year
24
22
2 to 3 times per year
42
31
Once per year
138
119
I have never visited or attended
1668
1419
0 500 1000 1500 2000
Year 7 Year 10

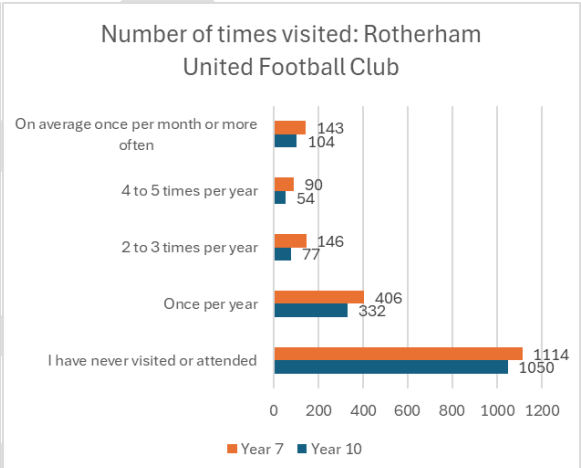

Number of times visited: An urban park or green space
On average once per month or more often
366
356
4 to 5 times per year
111
124
2 to 3 times per year
99
98
Once per year
144
174
I have never visited or attended
1172
847
0 200 400 600 800 1000 1200 1400
Year 7 Year 10

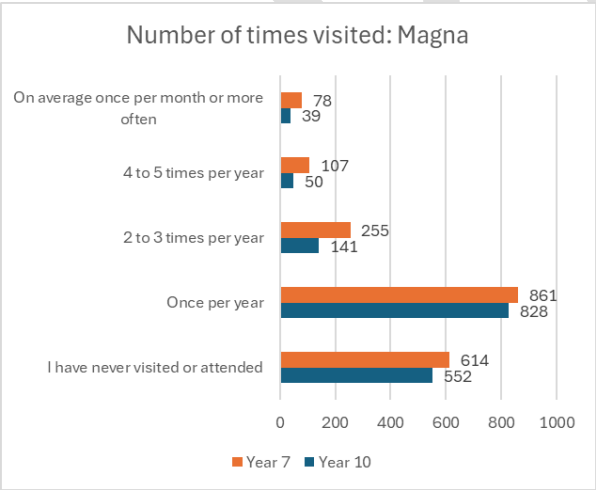

Number of times visited: Arc Cinema
On average once per month or more often
225
153
4 to 5 times per year
293
156
2 to 3 times per year
274
169
Once per year
296
237
I have never visited or attended
832
894
0 200 400 600 800 1000
Year 7 Year 10

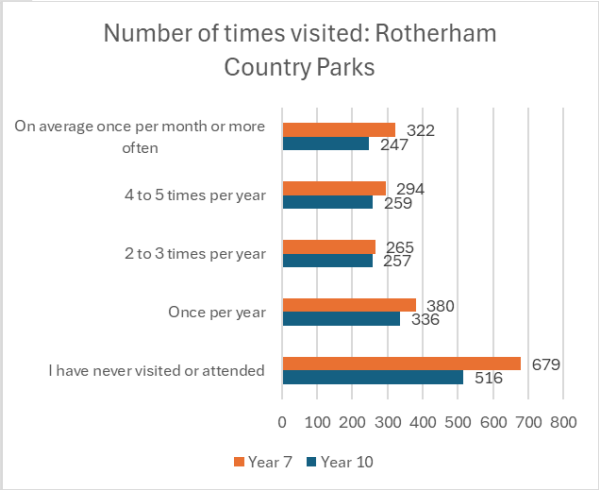

Number of times visited: Gullivers
On average once per month or more often
91
35
4 to 5 times per year
145
42
2 to 3 times per year
276
120
Once per year
844
593
I have never visited or attended
561
803
0
200
400
600
800
1000
Year 7
Year 10

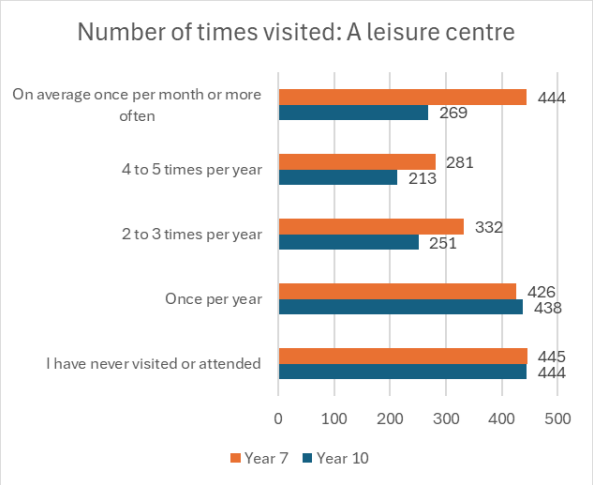

Number of times visited: Wentworth Woodhouse
On average once per month or more often
114
93
4 to 5 times per year
159
106
2 to 3 times per year
216
183
Once per year
358
360
I have never visited or attended
1060
874
0
200
400
600
800
1000
1200
Year 7
Year 10


Number of times visited: Grimm and Co
On average once per month or more often
37
26
4 to 5 times per year
36
23
2 to 3 times per year
56
45
Once per year
201
263
I have never visited or attended
1534
1226
0
500
1000
1500
2000
Year 7
Year 10


Number of times visited: Rotherham United Football Club
On average once per month or more often
143
104
4 to 5 times per year
90
54
2 to 3 times per year
146
77
Once per year
406
332
I have never visited or attended
1114
1050
0
200
400
600
800
1000
1200
Year 7
Year 10

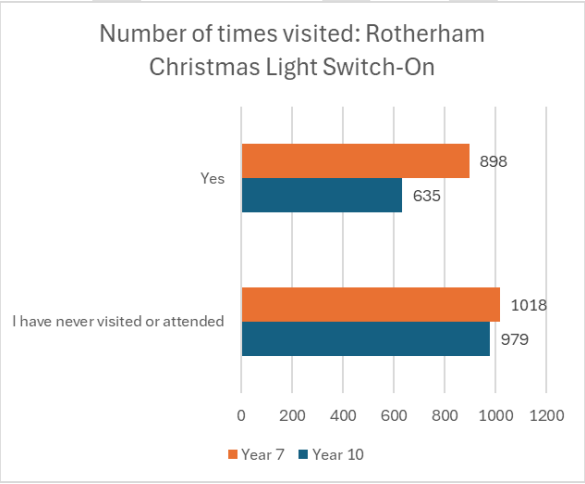

Number of times visited: Magna
On average once per month or more often
78
39
4 to 5 times per year
107
50
2 to 3 times per year
255
141
Once per year
861
828
I have never visited or attended
614
552
0
200
400
600
800
1000
Year 7
Year 10

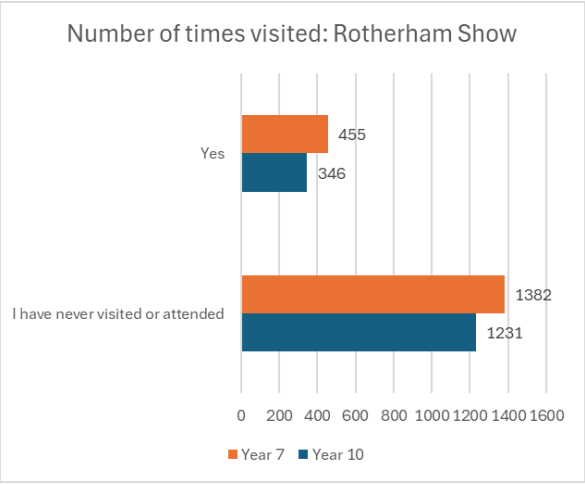

Number of times visited: Rotherham Country Parks
On average once per month or more often
322
247
4 to 5 times per year
294
259
2 to 3 times per year
265
257
Once per year
380
336
I have never visited or attended
679
516
0
100
200
300
400
500
600
700
800
Year 7
Year 10




There were two annual events asked about, so these have been presented together. As these are annual events, any affirmative answers have been grouped together as 'Yes':

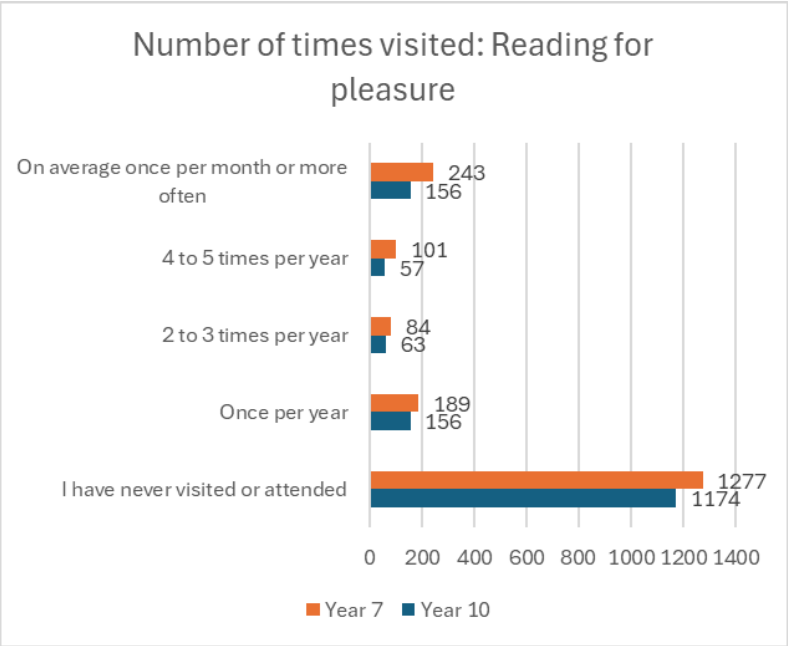
- Rotherham Christmas Lights Switch On
    - 1,533 respondents (43.4%) said they visited once per year or more often.
    - This equates to 33.3% of total participants.
- Rotherham Show
    - 801 respondents (23.5%) said they visited once per year or more often.
    - This equates to 17.4% of total participants.



Students were also asked about how often they read for pleasure, as opposed to reading as part of school curriculum. However, as this was phrased as 'Reading for Pleasure' in a set of questions about specific places or events, it is possible the respondents did not realise this was simply about the activity of reading for pleasure.

1,049 respondents (30.0%) said that they read for pleasure, equating to 22.8% of total participants.




## Perceptions of safety in the community

### Feelings of safety before and after dark:

Participants were asked about how safe they felt in their local neighbourhoods during the daytime and after dark. A different number of students responded to each time period; however, this was a very similar proportion of participants. 3,523 students responded when asked how safe they feel during the daytime, whilst 3,498 responded about how safe they feel after dark (76.6% and 76.0% respectively).

The majority of respondents reported to feeling very safe in their local neighbourhood during the daytime:

- 2,488 respondents (70.6%) feel very safe during the daytime (equates to 51.4% of total participants in 2025).

- 957 respondents (27.2%) feel safe sometimes during the daytime (and equating to 20.8% of total participants in 2025).
- 108 respondents (2.2%) never feel safe during the daytime (equating to 1.7% of total participants in 2025).

After dark, respondents were far less likely to feel very safe in their local neighbourhood, and more likely to feel safe sometimes:

- 934 respondents (26.7%) feel very safe after dark (equates to 20.3% of total participants in 2025).
- 1,973 respondents (56.4%) feel safe sometimes after dark (equating to 42.9% of total participants in 2025).
- 591 respondents (16.9%) never feel safe after dark (equating to 12.8% of total participants in 2025).

## Feeling safe in different areas

Students were asked how safe they feel in the town centre, local shops, parks and recreational areas, travelling on local buses/trains, and on the way to/from school.

3,494 students responded about safety in the town centre, although 271 said they had not visited. Excluding these, 3,223 students responded (70.0% of total participants). Of those who said they had been to the town centre:

- The majority of respondents felt safe sometimes (61.9%, 1994 respondents, equating to 43.3% of total participants).

## What to do when feeling unsafe

3,470 students responded when asked what they would do if they felt unsafe or scared in town (75.4% of total participants).

- 66.6% (2,312) of respondents said they would ring a family member or friend (50.2% of total participants).
- 7.2% (251) of respondents said they were unsure what they should do if I felt unsafe or scared (5.5% of total participants).

- 6.5% (227) of respondents said they would go into a shop and ask for help (4.9% of total participants).
- 6.3% (220) of respondents said they would ring the police (4.8% of total participants).
- Respondents were least likely to say they would ask someone on the street for help (57, 1.6% of respondents). Overall, this was 1.2% of total participants.
- 11.6% (403) of respondents selected the 'Other' option (8.8% of total participants).

## Open water swimming

Students were assessed about their experience of open water swimming and responses are detailed below.

When asked if they had ever swum in open water before, 3,484 students responded (75.7% of total participants). This question didn't differentiate between facilitated and well-managed open-water swimming activities, such as at Manvers and Thrybergh, and unsupervised open-water swimming.

- 1,456 (41.8%) respondents said they had swum in open water before, such as lakes and reservoirs (31.6% of total participants).
- Year 10 respondents (48.7%) were more likely than Year 7 respondents (36.0%) to say they had swum in open water before (37.0% and 27.2% of total participants respectively).

Following this, participants were asked, if they had swum in open water before, were they fully aware of the risks involved when they did?

- 2,423 students responded to this question, more than the number of students who said they had swum in open water before (52.7% compared to 31.6% of total participants). Either more students had swam in open water than those who answered initially, or students who hadn't swum in open water before misinterpreted the question.
- 1,979 (62.7%) respondents said they were aware of the risks involved when they went open water swimming (43.0% of total participants).

- 444 (14.1%) respondents said they were not aware of the risks involved when they went open water swimming (9.6% of total participants).
- Year 10 respondents (64.8%) were slightly more likely than Year 10 respondents (60.9%) to say they were aware of the risks involved when they went open water swimming (44.9% and 41.4% of total participants respectively).

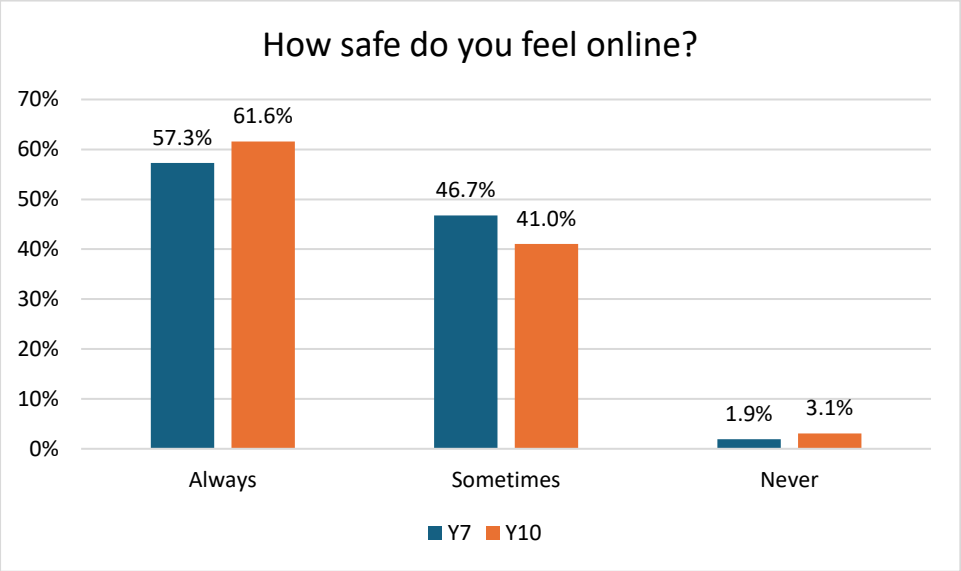
When asked if they would know how to rescue someone safely in open water, 3432 students responded (74.6% of total participants).

- 2,202 (63.8%) respondents said they would how to rescue someone in open water safely (47.8% of total participants).

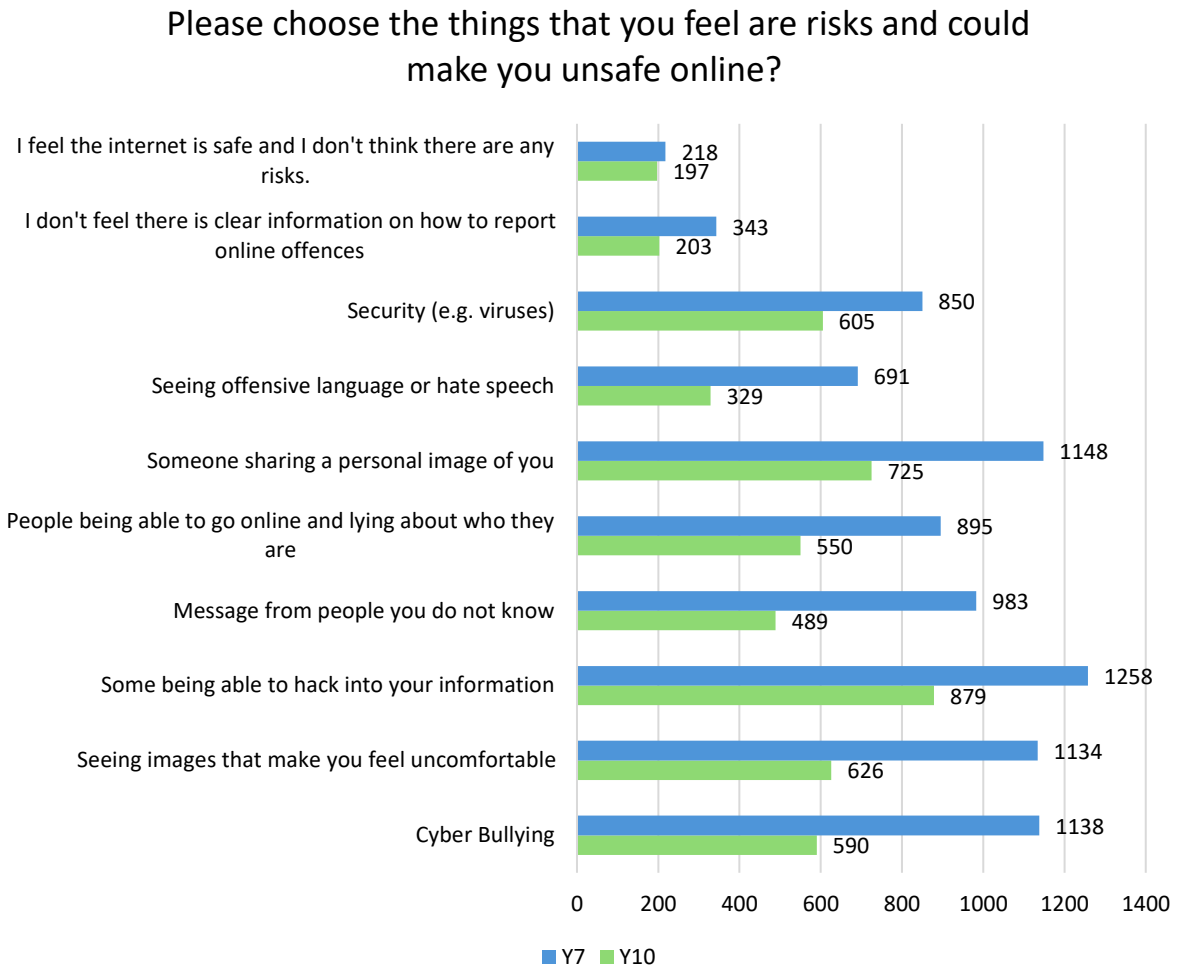
## Online Safety

Students were asked how safe they feel online, with 3,458 students responding (75.1% of total participants).

Year 10 respondents were slightly more likely to feel safe online compared to Year 7 respondents. A total of 84 students across both year groups answered that they never feel safe online (2.4% of respondents, 1.8% of total participants).



Students were then asked a follow-up question to assess what kinds of things make them feel unsafe online. 3,190 students answered this question (1,398 in Year 10 and 1,792 in Year 7) and the top answers were hacking, sharing of personal images and cyber bullying.

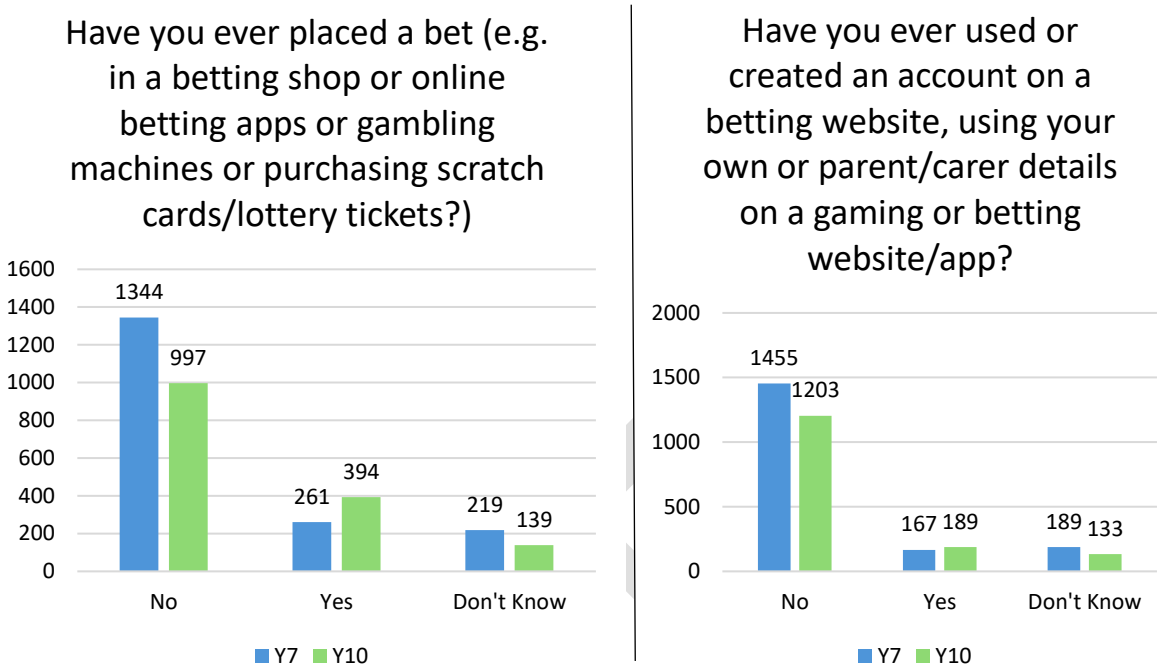



## Gambling

Students were asked about gambling and online purchases. The first question in this section asked, separately, how many students have placed a bet; used or created a betting account; or bought in-app purchases on games. The number of respondents ranged from 3,326-3354 respondents (72.3-72.9% of total participants):

- 655 (19.5%) respondents answered that they have placed a bet (14.2% of total participants):

- 356 (10.7%) respondents answered that they have either used or created a betting account (7.7% of total participants):

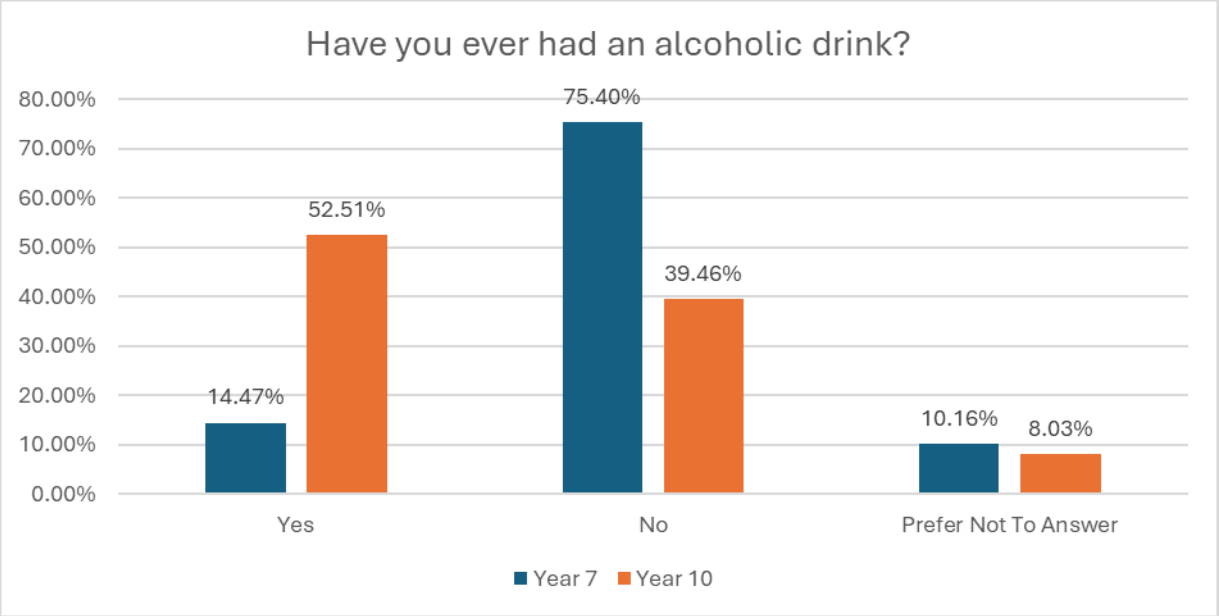



# Alcohol, Substance Misuse, Smoking and Vaping

## Alcohol

Students were first asked 'Have you ever had an alcoholic drink?' There is a note to say this must be a whole drink not just a small sip of someone else's. 3,387 students responded, 73.6% of total participants:

- Overall:
  - 31.9% (1,082) of respondents said they have had an alcoholic drink – 23.5% of total participants.
  - 9.2% (311) of respondents said they would prefer not to answer – 6.8% of total participants.
  - All other respondents said they had never had an alcoholic drink, making up the majority of respondents – 1,994 students, 58.9% of respondents., 43.3% of participants.

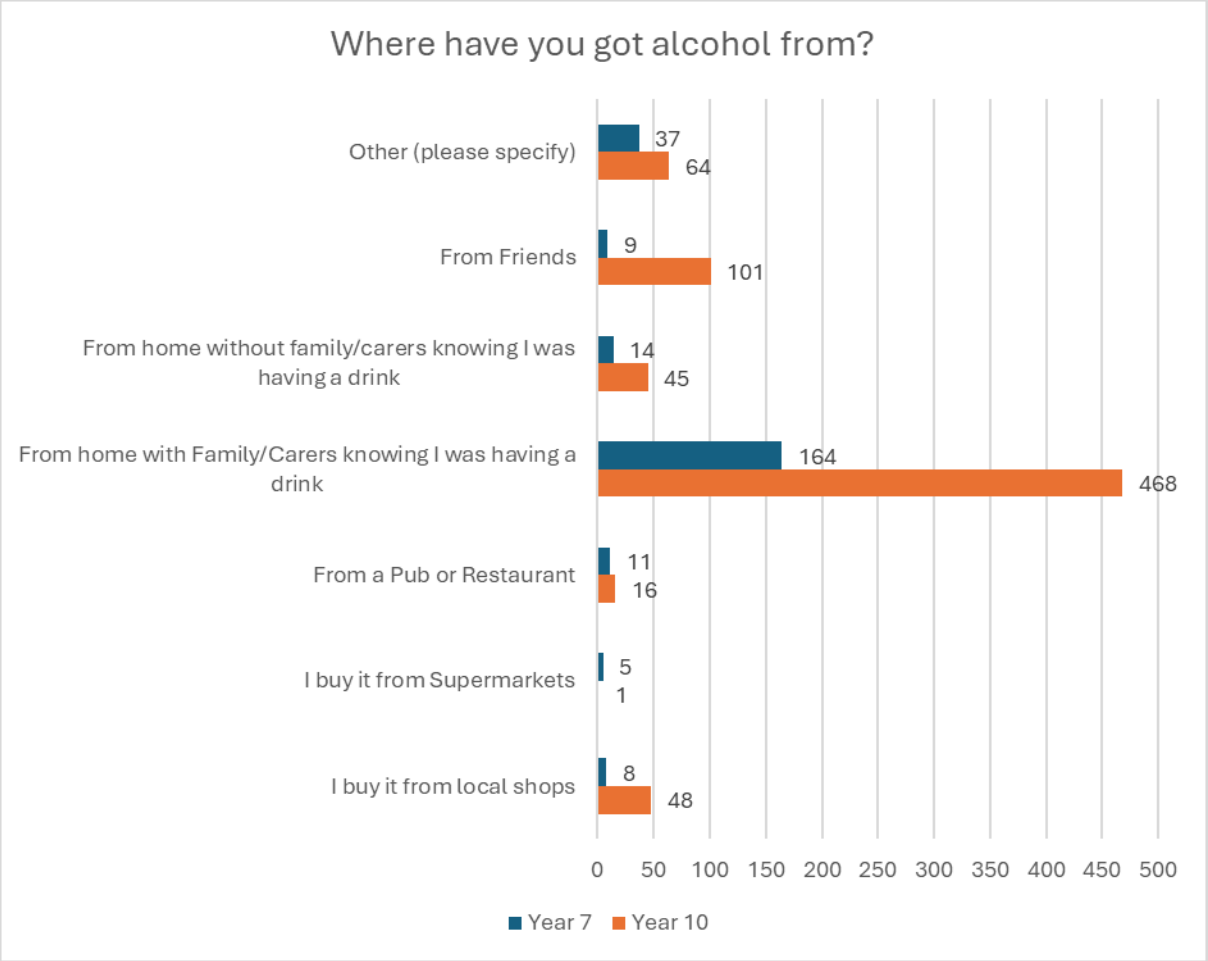



A further question was then asked to see how many times students have drunk alcohol both in the last 30 days and in the last year. Only the students who answered yes to having had an alcoholic drink were asked this question. 1,035 students responded, 22.5% of participants – the majority of respondents (744, 71.8%) were in Year 10, as many more Year 10 respondents said they had had an alcoholic drink before:

- Across both year groups, 865 respondents said they had drunk alcohol in the last Year – 83.6% of respondents, 18.8% of total participants.
- 677 Year 10 students said they had drunk alcohol within the last Year:
- 188 Year 7 students said they had drunk alcohol within the last Year:



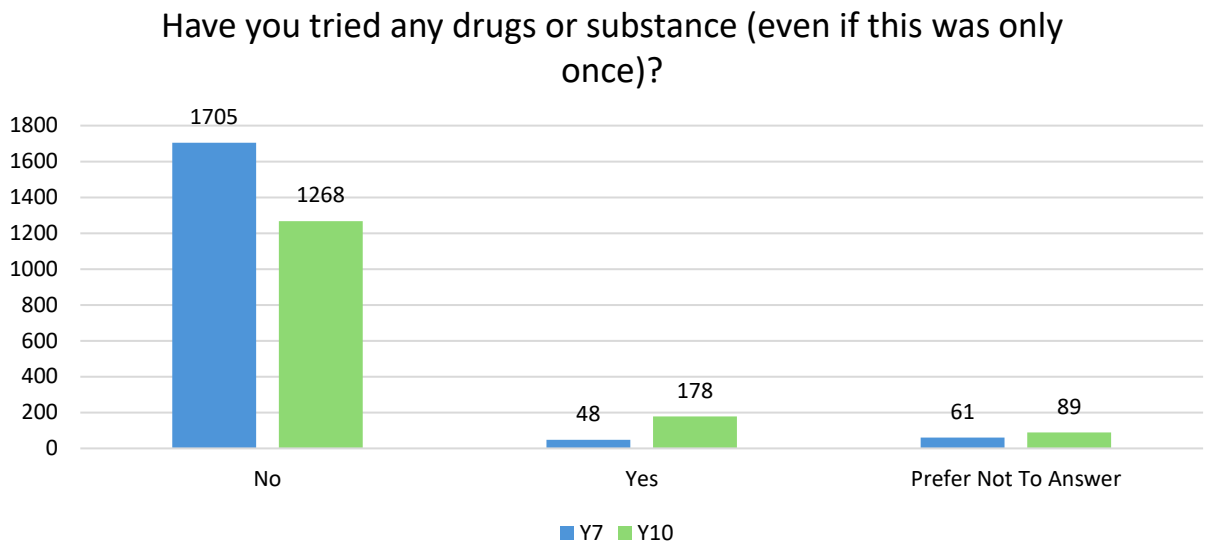
Students who responded to having drank alcohol were also asked where they got alcohol from. 991students responded:




## Substance Use

Initially, students were asked if they have ever tried drugs. 3,349 students answered this question (72.7% of the total participants).

- 2,973 respondents said they had never tried drugs before.
- 226 respondents said they had tried drugs before.
- 150 respondents said they preferred not to answer.




Students were then asked specifically about cannabis use, as this is typically the most common substance used by both adults and young people:

- Similarly to drug use, responses reporting cannabis use were significantly higher in Year 10 students compared to Year 7 respondents.
    - In the last Year, 117 Year 10s and 6 Year 7 respondents reported using cannabis.
    - In the last 30 days, 71 Year 10s and 5 Year 7 respondents reported using cannabis.

Finally, students were asked if they had ever been asked to store drugs, can easily obtain drugs and if they know where to buy drugs locally. Skip logic was active for this final question, and the total number of respondents were 183 in Year 10 and 62 in Year 7

All three of these situations asked within this question were more likely in Year 10 students compared to Year 7 students.

- 112 Year 10 students and 16 Year 7 students think that is it easy to obtain drugs locally.
- 97 Year 10 students and 16 Year 7 students said they know where to buy drugs locally.

- 44 Year 10 students and 8 Year 7 said they had been asked to sell or store drugs for someone.

## Smoking

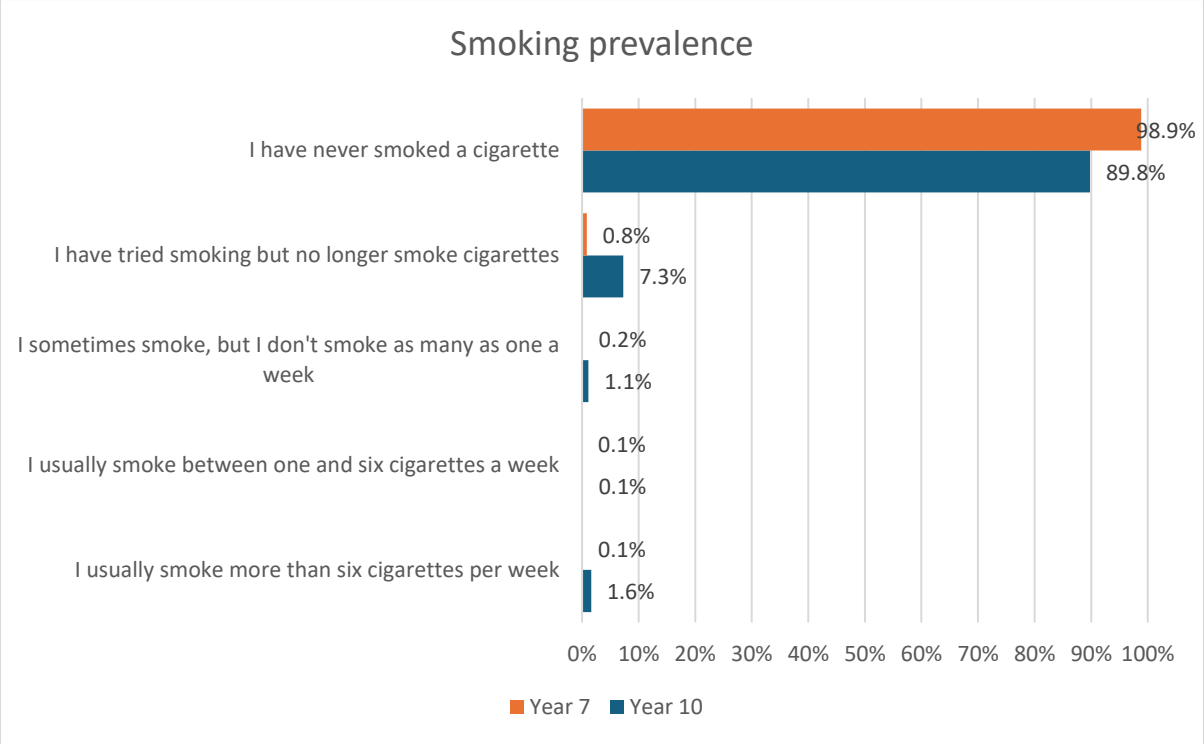
In total, 3,262 students responded to which statement best describes their smoking habits (70.9% of total participants).

Overall:

- 3,090 (94.7%) respondents reported they have never smoked a cigarette (67.1% of total participants).
- 124 (3.8%) respondents reported having tried smoking but no longer smoke cigarettes (2.7% of total participants).
- 48 (1.5%) respondents reported smoking at least some of the time or more (1.0% of total participants).

In Year 7, 1,752 (98.9% of respondents, 69.5% of total participants) students reported they have never smoked a cigarette, 15 (less than 1% of both respondents and total participants) students reported having tried smoking but no longer smoke cigarettes. 5 students reported to smoking at least some of the time or more.

In Year 10, 1,338 (89.8% of respondents, 64.2% of total participants) students reported they have never smoked a cigarette, 109 (7.3% of respondents, 5.2% of total participants) students have tried smoking but no longer smoke cigarettes, 43 (2.9% of respondents, 2.1% of total participants) students reported smoking at least some of the time or more.




Only students that had reported to smoking before were asked how regularly they have smoked cigarettes in both the last 30 days and in the last year. 124 students responded when asked about the previous 30 days and 119 responded when asked about the last year (2.7% and 2.6% of total participants respectively).

When asked about their smoking habits in the last 30 days:

- 84 respondents reported never smoking within the last 30 days
- 15 respondents reported smoking 1 to 9 days within the last 30 days
- 23 respondents reported smoking on 30 or more days
    - All respondents who reported this were in Year 10.
- No Year 7 respondents reported regular smoking in the last 30 days.

When asked about their smoking habits in the last year:

- 82 respondents reported never smoking
- 8 respondents reported smoking on 1 to 5 days
- 8 respondents reported smoking on between 5 and 29 days
- 21 respondents reported smoking on 30 or more days.
    - All respondents who reported this were in Year 10.

111 students responded to the question about smoking and vaping habits of the people they live with:

- 45 (40.5%) respondents did not live with anyone who smokes or vapes (1.0% of total participants).
- 15 (13.5%) respondents lived with someone who smokes (0.3% of total participants).
- 21 (18.9%) of respondents lived with someone at home who vapes (0.5% of total participants).
- 30 (27.0%) of respondents lived with someone who smokes and vapes (0.7% of total participants).

Respondents who smoked were asked where they obtain their cigarettes from, 65 students answered this question (1.4% of total participants):

- 14 reported buying their cigarettes from local shops
- 4 reported buying their cigarettes from local supermarkets
- 5 reported getting their cigarettes from a family member
- 11 reported getting them from friends
- 31 chose ‘other’

## Vaping

Students were asked which statement about their vaping habits best described them, 3,272 responded (71.1% of total participants):

Overall:

- 2,565 (78.4%) respondents reported they have never tried vaping (55.7% of total participants)
- 423 (12.9%) respondents reported having tried vaping but only once or twice and no longer use them (9.2% of total participants)

- 99 (3.0%) respondents reported vaping sometimes but not once a week (2.2% of total participants)
- 167 (5.1%) respondents reported vaping regularly, once a week or more (3.6% of total participants)

In Year 7:

- 1579 (90%) respondents reported they have never tried vaping (63% of total participants)
- 146 (8%) respondents reported having tried vaping but only once or twice and no longer use them (6% of total participants)
- 19 (1.1%) respondents reported vaping sometimes but not once a week (1% of total participants)
- 22 (1.2%) respondents reported vaping regularly, once a week or more (0.9% of total participants)

In Year 10:

- 986 (66.3%) respondents reported they have never tried vaping (47.3% of total participants)
- 277 (18.6%) respondents reported having tried vaping but only once or twice and no longer use them (13.3% of total participants)
- 80 (5.4%) respondents reported vaping sometimes but not once a week (3.8% of total participants)
- 145 (9.7%) respondents reported vaping regularly, once a week or more (7% of total participants)

Students were asked how pressured they feel by their friends to vape, where 0 was not pressured at all at 10 was extremely pressured. 2,186 students answered this question.

The majority of respondents reported little to no pressure to vape - with a score of 0-1 (34.6% of total participants).

- 94 of respondents felt extremely pressured to vape (score 10).

Students were asked to choose which option best describes why they vape; 324 students answered this question (7.0% of total participants). The majority of respondents (261, 80.6%) were in Year 10, as many more Year 10 respondents said they had had tried a vape before:

- 19 respondents reported they vaped to stop smoking
- 40 respondents reported they vaped and no longer smoking cigarettes
- 26 respondents reported they vaped and smoked cigarettes
- 237 respondents reported they vaped but have never smoked cigarettes

Students were asked about the frequency which they have used vapes within the last 30 days and last year. Vaping on at least three days in the last 30 days is defined as ‘regular use’.

683 students answered the question about their vaping habits in the last 30 days (14.8% of total participants):

- 394 respondents reported never vaping
- 71 respondents reported vaping on 1 to 2 days
- 27 respondents reported vaping on 3 to 5 days
- 23 respondents reported vaping on 6 to 9 days
- 18 respondents reported vaping on 10 to 19 days
- 17 respondents reported vaping on 20 to 29 days
- 133 respondents reported vaping on 30 or more days

662 students answered the question about their vaping habits in the last year (14.4% of total participants):

- 238 respondents reported never vaping
- 134 respondents reported vaping on 1 to 2 days
- 35 respondents reported vaping on 3 to 5 days

- 29 respondents reported vaping on 6 to 9 days
- 19 respondents reported vaping on 10 to 19 days
- 20 respondents reported vaping on 20 to 29 days
- 178 respondents reported vaping on 30 or more days

Students were asked where they get their vapes from; 475 students answered this question (10.3% of total participants):

- 144 reported getting them from friends
- 84 respondents reported buying their vapes from local shops
- 47 reported getting their vapes from a family member
- 6 reported buying their vapes from local supermarkets
- 71 chose 'other'

### Student Opinions on Health Behaviours

After the behavioural questions, students were asked their opinions on students of their age vaping, smoking, drinking and using substances. A different number of students responded to each statement, ranging from 3,240 to 3,249 (70.4-70.5% of the total participants).

Overall:

- 620 respondents said it was ok for people their age to drink enough alcohol to get drunk
- 427 respondents said it was ok for people their age to vape
- 141 respondents said it was ok for people their age to use cannabis
- 109 respondents said it was ok for people their age to smoke cigarettes
- 101 respondents said it was ok for people their age to use any other drugs

## Bullying

3,256 students responded to the question around if they had been bullied in the last 6 months (70.7% of the total participants).

1,297 students said they have been bullied in the last 6 months (39.8% of respondents, 28.2% of total participants:

- 688 (21.1%) respondents said they have been bullied once or twice in the last 6 months (15% of total participants).
- 216 (6.6%) respondents said they have been bullied 3 to 5 times in the last 6 months (4.7% of total participants).
- 52 (1.6%) respondents said they have been bullied about once a month in the last 6 months (1.1% of total participants).
- 150 (4.6%) respondents said they have been bullied about once a week in the last 6 months (3.3% of total participants).
- 191 (5.9%) respondents said they have been bullied about once a week in the last 6 months (4.2% of total participants).

Of those who were bullied, there were a mix of responses to the type of bullying experienced:

    - ‘being called names’ (992)
    - being ignored by others (856),
    - having lies or false rumours spread about them (764),
    - being left out of things or excluded from groups on purpose (731).
- Nearly a third of students who said they were bullied in the past 6 months said this included being ‘hit, kicked, punched or locked indoors’ (368)
- Although less common forms of bullying, a number of students said they had experienced racist, queerphobic and/or sexualised bullying.

When asked if they reported the bullying, 94.3% of the 1,297 respondents who said they have been bullied in the last 6 months responded (1,223, 26.6% of the total participants):

- Just over half of the respondents said they had reported the bullying they had experienced.

## Hate crime

Students were asked about their experiences with and knowledge of hate crime:

- 495 respondents (15.7%) have experienced hate crime (10.8% of total participants).
- 2,412 respondents (76.2%) know what hate crime is (52.4% of total participants).
- 1,473 respondents (46.7%) know how to report hate crime (32.0% of total participants).

## Next steps

These findings should be used in conjunction with the Joint Strategic Needs Assessment (JSNA). The results of this survey will be published on the JSNA website, here> Homepage – Rotherham Data Hub.

| | | |
|---|---|---|
| **BRIEFING** | **TO:** | Health and Wellbeing Board |
| | **DATE:** | 26/11/2025 |
| | **LEAD OFFICER** | Oscar Holden |
| | **TITLE:** | Corporate Improvement Officer, RMBC |

**Background**

**1.1** The Rotherham Health and Wellbeing Board Strategy 2025-30 was agreed at the Health and Wellbeing Board meeting on 25th June 2025. The Strategy was the endorsed by Cabinet on 15th September 2025.

**1.2** The Health and Wellbeing Board members then agreed its four priorities in principle by using nominal group technique to consider suggestions put forward by health and wellbeing system leaders at a workshop on 2nd October 2025 where the priorities were agreed in principle and the next steps were agreed.

**1.3** A follow up session will have taken place on 24th November with Health and Wellbeing Board members to agree the finalised wording and metrics for the priorities before coming to the Board meeting on 26th November for a formal agreement.

**Key Issues**

**2.1** Health and Wellbeing Strategy 2025 priorities agreed in principle are:

- Priority 1: We will reduce the prevalence of smoking in Rotherham to 5% by 2030
- Priority 2: We will increase the wellbeing of the people of Rotherham to above national average by 2030
- Priority 3: We will increase the proportion of people who feel they have the support and resources they need to manage their own health
- Priority 4: We will promote environments which support and enhance wellbeing.

**2.2** The finalised wording of the priorities presented at the Board meeting may differ slightly since these are being agreed informally be Board members two days prior to the Board meeting on 25th November but the general outline of each priority will remain consistent.

**2.3** The metrics for monitoring these for measuring these priorities are expected to be similar to the following:

**2.4** Life expectancy (taken from the Joint Strategic Needs Assessment) will be used as an overall measure for the priorities.

**2.5** Priority 1:

- Smoking rate (from existing Public Health metrics)
- Under 19s vaping rate (from the School Survey).

**2.6** Priority 2:

- Happiness measure for adults (from the Joint Strategic Needs Assessment)
- Lifestyle survey question on mental health for young people (from existing Public Health metrics).

**2.7** Priority 3:

- Patient Activation Measure scale (from existing RDaSH data).
- Access questions about services outside of primary and secondary care such as social prescribing; Citizens Advise Bureau; Gym Classes (to be confirmed prior to the Board meeting)

**2.8** Priority 4:

- Community safety measure (from existing Safer Rotherham Partnership metrics)
- One other metric that will include one of the following: access to healthy food, adults taking recommended exercise, air quality, public transport (to be confirmed prior to the Board meeting).

**2.9** The Rotherham Health and Wellbeing Board Strategy 2025-30 will be finalised upon the agreement of its priorities and will therefore require a new Action Plan. This will also be discussed at the meeting with Board members on 24th November with the suggestion noted below and any amendments will be noted at the Board meeting.

**2.10** The Board members will discuss the possibility of streamlining the Action Plan to resemble a high-level work plan that represents the actions of the Board as a 12-month rolling programme. An example of this format is included below that would be subject to Board member review:

**2.11**

| Meeting | Priority focus at Board meeting | Report/Strategy focus at Board meeting | Other significant item |
|---|---|---|---|
| June 2026 | Priority 1 | Integrated Care Board Forward Plan | Integrated Care Strategy |
| September 2026 | Priority 2 | Joint Health and Wellbeing Strategy | Other Special Interest Groups System Plans |
| November 2026 | Priority 3 | Joint Strategic Needs Assessment | Better Care Fund |
| January 2026 | Priority 4 | Public Needs Assessment | Review of system pressure for winter |
| March 2026 | Review of year | Director of Public Health Report | Forward Plan |

**2.11** The resolutions of the meeting with Board members meeting on 24th November with regards to the priorities and Action Plan will be explicitly laid out in the presentation given to the Board meeting on 26th November.

## Key Actions and Relevant Timelines

**3.1** The Board formally agrees the new priorities at the 26th November 2025 meeting including metrics after which these will be added to the Rotherham Health and Wellbeing Strategy as an appendix.

**3.2** The Board will then start using the new format of the Action Plan that is outlined above from the following meeting in January 2026.

**3.3** The Rotherham Health and Wellbeing Strategy 2025-30 will then be finalised entirely and due to run until the end of March 2030.

## Implications for Health Inequalities

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|---|---|
| **4.1** | An Initial Equality Screening (Part A) and Equality Analysis (Part B) were completed to accompany the Rotherham Health and Wellbeing Strategy 2025-30 when this document was presented to Cabinet for endorsement in September 2025. |
| **4.2** | The Part B notes that the Strategy impacts upon all protected characteristics and does so in a positive and supportive manner as much of the work endorsed by the Board supports groups suffering from inequalities relating to health and wellbeing. |
| **4.3** | As the priorities for the Strategy will be added to the existing Strategy as an appendix these will align with the equality implications of the existing Part B. |
| **Recommendations** | |
| **5.1** | For the Board to formally note the feedback on the suggested priorities provided by the Children and Young People's Partnership Board in October 2025. |
| **5.2** | For the Board formally agree the four priorities and the corresponding metrics that have been agreed at the meeting on 24th November 2025. |
| **5.3** | For the Board to agree to the new approach to the Health and Wellbeing Action Plan which as outlined in the slides. |

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# Rotherham Health and Wellbeing Strategy 2025-30 Priorities

Oscar Holden, Business Support Partner for
the Health and Wellbeing Board

# Priority One

**“We will reduce the prevalence of smoking in Rotherham to 5% by 2030”**

Metrics:

- Smoking rate (from existing Public Health metrics)
- Under 19s vaping rate (from the School Survey).

# Priority Two

**“We will increase the wellbeing of the people of Rotherham to above national average by 2030”**

Metrics:

- Happiness measure for adults (from the Joint Strategic Needs Assessment)
- Lifestyle survey question on mental health for young people (from existing Public Health metrics).

# Priority Three

**“We will increase the proportion of people who feel they have the support and resources they need to manage their own health”**

Metrics:

- Patient Activation Measure scale (from existing RDaSH data)
- Access questions about services outside of primary and secondary care such as social prescribing; Citizens Advise Bureau; Gym Classes (to be confirmed prior to the Board meeting).

# Priority Four

**“We will promote environments which support and enhance wellbeing”**

Metrics:

- Community safety measure (from existing Safer Rotherham Partnership metrics)
- One other metric that will include one of the following: access to healthy food, adults taking recommended exercise, air quality, public transport (to be confirmed prior to the Board meeting).

# Action Plan

| Meeting | Priority focus at Board meeting | Report/Strategy focus at Board meeting | Other significant item |
|---|---|---|---|
| **June 2026** | Priority 1 | Integrated Care Board Forward Plan | Integrated Care Strategy |
| **September 2026** | Priority 2 | Joint Health and Wellbeing Strategy | Other Special Interest Groups System Plans |
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| **March 2026** | Review of year | Director of Public Health Report | Forward Plan |

| | | |
|---|---|---|
| **BRIEFING** | **TO:** | Health and Wellbeing Board |
| | **DATE:** | 11/11/2026 |
| | **LEAD OFFICER** | Denise Littlewood |
| | **TITLE:** | Health Protection Principal |

**Background**

**1.1** The report provides a summary of the assurance functions of the Rotherham Metropolitan Borough Council Health Protection Committee and reviews performance for the Health and Wellbeing Board.

1.2 Health Protection is multi-agency. It is not just a local authority responsibility. Therefore, the Health Protection Committee is attended by colleagues across Rotherham Place.

1.3 The scale of work undertaken to prevent and manage threats to health is driven by national, regional and local guidance, intelligence and health risks. There are activities undertaken proactively and reactively to protect health and prevent ill health. The report will cover the following areas:

- Infectious disease management
- National programmes for screening
- National programmes for vaccination and immunisation
- Healthcare associated infections, including a spotlight on TB
- Infection prevention and control
- Health emergency preparedness and response.
- Environmental health and trading standards

**Key Issues**

**2.1** The scale of work undertaken to prevent and manage threats to health is driven by national, regional and local guidance, intelligence and health risks. There are activities undertaken proactively and reactively to protect health and prevent ill health. The report will cover the following areas:

- Infectious disease management

| | |
|---|---|
| | • National programmes for screening<br>• National programmes for vaccination and immunisation<br>• Healthcare associated infections, including a spotlight on TB<br>• Infection prevention and control<br>• Health emergency preparedness and response. |
| **Key Actions and Relevant Timelines** | |
| **3.1** | **Strategic Health Protection Actions**<br><br>1. **Provide Health Protection assurance and leadership** across Rotherham.<br>2. **Participate in national pandemic preparedness exercises** (Exercise Pegasus and Exercise Solaris).<br>3. **Strengthen community Infection Prevention and Control (IPC)** provision, including audits and care home support.<br>4. **Ensure clarity of roles and responsibilities** across Rotherham Place for rapid incident response.<br>5. **Maintain and enhance surveillance systems** for communicable diseases in partnership with UKHSA, focusing on emerging threats.<br>6. **Embed health protection work into local systems** to reduce health inequalities. |
| 3.2 | **Targeted Health Improvement Actions**<br><br>7. **Increase uptake of vaccination and screening** in deprived areas and underrepresented groups:<br>o Focus on childhood immunisations (MMR, HPV).<br>o Improve flu vaccination uptake, especially among 2–3-year-olds, pregnant women, and vulnerable groups.<br>o Support cervical, breast, and bowel screening uptake.<br>8. **Tackle Tuberculosis (TB)**:<br>o Improve awareness and screening.<br>o Target underserved populations.<br>o Understand latent TB prevalence in Rotherham.<br>9. **Address antimicrobial resistance (AMR)**:<br>o Implement a consistent approach via a new working group.<br>o Strengthen antimicrobial stewardship across health settings. |
| 3.3 | **Preparedness and Environmental Health**<br><br>10. **Refresh adverse weather policy** and ensure readiness for extreme weather events.<br>11. **Improve links with Sexual Health Strategy Group** for better assurance on STIs.<br>12. **Continue emergency planning improvements**, including thematic operational plans and integrated response frameworks. |

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| **Implications for Health Inequalities** | |
| **4.1** | Health protection measures (infectious disease control, environmental hazard management) can either mitigate or exacerbate health inequalities, depending on design and implementation. |
| 4.2 | Effective strategies require integrating health equity principles into emergency response, surveillance, and preventive programs. |
| 4.3 | Tackling upstream social determinants—housing, education, employment—is essential for sustainable health protection. |
| **Recommendations** | |
| **5.1** | **Strengthen System Leadership and Collaboration**<br>• Ensure all partners across Rotherham Place understand their health protection roles and responsibilities to enable rapid and coordinated responses to incidents.<br>• Maintain strong multi-agency collaboration between RMBC, UKHSA, NHS, and community organisations. |
| 5.2 | **Embed Health Protection in Inequality Reduction Strategies**<br>• Integrate health protection actions into local plans aimed at reducing health inequalities.<br>• Target interventions in areas of deprivation and among underserved groups, focusing on vaccination, screening, and TB prevention. |
| 5.3 | **Improve Uptake of Preventive Programmes**<br>• Work with primary care, schools, and community partners to increase uptake of:<br>  ○ Childhood immunisations (MMR, HPV).<br>  ○ Seasonal flu vaccination, especially for vulnerable cohorts.<br>  ○ Screening programmes (breast, bowel, cervical), with tailored support for people with learning disabilities and severe mental illness. |
| 5.4 | **Enhance Infection Prevention and Control**<br>• Expand IPC audits and training in care homes and community settings.<br>• Continue hydration and antimicrobial stewardship initiatives to reduce healthcare-associated infections and antimicrobial resistance.<br>• |
| 5.5 | **Prepare for Emerging Health Threats**<br>• Engage fully in national pandemic preparedness exercises (Pegasus and Solaris).<br>• Refresh adverse weather plans and ensure resilience for environmental hazards. |
| 5.6 | **Focus on Tuberculosis Control**<br>• Increase awareness and screening for TB among high-risk and socially vulnerable populations.<br>• Strengthen case management and explore additional screening opportunities. |

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# Health Protection Assurance Report
# Rotherham Metropolitan Borough Council

**July 2025**

Report authored by:
Denise Littlewood (Health Protection Principle)
Jaimee Wylam (Acting Consultant in Public Health)
Alex Hawley (Interim Director of Public Health)

With contributions from members of the Health Protection Committee.

# Contents

# 1 Introduction

1.1 This report provides a summary of the assurance functions of the Rotherham Metropolitan Borough Council Health Protection Committee and reviews performance for the Health and Wellbeing Board.

1.2 Health Protection is multi-agency. It is not just a local authority responsibility. Therefore, the Health Protection Committee is attended by colleagues across Rotherham Place.

1.3 The scale of work undertaken to prevent and manage threats to health is driven by national, regional and local guidance, intelligence and health risks. There are activities undertaken proactively and reactively to protect health and prevent ill health. This report will cover the following areas:

- Infectious disease management
- National programmes for screening
- National programmes for vaccination and immunization
- Healthcare associated infections, including a spotlight on TB
- Infection prevention and control
- Health emergency preparedness and response.
- Environmental health and trading standards

# 2 Assurance arrangements

2.1 Local authorities, through their Director of Public Health, have an assurance role to ensure that appropriate arrangements are in place to protect the health of their populations. The Director of Public Health has a role in working with the UKHSA and the NHS to ensure arrangements are in place for health protection.

2.2 The Health Protection Committee is mandated by the Health and Wellbeing Board to provide assurance that adequate arrangements are in place for prevention, surveillance, planning, and response to communicable disease and environmental hazards.

2.3 Summary terms of reference for the Committee are listed at Appendix 1.

2.4 A summary of organisational roles in relation to delivery, surveillance and assurance is included at Appendix 2.

# 3 Infectious Disease Management

**Surveillance Arrangements**

3.1 UKHSA provides a quarterly report to the Health Protection Committee containing epidemiological information on cases and outbreaks of communicable diseases of public health importance at local authority level.

3.2 Surveillance arrangements cover all relevant pathogens and hazards, including notifiable diseases.

3.3 Fortnightly bulletins are produced by UKHSA throughout the winter months, providing surveillance information on influenza and influenza-like illness and infectious intestinal diseases, including norovirus.

3.4 A Health Protection Dashboard is in use locally, which supports surveillance and assists the Health Protection Committee in reviewing available data.

**Infectious diseases**

3.5 In 2024/25 there were 285 notifications of infectious diseases (NOIDs) reports received for Rotherham.

3.6 During 2024/25 the Rotherham Council Public Health, Health Protection function provided a specialist response to infectious disease and hazard related situations across Rotherham. Situations responded to have included:

- An outbreak of Legionella in a Social Housing Complex
- Cases of cryptosporidium
- Cases of Syphilis and Gonorrhea in the Rotherham Area.
- Gastro-intestinal outbreaks in early years, schools and residential care settings
- Case of Tuberculosis

# 4 Screening programmes

4.1 There are a range of screening programmes available to the residents of Rotherham through their life course, including Antenatal and newborn screening, Cervical Screening, Breast screening, Abdominal Aortic Aneurysm, Bowel screening and Diabetic eye screening. The NHS has the responsibility for these programmes and provides assurance to Health Protection Committee.

4.2 An update to the report presented in 2024 is given below for each of the aforementioned screening programmes. The Rotherham plans and work throughout 2024/25 reflect both the national and Yorkshire and Humber priorities and programme changes.

4.3 Key areas of work/priorities include but are not limited to:

- Increasing uptake within Breast, Bowel and Cervical Cancer screening programmes. Continue local collaborative work with programme providers and partners to improve uptake of screening for individuals with a learning difficulty/disability, through Digital flagging work and extending this work to include patients with a known severe mental illness (SMI).
- Within the diabetic eye screening programme (DESP) the focus has been to clear the Slit Lamp Biomicroscopy (SLB) backlog and maintain invite intervals within standards, full implementation of extended screening intervals for patients with no evidence of diabetic retinopathy, introduction of Optical Coherence Tomography (OCT) and reduce the number of persistent non-attenders.
- Within Bowel screening, a priority was to embed age extension in line with national policy and ensure implementation of the inclusion of individuals diagnosed with Lynch syndrome into the bowel screening programme.
- The NHS Cervical Screening Programme – in addition to improving uptake, a focus has been on supporting the provider in their readiness for 'ping and book', scheduled to commence from Spring 2025, in line with the national strategy to fully digitise screening. This initiative will send alerts via the NHS App, and mobile phones to remind women they are due or overdue an appointment.

**Abdominal Aortic Aneurism - South Yorkshire & Bassetlaw Programme**

4.4 An Abdominal Aortic Aneurysm (AAA) is a swelling in the aorta, the main artery in the abdomen, which can cause serious health consequences and death.

4.5 The AAA screening programme, delivered by Doncaster and Bassetlaw NHS Teaching Hospital, is routinely offered to males during their 65th year. Anyone assigned male at birth who is over the age 65 or over can have AAA screening. Those previously eligible who did not take up the routine offer can continue to self-refer. Screening is also available via a request by their GP for trans and non-binary individuals assigned male at birth who have changed their gender marker on the health care records system (as the clinical risk remains unchanged).

4.6 The aim of the AAA screening programme is:

- To reduce AAA-related mortality by detecting aneurysms at an early stage,
- Ensure appropriate surveillance and referral to vascular services if required and improve outcomes/health for those with a detected AAA

4.7 Men with referrable aneurysms (≥5.5cm diameter) are referred to either Sheffield Vascular Services or Doncaster Vascular Services. The AAA screening provider works closely with both services to ensure timely assessment and intervention

4.8 The programme have performed well during 2024/25:

- 99.8% of eligible men invited
- 83.3% coverage (those screened out the total eligible population)
- 84% uptake (those screened from those invited)

These figures are above the minimum/acceptable standard of 75% and just below the achievable standard of 85%.

4.9 The screening provider has completed a Health Equity Assessment, which has been used to direct improvement work and reduce inequalities. This includes:

- work to reduce non-attendance at 1st appointment, particularly across Lower Super Output Areas, resulting in improved uptake.
- Invitation letters insert, signposting to interpreted information where English is not the first/spoken language.
- Improved provision for individuals with a Learning Disability, through lists being provided by GPs – allowing for reasonable adjustments to be put in place.
- Transwomen invited for screening following referral by GP.
- Screening for individuals who are housebound.
- Expansion of health promotion sessions in community group venues
- Health optimisation work – to improve fitness for men referred to surgery (ultimately reducing time from referral to surgery)

**Ante-natal and Newborn**

4.10 Antenatal and newborn (ANNB) screening covers tests conducted in pregnancy for infectious diseases, inherited/genetic conditions - Down's syndrome, Edward's syndrome and Patau's syndrome, and other physical abnormalities, and in newborn babies including newborn hearing, blood spot screening and physical examination. Screening is supported by The Rotherham NHS Foundation Trust, and the SY pathology network (via Sheffield Teaching Hospital and Sheffield Children's Hospital)

4.11 All key performance indicators (KPIs) are being met with no areas of concern to highlight. The maternity provider has made good progress in improving performance in relation to 'Avoidable Repeats Newborn Blood Spot (ARR NB2)', which regularly meets the standard of ≤ 2% for avoidable repeats samples.

4.12 Inequalities: The maternity provider in Rotherham continues to work in collaboration with the NHS England Public Health Programmes Team in South Yorkshire, using the Health Equity Audit Tool, to understand the reasons why women do not attend (DNA) for antenatal screening. This work has continued but has been impacted by workforce capacity within the maternity service and a change of ANNB screening lead. The assessment and resulting action plan will be continued into 2025/26.

**Diabetic Eye Screening**

4.13 The Diabetic Eye Screening Programme (DESP) covers all individuals aged 12 years and over with a diagnosis of diabetes and pregnant women diagnosed with diabetes during pregnancy. The aim being to identify, refer and where appropriate treat sight-threatening disease, occurring as a result of their diabetes, as early as

possible. The screening programme is delivered by Barnsley NHS Foundation Trust, and delivered at both Barnsley and Rotherham Hospital, and some local community outreach venues

4.14 Programme Delivery and Oversight is via monthly meetings between NHS England Public Health Programmes Team and the provider. Whilst capacity has significantly reduced at various points during 2024/25, due to workforce issues (vacancies and staff absence), the Barnsley and Rotherham programme continue to work to reduce the SLB backlog and improve the timeliness of SLB appointments, as well as working to reduce the number of repeat non-attenders. Service redesign and recruitment to support resilience going forward is being reviewed internally by Barnsley District General Foundation Trust.

4.15 Service Development: In line with nationally policy, in October 2024 the provider successfully implemented extended screening intervals for patients with no detectable /referrable disease in their last two screens, meaning that these patients will be invited for routine screening every 24 months, as opposed to the previous 12 months. Individuals with any level of disease will remain on the current 12-month recall pathway. This pathway change will help to support other changes/developments within the programme.

4.16 A key national programme change was the introduction of Optical Coherence Tomography (OCT) for patients in digital surveillance. This was planned from October 2024, with full roll out by October 2025. This has been delayed due to IT infrastructure (server requirements to support image storage), however, the NHS England Public Health Programmes Team have been and are continuing to work with the provider to implement OCT, from late summer 2025.

4.17 Inequalities: to improve access for the working population, the DESP provider has offered some evenings and weekend clinics, which have been well received. As part of their engagement work, the programme has been contacting people with a learning disability prior to their appointment to discuss any issues/concerns and ensure any reasonable adjustments are made. The provider will continue to assess and plan to address any inequalities within the programme and develop an action plan following completion of a Health Equity Audit.

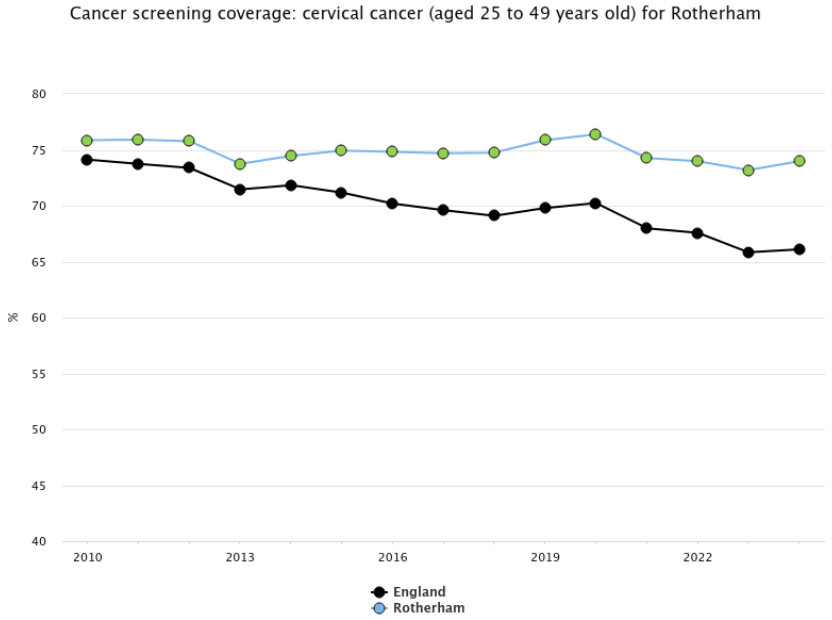
## Cervical Screening

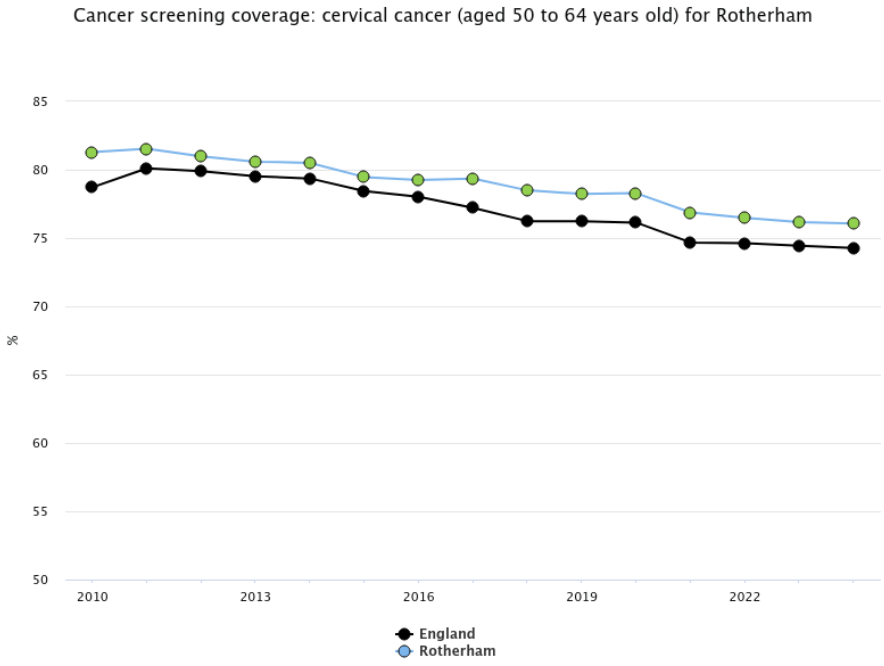
4.18 Cervical screening is a test to check the health of the cervix and is offered to people with a cervix aged between 25 to 64 years every three or five years depending on age.

4.19 There are three main components of the cervical programme. These include the cervical sample (often referred as the ‘smear’), testing/analysis in the laboratory and, if required, colposcopy, delivered by Rotherham NHS Foundation Trust. Whilst cervical screening is mostly undertaken in primary care (GP practice), it may also be accessed via Integrated Sexual Health Services on an opportunistic basis, and via extended access/hours clinics, providing screening during evenings and on weekends to increase uptake. From 1st April 2025 trans men and non-binary people with a cervix will be able to opt-in to receive routine automatic invitation

4.20 Uptake continues to be lower in the 25-49 year old cohort, compared with the 50–64 year-old cohort (also reflected nationally), though coverage in both age groups for Q1 2024/25 remains below the 80% acceptable standard. Work continues with practices and partners to try and improve uptake.

| Cohorts | Period | Target | Rotherham |
|---|---|---|---|
| 25-49 Years | 2024 | >80% | 74% |
| 50-64 Years | | >80% | 76.1% |




Source for table and graphs Fingertips | Department of Health and Social Care

4.21 Inequalities: For individuals with a diagnosis of learning disabilities, a code is

assigned to their GP record so that when they are due for cervical screening, support from the community learning disabilities team can be provided where required and reasonable adjustments made to accommodate their needs, thereby encouraging their attendance at screening. It is encouraged that Primary care then share the reasonable adjustments information (following consent) with TRFT Colposcopy unit should further tests/appointments be required.

**Bowel Screening South Yorkshire and Bassetlaw Hub**

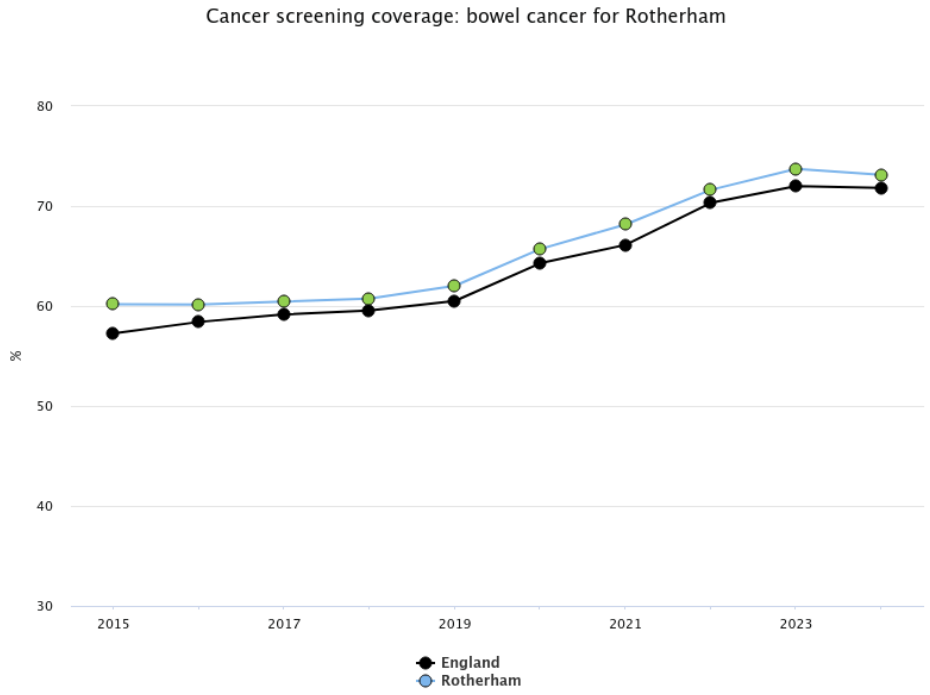
4.22 Bowel cancer screening is a test carried out at home to detect signs of bowel cancer. It is offered to everyone aged 50 to 74 years. The age of first screening offer is lower than it was previously. The Age Extension of the Bowel Screening Programme to individuals from 50 years of age has been a phased approach over the last four years and is now fully rolled out across Rotherham.

4.23 Bowel cancer screening for the population of Rotherham is coordinated by the Regional Bowel Screening Hub (in Gateshead) and South Yorkshire Bowel Screening Centre (led by Sheffield Teaching Hospital NHS Foundation Trust).

4.24 Individuals receive a bowel screening kit via the post. The sample is then returned to the Hub/lab for testing. If there is a need for further assessment, the Bowel screening centre nurse specialist contacts the patient and coordinates the assessment and referral of the individual to the respective endoscopy unit. Whilst most patients will attend The Rotherham NHS Foundation Trust Hospital, they are able to choose any of the hospitals within South Yorkshire.

4.25 The programme continues to perform well, with uptake above the upper (achievable) standard.

4.26 The bowel screening programme continues to offer screening to people diagnosed with Lynch syndrome in the form of a 2 yearly colonoscopy. Lynch Syndrome is an inherited condition which predisposes individuals to developing bowel cancer. The programme is meeting all standards, with no concerns to report.




Source for table and graphs Fingertips | Department of Health and Social Care

4.27 Inequalities: The screening centre has employed a health improvement practitioner whose focus, guided by the Health Equity Assessment, is to increase the awareness and ultimately uptake of bowel screening in areas of lower uptake, via dedicated sessions, roadshows etc. The initiative where GPs place a flag on the record of individuals with a diagnosis of learning disability (LD), thereby alerting the bowel hub to provide more accessible information when sending out the invitation, is now embedded in Rotherham with positive impact.

## Breast Screening

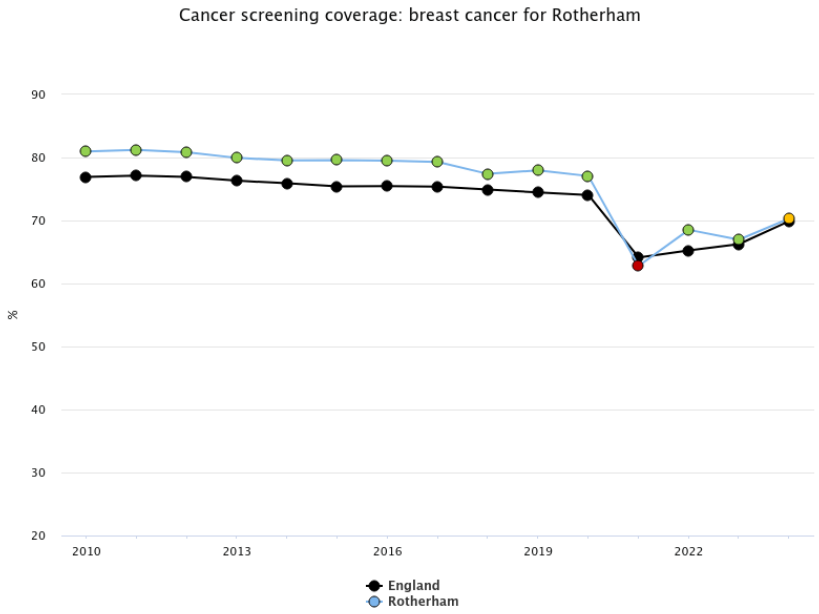
4.28 Breast screening is offered to all people registered as female at their GP practice aged between 50 and 71 years. The first invitation arrives between age 50 and 53 years, screening is offered every 3 years and is provided by Rotherham NHS Foundation Trust Hospital.

4.29 Women are receiving timely invitations in line with their next test due date. The programme has continued to use a “fixed appointment” model, as this has been shown to improve the uptake of breast screening and aid management of breast screening unit capacity.

4.30 Uptake for breast screening is improving, however ongoing work and collaboration with the Cancer Alliance and organisations within the community such as charities and voluntary sector to raise awareness of breast screening will support continued improvement in uptake.

| Period | Cohorts | Target | Rotherham |
|---|---|---|---|

| | | | |
|---|---|---|---|
| 2024 | 50-70 Years | Acceptable >70% Achievable > 80 % | 70.3% |




Source for table and graphs Fingertips | Department of Health and Social Care

4.31 Improvement work: The provider has completed a Health Equity Audit and action plan, with ongoing work to improve uptake including health promotion via Trust Comms and wider initiatives such as supermarket stands, delivering awareness sessions to GP practices, developing promotional videos, use of text messages (based on behavioural science insights) to reduce the number of women who do not attend (DNA).

4.32 Discussions continue between with the Public Health Programmes Team, Primary Care and Rotherham NHS Foundation Trust Hospital to increase uptake in people with a learning disability using the same approach to bowel screening. Similar flagging work has commenced using the Rotherham NHS Foundation Trust Learning disability nursing team and the plan is to extend this to include individuals with severe and enduring mental illness.

# 5 Immunisation/Vaccination programmes

5.1 The responsibility for vaccination and immunisation programmes lies with the NHS, who provide assurance to the Health Protection Committee. Programme delivery has continued as business as usual across all Section 7a Programmes throughout 2024/25, with a continued emphasis on restoring uptake and coverage to pre-pandemic levels and reducing inequalities within screening and immunisation.

5.2 The vaccination schedule includes:

- Childhood vaccination programme
- Maternal pertussis
- Shingles
- Pneuovax

- Seasonal influenza
- RSV
- COVID-19

Please note this report excludes Covid 19 vaccinations as this vaccination programme was not part of the Section 7a NHS England Commissioned Services during this time period.

5.3 To support delivery against the public health outcomes framework, the Rotherham Immunisation Improvement Plan aims to deliver improvement in delivery and uptake for:

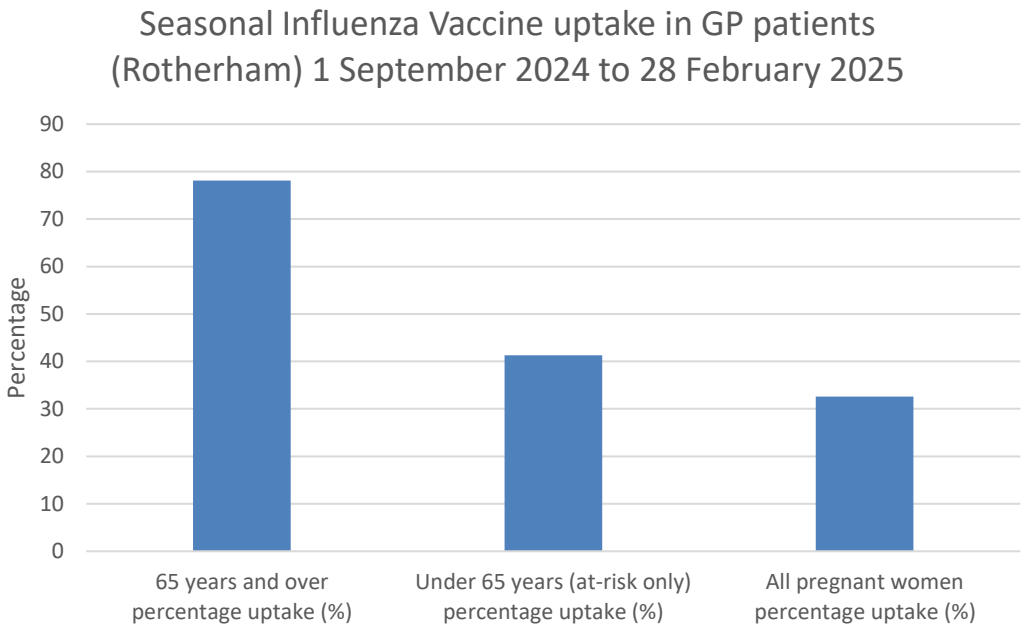
- MMR dose 1 by 2 years of age. As a minimum maintaining coverage of above 90% (minimum threshold), but aiming to build on previous improvement and move towards achieving the 95% optimal threshold required to ensure wider community protection
- Improving uptake of all routine adolescent programmes, as these are all significantly lower than pre-pandemic levels. This work includes reducing the variation between schools with the highest and lowest uptake and has a particular focus on HPV, which also supports the national cervical cancer elimination strategy.
- The new RSV (Respiratory Syncytial Virus) vaccination programme for pregnant women and older adults which commenced 1st September 2024.
- Maternal Pertussis vaccination, prioritised due to the increase in number of cases of pertussis and infant deaths nationally during 2024 and the downward trend seen across Rotherham over recent years, however uptake has remained above the 60% optimal threshold.
- Seasonal Flu – working with partners across Rotherham to enable focused place-based work to improve uptake across all cohorts but with a key focus on 2 and 3-year-olds, pregnant women, patients with chronic respiratory disease, immunocompromised patients and individuals with a learning disability or severe mental illness.

## Seasonal Flu

5.4 Seasonal flu vaccination is delivered annually via a variety of providers, including primary medical care (GP practices), community pharmacists, school-aged immunisation providers, maternity services and Trusts. Those eligible in 2024/25 remained unchanged from the previous season.

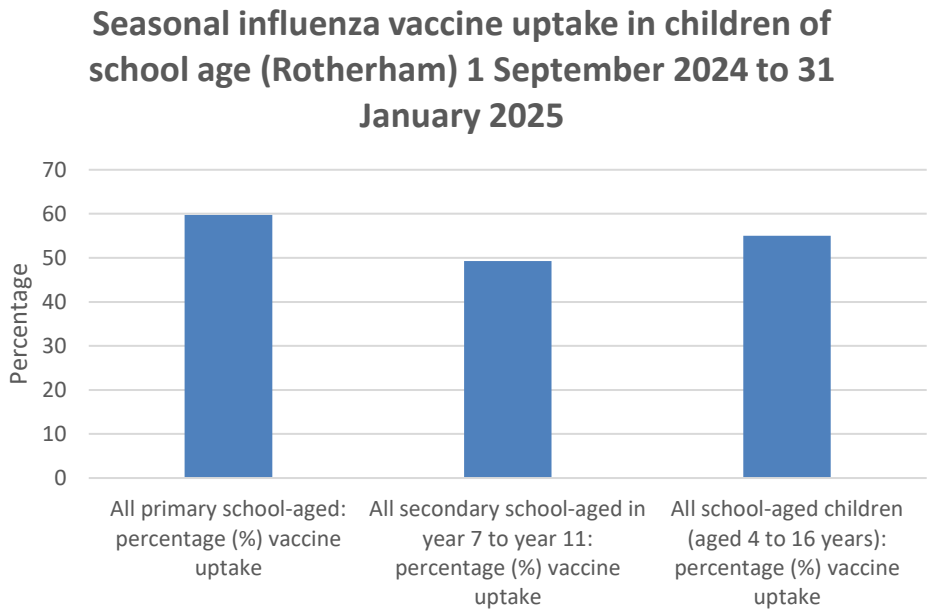
5.5 Ambitions for Flu season 2024/2025: The requirement was a 100% offer for all eligible individuals via call and recall, and with opportunistic offers or vaccination upon request between September and March each year.

5.6 Rotherham has seen a slight decrease amongst all the eligible cohorts. The reasons for this decline are not yet clear, but the downward trend is reflected regionally and nationally. Work will be undertaken to try and understand the reasons behind the decline and inform planning for 2025/26.




Source: Seasonal influenza vaccine uptake in GP patients: monthly data, 2024 to 2025 - GOV.UK

5.7 Across Rotherham, Intrahealth have continued to deliver flu vaccinations to all school-aged children, including those not in education/home schooled. Inactivated injectable flu vaccine has been offered and administrated where the porcine-containing nasal flu vaccine (LAIV) is contraindicated or declined for religious/cultural reasons. 2024/25 uptake is in line with the England average.




Source: Seasonal influenza vaccine uptake in children of school age: monthly data, 2024 to 2025 - GOV.UK

**Maternal Pertussis:**

5.8 Prenatal pertussis vaccine is offered from 16 weeks of pregnancy. Whilst this vaccination is offered opportunistically by Maternity Providers during their antenatal appointment at The Rotherham NHS Foundation Trust, work has progressed with the provider to establish a more routine offer as part of the wider vaccination in

pregnancy programme, this positive approach has provided a safe space for individuals to discuss any of the vaccinations offered during pregnancy.

5.9 Maternal pertussis vaccination also continues to be offered opportunistically and on request through Primary Care (GP).

5.10 There has been a slight decline in uptake of this vaccination since April 2022 with a wide variation between practices noted, however improvement work continues, with a focus on practices with less than 60% uptake and this has been supported by the national campaign which was launched in October 2024 and targeted work implemented by the South Yorkshire Local Maternity and Neonatal Service (LMNS) group.

## Respiratory Syncytial Virus (RSV)

5.11 From 1st September 2024 RSV vaccination was added to the routine vaccination schedule for pregnant people and older adults.

5.12 Maternal Programme: Pregnant women are recommended to have the RSV vaccine in each pregnancy (on or after 28 weeks of pregnancy), to protect their babies against respiratory syncytial virus (RSV). Whilst maternity services provide the initial offer, pregnant people can also access vaccination via their GP (opportunistically or on request).

5.13 The programme appears to have been well received by pregnant individuals, and The Rotherham NHS Foundation Trust maternity provider has been well engaged with the planning and delivery of the programme. Between 1st September and 31st March 2025, the Trust had administered 605 vaccines, with a further 108 delivered by primary care.

5.14 Older cohort: This cohort comprises those who turn 75 on or after the 1st September 2024, with a catch-up campaign for those aged 75 to 79 (including those who turn 80 before 31st August 2025), with the vaccination being delivered by GP Primary Care services. As of 31st December 2024, over 8,344 vaccines had been delivered to this cohort.

## Adolescent immunisations

5.15 The School Aged Immunisation Service in Rotherham is provided by Intrahealth. Although showing recovery and mostly meeting the minimum standard (80%) across all programmes, all adolescent vaccination programmes remain below pre-pandemic levels, a trend which is reflected nationally.

5.16 The provider continues to offer catch-up vaccinations to individuals through to Y11 via community clinics. Unvaccinated individuals remain eligible via their GP (opportunistically and on request) for MMR, with no upper age limit, and HPV and Men ACWY up to and including 24 years of age. Work has been undertaken in conjunction with Cancer Alliance to facilitate and encourage GPs to undertake proactive catch up of girls 18-25 (boys were not eligible at that time, as the male

programme only commenced in September 2019)

## Childhood Immunisations

5.17 The Public Health Programmes Team review practice-level data regularly, along with vaccination waiting lists for all practices, with action plans developed where required to facilitate timely access and delivery. The efficiency standard for these programmes is 90%, the optimal standard (required to ensure herd immunity) is 95%. See summary below from National COVER data 2024/25.

| | 12m Denominator | 12m DTaP/IPV/Hib/HepB% | 24m Denominator | 24m DTaP/IPV/Hib/HepB% | 24m MMR | 5y Denominator | 5y DTaP/IPV/Hib% | 5y DTaPIPV% | 5y MMR1% | 5y MMR 2 % |
|---|---|---|---|---|---|---|---|---|---|---|
| Rotherham ICB | 2758 | 95.1 | 2769 | 95.9 | 94.4 | 2957 | 95.9 | 88.9 | 95.5 | 90.3 |

## Improvement work

5.18 The NHSE Public Health Programmes Team are continuing to work with practices, the Local Authority Public Health Team and Child Health Services to identify barriers to vaccination and address high waiting/unvaccinated lists, including reviewing reasons why parents don't attend/bring their child, capacity, access, clinic management/appointing, communication to parents, number of children contacted.

5.19 Childhood immunisations is a national, regional and place priority. Local work has continued throughout the year, following which improvement has been noted via the national COVER data, with all childhood immunisations having increased slightly from the previous two years.

# 6 Health Care Associated Infections

6.1 Healthcare-associated infections (HCAIs) are those linked to healthcare, either as a direct result of healthcare interventions (e.g. medical or surgical treatment), or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections, such as MRSA, MSSA, C.Difficile, E.coli, Pseudomonas Auruginosa and Klebsiella.

6.2 HCAI's pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result infection prevention and control is a key priority for the NHS.

6.3 Strategic objectives relating to Infection Prevention and Control (IPC) and quality requirements are included in the NHS standard contract. These are to:

- Improve quality including safety, clinical outcomes and patient experience.
- Meet national and locally determined performance standards, threshold objectives/ targets (including guidance/ advisory)
- Focus on reducing infection levels.
- Focus on actions to reduce the risk of infections and to support early diagnosis and appropriate treatment which will have beneficial effects for both patient outcomes and service demand.
- Support the delivery of the AMR National Action Plan (2024-29)

6.4 The following table summarises the key performance position and developments for health care associated infections over 2024/25.

| HCAI: | TRFT | NHSR |
|---|---|---|
| MRSA | 1 | 1 |
| MSSA | 22 | 74 |
| Clostridium Difficile | 71 | 119 |
| E Coli | 71 | 233 |
| Klebsiella spp | 24 | 62 |
| Pseudomonas aeruginosa | 19 | 31 |

6.5 The following table summarises the key performance position and developments for health care associated infections over 2024/25 along with the thresholds and comparison to 2022/2023.

| HCAI | 24/25 | 24/25 | 24/25 Objective | | 23/24 | 23/24 | Comparison to 22/23 | |
|---|---|---|---|---|---|---|---|---|
| | TRFT | NHSR | TRFT | NHSR | TRFT | NHSR | TRFT | NHSR |
| MRSA | 1 | 1 | Zero tolerance | | 1 | 6 | | |
| MSSA | 22 | 74 | No objective | | 12 | 72 | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| C. Difficile | 71 | 119 | 44 | 89 | 44 | 103 | | |
| E Coli | 71 | 233 | 46 | 236 | 48 | 213 | | |
| Klebsiella Spp | 24 | 62 | 17 | 69 | 17 | 62 | | |
| Pseudomonas Aeruginosa | 19 | 31 | 9 | 22 | 10 | 26 | | |

## MRSA

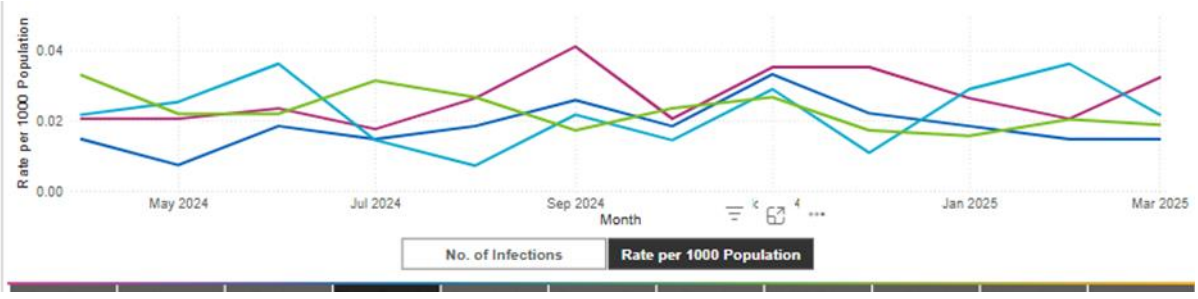
6.6 There is a zero tolerance approach to MRSA Blood Stream Infections. In 2024/5 there have been 2 cases; 1 hospital case that was identified as a likely contaminant and 1 community case. This is a reduction from last year when there were 6 cases in Rotherham.

6.7 Rotherham continues to be under the current threshold rate whereby PIR is required to be inputted on to the UKHSA Data Capture System (as was the expectation for all cases in the past).

## MSSA

6.8 There is no national threshold for this although numbers are monitored regularly. The number within the acute trust have increased and the community cases have decreased, although show an overall slight increase as a whole health community. The increase of hospital cases is addressed through the Patient Safety Incident Response Framework (PSIRF), with a focus on learning and improvement, and will continue to be monitored.

6.9 The graph below shows rate comparison over 2024-2025 with other South Yorkshire areas, where pale blue is Rotherham.




## Clostridium Difficile

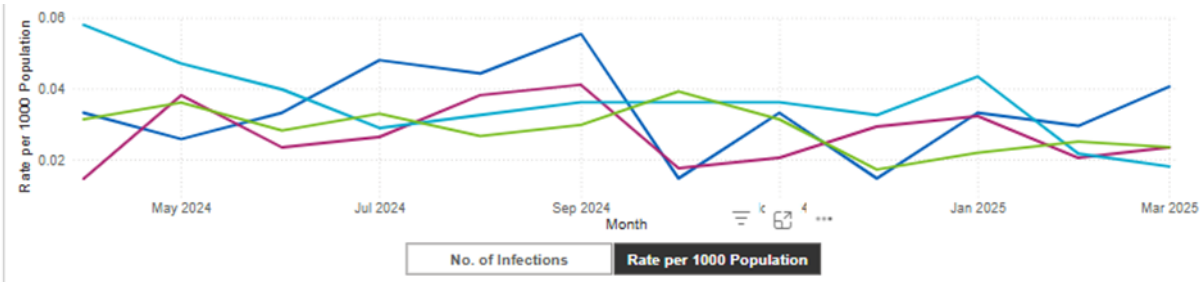
6.10 There has been am increase in cases in Rotherham. The increase of hospital cases is addressed through the Patient Safety Incident Response Framework (PSIRF), with a focus on learning and improvement.

6.11 Reviews have indicated some quality themes along with antibiotic prescribing. There have been targeted improvement strategies put into place that have shown reductions in Clostridioides Difficile (CD) cases as a result. There had been vacant microbiologist posts the situation has now improved with 2 Consultant Microbiology posts, one of which is a shared post with 2 Consultants who work between TRFT and Infectious Diseases, the other post is a Consultant who will start in July 2025. For Support there are 2 Specialist Registrars who will provide cover whilst in training. Antimicrobial stewardship has been identified as a quality priority for 2025/26.

6.12 The Antimicrobial Stewardship Group (ASG) re-established in September 2024, following an antimicrobial pharmacist appointment, the group oversees the antimicrobial stewardship activities of the Trust and includes representation from the ICB and GPs. This allows work streams to take place across the Rotherham health community.

6.13 Nationally there has been an increase in CD Infections. The thresholds set in the NHS Standard Contract remain unrealistic (particularly in Rotherham) due to the calculation process & are a poor measure in terms of quality improvement. This has been recognised nationally with discussions around how to measure rates opposed to case numbers.

6.14 The graph below shows rate comparison over 2024-2025 with other South Yorkshire areas, where pale blue is Rotherham. Green is Sheffield, Dark Blue is Barnsley, and Purple is Doncaster.




**Gram Negative BSI cases**

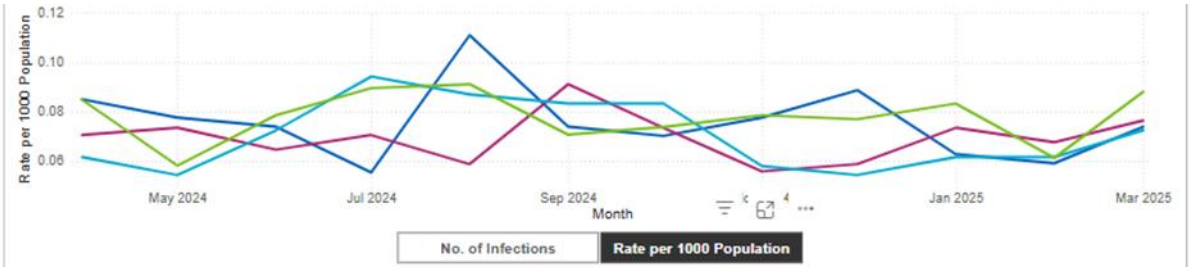
6.15 Gram negative infections remain predominantly urine related. E Coli, Pseudomonas and Klebsiella are all gram negative blood stream infections. There are variances in thresholds and case numbers with reasons for this being complex. There are ongoing surveillance and improvement projects.

- E coli –Rotherham place are below the threshold, TRFT have exceeded the threshold.
- Klebsiella – Rotherham place are below the threshold, TRFT have exceeded the threshold.
- Pseudomonas - Rotherham place and TRFT have exceeded the threshold.

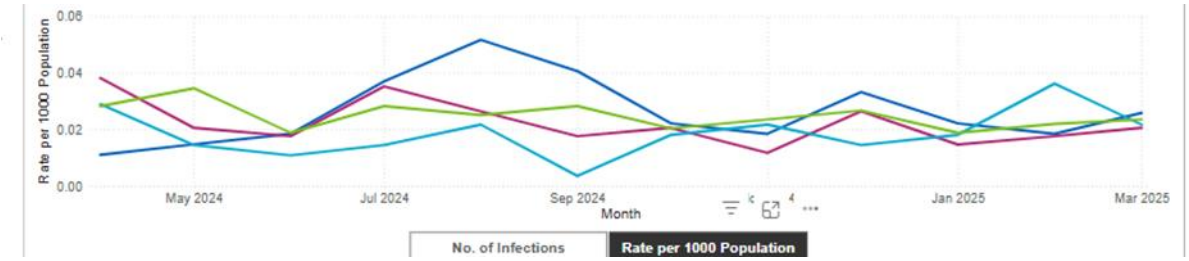
6.16 NHSE identified inadequate hydration as a possible causative factor. Rotherham place hydration project, with a multi-disciplinary team of health care professionals, have been working to improve hydration in care homes using specific measures and this has possibly had some positive effects on being below some thresholds.

6.17 The graph below shows rate comparison over 2024-2025 with other South Yorkshire areas, where pale blue is Rotherham.

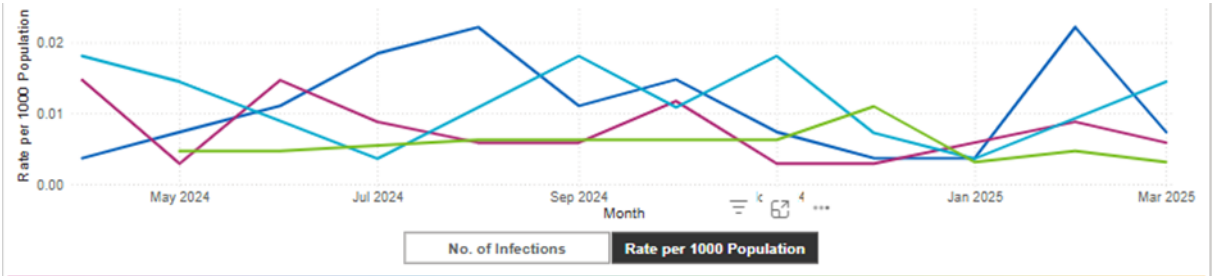
E Coli




Klebsiella




Pseudomonas




## Hydration Project

6.18 This project, mentioned above, focuses on hydration in care homes. Part of the project focuses on urinary tract infection (UTI) assessment, sampling and prescribing. This is planned to be expanded through Rotherham GPs.

6.19 The Rotherham hydration project team won an award (HSJ award for Place Based Partnership and Integrated Care Award). They were also shortlisted for the Gov.net "Smarter Working Live Awards" which is a Government run Innovation as a Service Award. One of the team achieved a personal award - a CAHPO Award 2024 (Chief Allied Health Professional Officer Award) for AHP Innovation and Improvement in

Integrated Care Systems.

6.20 The project has shown a decrease in:

- The number of UTI's read coded on the GP system.
- The number of antibiotic courses prescribed and repeat antibiotics prescribed.
- The number of ambulance call outs to care homes
- The number of laxatives prescribed
- The number of barrier products prescribed.

**Antimicrobial resistance**

6.21 The AMR plan includes themes around broad spectrum antibiotic prescribing and high volume antibiotic prescribing in GP practices. This links in with all HCAI IPC workstreams and reduction and improvement strategies.

6.22 The Antimicrobial Stewardship Group (ASG) oversees the antimicrobial stewardship activities of the Trust and includes representation from the ICB and GPs. This allows work streams to take place across the Rotherham health community.

6.23 Antimicrobial stewardship has been identified as a quality priority for 2025/26 at TRFT.

# 7 Spotlight: Tuberculosis

**Main Messages**

7.1 Tuberculosis (TB) notification rates in England in 2023 increased by 11.0% compared with 2022, the largest year-on-year increase in the current reporting period (2000 to 2023)

7.2 England remained below the World Health Organization (WHO) threshold of 10 per 100,000 population for a low incidence country, at 8.5 per 100,000 population in 2023 but the rate diverged further from the trajectory needed to meet the WHO End TB target by 2035.

7.3 Almost 80% of active TB notified in England was in people born outside the UK in whom rates increased by 7.2% to 40.1 per 100,000 compared with 2022.

7.4 The TB notification rate in people born in the UK in 2023 increased by 5.0% compared with 2022, this was the first rate-increase in UK-born individuals with TB UK since 2012 following a decade of continual decline.

7.5 The number of individuals born outside the UK notified with TB disease within 5 years of entry to the UK increased by almost 2-fold, compared with 2019; the largest increase was within people notified within 1 to 2 years of entry

7.6 The number of individuals with 2 or more social risk factors increased by 39% compared with 2018; these individuals often experience complex social needs and require enhanced support from services to access healthcare

**TB Action plan for England**

7.7 The TB action plan for England has 5 key priorities:

- Recovery from COVID-19
- Prevent TB
- Detect TB
- Control TB disease
- Workforce

7.8 These priorities are underpinned by:

- actions for specific population groups, that is, those with social risk factors, new entrants, people with drug resistant TB and children with TB
- measurable outcomes and indicators
- systems wide actions, that is, communications, surveillance, research and ensuring TB is included on prevention and health inequalities agendas

**GIRFT (Get It Right First Time)**

7.9 NHS England's prevention team commissioned the review to support the implementation of the National TB Action Plan for England 2021-2026 and to identify further improvements to sustain care and highlight good practice. A new data-driven national report produced by GIRFT into tuberculosis (TB) services across England outlines measures which can improve services for TB patients and the NHS staff who care for them.

7.10 The GIRFT TB review was to instigate a step change in care, reducing the burden of TB on patients, their careers, providers of TB services and the local and national health systems. The report includes recommendations for improvement which will need to be delivered by the NHS, NHS England and other key stakeholders, recognising that there are multiple organisations who need to be involved to deliver some of the improvements.

**TB in Rotherham**

7.11 Rotherham has a low incidence of TB but a significant proportion of cases have risk factors for poor treatment completion and onward transmission to others such as homelessness, drug or alcohol use, a history of imprisonment or mental health issues.

7.12 Case management is the comprehensive follow-up of a suspected or confirmed TB case. Case management requires a collaborative multidisciplinary team (MDT) approach. Case management is commenced as soon as possible after a suspected case has been identified. Enhanced Case Management (ECM) applies to any case

where more than the usual amount of TB Nurse time (as outlined by the RCN) is required for their management. Level 0 (zero) refers to Standard case management, and ECM levels ranged from 1-3 depending on their complexity. Rotherham cases are often in need of ECM level 3. Although the number of active TB cases is considered low, the cases are high in complexities, and support mechanisms such as Video Observed therapy have been utilised to support concordance with treatment.

7.13 Rotherham has a robust process to support the TB screening of high risk individuals that are new entrants to the country. The TB nursing service works closely with the Gate surgery to ensure the care of individuals, identified as having latent TB infection are seen and treated in timely fashion. Patients cared for who are diagnosed latent TB infection are also cared for using the Case management tool. Further work is planned to look at other TB screening opportunities to further support the reduction in active TB disease cases in the future

7.14 Cohort review has now been adopted, and a clinical network meeting format is in place and is held jointly with South Yorkshire TB services. This process supports clinical discussions of complex cases. The overall aim is to ensure that best practice has been followed in treatment and contact tracing and reflect on regional practices.

# 8 Infection, Prevention and control (IPC)

8.1 There are statutory responsibilities regarding IPC affecting a range of health and social care organisations. Direct responsibility for the health and safety of people within in a setting, such as a care home, lies with the provider. The Director for Public Health has a role to work with UKHSA and the NHS through the Integrated Care Partnership to ensure arrangements are in place for health protection. Such arrangements should include infection and prevention control within health and care settings.

8.2 Rotherham, as a geographical area, has a range of IPC staff roles. There are staff with specific IPC roles working within the Rotherham NHS Foundation Trust and the Rotherham Doncaster and South Humber NHS Foundation Trust, as well as a Lead Infection Prevention and Control Nurse for Rotherham based within the NHS ICB.

8.3 RMBC has a service specification for Care Homes for Older people which includes necessity for providers to have suitable IPC policies and procedures. RMBC commissioned care homes must adhere to the requirements, including training for staff, ensuring IPC policies and practice are in place and engaging with agencies such as UKHSA.

8.4 In 2024-2025 a Senior Public Health Practitioner with the local authority Public Health Team began to work on IPC, and this was formalised to 0.8 whole time equivalent (wte) dedicated to IPC work as of January 2025.

8.5 This staffing capacity is being used to carry out targeted work with Care Homes to support IPC audit and provide support to improve IPC capabilities and practice where this is required. Currently this post carries out the following work.

- Contacting all care homes with outbreaks and providing support and advice, recontacting them after 5 days to ensure the outbreak is controlled and no further interventions are required.

- Audits with care homes who agree to participate, with follow up when required.
- Engagement with contract compliance team at RMBC, and wider care home workforce as part of Risk Management Meetings.
- Arranging quarterly IPC Champions meetings, with representatives from every care home.
- Drafting a monthly IPC Newsletter, with updates and advice

8.6 Between Jan 2025 and March 2025:

- 10 audits have been undertaken
- 5 initial care home visits have taken place (to introduce care homes to the IPC offer)
- Support has been provided for 14 outbreak situations

# 9 Emergency planning and response

9.1 Through 2024/25, significant progress has been made to uplift and review emergency response plans, predominantly held by the Emergency Planning Service and that underpin the Council integrated response and recovery plan. Plan review was slowed because of the Covid 19 international pandemic and recovery from this has taken time.

9.2 Through 2024/25, significant progress has been made to uplift and review emergency response plans, predominantly held by the Emergency Planning Service and that underpin the Council integrated response and recovery plan. Plan review was slowed because of the Covid 19 international pandemic and recovery from this has taken time.

9.3 In line with the risk profile, the following plans are held and maintained by the Emergency Planning Service:

- Generic Incident response and recovery plan (formerly Major Incident Plan, Recovery framework and Council wide business continuity)
- Adverse Weather (all scenarios)
- Flood Response Plan
- Disruption to Fuel Supplies (in line with the national Emergency Plan for Fuel)
- Humanitarian Assistance (Rest Centre)
- Mass Fatalities response framework (LRF plan, developed and owned by the Emergency Planning Shared Service)
- Reservoir Inundation Plan

9.4 Of note, the Council's Integrated Response and Recovery Plan was the most complex review as it includes not only command and control arrangements, but generic response arrangements developed in line with the nationally recognised integrated emergency management concept. This has involved a wide range of consultation and external peer review which is complete.

9.5 To support and underpin the Integrated response and recovery plan, new thematic operational plans will need to be developed by services, in conjunction with the EPS, over 2025 / 26.

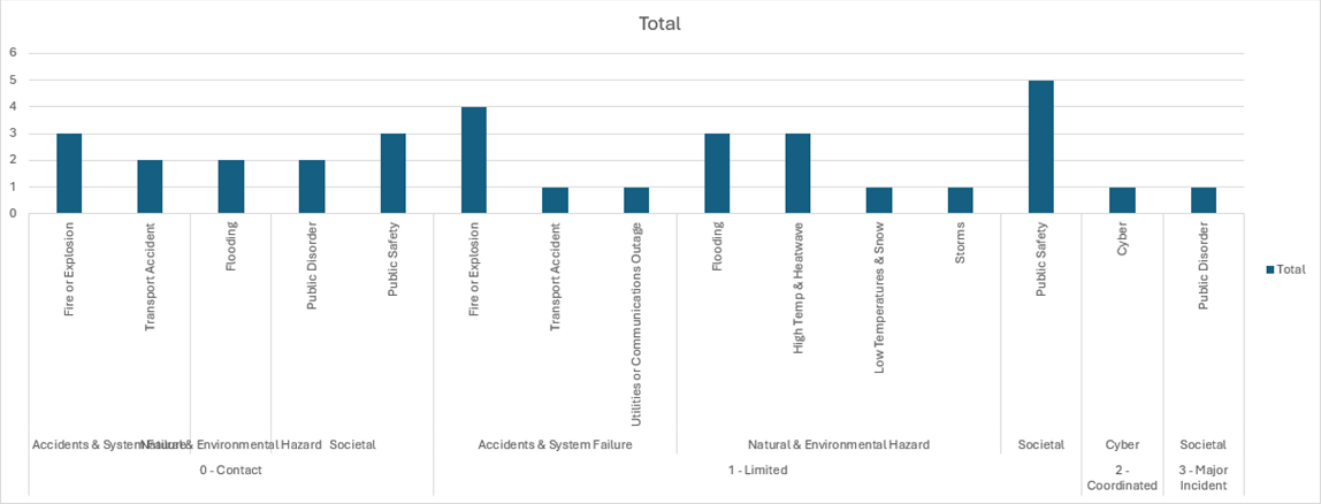
9.6 In tandem, the four Local Authorities (Rotherham, Sheffield, Barnsley and Doncaster) have developed a South Yorkshire rest centre plan with the aim of a county wide approach to deployment of provision, including common processes and training. Go live is expected over Summer 2025, to allow for four local authority training and readiness activities to take place.

## Incidents (including planned operations)

9.7 Through 2024/25, incident response mechanisms were either notified or mobilised to respond to 33 incidents in total across the Rotherham Borough. These are illustrated below, summarised by type and incident category in line with the council Integrated response and recovery plan (definition below):

(***Contact** – an arbitrary field added to capture misdirected / managed calls, Limited – limited activity,

**Coordinated** – several services involved with coordinated levels of support, Major Incident – as per the JESIP definition, major disruption with a range of serious consequences, requiring special arrangements to be put in place)




## Training & Exercise

9.8 During this period, local and regional exercises have continued. Substantial learning, improvement and good practice has been, and continues to be, identified and embedded within planning and plans.

9.9 Of note, Exercise Solaris a precursor to Exercise Pegasus, the Tier 1 Pandemic Exercise taking place in Autumn 2025, was delivered on 23 April 2025. During the full day play, each participating agency, including Rotherham, co-located to review pre-set questions, and then fed into a plenary session, resulting in a county wide debrief workbook to inform national play. Subsequently, the Rotherham representative group agreed to build on the local conversation and knowledge sharing in the creation of task and finish work streams to inform local plans and arrangements.

9.10 Exercise Pegasus in Autumn 2025 will start with Ministerial COBR decisions on three “Anchor Days”, which will be immediately followed by a “Commission Day” where the national exercise team will provide commissions to Government Departments and LRFs

based on the Ministerial COBR decisions. LRF activity will then take place as arrangements are currently being considered broadly; Emergence Phase (Health protection arrangements), Containment Phase, Mitigation Phase.

9.11 The Emergency Planning Service continue to work closely with the Director of Public Health Office on all training and exercises, including Exercise Pegasus.

## 10 Environmental Health and Trading Standards

10.1 The service delivers a broad range of enforcement and regulatory functions which are mainly statutory obligations to protect health or consumers. Priority enforcement and regulatory areas for prevention of infectious disease and non-infective public health risks include:

- Air Quality
- Private Sector Housing enforcement
- Contaminated Land inspection
- Animal Health and Welfare
- Food Hygiene and Standards
- Health and Safety at Work
- Infectious Disease investigation
- Tobacco Control
- Industrial Pollution
- Statutory Nuisance

10.2 The period 2024 to 2025 continued to be dominated by the response to cannabis cultivation, consultation on a new Selective Licensing scheme, dealing with our most disadvantaged localities and significant staffing challenges in Trading Standards function. Activity included:

- Almost 15,000 proactive visits and investigations undertaken
- Issuance of over 60 Fixed Penalty Fines for waste offences
- Food Safety inspections - 798 Food Hygiene Inspections and 582 Food Standards inspections were fully delivered. A significant increase in Enforcement activity for Food Safety was also recorded, with 14 Improvement Notices served, 1 Emergency Prohibition and one prosecution prepared for Court (to be heard in 2025/26).
- 950 formal Housing Act notices served in relation to hazardous housing conditions
- Seizure of illicit vapes to a value of £16,369
- Seizure of illicit tobacco to a value of £10,968
- 59 Responsible Retailer visits advising on the prevention of underage sales
- Funding secured for a full-time Tobacco Control Officer
- Funding secured for a Financial exploitation Officer and Support Analyst to combat the exploitation of vulnerable residents.
- Provision of enforcement during out of hours seven days each week
- Worked with UKHSA and Public Health to deliver improved handling of Infectious Disease investigation. This includes:

| Notification type | 2024/2025 |
|---|---|
| Shigella (Dysentery) | 6 |
| Hep A Viral Hepatitis | 2 |
| Salmonella enteritidis | 7 |
| Salmonella typhimurium | 4 |
| Salmonella | 42 |
| E.coli O157 | 8 |
| Giardia spp. | 4 |
| Cryptosporidium spp | 24 |
| Legionella | 1 |

# 11 Programme Priorities for 2025 / 2026

11.1 Ensure Health Protection assurance and leadership is provided in Rotherham.

11.2 Participate in national pandemic preparedness events (Exercise Pegasus and Exercise Solaris).

11.3 Build upon community IPC provision.

11.4 Ensure Health Protection roles and responsibilities across Rotherham Place are understood, to ensure a Rapid Response to an incident is possible.

11.5 Ensure that Rotherham has a competent surveillance system for managing communicable diseases – working alongside UKHSA. This work will also continue to focus on new and emerging concerns.

11.6 To ensure further work is carried out to ensure health protection, work programmes are embedded in local systems to support reducing health inequalities.

11.7 Tackling Tuberculosis through improving awareness to increase screening and treatment targeting underserved populations. Undertaking work to understand the latent TB population in Rotherham.

11.8 To continue to optimise the role of Rotherham Council in increasing uptake of vaccination and screening in areas of deprivation and underrepresented groups. Working with partners to ensure a system response with specific focus on understanding the reasons for reduced flu vaccine uptake to inform planning and activity

11.9 Reducing the impact of adverse weather on health, ensuring Rotherham is prepared for adverse weather events, including a refresh of the adverse weather policy in 2025-2026.

11.10 Continue to Improve links with the Sexual Health Strategy Group to increase assurance with regard to Sexually Transmitted Diseases.

11.11 To ensure a consistent approach for action to address Anti-Microbial Resistance, working with partners to provide assurance via a newly formed working group.

## Glossary

| | |
|---|---|
| AMR | Antimicrobial resistance |
| E. coli | Escherichia Coli |
| HPV | Human papillomavirus testing (for risk of developing cervical cancer) |
| IPC | Infection Prevention and Control |
| MMR | Measles, Mumps and Rubella (immunisation) |
| MRSA | Methicillin resistant Staphylococcus aureus |
| MSSA | Methicillin sensitive Staphylococcus aureus |
| NHSEI | NHS England and NHS Improvement |
| NIPE | New-born Infant Physical Examination |
| PPE | Personal Protective Equipment |
| SCID | Severe Combined Immunodeficiency |
| UKHSA | UK Health Security Agency |

## Appendices

**Appendix 1 Health Protection Committee terms of reference & affiliated groups**

**Appendix 2 Roles in relation to delivery, surveillance and assurance**

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**Appendix 1**

**HEALTH PROTECTION COMMITTEE**
**TERMS OF REFERENCE**

| Date | Version | Author | Comments |
|---|---|---|---|
| May 2013 | 1.0 | Jo Abbott | To be reviewed March 2014 to reflect changing health and social care architecture |
| March 2014 | 2.1 | Richard Hart | Re-drafted April 2014 in line with above above |
| July 2014 | 2.2 | Richard Hart | Amended following comments from Health Protection Committee |
| October 2014 | 2.3 | Richard Hart | Amended following further comments from Health Protection Committee |
| May 2015 | 2.4 | Richard Hart | Reviewed and amended as part of annual review |
| April 2022 | 2.5 | Catherine Heffernan & Richard Hart | Reviewed and amended following pause of HPC due to COVID-19 |
| April 2023 | 2.6 | Denise Littlewood | Reviewed and amended as part of annual review |
| July 2025 | 3.0 | Denise Littlewood / Jaimee Wylam | Reviewed and amended as part of annual health protection report review. |

**Aims**

- To provide collective strategic leadership and oversight for multi-agency response to protecting Rotherham's population against communicable diseases, chemical and biological incidents, environmental hazards and other health threats.
- To work in partnership to prevent, plan, prepare, detect and respond to outbreaks, incidents and other health threats for Rotherham.
- To enable the partners to plan their future work programmes effectively
- To ensure a rapid, coordinated response by the partners to unexpected developments
- To gain assurance that the elements of the system are working together well, that any temporary failings or tensions are quickly dealt with for the good of the system as a whole

**Scope**

The Health Protection Committee will look at health protection issues relating to the population of Rotherham (whether resident, working or visiting), namely:

- Emergency preparedness, resilience and response
- Communicable disease control

- Risk assessment and risk management
- Risk communication
- Incident and outbreak investigation and management
- Monitoring and surveillance of communicable diseases
- Response to public health alerts from the European Union (EU - via the European Centre for Disease Prevention and Control) and the World Health Organisation (WHO - through the International Health Regulations)
- Infection prevention and control in health and care settings
- Delivery and monitoring of immunisation and vaccination programmes
- Environmental public health and control of chemical, biological and radiological hazards

**Functions**

- Develop, monitor and review roles and responsibilities to provide a robust health protection function in Rotherham
- Maintain good working relationships between all agencies
- Plan and prepare multi-agency rapid response
- Review at least two areas of the health protection system annually to identify and implement actions to improve preparedness and response
- Ensure that there is effective surveillance of communicable diseases and health threats so that appropriate action can be taken where necessary
- Manage emerging health protection risks in delivering effective commissioning and provision of health and social care
- Share understanding of risk and escalate where appropriate
- Receive regular updates that appropriate policies and plans associated with health protection activities are in place
- Review incidents and share ‘lessons learned’ and other learning including resultant actions
- Enable commissioning decisions to be effectively informed by coordinating and agreeing plans, strategies and commissioning of programmes including developments required to address local or national directives / priorities
- Maintain good communications and engage with all relevant stakeholders.

**Membership**

- Core members consist of senior representatives from:
- RMBC – Director of Public Health/Consultant in Public Health & Health Protection Principal
- UKHSA – Consultant in Health Protection/Consultant in Communicable Disease Control
- ICS – IPC Nurse, medicines management representative
- TRNFT – Director of Infection Prevention and Control/Medical Director/Nursing Director/Director of Operations
- RDaSH – Medical Director/Nursing Director/Senior IPC Nurse
- RMBC – Senior Representative from Environmental Health
- RMBC – Senior Representative from Social Care/DAT
- RMBC – EPRR
- NHSE/I – Representative from Public Health & Primary Care Commissioning (screening and immunisations)/ EPRR/ representative from medical/nursing directorates

- Members will be responsible for attending each meeting, either in person or remotely and contributing to the agenda. Members can nominate deputies to attend on their behalf where attendance is not possible.
- Minutes of meetings will be shared with members after each meeting.
- Key individuals will be co-opted as and when required by the Committee.

**Frequency of Meetings**

- Quarterly with quorate membership the Chair (or their deputy) and a minimum of three other Committee members (or their representative with delegated authority to make decisions on their behalf) who will be from the medical, nursing, public health, environmental health professions representing the scope of health protection.
- Quarterly meetings will comprise of standing items and a 'deep dive' into a pre-agreed/pre-selected area of interest or hot topic. The latter part of the meeting will comprise of members and other invited participants.
- Meetings may be held between the main quarterly meetings if a need is warranted.
- The group will be chaired by the Director of Public Health who leads for health protection in the Local Authority and in their absence a deputy.
- All meeting papers will be circulated at least seven days in advance of the meeting.
- The agenda (standing items listed below) and minutes will be formally recorded. Minutes listing all agreed actions will be circulated to members and those in attendance within 14 working days of the meeting.

**Governance & Reporting Arrangements**

- The Health Protection Committee is accountable to the Health & Well-Being Board.
- The Health Protection Committee will provide regular reports to the Health & Well-Being Board, providing assurance of the work being done to plan, prepare, prevent and respond to incidents and outbreaks. Review of risks and mitigation of those risks will also be reported.
- Areas for escalation will be forwarded to members of the Health and Wellbeing Board and/or Local Health Resilience Partnership.

**Equality and Diversity**

- The Health Protection Committee has responsibility to equalities and diversity and will value, respect, and promote the rights, responsibilities, and dignity of individuals within all our professional activities and relationships.

# Appendix 2

# Definition of roles and arrangements in relation to delivery, surveillance and assurance

## 11.12 Prevention and control of infectious disease

Normal working arrangements are described in the paragraphs below. During an incident, such as a pandemic, there would be expected to be an enhanced response to infectious disease, with additional responsibilities taken on by partners. For example, Local Authority Public Health teams took on additional responsiblity in relation to COVID-19 tracing, isolation and containment, funded in part through the national Contain and Outbreak Management Fund.

UKHSA health protection teams lead the epidemiological investigation and the specialist health protection response to public health outbreaks or incidents. They have responsibility for declaring a health protection incident, major or otherwise, and are supported by local, regional and national expertise.

NHS England / Improvement is responsible for managing and overseeing the NHS response to any incident that threatens the public's health. They are also responsible for ensuring that their contracted providers deliver an appropriate clinical response.

The ICB ensure, through contractual arrangements with provider organisations, that healthcare resources are made available to respond to health protection incidents or outbreaks.

Local Authorities, through the Director of Public Health or their designate, has overall responsibility for strategic oversight of an incident or outbreak which has an impact on their population's health. They should ensure that an appropriate response is put in place by the NHS and UKHSA. In addition, they must be assured that the local health protection system response is robust and that risks have been identified, are mitigated against, and adequately controlled.

UKHSA provides a quarterly update to the Committee containing epidemiological information on cases and outbreaks of communicable diseases of public health importance at local authority level.

Surveillance information on influenza and influenza-like illness and infectious intestinal disease activity, including norovirus, is published during the Winter months.

## Screening and Immunisation

Population Screening and Immunisation programmes are commissioned by NHS England and Improvement under what is known as the Section 7A agreement.

NHS England is the lead commissioner for all immunisation and screening programmes except the six antenatal and new-born programmes that are part of the ICB Maternity Payment Pathway arrangements, although NHS England remains the accountable commissioner.

National screening and immunisation policy and standards is set nationally, through expert groups (e.g. the National Screening Committee and Joint Committee on Vaccination and Immunisation). At a local level, specialist public health staff in Screening and Immunisation Teams, employed by NHSE/I, work alongside NHS England Public Health Commissioning colleagues to provide accountability for the commissioning of the programmes and system leadership.

Local Authorities, through the Director of Public Health, are responsible for seeking assurance that screening and immunisation services are operating safely whilst maximising coverage and uptake within their local populations. Public Health Teams are responsible for protecting and improving the health of their local population under the leadership of the Director of Public Health, including supporting NHSE/I in efforts to improve programme coverage and uptake.

The Screening and Immunisation Team provides quarterly reports to the Health Protection Committee for each of the national screening and immunisation programmes.

Serious incidents that occur in the delivery of programmes are reported to the Director of Public Health for the Local Authority and to the Health Protection Committee.

Separate planning groups are in place for seasonal influenza.

## Emergency planning and response

Local resilience forums (LRFs) are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency, and others. These agencies are known as Category 1 Responders, as defined by the Civil Contingencies Act. The geographical area the forums cover is based on police areas.

The LRFs aim to plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities.

The Local Health Resilience Partnership (LHRP) is a strategic forum for organisations in the local health sector. The LHRP facilitates health sector preparedness and planning for emergencies at Local Resilience Forum (LRF) level. It supports the NHS, UKHSA and local authority (LA) representatives on the LRF in their role to represent health sector Emergency Planning, Resilience and Response (EPRR) matters.

All Councils continue to engage with the Local Resilience Forum and the Local Health Resilience Partnership in undertaking their local engagement, joint working, annual exercise programme, responding to incidents and undertaking learning as required.

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# Annual Health Protection Assurance Report 2025

# Assurance Overview

**Collaborative Multi-Agency Efforts**

Multiple agencies in Rotherham work together to safeguard public health through coordinated health protection arrangements.

**Health Protection Domains**

The report covers infectious disease control, screening, immunisation, emergency preparedness, and infection prevention.

**Stakeholder Assurance and Reporting**

The report informs stakeholders on current status, achievements, and areas needing attention in health protection.

# Screening Programmes

**Improved Screening Uptake**

Screening programmes in Rotherham have increased participation, especially in breast, bowel, and cervical cancer screenings.

**Accessibility for Learning Disabilities**

Collaborative efforts have improved screening accessibility for individuals with learning disabilities.

**Diabetic Eye Screening Progress**

Diabetic Eye Screening Programme addressed backlog and maintained compliance with national invite interval standards.

**Bowel Screening Age Extension**

Bowel screening programme expanded age coverage, supporting early detection and national policy compliance.

# Immunisation Programmes

**MMR Vaccination Coverage**

MMR dose 1 coverage by age two remains above 90%, aiming for 95% for effective community protection.

**Adolescent Immunisation Challenges**

Post-pandemic declines in adolescent vaccinations led to targeted interventions to improve school-based uptake.

**HPV Vaccination Focus**

HPV vaccination aligns with national cervical cancer elimination strategies to reduce disease incidence.

**RSV Vaccination Introduction**

RSV vaccine launched in 2024 for pregnant women and older adults to protect vulnerable groups.

# Maternal and Seasonal Immunisation

**Pertussis Vaccination for Pregnant Women**

Pertussis vaccination uptake among pregnant women remains above the 60% optimal threshold amid rising national cases and infant deaths.

**Targeted Seasonal Flu Vaccination**

Seasonal flu vaccination targets high-risk groups including young children, pregnant women, and immunocompromised individuals through focused initiatives.

**Focus on Vulnerable Populations**

Efforts prioritise individuals with chronic respiratory conditions, learning disabilities, or severe mental illness to reduce infectious disease impact.

# Healthcare-Associated Infections

**Pathogen Surveillance**

Monitoring key pathogens like MRSA, MSSA, C. Difficile, and E. coli is essential to control infection spread in healthcare settings.

**Effective MRSA Control**

MRSA cases decreased significantly, reflecting success of targeted infection control measures and protocols.

**Antimicrobial Stewardship**

Increased cases of C. Difficile are addressed by improved antimicrobial stewardship and staff interventions.

**Care Home Hydration Project**

Hydration initiatives in care homes support infection control by improving patient health and reducing complications.

# Tuberculosis (TB)

**Low TB Incidence in Rotherham**

Rotherham maintains a low TB incidence despite rising national rates through effective local health strategies.

**Enhanced Case Management**

Complex TB cases require enhanced case management to ensure proper treatment and thorough follow-up.

**Collaborative Health Protection**

Regional collaboration and cohort reviews promote best practices in TB screening and management.

**Support for Underserved Populations**

Proactive TB management includes ensuring care and support for underserved and vulnerable populations.

# Infection Prevention & Control (IPC)

**Leadership and Coordination**

A Senior Public Health Practitioner leads IPC initiatives, ensuring focused and organized infection control efforts across the community.

**IPC Audits and Outbreak Management**

Regular audits and outbreak management support help identify risks early and enable rapid response to infection incidents.

**Community Engagement and Training**

Engaging care homes and coordinating the IPC Champions Network strengthens infection prevention practices and staff competencies.

**Strategic Integration**

Embedding IPC within local authority structures ensures sustainable and cohesive infection control to protect public health.

# Emergency Planning & Response

**Incident Management**

Rotherham managed 33 emergency incidents in 2024/25, showing strong operational readiness and resilience.

**Training Exercises**

Participation in Exercise Solaris and preparations for Exercise Pegasus have improved emergency response capabilities.

**Regional Coordination**

The upcoming South Yorkshire-wide rest centre plan enhances coordinated support during emergencies.

**Preparedness and Improvement**

Continuous updates to planning and response frameworks emphasize public health safety during crises.

# Strategic Priorities for 2025/26

**Community IPC Strengthening**

Focus on enhancing infection prevention and control through community-based programs for greater health impact.

**Vaccination and Screening Uptake**

Improve vaccination and screening rates specifically in deprived and underserved populations to reduce health disparities.

**Preparedness and Surveillance**

Prepare for adverse weather and pandemics while enhancing surveillance systems to detect emerging health threats early.

**Addressing Antimicrobial Resistance**

Tackle antimicrobial resistance with targeted health strategies to protect public health and ensure effective treatments.

Agenda Item 13

Rotherham Metropolitan Borough Council

| | | |
|---|---|---|
| **BRIEFING** | **TO:** | Health and Wellbeing Board |
| | **DATE:** | 26th November |
| | **LEAD OFFICER:** | Gilly Brenner<br>Public Health Consultant<br>Public Health<br><br>Alex Hart<br>Public Health practitioner<br>Public Health |
| | **TITLE:** | Rotherham Food Network update |

## 1. Background

**1.1** **History of the Rotherham Food Network**

The food network was set up in April 2022 to support the implementation of national policies such as the National Food Strategy Plan (2021) and Rotherham's Full Council adoption of The Local Authority Declaration on Healthy Weight in January 2020. Rotherham Food Network was established to provide strategic oversight and collate an action plan to address local gaps on food-related issues, from a health and wellbeing and wider perspective. The group has broad membership of partner organisations across the voluntary and public sector.

The Rotherham food network became a member of Sustainable Food Places in April 2022 and achieved a bronze award in August 2024. This means Rotherham Food Network has demonstrated how communities, businesses and partner organisations can work together to make affordable good food a defining characteristic of Rotherham.

**1.2** **Wider relevance across Rotherham partners**

Addressing access to sustainable, affordable and healthy food is relevant to a range of Council and Rotherham place-based plans and strategies, including through themes such as:

- Strength-based prevention approaches and thriving neighbourhoods – food is a means of bringing communities together, building cohesion and support
- Inclusive economy and cost-of-living – access to crisis food and healthy food at an affordable cost
- Healthy workplaces and anchor institutions addressing health inequalities – how workplaces can support their workforce and customers to access healthy affordable food
- Regeneration and commercial determinants of health – how local regeneration plans can help promote and support sustainable healthier food provision, and the impact of advertising and marketing
- Planning considerations -use of supplementary planning documents such as restrictions to takeaway applications within 800m of a school
- Climate change and net zero ambitions – the carbon implications in food production, distribution and plastic packaging

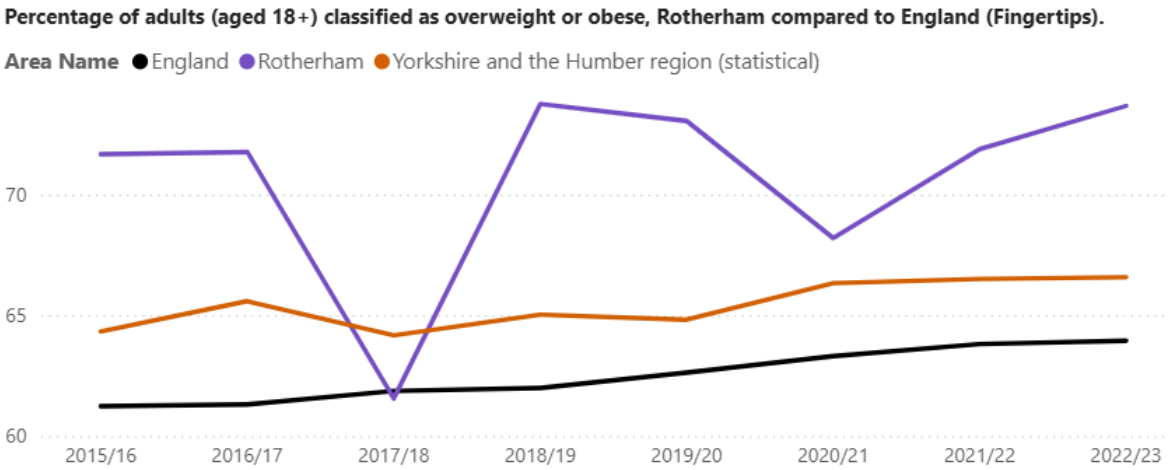
- Reducing the risks to health and exacerbation of ill health from poor diet and resulting risk factors such as excess weight, high blood glucose and high blood pressure.

**1.3** **Why good food matters**

The breadth of relevance across themes shows that accessibility of healthy sustainable food impacts on many different and inter-related outcomes for the borough. With regards to health and wellbeing, the most direct impacts are obviously related to diet and those impacts are distributed inequitably across population demographics.

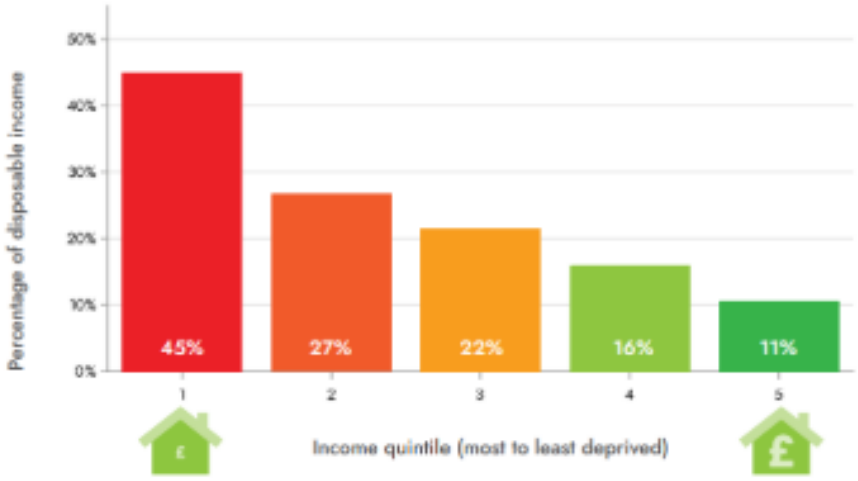
The Global Burden of Disease research estimates that of the top 5 risk factors for disability-adjusted life years (ie healthy life lost due to premature death, illness or disability) in Rotherham, only smoking doesn't relate to diet. Alongside the specific risk factor of diet, the risks of high BMI, high blood glucose and high blood pressure are all significantly influenced by diet.

In 2022/23, three-quarters of adults were overweight or obese in Rotherham (73.3%), highest amongst our CIPFA nearest neighbours and higher than the Y&H and England averages. QOF (23/24) data gives Rotherham adult obesity prevalence at 16.5%.




This trend starts early and increases quickly during childhood, with NCMP data for 21/22-23/24 three year combined) showing 24% of Rotherham YR (age 5-6) children were overweight or obese, increasing to 40.9% by Y6 (age 10-11).

Access to food underpins the inequality in outcomes for diet-related ill health. A significantly higher proportion of disposable income is spent on food for people with the lowest incomes.



| | |
|---|---|
| | The cost of food is rising, and the cost of healthier food is rising faster than unhealthier processed foods higher in fats, salts and sugars. National rates indicate that food insecurity has risen to almost 1 in 3 in the UK in the most deprived areas, with an average 14% of UK adults having experienced food insecurity.<br><br>Data from Fare Share, shows that for 2024/25 Rotherham distributed 208 tonnes of crisis food for 34 organisations, from 519 sites which equates to 494,000 meals, worth £729K and feeding 4,370 people a week. |
| **2. Key Issues** | |
| **2.1** | **<u>Action Plan</u>**<br>Over the last year, a new action plan has been developed by the network to align with progression towards the silver award for Sustainable Food Places. The action plan (Appendix 1) is broken down into six priorities, based upon Sustainable Food Places 6 key issues framework. Improving the diets of Rotherham people is an extremely complex system-wide challenge, based on a large range of inter-related factors and is influenced in particular by poverty and the international food industry. |
| **2.2** | • **Food governance and strategy** - *To transform Rotherham's food culture and food system through a strategic and collaborative partnership approach to good food governance and action with a vision backed by a clear action plan.*<br>Whilst the Rotherham Food Network continues to meet and have broad partner representation, there is a difficulty in addressing issues at pace or scale due to prioritisation, capacity and resource. Unlike in some other areas in the country, Rotherham does not have strong representation of advocacy or voluntary/community sector groups with food as their focus remit. Many voluntary/community sector organisations support food initiatives, such as crisis food provision, but this has come about through necessity to support communities rather than as a focus of interest.<br><br>A strength in this priority area is data and intelligence, as a broad range of data sources have been used to articulate risks to good food access across the borough, such as through takeaway density and food insecurity measures. |
| **2.3** | • **Good food movement** - *To build public awareness, active food citizenship, and a local good food movement within Rotherham.*<br>There are regular community events across the borough promoting healthy food and food growing. More prominent examples include the Made in Rotherham food growing competitions at Rotherham Show, allotment gardens at the RHS Flower Show at Wentworth, and Youth Cabinet being keen to promote healthy food to young people.<br><br>These events are currently ad-hoc and are not generally coordinated through the Food Network. To create a 'movement' would require additional capacity and resource to step change the level of engagement and visibility of message. |
| **2.4** | • **Healthy food for all** - *To tackle food poverty, diet-related ill-health, and access to affordable healthy food, by addressing the underlying causes of food poverty, changing the local food environment, and increasing knowledge, skills, resources, and support for people to feed themselves well.*<br>There is a Food in Crisis network of voluntary/community sector organisations involved in supporting crisis food provision through food banks and social supermarkets. This network is very locally responsive and effective but doesn't yet have a single point of referal or access, which can make signposting in difficult for external partners. Food provision is often supported by wider support, such as benefits advice. |

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| | The Holiday Activity Fund continues to provide free meals to children and young people on free school meals during the main longer holiday breaks. These sessions have also included healthy eating activities. Auto-enrolment to free school meals has also been successful locally in increasing the number of young people accessing meal support.<br><br>This year has seen the establishment of Food Works ready meal freezers in community venues to increase access to healthy and affordable meals, see 2.8.<br><br>Healthwave provides a 'tier 2' weight management service to support overweight and obese adults in Rotherham with advice and support around healthier food and sustainable behaviour changes to diet. This compassionate approach takes a holistic view and is person-centred so that the support is relevant and applicable to individual lives and circumstances. The service sees high demand and good outcomes.<br><br>There is an opportunity to consider wider support from healthcare professionals where diet-related risk factors are identified and where in pathways of care, diet can be further addressed and supported. |
| **2.5** | • **Sustainable food economy** - *To create a vibrant, prosperous, diverse, and sustainable food economy within Rotherham by putting good food entrepreneurs and enterprises at the heart of local economic development and promoting them to consumers.*<br>The regeneration of Rotherham town centre, including Forge Island, has seen independent and new food providers establishing a presence locally. However, there has been a desire to support food businesses regardless of the 'healthiness' or 'sustainability' of their food offer.<br><br>Further work and resource would be required to develop a genuine partnership with food business owners in Rotherham and to encourage them to work together to promote the borough as a place to eat good food. |
| **2.6** | • **Catering and procurement** - *To support catering and procurement and revitalise local and sustainable food supply chains across a wide range of settings, such as nurseries, schools to create demand for healthy, sustainable, and local food.*<br>The Council is unusual in providing a substantial number of local schools with a school catering service through Riverside Catering. This service offers a quality healthy meal for children and young people, continuing to meet the bronze standard for Food for Life. With the academisation of schools, continuing to build the number of schools in the contract remains challenging and procuring good food also creates a challenge for keeping meal costs low.<br><br>Within current resource limitations, it has not been possible to further expand the work in this priority area to consider other anchor institutions and the role they could play in procuring healthier or more sustainable food or the potential role of social value for contracts around healthy and sustainable food provision. As significant providers of food for patients, there are opportunities to consider procurement and quality of food provision in hospital and care settings, as well as schools. |
| **2.7** | • **Sustainable food environment** - *To tackle the climate and nature emergency through sustainable food and farming and an end to food waste.*<br>The Council declared a Climate Change Emergency and is working towards net zero by 2030. The Rotherham Together Partnership with broad representation of partners also signed a Climate and Nature Charter. Within current resource limitations, it has not been |

possible to engage with the wider businesses sector to consider how best to support more local sustainable procurement chains and providers.

The local Food Works freezer provision is however all provided through food surplus, see 2.8, therefore reducing food waste and improving sustainability.

**2.8** **Food Works freezer project**

The Council's Neighbourhoods team secured £60k of funding over a 2-year period for a project with Food Works, a social enterprise based in Sheffield on the border with Rotherham. In this first year of the project, freezers will be installed in 10 community spaces within Rotherham, facilitating the supply of healthy frozen meals, sold as Just Meals for a donation of a minimum of £1. Food Works are providing the freezers, transport of the meals, and guidance and advice, including training such as food hygiene to staff or volunteers at the community sites. However, the community site is required to handle payments and stock inventory. Roll out of the freezers has begun and an evaluation will follow to determine their usage levels and community feedback to consider next steps.

Proposed community sites hosting freezers are:

- Cortonwood Comeback, Brampton
- Dinnington Methodist Church, Dinnington
- Full Life Church, Maltby
- Kimberworth Park Community Partnership (Chislett Centre), Kimberworth
- Kiveton Park Community Development Trust
- Rotherham Hospital
- Rotherham Minster, Town centre
- St Margarets Church, Swinton
- The Centre, Brinsworth
- The Drop-In Centre, Rawmarsh

## 3. Key Actions and Relevant Timelines

**3.1** **Action plan ongoing**

The current Rotherham Food Network action plan in Appendix 1 continues to develop, with opportunities sought to further engage partners in delivering towards the priorities.

**3.2** **Food Works project**

As of the 10th November, four freezers have gone live, at Cortonwood Comeback, Kimberworth Park Community Partnership, Kiveton Park Community Development Trust and Rotherham Minister. By the end of November, it is expected that six of the ten freezers will be up and running. All ten freezers are expected to be fully open by the end of March 2026, with an evaluation of the first-year project starting once they are all in place. There is a second year of the project which will be informed by the evaluation and opportunities as to whether this is expansion of places hosting freezers, or a wider remit, such as hosting a wider food offer or cooking opportunities etc.

## 4. Implications for Health Inequalities

**4.1** As already described, poverty is a key driver of difference in diet, restricting options for residents. The Food Works project has enabled a quality 'home cooked' meals provision to be offered in key community locations at an affordable cost. Further engagement with users of the freezer meals and the community hub locations will help determine how best to expand this offer in year 2, to best meet needs and impact on inequalities.

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| **4.2** | Wider implications for health inequalities are considered as part of the action plan. In particular, the Food in Crisis partnership food provision, auto-enrolment of free school meals and Holiday Activity Fund sessions to ensure children and young people can reliably access food in school and during the holidays. |
| **5. Recommendations** | |
| **5.1** | For Health and Wellbeing Board Members to:<br>- Note the update from the Rotherham Food Network<br>- Note the impact of a lack of access to healthy sustainable food in Rotherham on health outcomes<br>- Note the challenges that arise from the tensions of poverty, regeneration, economic growth, climate change and the accessibility of healthy sustainable food.<br>- Consider in what further ways Board Members could commit to driving forward any elements of the action plan. |

**Appendix 1 – DRAFT Rotherham Food Network Action Plan 2025-2030**

| Priority | Action/s | Timescale | Lead(s) | RAG | Progress |
|---|---|---|---|---|---|
| **Food Governance and Strategy** | | | | | |
| **1.A. Establish a broad, representative, and dynamic local food partnership** | | | | | |
| 1.A.1 | A diverse cross sector partnership is in place with regular Rotherham Food Network meetings | Ongoing | Public Health Practitioner | | Quarterly network meetings ongoing |
| 1.A.2 | Update and agree on Terms of Reference annually to ensure open, transparent & democratic group | Annually | Public Health Practitioner | | Next review due December 2025 |
| 1.A.3 | Continue to grow the network of organisations within the Rotherham Food Network through regular stakeholder analysis | Annually | Public Health Practitioner | | Next review due December 2025 |
| 1.A.4 | Create and maintain a digital dashboard for the Rotherham Food Network and update annually | Annually (June) | Public Health Intelligence Analyst | | Dashboard available and shared with the group at each annual update |
| **1.B. Develop, deliver, and monitor a food action plan** | | | | | |
| 1.B.1 | Develop and ongoing monitoring of Rotherham Food Network partnership action plan | Ongoing | Public Health Practitioner | | Action plan reviewed as standard agenda item with actions flagged where necessary for review or progress. |
| 1.B.2 | Develop a branding logo for the Rotherham Food Network, to help promote the food vision and aims for Rotherham place and encourage individuals and organisations to get involved and contribute | June 2027 | Programme Leader Graphic Design, University Centre Rotherham | | RNN have offered some student capacity to progress this via degree projects. |
| 1.B.3 | Update the JSNA Rotherham Data Hub food section on a yearly basis | Ongoing (May) | Public Health Intelligence Analyst | | Food pages included in the JSNA. |
| 1.B.4 | Embed health and sustainable food practices in local policies, strategies and plans and take opportunities to respond to local, regional and national consultations. | Ongoing | Public Health Practitioner | | Ongoing identification of opportunities to influence local policies and strategies identified and discussed with Food Network or shared. |
| **Good Food Movement** | | | | | |
| **2.A. Inspire and engage the public about good food – events and public engagement activity** | | | | | |
| 2.A.1 | Develop awareness of the Food Works Just Meals freezer locations (see 3.A.7). | Ongoing 2026 | Public Health Practitioner | | As each freezer hub site launched, relevant comms shared. |

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| 2.A.2 | Develop and deliver a set of commercial determinants of health training with a focus on food | March 2026 | Public Health Practitioner | | Training to be developed and target audience and opportunities to deliver planned |
| 2.A.3 | Increase the uptake of secondary school children in the Rotherham healthy holidays (HAF) programme to ensure children have good access to food during school holidays. | Ongoing | Senior Family Support Worker | | Yearly report on the number of children within the HAF programme shared with Network. HAF promoted on extranet for partner awareness/engagement. |
| 2.A.4 | Ensure that the work of the Rotherham Food Network is in line with the Rotherham's compassionate approach, by using the communication toolkit. | Ongoing | Public Health Specialist | | Toolkit has been developed and will be shared with partners via the extranet. Review of implementation annually with network members. |
| 2.A.5 | Collaborate with Youth Cabinet and its partners to produce a teenage specific campaign to support health eating. | September 2025 | Public Health Practitioner | | Some delay due to Youth Cabinet capacity; options are being explored to link to Bite Back campaign materials. |
| 2.A.6 | Identify leads of our local allotment/s and develop the relationship between them and the food network. This will enable the development of any future projects relating to allotments. | December 2025 | Public Health Practitioner | | Meetings arranged and on track. |
| 2.A.7 | Support network members to advocate for advertising restrictions on food with High Fat, Salt and Sugar (HFSS) | December 2026 | Public Health Practitioner & Public Health Specialist | | Toolkit to be developed and shared on the extranet site for partners and agenda item for discussion. |
| 2.A.8 | Support network members by showcasing good practice and ongoing projects via Council comms channels including neighbourhood newsletters | Ongoing | Communications and Marketing Account Manager | | Process being discussed, but to use extranet site to share projects and case studies and link to comms. |
| **2.B. Foster food citizenship and a local good food movement** | | | | | |
| 2.B.1 | Work with local food providers to increase awareness of being able to buy locally sourced and more sustainable food. (Link with markets and town centre team) | 2027 | Public Health Practitioner | | Discussion with Markets team to be aligned to markets redevelopment and opportunities for promotion relating to fresh and local food. |
| 2.B.2 | Develop opportunities to work together to identify future grant/funding opportunities for the network, such as creating small grant funds. | Ongoing | Public Health Practitioner | | Grants/funding opportunities shared with the Food Network ongoing and via extranet. Currently no funding identified for additional small grants. |

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| 2.B.3 | Work with local food banks and social supermarkets to provide support on how to eat well on a budget. | To be confirmed | Public Health Practitioner | | Discussion to be had with Food in Crisis Partnership about opportunities to support healthy eating for those with food poverty related issues. |
| 2.B.4 | Expand Rotherhive's food section to include baby food and weaning information | March 2026 | Public Health Specialist | | Link to pages to be shared once complete. |
| 2.B.5 | Check and update Rotherhive's food pages annually, to enable current information and service to be included where appropriate | Annually (January) | Public Health Practitioner | | To be reviewed annually |
| **3. Healthy Food for all** | | | | | |
| **3.A. Tackle Food Poverty** | | | | | |
| 3.A.1 | Support the auto enrolment process of free school meals to ensure uptake is maximised to reduce impact of food poverty on children's diets | Ongoing | Public Health Practitioner | | Annual update on the number of children receiving free school meals (including opt outs) included in data dashboard and update to be shared with members. |
| 3.A.2 | Consider how the network can work with schools to maximise free school meal enrolment and ensure access to quality and healthy school meal provision | Ongoing | Public Health Specialist | | Discussions occurring to determine how best to work with schools not currently accessing Riverside Catering meals. |
| 3.A.3 | Continue to ensure all food banks and social supermarkets offer services linked to food poverty such as debt or housing support. | Ongoing | Head of Partnerships, VAR | | Update to be provided annually to food network on the food in crisis partnership. |
| 3.A.4 | Continue to increase the awareness between diet and oral health and inequalities | March 2026 | Public Health Specialist | | Update to be shared with food network on the oral health action plan and progress and issues in March 2026 |
| 3.A.5 | Update the RMBC money matters page food section, to make sure information and services are up to date. | Annually (January) | Public Health Practitioner & Communications Account Manager | | To be reviewed every year |
| 3.A.6 | Implement the Rotherham Food Works project, by collaborating with RMBC Neighbourhoods and vol sector organisations to establish 10 freezer sales points for Just Meals across the borough | March 2026 | Public Health Practitioner & Head of partnership, VAR | | Progress on track for all 10 freezer locations to be running by March. |

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| 3.A.7 | Evaluate the implementation of Just Meals freezers | June 2026 | Public Health Practitioner | | Evaluation plan being drawn up. |
| 3.A.8 | Develop a plan for Food Works project for year 2, to consider expansion or wider delivery options. | June 2026 | Public Health Practitioner | | Plan to be shared with network members for wider awareness and involvement. |
| 3.A.9 | Links to be maintained between the Rotherham Food in Crisis group and the Rotherham Food Network | Ongoing | Head of Partnerships, VAR | | Standard agenda items on both groups. |
| **3.B. Promote healthy eating** | | | | | |
| 3.B.1 | Maintain a Breastfeeding Friendly brough webpage, adding new businesses and promote through Rotherham Voice and other channels | Ongoing | Public Health Specialist | | Attended Voice session in April. Ongoing promotion to businesses required. |
| 3.B.2 | Explore opportunities to embed healthy food knowledge and support in social prescribing and related community-based services | November 2027 | Public Health Practitioner | | Consideration is being given to hosting training or a workshop at Social Prescribing Network event or via VAR |
| 3.B.3 | Promote and monitor uptake and impact of Simply Veg and other campaigns supported by school catering. | September 2026 | Catering Manager | | Annual update to be provided by Riverside Catering to the network to reflect on success and challenges. |
| 3.B.4 | Collaborate with the 0-19 oral health teams in incorporating both general and targeted messaging around sugar reduction and nutrition | March 2026 | Public Health Specialist | | Update to be shared with network around successes and challenges of this work. |
| 3.B.5 | The oral health needs assessment has been completed; the recommendations will be brought to the food network to identify any recommendations which the network we can support on | December 2025 | Public Health Specialist | | The oral health needs assessment will be shared with the group in December 2025. |
| 3.B.6 | Share progress on the expansion of the supervised tooth brushing clubs in early years settings. | March 2026 | Public Health Specialist | | Update to be shared with the network on the number of tooth brushing clubs within Rotherham and successes and challenges. |
| **4. Sustainable Food Economy** | | | | | |
| **4.A. Put good food enterprise at the heart of local economic development** | | | | | |
| 4.A.1 | Integrate the food risk index within the Rotherham Council planning process. | June 2026 | Health Improvement Principal | | Network has been shown the risk index and work is ongoing to adopt fully into processes. Next update to network will share further progress. |

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| 4.A.2 | Consider ways of improving access to drinking water in Rotherham's towns and villages. Consider Refill scheme and relevance to new town centre and towns and villages fund redevelopment opportunities. Relevant to climate change mitigation measures. | June 2026 | Public Health Practitioner | | Update to be provided to network on opportunities and challenges and discussion to be held on network involvement to take forwards. |
| **4.B. Promote healthy, sustainable, and independent food businesses to consumers** | | | | | |
| 4.B.1 | New town market development currently ongoing, explore opportunities for future projects to investigate ways to promote current and upcoming events within the markets | Ongoing | Public Health Practitioner | | Ongoing discussions about use of future market events and work with businesses to support promotion of healthy and sustainable produce / food. |
| 4.B.2 | Explore what is grown within Rotherham, including at local allotments, and identify what is done with surplus produce | December 2025 | Public Health Practitioner | | Growing subgroup created and update scheduled to the food network. |
| 4.B.3 | Use extranet site with members to continue to promote and share relevant activities and events and opportunities to link to local businesses | December 2025 | Public Health Practitioner | | Plan to be shared with the group by December 2025. |
| 4.B.4 | Explore opportunities to engage with food businesses across the borough and scope for working together to promote sustainability and good food offers | December 2027 | Public Health Practitioner | | To be undertaken as part of later phase of the action plan. |
| **5. Catering and Procurement** | | | | | |
| **5.A. Change policy and practice to put good food on people's plates** | | | | | |
| 5.A.1 | Compassionate approach training offered to catering staff on a yearly basis for new starters | June 2026 | Public Health Specialist & Public Health Practitioner | | Ongoing discussions with catering at regular meetings on the best dates for these sessions or the applicability of an online recorded session |
| 5.A.2 | Work with anchor institutions to explore food sustainability as part of their procurement processes | September 2026 | Public Health Specialist & Catering Manager | | Ongoing discussion with catering procurement about sustainability of food procured. |
| 5.A.3 | Identify case studies within RMBC catering which can be used to showcase best practice. | December 2026 | Catering Manager | | Quarterly meetings with catering which discussions about identified case studies based on their achievements can be gained |
| 5.A.4 | Identify priority areas within catering that are emerging public health issues and provide tailored training to help overcome issues which they may face. | Ongoing | Public Health Practitioner | | Quarterly meetings with catering which discussions about identified issues within catering. |

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| 5.A.5 | School Catering to continue to achieve annual bronze level accreditation with Food for Life | June 2026 | Catering Manager | | To be shared with group by June 2026 |
| **5.B. Improving connections and collaboration across the local supply chain** | | | | | |
| 5.B.1 | Work with anchor institutions to consider their commitments to local, healthy, and sustainable food offers | November 2027 | Public Health Practitioner | | To be undertaken as part of later phase of the action plan. |
| 5.B.2 | Awareness of the skills gaps in the borough's hospitality sector, and meeting those needs through offering relevant RMBC training | Ongoing | Catering Manager | | Discussions with catering about the issue of gaps within the sector are ongoing |
| **6. Sustainable Food Environment** | | | | | |
| **6.A. Promote sustainable food production and consumption and resource efficiency** | | | | | |
| 6.A.1 | Rotherham previously declared a climate change emergency and is working towards the council being Net Zero by 2030 and the borough by 2040. Rotherham food network will collaborate with the Climate team to input food related actions into the strategy as appropriate. | November 2026 | Climate Change Manager | | Policy to be shared once completed, and workshop invite has been shared with group members |
| 6.A.2 | Climate team to develop a tailored short version of climate training focused on food to members of the network | September 2026 | Climate Change Manager | | Training to be developed and delivered by September 2026 |
| 6.A.3 | Rotherham in Bloom – Showcasing local gardens in Rotherham to increase awareness of gardening. Rotherham Food Network to share the promotion materials across all members to increase awareness. | Ongoing (May-June) | Tenant Involvement Officer | | Materials to be received by March 2026, and shared among the group by June 2026 |
| **6.B. Reduce, redirect and recycle food, packaging and related waste** | | | | | |
| 6.B.1 | Continue to offer the carbon literacy training to all RMBC staff | March 2026 | Climate Change Manager | | To be shared among the group about availability on the extranet site |
| 6.B.2 | Rotherham is currently part of the Barnsley, Rotherham, Doncaster Waste partnership (BDR). 2025/26 BDR action plan to be shared to identify actions which the Rotherham Food Network can then support which align | June 2026 | Public Health Practitioner | | Action plan to be shared in April 2026 with the group, and comments to be made by June 2026 for any areas which the network could support |

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# Rotherham Food Network

November update

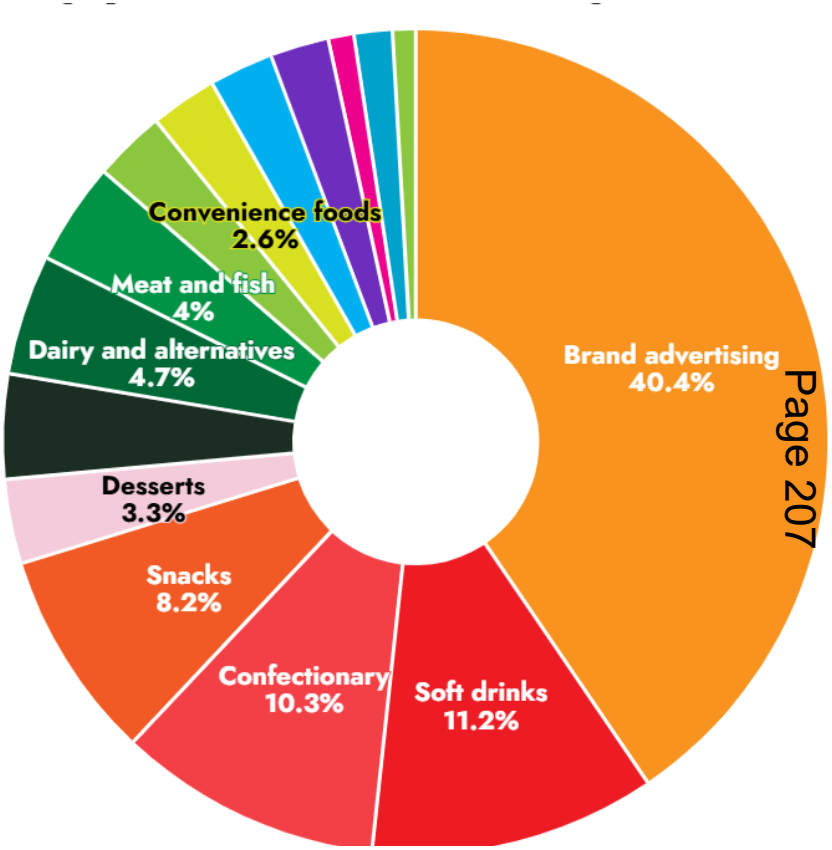
Gilly Brenner (Public Health Consultant)
Alexandra Hart (Public Health Practitioner)

# Why food matters

- Relevance across policy areas
- 4 of 5 top risk factors relate to diet
- ¾ of Rotherham adults overweight/obese
- High rates of overweight/obesity in cyp
- Inequality driven by poverty

# Food insecurity and inequality

- Inequalities in disposable income make healthy options too expensive
- Less healthy food is cheaper per calorie
- Marketing and offers promote unhealthy options




The Food Foundation

# Update

- Refresh of the action plan to cover next 5 years
- Interest in working groups for Youth Cabinet and Food Growing
- Continuation of Food in Crisis Partnership
- Food Works project creating 10 Just Meals freezer locations across Rotherham

# Food Works project

- £60K over 2 years from March 2025.
- Installing 10 freezers within local community spaces
- Provides healthy surplus food derived ready meals for minimum £1
- Evaluation to follow and inform year 2

# Risks and issues

- Food governance and strategy
- Good food movement
- Healthy food for all
- Sustainable food economy
- Catering and procurement
- Sustainable food environment

# Recommendations

- Note the update
- Note the impact on health outcomes
- Note the challenges that arise from the tensions of poverty, regeneration, economic growth, climate change and the accessibility of healthy sustainable food.
- Consider commitments to driving forward any elements of the action plan.

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| **BRIEFING** | **TO:** | Health and Wellbeing Board |
| | **DATE:** | 26/11/25 |
| | **LEAD OFFICER** | Joanne Martin – Programme Lead, Transformation and Delivery – NHS South Yorkshire |
| | **TITLE:** | Neighbourhood Working |

**Background**

**1.1** **Programme Overview:**
Rotherham has been accepted onto the National Neighbourhood Health Implementation Programme (NNHIP), a national initiative aimed at accelerating neighbourhood working and strengthening proactive care.

**1.2** **Local Context:**
Two local workshops have helped shape shared ambitions and define early priorities. Partners have confirmed strong commitment to building on community assets and existing neighbourhood models.

**1.3** **Purpose of Programme:**

- Align national expectations—focused on adults with multiple long-term conditions (LTCs) and those at rising risk—with local priorities including prevention, children's health, frailty, and employment support.
- Create the conditions for neighbourhood working to thrive through collaboration, improved data use, and rapid testing of new approaches.

**Key Issues**

**2.1** **National vs Local Priorities:**
There remains an inherent tension between the scope of the national programme and the breadth of local ambition. The national requirements are tightly defined, focusing on adults with two or more long-term conditions—or one condition with rising risk—particularly those experiencing deprivation, belonging to minority ethnic communities, or aged 18–40.

**2.12** In contrast, local partners have articulated a wider vision for neighbourhood working that encompasses prevention across the life course, frailty and end-of-life pathways, children and young people's health, and support to enable residents to return to work.

**2.13** The programme therefore needs to balance delivering the national ask while ensuring it meaningfully supports local priorities and adds value to existing initiatives.

**2.21** **Programme Delivery Challenges:**
Embedding proactive care and prevention within neighbourhood models represents a significant shift in how services work together. Partners will need to coordinate resources, agree shared operational processes, and collectively adapt to new ways of working.

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| **2.22** | Establishing governance structures that provide sufficient oversight, transparency, and accountability is essential—particularly as reporting will link to both the Place Leadership Team and the Health and Wellbeing Board. Ensuring these arrangements are robust, streamlined, and not duplicative will be critical for maintaining momentum. |
| **2.31** | **Data and Insight:**<br>Data remains both an enabler and a challenge. While Eclipse and local intelligence will support the identification of target cohorts, there is variability in data quality and completeness across the system. Partners will need confidence that cohort selection is accurate and reflective of neighbourhood needs. |
| **2.32** | The programme also requires rapid evaluation cycles to test, refine, and scale interventions at pace. This will demand strengthened analytical capacity, clear feedback loops, and consistent use of insight to inform decision-making and ensure learning is captured and shared across neighbourhoods. |
| **Key Actions and Relevant Timelines** | |
| **3.1** | **Immediate Actions (by Dec 2025):**<br>• Neighbourhood Compact Agreement signed (10th December 2025).<br>• Governance arrangements and operational groups established.<br>• Target cohorts defined and the proactive care model refined. |
| **3.2** | **Programme Milestones:**<br>• Kick-off workshops and system inception (February–September).<br>• Regional workshops completed and programme objectives agreed (September–October).<br>• Delivery framework to be finalised by December. |
| **3.3** | **Next 12 Months:**<br>• **National Programme:** Strengthen proactive care for rising-risk patients across PCN footprints.<br>• **Local Programme:** Advance prevention work on diabetes, heart health, and risk factors such as smoking, obesity, and hypertension, with targeted activity in Eastwood Village. |
| **Implications for Health Inequalities** | |
| **4.1** | Addressing health inequalities through this programme goes beyond improving outcomes for individuals; it strengthens the entire health and care system. By focusing on proactive care and targeted prevention, we aim to reduce the disproportionate burden of disease in deprived communities and among minority groups. This approach ensures that those most at risk receive timely, coordinated support, which not only improves quality of life but also prevents escalation to acute care. |
| **4.2** | For the wider system, these changes mean fewer emergency admissions, reduced outpatient demand, and more efficient use of resources. Integrated Neighbourhood models foster collaboration between health, social care, and voluntary sectors, creating a sustainable framework for long-term improvement. |
| **4.3** | Ultimately, this programme supports a cultural shift towards prevention and community-based care, building resilience and equity across the system. |

| Recommendations | |
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| **5.1** | **Note the Programme:**<br>The Board is asked to note the progress of the National Neighbourhood Health Implementation Programme (NNHIP) and the alignment of national requirements with Rotherham's local priorities. |
| **5.12** | This includes recognition of the programme's intended contribution to strengthening neighbourhood working, enhancing proactive care, and supporting wider prevention activity. |
| **5.13** | Acknowledging this programme formally ensures shared understanding across partners and confirms its place within the broader system transformation agenda. |
| **5.2** | **Agree Governance and Reporting Mechanisms:**<br>The Board is asked to approve the proposed governance structure, including the establishment of the Operational Group reporting to the Place Leadership Team, and onward reporting to the Health and Wellbeing Board as required. |
| **5.21** | These arrangements will ensure clear accountability, enable timely and informed decision-making, and provide a consistent framework for monitoring progress. Agreement of the governance mechanisms will support streamlined oversight and ensure that partners are working within a coherent and transparent structure. |

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National Neighbourhood Health Implementation Programme

# Neighbourhood Working in Rotherham: Aligning National Expectations with Local Ambition

Joanne Martin, Programme Lead – Transformation and Delivery & Local Neighbourhood Coach

Date 14th November 2025

# Purpose

- Provide a shared understanding of the Neighbourhood Working Programme and its alignment with the NNHIP Compact Agreement.
- Review progress to date and the proposed delivery framework
- Provide an overview of the key priorities and tasks for Year 1, with a focus on strengthening the Proactive Care Model and refining the target cohort for rising-risk patients.
- Outline expectations around data development, governance, and reporting arrangements to the Place Leadership Team and Place Board.
- Identify immediate actions, responsibilities, and timelines to support delivery by the end of December 2025.

The NNHIP is a **large-scale change programme,** that will gather and disseminate learning to create exemplars and embed the culture required for delivery.

It will be overseen by a joint DHSC/NHSE Taskforce which reports to the Secretary of State. The Taskforce has four enabler subgroups; workforce, digital/data, funding flows and estates.

The National Neighbourhood Health Implementation Programme (NNHIP) will adopt a test-and-learn approach to support delivery

## Initial focus for year one (2025/26)

### Supporting progress of NbH

- Working with **one place in each system** (43) during its initial phase
- Building on learning from Places so far and co-producing **evidence-based change components**
- Establishes a **social movement for change** and knowledge spread to other places and population cohorts.

### Coaching & building capacity

- **Provide dedicated coaching support and access to subject matter expertise** alongside workshops and networking to **implement change components, enable peer-to-peer learning and development of collaborative improvement and system leadership skills**
- **Build capacity and capability** in places to implement the vision and service model

### Informing strategy and policy

- Informing future strategy, policy and development of NH including **identifying barriers and solutions to implementation**
- **Rigorous monitoring of outcome metrics** monthly, with ongoing rapid insights capture and evaluation to test, learn and refine

**Components of NNHIP**

**Culture of change | External expertise | National coaches | Learning workshops and environment | Leadership development Building a social movement/Robust evaluation and monitoring of outcomes**

***Built on learning from places who have been progressing neighbourhood working across the country and previous programmes***

# The Programmes collective role is to create the conditions for NbH to flourish

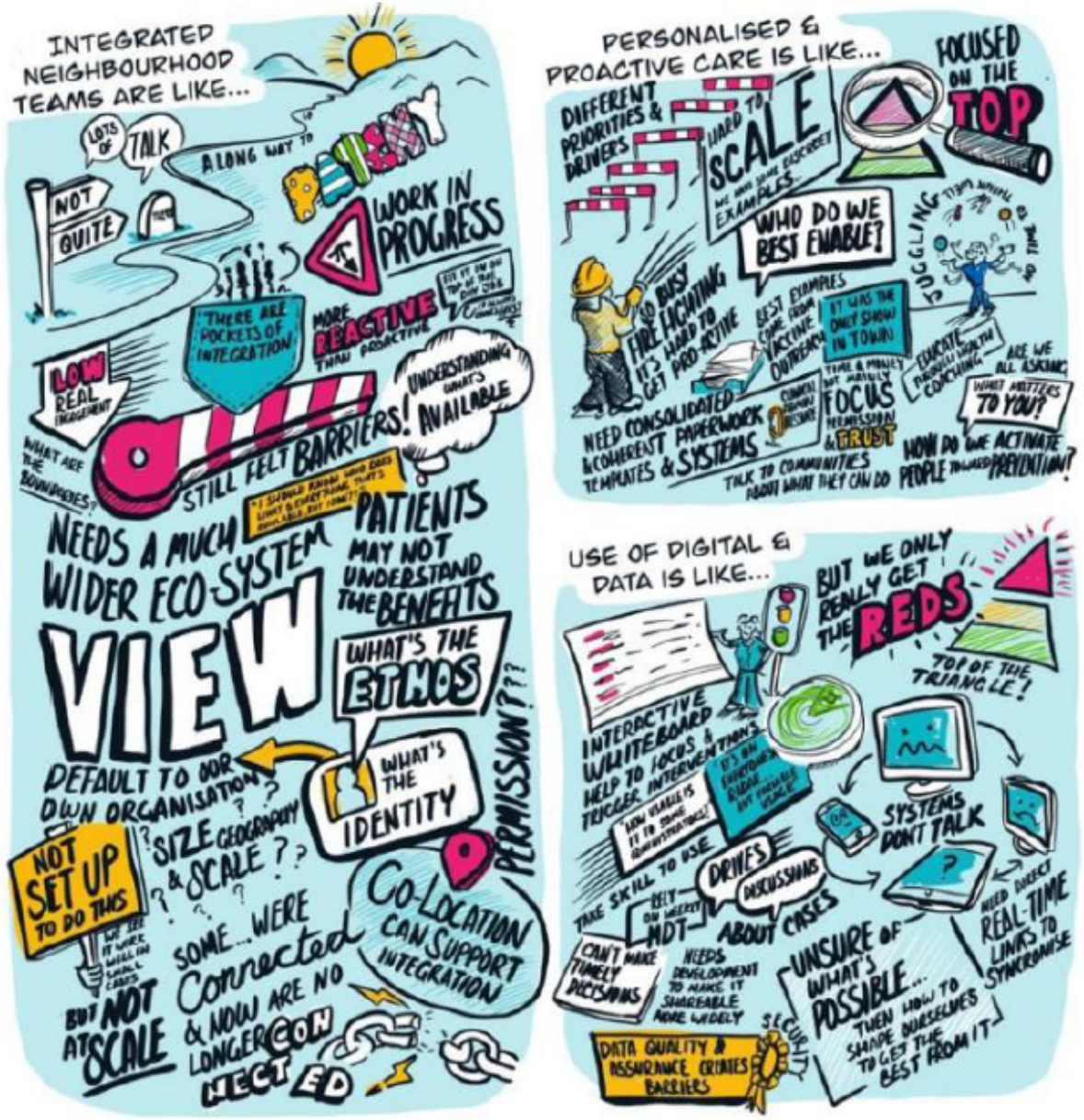
**The project**

- Building on existing mechanisms
- Focussing on a defined cohort
  - Adults with LTC and rising risk
  - Local prioritisation, existing pilot schemes
  - Most likely to have highest impact
- Refine, adapt, generate new ideas
- Rapid cycle testing driven by data (quants and quals)
- Shared learning

**The people**

- Working towards a shared purpose
- Building on relationships across the system
- Taking collective action and shared accountability
- Being curious and open-minded
- Not being afraid of ‘failure’
- Being action and delivery focused

# Call to action…




**This work is more than a programme – it's a social movement powered by collaboration.**

Our coaches act as catalysts, helping to create healthier and equitable neighbourhoods. But it's your leadership combined with the wisdom and innovation of the neighbourhood that wi shape the national story.

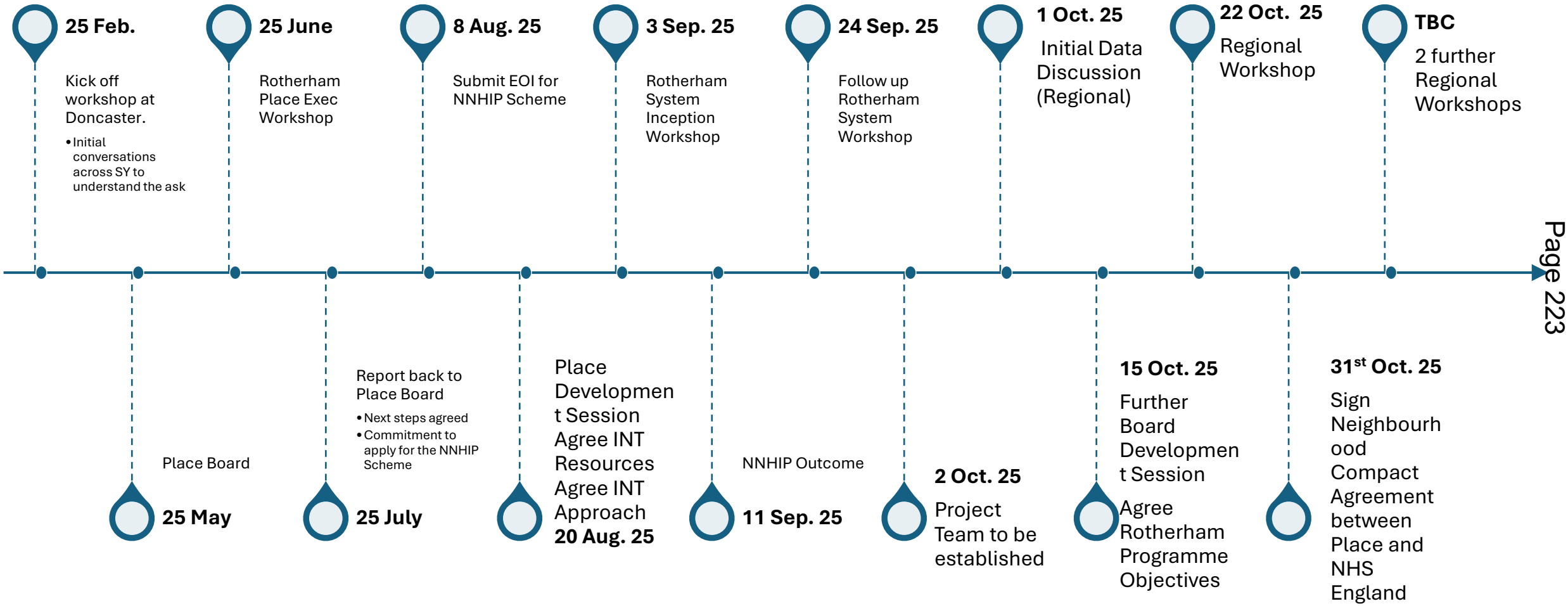
To do this well, we see the following leadership behaviours as especially important in shaping success:

- **Build trust** while also challenging and supporting others.
- **Encourage timely action and decision-making** so progress i optimised.
- **Escalate issues when needed**, ensuring barriers are addressed quickly.
- **Create psychological safety and foster collaboration**, enabling people to bring their best thinking and ideas.

Together, these behaviours will sustain momentum and ensure this movement achieves impact at both local and national levels.

# Rotherham's Journey so far.....

# Our Neighbourhood Journey so far.....



# Context

**National milestone**

- Rotherham has been successful in joining the National Neighbourhood Health Implementation Programme.

**Local foundation**

- Two workshops have shaped shared ambitions and early priorities for neighbourhood working in Rotherham.

**Partnership appetite:**

- Strong commitment from local partners to build on community strengths and existing models.

**Programme expectations**

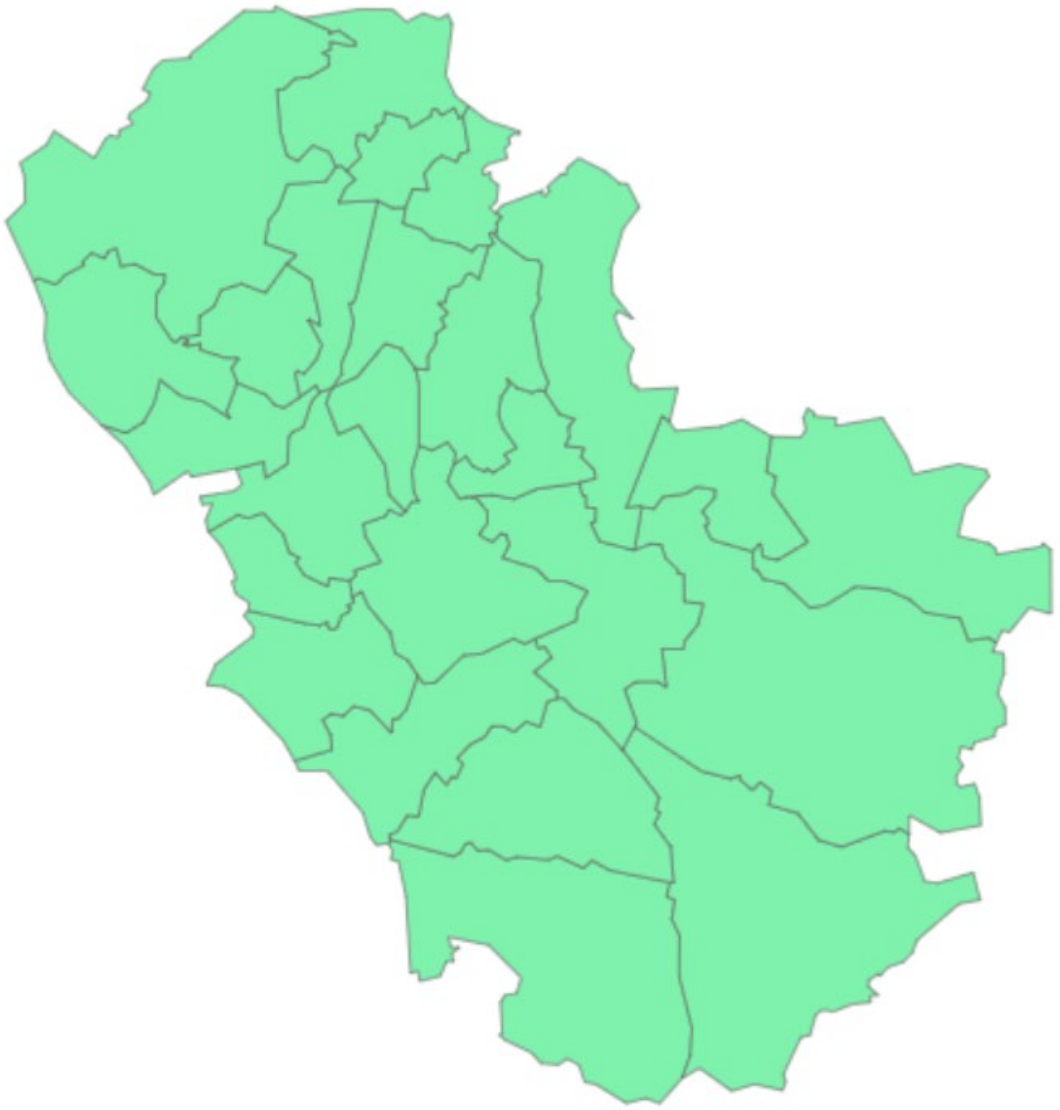
- Clear national milestones, delivery requirements, and support to accelerate progress.

**Opportunity:**

- Align national asks with local priorities to create a meaningful and sustainable neighbourhood model

# Rotherham's Definition of Neighbourhoods

# Rotherham's Definition of Neighbourhood



Place based approach to target opportunities based on need

E.G – Could be a need across all of Rotherham or targeted in a specific area where a different approach is needed.

**Consistent Universal Services**

Everyone gets the same baseline care and support across Rotherham.

**Flexible, Targeted Support**

*Resources can be adapted to meet local needs — no area left behind.*

**Data + Community Insights**

*Decisions shaped by both system data and real voices from our communities*

**Test, Learn, Adapt**

*Pilot new ideas in neighbourhoods, scale up what works best.*

A healthier, fairer Rotherham — built from the neighbourhood up

# National ask V Local Ask

# National Focus V Local Focus

<u>National Focus</u>

Adults with 2 or more LTC's with rising risk

Or

1 LTC with rising risk with

- Live in deprivation
- Belong to and ethnic minority
- Aged 18 - 40


<u>Local Focus</u>

Prevention

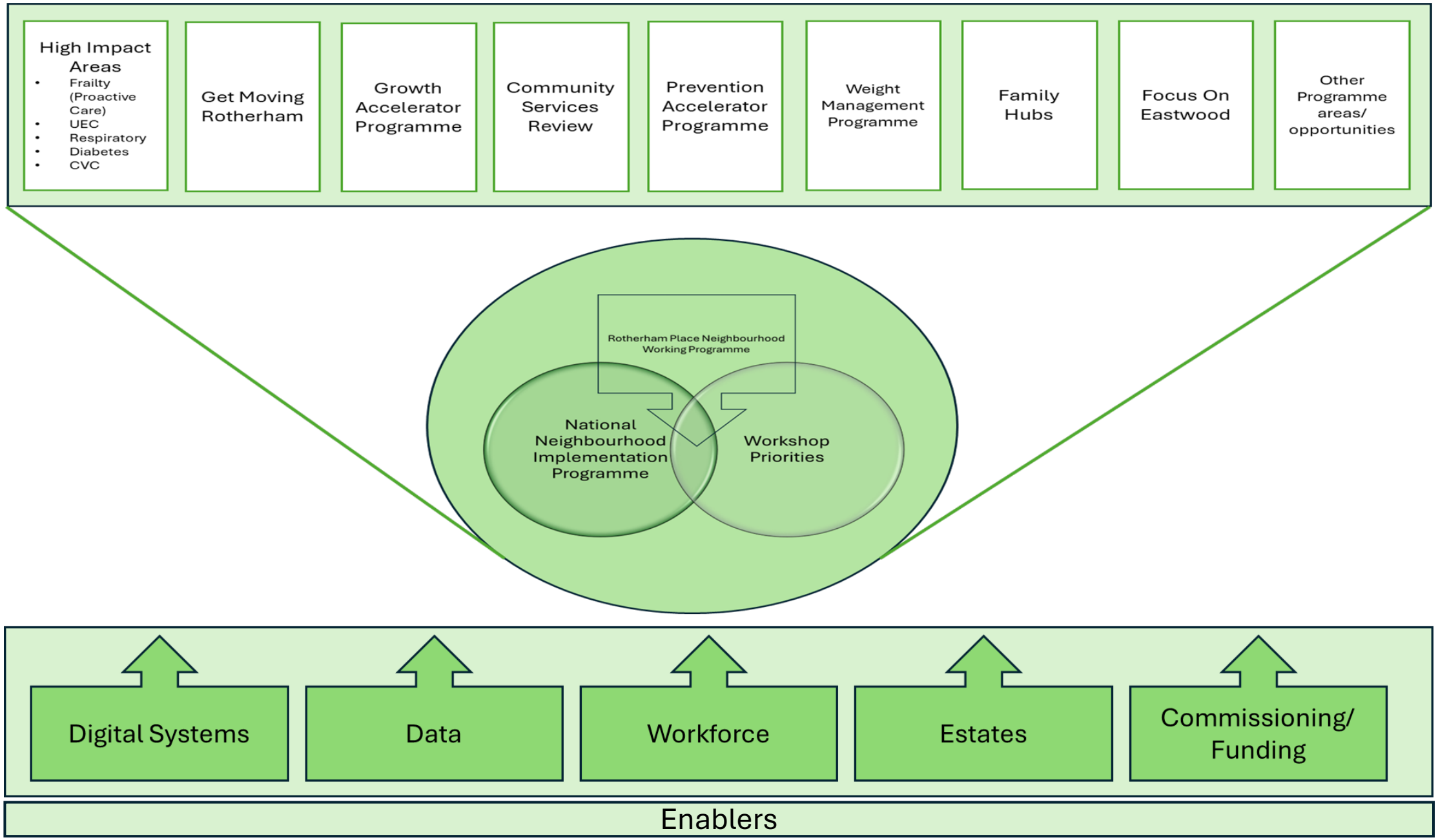
Children

Frailty (EOL)

Back to work

# Alignment of Existing Programmes & Enablers

# Rotherham Approach to Neighbourhood Working



# High level focus – next 12 months

# Suggested Neighbourhood Programme

## National Neighbourhood Programme

Proactive Care - Enhance Current Model

- Meets national cohort request
- Rotherham Place approach based on PCN footprint
- Involves all stakeholder participation
- Baseline established
- Data driven – via Eclipse and judgement

## Local Neighbourhood Programme

Place wide:

- Focus on prevention of diabetes and heart health
- Suggest focus on key drivers of LTCs
    - Smoking
    - Obesity
    - Hypertension

Targeted focus

- Eastwood Village

# Revised following regional feedback

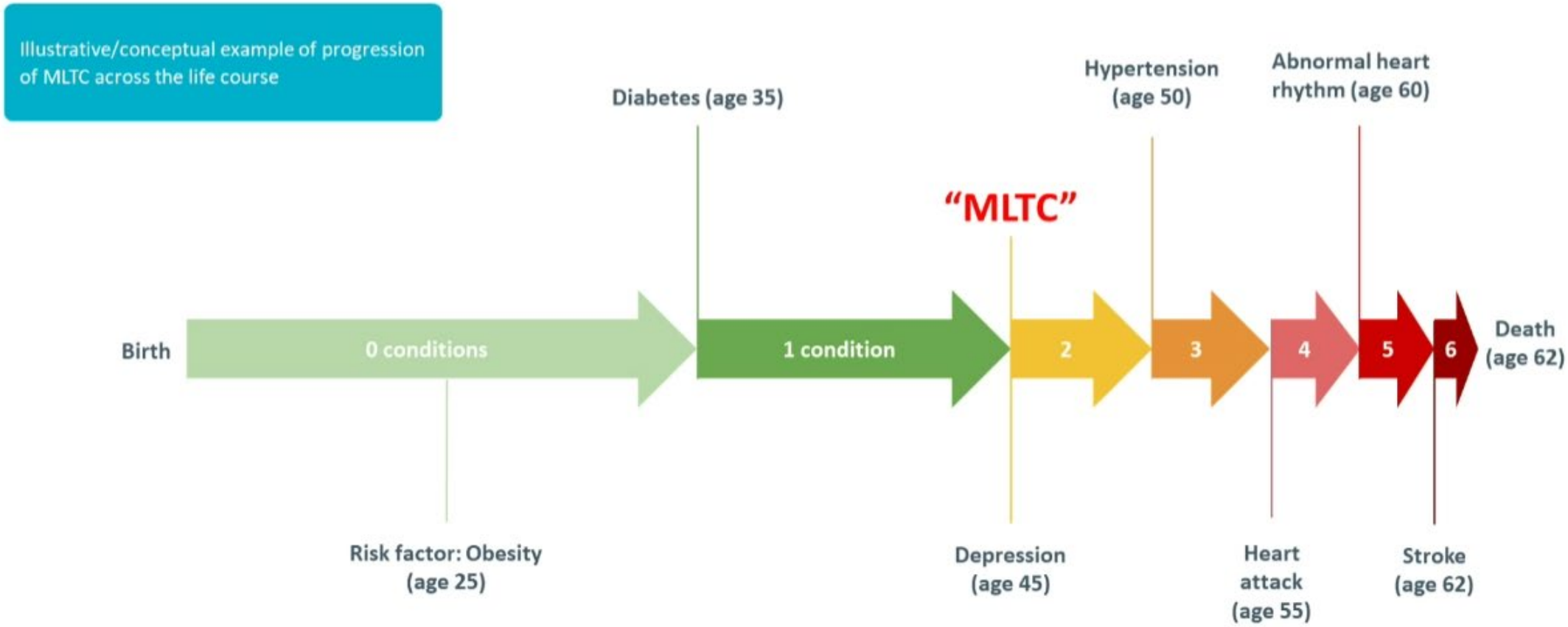
Proactive Care – Prevention

Proactive Care – Rising Risk

Proactive Care - Highly Complex Frailty

# Why Proactive Care

## Progression of multiple long term conditions (MLTC)



# Proactive Care

## Case Example – Complex MLTC

- Patricia, age 78
- Lives on her own
- Feels very lonely
- Has anxiety, HF, DM, CHD
- Recent admissions with HF
- Panics with breathlessness
- Has multiple appts
- Takes > 10 medicines
- Feels she has no control

**Through neighbourhood health:**

- Holistic, whole person care
- Supporting her psychosocial needs
- Care coordination and continuity
- Multidisciplinary input for complexity
- Remote monitoring and feedback
- Personalised single care plan
- Optimising proactive and reactive mx
- Avoiding inappropriate overtreatment
- Supporting her agency and confidence

Outcomes

Supports Left shift Acute to community

- Reduction in ED admissions
- Reduction in ED attendances
- Reduction in appointments to outpatients
- Less handovers

Benefits to the patient

- Feels in control of her health
- Less isolation
- Better continuity of care

# Proactive Care

Outcomes

Supports Left shift Acute to community

- Less DNAs
- Reduction in ED admissions
- Reduction in ED attendances

Benefits to the patient

- Feels in control of his health and self managing his condition
- Extended healthy years of life
- Extended life expectancy
- Potential reduction in further LTCs
- Better support for his children
- No longer in debt

## Case Example - Rising Risk

- Mark, age 35
- T2D for a few years
- Works on building site
- Irregular eating habits
- Living with obesity
- Struggling with debt
- Young children at home
- Feeling overwhelmed
- No response to appt invite

**Through neighbourhood health:**

- Proactively identifying and reaching out
- Understanding what matters to him
- Helping him access debt advice
- Supporting his psychological needs
- Clinical reviews outside of core hours
- Early identification of complications
- Addressing his modifiable risk factors
- Empowering self-mx and lifestyle change
- Interventions proven to reduce MLTC risk

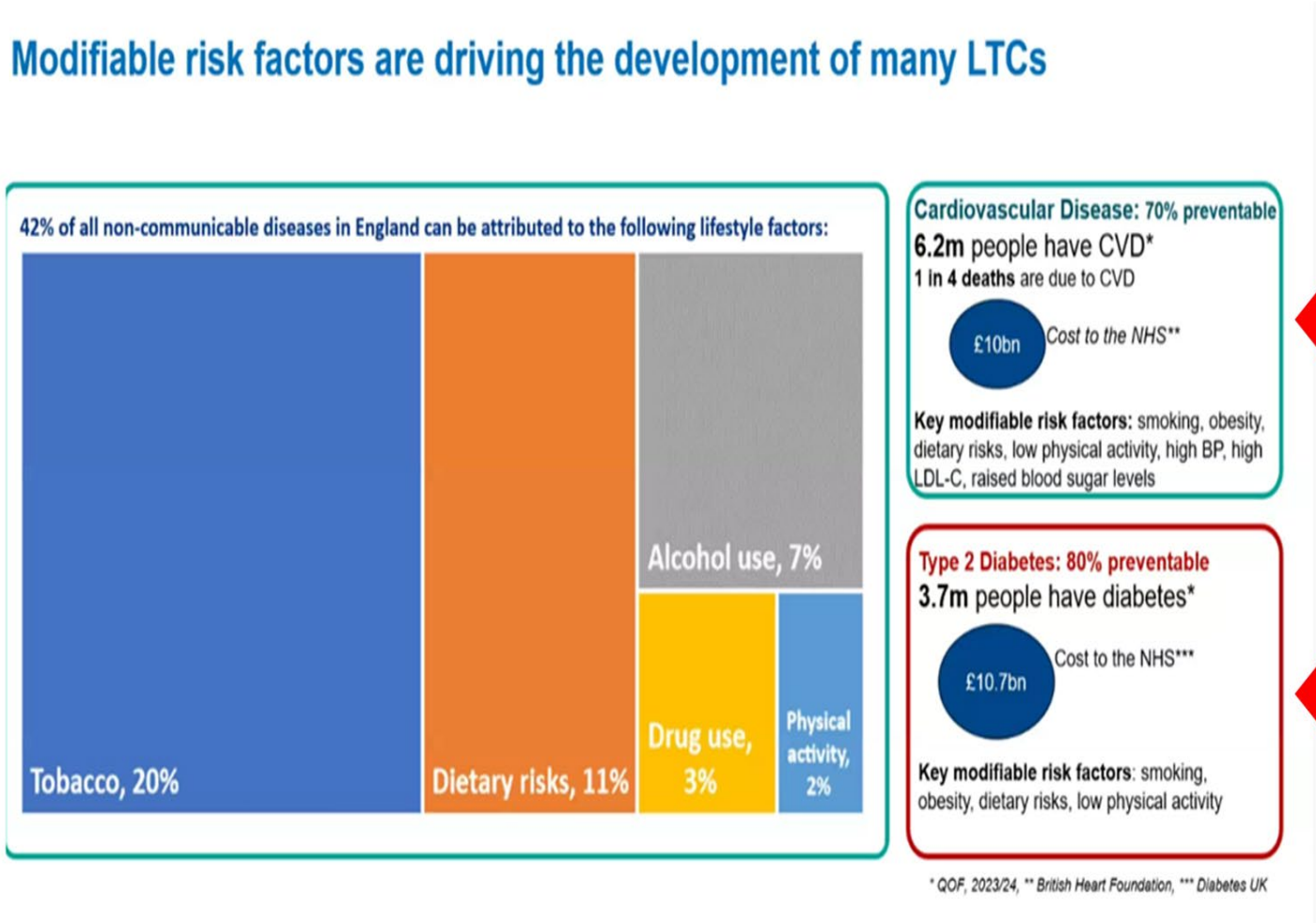
# Targeted Prevention

**High level Outcomes**

- Preventable conditions
- Prevention will be delivered in the community

(Left shift)

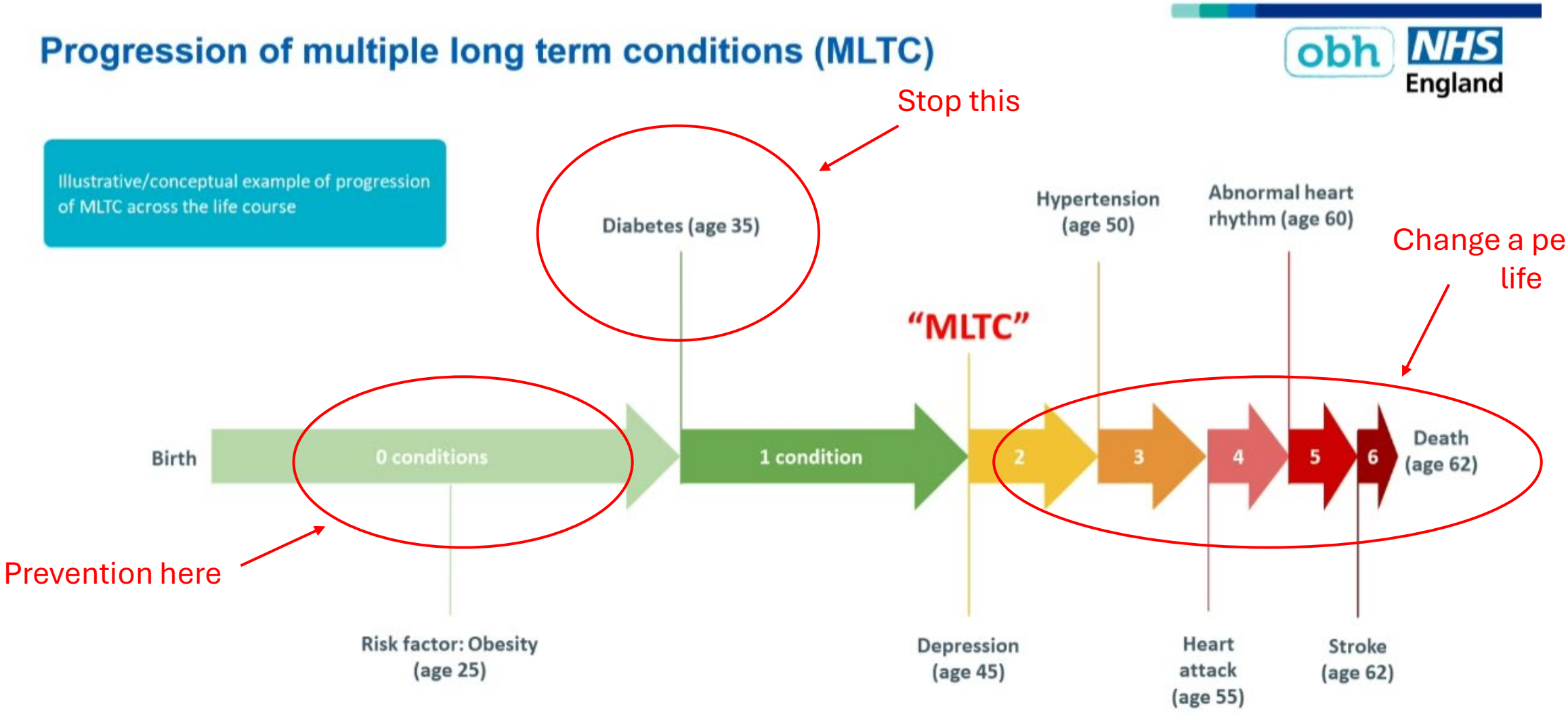
- - Should support a reduction in demand at ED and Acute admissions, outpatient appointments and primary care appointments (over time)




70% preventable

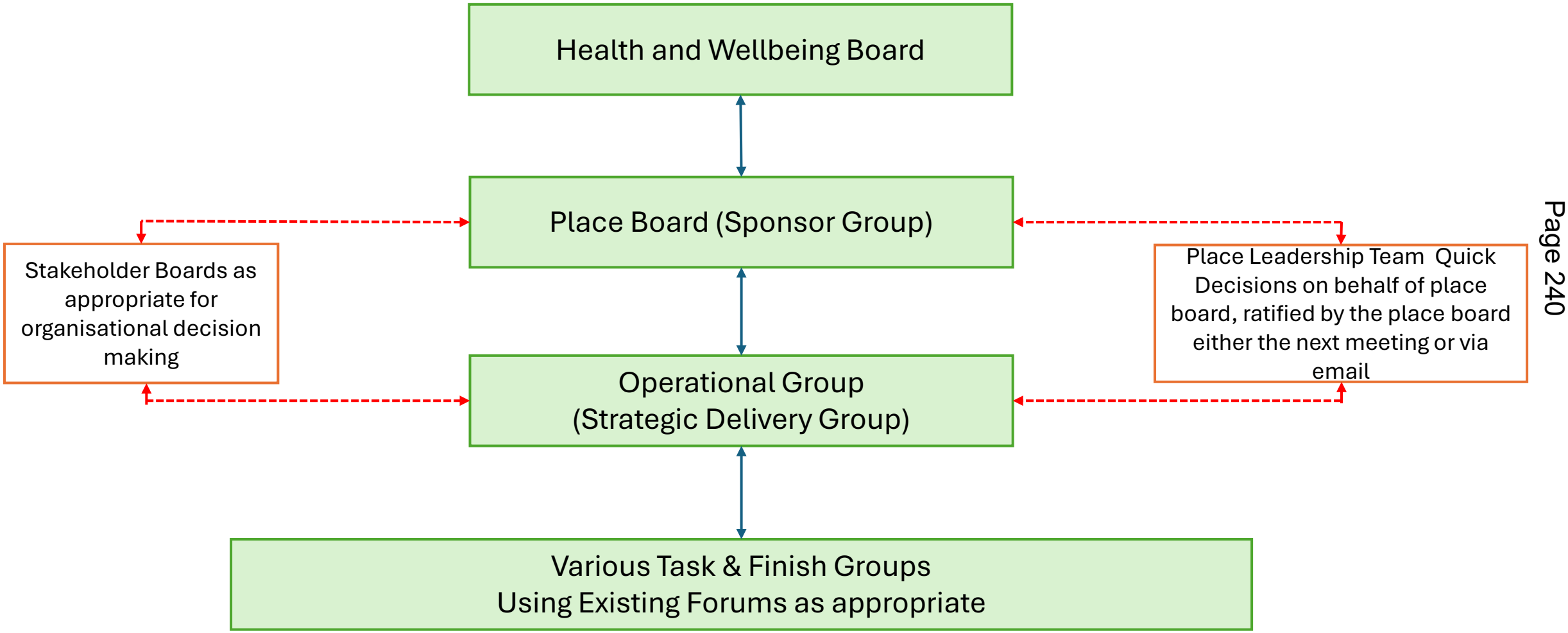
80% preventable

# Why Prevention



# Governance

# Governance Structure



# Questions/Comments

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Rotherham Metropolitan Borough Council

NHS South Yorkshire Integrated Care Board

| | | |
|---|---|---|
| **BRIEFING** | **TO:** | Health and Wellbeing Board |
| | **DATE:** | Wednesday, 24th September 2025 |
| | **LEAD OFFICER** | Steph Watt<br>Health and Care Portfolio Lead, SYICB/RMBC<br>E-mail: steph.watt@nhs.net |
| | **TITLE:** | HWBB Report for Rotherham BCF 2025/26 Quarter 1 Reporting Template |

**Background**

1.1 The purpose of this report is to agree the contents of the BCF Q1 Reporting Template which will be submitted to NHS England regarding the metrics and expenditure of Rotherham's Better Care Fund Plan for 2025/26.

1.2 The overall delivery of the Better Care Fund continues to have a positive impact and improves joint working between health and social care in Rotherham.

**Key Issues**

2.1 The BCF Quarter 1 template covers reporting on: national conditions, metrics and expenditure.

2.2 Below is a summary of information included within the BCF submission:

**2.3 National Conditions**

There are a total of 4 national conditions for 2025/26 which continue to be met through the delivery of the plan as follows:

- Plans to be jointly agreed.
- Implementing the objectives of the BCF.
- Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC).
- Complying with oversight and support processes.

**3. BCF Metrics**

There is a total of three BCF metrics within the BCF Q1 Template for 2025/26 which measures the impact of the plan as follows:

3.1 **Emergency admissions to hospital for people aged 65+ per 100,000 population –** Not on track to meet goal.

| | |
|---|---|
| | **Achievements** - This is the first quarter of 2025–26 for reporting this data. The national SUS data shows that in the first quarter there has been some month-on-month variation. In April, the actual figure was 2,034.7 compared to the planned 1,943.3, slightly above the plan. In May, the actual was 2,122.5 against a planned 2,103.8. June recorded 2,081.4, which was slightly above the planned 2,062.7. Overall, the quarter 1 figures are slightly higher than the planned values across all three months.<br><br>**Challenges and any support needs** - A key priority for the Rotherham urgent and emergency care recovery plan in 2025-26 is to reduce avoidable conveyances and admissions in order to meet the national 4-hour standard, G&A occupancy levels and no criteria to reside.<br><br>**Variance from Plan –** This is the first quarter of 2025–26 for reporting this data. Overall, the quarter 1 figures are slightly higher than the planned values across all three months.<br><br>**Mitigation for Recovery -** This includes developing alternative out of hospital pathways and four high impact change projects relating to frailty, ambulatory care and respiratory and diabetes pathways which are associated with high levels of admission. The growth of the virtual ward including frailty, respiratory and, most recently, the new heart failure pathway, are contributing to reducing avoidable admissions. |
| 3.2 | **Average length of discharge delay for all acute adult patients, derived from a combination of:**<br><br>• **proportion of adult patients discharged from acute hospitals on their Discharge Ready Date (DRD)**<br><br>• **for those adults patients not discharged on their DRD, average number of days from the DRD to discharge -** Not on track to meet goal.<br><br>**Achievements** - This is the first quarter of 2025–26 for reporting the Discharge Ready Date (DRD) metric, data shows that in April, the recorded average was 0.69 compared to a planned 0.65, May was 0.77 against the plan figure 0.72. June saw a slight decline to 0.67, above the planned figure of 0.65.<br><br>**Challenges and any support needs** – Whole system flow is a key priority in the Place urgent and emergency care programme. Targeted activity includes increasing same day discharges and improving system flow to reduce discharge delays. BCF funding including winter monies are being used to support this.<br><br>**Variance from Plan –** Q1 figures show the average length of discharge delay for all acute adult patients was higher than planned.<br><br>**Mitigation for Recovery -** There has been a sustained increase in demand in the Emergency Department resulting in increased admissions, with escalation beds remaining open over the summer. This has impacted on discharge pathways, particularly enablement. At times it has been necessary to place people in short term bedded community care, as there has been insufficient capacity to support people at home, in order to release acute bed capacity. Work continues to increase capacity in enablement, with waiting lists having been halved. A redesign of adult social care pathways and formation of the multi-disciplinary transfer of care hub is facilitating a more integrated approach to system flow. |
| 3.3 | **Long-term admissions to residential care homes and nursing homes for people age 65 and over per 100,000 population –** Not on track to meet goal. |

| | |
|---|---|
| | **Achievements** - The 2025-26 BCF target has been set to a population rate of 563.6, which equates to 317 admissions over the year. During Quarter 1 there have been 122 new admissions against a target of 82. At the end of Quarter 1, we are 40 over target, resulting in a population rate of 227.74 (per 100,000), against a Quarter 1 target population rate of 153.07.<br><br>**Challenges and any support needs** – Increased demand across the system and higher levels of acuity has resulted in pressure on services supporting people at home. There has been an increase in placing people in short-term care beds which has in turn impacted on longer term placements.<br><br>**Variance from Plan –** At the end of Quarter 1, we are 40 over target, resulting in a population rate of 227.74 (per 100,000), against a Quarter 1 target population rate of 153.07. Based on previous learning, it is anticipated that Q1 figures will reduce following data validation and mitigation activity.<br><br>**Mitigation for Recovery -** A task and finish group are looking at better health and social care linkages and solutions for people being discharged from hospital to ensure people are being supported home first. Quality Assurance processes are in place to ensure less restrictive options are always utilised before a long-stay placement considered / agreed. Adult Social Care are working with health on a project to reduce short term placements in care homes, many of which translate into long term stays. The Council also continues to closely monitor the rates of admission with a focus on home first and residential care being only considered where there are no other appropriate alternatives to meeting needs. BCF monies are being used to support more people being cared for at home. |
| **4.** | **Expenditure** |
| 4.1 | The Q1 Year-to-Date Actual Expenditure for BCF funded schemes. covering the period from 1st April to 30th June 2025, has been included in the Q1 template. |
| **Key Actions and Relevant Timelines** | |
| 5.1 | **The Better Care Fund Executive Group held on Monday 11th August 2025 approved (on behalf of the Health and Wellbeing Board) the:**<br><br>**(i) Documentation for submission to NHS England (NHSE) on Friday 15th August 2025.** |
| **Implications for Health Inequalities** | |
| 6.1 | 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. |
| 6.2 | BCF funded schemes which reduce health inequalities include carer support, social prescribing, Breathing Space and project support for the implementation of Population Health Management (PHM) priorities. |

| Recommendations | |
|---|---|
| 7.1 | **That the Health and Wellbeing Board notes the:**<br><br>**ii) Documentation for submission to NHS England (NHSE) on Friday 15th August 2025.** |

# Better Care Fund 2025-26 Q1 Reporting Template

**1. Guidance**

## Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements for 2025-26 (refer to link below), which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE).
https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#introduction

https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026

As outlined within the planning requirements, quarterly BCF reporting will continue in 2025-26, with areas required to set out progress on delivering their plans by reviewing metrics performance against goals, spend to date as well as any sigificant changes to planned spend.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off HWB chairs ahead of submission. Aggregated data reporting information will be available on the DHSC BCF Metrics Dashboard and published on the NHS England website.

**Note on entering information into this template**

**Please do not copy and paste into the template**

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

Data needs inputting in the cell

Pre-populated cells

**Note on viewing the sheets optimally**

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut and paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy and paste', please use the 'Paste Special' operation and paste Values only.

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

## Checklist ( 2. Cover )

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

## 2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2025-26 will pre-populate in the relevant worksheets.
2. HWB Chair sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

HM Government

NHS England

# Better Care Fund 2025-26 Q1 Reporting Template

**2. Cover**

**Version 1.0**

*Please Note:*

*- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.*

*- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.*

*- All information will be supplied to BCF partners to inform policy development.*

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

| | |
|---|---|
| **Health and Wellbeing Board:** | Rotherham |
| **Completed by:** | Hafsah Taj |
| **E-mail:** | Hafsah.Taj1@nhs.net |
| **Contact number:** | 01709 253870 |
| **Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission? ( Please provide name of HWB Chair)** | Yes |
| **If no, please indicate when the report is expected to be signed off:** | |

| **Checklist** | Complete: |
|---|---|
| | Yes |
| | Yes |
| | Yes |
| | Yes |
| | Yes |
| | Yes |

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

**Complete**

| | **Complete:** |
|---|---|
| 2. Cover | Yes |
| 3. National Conditions | Yes |
| 4. Metrics | Yes |
| 5. Expenditure | Yes |

For further guidance on requirements please refer back to guidance sheet - tab 1.

[<< Link to the Guidance sheet]

^^ Link back to top

# Better Care Fund 2025-26 Q1 Reporting Template

**3. National Conditions**

Selected Health and Wellbeing Board: Rotherham

| | | Checklist Complete: |
|---|---|---|
| **Has the section 75 agreement for your BCF plan been finalised and signed off?** | Yes | Yes |
| **If it has not been signed off, please provide the date section 75 agreement expected to be signed off** | | Yes |
| **If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.** | | Yes |

| **Confirmation of Nation Conditions** | | | |
|---|---|---|---|
| **National Condition** | **Confirmation** | **If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:** | |
| **1) Plans to be jointly agreed** | Yes | | Yes |
| **2) Implementing the objectives of the BCF** | Yes | | Yes |
| **3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)** | Yes | | Yes |
| **4) Complying with oversight and support processes** | Yes | | Yes |

**Better Care Fund 2025-26 Q1 Reporting Template**

**4. Metrics for 2025-26**

Selected Health and Wellbeing Board: Rotherham

For metrics time series and more details: BCF dashboard link

For metrics handbook and reporting schedule: BCF 25/26 Metrics Handbook

# 4.1 Emergency admissions

| Actuals + Original Plan | | Apr 24 Actual | May 24 Actual | Jun 24 Actual | Jul 24 Actual | Aug 24 Actual | Sep 24 Actual | Oct 24 Actual | Nov 24 Actual | Dec 24 Actual | Jan 25 Actual | Feb 25 Actual | Mar 25 Actual |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Emergency admissions to hospital for people aged 65+ per 100,000 population | Rate | 1,922.7 | 2,212.1 | 2,016.1 | 2,081.4 | 1,838.7 | 1,876.1 | 2,212.1 | 1,857.4 | 2,081.4 | 2,072.1 | 1,876.1 | 2,006.7 |
| | Number of Admissions 65+ | 1,030 | 1,185 | 1,080 | 1,115 | 985 | 1,005 | 1,185 | 995 | 1,115 | 1,110 | 1,005 | 1,075 |
| | Population of 65+* | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 |
| | | Apr 25 Plan | May 25 Plan | Jun 25 Plan | Jul 25 Plan | Aug 25 Plan | Sep 25 Plan | Oct 25 Plan | Nov 25 Plan | Dec 25 Plan | Jan 26 Plan | Feb 26 Plan | Mar 26 Plan |
| | Rate | 1,943.3 | 2,103.8 | 2,062.7 | 1,986.2 | 1,905.9 | 1,920.9 | 2,118.7 | 1,984.3 | 2,135.5 | 2,331.5 | 2,027.3 | 2,234.5 |
| | Number of Admissions 65+ | 1,041 | 1,127 | 1,105 | 1,064 | 1,021 | 1,029 | 1,135 | 1,063 | 1,144 | 1,249 | 1,086 | 1,197 |
| | Population of 65+ | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 |

| Do you want to update your Emergency Admission metric plan? | No |
|---|---|

Please set out how the ambition has been reached, including analysis of historic data, impact of planned efforts and how the target aligns for locally agreed plans such as Acute trusts and social care. ↓

| Updated Plan | Apr 25 Plan | May 25 Plan | Jun 25 Plan | Jul 25 Plan | Aug 25 Plan | Sep 25 Plan | Oct 25 Plan | Nov 25 Plan | Dec 25 Plan | Jan 26 Plan | Feb 26 Plan | Mar 26 Plan | What is the rationale behind the change in plan? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Rate** | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | |
| Number of Admissions 65+ | | | | | | | | | | | | | |
| Population of 65+ | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | |

| Assessment of whether goal has been met: | Not on track to meet goal |
|---|---|
| If a goal has not been met please provide a short explanation, including noting any key mitigating actions. | This is the first quarter of 2025–26 for reporting this data. Using locally held SUS data shows across the quarter, there has been some month-on-month variation. In April, the actual figure was 2,034.7 compared to the planned 1,943.3, slightly above the plan. In May, the actual was 2,122.5 against a planned 2,103.8. June recorded 2,081.4, which was slightly above the planned 2,062.7. Overall, the quarter 1 figures are slightly higher than the planned values across all three months. |

| | |
|---|---|
| You can also use this box to provide a very brief explanation of overall progress if you wish. | N.A |

| | |
|---|---|
| Did you use local data to assess against this headline metric? | Yes |
| If yes, which local data sources are being used? | SUS |

## 4.2 Discharge Delays

| Actuals | Apr 24 Actual | May 24 Actual | Jun 24 Actual | Jul 24 Actual | Aug 24 Actual | Sep 24 Actual | Oct 24 Actual | Nov 24 Actual | Dec 24 Actual | Jan 25 Actual | Feb 25 Actual | Mar 25 Actual |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)** | n/a | n/a | n/a | n/a | n/a | 0.66 | 0.67 | 0.69 | 0.64 | 0.74 | 0.86 | 0.78 |
| Proportion of adult patients discharged from acute hospitals on their discharge ready date | n/a | n/a | n/a | n/a | n/a | 84.4% | 83.5% | 84.3% | 84.1% | 83.6% | 83.2% | 85.4% |
| For those adult patients not discharged on DRD, average number of days from DRD to discharge | n/a | n/a | n/a | n/a | n/a | 4.24 | 4.07 | 4.37 | 4.02 | 4.49 | 5.15 | 5.35 |

| Original Plan | Apr 25 Plan | May 25 Plan | Jun 25 Plan | Jul 25 Plan | Aug 25 Plan | Sep 25 Plan | Oct 25 Plan | Nov 25 Plan | Dec 25 Plan | Jan 26 Plan | Feb 26 Plan | Mar 26 Plan |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Average length of discharge delay for all acute adult patients** | 0.65 | 0.72 | 0.65 | 0.63 | 0.68 | 0.66 | 0.71 | 0.65 | 0.65 | 0.69 | 0.66 | 0.71 |
| Proportion of adult patients discharged from acute hospitals on their discharge ready date | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% |
| For those adult patients not discharged on DRD, average number of days from DRD to discharge | 4.09 | 4.52 | 4.10 | 3.97 | 4.28 | 4.12 | 4.46 | 4.09 | 4.09 | 4.36 | 4.15 | 4.43 |

| | |
|---|---|
| Do you want to update your Discharge Delay metric plan? | No |

Please set out how the ambition has been reached, including analysis of historic data, impact of planned efforts and how the target aligns for locally agreed plans such as Acute trusts and social care. ↓

| Updated Plan | Apr 25 Plan | May 25 Plan | Jun 25 Plan | Jul 25 Plan | Aug 25 Plan | Sep 25 Plan | Oct 25 Plan | Nov 25 Plan | Dec 25 Plan | Jan 26 Plan | Feb 26 Plan | Mar 26 Plan | What is the rationale behind the change in plan? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Average length of discharge delay for all acute adult patients** | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of adult patients discharged from acute hospitals on their discharge ready date | | | | | | | | | | | | |
| For those adult patients not discharged on DRD, average number of days from DRD to discharge | | | | | | | | | | | | |

| | |
|---|---|
| Assessment of whether goal has been met: | Not on track to meet goal |
| If a goal has not been met please provide a short explanation, including noting any key mitigating actions. | This is the first quarter of 2025–26 for reporting the Discharge Ready Date (DRD) metric. Local SUS data shows that in April, the recorded average was 0.66 compared to a planned 0.65. May was 0.72 against the planned figure of 0.72. June saw a slight decline to 0.67, which was still above the planned figure of 0.65.<br><br>For the three months in the first quarter, the average proportion of adult patients discharged on their date of discharge was 83.5%, slightly below the planned average of 84.1%. |
| You can also use this box to provide a very brief explanation of overall progress if you wish. | N.A |

| | |
|---|---|
| Did you use local data to assess against this headline metric? | Yes |
| If yes, which local data sources are being used? | SUS |

## 4.3 Residential Admissions

**Actuals + Original Plan**

| | | 2023-24 Full Year Actual | 2024-25 Full Year CLD Actual | 2025-26 Plan Q1 (April 25-June 25) | 2025-26 Plan Q2 (July 25-Sept 25) | 2025-26 Plan Q3 (Oct 25-Dec 25) | 2025-26 Plan Q4 (Jan 26-Mar 26) |
|---|---|---|---|---|---|---|---|
| Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population | Rate | 556.3 | 599.2 | 153.1 | 153.1 | 154.9 | 154.9 |
| | Number of admissions | 298.0 | 321.0 | 82.0 | 82.0 | 83.0 | 83.0 |
| | Population of 65+* | 53570.0 | 53570.0 | 53570.0 | 53570.0 | 53570.0 | 53570.0 |

| | |
|---|---|
| Do you want to update your Residential Admissions metric plan? | No |

Please set out how the ambition has been reached, including analysis of historic data, impact of planned efforts and how the

| | |
|---|---|
| **Please enter plan number of admissions within the specific quarter** | target aligns for locally agreed plans such as Acute trusts and social care. ↓ |

# Better Care Fund 2025-26 Q1 Reporting Template

**5. Income & Expenditure**

Selected Health and Wellbeing Board: Rotherham

| Source of Funding | 2025-26 Planned Income | Updated Total Plan Income for 25-26 | Q1 Year-to-Date Actual Expenditure | Checklist Complete: |
|---|---|---|---|---|
| DFG | £3,801,597 | £3,801,597 | £225,203 | Yes |
| Minimum NHS Contribution | £28,410,232 | £28,410,232 | | Yes |
| Local Authority Better Care Grant | £17,864,126 | £17,864,126 | | Yes |
| Additional LA Contribution | £2,582,038 | £4,493,038 | | Yes |
| Additional NHS Contribution | £0 | £0 | | Yes |
| **Total** | **£52,657,993** | **£54,568,993** | | |

| | Original | Updated | % variance | |
|---|---|---|---|---|
| **Planned Expenditure** | **£52,657,993** | £54,568,993 | **4%** | Yes |

| | | % of Planned Income | |
|---|---|---|---|
| **Q1 Year-to-Date Actual Expenditure** | £11,970,049 | **22%** | Yes |

| | | |
|---|---|---|
| If Q1 Year-to-Date Actual Expenditure is exactly 25% of planned income, please provide some context around how accurate this figure is or whether there are limitations. | is not exactly 25% | Yes |
| If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change. | % change is less than 5% / Board minutes will show the revised budget | Yes |

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| BRIEFING | TO: | Health and Wellbeing Board |
|---|---|---|
| | DATE: | Wednesday, 24th September 2025 |
| | LEAD OFFICER | Steph Watt<br>Health and Care Portfolio Lead, SYICB/RMBC<br>E-mail: steph.watt@nhs.net |
| | TITLE: | HWBB Report for Better Care Fund (BCF) Call-Off Partnership / Work Order 2025/26 |

**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 2025/26, 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) published the BCF Policy Framework for the implementation of the Better Care Fund (BCF) for 2025-26.

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

- Objective 1: reform to support the shift from sickness to prevention.
- Objective 2: reform to support people living independently and the shift from hospital to home.

1.4 The government is committed to reforming and strengthening neighbourhood services across health and social care, with the goal of:

- providing more care closer to home
- increasing the focus on prevention so that people are living healthier and more independent lives
- harnessing digital technology to transform care

1.5 NHS England and the Government have published the BCF Planning Requirements for 2025/26, 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.

1.6 The use of BCF mandatory funding streams including NHS minimum contribution, Disabled Facilities Grant (DFG) and Local Authority Better Care Fund Grant 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).

To give local areas greater flexibility in how they meet the objectives of the BCF, the previously ring-fenced discharge fund has been consolidated within the BCF. While discharge funding is now consolidated, reducing discharge delays remains a critical shared priority across the NHS and local authorities, and plans should reflect a continued focus on this area. The ICB discharge funding has been consolidated into the NHS minimum contribution to the BCF. Local authority discharge funding has been consolidated into the Local Authority Better Care Grant, formerly known as the improved Better Care Fund.

| 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 the 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 2025/26 (Appendix 2). |
| 2.3 | The BCF Planning Requirements 2025-26 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 2025/26 needs to be fully signed by both partner organisations and in place by 30th September 2025. |
| 2.4 | The BCF Call-Off Partnership/ Work Order 2025/26 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 £54.5m BCF Plan for 2025/26. One fund, hosted by the SYICB (Rotherham Place), is valued at £20.7m and the other fund, hosted by the Council, is valued at £33.8m. Both funds sit under the same Section 75 Framework Agreement which provides governance for the BCF plan. |
| 2.9 | The BCF funding includes the minimum NHS contribution of £28.41m, Local Authority Better Grant of £17.86m, Additional LA Contribution of £4.49m and DFG of £3.8m for 2025/26 which amounts to a total of £54.56 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. |

| | |
|---|---|
| **Key Actions and Relevant Timelines** | |
| 3.1 | The BCF Call-Off Partnership / Work Order 2025/26 (Appendix 2) will go through various stages of the approval process as follows:<br><br>• BCF Executive Group – 11th August 2025<br>• Health and Wellbeing Board – 24th September 2025<br>• Signed by both partner organisations and in place by 30th September 2025. |
| **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. |
| 4.2 | 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:**<br><br>**(I) Better Care Fund (BCF) Call-Off Partnership / Work Order for 2025/26.** |

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# Better Care Fund (BCF) –

# Call Off Partnership Agreement / Work Order 2025/26

## 1. OBJECTIVES OF THE SCHEME

The Department of Health and Social Care (DHSC) and NHS England have specifically requested in the BCF Planning Requirements (2025-26) 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 **£33.812m**. This includes the Adults' revenue base budget as well as specific grants i.e. the Local Authority Better Care Grant (previously known as the iBCF) Disabled Facilities Grant and Adult Social Care Discharge Funding).

**Pool 2**; Hosted by the SYICB (Rotherham Place); Value of **£20.757m**. This also includes 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 2025/26 will be **£28.410m** and the Council's base contribution, will be **£26.159m** as per the table below:

| Better Care Fund 2025/26 Financial Monitoring | 2025/26 INVESTMENT | | | 2025/26 SPLIT BY POOL | |
|---|---|---|---|---|---|
| **BCF Investment** | **SYICB SHARE £,000** | **RMBC SHARE £,000** | **TOTAL £,000** | **Pool 1 RMBC Hosted £,000** | **Pool 2 SYICB Hosted £,000** |
| THEME 1 - Mental Health Services | 1,630 | 0 | 1,630 | 0 | 1,630 |
| THEME 2 - Rehabilitation & Reablement | 12,666 | 7,449 | 20,115 | 11,425 | 8,690 |
| THEME 3 - Supporting Social Care | 5,209 | 0 | 5,209 | 3,624 | 1,585 |
| THEME 4 - Care Mgt & Integrated Care Planning | 5,125 | 0 | 5,125 | 919 | 4,206 |
| THEME 5 - Supporting Carers | 561 | 230 | 791 | 791 | 0 |
| THEME 6 - Infrastructure | 246 | 0 | 246 | 50 | 196 |
| Risk Pool | 500 | 0 | 500 | 0 | 500 |
| Local Authority Better Care Grant | 0 | 15,096 | 15,096 | 13,619 | 1,477 |
| Discharge Funding | 2,473 | 3,384 | 5,857 | 3,384 | 2,473 |
| **Total** | **28,410** | **26,159** | **54,569** | **33,812** | **20,757** |

Appendix 1 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 **£14.5m** for 2025/26, however, the ASC Discharge Fund allocations are now rolled into the Improved Better Care Fund (iBCF), with the iBCF renamed to the Local Authority Better Care Grant, 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 2025-26 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 (renamed to the Local Authority Better Care Grant) 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 be 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 Rotherham Place will receive £2.473 million of this funding. Rotherham Council has also been allocated £3.384 million of the fund. Therefore, this amounts to a

total of £5.857 million of funding for Rotherham Place partners for. These funds are required to be pooled into the local Better Care Fund (BCF) plans and Section 75 agreements. The Rotherham Place Discharge Funding is no longer ring-fenced and therefore forms part of the whole minimum NHS minimum contribution for 2025/26. The Local Authority Discharge Fund allocations have been rolled into the Improved Better Care Fund (iBCF), with the iBCF renamed to the Local Authority Better Care Fund.

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 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 2025-26, 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

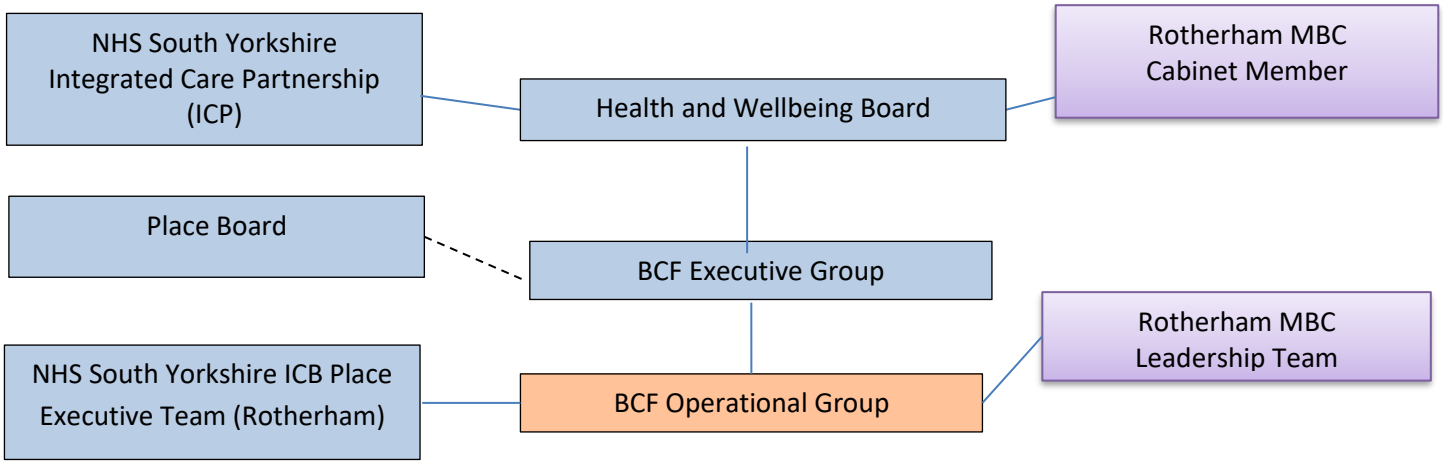
10.11 **Information and Reports**

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**




## 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 2025/26
- 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 2025/26. The metrics included for 2025/26 are as follows.

- **Emergency admissions to hospital for people aged over 65 per 100,000 population**
- **Average length of discharge delay for all acute adult patients, derived from a combination of:**
  - proportion of adult patients discharged from acute hospitals on their Discharge Ready Date (DRD)
  - for those adults patients not discharged on their DRD, average number of days from the DRD to discharge
- **Long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population.**

The metrics relating to the proportion of older people (65 years and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services are no longer included.

Metric descriptions are below.

**Table 4 – BCF Metrics Definitions**

| | Metric | Numerator | Denominator |
|---|---|---|---|
| **1** | Emergency admissions to hospital for people aged over 65 per | Count of Emergency spells to hospital for people aged over 65. | Mid-year population estimates for England |

| | Metric | Numerator | Denominator |
|---|---|---|---|
| | 100,000 population | | published by the Office for National Statistics (ONS) |
| **2** | Average length of discharge delay for all acute adult patients, derived from a combination of:<br><br>proportion of adult patients discharged from acute hospitals on their Discharge Ready Date (DRD)<br><br>for those adults patients not discharged on their DRD, average number of days from the DRD to discharge. | This is an average: it is based on the % of adult patients discharged from acute hospitals on their Discharge Ready Date, multiplied by the average number of days from the DRD to discharge. (Taken from SUS) | Non |
| **3** | Long-term admissions to residential care homes and nursing homes for people aged 65 and over 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 CLD. | Mid-year population estimates for England published by the Office for National Statistics (ONS) |

***Emergency admissions to hospital for people aged over 65 per 100,000 population***

This indicator measures the rate of emergency hospital admissions among people aged 65 and over, expressed as a crude rate per 100,000 population. Emergency admissions are unplanned, urgent admissions that may occur via A&E, direct referral from a GP, or other clinical pathways.

The indicator follows NHS England methodology and counts the number of admissions, or ‘spells’, defined as a continuous period of admitted patient care within one healthcare provider for a single patient. A spell may consist of one or more

episodes of care, with each episode representing a continuous period under one consultant. The activity counts do not necessarily represent the number of distinct patients, as an individual may be admitted multiple times within the same period.

The count of emergency admissions is combined with ONS mid-year population estimates to calculate a crude rate for people aged 65 and over.

A full methodology can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/provisional-monthly-hospital-episode-statistics-for-admitted-patient-care-outpatient-and-accident-and-emergency-data

***Average length of discharge delay for all acute adult patients, derived from a combination of:***
***• proportion of adult patients discharged from acute hospitals on their Discharge Ready Date (DRD)***
***• for those adults patients not discharged on their DRD, average number of days from the DRD to discharge***

The Discharge Ready Date (DRD) marks the date when a patient is ready to leave the acute setting, either to their home or an intermediate care facility. It is the first day they no longer meet the Criteria to Reside and helps identify delays between readiness and actual discharge.

The DRD should be recorded for all inpatients with an overnight stay who no longer meet the Criteria to Reside. For patients discharged on the same day they become ready (no delay), this field may be left blank (NULL). The DRD can be earlier than the discharge date if a patient remains in bed despite not meeting the Criteria to Reside. Once agreed, the DRD should be reviewed at every ward round while the patient remains in hospital.

In 2025/6 the BCF is using the DRD for a new metric, the average length of discharge delay for all acute adult patients. This measure is calculated using two measures: The proportion of adult patients discharged from acute hospitals on their Discharge Ready Date (DRD) and the average number of days from their DRD to discharge for those not discharged on their DRD.

Full guidance and methodology can be found:
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2023/12/DRD-Guidance-1.pdf

***Long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population.***

Rotherham's strategic aim is to support more people to remain independent for longer at home. We have therefore used BCF monies to support this. An impact of the strategy is to reduce admissions to care homes. This does need to be balanced against the ageing population and Rotherham's challenging levels of

deprivation. Adult Social Care are working with health on a project to reduce short term placements in care homes, which can translate into long term stays.

A target of 317 admissions was set in 24/25 and was narrowly exceeded with 327 admissions for the year. The 25/26 target has been set at 330 for the coming year, and remains a challenging target which equates to a rate per 100,000 of 616, in line with the regional benchmark.

Adult social care continues to closely monitor the rates of admission with a focus on home first. Residential care is only being considered where there are no other appropriate alternatives to meeting needs. This approach is supported by BCF funded services that enhance out of hospital delivery of care and reduce admissions to 24-hour care including; short-term packages of social care, an enhanced enablement offer, rehabilitation, intermediate care, home from hospital, assistive technology, equipment and adaptations and other community services which are funded by BCF and partners.

In addition there is ongoing work to improve thematic understanding around the routes of admissions. Enhanced reporting, coupled with review and audit work, are being used to inform strategic decisions and commissioning activities. This ensures resources are targeted to high quality support planning and provisioning which enables people to achieve their outcomes and maximise independence.

## 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 | Riverside House Main Street Rotherham S50 1AE | 01709 302025 | wendy.allott@nhs.net |

| Partner | Lead Officer | Address | Tel. No. | Email Address |
|---|---|---|---|---|
| RMBC | Head of Finance – (Adults, Public Health and Housing) | Riverside House<br>Main Street<br>Rotherham<br>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 | | 21 August 2025 |
| Name of signatory (print) | John Edwards | Christopher Edwards |
| Title or role of signatory (print) | Chief Executive, RMBC | Deputy Chief Executive / Place Director - Rotherham |

## Appendix 1 – Detailed BCF Schemes

| Better Care Fund Budget 2025-26 | Budget 2024-25 | Investment (+) /Disinvestment (-) | 2024/25 Underspend b/f | Budget 2025-26 |
|---|---|---|---|---|
| | £'000 | £'000 | | £'000 |
| | | | | |
| **THEME 1 - Mental Health Services** | | | | |
| Adult Mental Health Liaison | 1,505 | 125 | | **1,630** |
| **THEME 2 - Rehabilitation & Reablement** | | | | |
| Falls Service | 534 | 11 | | **545** |
| **Home Enabling Services :** | | | | |
| Reablement | 1,087 | | | **1,087** |
| Pressures on Domiciliary Care Budgets | 758 | | | **758** |
| Community Stroke Service | 597 | 13 | | **610** |
| Community Neuro Rehab | 184 | 4 | | **188** |
| Breathing Space | 2,088 | 45 | | **2,133** |
| Otago | 20 | | | **20** |
| Mediquip (Wheelchairs & Equipment) | 1,962 | 65 | | **2,027** |
| Community OT | 929 | 11 | | **940** |
| Disabled Facilities Grant | 4,842 | (1,040) | 1,295 | **5,097** |
| Age UK Hospital Discharge | 173 | | | **173** |
| Stroke Association Service | 59 | | | **59** |
| **Intermediate Care Pool:** | | | | |
| Therapy & Nursing cover to support vulnerable patients and Fast Response team | 122 | 3 | | **125** |
| Intermediate Care/surge Beds (LH/DC) | 1,920 | | | **1,920** |
| Intermediate Care beds (30) - Davies Court | 1,039 | | | **1,039** |
| Home first | 886 | 19 | | **905** |
| Intermediate Care 24 Beds - Althorpe | 1,508 | 32 | | **1,540** |
| Intermediate Care Therapy(TRFT) | 420 | | | **420** |
| RDASH Therapies | 100 | 8 | | **108** |
| GP Support - medical cover | 36 | | | **36** |
| Other Intermediate care (TRFT) | 377 | 8 | | **385** |
| **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** |
| 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** |
| Free Nursing Care | 1,472 | 113 | | **1,585** |
| **THEME 4 - Care Mgt & integrated Care Planning** | | | | |
| GP Case Management | 1,172 | | | **1,172** |
| Care Home Support Service | 321 | 7 | | **328** |
| Hospice - End of Life care | 994 | 30 | | **1,024** |
| Social Prescribing | 880 | (139) | | **741** |
| **Social Work Support (A&E, Case management, Supported Discharge):** | | | | |
| Single Point of Access | 100 | | | **100** |
| Integrated Rapid Response | 60 | 60 | | **120** |
| Fast response Nursing team(TRFT) | 60 | (60) | | **0** |
| Integrated Discharge Team | 433 | | | **433** |
| Early Planning Team | 230 | | | **230** |
| Mental Health Crisis Team | 36 | | | **36** |
| Care Co-ordination Centre | 921 | 20 | | **941** |
| **THEME 5 - Supporting Carers** | | | | |
| **Carers Support Service:** | | | | |
| Carers Strategy | 467 | 0 | | **467** |
| Carers Emergency Service | 23 | | | **23** |
| Direct Payments (Older People) | 251 | | | **251** |
| Crossroads | 50 | | | **50** |
| **THEME 6 - Infrastructure** | | | | **0** |
| Joint Commissioning Team | 50 | | | **50** |
| IT to support Comm Trans | 192 | 4 | | **196** |
| **RISK POOL** | | | | |
| Risk pool | 500 | 0 | | **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 | | 32 | **102** |
| 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** |
| Perform Plus | 48 | | | **48** |
| Reablement - 2 posts | 87 | | | **87** |
| Spot purchase reablement beds | 107 | | | **107** |
| Mediquip (RMBC Revenue contribution) | 92 | | | **92** |

| | | | | |
|---|---|---|---|---|
| Escalation Wheel | 12 | | | **12** |
| ibcf Contingency 23/24 - (Attain/Capacity Demand Community Services) | 0 | | | **0** |
| HealthWatch new contract | 60 | | | **60** |
| Health & Care Portfolio Lead (ICB post) | 50 | | 50 | **100** |
| Virtual Wards (ICB) | 47 | | 47 | **94** |
| **Winter Pressures/Other Grant Income** | | | | |
| Tactical Brokerage | 110 | | | **110** |
| Resource for Winter Bed Capacity (ICB) | 500 | | | **500** |
| Integrated Discharge Team | 225 | | | **225** |
| Early Planning Team | 237 | | | **237** |
| Additional Winter Capacity | 273 | | | **273** |
| | | | | |
| **IBCF Balance b/fwd 22/23 (non- Recurrent):** | 0 | | | **0** |
| - Additional Social Work Capacity - continuation from 23/24 | 470 | -470 | 59 | **59** |
| - Forecast underspend in 23/24 (RMBC) | 349 | -349 | 228 | **228** |
| - Crisis Support (ICB) | 200 | -200 | 200 | **200** |
| | | | | |
| **Adults Discharge Funding (RMBC)** | | | | |
| **2024/25 Discharge Grant Allocation** | 3,384 | | | **3,384** |
| **ICB (Rotherham Place) Discharge Funding** | | | | |
| **2024/25 Discharge Grant Allocation** | 2,473 | | | **2,473** |
| | | | | |
| **Grand Total** | **54,338** | **-1,680** | **1,911** | **54,569** |

## Appendix 2 – Terms of Reference for BCF Executive and Operational Groups

### 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) Director of Partnerships / Deputy Place Director (Rotherham) |
| SYICB (Rotherham Place) Director of Financial Transformation (Rotherham) |
| SYICB (Rotherham Place / RMBC Health and Care Portfolio Lead, Transformation and Delivery |
| 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 |
| RMBC 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 Director of Public Health 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.<br>• To be responsible for maintaining the risk register and ensuring risk mitigation plans are in place.<br>• 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.<br>• To create the funding plan to be then signed off by the Executive group.<br>• 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.<br>• 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.<br>• To ensure that the accountable leads of the BCF performance measures and the BCF action plan are collectively discussing their progress and key actions.<br>• To identify the areas which need to be reported on progress and performance by exception to the BCF Executive Group.<br>• To ensure the BCF conditions are met.<br>• To co-ordinate partner activity within the BCF Plan, ensuring that all elements of the plan are linked together to deliver positive outcomes.<br>• 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.<br>• 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) Director of Financial Transformation and the RMBC Assistant Director, Strategic Commissioning. |

| **Membership of Group** |
| --- |
| SYICB (Rotherham Place) Director of Financial Transformation (Rotherham) (co-Chair) |
| SYICB (Rotherham Place) / RMBC Health and Care Portfolio Lead, Transformation and Delivery |
| SYICB (Rotherham Place) Senior Data Analyst |
| 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 Business Intelligence Manager, RMBC |
| 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.<br>• Maintain a risk register appropriate to the level of group operation.<br>• Coordinate the completion of reports for the Health and Wellbeing Board and the Department of Health |

Rotherham Metropolitan Borough Council

NHS South Yorkshire Integrated Care Board

| | | |
|---|---|---|
| **BRIEFING** | **TO:** | Health and Wellbeing Board |
| | **DATE:** | Wednesday, 26th November 2025 |
| | **LEAD OFFICER** | Steph Watt<br>Health and Care Portfolio Lead, SYICB/RMBC<br>E-mail: steph.watt@nhs.net |
| | **TITLE:** | HWBB Report for Rotherham BCF 2025/26 Quarter 2 Reporting Template |

**Background**

1.1 The purpose of this report is to agree the contents of the BCF Q2 Reporting Template which will be submitted to NHS England regarding the metrics and expenditure of Rotherham's Better Care Fund Plan for 2025/26.

1.2 The overall delivery of the Better Care Fund continues to have a positive impact and improves joint working between health and social care in Rotherham.

**Key Issues**

2.1 The BCF Quarter 2 template covers reporting on: national conditions, metrics and expenditure.

2.2 Below is a summary of information included within the BCF submission:

**2.3 National Conditions**

There are a total of 4 national conditions for 2025/26 which continue to be met through the delivery of the plan as follows:

- Plans to be jointly agreed.
- Implementing the objectives of the BCF.
- Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC).
- Complying with oversight and support processes.

**3. BCF Metrics**

There is a total of three BCF metrics within the BCF Q2 Template for 2025/26 which measures the impact of the plan as follows:

3.1 **Emergency admissions to hospital for people aged 65+ per 100,000 population –** Not on track to meet goals.

**Achievements** - This indicator measures the rate of emergency hospital admissions among people aged 65 and over, expressed as a crude rate per 100,000 population.

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| | Emergency admissions are unplanned, urgent admissions that may occur via A&E, direct referral from a GP, or other clinical pathways.<br><br>As part of quarterly reporting, figures are provided for each month.<br><br>The figures below show reporting for the second quarter(Q2) of 2025–26. Across the quarter, there has been some month-on-month variation. In July, the actual figure was 2,081.4 compared to the planned 1,986.2, slightly above the plan. In August, the actual was 1965.7 against a planned 1,905.9. September's data is not yet complete, but the data available shows a rate of 2057.1, which was above the planned 1,920.9.<br><br>**Challenges and any support needs** - A key priority for the Rotherham urgent and emergency care recovery plan in 2025-26 is to reduce avoidable conveyances and admissions in order to meet the national 4-hour standard, G&A occupancy levels and no criteria to reside.<br><br>**Variance from Plan –** Overall, the quarter 2 figures are slightly higher than the planned values across all three months.<br><br>**Mitigation for Recovery –** There is a significant amount of activity happening to reduce avoidable conveyances and admissions, however due to the aging population and Rotherham's health inequalities we are continuing to see high levels of demand, particularly as winter respiratory infections start to impact. TRFT opened a new Medical SDEC in July 2025 which is providing an alternative pathway to unplanned admissions. In addition, four high impact change projects relating to frailty, ambulatory, respiratory and diabetes pathways are targeting high levels of admission. The growth of the virtual ward including frailty, respiratory, heart failure and a new tech enabled hypertension modelling pathway are contributing to reducing avoidable admissions. |
| 3.2 | **Average length of discharge delay for all acute adult patients, derived from a combination of:**<br><br>**• proportion of adult patients discharged from acute hospitals on their Discharge Ready Date (DRD)**<br><br>**• for those adults patients not discharged on their DRD, average number of days from the DRD to discharge -** Not on track to meet goals<br><br>**Achievements** - The Discharge Ready Date (DRD) is the specific date that a patient is ready to be discharged from the acute setting either to their 'home' or to any intermediate level of care. It can be used to identify any delay between DRD and their actual date of discharge.<br><br>The indicator metric used is an average derived from a combination of proportion of adult patients discharged from acute hospitals on their Discharge Ready Date (DRD) and the average number of days patients that are not discharged on their discharge ready date take to be discharged.<br><br>This is the second quarter(Q2) of 2025–26 for reporting the Discharge Ready Date (DRD) metric. Data shows that in July, the recorded average was 0.70 compared to a planned 0.63. August was 0.59 which was lower than the planned figure of 0.68 and September saw an increase from August to 0.74, above the planned figure of 0.66.<br><br>**Challenges and any support needs** – Rotherham Place is currently reviewing the falls and frailty pathway for care homes to reduce avoidable conveyances and discharges. |

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| | **Variance from Plan –** In Q2 2025–26, the Discharge Ready Date (DRD) metric showed mixed variance from the plan. July's average (0.70) was above the planned 0.63, August was below plan at 0.59 vs. 0.68, and September exceeded the planned 0.66 with an actual of 0.74.<br><br>**Mitigation for Recovery –** TRFT have carried out extensive work to reduce discharge delays for pathway 0 patients, including 'Every Minute Matters' MADE (Multi-agency discharge) events. The second phase of development of the multi-disciplinary Transfer of Care Hub has been completed. There is now a single referral form which is being processed by the Hub. Once embedded new ways of working will reduce delays in decision making and facilitate a more flexible allocation of resource to support right care time and place. Enablement service improvement activity will contribute to releasing capacity to reduce waiting times. Regional performance metrics are indicating an improvement in No Criteria to Reside measures and Rotherham is performing well regionally in relation to discharge ready metrics, though it is recognised there is further to go. |
| 3.3 | **Long-term admissions to residential care homes and nursing homes for people age 65 and over per 100,000 population –** Data not available<br><br>**Achievements** - Rotherham's strategic aim is to support more people to remain independent for longer at home and BCF funding is being used to support this. An impact of the strategy is therefore to reduce admissions to care homes. However, this needs to be balanced in the context of an ageing population and Rotherham's challenging levels of deprivation.<br><br>Adult Social Care are continuing to work with Health partners to reduce short term placements in care homes, many of which translate into long term stays.<br><br>The Council also continues to closely monitor the rates of admission with a focus on home first, and residential care being only considered where there are no other appropriate alternatives to meeting needs.<br><br>Activity and outturn data is subject to amendments and additional system recording with revised admissions totals for each month.<br><br>The 2025-26 BCF target has been set to a population rate of 563.6, which equates to 317 admissions over the year.<br><br>During Quarter 2 there have been 116 new admissions against a target of 82. As with previous quarters this number is likely to be revised down during the following months.<br><br>At the end of Quarter 1, we reported being 40 admissions over target, that number has now being revised down and is now 10 over target. This downward revision has occurred previously when this data has been collected, and further revision is likely to occur which may bring the admissions in line with target.<br><br>The current year to date position prior to ongoing revision is 208 admissions against a target of 164.<br><br>**Challenges and any support needs** – Shortage of capacity in pathway 1 can result in increased numbers of short stay placements. National and local evidence shows that those placed in short term care often convert to longer term care. |

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| | **Variance from Plan –** During Q2, there were 116 new admissions against a target of 82, though this figure is expected to be revised downward in the coming months. At the end of Q1, the reported variance of 40 admissions over target has already been adjusted to 10 over target, reflecting a pattern of downward revisions seen previously. The current year-to-date position, prior to further adjustments, stands at 208 admissions compared to a target of 164.<br><br>**Mitigation for Recovery –** The aim of the Transfer of Care Hub is to support more people to be discharged home. In year investment in enablement will enable the expansion of the discharge to assess pathway which should support more people at home through more timely and accurate assessments. A Pathway 2 task and finish group is reviewing admission to and through the commissioned bed base with the aim of reducing the number of spot purchase beds and support more people home from short term placements. Quality Assurance processes are in place to ensure least restrictive options are always exhausted before a long-stay placement considered / agreed. The Council also continues to closely monitor the rates of admission with a focus on home first and residential care being only considered where there are no other appropriate alternatives to meeting needs. |
| **4.** | **Expenditure** |
| 4.1 | The Q2 Year-to-Date Actual Expenditure for BCF funded schemes. covering the period from 1st July to 30th September 2025, has been included in the Q2 template. |
| **Key Actions and Relevant Timelines** | |
| 5.1 | **The Better Care Fund Executive Group held on Tuesday 21st October 2025 approved (on behalf of the Health and Wellbeing Board) the:**<br><br>**(i) Documentation for submission to NHS England (NHSE) on Tuesday 11th November 2025.** |
| **Implications for Health Inequalities** | |
| 6.1 | 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. |
| 6.2 | BCF funded schemes which reduce health inequalities include carer support, social prescribing, Breathing Space and project support for the implementation of Population Health Management (PHM) priorities. |
| **Recommendations** | |
| 7.1 | **That the Health and Wellbeing Board notes the:**<br><br>**ii) Documentation for submission to NHS England (NHSE) on Tuesday 11th November 2025.** |

# Better Care Fund 2025-26 Q2 Reporting Template

**1. Guidance**

## Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements for 2025-26 (refer to link below), which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE).
https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#introduction

https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026

As outlined within the planning requirements, quarterly BCF reporting will continue in 2025-26, with areas required to set out progress on delivering their plans by reviewing metrics performance against goals, spend to date as well as any sigificant changes to planned spend.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off HWB chairs ahead of submission. Aggregated data reporting information will be available on the DHSC BCF Metrics Dashboard and published on the NHS England website.

**Note on entering information into this template**

**Please do not copy and paste into the template**

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

| |
|---|
| Data needs inputting in the cell |
| Pre-populated cells/Not required |

**Note on viewing the sheets optimally**

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

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut and paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy and paste', please use the 'Paste Special' operation and paste Values only.

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

## Checklist ( 2. Cover )

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

## 2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric goals from your BCF plans for 2025-26 will pre-populate in the relevant worksheets.
2. HWB Chair sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

HM Government

NHS England

# Better Care Fund 2025-26 Q2 Reporting Template

**2. Cover**

**Version 1.0 [unlocked]**

*Please Note:*

*- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.*

*- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.*

*- All information will be supplied to BCF partners to inform policy development.*

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

| | |
|---|---|
| **Health and Wellbeing Board:** | Rotherham |
| **Completed by:** | Hafsah Taj |
| **E-mail:** | Hafsah.Taj1@nhs.net |
| **Contact number:** | 01709 253870 |
| **Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission?** | Yes |
| **If no, please indicate when the report is expected to be signed off:** | |

**Checklist**

| Complete: |
|---|
| Yes |
| Yes |
| Yes |
| Yes |
| Yes |
| Yes |

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

**Complete**

| | Complete: |
|---|---|
| 2. Cover | Yes |
| 3. National Conditions | Yes |
| 4. Metrics | Yes |
| 5. Expenditure | Yes |

For further guidance on requirements please refer back to guidance sheet - tab 1.

<< Link to the Guidance sheet

^^ Link back to top

# Better Care Fund 2025-26 Q2 Reporting Template

**3. National Conditions**

Selected Health and Wellbeing Board: Rotherham

| Confirmation of Nation Conditions | | | Checklist Complete: |
|---|---|---|---|
| **National Condition** | **Confirmation** | **If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:** | |
| **1) Plans to be jointly agreed** | Yes | | Yes |
| **2) Implementing the objectives of the BCF** | Yes | | Yes |
| **3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) and Section 75 in place** | Yes | | Yes |
| **4) Complying with oversight and support processes** | Yes | | Yes |

**Better Care Fund 2025-26 Q2 Reporting Template**

**4. Metrics for 2025-26**

Selected Health and Wellbeing Board: Rotherham

For metrics time series and more details: BCF dashboard link

For metrics handbook and reporting schedule: BCF 25/26 Metrics Handbook

# 4.1 Emergency admissions

| Plan | | Apr 25 Plan | May 25 Plan | Jun 25 Plan | Jul 25 Plan | Aug 25 Plan | Sep 25 Plan | Oct 25 Plan | Nov 25 Plan | Dec 25 Plan | Jan 26 Plan | Feb 26 Plan | Mar 26 Plan |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Emergency admissions to hospital for people aged 65+ per 100,000 population | Rate | 1,943.3 | 2,103.8 | 2,062.7 | 1,986.2 | 1,905.9 | 1,920.9 | 2,118.7 | 1,984.3 | 2,135.5 | 2,331.5 | 2,027.3 | 2,234.5 |
| | Number of Admissions 65+ | 1,041 | 1,127 | 1,105 | 1,064 | 1,021 | 1,029 | 1,135 | 1,063 | 1,144 | 1,249 | 1,086 | 1,197 |
| | Population of 65+ | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 | 53,570.0 |

| | |
|---|---|
| Assessment of whether goal has been met in Q2: | Not on track to meet goal |
| If a goal has not been met please provide a short explanation, including noting any key mitigating actions. | There is a significant amount of activity happening to reduce avoidable conveyances and admissions, however due to the aging population and Rotherham's health inequalities we are continuing to see high levels of demand, particularly as winter respiratory infections start to impact. TRFT opened a new Medical SDEC in July 2025 which is providing an alternative pathway to unplanned admissions. In addition, four high impact change projects relating to frailty, ambulatory, respiratory and diabetes pathways are targeting high levels of admission. The growth of the virtual ward including frailty, respiratory, heart failure and a new tech enabled hypertension modelling pathway are contributing to reducing avoidable admissions. |
| You can also use this box to provide a very brief explanation of overall progress if you wish. | This reporting covers Quarter 2 of 2025–26. Using locally held SUS data, there has been some month-on-month variation across the quarter. In July, the actual figure was 2,081.4 compared with a planned 1,986.2, slightly above plan. In August, the actual was 1,965.7 against a planned 1,905.9. September's data is still provisional, currently recorded at 2,057.1, which is slightly above the planned 1,920.9. Overall, the Quarter 2 figures are marginally higher than planned across all three months. |

| | |
|---|---|
| Did you use local data to assess against this headline metric? | Yes |

| | |
|---|---|
| If yes, which local data sources are being used? | SUS |

## 4.2 Discharge Delays

| Original Plan | Apr 25 Plan | May 25 Plan | Jun 25 Plan | Jul 25 Plan | Aug 25 Plan | Sep 25 Plan | Oct 25 Plan | Nov 25 Plan | Dec 25 Plan | Jan 26 Plan | Feb 26 Plan | Mar 26 Plan |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)** | 0.65 | 0.72 | 0.65 | 0.63 | 0.68 | 0.66 | 0.71 | 0.65 | 0.65 | 0.69 | 0.66 | 0.71 |
| Proportion of adult patients discharged from acute hospitals on their discharge ready date | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% | 84.1% |
| For those adult patients not discharged on DRD, average number of days from DRD to discharge | 4.09 | 4.52 | 4.10 | 3.97 | 4.28 | 4.12 | 4.46 | 4.09 | 4.09 | 4.36 | 4.15 | 4.43 |

| | |
|---|---|
| Assessment of whether goal has been met in Q2: | Not on track to meet goal |
| If a goal has not been met please provide a short explanation, including noting any key mitigating actions. | TRFT have carried out extensive work to reduce discharge delays for pathway 0 patients, including 'Every Minute Matters' MADE (Multi-agency discharge) events. The second phase of development of the multi-disciplinary Transfer of Care Hub has been completed. There is now a single referral form which is being processed by the Hub. Once embedded new ways of working will reduce delays in decision making and facilitate a more flexible allocation of resource to support right care time and place. Enablement service improvement activity will contribute to releasing capacity to reduce waiting times. Regional performance metrics are indicating an improvement in No Criteria to Reside measures and Rotherham is performing well regionally in relation to discharge ready metrics, though it is recognised there is further to go. |
| You can also use this box to provide a very brief explanation of overall progress if you wish. | This report covers data for the second quarter of 2025–26 relating to the Discharge Ready Date (DRD) metric. Local SUS data shows that in July, the recorded average was 0.70 compared with a planned 0.63. The figure decreased in August to 0.59 below the planned 0.68, before increasing in September to 0.74, slightly above the planned 0.66. Across the three months of Quarter 2, the average proportion of adult patients discharged on their date of discharge was 81.4% in July, 84.0% in August, and 82.7% in September.<br><br>For adult patients not discharged on their DRD, the average number of days from DRD to discharge decreased during the first two months of Quarter 2 compared with Quarter 1, at 3.76 days in July and 3.69 days in August. Provisional data for September shows an increase to 4.30 days. |

| | |
|---|---|
| Did you use local data to assess against this headline metric? | Yes |

| | |
|---|---|
| If yes, which local data sources are being used? | SUS |

## 4.3 Residential Admissions

| Actuals + Original Plan | | 2023-24 Full Year Actual | 2024-25 Full Year CLD Actual | 2025-26 Plan Q1 (April 25-June 25) | 2025-26 Plan Q2 (July 25-Sept 25) | 2025-26 Plan Q3 (Oct 25-Dec 25) | 2025-26 Plan Q4 (Jan 26-Mar 26) |
|---|---|---|---|---|---|---|---|
| Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population | Rate | 556.3 | 599.2 | 153.1 | 153.1 | 154.9 | 154.9 |
| | Number of admissions | 298.0 | 321.0 | 82.0 | 82.0 | 83.0 | 83.0 |
| | Population of 65+* | 53570.0 | 53570.0 | 53570.0 | 53570.0 | 53570.0 | 53570.0 |

# Better Care Fund 2025-26 Q2 Reporting Template

**5. Income & Expenditure**

Selected Health and Wellbeing Board: Rotherham

| Source of Funding | 2025-26 Planned Income | 2025-26 Updated Total Plan Income for 25-26 | 2025-26 DFG Q2 Year-to-Date Actual Expenditure | Checklist Complete: |
|---|---|---|---|---|
| DFG | £3,801,597 | £3,801,597 | £225,203 | Yes |
| Minimum NHS Contribution | £28,410,232 | £28,410,232 | | Yes |
| Local Authority Better Care Grant | £17,864,126 | £17,864,126 | | Yes |
| Additional LA Contribution | £2,582,038 | £4,493,038 | | Yes |
| Additional NHS Contribution | £0 | £0 | | Yes |
| **Total** | **£52,657,993** | **£54,568,993** | | |

| | Original | Updated | % variance | |
|---|---|---|---|---|
| **Planned Expenditure** | **£52,657,993** | £54,568,993 | **4%** | Yes |

| | | % of Planned Income | |
|---|---|---|---|
| **Q2 Year-to-Date Actual Expenditure** | £23,346,914 | **43%** | Yes |

| | | |
|---|---|---|
| If Q2 year to date actual expenditure is exactly 50% of planned expenditure, please confirm this is accurate or if there are limitations with tracking expenditure. | | Yes |
| If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change. | Planned expenditure change agreed at Quarter 1 Reporting | Yes |

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| Minutes | |
|---|---|
| **Title of Meeting:** | Rotherham Place Board: **ICB Business** |
| **Time of Meeting:** | 10.45 – 11.30am |
| **Date of Meeting:** | Wednesday 16 July 2025 |
| **Venue:** | John Smith Room, Rotherham Town Hall |
| **Chair:** | Chris Edwards |
| **Contact for Meeting:** | Lydia George: lydia.george@nhs.net/<br>Wendy Commons: wcommons@nhs.net |

| | |
|---|---|
| **Apologies:** | W Allott, Director of Financial Transformation Rotherham, NHS SYICB<br>J Edwards, Chief Executive, Rotherham Metropolitan Borough Council<br>I Spicer, Deputy Chief Executive, Rotherham Metropolitan Borough Council<br>R Jenkins, Chief Executive, The Rotherham NHS Foundation Trust<br>T Lewis, Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust<br>M Cottle-Shaw, Chief Executive Officer, Rotherham Hospice<br>Dr A Barmade, Medical Director, Connect Healthcare Rotherham<br>Cllr J Baker Rogers, H&WB Board Chair, RMBC<br>G Laidlaw, Head of Communications – Rotherham, NHS SY ICB<br>Bob Kirton, Managing Director, The Rotherham NHS Foundation Trust |
| **Conflicts of Interest:** | General declarations were acknowledged for Members as providers/commissioners of services. |
| **Quoracy: (Quorate)** | No business shall be transacted unless at least 60% of the membership (which equates to 4 individuals) and including the following are present: (1) Executive Place Director and (2) Independent Non-Executive Member. |

## Members:

Chris Edwards (**CE**), Executive Place Director (Rotherham) NHS South Yorkshire Integrated Care Board
Claire Smith (**CS**), Director of Partnerships (Rotherham) NHS SY ICB
Andrew Russell (**AR**), Director of Nursing – Rotherham & Doncaster, NHS SY ICB
Dr Jason Page (**JP**), Medical Director, (Rotherham), NHS SY ICB
Shahida Siddique (**SS**), Independent Non-Executive Member, NHS SY ICB

## Participants:

Jude Archer (**JA**), Assistant Director of Transformation, NHS SY ICB
Andrew Brankin (**AB**), Rotherham Care Group Director, Rotherham, Doncaster and South Humber NHS Foundation Trust
Lydia George (**LG**), Transformation & Partnership Portfolio Manager (Rotherham), NHS SY ICB
Alex Hawley (**AH**), Interim Director of Public Health, Rotherham MBC
Shafiq Hussain (**SH**), Chief Executive, Voluntary Action Rotherham

## In attendance

Wendy Commons, (minute taker) Business Support Officer (Rotherham), NHS SY ICB

| Item Number | Discussion Items |
|---|---|
| **I31/07/25** | **Place Integrated Performance Report** |

JA updated Members on performance noting:

- Due to the time lag in data, the percentage of A&E patients seen within 4 hours is more positive than shown at 68.6% but now over 70%
- The Category 2 ambulance response time is being met whilst the average handover time, although not being met had improved positively from the previous period
- Bed occupancy was outside the national standard at by just 0.2% at 92.2% and showing a big improvement on last month.
- There had also been an improvement on No Criteria to Reside which stands at 14.8%.
- The national target for urgent community referrals to be seen within 2 hours was being met at 85% and virtual ward utilisation showing positive outcomes.
- Rotherham continues to offer the highest number of primary care appointments across South Yorkshire per head of population.
- On elective care there had been a slight improvement on the numbers waiting over 52 weeks
- Rotherham was just under target for the percentage of patients receiving diagnostic tests within 6 weeks at 94.8%.
- The percentage of patients with cancer diagnosis communicated within 28 days was under the standard of 80% at 79.6%. There were also challenges in meeting the 62-day referral to treatment standard (75%) at 67.9%

From an overarching perspective focussing more on performance data across South Yorkshire, A&E attendances have increased but are not transferring into admissions as the level of acuity not as prevalent as it was.

GP appointments are down on the trajectory with a reduction in the number of appointments, an increase in attendances and reduction on admissions.

It was noted that generally, Rotherham performance is strong.

| | |
|---|---|
| **I32/07/25** | **Rotherham Place Committee Annual Report 2024/25** |

In June, Members had received the annual report and reflected on the activity undertaken in year. The members presented at the meeting were assured that it delegated duties had been discharged in accordance with the Committee's terms of reference and its workplan. However, as the meeting was not quorate at that time, it was agreed that the Chair would contact the absent member to get a view.

SS confirmed that she was happy to concur with Members and complete assurance from Rotherham Place Committee was confirmed.

The Chair's comments have also been added to the annual report which will go to the NHS SY ICB Board in September.

In his comments, CE had also added his thanks to team members for their energy, commitment and consistency in driving forward Place priorities and strong partnership working, as well as acknowledging the challenges and opportunities to be faced within the forthcoming year.

| I33/07/25 | ICB Board Assurance Framework, Risk Register & Issues Log |
|---|---|

All members had received and reviewed the board assurance framework, risk register and issues log.

LG asked Members to consider two risks for Rotherham Place, RRP 008 relating to MHRA Bed Alert and RRP 0013 relating to Hospice Funding. Following discussion it was agreed that both risks could now be retired as necessary action had been taken in relation to the bed alert, and the Hospice contract had been agreed and signed off for this year.

There were no new risks to be added, but Members were encouraged to advise the Chair at any time with details of any potential additions.

| I34/07/25 | Quality, Patient Safety and Experience Dashboard |
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AR presented this month's report advising that TRFT had presented a paper to its Board of Directors in June outlining findings from the Royal College of Physicians into the ERCP service delivered between 2016 and 2021 following a pattern of adverse incidents and complications. Patients and families had been contacted with an apology and explanation offered as well as going support made available. Place Board was assured that recommendations from the external review have been implemented and the service has since been provided by Sheffield Teaching Hospitals NHS Foundation Trust without concern.

AR went on to highlight:

- The Trust has implemented Call4Concern (Martha's rule) to help improve the quality and safety of care for patients who condition is worsening. The initiative empowers patients, families, carers and staff to ensure their concerns are listened to and acted upon. A positive impact is already being seen.
- Rotherham Place CHC team continues to experience significant staffing issues due to ongoing absences and vacancies, despite some actions taken to mitigate the risks. Following scrutiny from NHS England, the focus is on areas around quality, safety and business continuity.
- The trajectories around healthcare associated infections for 2025/26 will be in the next report.

JP added that since the report was written, Shakespeare Road GP Practice has moved out of the CQC overall rating from 'requiring improvement' into' good'.

Members noted the contents of the report.

| I35/07/25 | Feedback from Rotherham Place Executive Team (RPET) |
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CS advised that RPET had considered the following items:

- Talking Therapies Memorandum of Understanding Employment Advisors between RDaSH and NHS SY ICB - continuation of employment advisors in the NHS Talking Therapies Initiative was supported.
- All-Age Neurodevelopment Service Procurement Outcome Report – supported the recommendation to award the NHS Standard Contract as outlined in the report.
- Rotherham Prescribing Incentive Scheme – supported as presented and encouraged to move to a South Yorkshire approach.
- Minor Surgery Service – supported the continuation of service in a different format.

- Proposal for continuation of a high complex frailty pathway – supported given good evidence base following a test and learn pilot in line with wider proactive care programme.

Place Board Members noted the business conducted through Rotherham Place Executive.

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| **I36/07/25** | **Rotherham Place Executive Team (RPET) Terms of Reference** |

Rotherham Place Executive Team had undertaken a review of its terms of reference with minor changes. The revised version was presented for ratification by ICB Place Committee in line with governance.

Members ratified the revised terms of reference for RPET.

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| **I37/07/25** | **Minutes and Action Log and Assurance Report from the last Meeting** |

The minutes from the meeting held on Wednesday 18 June 2025 were accepted as a true and accurate record.

The action log was reviewed. There was one amber rated action around an enquiry from BK about the impact of moving from Rotherham Health Record to Yorkshire & Humber Care Record and whether there would be loss of functionality currently available through RHR. Andrew Clayton has been invited to come along to give a digital update to September Place Board and will advise then.

The assurance report for the Integrated Care Board noted that there are no actions arising from June minutes to be escalated.

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| **I38/07/25** | **Communication to Partners/Promoting Consultations & Events** |

None.

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| **I39/07/25** | **Risks and Items for Escalation** |

None.

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| **I40/07/25** | **Forward Agenda Items** |

Standing Items

- Rotherham Place Performance Report (monthly)
- Risk Register (Monthly for information)
- Place Prescribing Report (Quarterly)
- Quality, Patient Safety and Experience Dashboard (Bi- monthly)
- Quarterly Medical Director Update (September)

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| **I41/07/25** | **Date of Next Meeting** |

The next meeting will take place on **Wednesday 17 September 2025** in the John Smith Room, Rotherham Town Hall.

## Membership

| | | |
|---|---|---|
| Chris Edwards (Chair) | Executive Place Director/Deputy Chief Executive, ICB | NHS South Yorkshire Integrated Care Board |
| Claire Smith | Director of Partnerships, Rotherham Place | NHS South Yorkshire Integrated Care Board |
| Wendy Allott | Director of Financial Transformation, Rotherham | NHS South Yorkshire Integrated Care Board |
| Andrew Russell | Director of Nursing, Rotherham & Doncaster Places | 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 |

## Participants

| | | |
|---|---|---|
| Alex Hawley | Acting Director of Public Health | Rotherham Metropolitan Borough Council |
| Shafiq Hussain | Chief Executive | Voluntary Action Rotherham |
| Ian Spicer | Strategic Director, Adult Care, Housing & Public Health | Rotherham Metropolitan Borough Council |
| Richard Jenkins | Chief Executive | The Rotherham NHS Foundation Trust |
| John Edwards | Chief Executive | Rotherham Metropolitan Borough Council |
| Toby Lewis | Chief Executive | Rotherham, Doncaster and South Humber NHS Foundation Trust |
| Cllr Joanna Baker-Rogers | H&WB Board Chair | Rotherham Health and Wellbeing Board/ Rotherham Metropolitan Borough Council |
| Dr Anand Barmade | Medical Director | Connect Healthcare Rotherham |
| Bob Kirton | Managing Director | The Rotherham NHS Foundation Trust |
| Kym Gleeson | Service Manager | Healthwatch Rotherham |
| Mat Cottle-Shaw | Chief Executive | Rotherham Hospice |
| Lydia George | Transformation & Partnership Portfolio Manager (Rotherham) | NHS South Yorkshire Integrated Care Board |
| Gordon Laidlaw | Head of Communications (Rotherham) | NHS South Yorkshire Integrated Care Board |

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| Minutes | |
|---|---|
| **Title of Meeting:** | **PUBLIC** Rotherham Place Board: Partnership Business |
| **Time of Meeting:** | 9.30am – 10.30am |
| **Date of Meeting:** | Wednesday 16 July 2025 |
| **Venue:** | John Smith Room, Rotherham Town Hall |
| **Chair:** | Chris Edwards |
| **Contact for Meeting:** | Lydia George: lydia.george@nhs.net/<br>Wendy Commons: wcommons@nhs.net |
| **Apologies:** | Wendy Allott, Director of Financial Transformation - Roth, NHS SY ICB<br>Anand Barmade, Clinical Director, Connect Healthcare Rotherham<br>Richard Jenkins, Chief Executive, The Rotherham NHS Foundation Trust<br>John Edwards, Chief Executive, Rotherham Metropolitan Borough Council<br>Toby Lewis, Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust<br>Ian Spicer, Deputy Chief Executive, Rotherham Metropolitan Borough Council<br>Bob Kirton, Managing Director, Rotherham NHS Foundation Trust<br>Kym Gleeson, Service Manager, Healthwatch Rotherham |
| **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:**
Chris Edwards (**CE**), Rotherham Place Director, NHS South Yorkshire ICB
Mat Cottle-Shaw (**MCS**), Chief Executive Officer, Rotherham Hospice
Alex Hawley (**AH**), Acting Director of Public Health, Rotherham Metropolitan Borough Council
Shafiq Hussain (**SH**), Chief Executive, Voluntary Action Rotherham
Dr Jason Page (**JP**), Medical Director, Rotherham Place, NHS SY ICB
Jodie Roberts (**JR**), Director of Operations, The Rotherham NHS Foundation Trust (deputising)
Andrew Russell (**AR**), Director of Nursing – Rotherham & Doncaster, NHS SY ICB
Claire Smith (**CS**), Director of Partnerships Rotherham Place, NHS SY ICB (deputising)
Andrew Brankin (**AB**), Rotherham Care Group Director, Rotherham, Doncaster and South Humber NHS Foundation Trust (deputising)

**Participants:**
Cllr Joanna Baker-Rogers (**JBR**), Health & Wellbeing Board Chair, RMBC
Lydia George (**LG**), Transformation & Partnership Portfolio Manager, NHS SY ICB
Shahida Siddique (**SS**), Non-Executive Member, NHS SY ICB

**In attendance:**
Jude Archer (**JA**), Assistant Director of Transformation, NHS SY ICB
Helen Sweaton (**HS**), Joint Assistant Director – C&YP, RMBC/ICB

**Minute Taker:**
Wendy Commons, Business Support Officer (Rotherham), NHS SY ICB

| Item Number | Discussion Items |
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| **24/07/25** | **Public & Patient Questions** |
| There were no questions from members of the public. | |
| **25/07/25** | **Maternity, Children & Young People's Update** |

Helen Sweaton reminded Members that the key priorities for the group are:

- Best Start for Life
- Mental health and emotional wellbeing
- Special Educational Needs and Disabilities
- Looked after Children
- Preparation for Adulthood

HS updated on progress with the priority for all children getting the best start in life and going on to achieve their potential, including:

- The publication of positive evaluations of Rotherham's pilots for diabetes family support and hospital youth workers
- Updating of the start for life brochure which has been shared in baby packs and with midwifery teams. It now includes safe sleep and improved guidance on family hub registration.
- First stage assessment for Children's Centres BS5 took place on 1 May 2025 with formal accreditation expected in the coming months.
- In March SENCO Network TakeOver saw CAMHs and Education practitioners coming together where it was agreed to update the neurodevelopmental pathway to request two cycles of plan to review rather than two terms. Demand continues to increase significantly.
- Recruitment had been successful to increase available assessments in the Child Development Centre via the children's work programme pooled budget non recurrent funding.
- To improve accessibility and maintain confidence in clinical appropriateness, the pathway for neurodevelopmental assessment under patient choice via school based referral and intermediary service has been streamlined.

HS advised of the challenges and risks to delivering some of the priorities:

- Despite mitigations being agreed, the reduction in funding into the Smoking at Time of Delivery Service may reduce uptake of the service by the most vulnerable and may also impact on capacity to deliver the new national incentive programme. The risk register has been updated. HS will give a more detailed update to Place Board next month.
- Work on waiting time trajectories in the child development centre and in CAMHs are moving forward in line with the plan already in place
- Increased demand for therapy service is impacting on waiting times. Work has been done to understand demand and capacity which has informed proposals for the SEND Executive Board to further embed a graduated response.
- Additional special school sites have impacted the ability of therapy service to meet the needs identified in EHCPs.
- To align with the timeframe for development of technology to reach into multiple system, the timeframe for the health passport has been revised to Quarter 4 of 24/25.

Going forward the group will be focussing on:

- the plan to address the waiting time trajectories in CDC are delivered and this will be overseen by the SEND Executive Board
- Work will continue to increase capacity and throughput of assessment to reduce waiting time for children 5-19 neurodevelopmental pathway
- Development and delivery of a system wide graduated response for therapy services
- A system review of provision of therapies in special schools to consider how best to meet pupil need and ensure efficient use of resource.

JBR thanked for presentation and highlighted the success in 98% distribution of baby packs as well as the good feedback from families with parents reporting their satisfaction with contents. Members noted that these have provided an opportunity to access sometimes hard to reach families to address other issues.

Place Board thanked HS for the update and she left the meeting at this point.

| 26/07/25 | Update from the Director of Public Health |
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AH announced that a new Director of Public Health had been appointed. The decision is being ratified at Council Board later today after which Partners will be notified by email.

AH updated on a number of health protection areas including:

- There are currently no concerns locally with flu or covid, although it was noted that levels continue to fluctuate as the virus mutates.
- Following recent exceedance in the levels of cryptosporidium seen in parents of young children after visiting petting farms, messages around hand washing are being reinforced.
- Infection Prevention and Control support is being given in care homes with IPC champions devising an award system which is working well and raising standards. An audit of old person's care homes is also currently underway to check IPC compliance.
- An encouraging report from Trust has shown that efforts around antibiotic prescribing for C-Diff is having a positive impact.
- The Health Protection Annual Report is largely completed and will go to the Health and Wellbeing Board.
- A national pandemic scenario, Exercise Pegasus is planned to take place in September, October and November. Rotherham partners including the Voluntary Sector and the Hospice will be required to take part and we will be advised of roles and responsibilities nearer the time. Learning from the exercise will be shared and will assist us in being better prepared going forward. AH will continue to keep partners updated.
- Gonorrhoea and Mpox vaccinations are due to be rolled out and further guidance is awaited.
- Once the new Director of Public Health is in post, a workshop will be planned to review and refresh the Health and Wellbeing Strategy. This can also be used to consider the new arrangements following the change in role for the ICB and explore the future relationship between Rotherham Place and the H&W Board.
- Place Leadership Team (PLT) has approved Phase 1 of a town centre development approved for community health services to be brought together in a

health hub which is linked to the economic regeneration of the town centre and neighbourhood hubs presenting opportunities for partners to explore.

- The Sport England Place Expansion Programme, which is known locally as Every Move Counts, has been launched with positive results. It is aimed at people with low mood, diabetes etc and there is a possibility of further funding as part of the programme.
- A consultation has been launched by the Ministry of Housing, Communities and Local Government on a proposed local government outcomes framework. RMBC intends to respond on the 15 proposed areas by the deadline of 12 September. The consultation document is available on line should partners wish to review or respond separately.
- As of July 2025, the government has set statutory targets for local authorities to improve early childhood development, aiming for 75% of children to achieve a 'good level of development' by age five, with plans to develop local 'Best Start' strategies and family hubs to support this goal. AH highlighted that family hubs will be important and are now being seen as a permanent arrangement with funding confirmation to be confirmed.

CE thanked AH for his update and support to Rotherham Place Board as the Interim DPH.

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| **27/07/25** | **Fit for the Future: 10 year Health Plan for England** |

The 10 Year Health Plan had been published on 3 July 2025 and CE shared the letter from Dr Penny Dash and Sir James Mackey sent to ICB and NHS Trust Chairs and Executive Teams encouraging leaders to inspire their teams to be bold and impatient for change.

In the short term, focus should be on prioritising financial discipline, delivering commitments and a relentless focus on winter preparations this year with NHS England moving to medium term planning and working with us to agree a collective delivery approach and aligning how the centre and regions work better to support us to deliver priorities by simplifying the rules and accountability.

MCS expressed disappointment from a Hospice perspective that the Plan had little about death, dying and end of life care with no clear targets, recommendations or commitment to funding.

Place Board noted the plan and acknowledged that there were several areas omitted and no implementation/delivery plan at this stage.

NHS SY ICB intends to respond to the Plan.

JBR will consider taking the presentation on the 10 Year Health Plan to Health and Wellbeing Board.

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| **28/07/25** | **Rotherham Place Partnership Update** |

Place Board received the update for May and June 2025. Partners are encouraged to share widely within their own organisations and Boards highlighting the good work taking place across the partnership.

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| **29/07/25** | **Communications to Partners/Promoting Events & Consultations** |

10 Year Health Plan – to be considered for the next Health and Wellbeing Board.

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| **30/07/25** | **Draft Minutes and Action Log from Public Place Board** |
| The minutes from the meeting held on 21 May 2025 were agreed as a true and accurate record.<br><br>The action log was reviewed. There was one amber rated action which related to the mapping of public/partner consultation activity which has been scheduled for September Place Board. | |
| **31/07/25** | **Risks and Items for Escalation to Appropriate Board** |
| There were no new risks to note and nothing for escalation at this time. | |
| **32/07/25** | **Future Agenda Items:** |
| ***Standing Items***<br>– Updates from all groups (as scheduled)<br>– Bi-Monthly Place Partnership Updates<br>– Feedback from SY ICP Meetings – Bi Monthly<br>– Place Achievements (as and when) | |
| **33/07/25** | **Date of Next Meeting** |
| There will be no meeting held in August as Place Board will be holding a development session, therefore the next meeting will take place on ***Wednesday 17 September 2025*** in the John Smith Room, Town Hall, Rotherham. | |

**Members**

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|---|---|---|
| Chris Edwards (Joint Chair) | Executive Place Director/ICB Deputy Chief Executive | NHS South Yorkshire Integrated Care Board |
| John Edwards (Joint Chair) | Chief Executive | Rotherham Metropolitan Borough Council |
| Ian Spicer | Strategic Director, Adult Care, Housing and Public Health/Deputy CE | Rotherham Metropolitan Borough Council |
| Alex Hawley | Interim Director of Public Health | Rotherham Metropolitan Borough Council |
| Richard Jenkins | Chief Executive | The Rotherham NHS Foundation Trust |
| Bob Kirton | Managing Director | The Rotherham NHS Foundation Trust |
| Shafiq Hussain | Chief Executive | Voluntary Action Rotherham |
| Toby Lewis | Chief Executive | Rotherham, Doncaster and South Humber NHS Foundation Trust |
| Dr Anand Barmade | Medial Director | Connect Healthcare Rotherham (GP Federation) |

**Participants**

| | | |
|---|---|---|
| Cllr Joanna Baker-Rogers | Chair of H&WB Board | Rotherham Health and Wellbeing Board |
| Claire Smith | Director of Partnerships, Rotherham Place | NHS South Yorkshire Integrated Care Board |
| Andrew Russell | Director of Nursing, Rotherham & Doncaster Place | NHS South Yorkshire Integrated Care Board |
| Dr Jason Page | Medical Director, Rotherham Place | NHS South Yorkshire Integrated Care Board |
| Wendy Allott | Director of Financial Transformation Rotherham Place | NHS South Yorkshire Integrated Care Board |
| Shahida Siddique | Independent Non-Executive Member | NHS South Yorkshire Integrated Care Board |
| Nicola Curley | Director of Children's Services, RMBC | Rotherham Metropolitan Borough Council |
| Matt Cottle-Shaw | Chief Executive | Rotherham Hospice |
| Kym Gleeson | Service Manager | Healthwatch Rotherham |
| Lydia George | Transformation and Partnership Portfolio Manager (Rotherham) | NHS South Yorkshire Integrated Care Board |
| Gordon Laidlaw | Head of Communications | NHS South Yorkshire Integrated Care Board |
| Andrew Brankin | Rotherham Care Group Director | Rotherham, Doncaster and South Humber NHS Foundation Trust |