Rotherham Joint Health and Wellbeing Strategy

2015-2018 (draft – version 4)

Foreword

Health and wellbeing is important to everybody in Rotherham and enables people to live fulfilling lives and to be actively engaged in their community. The way individuals achieve good health will differ according to their experience, abilities and resources. Unfortunately, we know too many people in Rotherham are not in good health and that significant differences exist between our most and least deprived communities. It is only right, however, given Rotherham's situation that a key focus of the strategy is children and young people, but taking care not neglect other important aspects of health and wellbeing.

As our population grows and changes, health needs change and we need to ensure we are responsive to these changes and continue to offer services that provide high quality care and are accessible to all. We need to also ensure that we have a customer led focus in what we do.

Public sector finances are becoming increasingly stretched, which means that all partners on the Health and Wellbeing Board need to work together to find new ways to deliver services. We hope that this strategy will help to meet these challenges through a shared vision for the health and wellbeing in Rotherham.

The Health and Wellbeing Strategy provides a high level framework which will direct the Health and Wellbeing Board activity over the next three years; it will support the Board's role to provide leadership for health and wellbeing by making the most of our collective resources in the Borough. It doesn't, however, reflect everything we will consider as a Board or that the partners will deliver. It also identifies where the Health and Wellbeing Board can add value to existing strategies and plans for Rotherham. The Health and Wellbeing Strategy and the work of the Health and Wellbeing Board are about working together and I believe it is clear that the Board is now a real partnership, which can only be for the good.

The strategy contains some ambitious aims, but by working creatively, and working together, we feel that they are achievable and that we can make long-lasting changes that will improve health and wellbeing throughout Rotherham.

Cllr David Roche

Advisory Cabinet Member for Adult Social Care and Health and Chair of Rotherham Health and Wellbeing Board

## *1.0 Introduction*

1.1 This is the second Health and Wellbeing Strategy for Rotherham, which has been produced in collaboration with Health and Wellbeing Board partners. This fulfils the duty set out in the Health & Social Care Act (2012) to set the overarching framework for health and care commissioning plans for Rotherham.

## *2.0 What do we mean by health and wellbeing?*

2.1 Health is about feeling physically and mentally fit and well, whilst wellbeing considers whether people feel good about themselves and are able to get the most from life.

2.2 Health is not just about individuals, however, but also about populations. Population health considers how we respond to potential threats to our health, such as the impact of where and how we live our lives, and identifies how best to provide health services that are capable of meeting people's different needs[1].

2.3 People's experience of health and wellbeing is influenced by more than health and care services, and there are stark differences in the life expectancy of people living in the best and worst off parts of the borough. The quality of our built or physical environment, employment and socioeconomic status, housing, transport and access to green spaces are all wider determinants of our health and wellbeing. Black and Minority Ethnic communities generally have poorer health than the general population; whilst much of this difference can be explained by differences in socio-economic status a number of other factors also contribute, including lower take-up of healthcare, biological susceptibility to certain long-term conditions and the impact of racism and discrimination[2].

2.4 Local people can be supported to take responsibility for their health and wellbeing by having a good understanding of their own and their family's health status and the behaviour changes they can make to improve their health now or to prevent ill health developing in the future. Most health behaviours are determined during pregnancy, infancy, childhood and adolescence and by improving the health of children and young people we can start to influence the health and wellbeing of the wider population.

## *3.0 National context*

3.1 *Fair Society, Healthy Lives: The Marmot Review* (2010) provides a framework for tackling health inequalities throughout a person's life. It provides evidence of the social gradient in health – the lower a person's social position, the worse his or her health. This social gradient

[1] Department of Health (2010). *Our Health and Wellbeing Today* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215911/dh_122238.pdf

[2] Parliamentary Office of Science and Technology (2007) Postnote: Ethnicity and Health http://www.parliament.uk/documents/post/postpn276.pdf

in health is starkly apparent in Rotherham with significant differences in life expectancy between our most and least deprived areas. Attempting to reduce this gap, by focusing on raising the health status of the poorest fastest, will contribute to local NHS priorities to reduce the potential years of life lost as a result of ill-health.

3.2 Central to *Fair Society, Healthy Lives* is the life course approach. It recognises that disadvantage starts before birth and grows throughout life; therefore, the actions to tackle inequality in health also need to start before birth and continue through childhood and adolescence, working age and into retirement and later life.

3.3 The report highlights six policy objectives:

- Give every child the best start in life (FSHL1)
- Enable all children young people and adults to maximise their capabilities and have control over their lives (FSHL2)
- Create fair employment and good work for all (FSHL3)
- Ensure healthy standard of living for all (FSHL4)
- Create and develop healthy and sustainable places and communities (FSHL5)
- Strengthen the role and impact of ill health prevention (FSHL6)

Our Health and Wellbeing Strategy has been developed with these as guiding principles; the priorities we have identified will each link to one or more of Marmot's policy objectives.

3.4 The *Children and Families Act 2014* sets out the challenge for radical reform of services for children and young people. It seeks to improve services for vulnerable children and ensure that all children and young people can success, no matter what their background. Support for young people with a disability or a special educational need now receive support up to the age of 25. The cross-Government policy for young people aged 13-19 (25 for those with a disability or special educational need) *Positive for Youth*, sets out a shared vision for how partnership working can support families and improve outcomes for young people, particularly those who are most disadvantaged or vulnerable.

3.5 The Coalition Government announced the Better Care Fund in 2013. It redirects funding into a local single pooled budget between clinical commissioning groups (CCGs) and local authorities to drive closer integration and improve outcomes for people with health and care support needs. Local plans for how the fund will be used must be agreed by the Health and Wellbeing Board and signed off by the CCG and local authority.

3.6 The development of the Health and Wellbeing Strategy has taken two further key national policy documents into account: the *NHS 5-year Forward View* (October 2014) calls for a radical upgrade in prevention and public health, and The Care Act (2015), which aims to give people more control over their care and help people stay independent for longer.

***4.0 Health and wellbeing boards and strategies***

4.1 Health and Wellbeing Boards were introduced in the Health & Social Care Act (2012) to ensure a more joined up approach to plan how best to meet the health and wellbeing needs of the local population and tackle inequalities in health. The boards are managed by local authorities and bring together representatives from NHS commissioners, public health, adult and children's services, Healthwatch and elected members as the statutory board members. In Rotherham, the Health and Wellbeing Board also has representatives from Voluntary Action Rotherham, our NHS providers (Rotherham NHS Foundation Trust and Rotherham, Doncaster and South Humber NHS Foundation Trust), South Yorkshire Police and other key partners.

4.2 The Health and Wellbeing Board uses data from the Joint Strategic Needs Assessment (JSNA) and refers to other borough-wide strategies in the development of a Health and Wellbeing Strategy. This sets the local priorities for joint action and will inform commissioning decisions for health and wellbeing.

4.3 As partners we invest many millions of pounds in Rotherham which influence health and wellbeing, through investment in the economy, transport, housing and community safety as well as health and social care services, where Rotherham Clinical Commissioning Group (CCG) and the Council invest over £530m. The Health and Wellbeing Board has the opportunity to influence and challenge this investment. The current and future limits on resource require us to work more collaboratively than ever, integrating our commissioning of services to ensure that every pound spent in Rotherham on health and care supports improvements in health and wellbeing and the reduction of health inequalities. The Health and Wellbeing Board can support collaboration and integration, and has a role in breaking down barriers between agencies, focusing on getting the most out of the whole system.



***5.0 How the strategy has been developed***

5.1 In developing the Health and Wellbeing Strategy our aim is to identify outcomes based on strong evidence, stakeholder and public feedback, and specific areas where the Health and Wellbeing Board could have the biggest impact. We have identified specific criteria for each outcome showing what we would expect to see in the long term if the strategy is successful.

5.2 Rotherham's JSNA and Pharmaceutical Needs Assessment (PNA) provide a comprehensive and rigorous analysis of the issues that need to be considered when planning for the protection and improvement of the health and wellbeing of the people of Rotherham. The JSNA identifies the current and future health and wellbeing needs of the population, including differences in life expectancy within and between communities and the impact of ill health on the quality of life experienced by local people. It also recognises the importance of mental health and wellbeing, which is important for the resilience of individuals and communities, enabling people to take control of their health and health behaviours. The PNA outlines how pharmaceutical services can contribute to meeting the health needs of the population.

5.3 This Health and Wellbeing Strategy complements other local strategies:

- Rotherham CCG's Commissioning Plan
- Rotherham's Improvement Plan: *A Fresh Start*
- Children and Young People's Improvement Board Action Plan
- Better Care Fund plan
- Rotherham Economic Growth Plan
- Safer Rotherham Partnership Plan
- Rotherham's Local Plan
- Joint Commissioning Plan – Children and Young People
- Child Sexual Exploitation (CSE) Delivery Plan
- Emotional and Wellbeing Strategy

It adds value, capacity and resources to the current strategic priorities for the borough and reflects the priorities of local people and stakeholder organisations.

5.4 In drafting the strategy we have also taken into account views from stakeholder events with partners from the statutory and voluntary sectors within Rotherham and, via Healthwatch, from patients and the public. We have also considered the feedback from RMBC's Commissioner Roadshows. A consultation process for the draft strategy has also taken place; the timeline for this can be found at Appendix 1.

**Table 1: Rotherham – at a glance**[3] [to be presented as an infographic]

- The health of people in Rotherham is generally poorer than the England average
- Life expectancy for men and women is lower than the England average and is 9 years lower for men and 7 years lower for women in the most deprived areas of Rotherham compared to the most affluent areas
- Rotherham's population is changing:
  - the number of older people is increasing and people will live longer with poorer health
  - our Black and Minority Ethnic community is changing, with a higher proportion of younger people and a growing Roma community
- Deprivation is higher than average and more than 11,000 children live in poverty

- 11,700 people in Rotherham are economically inactive (neither in work nor looking for a job or available for work) due to long-term sickness
- 9.6% of benefit claimants in Rotherham are claiming Employment Support Allowance, Incapacity Benefit or disability-related benefits.
- 4060 people in Rotherham receive benefits due to their role as a carer
- Household incomes in Rotherham are lower than the Yorkshire and Humber and UK average
- 9% of homes are in fuel poverty with some localised rates near 24%

- Rotherham's breastfeeding rate is amongst the lowest in the region – contributing to levels of

[3] Public Health England (2015) *Health Profiles*

childhood obesity and paediatric hospital admissions

- 18.3% of mothers smoke during pregnancy. Smoking in pregnancy contributes to increased risk of stillbirth, low birthweight and neonatal deaths.
- 23.4% of children leaving primary school are obese.
- 5.9% of 16-18 year olds in Rotherham are not in employment, education or training, compared to 4.7% nationally
- 1550 people aged 15-24 in Rotherham were newly diagnosed with a sexually transmitted infection in 2013. This is a higher rate than the England average.

- Nearly 3 in 10 adults in Rotherham are obese (28.5%) – worse than the average for England
- 1688 hospital admissions in Rotherham during 2013/14 could be attributed to alcohol
- 35.1% of the Rotherham population are estimated to drink at a level that puts their health at risk, of which 8.9% (17,996 people) are causing themselves actual harm
- An estimated 18.9% of adults in Rotherham smoke
- There are nearly 500 smoking related deaths each year in Rotherham – significantly higher than the England average
- On average, one in four people will have mental health problems at some point in their lives.

**Table 2: There have been some notable improvements in health and wellbeing in Rotherham over recent years[4]. Good progress doesn't mean, however, that we don't have more to achieve.**

School readiness (children achieving a good level of development at the end of reception year) and GCSE achievement are now better than national averages.

The rate of under-18 conceptions in the borough has reduced and is now the same as the England average.

Smoking rates have been falling and we now have our lowest ever adult smoking rate. Smoking during pregnancy has reduced quicker than in any of our comparator local authorities following changes to how the service was delivered five years ago.

Rotherham's healthy weight framework to address overweight and obesity is recognised nationally as an example of best practice.

More people are having routine vaccinations and cancer screening in Rotherham than the national average.

Rotherham's performance on opiate users leaving treatment successfully has improved significantly from being one of the lowest in the country to above the national average.

Excess winter deaths have seen a significant reduction and are now below the England average.

[4] Public Health England (2015) *Health Profiles*
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### *6.0 How we will use the strategy*

6.1 The Health and Wellbeing Strategy places particular emphasis on a shared vision and leadership for improving health and care services. We will use the strategy to develop action plans that we are all signed up to, to hold each other to account and to use our resource collectively to deliver the best outcomes for Rotherham.

6.2 We have identified five key aims with associated objectives where we will look for improvement in order to demonstrate progress. This is not a final list of everything that the board and partners will do, but a set of the most pressing health and wellbeing priorities for Rotherham.

6.3 Health and Wellbeing Board members are responsible for a wide range of services that impact on health and wellbeing, and the board and strategy will also influence the direction of other strategies and plans, including planning and development, transport and economic growth. The Health and Wellbeing Strategy provides a framework for commissioning plans for the council and CCG and specifically for the development of the Better Care Fund proposals and for joint commissioning of services to ensure seamless, effective and efficient service delivery. The areas where the strategy will add weight include early help services, mental health and wellbeing, special educational needs and disability, 0-19 services, support for carers and young carers, housing and the local planning framework.

6.4 There is also an explicit relationship between the local and sub-regional partnership structures providing opportunities to influence wider determinants including air quality and economic investment.

### *7 Managing and monitoring the strategy*

7.1 We will monitor progress on the strategy by focusing on the impact it will have on people's lives. We have identified a number of indicators and data sources for each aim that will help us measure progress.

7.2 We will establish a sub-group of the Health and Wellbeing Board that will act as an 'engine room' and make the strategy happen. It will ensure that the indicators we have selected are the best to demonstrate improvement and will seek out new guidance and evidence that could help us deliver the aims most effectively. The sub-group will have representation from Rotherham Healthwatch to help us ensure, through a process of managed public engagement, that we keep the needs of the Rotherham population at the heart of our work.

7.3 The major changes that are being sought in this strategy will take time and we expect to see gradual, but measurable, improvements.

7.4 The Health and Wellbeing Board will use its strategic influence with other key groups, such as Rotherham Together Partnership's Chief Executive Officers Group, to ensure that all partners are contributing to delivering the strategy through:

- Regular performance reports from the sub-group
- Publishing an annual 'healthcheck' on progress

## 8 Rotherham Health and Wellbeing Strategy Aims 2015-2018

8.1 We have identified five key aims for Rotherham that can best be tackled by a 'whole system' approach, where we need the involvement of the whole health and care system to achieve improvement. We have used five questions in selecting the aims:

- Is there more that can be done to tackle this issue?
- Is it an issue that is amenable to intervention?
- Is the delivery of this issue important to all partners on the Health and Wellbeing Board?
- Is it of strategic importance?
- Would this issue lead to considerable impact across the borough, or to one of our vulnerable target groups?

8.2 Each aim will be underpinned by a comprehensive action plan. There are a number of supporting principles that will apply consistently across these action plans:

- To reduce health inequalities we need to ensure that the health of our most vulnerable communities, including those living in poverty and deprivation and those with mental health problems, learning or physical disabilities, is improving the fastest.
- Prevention of physical and mental ill-health should be our primary aim, but where it is already an issue, we should intervene early to maximise the impact of services for individuals and communities
- We will work with individuals and communities to increase resilience and enable people to better manage and adapt to threats to their health and wellbeing, using an asset-based approach that values the capacity, skills, knowledge, connections and potential within communities
- Integrating our commissioning of services wherever possible to support improvements in health and wellbeing and the reduction of health inequalities
- We need to ensure pathways are robust, particularly at transition points (e.g. from children and young people's services into adult services), to be sure that nobody is left behind
- All services need to be accessible and provide support to the right people, in the right place, at the right time

## 9. Aim 1: All children get the best start in life

### *9.1 Objectives:*

- Improve emotional health and wellbeing for children and young people
- Improve health outcomes for children and young people through integrated commissioning and service delivery
- Ensure children and young people are healthier and happier

***9.2 Why this is an issue?***

9.3 All aspects of our development – physical, emotional and intellectual – are established in early childhood. Development in the early years (including in the womb) can have a lifelong impact on health and wellbeing, educational achievement and economic status. By placing an increased focus on health and wellbeing in those early years we hope that all Rotherham children will be able to fulfil their potential.

*9.4 Early Help* describes a range of interventions to identify and respond to individual needs and prevent these escalating into complex and costly issues at a later point. Delivered through partnership working across health and social care, and using a single assessment to target the early help offer, we will prevent the need for social care interventions and secure better outcomes for children, young people and their families. Early help spans a wide age range (0-19 years, or up to 25 years if the individual has a disability or special educational need) and has a critical role to play in the key transition points in a child's journey from dependence to independence.

9.5 We have, on average, more than 3,000 births in Rotherham each year and around 16,000 children aged 0-4 years. Too many of these children are not currently getting the best start in life.

9.6 The percentage of children living in poverty in Rotherham is higher than regional and England averages, with 11,320 children and young people aged 0-16 living in families whose income is less than 60% of median income (2012). Child poverty influences educational achievement (by the age of three, poorer children are estimated to be nine months' behind children from more wealthy backgrounds – and this gap continues throughout the educational stages) and health, with children in poverty almost twice as likely to live in poor housing and be affected by fuel poverty[5].

9.7 More than 500 babies are born every year in Rotherham to mothers who smoke or drink alcohol during pregnancy. These children are at significant risk of preventable health conditions and developmental delay.

9.8 Breastfed babies have fewer chest and ear infections, fewer gastrointestinal problems, are less likely to become obese and therefore of developing obesity-related problems in later life, and are less likely to develop eczema. It is therefore a concern that fewer babies in Rotherham are being breastfed and for a shorter a time than the England average.

9.9 Rotherham has higher than regional and national average levels of tooth decay in both 3 and 5 year olds, with 3 year olds having the poorest oral health in South Yorkshire. The most common dental diseases (tooth decay and gum disease) can cause pain and infection and lead to tooth loss, disruption to family life and absence from education.

[5] Child Poverty Action Group http://www.cpag.org.uk/content/impact-poverty

***9.10 Rotherham Health and Wellbeing Board will:***

- Work with Rotherham's Children and Young People's Improvement Board to maximise the health impact of their action plan
- Reduce the long-term ill-health implications of child poverty through supporting the implementation of Rotherham's Early Help strategy, working with families with multiple and complex needs.
- Engage with early years services in developing parenting skills and capacity, which will in turn support improvements in health and wellbeing in the early years
- Review and strengthen pathways to ensure services are delivering high quality interventions as required by the Healthy Child programme.
- Commission an integrated public health service for children and young people aged 0-19 that ensures a seamless pathway across key transitions and focuses the most intensive support on our most vulnerable children and young people.
- Ensure all pregnant mothers who smoke receive consistent specialist advice on the risks to the pregnancy and their baby and high quality stop smoking support for those who wish to quit.
- Ensure all new mothers receive accurate and consistent information and support to facilitate breastfeeding.

**Table 3: Did you know?**

In 2015 Broom Valley Community School won a Healthy School Good Practice Award for their oral hygiene campaign, which engaged staff, parents and children across the whole school. Practical sessions were combined with curriculum activity and presentations to parents. Parents have registered their children with a dentist and some children have attended their first dental appointment as a result of the campaign. Links with the oral health outreach team ensure parents who lacked confidence in making the changes receive additional support.

Healthy Schools Rotherham

**10. Aim 2: Children and young people achieve their potential and have a healthy adolescence and early adulthood**

***10.1 Objectives:***

- Reduce the number of young people at risk of child sexual exploitation
- Reduce the number of young people experiencing neglect
- Reduce the risk of self-harm and suicide among young people
- Increase the number of young people in education, employment or training
- Reduce the number of young people who are overweight and obese
- Reduce risky health behaviours in young people

***10.2 Why this is an issue?***

10.3 Whilst tackling inequalities in health needs focused action from the start of life and in the early years, the commitment needs to be maintained throughout childhood and adolescence. We need to provide good education and healthcare, and opportunities for good work and training in order to support young people to thrive. In common with all the priorities, whilst we need to ensure these are available for all children and young people within the borough, we must focus on those children and young people who are most vulnerable: those who are looked after, those with mental health problems, physical and learning disabilities and those from our most deprived communities.

10.4 This is a key period for developing individual resilience: developing a sense of purpose and self-esteem, becoming emotionally aware, taking responsibility for your own physical and emotional needs and being connected to others. Resilience enables children and young people to cope with the challenges they face and to contribute positively within their community.

10.5 The risk of child sexual exploitation (CSE) must remain at the forefront of all our plans. Health services can be well placed to identify early signs of exploitation and we must ensure that all staff have robust training in how to spot the signs and know how to respond. Young people who have been victims of CSE need access to high quality support for their emotional wellbeing.

10.6 Neglect, or the ongoing failure to meet a child or young person's basic needs, can have serious and long-lasting effects on physical and mental wellbeing. Young people who have been neglected are more likely to experience mental health problems including depression and post-traumatic stress disorder. In addition, these young people may be more likely to take risks, such as running away from home, using drugs or alcohol, or getting involved in dangerous relationships which, in turn, makes them vulnerable to sexual exploitation.

10.7 We must ensure that the Health and Wellbeing Board's work complements Rotherham's Children and Young People's Services Improvement Board action plan and contributes to the achievement of the vision for Children and Young People's Services.

10.8 Educational development and attainment are generally good in Rotherham; more children achieve a good level of development at the end of reception year and more young people achieve 5 or more GCSEs at grades A*-C (including English and maths) than the England average. However, by age 16-18 our young people are beginning to struggle, with a higher number not in education, employment or training than the England average.

10.9 During adolescence young people become more independent. With this increasing autonomy they may experiment with risk-taking behaviours. They may try alcohol, tobacco and other substances, and may become sexually active. Modelled estimates suggest 10% of 15 year olds in Rotherham smoke regularly (daily or weekly), which is higher than the England estimate. Alcohol-specific hospital admissions for under 18s, however, are significantly better in Rotherham than the England average (29.1 per 100,000 under 18 year olds in Rotherham, compared to 40.1 per 100,000 for England).

10.10 Self-harm, when somebody chooses to inflict pain on themselves, might be used because people think it will relieve tension or anxiety or to help them gain control of issues that are worrying them. Research suggests that nationally around 10% of 15-16 year olds have self-harmed. Self-harm is more common in young women, although it is on the increase among young men. Self-harm can sometimes indicate that a young person may be at risk of suicide[6]. An awareness of the signs of self-harm and suicidal thoughts is essential if we are to be able to respond to these vulnerable young people quickly and effectively. There is further discussion of mental and emotional wellbeing for people of all ages in Aim 3.

10.11 Childhood is an important time in the development of obesity, as levels more than double between Reception (aged 4-5 years – 9.7% obese, similar to the England average) and Year 6 (aged 10-11 years – 23.4% obese, higher than the England average). There will be many contributing factors to this increase: lifestyle and diet choices of the children, their parents, their school, and the local environment. School stay-on-site policies have been shown to reduce the consumption of unhealthy food during the school day.[7]

10.12 In Rotherham we have a higher diagnosis rate of new sexually transmitted infections (STIs) than the England average. Care needs to be taking in interpreting this data, however, as higher diagnosis rates may not necessarily indicate that more young people have STIs than in other areas, but may reflect local services that are accessible and young people friendly.

***10.13 Rotherham Health and Wellbeing Board will:***

- Work with Rotherham's Children and Young People's Improvement Board to maximise the health impact of their action plan

[6] http://www.youngminds.org.uk/for_children_young_people/whats_worrying_you/self-harm/what_self-harm

[7] Crawford et al (2012) A Feasibility Study to Explore the Nutritional Quality of 'Out of School' Foods Popular with School Pupils
http://www.gcph.co.uk/assets/0000/3539/Out_of_school_foods_report_-_final.pdf
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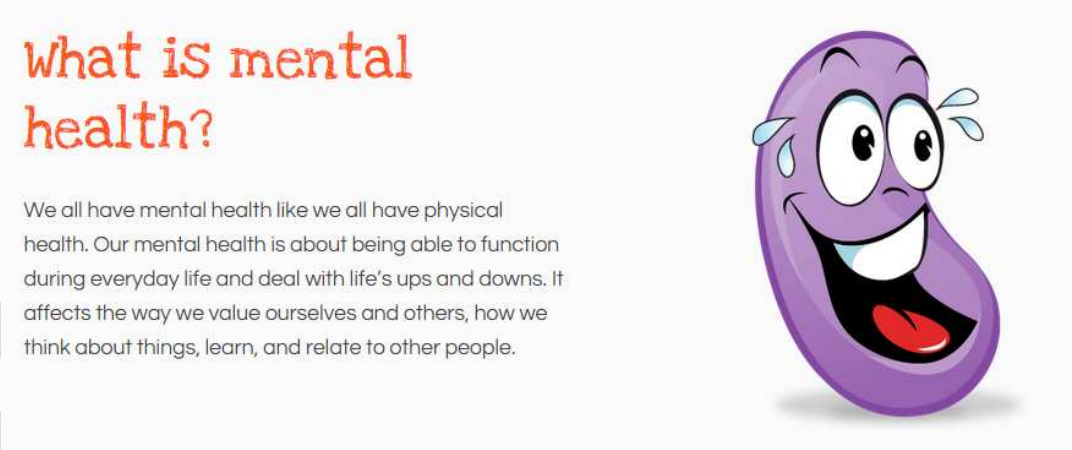
- Review and strengthen pathways to ensure services are delivering high quality interventions as required by the Healthy Child programme.
- Commission an integrated public health service for children and young people aged 0-19 that ensures a seamless pathway across key transitions and focuses the most intensive support for our most vulnerable children and young people
- Deliver on the actions in the Rotherham Sexual Health Strategy Delivery Plan
- Involve and engage young people with our work programme, for example through holding joint meetings with Rotherham Youth Cabinet
- Engage more closely with schools and colleges on the health and wellbeing agenda through cluster meetings, personal social and health education (PSHE) leads meetings and governor training and development

**Table 4: Did you know?**

mymindmatters.org.uk has been launched to provide information and support to children and young people, parents, carers and practitioners in Rotherham on mental health and emotional wellbeing. Taking a one-stop-shop approach, as well as separate sections for children (Wellbeenz) and young people, there is also information and practical advice for parents and professionals to ensure the whole community around the child or young person can respond appropriately and with confidence.



## 11. Aim 3: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life

### *11.1 Objective:*

- Improve support for people with enduring mental health needs, including dementia, to help them live healthier lives
- Reduce the occurrence of common mental health problems
- Reduce social isolation

### *11.2 Why this is an issue?*

11.3 Mental health problems can affect anybody at any age. It is estimated that one in four of us will suffer from mental health problems at some point in our lives. Half of those with lifetime mental illness (excluding dementia) first experience symptoms by the age of 14, and three-quarters by their mid-20s[8]. It is vital that positive mental and emotional wellbeing is a priority at every age. Therefore the actions identified within this aim apply across the life course.

11.4 Mental health problems are the biggest cause of illness and incapacity in the borough and are related to deprivation, poverty and inequality. People with long term mental health problems are also more likely to live in the most disadvantaged sections of society. Austerity and socioeconomic insecurity increase the risk factors for poor mental health[9], particularly for those on low income and those who face loss of income and/or housing. In Rotherham the underlying economic determinants of mental health are worse than the national average.

11.5 Communities that lack social support and social networks are less likely to experience positive mental health and wellbeing. For young people, the most common mental health problems are depression, anxiety and misuse of alcohol and other drugs, with one young person in ten experiencing some form of problem with their emotional and mental health in the course of a year. Older people are especially vulnerable to feelings of isolation as a result of the loss of friends and family, limited mobility or income that comes with age. Social isolation and loneliness is associated with mental health problems and can result in increased use of emergency healthcare and earlier admission to residential care. We need to ensure our communities are resilient communities, with the right services, facilities and infrastructure to enable people to confront and cope with life's challenges.

11.6 Another consequence of our ageing population is the increasing number of people living with dementia. By the age of 90, around 30% of people will be living with dementia. On average, people live for around seven years after the onset of symptoms and two years after diagnosis. Most people with dementia live at home, supported by family, neighbours, mainstream health services and the community. The impact of dementia on carers' physical and mental health must also be taken into account.

[8] The World Health Report (2001). *Mental Health – New Understanding, New Hope*. World Health Organisation, Geneva

[9] WHO (2011) Impact of economic crises on mental health

11.7 In recent years suicide rates nationally have increased following several years over which there had been a steady decline. Locally Rotherham has also seen an increase in the number of death registrations classified as suicides/deaths of undetermined intent. These deaths fell sharply between 2008 and 2010 but have increased between 2010 and 2013. Rotherham's suicide rate for 2011-13 is virtually the same as the England average.

11.8 The latest suicide prevention strategy for England[10] and a recent report from The Samaritans[11] have both identified middle aged men, especially those from poorer socioeconomic backgrounds as one of the high risk groups who are a priority for suicide prevention. Our experience of suicide in Rotherham has tended to follow national trends.

***11.9 Rotherham Health and Wellbeing Board will:***

- Ensure our work embeds action to promote mental wellbeing, build individual and community resilience and prevent and intervene early in mental health problems
- Deliver on the actions in the Rotherham suicide prevention and self-harm action plan
- Identify, coordinate and promote initiatives to address social isolation, working in partnership with local voluntary, community and faith sector organisations
- Review and strengthen pathways between health and social care to ensure nobody can fall through gaps in the system
- Ensure all users of mental health services have equality of access to health services and behaviour change services to support them to live healthy lives
- Require all our mainstream health services to undertake mental health awareness training and to become dementia friendly services

**Table 5: Did you know?**

The Rotherham Less Lonely campaign aims to reduce social isolation for the borough's older residents through a range of activities. These range from lunch clubs to one-to-one befriending to providing transport for an older person to attend a social group.

Rotherham Less Lonely receives no statutory funding, but through partnership working with statutory and voluntary sector organisations and with support from committed volunteers it is making a real difference to many of the 4,000 people in Rotherham who said they feel lonely every day of their lives.
www.rotherhamlesslonely.org

[10] HM Government (2012) Preventing suicide in England: A cross-government strategy to save lives
https://www.gov.uk/government/publications/suicide-prevention-strategy-launched
[11] Samaritans (2012) Men, Suicide and Society: Why disadvantaged men in mid-life die by suicide.
D:\moderngov\Data\AgendaItemDocs\9\4\1\AI00073149\$r13ds4aw.docx

**12. Aim 4: Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing**

***12.1 Objectives:***

- Reduce the number of early deaths from cardiovascular disease and cancer
- Improve support for people with long term health and disability needs to live healthier lives
- Increase the opportunities for participation in physical activity
- Reduce levels of alcohol-related harm
- Reduce levels of tobacco use

12.2 ***Why this is an issue?***

12.3 Life expectancy and healthy life expectancy in Rotherham are lower than average for both men and women. Within Rotherham, life expectancy is 9 years lower for men and 7 years lower for women in the most deprived areas of the borough compared to the most affluent areas.

**Table 6:**

| 2011-2013 | Life expectancy at birth | Healthy life expectancy at birth |
|---|---|---|
| **Rotherham men** | 78.1 years | 57.1 years |
| **England average** | 79.4 years | 63.3 years |
| **Rotherham women** | 81.4 years | 59 years |
| **England average** | 83.1 years | 63.9 years |

[this table will be displayed as a graph in the printed version, which demonstrates the gap in a visual manner]

12.4 This inequality in health leads to almost 7,000 years of life being lost each year in Rotherham through causes considered amenable to healthcare. This is almost 1,500 years more than might be expected based on the England average.

12.5 The main drivers of the excess years of life lost in Rotherham are problems of the circulation (principally stroke and ischaemic heart disease), respiratory disease and cancer. Tackling premature mortality will require a coordinated approach from all members of the Health and Wellbeing Board.

12.6 Our concern should not, however, be just about extending life: it should also cover the factors that contribute to healthy life expectancy. The difference in health life expectancy means that people in Rotherham develop poor health around 5 or 6 years earlier than the average for England. This disability burden has significant implications for public services locally, on the need for health and social care and for employment opportunities. This is because, on average, people in Rotherham will develop long term conditions around 8 years before the new state pension age of 67. This means more working age people living with

long term conditions such as heart disease, diabetes, dementia, chronic mental health disability and surviving after cancer treatment.

12.7 The actions we are recommending through the early years, childhood and adolescence will all contribute to increasing life expectancy and healthy life expectancy, but we also need to focus on those who are already in adulthood, or who may have already developed long term conditions. The link between good work and health is particularly important here: being in work is, in itself, good for physical and mental health, but for those people of working age who may have a long term condition, we need to ensure employers continue to support them to have a fulfilling working life. Economic growth within Rotherham will play its part in reducing health inequalities.

12.8 The risk of early death and disability from the three main contributors to the years of life lost in Rotherham can be effectively reduced by reducing levels of overweight and obesity, increasing levels of physical activity, not smoking, and limiting alcohol consumption. It must be recognised that individual behaviour change is difficult and needs support. A multifactorial approach that addresses all risk factors yields most benefit. This is because tackling multiple risk factors in individuals has a cumulative effect in reducing the chance of death. Screening programmes and health assessments such as the NHS Healthcheck programme provide early identification of certain conditions and can enable referral into effective treatment programmes.

12.9 We need to ensure that people who have a long-term condition or disability and those with mental health problems receive the **right care in the right place at the right time**. Too many people are admitted to hospital unnecessarily and are kept in hospital for too long as the services to support them on discharge are taking too much time to put in place. We need to increase access to health services in the community and to reduce the proportion of care that occurs in hospital. Work to support the most vulnerable to remain independent for as long as possible is required across health and social care, as is high quality support for their friends and family who provide unpaid care. The impact of the Better Care Fund should be felt most by these Rotherham residents.

12.10 People approaching the end of their life are entitled to high quality care, wherever that care is delivered. Good end of life care should be planned with the individual and the people close to them to ensure it is tailored to their needs and wishes and includes management of symptoms, as well as provision of psychological, social, spiritual and practical support. We need to ensure that more people in Rotherham are able to exercise choice over their end of life care and the place of their death.

***12.11 Rotherham Health and Wellbeing Board will:***

- Ensure effective pathways are in place into screening and behaviour change services to help reduce premature mortality
- Ensure integrated commissioning and delivery across all health, social care and community organisations to deliver effective support for people with long term conditions, physical and

learning disabilities and mental health problems so that people receive the right care in the right place at the right time

- Support the delivery of Rotherham's Economic Growth Plan to increase the opportunities for residents to access good work, housing, transport and green space
- Actively participate in Rotherham's multi-agency strategy groups tackling the behavioural contributors to preventable ill-health to deliver quantifiable improvements in overweight and obesity and smoking prevalence

**Table 7: Did you know?**

Voluntary Action Rotherham runs a social prescribing service to help people with long term conditions access a variety of services and activities provided by local voluntary organisations and community groups. Funded by Rotherham Clinical Commissioning Group, the service sees staff from the health and voluntary sectors working with colleagues in social care to establish a coordinated care plan for people with long term conditions to improve quality of life and reduce the risk of hospital admissions.

www.varotherham.org.uk

## 13. Aim 5: Rotherham has healthy, safe and sustainable communities and places

### *13.1 Objectives:*

- Develop high quality and well-connected built and green environments
- Increase the number of residents who feel safe in their community
- Reduce crime and antisocial behaviour in the borough
- Ensure planning decisions consider the impact on health and wellbeing
- Increase opportunities for people in Rotherham to use outdoor space for improving their health and wellbeing

### *13.2 Why this is an issue?*

13.3. As previously discussed, health is influenced by more than just the healthcare we receive. The physical environment in which we live, work and spend our leisure time and how safe we feel in our communities also impacts on health outcomes.

13.4 The quality of housing, the condition of streets and public places, noise, access to green space and levels of antisocial behaviour and crime contribute to inequalities in health. Tackling these wider determinants of health will also benefit the sustainability and economic growth agenda through the promotion of active travel, public transport, energy efficient housing and increasing access to green space, as well as supporting the other aims within this strategy. For example, through community regeneration programmes we can also help to reduce social isolation and increase community resilience.

13.5 A healthy economy leads to a healthy community; it offers good jobs, incomes and opportunities which increase aspiration and, therefore, health and wellbeing. Equally, healthy, resilient people are better able to contribute to their local community, secure a better job and be more productive in the workplace, supporting a healthy economy.

13.6 Planning decisions can have significant impact on health and wellbeing. Ensuring buildings and public spaces are designed in a way that enables people to be more physically active, or using planning levers to limit the growth of fast food takeaways, for example, can contribute to the broader effort to reduce growing levels of overweight and obesity. Encouraging a vibrant high street with diverse local and independent food traders can increase choice and access to healthy, fresh food for all. Planting regimes can reduce noise pollution from major roads and improve air quality for local residents. Rotherham's Local Plan has a clear objective to create safe and healthy communities and to engage health services in key planning decisions.

13.7 Poor housing costs the NHS at least £2.5 billion a year in treating people with illnesses directly linked to living in cold, damp and dangerous homes[12]. Cold homes and poor housing can have a negative impact on physical and mental health and wellbeing and may ultimately result in excess winter deaths. Associated health inequalities can occur across the life course, from early years through to the frail elderly population.

13.8 An increasingly older population, living longer with long term conditions and disability, will require more homes with adaptations to enable them to continue with a good quality of life and to maximise their independence.

***13.9 Rotherham Health and Wellbeing Board will:***

- Work in partnership to maximise the health impact of:
  - Rotherham's Local Plan
  - Rotherham's Housing Strategy 2013-2043
  - Rotherham's Economic Growth Plan
  - Safer Rotherham Partnership Plan
  - South Yorkshire's Local Transport Plan

13.10 Appendix 2 contains tables indicating how this strategy will complement other key borough-wide plans.

**Table 8: Did you know?**

Rotherham led the work to develop national guidance and resources around cold home: Winter Warmth England. Partners including the NHS, RMBC, emergency services and voluntary sector organisations worked together to ensure that older people whose health might be at risk due to a cold home receive clear, correct, consistent and useful advice and information from local services who support them.

www.winterwarmthengland.co.uk


[12] Local Government Association (2014). Healthy Homes, Healthy Lives
http://www.local.gov.uk/documents/10180/5854661/L14+-+85+Housing+and+Health+case+studies_14.pdf/b4620ef6-87bc-4e12-964a-5cbd4433dd47

### *14. What we want for the future*

14.1 We hope that this strategy will help to build the individual, community and economic resilience needed to enable Rotherham people to make positive choices that maintain and improve their health and wellbeing. Its delivery relies on a shared commitment from Health and Wellbeing Board members, but also from a wider range of partners – statutory and community organisations as well as individuals – to working collaboratively, shifting resources from treatment to prevention and focusing on improving the health and wellbeing of our most vulnerable communities the fastest.

14.2 The actions plans that will accompany this strategy will be living documents, regularly reviewed and updated in light of new and updated local strategies and national guidance. We will ensure that these plans also reflect ongoing feedback from Rotherham residents obtained through ongoing consultation with individuals and community groups.

14.3 If you would like to get involved in the delivery of this strategy, please contact:

| | | |
|---|---|---|
| Public Health: Alison Iliff | Alison.iliff@rotherham.gov.uk | 01709 255848 |
| Policy and Partnerships: Michael Holmes | Michael.holmes@rotherham.gov.uk | 01709 254417 |
| Rotherham CCG: Ian Atkinson | Ian.atkinson@rotherhamccg.nhs.uk | 01709 302000 |

**Table 9**

| Aims | Objectives | Indicator bundle | Reporting mechanism | Frequency of reporting |
|---|---|---|---|---|
| **1. All children get the best start in life**<br><br>*Link to Marmot policy objective FSHL1* | • Improve emotional health and wellbeing for children and young people<br>• Improve health outcomes for children and young people through integrated commissioning and service delivery<br>• Ensure children and young people are healthier and happier | Free school meals Yr 3 upwards | Department for Education Pupil Census (data source: schools via DfE COLLECT data management system) | Termly |
| | | Breastfeeding<br>a) % of all mothers who breastfeed their babies in the first 48hrs after delivery<br>b) % of all infants due a 6-8 week check that are totally or partially breastfed | a) PHOF 2.02i (data source: NHS England)<br>b) PHOF 2.02ii (data source: NHS England) | Quarterly |
| | | Children aged 5 years with one or more decayed, filled or missing teeth | CHIMAT Child Health Profile (data source: National Dental Epidemiology Survey) | Annual |
| | | School readiness<br>a) % children achieving a good level of development at the end of reception<br>b) % children achieving the expected level in the phonics screening check | PHOF 1.02i and 1.02ii (data source: 1.02i DfE EYFS Profile statistical series; 1.02ii DfE Teacher Assessments: Phonics screening check statistical series) | Annual |
| | | Low birth weight of term babies | PHOF 2.01 (data source: Office for National Statistics) | Annual |

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|---|---|---|---|---|
| **2. Children and young people achieve their potential and have a healthy adolescence and early adulthood**<br><br>*Links to Marmot policy objectives FSHL1, FSHL2* | • Reduce the number of young people at risk of child sexual exploitation<br>• Reduce the number of young people experiencing neglect<br>• Reduce the risk of self-harm and suicide among young people<br>• Increase the number of young people in education, employment or training<br>• Reduce the number of young people who are overweight and obese<br>• Reduce risky health behaviours in young people | % 16-18 year olds not in education, employment or training | PHOF 1.05 (data source: Department for Education) | Annual |
| | | Number of education, health and care plans (EHCPs)<br>a)Number of new EHCPs<br>b) Number of transferred EHCPs<br>c) Total number of EHCPs | Department for Education Statements of SEN and EHC plans statistical release (data source: annual SEN2 data return) | Annual |
| | | Emotional wellbeing of looked after children: Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31 March. | PHOF 2.08 (data source: Department for Education) | Annual |
| | | Reduced suicide and self-harm:<br>a) Hospital admissions caused by unintentional and deliberate injuries (0-14 and 15-24 years)<br>b) Hospital admissions for mental health conditions (0-17 years)<br>c) Hospital admissions as a result of self-harm (10-24 years) | a) PHOF 2.07i and 2.07ii (data source: PHE Knowledge and Intelligence Team (South West))<br>b) CHIMAT Child Health Profile (data source: Hospital Episode Statistics)<br>c) CHIMAT Child Health Profile (data source: Hospital Episode Statistics) | a) Annual<br>b) Annual<br>c) Annual |
| | | Number of health assessments for looked after children completed within recommended timescales | RMBC CYPS monthly report (data source: RMBC CYPS and RCCG) | Monthly |

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|---|---|---|---|---|
| | | Number of children and young people presenting at risk of CSE | RMBC CYPS monthly report (data source: RMBC CYPS social care database) | Monthly |
| | | Number of children and young people presenting with neglect | RMBC CYPS monthly report (data source: RMBC CYPS social care database) | Monthly |
| | | School attainment<br>a) key stage 2<br>b) key stage 4<br>c) progress between KS2 and KS4 | Department for Education (data source: national curriculum assessments for KS2 and KS4) | Annual |
| **3. All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life**<br><br>*Links to Marmot policy objectives FSHL3, FSHL4, FSHL5, FSHL6* | • Improve support for people with enduring mental health needs, including dementia, to help them live healthier lives<br>• Reduce the occurrence of common mental health problems among adults<br>• Reduce social isolation | Social isolation<br>a) % of adult social care users who have as much social contact as they would like<br>b) % of adult carers who have as much social contact as they would like | a) PHOF 1.18i / ASCOF 1Ii (data source: Adult Social Care Survey)<br>b) PHOF 1.18ii / ASCOF 1Iii (data source: Personal Social Services Survey of Adult Carers in England) | a) Annual<br><br>b) Biennial (next scheduled 16/17) |
| | | Suicide rate | PHOF 4.10 (data source: Public Health England, based on ONS source data) | Annual |
| | | Excess under 75 mortality rate in adults with serious mental illness | PHOF 4.09 (data source: HSCIC) | Annual |
| | | Estimated diagnosis rate for people with dementia | PHOF 4.16 (data source: HSCIC) | Annual |

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|---|---|---|---|---|
| | | Rate of domestic abuse incidents recorded by the police per 1,000 population | PHOF 1.11 (data source: Crime Statistics, Focus on Violent Crime and Sexual Offences. ONS) | Annual |
| | | Social care-related quality of life<br>a) Service users<br>b) carers | a) ASCOF 1A (service user) (data source: Adult Social Care Survey)<br>b) ASCOF 1D (carer) (data source: Survey of Adult Carers in England) | a) Annual<br>b) Biennial (next scheduled 16/17 |
| **4. Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing**<br><br>*Links to Marmot policy objectives FSHL3, FSHL4, FSHL6* | • Reduce the number of early deaths from cardiovascular disease and cancer<br>• Improve support for people with long term health and disability needs to live healthier lives<br>• Reduce levels of alcohol-related harm<br>• Reduce levels of tobacco use | Potential years of life lost considered amenable to healthcare | NHSOF 1.1 (data source: Primary Care Mortality Database via Health and Social Care Information Centre) | Annual |
| | | Proportion of older people (65+) still at home 91 days after discharge into rehabilitation | Better Care Fund metric. ASCOF 2Bi (data source: Adult Social Care Short and Long Term Return (ASC-SALT)) | Annual |
| | | Non-elective first finished consultant episodes | Better Care Fund metric (data source: Unify 2, MAR Commissioner, Department of Health) | Monthly |
| | | Delayed transfers of care from hospital per 100,000 population (number of days delayed) | Better Care Fund metric (data source: NHS England) | Monthly |
| | | Emergency readmissions within 30 days of discharge from hospital | Better Care Fund metric (data source: The Rotherham NHS Foundation Trust via Secondary Uses Service (SUS)) | Monthly |

| | | | | |
|---|---|---|---|---|
| | | Permanent admissions of older people (aged 65+) to residential and nursing care homes, per 100,000 | Better Care Fund metric ASCOF 2A part 2 (data source: Adult Social Care Short and Long Term Return (ASC-SALT) and ONS) | Monthly |
| | | % deaths not in hospital | End of Life Care group local metric (data source: ONS) | Quarterly |
| **5. Rotherham has healthy, safe and sustainable communities and places**<br><br>*Links to Marmot policy objective FSHL5* | • Develop high quality and well-connected built and green environments<br>• Increase the number of residents who feel safe in their community<br>• Reduce crime and antisocial behaviour in the borough<br>• Ensure planning decisions consider the impact on health and wellbeing<br>• Increase opportunities for people in Rotherham to use outdoor space for improving their health and wellbeing | Fuel poverty | PHOF 1.7 (data source: Department for Energy and Climate Change) | Annual |
| | | Fear of crime | South Yorkshire Police Q5 (data source: Your Voice Counts Survey) | Annual |
| | | Proportion of service users who feel safe | ASCOF 4A (data source: Adult Social Care Survey) | Annual |
| | | | | |

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|---|---|---|---|---|
| **Behaviour change indicator bundle that impact across the life course and upon all aims** | | Overweight and obesity<br>a) % of children aged 4-5 classified as overweight or obese<br>b) % of children aged 10-11 classified as overweight or obese<br>c) % adults classified as overweight or obese | a) PHOF 2.06i (data source: HSCIC - National Child Measurement Programme)<br>b) PHOF 2.06ii (data source: HSCIC - National Child Measurement Programme)<br>c) PHOF 2.12 (data source: Active People Survey, Sport England) | Annual |
| | | Alcohol use<br>a) Number of people in tier 3 alcohol treatment services aged under 18<br>b) Number of people in tier 3 alcohol treatment service aged 18+ | Public Health England Adult Alcohol Statistics and Young People Statistics (data source: National Drug Treatment Monitoring System) | Quarterly |
| | | Smoking prevalence<br>a) % women who smoke at time of delivery<br>b) Smoking prevalence at age 15 – current smokers and regular smokers<br>c) Prevalence of smoking among persons aged 18 years and over | a) PHOF 2.03 (data source: HSCIC)<br>b) PHOF 2.09i and 2.09ii (data source What About YOUth (WAY) Survey)<br>c) PHOF 2.14 (data source: Integrated Household Survey) | a) Quarterly<br>b) Annual<br>c) Annual |

| | | | | |
|---|---|---|---|---|
| | | % of people using outdoor space for exercise/health reasons | PHOF 1.16 (data source: Natural England: Monitor of Engagement with the Natural Environment (MENE) survey) | Annual |

**List of abbreviations:**

PHOF: Public Health outcomes Framework

NHSOF: NHS Outcomes Framework

ASCOF: Adult Social Care Outcomes Framework

PHE: Public Health England

HSCIC: Health and Social Care Information Centre

ONS: Office for National Statistics

CHIMAT: Child and Maternal Health Intelligence Network

FSHL: *Fair Society, Healthy Lives*

**Appendix 1: Draft strategy consultation timeline**

| | |
|---|---|
| 20 July* | Draft circulated to Health and Wellbeing Strategy Task and Finish Group |
| 27 July | Informal consultation with Rotherham Clinical Commissioning Group and Rotherham Together Partnership Chief Executive Officer Group |
| 3 August | Circulated to Health and Wellbeing Board and other partners for comments |
| 17 August | Discussed at RMBC Senior Leadership Team |
| 31 August | Draft discussed at Local Children's Safeguarding Board |
| 7 September | Draft discussed at advisory cabinet |
| 28 September | Final report signed off at Health and Wellbeing Board |

* all dates indicate week commencing