FINAL DRAFT V3.0

(Following February Place Board for March 2020 H&WBB)

Rotherham's Integrated Health and Social Care Place Plan

(incorporating our response to the NHS Long Term Plan)

2020-22

ROTHERHAM

INTEGRATED CARE PARTNERSHIP | HEALTH AND SOCIAL CARE

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1 Introduction

1.1 Rotherham Partners Commitment

The Rotherham's Health and Social Care Community has been working in a collaborative way for many years to transform the way it cares for and achieves a positive change for its population of 265,000. Our successful track record in developing and delivering new solutions makes Rotherham the perfect test bed for new innovations. We are passionate about providing the best possible services and outcomes for our population and are committed to a whole system partnership approach. Only through working together can we provide sustainable services over the long term that aim to help all Rotherham people live well for longer.

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

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

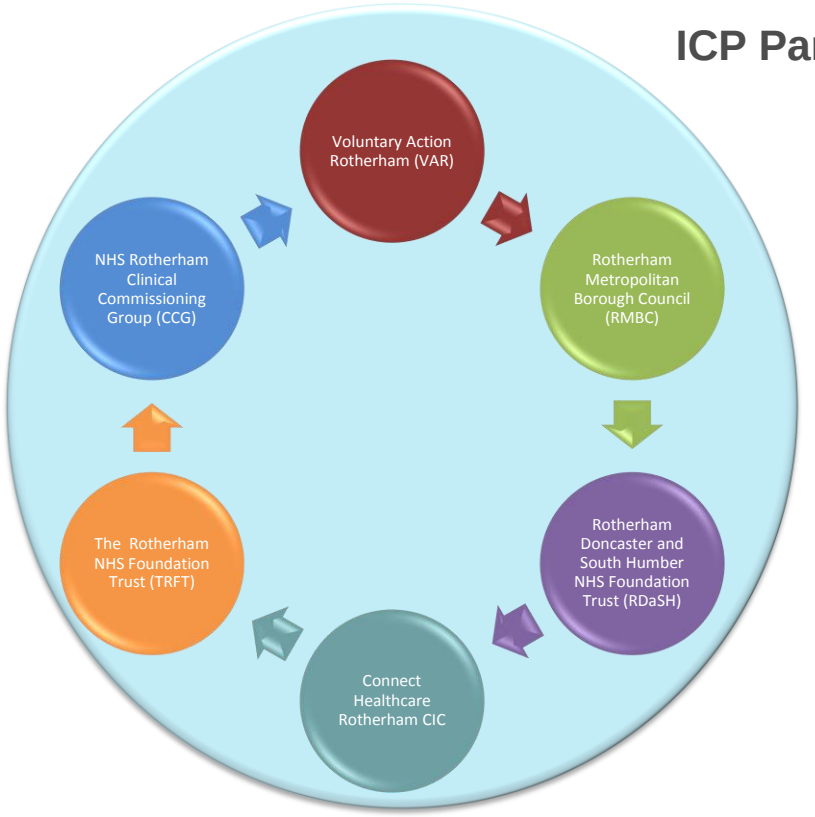
The first Rotherham Integrated Health and Social Care (IH&SC) Place Plan, was developed in November 2016. The Plan was refreshed in 2018, to ensure close alignment with the new Rotherham Health and Wellbeing Strategy. The 2020-22 Plan, this version, describes our achievements to date, future strategic intent and how the relationships between the health and social care community have continued to successfully mature to move us forward at pace.

The Plan is intended to work as a catalyst to deliver sustainable, effective and efficient health and care support and community services with significant improvements underpinned by collaborative working through the development of the Rotherham Integrated Care Partnership (ICP).

Partners are fully committed to working together to make decisions on a best for Rotherham basis to achieve the transformations set out in this Plan. This is underpinned by robust governance arrangements, including the Rotherham Agreement, a document that captures how we work together.

A further example is Rotherham's Thriving Neighbourhoods Strategy is clear evidence of all partners' commitment to putting communities at the heart of everything we do. It illustrates how our partners are working with communities and building on community assets to find local solutions to local problems and co-design integrated, personalised and flexible services.

ICP Partners



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1.2 Rotherham Culture and Leadership

Rotherham Place has a strong, experienced and cohesive executive leadership team who have set clear expectations and the spirit of collaboration and inclusiveness across the Rotherham ICP with the key aim of driving forward the transformation set out within this Plan. It sets a high standard of integrity amongst leaders across all partners, and a culture of empowering and engaging with all staff.

To realise our vision we want everyone who works or lives in Rotherham– patients, people, families – to work together for a better Rotherham, to establish an individual and collective widespread aspiration for improved health and social care.

The Rotherham culture means that staff are confident to challenge and change things to improve services for people, aligning to the vision and principles within this plan. A key strength in Rotherham is the trust and openness between partners and their commitment to the shared vision.

"Culture eats strategy for breakfast" is a well- known management phrase – we can create a first-class strategy, but the hard part is its implementation and achieving the goals it sets. This can only be done by winning the hearts and minds of our staff, through adapting to diverse approaches and styles and building mutual benefit. This updated Plan therefore focusses, quite rightly, on how we will support and develop the systems workforce.

As well as a shared vision, Rotherham partners have agreed a shared set of principles by which we work to achieve our vision for Rotherham:

1. Focus on people and places rather than organisations, pulling pathways together and integrating them around people's homes and localities; we will adopt a way of working which promotes continuous engagement with and involvement of local people to inform this.
2. Actively encourage prevention, self –management and early intervention to promote independence and support recovery, and be fair to ensure that all the people of Rotherham can have timely access to the support they require to retain independence.
3. Design pathways together and collaborate, agreeing how we do pathways once collectively, to make our current and future services work better.
4. Be innovative, using international evidence and proven best practice to shape our pathways to achieve the best outcomes for people in the most cost effective way.
5. Strive for the best quality services based on the outcomes we want within the resource available.
6. Be financially sustainable and this must be secured through our plans and pathway reform.
7. Align relevant health and social care budgets together so we can buy health, care and support services once for a place in a joined up way.

1.3 Rotherham successes

We are proud that through collaboration we have had significant success in moving forward the priorities, these include:

- **Rotherham Health Record (RHR)** is a single common interface for all users regardless of the setting where they work. It enables health and care workers to access patient information to make clinical decisions. RHR has been rolled out to all GP practices, social care, Rotherham Hospice and Rotherham Doncaster and South Humber NHS Trust.
- **Rotherham Health App** is a brand new service providing patients with online access to manage their healthcare. It is available 24/7, wherever you are, on desktop, tablet, or mobile devices.
- **Six Primary Care Networks (PCN**) have been established across Rotherham, each with an identified clinical director. PCNs seek to link staff from general practice, community – based services, hospitals, mental health services, social care and voluntary organisations to deliver joined-up care for populations of 30-50K.
- **Integrated Discharge Team (IDT)** – by working together across health and social care, the service will: improve patient experience, reduce delayed transfers of care (DTOC) and provide better value for money. The IDT has **won an HSJ value award.**
- **Re-design of Rotherham Intermediate Care day service** has taken place to form the Independent and Active at Home Service. The new service is delivered in patient's homes or local hubs, meaning any social activity is local and sustainable, where as

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previously it was delivered borough wide.

- **Primary Care Extended Access** has delivered 4 hubs across Rotherham, delivering significant numbers of appointments, **99%** of patients surveyed described their experience as good or very good.
- Significant progress has been achieved with **Child and Adolescent Mental Health Service** (CAMHS), extensive service change has led to substantial improvement in both assessment and treatment and waiting times.
- Rotherham was successful in its joint bid with Doncaster to pilot the national **CAMHS trailblazer,** the pilot is one of 25 nationally. In Rotherham we expect to see **8000** young people receive additional support in schools during the 2-year pilot and reduce our CAMHS waiting time to 4 weeks.
- Implementation of the **Core 24 service,** which is a 24/7 mental health crisis liaison. The full service went live in January 2019.
- Key progress has been made in implementation of the **Suicide Prevention Action Plan**, this includes securing NHS England funding, roll out of Safe-talk prevention training and small grants scheme.
- ***'Be The One'*** is a new campaign aimed at bringing down suicide rates in Rotherham. It aims to encourage people to talk, listen and care. It was launched on World Suicide Prevention Day 2019, and has since gathered more than 200,000 website hits and over one million social media impressions, as well as messages from people touched by suicide. (https://www.be-the-one.co.uk/)
- A clear strategy to improve the **Social Emotional Mental Health of Children and Young People** has been developed, including an action plan for implementation over the next few years. The **Special Educational Needs and Disability (SEND) Sufficiency Plan** and developments, both with a health and an education lens, is in place to help make joint commissioning decisions, for example, school placements, therapies, training.
- Launch of the **Five Ways to Wellbeing Campaign** took place in May 2018, with international interest in the Rotherham campaign video *(https://www.youtube.com/watch?v=jb5NqV2bqGI&feature=youtu.be)*
- Rotherham continues to be seen as a National Leader for **Social Prescribing.**
- The Rotherham **ICP Digital Strategy** was approved in November 2019, it sets out a three-year roadmap for digital services.

These achievements have been enabled through **clear leadership, outstanding relationships and wider partnership engagement and strong governance:**

- The ICP governance was developed and agreed by all place partners through a series of development sessions. The Place Board has met since June 2017, and in public since May 2018.
- The ICP weekly executive meeting has met since 2016, attended by all place chief executives, and other senior officers, strengthening the excellent relationships already in place and providing leadership and ambition for place transformation.
- Governance comprises of ICP Place Board, ICP Delivery Team, three Transformation Groups and six Enabling Groups. All are multi-agency, represented by all place partners, and all transformation groups have clinical representation.
- A Performance Report ensures that Place Board can monitor progress against the implementation of the Plan, it is produced quarterly and is received by the Health and Wellbeing Board.
- The Rotherham ICP Agreement was developed and approved by all partners. Based on a Memorandum of Understanding approach, it aims to provide an overarching arrangement to oversee the development of integrated multi-agency solutions for health, care and support across Rotherham.
- As well as a shared vision, Rotherham partners have agreed a shared set of principles by which they will work to achieve the vision for Rotherham.
- Internal Audit reviewed CCG Governance / Place Governance, with the outcome of significant assurance.
- The Local Government Authority (LGA) wrote a very positive case study on integrating health and social care in Rotherham.
- A key success is the joint focus on delivery, supporting place maturity, building trusting relationships and adopting new approaches to improving services leading to the creation of a range of joint roles, and the establishment of four system wide roles.

1.4 Plan on a Page

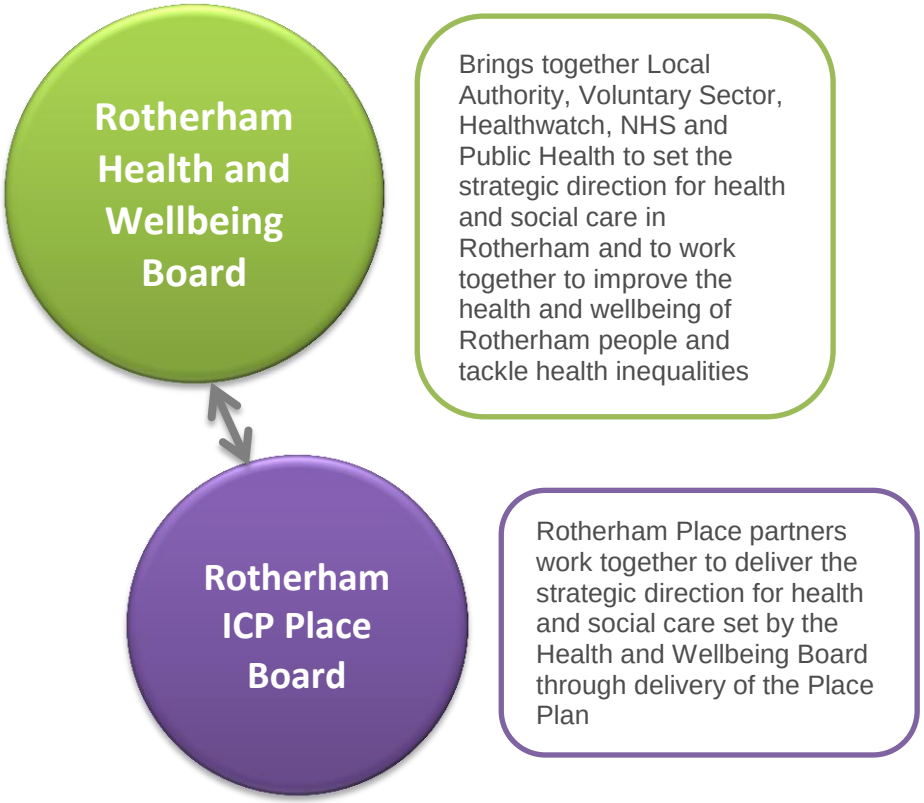
Vision	**Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery**						
Gaps	**Health and Wellbeing** *Be serious about prevention, improve healthy life expectancy, reduce the gap in health inequalities and support individuals to maintaining active and healthy lifestyles*		**Care and Quality** *Reshape care delivery, harness technology, drive down variations in quality and safety of care so patients' changing needs are met and unacceptable variations in outcomes stop*		**Finance and Efficiency** *Match funding levels with wide-ranging system efficiencies to avoid a combination of worse services, fewer staff, deficits and restrictions on new treatments*		
Challenges	Life expectancy is less than the England average by more than 1 year	Significant inequalities in life expectancy across Rotherham	Increase in hospital attendances and admissions	Increasing numbers of people with long term conditions and people living longer in poorer health	One in four adults experience a diagnosable mental health problem in any given year	Significantly more children affected by income deprivation, particularly in the most deprived areas	Significant joint financial challenge
Transformation	**Children and Young People**		**Mental Health, Learning Disability and Neurodevelopmental Care**		**Urgent and Community Care**		
Enablers	**Digital** (including Information Technology and Governance)	**Workforce Development** (including Organisational Development)	**Communications** (including Engagement)	**Estates** (including Housing)	**Finance**	**Prevention**	
Principles	Focus on people and places	Actively encourage prevention, self-management and early intervention	Design pathways together	Strive for best quality services based on best outcomes	Be financially sustainable	Jointly buy health, care and support services once for a place	
Partners	**Voluntary Action Rotherham (VAR)**	**Rotherham Metropolitan Borough Council (RMBC)**	**Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)**	**Connect Healthcare Rotherham CIC**	**The Rotherham NHS Foundation Trust (TRFT)**	**NHS Rotherham Clinical Commissioning Group (CCG)**	

Read from left to Right

2 Local Context

2.1 The Rotherham Plan

The Rotherham Plan provides a framework for partners' collective efforts to create a borough that is better for everyone who wants to live, work, invest or visit Rotherham. It sets out some of the big projects, or "game changers" that partners will be focusing on until 2025 and forms part of a bigger picture which includes a number of partnership boards, of which the Health and Wellbeing Board is one.



2.2 Rotherham Health and Wellbeing

The Health and Wellbeing (H&WB) Board is a statutory sub-committee of Rotherham Metropolitan Borough Council (RMBC). Locally, it is the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health and other services directly related to health and wellbeing. It aims to secure better health and wellbeing outcomes for the whole Rotherham population, better quality of care for all patients and care users and better value for the taxpayer.

The third H&WB Strategy for Rotherham was produced in March 2018, it sets the strategic vision for health and social care and improving health and wellbeing outcomes for local people. The role of the H&WB Board is to oversee its implementation and to take action where needed to remove blockages, identify gaps and to hold organisations, worksteams and strategy leads to account for delivery; ensuring opportunities for improving health and wellbeing are maximised.

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

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

There are a number of principles which underpin the aims f the H&WB Strategy. This includes focusing on reducing health inequalities by ensuring that the health of our most vulnerable communities, including those living in poverty and deprivation and those with mental health problems, learning or physical disabilities, is improving the fastest.

2.3 Rotherham Place

In 2018, the second Rotherham IH&SC Place Plan was refreshed so that it closely aligned to the revised H&WB Strategy and became the delivery mechanism for the health and social care elements of the H&WB Strategy. The 2020-22 Plan (this document) builds on the previous plans and takes into account the expectations set out in the NHS Long Term Plan.

The transformation approach has been to identify five closely interlinked transformational workstreams to maximise the value of our collective action and transform our health and care system so that we can reduce demand for acute services, achieve clinical and financial sustainability and thus close the three gaps (section 4.4). These five transformation workstreams align to the H&WB Strategy and will underpin its delivery.

The transformation workstreams will be taken forward through three transformation groups, and will report through the ICP Delivery Team to the ICP Place Board. Existing mechanisms have been used so as not to duplicate any work within the system, the three transformation groups are; Children and Young People, Mental Health and Learning Disabilities and Urgent and Community Care.

Each of the three transformation groups have agreed a set of priorities that they will take forward over the next two years. These priorities are areas that will make the most impact if addressed collectively across health and social care, and build on existing collaborative work. The transformation priorities are listed below and section 6 provides detail for each of these.

Our collective approach to Place Plan delivery allows a 'Golden Thread' from our 'Health and Well Being' strategy aims through to the transformation group delivery. We fully acknowledge that each of the transformation groups have identified priorities which cross cut between groups, we manage this through the ICP Delivery Team.

1. The First 1001 Days
2. Special Educational Needs and Disabilities
3. Looked After Children
4. Children and Young People's Mental Health and Emotional Wellbeing
5. Transitions to Adulthood

1. Improving Access to Psychological Therapies (IAPT) service
2. Dementia diagnosis and post-diagnostic support
3. Adult Severe Mental Illnesses (SMI) in the Community
4. Mental Health Crisis and Liaison
5. Suicide prevention
6. Better Mental Health for All, including loneliness
7. Improving residential, community and housing support for people with Mental Health and/or Learning disability
8. Delivering the NHS Long Term Plan for people with a learning disabilities and / or autism (this includes Transforming Care)
9. Delivery of My Front Door transformation programme
10. Delivery of Autism Strategy and Neurological Pathway

1. Integration of the Points of Contact across Rotherham
2. Implementation of the Intermediate Care and Reablement reconfiguration.
3. Development of a coordinated approach to care homes support

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To support delivery of our Plan we have also identified enabling workstreams for; Finance, Communication and Engagement, Workforce and Organisational Development, Estates and Digital. Each enabling workstream meets as a group on a monthly basis, and reports to Place Board twice per year.

However, we strongly recognise that underpinning our work is prevention, and the NHS Long Term Plan crystallises this. In the coming years we anticipate growing pressures across a range of services. This will include not only health and social care but also supported housing, informal care and other services. As a result we are establishing a sixth enabling group for Prevention, this will report directly to the H&WB Board and secondary to the Place Board.

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2.4 South Yorkshire and Bassetlaw Integrated Care System

The Integrated Care System (ICS) is a partnership of 23 organisations responsible for looking after the health and care of the 1.5 million people living in Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. It is made up of NHS organisations who consult with Local Authorities and key voluntary sector and independent partners in the region. Through working together, it was chosen by NHS England as one of the first areas of the country to become an Integrated Care System.

An ICS is another way of describing the local ambition, supported by our patients and staff, to ensure health and care services are the best they can possibly be. Working together in this way enables better joined up primary and secondary care services, physical and mental healthcare, social care and gives patients the seamless care they have told us they want.

Through partnership working, real and long lasting improvements can be made to the health of local people that would never be achieved working in isolation. The goal is for everyone in South Yorkshire and Bassetlaw to have a great start in life, with the support they need to stay healthy and live longer.

An ICS ensures that the most pressing needs within the health system are met and that health resources are used without duplication or waste. The primary role of ICS is to establish planning and management functions for responding partners to work in a coordinated and systematic approach.

A key focus for the ICS has been an independent hospital services review, which was set up to review the sustainability of some acute services across SYB (as well as in two providers outside the ICS). The outcomes of the review will require health providers involved to work in different ways, acting as 'one system', and driving greater collaboration between commissioners. The ICS has also made a decision to

reconfigure hyper acute stroke services across SYB, the implementation of which is now under way.

The independent hospital services review objective, set against a background of financial pressures and challenges in quality and performance, was to identify a delivery model (or models) that would secure the sustainability of five acute services across the hospitals:

- urgent and emergency care
- maternity
- care of the acutely ill child
- gastroenterology and endoscopy
- stroke

The review produced a final report in May 2018. This included a key recommendation that the hospitals develop 'networks of care' in each of the service areas, with a different hospital taking responsibility for each.

2.4.1 Networked Hospital Services

A number of services are facing challenges particularly in terms of rising demand, national shortages of certain professional roles and the changing ways in which healthcare is being delivered (confirmed through the Hospital Services Review (HSR), published in May 2018). To address these challenges, it will be essential that Trusts work even more closely together, in a variety of different ways. This includes the development of "hosted networks".

Each of the Acute Trusts in South Yorkshire and Bassetlaw have agreed to be the 'host' to lead a network for one of the five priority services identified in the HSR. The Rotherham NHS Foundation Trust will be the host Trust for Maternity services.

A Clinical Lead is currently being appointed for this Hosted Network and, once in position, will develop the network priorities alongside fellow clinicians, nurses, other professionals, and leaders from across the Trusts.

The role of the host is to coordinate the running of the Network. It is a supportive role, providing leadership through convening and facilitating shared working between the Trusts. The emphasis is on collaboration between organisations and matches the ambitions of the NHS Long Term Plan.

The greatest benefits will initially come from system wide co-design of functions covering workforce, reducing unwarranted variation and innovation. This should support improved sustainability, consistency of standard of service and clinical practice, and retaining our skilled workforce.

2.5 National Expectations

The NHS Five Year Forward View set out a clear goal that *"the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care".* It placed integrated, holistic person-centred support at the heart of health and care systems, breaking down barriers to the traditional divides, further developing out of hospital services and fostering community resilience. With the aim that people and families can be better supported, services provided closer to home and demand for hospital services can be reduced.

The Five Year Forward View identified three widening gaps; health and wellbeing, care and quality and finance and efficiency. These gaps resonate with the challenges faced at a Rotherham Place level, see section 4.3.

The NHS Long Term Plan builds on the policy platform laid out in the *NHS five year forward view* which articulated the need to integrate care to meet the needs of a changing population. This was followed by subsidiary strategies, covering general practice, cancer, mental health and maternity services.

In June 2018, the Prime Minister announced a new five-year funding settlement for the NHS: a 3.4 per cent average real-terms annual increase in NHS England's budget between 2019/20 and 2023/24 (a £20.5 billion increase over the period). To unlock this funding, national NHS bodies were asked to develop a long-term plan for the service.

The resulting document, the *NHS long-term plan*, was published on 7 January 2019, in summary:

- **Chapter1** - sets out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting.
- **Chapter 2** - sets out new, funded, action the NHS will take to strengthen its contribution to prevention and health inequalities.
- **Chapter 3** - sets the NHS's priorities for care quality and outcomes improvement for the decade ahead.
- **Chapter 4** - sets out how current workforce pressures will be tackled, and staff supported.
- **Chapter 5** - sets out a wide-ranging and funded programme to upgrade technology and digitally enabled care across the NHS.
- **Chapter 6** - sets out how the 3.4% five year NHS funding settlement will help put the NHS back onto a sustainable financial path.
- **Chapter 7** - explains next steps in implementing the Long Term Plan.

Adult Social Care - *The Care Act 2014* sets out in one place, local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support.

Under the Care Act 2014, local authorities must:

- carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care
- focus the assessment on the person's needs and how they impact on their wellbeing, and the outcomes they want to achieve
- involve the person in the assessment and, where appropriate, their carer or someone else they nominate
- provide access to an independent advocate to support the person's involvement in the assessment if required
- consider other things besides care services that can contribute to the desired outcomes (e.g. preventive services, community support)
- use the new national minimum threshold to judge eligibility for publicly funded care and support.

The Place Plan takes into account these national drivers and will continue to drive integrated working across health and social care in Rotherham.

2.6 How this plan was developed

Rotherham's Place Plan details our joined up approach to delivering key initiatives that will help achieve the Rotherham Health and Wellbeing Strategy. All services should be provided as close to the patient as possible, the only reason for services being provided outside Rotherham is where there is a compelling reason of clinical safety or improved patient experience. Providing the right care in the right place will mean that more people will receive care closer to their home. The development of the Place Plan is a joint collaboration with representatives from key stakeholders across Rotherham's health and social care services.

The Place Plan does not replace partners' individual plans but rather builds upon them identifying areas where we can do more together. It uses insights from the H&WB Strategy and the JSNA, and takes account of other key relevant documents, both local and national.

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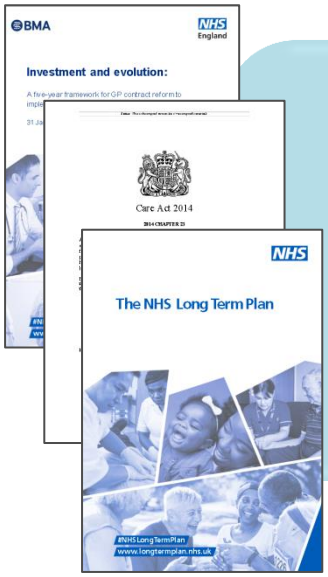
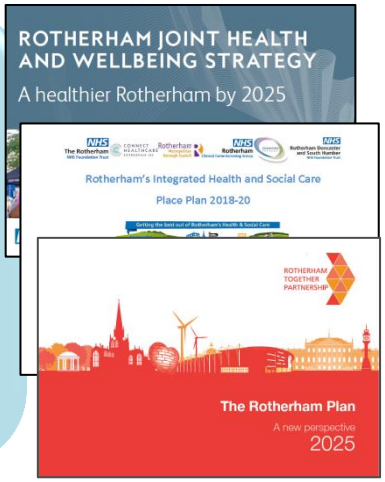


National

- NHS Mandate to NHS England (revised) 2018-19
- Five Year Forward View (2014), Implementing FYFV (2016), Delivering the FYFV (2015) and Next Steps FYFV (2017)
- Five Year Forward View for Mental Health (2016)
- General Practice Forward View (2016)
- NHS Long Term Plan (2019), Interim People Plan, NHS Mental Health Implementation Plan

Local

- The Rotherham Plan 2018
- Rotherham Health and Wellbeing Strategy (2018)
- Rotherham Health and Social Care Place Plan (2018)
- South Yorkshire and Bassetlaw ICS Plan (2019)
- NHS Rotherham CCG Commissioning Plan 2018-20
- Rotherham Strategy for Primary Care 2019



3 Achieving Our Aspirations

3.1 Rotherham – an overview

A Rotherham pen-picture:

Geography

- Rotherham is a borough covering 110 square miles
- The population of 264,700 is estimated to be growing by about 1,200 annually, mostly living in urban areas, equating to 108 thousand households
- It is also made up of many towns, villages and suburbs which form a wide range of geographic communities
- Rotherham has a wealth of green space across the borough, in the form of country and urban parks, nature reserves, woodlands and playing fields. Although used well in some areas, others offer an often untapped resource within communities

Age structure

- The local age structure is slightly older than the national average, with a lower proportion of those aged 16-44 but a higher proportion of those aged 45-74, and noticeably fewer aged 18-24 reflecting students moving away
- The number of people aged over 85 is expected to increase by 33% between 2018 and 2028
- Of the 264,700 population there are 51,300 children aged 0-15 and 25,900 young people aged 16-24 (MYE 2018)

Deprivation

- The links between poverty and poor health outcomes are well established
- 57,600 people (22%) live in areas that are amongst the most deprived 10% in England
- Universal Credit roll out began in Rotherham in July 2018 and is estimated to have a significant impact
- 12,543 children live in poverty (21.5%, latest data from HMRC 2016), with 10,700 in workless families
- At ward level child poverty (2015 data) ranges from 9% in Sitwell to 45% in Rotherham East, 33% in Rotherham West and 36% in Valley

- Based on data published in the End Child Poverty 2018 Report, all age poverty was estimated at 18.6% (49,000) based on absolute low income

Ethnicity

- Rotherham's Black, Asian and minority ethnic (BAME) population is relatively low (8.1% in 2011) when compared to the national average (13% in 2011), though this is estimated to have increased by at least 10% since census data
- The largest of these communities are Pakistani/Kashmiri and Slovak/Czech Roma

Physical Activity

- There is evidence to suggest access to green space has a beneficial impact on physical and mental wellbeing; yet modelled survey data suggests only 13.5% of people locally use outdoor space for exercise or health reasons
- The percentage of adults walking (15.3%) or cycling (0.6%) for travel at least 3 days per week are both significantly lower than the England averages (23.1% and 3.2%) (2017/18 data)
- The increasing use of private cars affects congestion and air quality, in addition to the missed opportunities and benefits of physical activity. Encouraging active travel would help improve health and reduce the particulate air pollution which is estimated to cause around 4% of deaths locally

Education

- Rotherham has 95 primary schools, 16 secondary schools and 6 special schools
- GCSE performance is similar to the national average and has risen in 2019, but the performance of children from Rotherham's poorest families compares unfavourably with the national averages on many educational attainment measures
- The percentage of 16-17 year olds not in education, employment or training (5.9%) is similar to the England average (6%)
- The rate of Looked After Children (LAC) is significantly higher than the national average
- The percentage of children achieving a good level of development at the end of reception (school readiness) 73.1% is higher than the England average (71.5%).
- Pupil absence rates (5.1%) are higher than the England average (4.8%).

Voluntary Sector

- The borough benefits from a vibrant Voluntary and Community Sector (VCS), comprising almost 1,400 organisations with 3,600 staff and around 49,000 volunteer roles
- In 2015 it was estimated by Sheffield Hallam University that the paid VCS workforce contributed £99m to the economy per annum and that volunteers provide approximately 85,000 hours of time per week

Carers

- Carers make a significant contribution to family support for those in ill health or with disabilities
- 8,772 people (aged 16-65) in Rotherham are entitled to Carers Allowance with 6,042 receiving the payment due to their role as a carer
- Cohesive communities and good social links support mental health and resilience, but the percentage of those who have 'as much social contact as they would like' is 46.0% for adult social care users and 36.3% for adult carers, however this is comparable with the national average

Economy

- Rotherham has a fast growing economy with jobs being created to meet identified needs and local employment levels at a historically high rate, close to the UK average
- 70 businesses signed up as Rotherham pioneers; McLaren signed a 20 year deal to be based at the Advanced Manufacturing Park
- Rotherham's employment rate has risen recently then fallen again (71.8% in Rotherham and 75.6% nationally in March 2019)
- There are 104,400 jobs in Rotherham, an increase of 11.4% since 2011. However, whilst employment rates are improving, the gap is increasing for vulnerable groups, such as those with learning disabilities or in contact with secondary mental health services
- Earnings in Rotherham are lower than both the regional and national average; in 2018 the weekly average salary was 86% of the national average

- Working-age people in Rotherham are more likely to work in lower skilled occupations (process plant and machine operatives, elementary occupations) and less likely to be employed in higher skilled occupations (managerial, professional and technical roles)
- The Annual Population Survey shows that 17,700 people in Rotherham were either unemployed or long-term sick in 2018/19, which is 11% of the working population (16-64) and above the England average of 8%
- Significant redevelopment has included the University Centre Rotherham, bus interchange and the internationally recognised Advanced Manufacturing Park, with more planned as part of the agreed Town Centre Masterplan

Housing

- House prices have risen significantly – 17% over 5 years but income (gross weekly pay) has only increased 10% over the equivalent period of time.
- The average income is below national average and the average house price (£151,400) is 4:5 times the average income level, pricing a large proportion of the population out of home ownership and leaving them reliant on social or private rented housing.
- 10.1% of homes across Rotherham are in fuel poverty (2017 data released in 2019), this is just below the national average of 10.9% and is the lowest level since 2013. However when considered on a ward basis, some areas are as high as 27.5%.
- The percentages of adults with learning disabilities or in contact with secondary mental health services that live in stable and appropriate accommodation are better than the England average
- Poor quality housing, a contributor to excess winter deaths, is an issue for Rotherham particularly in the private sector, where 7% are in a state of disrepair, this increases to 10% in the private rented sector. 13% of private sector are estimated to have some level of health and safety risk under the Housing Health and Safety Rating Standard (HHSRS) this increased to 16% in the private rented sector. 4.2% have an Energy Performance Certificate (EPC) rating below band E. 20% of the boroughs private sector households are classed as low income, with 11% estimated to be in fuel poverty.
- The Strategic Housing Market Assessment estimates between 550-650 new homes are needed annually to keep up with population and demographic change. It also highlighted increasing affordability issues and suggests 716 affordable homes are required to ensure people are adequately housed in homes that meet their needs and that they can afford to run.
- An Action Plan has been developed in response to the Government's Housing Delivery Test, to ensure Rotherham increases its delivery to the levels recommended. Since the Local Plan Sites and Policies Document of June 2018; the Council has granted permission for over 1,500 new homes, with a further 1,000 in the pipeline to be determined in coming months, which will contribute towards the shortfall. The Council has also directly delivered over 230 new homes through its new build programme over the last five years, many of which meet the needs of older residents or households with a disabled family member.
- The Council manages just over 20,000 homes for social rent, all of which continue to meet the national decency standard.

Local **health and social care** services:

30+ nursing/residential homes	**One lead body for voluntary and community sector groups**	**6 Primary Care Networks/ 30 GP practices**
One local authority	**261,000 population**	**One Clinical Commissioning Group**
One hospital (acute and community health services)		**One GP Federation**
One ambulance provider	**One mental health provider**	**One Hospice**

3.2 Rotherham's population - health and wellbeing

The Rotherham Joint Strategic Needs Assessment (JSNA) has been re-designed and this refreshed JSNA sets out more clearly the range of data which informs how health and wellbeing in Rotherham is influenced by a wide range of factors. Local profiles help to describe the differences within Rotherham, as well as contextualise Rotherham in comparison to our nearest neighbours, and the regional and national picture. The JSNA will help to inform strategic direction and highlight recommendations for action.

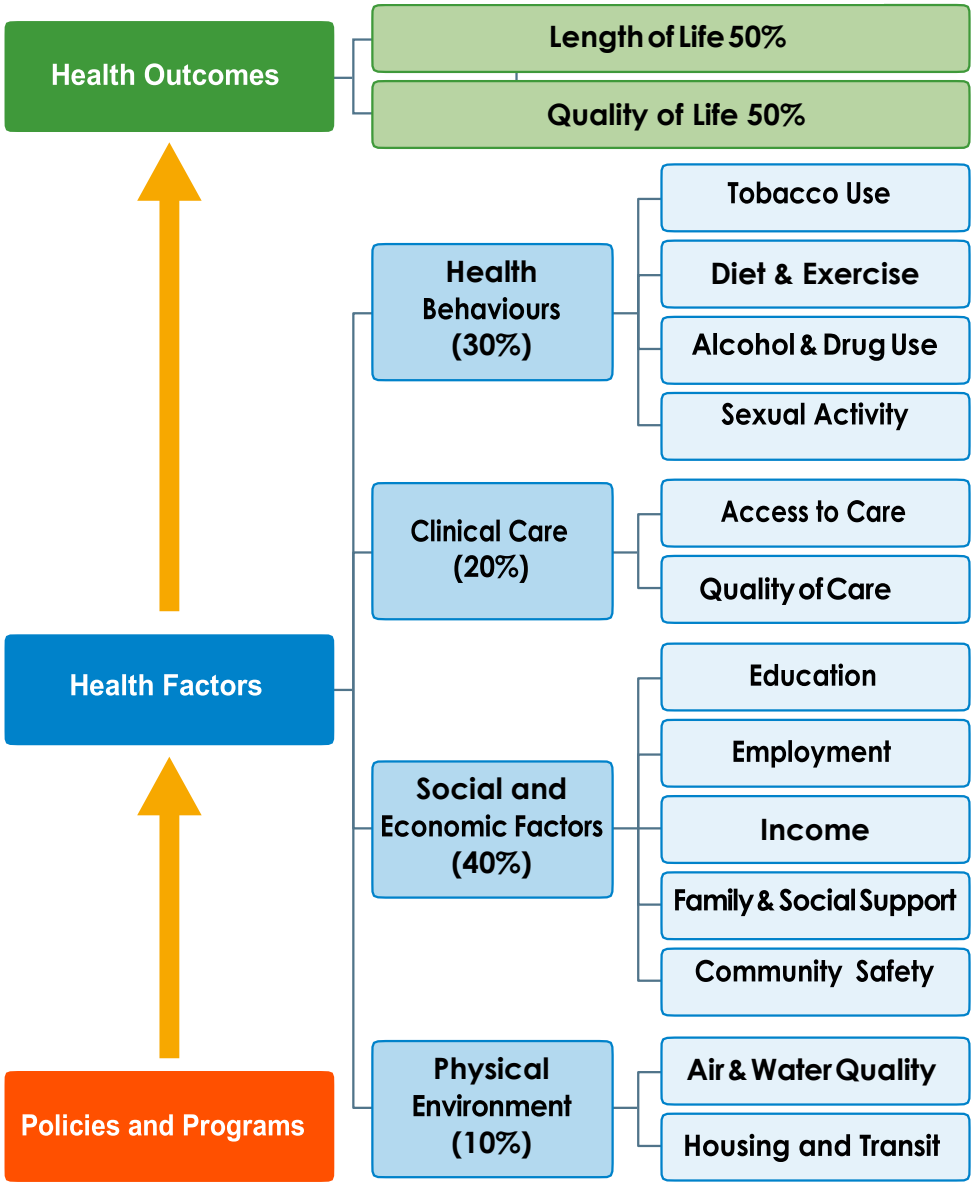
Peoples experience of health and wellbeing is influenced by more than health and care services. There are stark differences in the life expectancy of people living in the best and worst off parts of the borough, with a difference in life expectancy of up to 10.8 years. The single biggest cause of ill health and health inequalities are socio-economic factors such as education, employment and income, as well as family and social support networks available to people and the physical environment, housing, transport and access to green spaces.

The following diagram demonstrates the things that can impact on people's ability to live a healthy life and the strength of association between these health factors and health outcomes. Healthcare is only responsible for a fifth of people's health outcomes, though with greater attention to inequalities around services this could be increased. Addressing health behaviours, partly through lifestyle interventions but also through changing social norms, the availability and cost of tobacco and alcohol, etc will make a bigger difference.

The greatest improvements in population health will be gained through addressing the social and economic determinants of health, which will need concerted partnership action. Not only will this make a difference to life expectancy but it will also improve people's quality of life.

(County Health Rankings Model 2016: https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model)

The Causes of poor health and wellbeing



This table shows some of the **significant challenges** for Rotherham as shown in the JSNA.

The health of people in Rotherham is generally poorer than the England average	Life expectancy in Rotherham is lower compared to the national average by 1.8 years for males and 1.4 years for females (2015-17)	The gap in life expectancy between the most and least deprived parts of Rotherham for males is 10.8 years and females is 8.4 years	Deprivation in Rotherham is amongst the highest 20% in England, 45% of the population live in one of the 30% most deprived SOAs in England	10.2% of 4-5 year olds and 23.6% of 10-11 year olds are obese, this is significantly above the national average	The rate of hospital admissions for dental extraction in children aged 0-5 years in Rotherham is one of the highest in the country	Above average overall rate of hospital admissions for alcohol-related conditions but a below average rate of under 18s being admitted to hospital.
In older people aged 65 and over, hip fracture rates are in line with the national average, though there are significantly higher hospital admissions due to falls in those over 80 years.	Mental health problems affect one in four people at some point each year	An estimated 18.9% of Rotherham adults smoke, above the national average of 14.4%, smoking related hospital admissions are 42% above average.	The number of older people is increasing, and people will live longer with poorer health On average, men will spend 24% of their life in poor health and women 30%.	The percentage of adults walking (15.3%) or cycling (0.6%) for travel at least 3 days per week are both significantly lower than the England averages (23.1% and 3.2%)	Despite local actions Rotherham's suicide rate is significantly higher than England and one of the highest in the country. However, the most recent data showed a good decrease	The gap in employment rates between vulnerable groups and the rest of the population is increasing, such as for those in contact with secondary mental health services.
Depression prevalence (14.3%) is significantly higher than England. An estimated 18.6% of 16+ have a common mental health disorder and 10.9% of 18+ have a long term mental health problem, (both higher than England average)	GCSE performance in 2019 of children from Rotherham's poorest families compares unfavourably with the national averages on many educational attainment measures	From national survey data, Rotherham has significantly higher rates of self-reported low satisfaction, low happiness and high anxiety	17.9% of mothers smoke during pregnancy contributing to increased risk of stillbirth, low birth weight and neonatal deaths	5.9% of 16-17year olds in Rotherham are not in employment, education or training (or activity not known), same as the 6.0% nationally	30% of the Rotherham population are estimated to drink at a level that puts their health at risk (14 units per week) and the rate of alcohol-related harm hospital stays is worse than the average for England	There are about 6,550 Potential Years of Life Lost each year in Rotherham through causes considered amenable to healthcare, this is around 1,400 years more than might be expected based on the England average
Early deaths from cancer, heart disease and stroke have fallen, but remain worse than the England average	Significantly more Rotherham children are affected by income deprivation 24.3%, compared to 19.9% nationally.(ID 2015)This rises to 50% for children living in the most deprived areas	Rotherham's breastfeeding initiation rate is amongst the lowest in the region at 56.0%, contributing to levels of childhood obesity and paediatric hospital admissions	Premature respiratory mortality rates are relatively unchanged and liver disease mortality rates have increased	9.4% of working age people in Rotherham are claiming long term sickness or disability-related benefits	Half of people aged 75 years and over live alone and most experience loneliness, especially those who are widowed	Almost 500 smoking related deaths each year in Rotherham – 30% higher rate than the England average

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It is good to highlight that whilst we have significant challenges we also have **significant successes**:

- Jobs are being created in Rotherham to meet identified needs and the local employment rate has risen significantly, now almost matching the national figure; gross value added (GVA) growth is predicted to rise from £4.3 billion in 2017 to £4.8 billion in 2028.
- Childhood vaccination rates in Rotherham are generally good, but there are certain population groups where rates are not as high
- Two year-old early education take-up in Rotherham has shown a continued increase and is above the national average of 72% as at January 2019.
- At Key Stage 5, the Rotherham 'A' Level or equivalent pass rate (A*- E grades) was 99.0% in 2019, which is 1.4% above the national pass rate of 97.6% (as reported on the BBC)
- Rotherham special schools are all judged good or outstanding by OFSTED; the percentage of pupils with SEND support achieving a good level of development in Rotherham has increased in 2019 and is 8.2% above their national average counterparts.
- Primary and secondary attendance figures have increased in 2019, persistent absence figures have decreased in 2019, and the overall rate of primary and secondary fixed term exclusions has decreased in 2019.
- The rate of under 18 conceptions in the borough has more than halved in the last 10 years although still above the England average.
- More people are having routine vaccinations and cancer screening in Rotherham than the national average.
- The percentage of obese adults has fallen recently (from 71.2% to 62.7%) bringing Rotherham in line with the England average, though poor diet and lack of physical activity will hinder further improvement.
- Mortality rates have reduced over the long-term (since 2001-03), including infant mortality (below England for 2016-18), mortality from causes considered preventable and premature deaths from cardiovascular disease and cancer.
- Cancer screening uptake rates are significantly higher in Rotherham compared to England for breast cancer, cervical cancer and bowel cancer. Abdominal aortic aneurysm screening is in line with the national average.
- Dementia diagnosis rates are significantly better than nationally; it is estimated that 85.5% of those with dementia who are aged 65+ years have been diagnosed.
- The number of people newly diagnosed with a sexually transmitted infection is below the national average

3.3 The Case for Change

The JSNA clearly tells us that we have significant challenges to address. In the coming years we anticipate growing pressures across a range of services. This will include not only health and social care but also supported housing, informal care and other services. We expect these pressures because of a range of factors as described in the table above.

We still, however, all want health and care services that can meet our needs now and in the future. Rotherham partners aim to offer safe, compassionate and high-quality care, however, the challenges we face mean that we need to change the way we work to improve care and get better value for the resources we have available.

As our population grows, and more people live with more long-term conditions, the demands on our services are changing and increasing. Current services are not necessarily designed for todays or future needs, and it is increasingly harder to keep up with rising costs.

In the past 10 years, the number of people aged 65 and over in England has increased by 1.4 million, a 17% rise and the number of people reaching their 80th birthday. These people are more likely to be living with complicated conditions that mean they need support. We need to make the most of opportunities to improve health and wellbeing, prevent illness and support people to manage existing conditions and stay independent.

Rotherham partners have come together to commission and provide services. By working together we can transform the way we work and further improve the health and wellbeing of our population and at pace.

Our vision is to put local people at the heart of services, helping people to stay well and independent in their own homes and communities and avoid being admitted to hospital, we want to:

- improve the health and wellbeing of local people
- deliver high-quality, joined-up health and social care
- offer access to the right care and support in the right place, at the right time
- ensure staff are able to continue to deliver the caring ethos of the NHS and social care
- better meet people's needs within existing funding
- build health and care services that are sustainable for years to come

The Five Year Forward View identified three widening gaps; health and wellbeing, care and quality and finance and efficiency. These gaps resonate at a local level, as described at section 4.3.1 to 4.3.3. The transformation workstreams we have identified - children and young people, mental health, learning disabilities, urgent and emergency care - aim to address both the challenges for Rotherham and close these three gaps.

3.3.1 Better Health and Wellbeing

A major cause of ill health and premature death is due to diseases that could be prevented by living healthier lives. We aim to get serious about prevention, improve healthy life expectancy and reduce the gap in health inequalities and support individuals to maintain active and healthy lifestyles.

We want health and care to be managed long before someone needs to have hospital treatment or experiences problems in their life. We want to do this in a way that is right for them, whether this is through providing information and advice, or through more active management.

We want a culture in Rotherham where people feel empowered to be part of the decisions around their care and support, to maintain dignity and independence and drive their own care.

We will better meet the needs of local people by targeting individuals that can gain most benefit. We will do this through expanding our Social Prescribing service both for those at risk of hospitalisation and for mental health clients and through continued systematic use of Healthy Conversations (brief interventions) and advice by every statutory organisation using Making Every Contact Count (MECC) and Five Ways to Wellbeing. We will train front-line staff to talk about sensitive issues such as loneliness, suicide, alcohol use, healthy eating habits, increasing physical activity, mental wellbeing and quitting smoking. We will also ensure quick and easy referral to evidence based lifestyle services (e.g. treatment of tobacco dependence) to support those that are ready to change and in a way that is right for them.

In section 9 we detail further transformation priorities that will help us to achieve our aspirations for improved health and wellbeing for our population. These initiatives will allow us to better support individuals to make positive, sustained lifestyle changes by adopting a person-centred and a whole community approach to improving health and well-being.

3.3.2 Better Standards of Care and Quality

There are variations in the quality of care received and differences in how services are delivered and the outcomes received. We aim to work together to reshape care delivery, harness technology, drive down unwarranted variations in quality and safety of care so patients' changing needs are met and unacceptable variations in outcomes stop.

We want health and care services that provide people with an alternative to entering services or having a hospital admission. We want to continue to support increased community care to improve patient outcomes, improve flow through the system and provide effective facilitated discharge, with a 'Home is Best' ethos.

We will continue to build on the progress so far, taking a more holistic and integrated approach across physical and mental health, social care and the voluntary and community sector in order to develop and embed an integrated model of care which supports individuals and their carers. We will use new technology to support the delivery of our key priorities and use Population Health Management to understand current and future health and care needs so we can better tailor care and support and design more joined up and sustainable services.

In section 9 we detail further transformation priorities that will help us to achieve our aspirations for improved standards of care and quality for our population. These initiatives will increase quality and standards across the health and social care system, reduce inappropriate hospital admissions and reduce waiting times. We aim to provide equitable services to meet the needs of our population.

3.3.3 Better use of funds (spending the Rotherham £)

The forecast is for an inevitable continued growth in demand for services, largely from our growing and aging population.

We aim to manage demand by supporting people to be healthy, increase productivity and efficiency to maximise available resources and redesign services to develop new ways of delivering joined up care. By matching funding levels with wide-ranging system efficiencies we will avoid a combination of deteriorating services, fewer staff, deficits and restrictions on new treatments.

In Rotherham we collectively spend in the order of £650m on Health and Adult Social Care and Children's Services.

System partners fully acknowledge that they are jointly responsible for ensuring the effective use of the available financial resource within the Rotherham place. Place based thinking and new ways of working will continue to take us beyond existing organisational boundaries for both the commissioning and delivery of provision. As we mature into our place base culture of working, unsurprisingly, we will increasingly make transparent financial decisions that not only support individual partners to be sustainable, but consider the impact on the wider place position.

Our commitment to working in partnership to best utilise the Rotherham pound is strong. However we cannot underestimate the on-going significant financial challenge facing individual place partners within our system:

- The **CCG**, although forecasting financial balance in the current year, has identified an efficiency requirement in the range of £10m to £12m per annum over the next five years.

- Through prudent financial management, **RMBC** has delivered balanced financial outturns over the last three years, whilst continuing to deal with significant social care pressures and year on year reductions in Government funding. The Council's two-year budget for 2019/20 and 2020/21 requires delivery of a further £30m savings alongside driving transformational change in service delivery across the Council. Expectations are that the Council will maintain a balanced budget outturn for the current financial year.

- **TRFT** is operating to a financial plan of breakeven in 2019/20. This includes £14.8m of Provider Sustainability and Financial Recovery Funding. This funding is only received on delivery of the quarterly financial targets.

  At the end of November, the Trust is £0.5m adverse to plan reflecting activity/acuity pressures impacting on increased workforce costs. The Trust is still forecasting delivery of its financial plan though with risks around workforce and winter pressures.

- **RDaSH** is operating to a breakeven position and if achieved will receive £1.2m of Provider Sustainability Funding.

As at the end of December 2019, RDaSH is on plan to meet its break even duty overall as a Trust. The Trust is experiencing a significant 20% overspend against its agency staff cap and this is driving a number of cost pressures in operational services. In addition the Trust is forecasting an underachievement against its internal cost improvement programme. This will amount to a cost pressure of £1.8m in 2019/20 equivalent to 32% of the overall cost improvement challenge. This pressure will have to be carried forward into 2020/21 and delivered in that financial year to ensure overall financial stability is maintained.

Given the respective financial positions of partners, we will need to continue to make difficult financial decisions within our Rotherham Place. Of increasing importance is that we do this wherever possible collectively, ensuring that we mitigate any impact on other place partners.

4 Enabling Workstreams

4.1 Workforce Development

Our workforce and communities are key to delivering the Rotherham Integrated Health and Social Care vision and bringing the "Place" to life. To realise this we need to encourage and support our workforce to think innovatively to help to create a future model of service provision that puts the Rotherham people at the very heart of everything we do. We need to actively engage with the population of Rotherham to empower them to be dynamically involved in maintaining and supporting their physical, mental and social health, thus ensuring that communities are confident to be self sufficient and know how to access the right support and service at the right time to meet their needs

Our workforce is our most unique and valuable asset but also our biggest challenge due to changing needs and requirements of the population we serve. Robust systems and processes are being cultivated to secure and develop the current and future workforce, including embracing alternative workforce solutions by creating unique opportunities to introduce cross organisational posts to allow a more efficient and seamless service for users.

Place partners are committed to investing in our workforce; ensuring that there is a skilled, experienced and motivated workforce working within the right environment and demonstrating the right behaviours that are vital for delivery. This incorporates adapting roles to allow us to achieve our place plan objectives, in conjunction with organisational development to change behaviours and cultures, fostering a culture of honesty and transparency which transcends across all levels within all partners.

As our Place base working matures, aligns and integrates our systems and structures, we recognise there is a stronger need to focus on our workforce. To develop this further we need to be proactive in changing ideas and concepts regarding workforce at all levels across our place , which in turn will change our culture towards one of 'Place first, organisation second'.
With the ethos of "Place first, organisation second" there are five key points which are interwoven within our plans:

- Making the Place the best place to work
- Improving leadership capability
- Tackling the workforce challenge
- Delivering 21st Century Care
- New operating model for workforce

An assets and strengths based framework needs to be developed and embedded to allow for collaborative working; a more engaged workforce and population ensures increased productivity and effective working which ultimately results in high quality care delivery. Mapping population health to enable the workforce to develop is essential in ensuring the right skill mix and appraised training takes place to meet the needs of the changing population, which, combined with an engaged population, who are actively encouraged to participate in their own health and wellbeing, will result in greater choice and control. This multifaceted approach will contribute towards individual personalised support and care planning according to individual needs, ensuring that

the population are empowered to take control and ownership of all elements of their health and wellbeing and have the appraised support of a mature and developed workforce.

Organisational Development

As a place we have agreed that we need to adopt one framework for organisational development across all partners. The model of choice is the Burke-Lit win model.

The model identifies that change is influenced from environmental factors not just organisational factors and by embracing these concepts within the 'Rotherham Place' we can develop and deliver positive change across all partner organisations, acknowledging that these different factors influence and direct changes. A skilled and experienced workforce, working within the right environment and culture is key to delivery. Eight parts of the identified framework have been focused upon to create and define appropriate systems, including where we place emphasis on the local community development to improve population engagement with health and social care services which will ultimately improve population health. Opportunities for improvement have been identified below:

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

The changing workforce

Rotherham as a Place needs to be the employer of choice, ensuring that recruitment and retention is effective in a very competitive employment market. This includes being a flexible employer, tackling bullying and harassment and having an inclusive and compassionate culture. Effective inclusive leadership is fundamental in developing and changing culture. Leadership needs to be developed as a priority to create a culture that focuses on people, inspiring and motivating the workforce to be committed and engaged in working more effectively and efficiently to provide high quality care across partner organisations.

Our workforce across the Place is changing both in terms of the people who work within it and the way in which we, as partners, manage and develop our workforce to ensure we deliver the best service we can to our communities. We need to empower our population and communities to take ownership of all aspects of their health, developing an assets and strengths based framework which supports and enables this.

Workforce shortages are significant across every workforce group with vacancies and a lack of stability across a number of key professions. There is a definitive need to ensure that as a Place we develop a talent pipeline that feeds the workforce. This needs to be sustainable and meet the demands of the changing population. This will include effective recruitment and retention processes and ensuring that there is an effective adaptive skill mix model which has strong links with social care to enhance the wellbeing of communities. To realise this ambition there is a need to transform the workforce through the introduction of new roles covering areas such as data, science and digital skills.

A key challenge across the Place is to ensure that there are the right number of staff with the right skills in the right place to meet the population's needs. The long term plan is clear that local health and care organisations need to work with Integrated Care Systems (ICS), as they mature, to help equip them with the tools and resources needed for place-based workforce planning and transformation. As a Place it is acknowledged that some of the acute and community based specialties would benefit from a networked approach for workforce that would provide greater sustainability.

Rotherham has a diverse and active voluntary and community sector (VCS), underpinned by thousands of volunteers. It is recognised that building on a 'community asset' based approach requires the VCS to be rooted within our local communities and neighborhoods; and that the VCS plays a crucial role in prevention and early intervention, enabling self-help, and supporting community resilience. As a Place there is acknowledgement that a VCS offer of support delivery does not mean zero cost and that appropriate investment is required to support delivery of our plans.

Across the Rotherham Place, partners have developed strong relationships, with local colleges, universities and also Health Education England. We see these relationships developing further and being built upon. These organisations are key to supporting the Rotherham Place to deliver our workforce challenges.

4.2 Finance, including System Efficiency

System partners recognise the challenges of delivering improvements and transforming health and care services at a time of increased demand and lower growth in resources, and understand the importance of working collaboratively to address these challenges.

To help facilitate this, the ICP Finance group was established in May 2019, membership consists of Chief Finance Officers and Directors of Finance representing all Rotherham ICP partners.

Its role is to support delivery of the ICP Place Plan by providing specialist financial advice to the ICP; this includes assessing and advising on financial matters linked to or arising from the ICP Place Plan and its underpinning initiatives and schemes.

Importantly, the group provides a forum for the ICP Place Board to refer financial matters to and a forum for individual system finance leaders to refer financial matters to.
Key deliverables include:

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

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

Whilst system partners acknowledge the joint responsibility for the effective use of the available financial resource within the Rotherham place, each partner also has its own challenges and mitigations:

- **RMBC** has a three-year Medium Term Financial Strategy and has moved to setting two-year budgets with effect from 2019/20. Regular reports on finance are submitted to Cabinet which review current financial performance and develop and agree budget savings proposals to meet future funding shortfalls.

  Medium Term financial plans take into account forecasts of demand, particularly for social care services and assessment of risks around the pace of delivery of transformational change. The Council's overall financial sustainability is underpinned by integrated financial strategies which are developed through the budget engagement processes.

  There is a quarterly Performance reporting process in place where performance, finance and HR data are reviewed in parallel, firstly by the Strategic Leadership Team and then reviewed with Members through formal reporting to Cabinet and Overview and Scrutiny Management Board.
- **CCG** 5 year allocations were published during January 2019, followed later by a requirement for Integrated Care Systems (ICS) to submit 5 year financial plans during November 2019. The CCGs own financial plan is a constituent part of the overall ICS plan. We work closely with health partners, in particular with those at Place, to align our financial planning assumptions as far as possible and the CCGs financial plan is constructed with clinical input and oversight and signed off through internal governance processes. Performance against plan is reported monthly up to Governing Body, who also monitor progress of the Quality, Innovation, Productivity and Prevention (QIPP) schemes, an important element of ensuring financial sustainability.
- **TRFT** has a 5-year strategy and plan which provides the forward look and golden thread to the annual operational plan. Delivery against the operational plan is managed through the Trust Management Committee, with assurance provided to the Finance & Performance Committee and Board of Directors.
- **RDaSH** has a 5-year strategy 2019-24 which provides focus and direction, the context of which drives financial planning. Workforce, digital and collaboration to drive improved safety and quality standards remain the core pillars for the future, which align with our local ICS and Place Plans. Robust governance through the Finance, Performance and Informatics Committee and subsequently Board assess delivery against plans. Future control totals have been received and accepted by the Trust Board. Risks and opportunities are identified and managed through the contracting cycles, with the inherent risk of cost improvement challenges and costs pressures assessed at the start of each financial year and monitored in line with reporting requirements.

We will continue to review external reporting at the most appropriate unit of accountability, which going forward may include Primary Care Networks. Our aspiration is to better direct financial resources to deliver more impact on health outcomes.

4.2.1 Social Value

Social Value is the added value, delivered in addition to a contract. It is about improving the lives of local people by increasing the economic resilience of our place, supporting a thriving civic society, improving our green spaces and building a Rotherham that is inclusive and caring that people are proud to call home.

Rotherham has one of the fastest growing economies in Yorkshire, and it is vital that all residents benefit from this continued growth. As key anchor institutions, we collectively spend in the order of £650m per year across the health and social care system, and we can harness

this purchasing power to bring added value to our local communities. By embedding social value in our contracts and commissioning processes we can help to improve the local economy, increasing spend locally, developing innovative delivery models and creating new opportunities.

When all public sector partners act together adopting similar social value principles, the impact is amplified across the local economy. Rotherham Together Partnership are developing a Social Value Charter for Rotherham, which will set out how public sector commissioners and procurers, service providers and community organisations will work together to maximise the amount of Social Value in our place.

By signing up to this charter, partners are committing to principles, such as:

- To ensure that as many residents as possible are paid the Joseph Rowntree Living Wage
- To spend local with the voluntary sector and SMEs where possible
- To improve the education and skills of residents
- To give employment opportunities to disadvantaged residents, including those who are disabled
- Supporting fair and worthwhile employment where workers have strong rights and good working conditions

Embedding these principles within each of our organisations will support our collective commitment as partners to best utilise the Rotherham £ and reduce health, social and economic inequalities within the borough. All partners signed up to the charter will develop appropriate social value requirements which reflect these principles and measure and report on the amount of social value generated annually to the Rotherham Together Partnership.

4.3 Communication and Engagement

The communications and engagement strategy describes the approach and direction that focusses on informing, sharing, listening and responding to the people of Rotherham; and how we can work together collaboratively to improve both services and lives. All partners have statutory duties in terms of engagement, but more than that, we know that real and meaningful engagement with the people that are using or may use our services is fundamental in ensuring that plans will be effective and practical. Specific communication and engagement will take place, with a variety of stakeholders, for each of our five transformational workstreams and we will continue to develop meaningful communication, in a simple and easy to understand way that demonstrates how we will drive transformation. We will consider the most effective ways of communicating and engaging with local people, including those who are hardest to reach and for those whom English is not their first language.

Communication and engagement messages will focus on what the plans will mean for children, young people and adults in Rotherham; making the plans more tangible and encouraging participation and engagement. As the work develops, we will share the impact of engagement through examples, stories and case studies.

Planning and delivery of our communication and engagement in Rotherham will be co-ordinated with the activity at an overarching ICS level. Our inclusive approach to communication and engagement with individuals and groups will include:

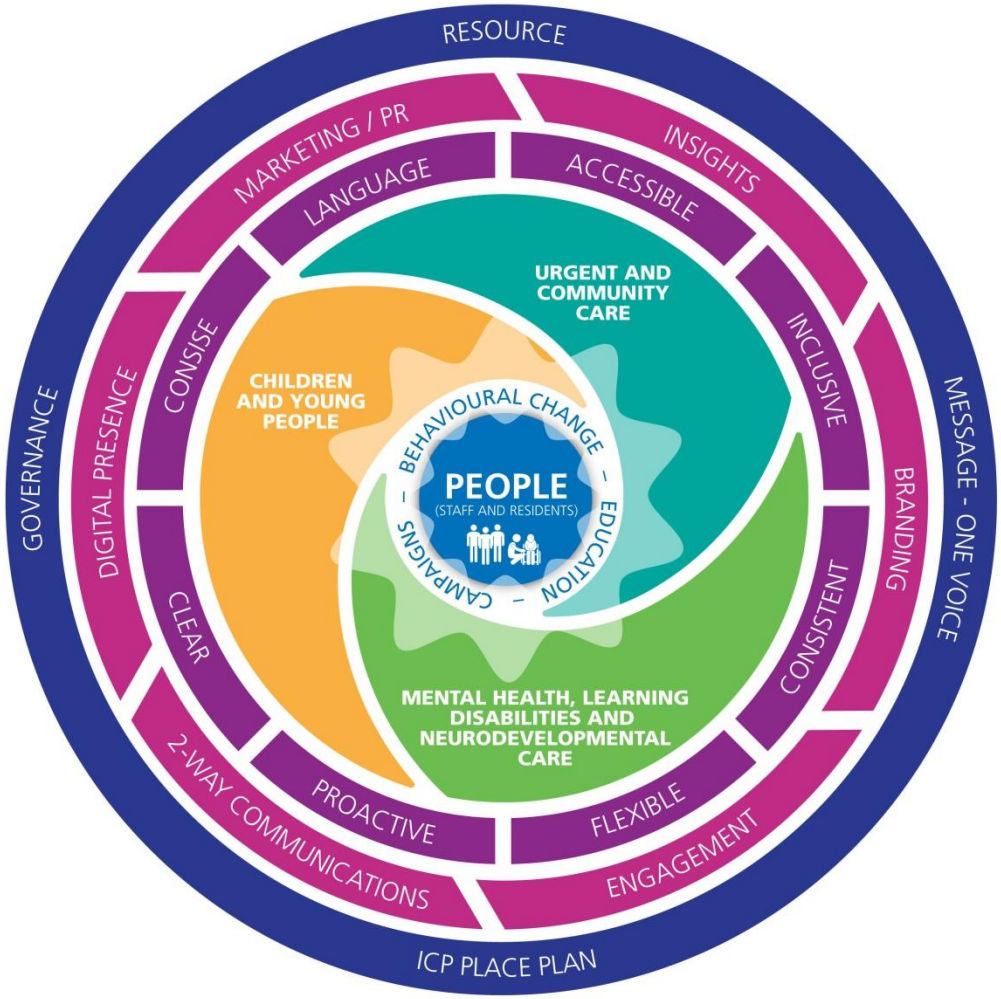
- proactively and effectively communicating our vision, transformational priorities and achievements. Being proactive is central to our vision for communication and engagement with local people
- developing two-way communication opportunities; where we share news, we listen and respond and are visible to local people. Where appropriate, we will look to use new and innovative ways to engage and communicate with our local communities in an ever growing digital environment, whilst considering the needs of individuals with limited digital access or knowledge.

- implementing relevant and effective communication and engagement tactics with key audiences and stakeholders
- encouraging people of Rotherham to take care of themselves, making healthy choices with a focus on prevention and self-management. We want people to be active, happy and comfortable in their own homes where possible
- using an asset based approach; making the most of our joint resources; avoiding duplication of activity, and building on the skills and knowledge of Rotherham people
- using a variety of mechanisms for engagement, utilising skills, resources and contacts in a manner proportionate and appropriate to the issue; with opportunities covering the spectrum from seeking feedback to co-creation.

We recognise our staff as one of our biggest assets in the development and transformation of health and care. We will develop co-ordinated and timely staff and clinical communications and engagement activity across all partner organisations, allowing them to shape the transformation process and have their say on what matters to them.

We are committed to the active participation of local people in the development of health and social care services and as partners in their own health and health care. Local people will have an important voice in how services are planned, delivered and reviewed. We need local people in Rotherham to influence change that will improve services, health outcomes and their experience of care.

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



The following examples describe some of our key successes and how we have used the intelligence we have received. Looking forward we have ongoing plans for engagement, focused on enabling delivery of the place plan.

Trailblazer Supporting Children's Mental Health

Rotherham and Doncaster are piloting a ground-breaking project to support Children's Mental Health, with staff based in schools to offer support. Co-design has been a feature throughout development of the project, with a series of workshops in schools involving primary and secondary age children and young people. The young people were very clear about all aspects of the project, from the promotional materials, to access and what they wanted to see in place – some of which was incorporated, though other suggestions, such as school dogs, perhaps was a little more challenging to act on. Information and promotional materials have been developed and distributed to assist the teams providing support in the schools involved in the pilot.

Rotherham Health App – Patient Story

Six years ago I had to have an operation to have my thyroid removed, which means I now have to have an annual review of my health, regular medication and blood tests. I'm a busy mum of three young children and teach outside of the Rotherham area, which means fitting in time to contact the GP practice is hard, as I set off before the practice is open and when I get back from work I need to see to the kids. By the time I sit down the practice is closed. This means I have to ring when I get breaks. Often the phone just rang out meaning I had to call back quite a few times to get a response.

When I heard about the Rotherham Health app it sounded too good to be true; being able to book appointments in the practice without ringing, and order my medication seemed to really address the issues I was experiencing. I was also told about being able to use the app on behalf of my kids, which was another reason I wanted to use it.

The app has really changed how we access care in my family. I feel the biggest thing is that it gives me better control over my health, as I can see when my annual reviews are coming up and book in when I need to – even on an evening and weekend! If I hadn't got the app I don't think I'd have known about the extended access evening and weekend appointments.

I'm no longer wasting time waiting on the phone, I can just log on to the app and because the app tells you what each clinician can do you can make sure you book into the right person straight away.

Primary Care Access

During Winter 2018, we used the texting service to ask patients about primary care access, and what they wanted and needed. We had over 2,000 responses.

From this, the challenges in accessing primary care for people in work, or with other commitments such as caring were clear, a number of people referred to the challenges of access for shift workers, and the difficulties in seeking routine care for check-ups and tests. It was also apparent that although many people's first preference was for a face to face appointment, that a large number of people would consider an alternative means of accessing care, if this meant that access was prompt and convenient. Younger people and those in work particularly expressed interest in using new technologies; and it was noted that these may increase access for those with poor mobility or young children.

As a result of this, we are improving access through the Rotherham Health App and the Extended Access Hubs, which provide appointments with an appropriate clinician on evenings at weekends.

Integrated Discharge Team: Patient Story

Evidence suggests that patients are more likely to make a better recovery at home and regain or retain independence the earlier they return home or to a suitable care home setting. However, delayed transfers of care are a significant challenge nationally, particularly for patients who have complex needs and requirements. In response to this challenge an Integrated Discharge Team (IDT) was formed, made up of nurses, social workers and therapists and has had a significant impact on outcomes for patients.

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

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

Men's Mental Health

Partners have been working with stakeholders and communities across Rotherham to improve support for mens mental health needs at a community level. Two key projects are thesmall grants scheme and 'Be the One' suicide prevention campaign.

A report on the first set of small grants has demonstrated the real difference and benefit these small amounts of targeted funding can bring. They target 'upstream' interventions; ensuring that mental health is on the agenda; is in men's vocabulary and building conversations. Organisations have told us that as a result, some are using the funding as a basis for additional funding; others about men now ready to join mainstream groups, who are working again for the first time in years, and men who have found creative outlets that have allowed them to express themselves as never before.

'Be the one' is a campaign encouraging all of us to be the person that will talk and listen for friends and family that are struggling; people with lived experience of mental health problems were fundamental in designing and building the approach. The campaign website received around 200,000 hits and reached one million people on social media in the first two months. Individual stories have been shared since the launch of the campaign that demonstrate the impact of the powerful messages.

4.4 Digital

Digital is already established as an enabling workstream to support the three transformation groups (Children and Young People, Mental Health, Learning Disabilities and Neurodevelopmental Care and Urgent Care and Community). We report to the ICP Delivery team and upwards to the Rotherham ICP Place Board and Health and Wellbeing Board. These governance arrangements ensure all our digital programmes and activities focus on achieving the ambitions of the Place Plan and wider Health and Wellbeing Strategy.

We have recently developed the Rotherham ICP Digital Strategy that will help us to deliver the transformation objectives articulated in this Place Plan and the digital requirements of the NHS Long Term Plan.

The NHS Long Term Plan (2019) sets out a 10-year blueprint that has informed the development of our digital strategy. The five key aims of the Long Term Plan are to:

1. Boost 'out-of-hospital' care and dissolve the historic divide between primary and community health services;
2. Reduce pressure on emergency hospital services;
3. Give people more control over their own health and more personalised care when they need it;
4. Digitally enable primary and outpatient care;
5. Increase the focus on population health and local partnerships with local authority-funded services, through Integrated Care Systems.

Digital Primary Care is a developing ambition nationally and has been championed in the Long Term Plan to ensure that "by 2023/24 every patient in England will be able to access a digital first primary care offer". Emerging national initiatives and programmes have been established to enhance the use of digital services and solutions in the primary care setting. Our strategy explains how we seek to deliver these programmes, and our ambitions to expand delivery beyond primary care and into the wider health and care landscape.

Our Strategy is focused on making the best use of existing investments, regional digital developments and ensuring that investments made at organisation level will support both organisation and place objectives. It replaces our Local Digital Roadmap which identified place wide digital programmes of work between 2016/ 2019.

Our strategy focuses on the delivery of four programmes of work (key activities in brackets):

- Infrastructure (maintenance and refresh of digital infrastructure; IT services review; skills and resource collaboration)
- Sharing care records (further develop the Rotherham Health Record system; increased adoption of the Rotherham Health Record system; integration with the Yorkshire and Humber Care Record)
- Patient Access and Engagement (Rotherham Health App development; Place wide website; Place wide Communications and Engagement strategy)
- Intelligence and Analytics (development of a population health management tool; clinical analytical support; alignment with Yorkshire and Humber Care Record)

4.4.1 Information Governance

As we deliver more digital programmes to support the delivery of this Plan, the scope of data we will collect, and re-use will broaden, and we will need to regularly review our arrangements and policy in this area. We currently use the ICP Digital Group to sign off sharing agreements between partners.

Partner organisations are individually responsible for Information Governance, collectively our aim is to focus and make sure that we will always use legal and secure methods to collect the data we use and share about Rotherham people. Working with our commissioning and service delivery partners, we will ensure that individuals and service users understand the reasons, purposes and value of their data and how it is used.

Ensuring that data that is recorded, collected, managed, maintained and accessed transparently, legally and securely under General Data

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Protection Regulations (2018) is a high priority and key responsibility for all health and care service providers in Rotherham. We will continue to ensure we meet all legal and statutory requirements in this area and apply best practice.

4.4.2 Infrastructure

Our aspiration is to provide a flexible and scalable infrastructure to support the delivery of high-quality integrated care and to allow a growing number of professionals to work seamlessly together in an agile manner. We also want to make sure we are connecting our local core systems to enable the faster flow of information between services and organisation boundaries. We are making good progress towards this with each of our partner organisations implementing secure Wi-Fi services through the GovRoam programme and the implementation of regular infrastructure refresh programmes. Similarly, each of our partner organisations have a good level of digital maturity and a stable systems landscape.

Whilst what we have now is good, we do feel it could be better and our programmes of work in this area are:

- An infrastructure optimisation programme to ensure all staff can work in an agile manner across our joint estate;
- Joining up and enhancing our data networks across the place, ensuring greater coverage for our health and care services;
- Ongoing maintenance and refresh including networks, desktop, storage and cyber security;
- An IT Service Review to identify areas for further collaborative working;
- Further skills and resource sharing, particularly in relation to technical skills and procurement.

4.4.3 Sharing Care Records

The seamless flow of information across organisation boundaries with patients able to access and contribute to their own care record is essential for the delivery of high-quality, joined-up health and social care to the people of Rotherham. To achieve this, we will use existing digital solutions and services to support better, faster, safer sharing of patient records across care settings and to ensure we keep improving the flow of information.

We already have the Rotherham Health Record, a web-based solution developed by The Rotherham NHS Foundation Trust (TRFT) to display acute, community GP, Social Care, Pathology and Ambulance records. We have also procured the Rotherham Health App which is offered to all Rotherham patients and supports online consultation, access to patient online services, booking into extended access services and lifestyle management support.

The Rotherham Health Record and Rotherham Health App will be our primary digital tools for sharing information.

In addition to these tools we are also participating in the Yorkshire and Humber Local Health Care Record Exemplar (LHCRE) Programme to provide a shared record across the Yorkshire and Humber region. This will support record sharing for patients who travel out of Rotherham Place for part of their care.

Our Programme of work in this area includes:

- The development and wider adoption of the Rotherham Health Record (RHR) to support integrated care delivery, focusing on how it can help to support the priorities against the three workstreams identified in this Plan;
- Using the RHR to support the delivery of national initiatives such as the digital maternity record and digital Red Book;
- Further develop the RHR to support shared care plans for use across the health and care community;
- An RHR adoption and expansion programme working with the transformation workstream leads to determine how best to facilitate adoption of the solution to support their business processes and to identify priority developments to support transformation;
- Establishing a proactive communications programme to ensure that patients and the public are aware of RHR, how it is used for their care and the information governance policies in place to ensure the security of their data.

We plan to work with the supplier to ensure the Rotherham Health App is a useful tool to support information sharing and giving Rotherham people the ability to contribute to their own records:

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- Integration of the App with RHR to allow patient access to health and care records;
- Linking the app with self-testing devices to allow patients to input data directly into their GP record.

We are keen to learn from successful shared record programmes elsewhere and we will re-use proven standards if they can help us to achieve of our local aims. With so many similar programmes happening across the country we will keep sight of these programmes and will use the RHR Steering Group and the ICP Digital Group to discuss further possibilities for this solution.

4.4.4 Patient Access & Engagement

Our vision in the Place Plan puts local people at the heart of services, helping people to stay well and independent in their own homes and communities and avoid being admitted to hospital. We want to find the right digital tools to help empower Rotherham people and transform their experience of health and care, starting with the Rotherham Health App.

Our aspiration is to use digital services to make it simpler and easier for individuals to access our services and engage with health and care professionals and give access to the right information and services for their needs as well as manage and contribute to their own records and care planning.

We recognise that we have a diverse population with differing needs and variable access to technology. We will prioritise making our services digitally available to everyone. We do not want to leave anyone out, from people with complex, long term conditions to finding ways to keep people healthy and well from birth.

The programmes of work and activity in this area will include:

- Use of consistent solutions such as video consultation tools across provider organisations to help empower Rotherham people and transform their experience of health and care, prioritising the development of the Rotherham Health App to be the digital “front door” to health and care services in Rotherham, starting with primary care;
- Expanding the Rotherham Health App functionality for Place-wide usage. There are plans in place to develop the app to allow the booking and delivery of outpatient appointments at TRFT, and to incorporate the Cancer Holistic Needs Assessment for patients to complete via the app.
- Linking the Rotherham Health app with Gismo, the Rotherham directory of organisations to help people living and working in Rotherham find the right groups and services for their needs.
- A Place-wide digital inclusion programme - working with RMBC and partners to agree a strategy for digital inclusion for the entire town.

We will use the existing ICP workstreams, specifically the Digital and Communications Group forums to align our individual organisation digital programmes and to identify opportunities where we can deliver our digital strategy jointly.

4.4.5 Intelligence & Analytics

Population Health Management (PHM), and the Business Intelligence to support this, is a key enabler for delivery of the Rotherham Health and Wellbeing Strategy and Place Plan. PHM recognises that health and wellbeing is more than just being ‘without disease’. It moves away from managing disease in silos to an approach based on ‘populations’ that may be defined geographically or by common health and care needs. This requires a shift in thinking from planning based on services to a citizen focus and a significant development of our analytics capability.

We aim to be in a position where the focus on health and care service planning is focused on the citizen and everyone involved in planning, designing and delivery of care in Rotherham has the necessary data to support evidence-based decision-making.

We will develop our intelligence and analytics capability by continuing to work closely with regional partners across South Yorkshire and Bassetlaw ICS to share knowledge and learning. Providing the best understanding of Rotherham citizen’s needs and service usage.

We will explore the best use of new technologies across the Place, to improve how data is analysed, reported and visualised. Using these

technologies as appropriate to present and visualise citizen data, generating insight beyond traditional service based reporting.

We will focus on:

- Aggregating citizen-level data (including health, social care, economic and environmental data) and ongoing development of these linked data sets;
- Development of a population segmentation model against which we will analyse this data based on common characteristics rather than by disease;
- Identification of cohorts of citizens with similar health and care needs;
- Identifying appropriate interventions for those needs.

Once this capability is developed, maximising the use and positive effects of the evidence-based decision-making, it will require development of the interpretive skills of our clinical and commissioning decision-makers.

4.4.1 Digital Inclusion

We recognise that we have a diverse population with differing needs and variable access to technology. We will prioritise making our services digitally available to everyone. We do not want to leave anyone out, from people with complex, long term conditions to finding ways to keep people healthy and well from birth. Rotherham is committed to delivering information and services digitally wherever possible and will try to ensure we address the needs of the people in Rotherham who are most likely to be digitally excluded.

We will be launching a Place-wide digital inclusion programme, working with RMBC and others to agree a strategy for digital inclusion across the borough, and work collaboratively to reduce digital exclusion for our population. All partners involved in the programme will be actively involved to ensure we make services fully available to all ages and ensure that the digital services we deliver are as inclusive as possible.

Several schemes are being considered to help educate and promote digital skills in the community. We will look to establish partnerships beyond our partner organisations, to make as much progress as we can in improving digital inclusion. Moving forward with these schemes will aid us in achieving our objectives and in increasing the take up of digital services for people in Rotherham.

4.5 Housing, Communities and Estate

If we are to be successful in the delivery of our place ambition, we need to ensure that our available housing and estates act as an enabler to our strategic transformation workstreams. Partners recognise the value of working together and taking a strategic approach to asset management and getting the most from our collective assets. As well as buildings, this includes community assets: the skills and knowledge of local people; community groups; informal networks; and public spaces.

Working within a 'One Public Estate' model, system leaders within the Rotherham place have agreed four key principles for how we will approach our place discussions regarding housing and estates:

1. We collectively value our best assets and will engage in constructive dialogue to maximise their optimisation
2. When making decisions we will take into account the impact on partners and not just our own organisations
3. We will work together to co-ordinate Rotherham Partners' Estates Strategies.
4. Our estate decisions will support the wider Rotherham Economic Growth Plan, Housing Strategy, Thriving Neighbourhoods Strategy and the Rotherham Together Partnership.

Our established Strategic Estates Group continues to work constructively, identifying available estate across the system, ensuring it is fit for purpose and identifying disposals where possible. It will continue to respond to the changing needs of services and the population. Examples of work to date include the successful One Public Estate Phase 6 (OPE6) bid for resources to support transformation including a scheme to create shared storage across the system.
Rotherham place was also successful in 2017 in securing funding to facilitate agile working across providers to enable community teams to

work more effectively and reduce the footprint required. Rotherham place is also working with the ICS Strategic Estates Board in developing and delivering the ICS Estates Strategy and with the Sheffield City Region's Public Asset Development Group to develop their Estates Transformation Strategy, to ensure estates strategies work beyond the Rotherham boundary. System leaders are clear that our approach to utilising estate needs to be driven by our Place Plan transformation; there are a number of key estate decisions that will need to be made at a Place level during the period of this plan. These will include, but not limited to, the future use of the Joint Service Centre at Rawmarsh, the future use of the Badsley Moor Lane Campus and how the wider Partners can support the requirement to invest in the Primary Care estate

It is important that people have access to local, well managed services but the type of housing they live in also has a huge impact on health. Good quality, affordable housing provides the basis for people to live healthy, independent and fulfilling lives.

The population continues to age and pressures on the health services to support individuals is increasing. Therefore it is important that we plan for housing that is care and support ready so that people can live in their home for as long as they wish, whilst reducing reliance on public services and encouraging independence.

The Housing Strategy sets out how RMBC and partners can deliver the right homes in the right places so we continue to meet people's needs now and in the future. The role of housing goes beyond bricks and mortar; providing investment in council stock, encouraging improvements in private housing provision, development of new homes, and engagement with tenants and residents all contribute to creating healthy, stronger and more resilient communities. Getting people in the right housing and building community resilience can lead to improved health outcomes, financial wellbeing and reduced social isolation.

4.6 Prevention

Prevention priorities need to take into account where people live, work and play, and include:

1. Reducing tobacco dependence throughout the borough
2. Supporting everyone to achieve a healthier weight
3. Encouraging daily physical activity for all
4. Ensuring alcohol is consumed responsibly throughout Rotherham
5. Tackling climate change and air pollution
6. Slowing the development and spread of antimicrobial resistance.
7. Taking co-ordinated action on the social determinants (the causes of the causes) of health

A key part of prevention should be addressing health inequalities as detailed at the end of this section. This should focus on where people live, work and play as much as on health services.

Prevention should be a universal offer. However, in order to address health inequalities it will be necessary to additionally ensure that prevention activities are effectively targeted and appropriate for those in the greatest need.

Also important to addressing health inequalities is reducing variation in access to treatment, quality of care received, and differences in delivery and outcome. This links to the remit of primary care section 6, planned care section 7 and major conditions section 8. There are also a number of activities which do not necessarily quite fit into the above priorities but support prevention:

- Enabling digital inclusion by increasing digital literacy and access to information on health including prevention, for example via the Rotherham App
- Social prescribing
- Improving workforce health in RMBC, TRFT to allow staff to better engage the public in discussions on their health (Making Every Contact Count)
- Healthy hospitals
- Consistent communication messages across sectors
- Personal health budgets/self-management

People will also be supported to manage their own health through core health services and the provision of high quality primary care services. Population health management capabilities and capacity are being developed, and services are being designed to meet the needs of communities with the greatest needs. This will enable prioritisation of services which have the biggest potential to decrease inequalities and help change the culture of the NHS to recognise prevention as a core responsibility of staff all support prevention.

The following provides highlights for each of the prevention priorities. In appendix 1 we detail the challenge, what we are doing to address it, and the expected benefits.

Tobacco Dependence

Tobacco dependence is the single biggest cause of preventable illness, and the prevalence rate for smoking in adults in Rotherham has recently increased to 18.9%, the highest since 2015, and it is higher than the England average of 14.4%. It accounts for half of the health gap between the poorest and most affluent communities, as well as being a major contributor to the 15 – 20 years gap in life expectancy between people with a severe mental health illness and the general population.

Tackling tobacco dependence in Rotherham involves:

- Providing the Public Health commissioned smoking cessation service for adults within the Get Healthy Rotherham (GHR) Integrated Lifestyle wellness service.
- Partnership working between Public Health and TRFT to reduce the prevalence of women smoking at time of delivery to 16% or less by end of 2022.
- Systematic implementation of the QUIT programme, to treat tobacco dependency of patients in secondary care (acute and mental health trusts) and provide ongoing support
- Trading standards working across Rotherham to enforce legislation on smokefree public places and standardised packaging, as well as ensuring reduction of access to illicit tobacco and preventing the sale of tobacco products to children.

Obesity

Tackling the high levels of overweight or obesity in our society is important for preventing a number of conditions, such as type 2 diabetes, coronary heart disease, stroke and some types of cancer, as well as psychological problems. In Rotherham 24.2% of 4-5 year olds, 37.1% of 10-11 year olds, and nearly two-thirds of Rotherham adults are overweight or obese.

Reducing the high prevalence of overweight and obesity in Rotherham requires a whole-system approach across the borough:

- Development of a local 'Healthy Weight for All' Plan to promote healthy weight and reduce obesity across all ages, by all NHS partners and council
- Adoption of the Local Authority Declaration on Weight to create healthy environments for local people.
- Development of a local plan by the Rotherham Activity Partnership (RAP) to get the population of Rotherham more engaged in physical activity
- WHAM (weight, health and attitude management service), the public health commissioned child weight management service delivered by the 0-19 Service at TRFT.
- The Get Healthy Rotherham weight management support offer in partnership with Slimming World.
- Implementing new Supplementary Planning Document for health and inequalities, including restrictions on new fast-food takeaways near schools and colleges.
- All partners reviewing food provision in council buildings, hospitals, leisure centres and schools, to ensure consistenthealthy weight messages are given in all settings to the public and the workforce.
- NHS partners promoting physical activity within clinical services
- All partners developing active travel plans
- Promotion of workforce health so staff can act as champions of health to the public

Alcohol
Long-term alcohol misuse is associated with an increased risk of high blood pressure, stroke, liver disease, pancreatitis and a number of cancers, as well as harms from accidents, poor mental health, violence, antisocial behaviour, impacts on education and employment, family break-up and divorce, domestic abuse, financial problems and homelessness.

Rotherham's rate of hospital admissions related to alcohol is significantly higher than England with over 1,800 people admitted in 2017/18.

A number of actions to tackle excess alcohol consumption and treat alcohol dependence are being undertaken::

- Alcohol partnership events are being held and a rapid alcohol health needs assessment was undertaken to identify the key priorities for action.
- The Challenging, Leadership and Results (CLeaR) assessment for responsible drinking has been completed to inform work on responsible drinking and the licensing process.
- Get Healthy Rotherham provide brief interventions to individuals identified as having high levels of alcohol consumption
- The Change Grow Live (CGL) supports problem drinkers with alcohol treatment services
- The Alcohol Care Team in TRFT to reduce emergency attendances and admissions bed days, readmissions and ambulance callouts.

Air Pollution
Air pollution is strongly associated with major diseases that pose a great health and economic burden, including childhood asthma, coronary heart disease, stroke, and lung cancer. Poor air quality is estimated to be responsible for 4.1% of mortality in Rotherham. Air quality is good in most of Rotherham but there are areas of elevated air pollution which have been declared as Air Quality Management Areas (AQMA).

A number of actions need to be undertaken which will feed into the wider work to tackle the climate emergency:

- Implementation by the Council of a range of measures as part of Air Quality Action Plans to work towards achieving compliance with the air quality objectives identified in the AQMAs.
- Production of a plan with a range of targeted measures to reduce emissions from vehicles and achieve compliance with the European Union Ambient Air Quality Directive in the shortest possible time as required by the Government.
- Supporting strategies for improvements to air quality and reduce inequalities in health via the Rotherham Local Plan by the promotion of walking, cycling and the provision of open spaces and recreation facilities.
- Use of Ultra Low Emission Vehicles to replace conventionally fuelled ones for undertaking Council and NHS business, with provision of public Electric Vehicle (EV) charging points in car parks across the borough, country parks, hospital car parks and leisure centres.
- Supporting the work of the Rotherham Activity Partnership to tackle air pollution by encouraging active travel as part of being more physically active.
- Reduced business mileage by active travel and use of technology for virtual meetings and appointments
- Phasing out primary heating from coal and oil fuel in NHS premises

Anti-Microbial resistance
The overuse of antimicrobials is leading to increasing resistance to antibiotics that is spreading worldwide. Antimicrobial resistance (AMR) makes treating infections caused by multi-drug resistant organisms increasingly difficult, which is both costly and a safety risk. Of particular concern is the potential for levels of AMR to rise quickly, which reinforces the need for proactive control measures to prevent the rapid development of resistance.

A number of actions are being undertaken:

- TRFT and the CCG have been active participants of the national surveillance scheme for Healthcare Associated Infections and

antimicrobial stewardship to monitor performance around antibiotic prescribing rates.

- RMBC, CCG commissioners and the CQC continually monitor and seek assurance that patient safety and service quality are maintained for Infection Prevention and Control in the public and independent sectors who deliver regulated services.
- Through medicines management actions are being undertaken to optimise the use of antibiotics, reduce unintentional exposure to them and the requirement for them, and benchmarking against surrounding areas
- Engagement with the UK wide Antibiotic Guardian campaign to raise awareness and to stimulate behaviour change in members of the public, healthcare professionals and other local stakeholders.

Stronger Action on Health Inequalities

Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs. This is exemplified by life expectancy for men and women in Rotherham being below the England average, and differences in life expectancy between the richest and poorest areas within Rotherham.

This necessitates stronger action from all partners across the life-course. The NHS Long Term Plan emphasises a need to commit to progressively increase the NHS focus on prevention and ensure that reducing health inequalities is central to any local system plans agreed in partnership with local authorities. A particular focus should be on the most vulnerable in society.

Actions to address health inequalities should be at both the individual level, such as improvements to knowledge around services and self-management abilities, and at the community or population level, such as those to address the underlying social determinants of health. Care needs to be taken to ensure that any actions to improve health and wellbeing do not unintentionally exacerbate health inequalities. The refreshed Joint Strategic Needs Assessment should inform strategies to tackle the leading causes of morbidity and mortality, and create sustainable, place-based health and care across partners in Rotherham and reduce inequalities for all ages.

Improving the health of the worst off in society and reducing co-morbidities as a result of tackling the underlying causes of ill health is a key part of reducing the overall burden on the health and social care system. Across the UK, of all the potential years of life lost due to inequality, half come from the most deprived fifth of the population, but a further quarter come from people in middle socioeconomic deciles. Improving inequalities across the whole of society will therefore lead to better outcomes for all.

5 Personalised Care

Personalised care means people have a say in how their care is planned and delivered, based on ‘what matters’ to them, their individual needs and preferences.

Nationally it will benefit up to 2.5 million people by 2024 and provide the same choice and control over their mental and physical health as they have become to expect in every other aspect of their life.

The NHS Long Term Plan set out **key commitments and actions** to be delivered by 2023/24 as:

1. Personalised Care will benefit up to 2.5 million people giving them the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life;
2. Over 1,000 trained social prescribing link workers will be in place by 2020/21 rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then. Social prescribing link workers connect people to wider community support which that can help improve their health and well-being and to engage and deal with some of their underlying causes of ill health.

3. 200K people will have a personal health budget so they can control their own care, improve their health experiences and experience better value for money services over a “one size fits all” approach;
4. 750,000 people have a personalised care and support plan to manage their long term health conditions;
5. Develop the skills and behaviours of 75,000 clinicians and professionals through practical support to use personalised care approaches in their day-to-day practice
6. That we deliver universal implementation of the Comprehensive Model of Personalised Care across England, which fully embeds the six standard components.

Rotherham ICP supports the national view that individuals should be encouraged to support their own health care, endorsing the six standard components within the Comprehensive Model for Personalised Care:

1. shared decision making
2. personalised care and support planning
3. enabling choice
4. social prescribing
5. supported self management
6. personal health budgets

5.1.1 Enabling Patient Choice

Patient choice is at the heart of the NHS and there are a range of choices that patients should expect to be offered in the services they use. The Choice Framework, published by the Department of Health, sets out the nine main types of choices that should be available to patients, some of these choices are legal rights, while some are subject to specific exceptions.

NHS England established a major programme of work to drive forward patient choice and set a vision for 2020, with initial priorities of: strengthening choice in elective services, enhancing the choice available in maternity services, improving choice in end of life care, securing choice in the new care models.

Rotherham ICP recognises that Patient Choice is fundamental to delivery of a truly patient-centred health service by empowering people to get the health and social care services they want and need.

The NHS Long Term Plan continues the commitment to patient choice, and Rotherham partners will continue support and enhance patient choice through their commissioning and delivery of services.

5.1.2 Social Prescribing

Funded through the Integrated Better Care Fund, Rotherham has two award winning social prescribing schemes running, one for people with long term conditions who are referred through their GP to Voluntary Action Rotherham (VAR), and one to help patients under the care of RDaSH with a mental health diagnosis to be supported out of long term statutory mental health services. The mental health scheme has been so successful that spare capacity has been converted into a pilot for 3 months to allow Primary Care Networks (PCN) nominated GP practices to refer patients with low level mental health issues into the scheme as part of the care navigation model. This changes the model of care into a preventative model, upstreaming the access to “before a crisis” rather than after.

During winter 2018, social prescribing advisors based at VAR were retrained to deliver personal health budgets (PHB) as part of their social prescribing work, this work has been completed, so now every patient with a social prescription receives a PHB. Work is ongoing with NHS England/Improvement to allow these social prescription PHB’s to be included in our figures.

There is a further pilot as part of their social isolation work in the south of the borough, for any professional (social worker, district nurse, police etc) who comes across someone who is socially isolated to make a referral into VAR for social prescribing. This has only just got underway but we are hoping this cross place working will be really beneficial and if the expected outcomes are proven then this could be rolled out across the borough.

In the spring, NHS England published a new ambition and model for the expansion of social prescribing through PCNs. Rotherham’s six

PCN Clinical Directors have taken this initiative forward, utilising the framework of the GP Federation with a contract to VAR to host the six new social prescribing link workers on their behalf.

5.1.3 Personal Health Budgets (Self Care/Self Management)

We strongly believe that taking a person centred approach and empowering patients to take control of their own health care will add value to patients experience and support delivery of care within the community setting. Our leading national work on Social Prescribing has demonstrated this. Section 4.6, prevention, sets out more of our aims.

Where clinically appropriate we will encourage individuals to enter into arrangements for PHBs across our place, with a focus on self care and self management. Individuals and community stakeholders need to be involved in the co-production and co-design of services, reflecting on what works well, what does not work so well and how improvements can be made to enable people to self care.

We plan to grow our well established Social Prescribing service, see 6.1.2, which empowers those individuals living with long term conditions to gain support to manage their own care in the community.

Personal Health Budgets (PHB) are well established in Rotherham and we aim to increase the numbers of people with a PHB in line with the agreed South Yorkshire and Bassetlaw targets and the national expectation.

In addition, we will continue to promote the Rotherham Health Care Record and the Rotherham App, allowing people to take control of their own care.

6 Primary Care

In 2018/19, general practice provided over 1.5 million appointments in Rotherham. General practice is essential to Place Plan delivery and is undergoing significant change. In January 2019, as part of the NHS Long term plan, a five year framework for GP contractual reform was produced 'Investment and Evolution' this contains significant change for primary care over the next 5 years. The key priorities for Rotherham are:

- **The creation of Primary Care Networks (PCNs)** – the purpose of the networks is to enable practices to work at scale (without the requirement to merge), enabling improved quality and consistency of service. In Rotherham, six PCNs are now in place supporting populations of between 30 and 50 thousand people. Each has a Clinical Director who are meeting regularly and establishing excellent links across the Rotherham Place. Each Network has submitted a development plan to aid its development and 4 out of 6 networks have additional pharmacist roles in place and are just implementing additional social prescribing support which compliments the existing infrastructure. The Clinical Directors will be actively involved in shaping services, for example the revised respiratory pathway and delivery of the primary care strategy. The Clinical Directors will also work with the primary care team to understand how the expected new national service specifications can be implemented to improve care in Rotherham.

- **Improving access** – Rotherham already provides 7 day extended access for the whole population and the number of hours available will increase again over the next year to support accessibility for the working population and also avoid wherever possible primary care attendance at the Urgent and Emergency Care Centre. The NHS Long Term Plan envisages PCNs joining up the delivery of urgent care in the community and work is already ongoing between providers to make this happen. Practices now have to show 25% of their appointments online and work is ongoing to increase this to 40%. Rotherham Health App is a digital platform (which can be used on smart phones, tablets or computers) providing patients

with a symptom checker, access to their medical records and the ability to order repeat prescriptions, book relevant appointments, facilitate online consultation and video consultations. The App is being developed at Rotherham place to incorporate wider health and social care requirements e.g. cancelling secondary care appointments, organising maternity care, enabling telehealth and supporting RMBC single point of access.

- **Delivery of new services to achieve NHS long term plan commitments -** The CCG will work with the PCNs to deliver seven national 'network service specifications' and their subsequent delivery. Five of the seven commence by April 2020:
  - Structured medication reviews
  - Enhanced health in care homes
  - Anticipatory care (with community services)
  - Personalised care
  - Supporting early cancer diagnosis
  - The remaining two, cardio-vascular disease case finding and locally agreed action to tackle inequalities will commence 2021.

  By 2020 there will be a new Network Dashboard covering population health, urgent and anticipatory care, prescribing and hospital use. A national network investment and impact fund will start in 2020 which is intended to help networks make faster progress against the dashboard and NHS LTP goals.

- **Developing the primary care workforce** – working with practices and PCNs to consider alternative roles and support the training of new primary care practitioners e.g. newly qualified nurses, student nurses, apprentices, care navigators. Care navigators are now in place across all practices ensuring patients are navigated to the most appropriate service or clinician. Physiotherapy First has been rolled out to all practices, enabling patients with musculo- skeletal issues to be assessed more quickly by an experienced physiotherapist, it is understood that this is releasing GP and nurse capacity in practices by at least 10% improving access for other conditions.

- **Continuing to develop the Federation arrangements in Rotherham to strengthen general practice** – Connect Healthcare are a member of the ICP and as such sit on the Rotherham Place Board to ensure primary care has a voice in place. They are supporting collaborative arrangements for out of hours with secondary care and already provide extended access in 4 locations in Rotherham. The Federation also host a number of additional roles on behalf of the PCNs and are support the network development programme.

- **Population health management –** Work is being undertaken in relation to segmentation of population health data to better inform place and primary care networks of their population requirements. The CCG will continue to expand the GP led, multidisciplinary, case management of patients in Rotherham at highest risk of admission to hospital through the continuation and expansion of the GP Case management programme. This includes maximising the visibility of case management plans to other clinicians. These arrangements will be reviewed once more detail is available in relation to a network specification which is being developed nationally. Locally a scheme has been developed with PCN directors to support networks to identify gaps in their population health requirements and develop support to meet these requirements locally e.g. if diabetes is a particular issue the network would be able to put in place services beyond the current CCG funded arrangements, for example, additional specialist nursing time or additional patient education to support improvement.

7 Planned Care

The delivery of high-quality and sustainable elective care continues to be a key priority across Rotherham Place.

Historically, Rotherham has performed well in regard to planned care delivery and has a track record of delivering the 18 week wait standard, with outstanding performance across diagnostics. To build on this success, Rotherham partners will continue to work together to transform how we deliver planned care, how we share and roll out good practice and how we develop our care pathways to be as effective as possible.

We aim to support the ambition set out in the NHS Long Term Plan that nationally the NHS will avoid 1/3rd of face-to-face outpatient appointments within five years. Supporting this change will require a cultural shift across Rotherham with a step change towards self-care, digital solutions and enablers, and a shift of activity away from the secondary care sector.

We have made strong progress to date on our digital agenda. We have implemented a virtual fracture clinic to support our patients, teledermatology has been rolled out to all GP Practices and we have developed a digital offer for patients as part of our Rotherham Health App which enables online and digital consultations to take place. In Speech and Language Therapy we have started to deliver video follow up clinics for voice therapy patients and are already exploring how this system can be expanded to other areas. We have also implemented clinical referral thresholds to help standardise planned care across the system and have rolled out Advice and Guidance to all GP practices to enable specialist advice to be provided locally.

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

We will continue to make improvements to our surgical pathways to enable an increasing amount of patients to be treated as day cases. We will also continue to work collaboratively across partners to expand access, through initiatives such as direct access to Musculo Skeletal First Contact Practitioners and our integrated community approach using the principle of every contact matters, to offer better access to services closer to, or even in, the patient home.

All partners in Rotherham accept that to continue to deliver high quality, safe and sustainable planned care across Rotherham we must continue to work together with an increasing focus on proactive and preventative care, a move of activity out of the acute setting and an increasing use of digital technologies.

8 Major Health Conditions

Performance in all major health conditions has improved significantly over the last decade, but there is still a degree of unmet need and unwarranted variation for the biggest killers and disablers of the population.

The NHS long term plan sets out two clear areas for further progress on care quality and outcomes 1) enabling a strong start in life for children and young people (see section 9.1); and 2) providing better care for major health conditions.

Our plan builds on the requirements of the NHS five year forward view and extends to providing better care for major health conditions such as cardiovascular and respiratory conditions, learning disability and autism, among others.

8.1.1 Research and Innovation

We recognise that research and evaluation provides the essential evidence we need to transform services and improve outcomes. Understanding what works well and what does not and applying this to decision-making.

Patients can benefit with breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recovery. Linking genomics, clinical data and data from patients provides routes to new treatments, diagnostic patterns and information to help patients make informed decisions about their care, examples include personalised medicine and shared decision making.

Rotherham partners will continue to support Research and Innovation work at Regional, ICS and national level.

8.1.2 Cancer

Rotherham, like other areas has increasing cancer prevalence, with restricted capacity to deliver significant workforce issues across specialties particularly histopathology, dermatology, urology and gastroenterology.

The increase also impacts on primary care which is also challenged with capacity issues.

We have implemented risk stratified pathways in urology and lower GI to release capacity in secondary care, and work is underway in relation to primary care with support from the GP Federation lead nurse and the appointment of a Macmillan GP.

We have also implemented straight to test for colonoscopy, straight to MRI for urology, and undertaken significant pathway work with all specialties including the implementation of a breast lump pathway, testicular lump pathway and vague symptoms pathway to enable achievement of 7, 28 and 62 day targets.

Faecal Calprotection Testing and Faecal Immunochemical Test (FIT) testing for symptomatic and non-symptomatic has been rolled out in accordance with national policy.

We will continue our pathway work particularly in the challenged specialties. The Macmillan GP and workers from within the Living With And Beyond Cancer team are working in general practice to ensure appropriate referrals, learning for significant events and improved consistency in cancer care reviews. We hope to be chosen to pilot a version of cancer support workers in primary care.

Work is underway with multi-disciplinary teams in secondary care to ensure that patients, as appropriate, have more discussion time and to enable patients to commence treatment quicker.

Our aim is for improved patient pathways and shortened treatment times to enable the achievement of 7, 28 and 62 day targets, and to improve consistency in primary care management of patients living with cancer and those in remission and to enable care for patients in their own community and not in secondary care.

8.1.3 Cardiovascular Disease

In the management of Atrial Fibrillation (AF) Rotherham appears to under diagnose the condition, in the treatment of AF Rotherham's rate of anticoagulation (89.89%) is slightly below the average for England (90.04%) and that of neighbouring CCGs. However, Rotherham's rate of hospital admissions for stroke where AF is a secondary diagnosis is below the Yorkshire and Humber average.

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The GRASP AF tool has been promoted to all practices and its use forms part of the CCGs Quality Contract. AF management has been compared to pathways in neighbouring CCGs where it was found that management is more secondary care based.

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Analysis of prescribing data shows no evidence that Rotherham is not utilising the Direct Acting Anticoagulants (DOACs). The well established CCG/Secondary care anticoagulation working group will continue to review all aspects of anticoagulation management.

The CCG prescribing incentive scheme incorporates a series of coronary heart disease (CHD) criteria, where the evidence base proves that pharmacological intervention results in improved mortality or event reduction. The CCGs performance improves year on year whilst the variability between practices decreases.

Rotherham has the second highest prescribing rate for cholesterol lowering drugs in Yorkshire and Humber and comparative data indicates that cholesterol is well managed.

We will continue to support the joint South Yorkshire and Bassetlaw ICS agenda regarding CHD prevention, diagnosis and treatment and continue to support the reduction in practice variability regarding evidenced based prescribing interventions.

Our aim is for improved CHD related mortality, reduction in CHD events and reduction in hospital admissions.

8.1.4 Stroke Care

There are significant workforce challenges in this specialty in the medical and nursing workforce, and Rotherham has been challenged significantly in relation to achieving the Sentinel Stroke National Audit Programme (SSNAP) requirements.

Centralisation of hyper-acute stroke services has commenced and the new pathway is working well to date.

Rotherham has high performing early supported discharge from the acute stroke unit enabling patients to be rehabilitated quickly in their own environments.

We will continue to review the stroke pathway to ensure early supported discharge levels are sustained and to ensure the SSNAP requirements are improved and sustained.

Work will continue with with partners to ensure stroke patients who would benefit from medical thrombectomy are transferred quickly to Sheffield who deliver this on behalf of South Yorkshire and Bassetlaw.

Our aim is for patients to receive consistent care across South Yorkshire and Bassetlaw at all times of the week and to ensure patients are rehabilitated more quickly in their own environments instead of using 'false' environments to support rehabilitation.

8.1.5 Diabetes

There is increasing prevalence of Type 2 diabetes linked to obesity levels, inconsistent engagement of primary care in diabetes management and challenges within the acute workforce unit to support community arrangements. This can lead to limited support for patients to manage their own conditions.

We have implemented the Super Six model across Rotherham, which began to show some 'buds' of improvement with early success of the Diabetes Remission Course in reversing type 2 diabetes.

There has been large scale education and training in the Primary Care workforce to improve treatment targets, including competency packages for Practice Nurses. We have implemented a dedicated advice line for Primary Care and held targeted workshops/education with hard to reach and BME patients with diabetes.

Year 3 of the National Diabetes Prevention Programme (NDPP) has been implemented and we have reviewed our multidisciplinary footcare offer within Rotherham.

A further review of the diabetes pathway is being undertaken to identify how further improvements can be made to the pathway to increase compliance with the treatment targets.

We plan to increase the roll-out of the Remission programme which has delivered excellent success, increasing the numbers who attend the NDPP to reduce the numbers who eventually are medicated.

A wide range of audits are being conducted across the general practices to establish where HbA1C management can be improved. The results of this audit will identify areas for individual practice improvement and also inform how the CCGs community diabetes service will develop in the future.
Our aim is to improved diabetes control for patients with Type 1 and Type 2 Diabetes and reduce the number of patients with type 2 diabetes requiring medication for this condition.

8.1.6 Respiratory Disease

The Right Care programme highlighted that we have high cost respiratory services, high admission levels and poorer outcomes for our patients than our counterparts across the ICS.

Non elective admission levels are high particularly for chronic lower respiratory, especially COPD. Asthma, influenza and pneumonia were also highlighted as areas where Rotherham admitted more non-electively than the Right Care peer group.

We also have the 2nd highest cost per patient for oxygen in the Yorkshire and Humber Region.

Improvements have been made from the latest refresh of Right Care data. These include:

- A respiratory support unit opened at TRFT to provide more structured care particularly for non-invasive ventilation
- We have undertaken a review of respiratory services and are entering an engagement phase
- Pulmonary rehabilitation is already well attended in Rotherham.

We will enhance our model of respiratory care provision with increased community and primary care involvement and increased nurse respiratory support into the acute unit to prevent/shorten admission to:

- Provide a single, integrated pathway for respiratory patients to ensure a more consistent approach to primary care management
- Improve diagnosis across Rotherham
- Improve the management of respiratory patients including self management and provide digital options, for example, myCOPD / Rotherham Heath App
- Reduce the risk of admission to hospital
- Expedite discharge home for those who do require admission, with nurse support from the community team based in an acute setting
- Improved experience for this cohort of patients and their families
- Optimise breathing space for outpatient respiratory particularly pulomonary rehab and patient education to improve patient self management of their condition.
- Care pathways will integrate with TRFT, with more specialist care at Sheffield where appropriate, but with the aim to deliver as much care as possible closer or in the patients own home.
- Uniform prescribing so that the same treatments particularly in the form of inhaler therapy are used in primary and secondary care.

Our aim will be to upskill staff across primary and community care to better support patients and improve outcomes. All respiratory patients accessing care at the hospital will be known to the community team and all patients who are on home oxygen will receive a follow up to ensure they are on the correct prescription.

We will provide more comprehensive assessment and screening and increased referral rates to pulmonary rehabilitation will improve patient outcome. Patients will be able to go home earlier and recovering care will be at home in line with the NHS Long Term Plan.

We will support patients to self-manage, to understand their conditions, what to do to manage their exacerbation and support to manage anxiety and depression of the disease.

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9 Transformation Workstreams

As previously described, our approach has been to identify five closely interlinked transformation workstreams to maximise the value of our collective action and transform our health and care system.

These workstreams will be taken forward through three transformation groups; children and young people, mental health, learning disabilities and neurodevelopmental care and urgent and community care. The following pages provide further information for each of these workstreams and set out the priorities each have chosen to take forward collectively over the next two years.

9.1 Children and Young People

Overview

Children and young people are a key priority for partners in Rotherham. The evidence is clear that healthy foundations in the early years are important to lifelong wellbeing that will increase the health, happiness and prosperity of the Rotherham population.

Our commitment to supporting children and young people is set against a context of increasing levels of demand across several key areas. The number of Looked After Children in Rotherham is high but remains stable; the number of requests for Education, Health and Care plans for children with special educational needs and disabilities continues to rise, as does the rate of referral for assessments for neurodevelopmental diagnosis. The number of children with chronic health conditions is increasing and rates of obesity for children at age 11 are higher than in other parts of the country.

Children and families access health and social care, treatment and education in a range of different ways; they go to nursery and school, see GPs and community nurses. They may receive help and support from the local authority's early help and social care pathway, go to minor injury units, pharmacists, walk-in centres or children's assessment units. They may call 111 or 999. Rotherham is one of five district hospitals providing paediatric services with a specialist neo-natal department at Sheffield Teaching Hospitals and a specialist tertiary centre, Sheffield Children's Hospital.

From the moment that they are conceived, children need help and support to stay safe and thrive. As local partners it is our responsibility to ensure that pathways to the right care and support are easy to access and high quality.

Strong partnership working is a way to support children to thrive and achieve positive outcomes in all aspects of their lives. Each of our priorities requires us to take partnership working to the next level, developing integrated pathways, joint commissioning arrangements and a shared view of our performance. Each priority will focus on a distinct cohort of children whose needs and vulnerabilities require fully integrated pathways to enable them to achieve positive outcomes without the barriers of organisational silos or funding restrictions. Whilst the priorities are not necessarily part of a single integrated pathway, they are sometimes overlapping and interdependent.

Our work in Rotherham will also take account of wider developments in South Yorkshire and Bassetlaw, where the Integrated Care System has been working to create a single clinical network for hospital paediatrics.

The core network includes paediatricians from each hospital alongside colleagues from GP practices, emergency care, children and adolescent mental health and the ambulance services. There are close links to public health, commissioners, hospital management, and public and patient engagement teams.

Our key areas of focus are on some of our most vulnerable groups of children, from conception to their third birthday, children who are looked after and have special educational needs and disabilities. We will work together to support children and young people to have good mental health and to feel supported as they grow to adulthood. We will make pathways to support as simple as possible, we will be accountable to each other and to children whose voice, individually and collectively, will guide our work.

Across all transformation workstreams, we have identified the data sets that will bring most benefit to our services and support our transformation workstreams are:

- Community data
- Troubled Families data
- Primary Care data
- Mental Health data

Our transformation leads and service representatives will continue to work with colleagues to define the data sets and in ensuring the best use of the Population Health Management (PHM) tool to support our transformation priorities.

Looking forward our priorities will be:

1. The First 1001 Days
2. Special Educational Needs and Disabilities
3. Looked After Children
4. Children and Young People's Mental Health and Emotional Wellbeing
5. Transitions to Adulthood

Priority 1: The First 1001 Days

The first 1001 days from conception to age two is a critical stage and period of rapid growth. During this time babies' growing brains are shaped by their experiences, particularly the interactions they have with their parents and other caregivers. What happens during this time lays the foundations for future development. Every aspect of a baby's environment influences its physical, emotional and social development. In an environment that allows the child to develop in the most optimal way, with emotional wellbeing, capacity to form and maintain relationships, healthy brain development and language development leading onto cognitive development, school readiness and lifelong learning will enable the child to contribute to society and also improves their life chances.

The evidence shows that:

- Ensuring that the brain achieves its optimum development and nurturing during this peak period of growth is therefore vitally important and enables babies to achieve the best start in life.
- From birth to age 18 months, connections in the brain are created at a rate of one million per second! The earliest experiences shape a baby's brain development and have a lifelong impact on that baby's mental and emotional health.
- A foetus or baby exposed to toxic stress can have their responses to stress (cortisol) distorted in later life. This early stress can come from the mother suffering from symptoms of depression or anxiety, having a bad relationship with her partner, or an external trauma such as bereavement.
- International studies show that when a baby's development falls behind the norm during the first year of life, it is then much more likely to fall even further behind in subsequent years, than to catch up with those who have had a better start.
- Attachment is the bond between a baby and its caregiver/s. There is longstanding evidence that a baby's social and emotional development is strongly affected by the quality of their attachment.
- Babies are disproportionately vulnerable to abuse and neglect. In England they are seven times more likely to be killed than older children. Around 26% of babies (198,000) in the UK are estimated to be living within complex family situations, of heightened risk where there are problems such as substance misuse, mental illness or domestic violence. 36% of serious case reviews involve a baby under one.

The best chance to turn this around is during the 1001 critical days. At least one loving, sensitive and responsive relationship with an adult caregiver teaches the baby to believe that the world is a good place and reduces the risk of them facing disruptive issues in later life. Every child deserves an equal opportunity to lead a healthy and fulfilling life, and with the right kind of early intervention, there is every opportunity for secure parent infant attachments to be developed. From cross party manifesto www.1001criticaldays.co.uk

Our Progress
During the first Place Plan, the 0-19 Healthy Child pathway was an area of focus. The work supported the transformation agenda for the 0-19 Service. The service has undergone a significant re-design and continues to try and balance the requirements of the Healthy Child Programme (with prevention at its heart) and the need to meet high levels of presenting need.

Our Plan
A systematic approach to improving support for children, parents and families during this vulnerable period which requires a long-term and co-ordinated response is needed.

As outlined in the House of Commons Health & Social Care Committee, First 1001 days of life, February 2019:
High quality local services for children, parents and families should be founded on the following six principles:

- Proportionate universalism, so services are available to all but targeted in proportion to the level of need
- Prevention and early intervention
- Community partnerships
- A focus on meeting the needs of marginalised groups
- Greater integration and better multi-agency working; and
- Evidence based provision

In Rotherham we will develop, jointly with all stakeholders and partners, a clear and ambitious plan to improve support for children, parents and families in the first 1001 days which will reflect these principles and set out key actions.

A partnership Steering Group will be developed to provide strategic leadership, management and co-ordination of this priority and reports to the Place Board and associated governance.

Key Outcomes
Children in Rotherham are healthy in the first 1001 days and have good foundations for lifelong wellbeing.

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- Local leadership and governance in place to deliver on the first 1001 days – Q1 2020
- Carry out a scoping exercise and gap analysis to identify services already contributing to the first 1001 days and what we need to develop – Q3 2020
- Development of a local action plan to deliver on the first 1001 days – Q3 2020
- To explore realigning commissioning pathways and commissioning arrangements in relation to 0-19 services – Q4 2022

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- Increase breastfeeding prevalence at 6-8 weeks
- Increase the proportion of children aged 2-2 half years receiving ASQ-3 as part of the Healthy Child Programme or integrated review
- Reduce percentage of women smoking at time of delivery

Priority 2: Special Educational Needs and Disabilities
The Special Educational Needs and Disability (SEND) Code of Practice Statutory Guidance (2015) sets out how local areas will work together to ensure that children and young people with special educational needs and disabilities are identified early, have their needs met and achieve positive outcomes.

Partners from the local authority, Rotherham schools and colleges and all health partners work together to ensure that outcomes for children with SEND are positive. The SEND Strategic Board is established and has recently agreed a clear set of outcomes that will help us to assess if our work together is making a difference.

Our Progress
A SEND Sufficiency Strategy has been agreed for both health and education. New arrangements are in place to add capacity to the health system, including speech and language, special school nurses

(to add training capacity) and occupational therapy resources to enable the delivery of a new sensory model.

New special school places have been created, and a further 111 school places in the borough will be developed by September 2020

New arrangements are in place to deliver specialist equipment to children and young people; a process is in place to agree funding and waiting lists have reduced significantly

Co-production arrangements are in place and the VOICES Day held in November 2019 will ensure that the new SEND strategy embeds the principles of co-production into planning and identifies our ambition for the next 3 years.

Our Plans
The SEND Strategic Board will continue to monitor the progress made towards the delivery of projects that will deliver the identified outcomes. The focus will be on joint commissioning arrangements and ensuring that clear pathways are in place to support children with SEND to be healthy, fulfil their educational potential and prepare well for adulthood.

Key Outcomes
- All children and young people in Rotherham with SEND to enjoy good physical and mental health
- All young people in Rotherham with SEND are well prepared and supported to exercise choice and control to enable them to enjoy fulfilling lives
- All Children and Young People in Rotherham with SEND and their families have their voices heard and this makes a difference to their experiences and outcomes
- All children and young people in Rotherham with SEND have positive opportunities to make progress in a person-centred way

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***
- The Rotherham Sensory Model is implemented and embedded.
- Roles and responsibilities to support children with Special Educational Needs and Disabilities in school are clearly understood
- A graduated response is in place and supported by a clear commissioning framework for all of the following areas:
  - Dyscalculia
  - Dyslexia
  - Dyspraxia
  - Hearing Impairment
  - Moderate Learning Difficulties
  - Physical Needs
  - Social Communication Autism Spectrum
  - Social Emotional and Mental Health
  - Visual Impairment

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***
- % of services are delivered in the required time period (18 weeks) (SALT (Speech and Language Therapy), OT (Occupational Therapy), PT(physio Therapists)
- % of Education, Health and Care Plans completed within the statutory timescale (20 weeks)

Priority 3: Looked After Children
This area of work has previously been overseen by the Corporate Parenting Board. It is positive that Place Plan partners will have oversight of key opportunities to work together to support Looked After Children (LAC).

The LAC Physical and Mental Health Needs group is an existing group that will drive forward this scheme of work, having already made significant progress in improving the percentage of LAC Initial Health Assessments completed within timescale.

Our Plans
The Local Authority are the corporate parents of Rotherham's Looked After Children. As parents we want our children to achieve the best possible outcomes in all areas of their lives. We want our children to do well at school, be healthy and have the skills they need to be successful for the rest of their lives.

The children in our care may have additional vulnerabilities due to their earlier childhood experiences; they must have a service offer that is accessible and meets their needs.

Place Plan partners can make a difference to the lives of Looked After Children by ensuring that their health needs are met, and that the service offer is engaging and integrated with the education and social care offer, regardless of how hold they are and where they live. Our joint responsibilities are set out in the Childrens Act.

There is an opportunity to work together to ensure we meet our responsibilities and support children to succeed.

The number of Looked After Children in Rotherham is higher than that of statistical neighbours, creating additional demand pressures across the system. This pressure is particularly acute in terms of identifying and supporting the right placements for children, and in assessing and meeting their health needs. This scheme of work will focus on being able to support children and young people within family-based settings wherever possible, or in local residential provision. To achieve this will require local placements that are supported by the right education offer, and access to support for their psychological and therapeutic needs.

There will also be a focus on working together to ensure that Health Needs Assessments are high quality and timely through clear commissioning arrangements. There is also an opportunity to explore how to meet the needs of adolescents. Approximately 20% of the shortfall in Health Needs Assessments is due to adolescents refusing the opportunity to access them. As a result they are at risk of not having their health needs best met including advice on alcohol, tobacco and safer sex which may lead to them being vulnerable to ill-health as an adult.

Key Outcomes
Looked After Children live in stable placements and their education and health needs are understood and met.

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- Refreshed commissioning arrangements are in place to complete LAC health assessments.
- A review of therapeutic services includes key recommendations to support the social, emotional and mental health needs of Looked After Children.

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- % of LAC in a Family Based Setting
- % of LAC Health Assessments taken place in time
- Placement stability - % of children with less than three placement moves in previous 12 months.

Priority 4: Children and Young People's Mental Health and Emotional Wellbeing
There is intense focus on meeting the needs of children and young people who need support to have good social, emotional and mental health. This terminology is used to describe children who have diagnosed mental health problems but is equally applied to those whose behaviour is triggering concerns about their overall wellbeing.

Such a wide range of need cannot be met by a single organisation or be described using a simple pathway. There is a requirement for the whole system to mobilise to ensure that need is identified and met appropriately and as early as possible. The goal is that children and young people, parents and carers, and practitioners should experience no wrong door when it comes to meeting the needs of children who need support with social, emotional and mental health needs.

Progress

- The locality advice and consultation model is increasingly well established; includes effective links with Early Help
- Trauma-informed care becoming established through joint work with Operation Stovewood
- 100% of referrals are assessed within 6 weeks
- 100% of referrals are receiving treatment within 6 weeks
- Rotherham was successful in its joint bid with Doncaster for Wave 1 of the Mental Health in Schools Trailblazer

Our Plans

There are three key areas that require our focus in this scheme of work; these are:

- To improve the pathway for children and young people who need support with neurological development
- To provide seamless pathways and meet need as early as possible with the right service through implementation of the mental health trailblazer and dissemination of learning across the system
- To understand and meet the needs of the children's workforce to respond to children who need support with their mental health and emotional wellbeing.

Key Outcomes

TBC

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

TBC

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

TBC

Priority 5: Transitions to Adulthood

There is a need to put in place clear arrangements for children with long-term conditions who are reaching adulthood. Transitional arrangements are also high on the national agenda and have been identified as one of the six key priorities identified by the National Clinical Director for Children and Young People.

The long-term conditions of asthma, epilepsy and diabetes (for those under 19 years of age) are key priorities.

A report by the Care Quality Commission (CQC) in June 2014 found that young people who have physical disabilities or illnesses do not always receive the care and support they need when they move on to adult care services and transitional arrangements will be scrutinised as part of the Care Quality Commission.

Progress

In the last Place Plan the focus was on Preparation for Adulthood; this is the terminology that is applied specifically to children and young people with special educational needs and disabilities. Progress was made through the creation of a data portal that identifies children with additional vulnerabilities who will require support in adulthood, and through the increase in local education opportunities for children over the age of 16, including the introduction of a supported internships.

Our Plans

Adult and children's services across the health system have identified gaps within their transitional arrangements, including services for people with diabetes, neurodevelopmental conditions, physical disability, asthma, epilepsy and complex and multiple health conditions. There is need put in place clearer arrangements to ensure that transitional arrangements are compliant with National Institute for Clinical Excellence (NICE) guidance (transition from children's' to adults' services for young people using health or social care services, Feb 2016).

Final Draft 3.0
Final Draft 3.0

The primary task will be to define the scope of the work and put in place a clear work plan that sets out how we will work together to improve local arrangements.

Key Outcomes
TBC

Milestones
TBC

KPIs
TBC

9.2 Mental Health, Learning Disabilities and Neurodevelopmental Care

Our success
Improving the care and support we offer for people in the areas of Mental Health, Learning Disability and Neurodevelopmental Care has been a priority for Rotherham Place partners over the period of our previous place plan, we have delivered the following improvements across the Rotherham Place:

- Introduced **24 /7 Adult Mental Health Liaison** services, which was launched in January 2019 (Mental Health 5 Years Forward View **Core 24** standard achieved)
- Implemented the Rotherham **Suicide Prevention Strategy**, rolling out Safe-talk and self-harm training, introduced small grants schemes to work with men's groups. Commissioned a Listening service to support families bereaved by suicide and also launched our very successful **Be the One campaign** reaching over 1 million people.
- Launched an Enhanced **Perinatal Mental Health Service** in May 2019 (developed in partnership with partners from Sheffield CCG, Doncaster CCG, SHSC and RDaSH / NHS England Perinatal funding secured in 2018/19)
- Worked with partners from across the South Yorkshire and Bassetlaw Integrated Care System to secure funding for **Individual Placement and Support** (IPS).
- In partnership worked with RDaSH and South Yorkshire Police to successfully pilot the Police Street Triage over the Christmas period 2018/19
- In partnership with Crossroads the CCG has enhanced support for those caring for people with mental health problem. These include:
  - Mental Health Carers Support pilot launched
  - Carer Awareness Training for Primary Care
  - Development of a Carers Hub
  - Development of a series of workshops

Rotherham has developed programmes to support delivery of Transforming Care, this has resulted in:

- Agreed to commission an All Age Neurodevelopmental pathway which will be rolled out in February 2020.
- Successfully delivered the agreed number of discharges with the Sheffield, Doncaster, Rotherham, North Lincolnshire (SDRNL) Transforming Care Partnership in 2018/19.
- Introduced a Learning Disabilities Mortality Review (LeDeR) group to coordinate reviews where deaths of people with a learning disability have occurred.
- Created a 'data warehouse' to enable better and more effective planning for young people in Rotherham's preparing for adulthood cohort.

Mental Health transformation leads have engaged on the development of the Population Health Management (PHM) Tool which will be available from 2020. It has been agreed that the mental health transformation workstream will be the priority focus for first use of the PHM tool.

Across all transformation workstreams, we have identified the data sets that will bring most benefit to our services and support our transformation workstreams are:

- Community data
- Troubled Families data
- Primary Care data
- Mental Health data

Mental Health service representatives will take an active role in defining the data sets and in ensuring the best use of the PHM tool to support our mental health priorities.

Looking forward the priorities identified are:

1. Improving Access to Psychological Therapies (IAPT) service (referred to as ' Adult Common Illness (IAPT)' in the NHS Long Term Plan)
2. Dementia diagnosis and post-diagnostic support
3. Adult Severe Mental Illnesses (SMI) in the Community
4. Mental Health Crisis and Liaison
5. Suicide prevention
6. Better Mental Health for All, including loneliness
7. Improving residential, community and housing support for people with Mental Health and/or Learning disability
8. Delivering the NHS Long Term Plan for people with a learning disabilities and / or autism (this includes Transforming Care)
9. Delivery of My Front Door transformation programme
10. Delivery of Autism Strategy and Neurological Pathway

Priority 1: Delivering improved outcomes and performance in the Improving Access to Psychological Therapies (IAPT) service

Mental health issues are impacting more significantly on people in Rotherham than the nationally recognised issue. The most recent data from Public Health indicates that:

- In 2017/18 13.4% of adults over 18 in Rotherham had depression compared with an England average of 9%
- In 2017 the estimated prevalence of common mental health disorders in those aged 65 and over in Rotherham was 11.6%
- For self-reported emotional wellbeing, in 2017/18 Rotherham residents reported high levels of; low satisfaction with life, low happiness and high anxiety. These rates were higher than the average for England and for the Yorkshire and Humber region as a whole

The number of people over 65 is projected to increase by 18% over the next ten years (2016 to 2026), from 50,500 to 59,700. Almost all of this growth will take place in people aged over 70 years. This will mean an increase in the number of people with long term conditions such as heart disease, diabetes, dementia and cancer. To optimise the physical health care of patients with long-term conditions, it is essential that their mental health and wellbeing are addressed at the same time.

- Sustained the IAPT waiting time access targets (75% with 6 weeks, 95% within 18 weeks)
- Developed a perinatal IAPT pathway
- Workforce development improved by:
  - 3 psychological wellbeing practitioner (PWP) and 3 Cognitive Behaviour Therapy (CBT) trained in long term conditions
  - 2 trainee CBT
  - 3 trainee PWP
  - Veteran lead established
- Delivered the Mental Health Forward View and Long-term Plan 'Adult Common Mental Illnesses (IAPT)' ambitions.

Our Plan

- We will reduce IAPT CBT waiting times
- Expand and develop the Rotherham IAPT workforce
- Improve access to IAPT services (Core and LTC) across Rotherham, by developing the local digital offer, as well as establishing stronger links with workplaces and initiatives, such as the 'Be Well at Work'
- Improve access for older people to IAPT services (core and LTC)
- Sustain the MH 5 Year Forward access standards (6 weeks – 75% / 18 weeks – 95%)

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- Identify and agree workforce development for both Core and LTC IAPT (including training requirements), in line with the requirements of the Long-term Plan – Q4 19/20
- Reduction in the IAPT CBT waiting times – Q4 20/21
- Delivery of Mental Health 5 Year Forward 2019 /2020 target – Q4 20/21

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- 75% of people referred to IAPT commencing treatment within 6 weeks of referral
- % Compliance of those who have entered (i.e. received) treatment as a proportion of people entering treatment with anxiety or depression
- % of people who have completed treatment having attended at least 2 treatment contacts and are moving to recovery

Priority 2: Improving Dementia diagnosis and support

Dementia is a growing challenge. As the population ages and people live for longer, it has become one of the most important health and care issues facing the world. Currently, it is estimated that in Rotherham around 3,109 people have dementia, which is projected to rise to nearly 4,500 by 2025.

Dementia mainly affects older people, and after the age of 65, the likelihood of developing dementia roughly doubles every five years. However, for some dementia can develop earlier, presenting different issues for the person affected, their carer and their family.

There are around 4,000 carers of people with dementia in Rotherham. It is estimated that one in three people will care for a person with dementia in their lifetime. To support this:

- Dementia diagnosis rates continue to remain high (85% against national target of 67%)
- Expansion of Carers clinics across Rotherham
- Developed of a programme of training sessions to support people with dementia and their unpaid carers
- Development of the Crossroads Carers Hub has commenced
- Delivered the Prime Minister's 2020 Dementia Challenge / NICE compliant service.

Our Plan

- We will re-design our diagnostics pathway to maintain Rotherham's high dementia diagnosis rate
- We will improve the offer of support to those caring for someone with dementia (NICE Compliant)
- We will work with Dementia Carers Resilience Service to extend the carer offer.
- We will improve the offer of post diagnostic support to people living with dementia and their carers
- Primary care workforce development – to improve the understanding of how to support carers
- We will improve and timely access to services closer to home

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- NICE compliant dementia diagnostic pathway to be agreed – Q1 20/21
- NICE compliant dementia post-diagnosis pathway to be agreed – Q1 20/21
- To implement the new dementia pathway across the Rotherham place – Q4 20/21
- To rollout a programme of training sessions to support people with dementia and their unpaid carers – Q4 20/21

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- Dementia diagnostic rates % (national target 67%)
- % diagnosed within 6 weeks of referral by march 2021
- % of GP practices achieving 62% of post diagnostic support plans recorded in last 12 months

Priority 3: Adult Severe Mental Illnesses (SMI) Community Care
There is an estimated 2389 people in Rotherham that have a Severe Mental Illness (SMI). On average men living with severe mental illness die 20 years earlier, whilst women living with a severe mental illness die 15 years earlier. Public Health England research and analysis indicates that people with severe mental illness experience the following physical health inequalities. People with SMI in England:

- die on average 15 to 20 years earlier than the general population
- have 3.7 times higher death rate for ages under 75 than the general population
- experience a widening gap in death rates over time

It is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that can be prevented. This disparity in these health outcomes is partly due to this cohort of patients not being offered appropriate or timely physical health assessments.

Furthermore, this cohort of people is more likely to experience difficulties gaining employment.

Our Plan

- Working in partnership with primary care and RDaSH the CCG has developed a **Severe Mental Illness** Local Enhanced Service (LES), including a local Shared Care Protocol
- Improve access and increase uptake in physical health check for individuals on the SMI registered (increase life expectancy /reduce inequalities)
- Increase in support available to help people with a **severe mental illness** access employment (Reduction in the employment inequalities) - *to be delivered by IPS programme*
- Increase in the number of people living with **a severe mental illness** receiving a comprehensive annual physical health check
- To ensure that primary care staff teams feel confident in actively supporting people with severe mental illness to access relevant physical health screenings and interventions.
- To improve and ensure early access to specialist NICE compliant **early intervention in psychosis** provision.
- Improved recovery outcomes
- Increase in support for the families of people with psychosis

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- Oversee full implementation by ALL GP practise of the Severe Mental Illness Local Enhanced Service (SMI LES) and Shared-Care protocol – Q3 20/21
- Achieve Level 3 Early Intervention Psychosis NICE concordance standard – Q3 20/21
- Support the delivery of the ICS Individual Placement Support programme - Q4 20/21

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- 60% of people on the SMI register receive an annual health check
- % of people receiving a NICE-recommended package, with a specialist Early Intervention Psychosis (EIP) service in 2 weeks

Priority 4: Mental Health Crisis and Liaison
It is known that the experience of one person and their perception of a mental health crisis is as unique and individual, as the person and what for one person may feel manageable may for another person feel completely devastating or overpowering.

A mental health crisis may take a number of forms including, but not limited to, anxiety or panic attacks, psychotic experiences such as hallucinations, feelings of paranoia, relapse of a serious mental illness or thoughts of suicide or acts of self harm. We know that:

- People have reported contact with at least three different services when experiencing a mental health crisis.
- People with a mental health problem are almost five times more likely to be an emergency inpatient admission than someone without mental ill health.

We want to improve people's experience at the time of crisis, offering high quality timely care and support.

Successes in 2019/20

- Pilot work ongoing to allocate mental health worker into safer neighbourhood teams to support Police colleagues and service users in crisis
- 24 /7 Adult Mental Health Liaison service launched January 2019 (Mental Health 5 Years Forward View Core 24 standard achieved)
- Expansions of the crisis resolution /home treatment team

Our plan

- We will expand services for people experiencing a mental health crisis (timely access to support in a crisis)
- Continue to ensure that the Rotherham Mental health Liaison Service continues to meet the core 24 standards for adults and older people
- Delivery of the Mental Health Forward View and Long-term Plan 'Mental health Crisis Care and Liaison' ambitions
- Reduced inappropriate out of area placements for acute mental health care
- Worked with partners from across the SY&B ICS to develop section 136 and places of safety provisions

Key Outcomes

- Increase the offer of support for people in crisis and their unpaid carers
- Enhance social care input in the mental health wards (reduction in Delayed Transfers of Care)
- Improve care act compliance
- Workforce development
- Improved recovery outcomes for people experiencing a crisis

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- Workforce development training (PITT) – Q3 19/20
- Establish a social worker co-ordinator post to operate across the mental health wards – Q4 19/20
- Review of the social care delivery model (increase social care capacity / improve care act compliance)- Q3 20/21
- Workforce development of the Crisis Resolution and Home Treatment Teams (CRHTT) and increase social care capacity – Q4 19/20
- Establish a CRHTT service that operates in line with best practice – Q4 20/21
- Maintain Mental Health Liaison (Core 24 compliant) service – Q4 19/20
- Develop at least one alternative crisis service to hospital admission – Q3 20/21
- Reduction in the number of out of area placements- Q4 20/21

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- Referrals who require a face to face assessment who were seen within 4 hours % compliance for both MH Liaison and Crisis
- 72 -hour follow-up post discharge (CQUIN data)
- Urgent and emergency MH response within 1 hour of receiving an urgent referral (core 24)
- Urgent and emergency MH response within 1 hour of receiving an urgent referral (CRHTT)
- Reduction in the number of inappropriate out of area placements
- Reduction in the number of mental health delayed transfers of care

Priority 5: Quality provision (residential, community and housing support)

Many mental health problems can be treated successfully. However some people are left feeling anxious about recurrence or relapse and others continue to experience symptoms. Despite the de-institutionalisation agenda for people at the acute end of provision, many people with long-term health problems continue to anticipate discrimination and health services remain a central part of people's day-to-day life. Significant cohorts of people with mental ill-health also remain in long-term inappropriate residential care settings. A recovery model is needed to support people back into an independent life.

Recovery happens in life, not in the health system. This means providing help to people as they engage or re-engage in everyday activities and mainstream participation. We now know a lot about the types of support which help Recovery. Focus to continue on:

- increasing control (e.g. by reducing coercion and restraint; pushing forward the development of Recovery-oriented services);
- agency (e.g. by supporting the use of personal budgets, self-management and patient activation) ; and
- opportunity (e.g. by addressing health inequalities and working to create a Recovery-oriented society).

Whilst the Place Plan is aligned with the NHS Long Term plan, funding constraints have meant that the majority of resources have been targeted at reactive services rather than preventative or early intervention work. Notable exceptions include the Working Win work programme supporting people with mental ill-health into work and proactive interventions to support the place strategy for suicide prevention. These upstream approaches have demonstrated positive progress in tackling health inequalities and the wider determinants of mental ill-health.

The development of a recovery pathway would include the scoping of the current system to identify areas of good practice, challenges and opportunities. There are already pockets of good practice in the Place and wider work-streams that have a positive impact on recovery. The initial scoping would seek to map out the current system landscape and the underlying causes of mental-ill health.

For example, SY&B ICS work is underway looking at those people with complex lives, street homelessness and people at risk of homelessness. Local housing providers have identified childhood trauma as a key underlying risk factor for this cohort and other people covered by the Homelessness Reduction Act 2018.

Our Plan

- Develop a recovery pathway (mental health community provision)
- Reduced length of stay within residential care settings
- Smoother transition between services (e.g. CAMHs and Adult Mental Health Services)
- Increase in employment and economic activity

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- Scoping the current system to identify challenges and opportunities within a recovery model – Q3 20/21
- Co-production of a vision for recovery – Q3 20/21
- Service transformation model to be agreed – Q1 21/22

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- Length of stay in setting
- Number of people with mental ill-health receiving re-enablement

Priority 6: Suicide prevention

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

Suicide Prevention is a high priority in the borough. There are strong governance arrangements with links to the Health and Wellbeing Board and the Place Board.

Rotherham suicide rates for 2016-18, the 3-year directly age-standardised rate (DSR), are above the rate for England (9.6 per 100 000) and the Yorkshire and Humber Region (10.7 per 100 000). After a small decrease between 2013-15 and 2014-16, the 3-year directly age-standardised rate (DSR) increased from 13.9 to 15.9 deaths per 100,000 between 2014-16 and 2015-17. The latest data for 2016 – 2018 shows that this has now dropped to 13.1 deaths per 100,000 a decrease of nearly 18%.

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

A symposium in June 2019 provided an opportunity for Rotherham partners to hear about national research and best practice in relation to suicide prevention. It acted as a self-assessment of the Rotherham Suicide Prevention and Self Harm Action Plan. Following the symposium the action plan was refreshed, key actions are:

- Rotherham's suicide prevention campaign 'Be the One', which launched September 2019, www.be-the-one.co.uk
- Delivery of NHSE year 2 suicide prevention funding
- Delivery of ICS wide suicide prevention activity
- Implementation of Rotherham Suicide Prevention and Self Harm Action Plan

Our Plan

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

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- Delivery and evaluation of Year 2 NHSE funded projects – Q4 19/20
- Delivery of Self-harm train the trainer – Q4 19/20
- Delivery of self-harm awareness training programme to commence – Q1 20/21
- Delivery of 20/21 actions within local plan – Q4 20/21
- Evidence of impact of the Be the One campaign – Q4 20/21
- Delivery and evaluation of Year 3 NHSE funded projects – Q4 20/21

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- To reduce the suicide rate by 10% from the 2016-2018 baseline (15.9 per 100,000)
- % of people trained as self-harm train the train the trainers (against target – 15 places commissioned per course)
- Number of people attending self-harm T-T

Priority 7: Better Mental Health for All and Loneliness

Rotherham place partners joined together to promote the Five Ways to Wellbeing campaign in Rotherham. This campaign is about getting people of all ages to look after their mental health. It is applicable to people without a mental health problem and for people who have a mental health condition. It is an asset based approach encouraging people to access things around them so it does not need to cost money.

Final Draft 3.0
Final Draft 3.0

There are a range of resources available, including a toolkit and presentation which are available on the Council's website www.rotherham.gov.uk/health. This includes a film to launch the campaign which can be viewed at www.rotherham.gov.uk/health

We all have mental health, just like we have physical health and it's important that we take steps to look after it. The following steps, known as the 'Five Ways to Wellbeing' are easy and can be incorporated into our daily lives almost straight away.

Be Active: Regular physical activity is associated with lower rates of depression and it doesn't have to be intense to make a difference. Do as much or as little as you can – you could try walking, dancing, running, cycling or gardening.

Connect: People who are connected with family, friends or people living in their community are happier, physically healthier, live longer and generally have fewer problems mental health problems. To connect with others, you could join a group, help a friend, family member or colleague or try volunteering.

Give: It has been proven that people who offer an act of kindness once a week over a six-week period report an improvement in their wellbeing. Giving could be smiling at someone and saying thank you. It could be volunteering within the local community or doing something nice for a colleague or friend.

Keep Learning: People should never stop learning. Learning throughout life enhances self-esteem, increases confidence, encourages social interaction and generally leads to people having a more active life. Why not learn a new skill like cooking, playing an instrument, fixing a bike, photography or painting.

Take Notice: Life can be very busy with little time to stop and reflect. Studies have shown that when people are aware of what is taking place in the present it directly enhances well-being. People worry less about the future and what has happened in the past and can see what really matters, allowing them to make positive choices. Stopping and observing; spending time with friends and family; enjoying nature; and taking a different route home from work or the shops noticing what is different are all ways to take notice.

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- Evidence of integration of Five Ways messages within provider and commissioned services – Q4 19/20
- Evidence of impact- case studies – Q1 20/21

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- Self-reported wellbeing PHOF; ONS Annually It is a measure of overall wellbeing in the community

Loneliness

Loneliness is a bigger problem than simply an emotional experience. Research shows that loneliness and social isolation are harmful to our health: lacking social connections is a comparable risk factor for early death as smoking 15 cigarettes a day, and is worse than well-known risk factors such as obesity and physical inactivity. Loneliness increases the likelihood of mortality by 26%. While many think of loneliness as a social issue, it also affects people's physical and mental health and wellbeing. Loneliness affects people of all ages. Numerous pieces of research, including the Government's National strategy, have suggested that a whole life course approach should be taken when attempting to tackle loneliness. Traditionally people have assumed that it was exclusively the elderly that suffered loneliness, however research by the Office for National Statistics (ONS) has found that, while this demographic group are still significant when it comes to loneliness, there are other demographic groups, including young people, who experience loneliness.

Data on older people living alone (aged 65+) from the 2011 Census and for the percentage of adult social care users who had as much social contact as they would like (2018/19) shows Rotherham values were around England average.

Specific loneliness measures are to be included in the Public Health England Public Health Outcomes Framework with data predicted to be published in November 2020.

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- To launch the partnership action plan – Q1 20/21
- Implementation and delivery of 20/21 loneliness action plan – Q4 20/21
- To pilot Making Every Contact Count in south of borough and make recommendations for future rollout March 2020 – Q4 19/20
- Expand MECC and loneliness across the borough – Q4 20/21
- Establish loneliness data baseline – Q3 20/21

KPI ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- UCLA Loneliness measure
- How often do you feel that you lack companionship?
- How often do you feel left out?
- How often do you feel isolated from others?
- How often do you feel lonely?

Priority 8: Delivering the NHS Long Term Plan for people with a learning disabilities and / or autism (this includes Transforming Care)

The Transforming Care Programme (TCP) aims to transform services and support for children, young people as well as adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. The programme was to close in March 2019, but has been in effect extended and integrated into NHS England's Long Term Plan.

Since 2015 and the publication of Building the Right Support[1] the TCP had two objectives that CCGs, local authorities and partners work together to:

1. Reduce both the need and reliance on hospital beds for people with a learning disability and / or autism (children and adults)
2. Transform both the approach, services and systems to ensure that people with a learning disability and / or autism have access to the best support to prevent mental health and or challenging behaviour issues developing and remain at home and in the community.

The national TCP has expanded to include:

- Creation of dynamic risk registers for both adults with a learning disability and / or autism and children and young people with a learning disability and / or autism.
- Care and Treatment Reviews (CTR's) and Care, Treatment and Education Treatment Reviews (CETR)
- Learning Disability GP Health Checks.
- Learning Disabilities Mortality Review (*LeDeR*) Programme - stopping people dying earlier than they should.
- STOMP-STAMP (Stopping over medication of people with a learning disability, autism or both-Supporting Treatment and Appropriate Medication in Paediatrics) - making sure that if people with a learning disability need medication, that they get the right medication, at the right time and for the right reason.

The NHS Long Term Plan retains the priority to transform and improve the health and care outcomes for people with a learning disability. The Plan still retains all the objectives developed under the Transforming Care Programme and it proposes the following additional developments:

- Reduction in reliance on inpatient care for people with a learning disability and/or autism (CCG-funded) to 18.5 inpatients per million adult population by March 2020.
- At least 75% of people on the learning disability register should have had an annual health check.
- CCGs are a member of a Learning from Deaths report (LeDeR) steering group and have a named person with lead responsibility.
- There is a robust CCG plan in place to ensure that LeDeR reviews are undertaken within 6 months of the notification of death to the local area.
- CCGs have systems in place to analyse and address the themes and recommendations from completed LeDeR reviews.

[1] https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf

- An annual report is submitted to the appropriate board/committee for all statutory partners, demonstrating action taken and outcomes from LeDeR reviews.

This priority seeks to ensure timely delivery of both local and national priorities for the ongoing transformation of outcomes for people with a learning disability and autism

Key Outcomes
The priorities will meet the aspirations that people with a learning disability and/or autism:

- All children, young people, adults and their families are at the centre of everything we do.
- Focus on people's strengths to overcome barriers.
- Guidance, information and support are easily available.
- The right support at the right time and making every contact count.
- Increasing awareness of both learning disability and autism across Rotherham.
- Supporting individuals to live the life they choose.

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- RMBC and CCG to agree process for funding learning disability joint placements – Q4 19/20
- Commissioning solutions to be in place to meet individual trajectories – Q4 19/20
- Continue to reduce reliance on inpatient care for adults aged 18 and over with a learning disability, autism or both so that by March 2020 there is no more than 3 people detained – Q419/20
- Ensure no more than 3 people are detained in hospital at one time – Q4 20/21

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- % of people receiving CTR prior to a planned admission to an Assessment and Treatment Unit or mental health inpatients: adults
- % of patients in an Assessment and Treatment Unit receive a Care and Treatment Review (CTR) every 6 months
- Reduce the number of people admitted in line with the South Yorkshire and North Lincolnshire LD TCP trajectory (local reporting)
- Number of people with LD admitted to ATU (maintain at 3 or less)

Priority 9: My Front Door: Learning Disability Transformation
ICP partners and people with a learning disability, autism or both want individuals to have the same quality of life as everyone else. They also want everyone to have the opportunity to realise their dreams and for people to access a wider range of support that is part of their local community - where people can access employment opportunities, build friendships and travel as independently as possible around the borough.

There are an estimated 31,604 unpaid carers in Rotherham, of which approximately 8009 are older people and of these, 3,760 (39%) are providing 50+ of care and support hours per week (Source: POPPI). This resource supports people of all age and client group and demonstrates a significant contribution to cost avoidance and reduction of dependence on formal services.

There are 347 Unpaid Carers, aged 55-69, currently supporting a person with a Learning Disability in Rotherham borough.

Rotherham recognises the vital role that carers play in both the community and the economy. There is an acknowledgement that more can be done to support carers in order to minimise, where possible, the impact that caring can have on their health and wellbeing.

Family carers of people with learning disabilities have often been carers for the lifetime of the person for whom they care. These carers have a lifetime experience of caring and supporting, coping with many challenges and changes.

The My Front Door Strategy will make sure all people with a learning disability have access to community based services that promote independence, wellbeing and social inclusion, it:

- is the vehicle for communication and engagement with all our key stakeholders.
- builds on the Learning Disability Strategy and Adult Social Care Vision ensuring the information is accessible and relatable to individuals, carers and families.
- supports potential providers to "buy into" our Learning Disability Transformation Programme by pitching their services in real-life ways.
- is our personalised approach to our Learning Disability Transformation Programme moving hearts and minds towards a positive future.
- ensures person centred planning and enables our practitioners to engage with people in new and different ways.
- creates a narrative that changes all our thinking from a focus on decommissioning services to a focus on the real alternatives and opportunities available for individuals
- will have engagement activities that are co-produced with individuals and will enable further consultation on new opportunities.
- develop a new offer to support unpaid carers.

Key Outcomes

- Each person with a learning disability has a review based on person centred approach.
- A dedicated team of social workers with the support of the existing staff will undertake the reviews.
- All people will have the opportunity to make sure each day in their life is meaningful, of value and leads to them having a 'Good Day'.
- Doing things which have a purpose, being in ordinary places doing things most other people in the community would be doing.
- More people have the opportunity to participate in paid employment.
- A strength based approach will be taken to develop a range of opportunities, including Shared Lives, use of personal budgets, develop skills for independent living provide support when the carer needs it and making sure more people have ***their own front door*.**

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- Delivery of My Front Door – Q4 19/20
- Complete annual health check – Q4 20/21
- Support adults with a learning disability into paid employment

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- Proportion of eligible adults with a learning disability having a GP health check
- Proportion of adults with a learning disability who are in paid employment

Priority 10: Draft Autism Strategy and Implementation of all age Neurological Pathway

Rotherham has developed a draft autism strategy with an accompanying implementation plan. The strategy is all age and has connections to the transformation of children and young people's services.

Therefore the focus of activity will be to develop a local adult diagnostic pathway and service, aligning to current RDaSH provision in relation to:

- children and young people Autism and attention deficit hyperactivity disorder (ADHD) diagnostic and post diagnostic support provided through the neurodevelopmental pathway.
- adult learning disability community health provision.

Recent reviews and looking at current commissioned activity it appears that Rotherham's autism pathway is fragmented and has created lots of 'hand off's' which could cause delays. This is reflected from feedback given at recent engagement events with people with autism. Their families have flagged the following issues:

- the lack of support groups post diagnosis.
- a gap in the pathway for young people moving into adulthood between Children and Adult services
- Difficulty accessing allied health professional assessments (Speech and Language Therapists, Occupational Therapy – in particular access to special assessments in relation to Sensory Integration[2] (SI)

Rotherham's autism strategy will oversee the delivery of the transformation of autism diagnosis and post diagnosis support for children and adults.

Key Outcomes

The all age pathway sees the opportunity to:

- Develop a local Rotherham based diagnostic service as per NICE guidance.
- Create a single Neurodevelopmental pathway encompassing the diagnosis and post diagnosis support of both autism and ADHD in children's and adults
- Align activity for adult diagnosis and post diagnosis support for autism.
- Develop an enhanced therapy offer using current commissioned services in RDaSH
- Sustain the adult ADHD pathway

[2] Sensory integration is about how our brain receives and processes sensory information so that we can do the things we need to do in our everyday life.

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- Complete the development of the Autism Strategy (including action plan – Q4 19/20
- Development of Rotherham based Autism and ADHD diagnostic pathway – Q4 19/20

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- % people receiving a diagnosis of autism within 18 weeks following referral or/+
- Reduction in the number of people waiting over 18 weeks

9.3 Urgent and Community

Overview

The case for change and the need for action is clear, services across Rotherham, and the wider NHS, are facing growing pressures as demand rises and our health and care needs become increasingly complex. As our population grows and ages there are increasing numbers of people who need our support.
This is a further pull on already stretched resources and if we do not change the services we offer we will not be sustainable and we will not be able to provide the level of care that we want the people of Rotherham to receive.

In response to these challenges we must look to keep people healthier and independent for longer. We need to make interventions earlier in pathways, reduce handoffs between services and then support people to recover and return to a healthy and independent lifestyle, shifting away from emergency activity into planned activity within the community closer to the individual's home or usual place of residence.

We also know that to do this we must work together, partners recognise that they cannot resolve these issues as individual organisations. A partnership wide approach to the design and delivery of health and care services will provide the opportunity to provide support across an individual's whole pathway, stimulate personal resilience and help to reduce demand for our services. We must make

better use of our resources and our people, supporting them with the right infrastructure to allow them to offer more effective care.

In response to these challenges the Urgent and Community Care Transformation workstream have identified key actions to create an overarching framework. The framework will guide work over the coming years allowing it to quickly identify and deliver key priority programmes of work while continuing to work within a consistent framework, ensuring that our work is aligned. The framework is based on:

1. Integrating our Points of Contact across the system for our population, patients and professionals to make it easier to enter and navigate our system.
2. Integrating our pathways and interventions to provide joined up more effective and efficient care
3. Working closely with the Rotherham Place enabling groups to support the identification of opportunities for improvement and the ability of our teams to deliver the right care when working together.
4. Integrated Community Working to consider what other pathways, services and interventions would most benefit from a collaborative and integrated approach across Rotherham partners.

A key part of the workstream is to focus on priorities that have a clear benefit to the Rotherham population and involve multiple partners across Rotherham working together. There will continue to be work within urgent and community care that sits outside of this transformation workstream and delivered within individual organisations, for example A&E performance improvement, but we will ensure that its work is aligned with these other developments.

While our initial focus will be the implementation and embedding of the redesign of our Intermediate Care and Reablement (ICR) services we have set ourselves a clear task to consider what other pathways, services and interventions would most benefit from a collaborative and integrated approach across Rotherham partners. Population Health data and stakeholder input will be utilised to determine where the biggest impact can be made and to identify key interventions, pathways and teams which would benefit from integration and consequently building a community function from the bottom up.

We must change how we deliver care across Rotherham to realise the ambition of earlier intervention, more proactive and preventative care and help to make services more sustainable by managing demand into high cost services.

The benefits realised from our previous work has made clear the need for integrated working across health, social care, voluntary sector and other partners. We have also learnt lessons from the Health Village pilot and that the approach taken, while positive, is not scalable across the whole of Rotherham.

This approach will support our need to reduce the demand for acute services, increase our capacity to deliver care in the community and closer to the patient's home and provide better use of limited Rotherham resources. This work will also explore how we utilise the opportunity that the creation of Primary Care Networks (PCNs) have provided to Rotherham.

Across all transformation workstreams, we have identified the data sets that will bring most benefit to our services and support our transformation workstreams:

- Community data
- Troubled Families data
- Primary Care data
- Mental Health data

Our transformation leads and service representatives will continue to work with colleagues to define the data sets and in ensuring the best use of the Population Health Management (PHM) tool to support our transformation priorities.

As we move towards greater integration between services we need to make sure that the key tools that our teams use continue to be fit for purpose. Working closely with the enabling groups within the Rotherham Place is critical to providing this. Whether it be the

continued development of an integrated health and care record through the digital group or helping to ensure we have the right staff and skills through our workforce group, they are critical to the success of this workstream.

Therefore we must be proactive and clear in what our requirements are from these groups, working with them to develop and set their priorities through an understanding of what it is we will need and what it is that is possible.

Our Success

We have made considerable progress since the 2018 Place Plan. Of the original six priorities, two have been fully completed with work continuing to progress against the other four in line with expectations and, where applicable, evolved as part of our new priorities. The learning from our work so far has helped guide our current work and will continue to do so.

Priority One: Integrated Point of Contact

- Increased skills and experience within the RMBC Single Point of Access (SPA) has resolved more issues at the first point of contact
- Location of the Care Co-ordination Centre (CCC) with the Integrated Rapid Response and therapies team
- Integration of Mental Health referrals into the CCC
- Pilot established to transfer staff between the CCC, SPA and Mental Health services to enable closer working

Priority Two: Integrated Rapid Response (completed)

- Separation of planned / unplanned district nursing referrals allowed for the creation of a borough wide unplanned hub
- Creation of additional clinical capacity through a single triage function
- Released 29hours per week of admin time through process improvement

Priority Three: Integrated Discharge (completed)

- Discharges to the usual place of residence have increased by 7% and 5% for the over 85s and 65s respectively
- Delayed Transfers of Care (DTOCs) reduced from 7.5% in May 2017 to a low of 1.8% in February 2019
- An estimated £0.5m saving to the Rotherham System through a reduction in acute bed days
- Implementation of a new single electronic referral system has been estimated to save 30mins per patient, time which has been reinvested into patient care.
- Introduction of a community multi disciplinary team (MDT) review of all longer stay patients based on the Emergency Care Intensive Support Team (ECIST) model of good practice.
- The team were nationally recognised and received the Health Service journal award for Value for Money.

Priority Four: Integrated Locality Working

- Completion of the 'Health Village' locality pilot which brought together nursing, therapy, social care and mental health provision in a single MDT
- The introduction of a joint health and social care review of patients requiring double handling has freed 91hours of care time per week to reinvest into direct patient care
- Learning from the pilot have informed the development of the ICR model (see priority 5)

Priority Five: Intermediate Care and Reablement

- Early adoption of a home first ethos saved £300,000 in building and transport costs by incorporating the Rotherham Intermediate Care Centre into the wider reablement team to provide greater at home reablement
- A community led Trusted Assessor pilot working into Urgent and Emergency Care Centre (UECC) and AMU has seen a 15% increase in patient supported at home and a 5% reduction in admissions for referred patients. This was recognised by an Allied Health Professional regional workforce award.

- ICR Business Case approved by all partners for the redesign of services moving away from bed based provision to seeing 500 more patients within their usual place of residence

Priority Six: Care Home Support

- Each residential and nursing home has a named linked GP practice with a GP or Advanced Nurse Practitioner (ANP) visits at least once a fortnight
- Provision of 24/7 specialist health advice including rapid response through the CCC
- The End of Life Hospice at Home Care Home Pilot has been extended. To date this pilot has supported over 1,500 people and avoided over 2,000 admissions

Looking forward our main priorities will be:

- Integration of the Points of Contact across Rotherham
- Implementation of the ICR reconfiguration.
- Development of a coordinated approach to care homes support

Further priorities will be developed following the implementation of the ICR work and the learning we take from that project. Currently the priorities are broad and based around connected pieces of work rather than specific projects. As such we have developed priorities to ensure that we continue to progress this area and have some flexibility over future developments as they begin to emerge.

Priority 1: Integration of the Points of Contact across Rotherham

There are multiple access points into our health and care services across Rotherham. These multiple, often unconnected routes for individuals, patients and professionals can lead to confusion, duplication and delays through multiple handoffs and multiple referrals.

Our Plan

This incorporates the original priority – Integrated Point of Contact. However, the ambition has been updated to reflect our learning from the RMBC Single Point of Access (SPA) implementation and the Health Village Pilot. The goal has now moved on from a structural change (creating a single entry point) to an operational change focusing on how the contact points work together and on developing more productive teams delivering trusted assessors, streamlining of systems and improved digital communication.

Key Outcomes

- Promotion of self-care and independent living
- Reduction in attendances and admission to A&E
- Timely discharge from hospital and referral into the right community service
- Removal of duplication and points of delay
- Increased use of digital and automated services

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- Service Improvement within Care Coordination Centre to facilitate further integrated working – Q1 20/21
- Streamlining access, triage and referral of integrated ICR pathways –Q1 20/21

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- Number of people provided with information and advice at first point of contact (to prevent service need)
- Proportion of patients who contact CCC who have an outcome as 'alternative level of care'
- Number of GP urgent admissions to AMU (including those referred through CCC)
- Of the new clients who have had a formal social care assessment completed this year, what percentage went on to receive long term social care support

Priority 2: Implementation of the Intermediate Care and Reablement (ICR) reconfiguration

The implementation of the ICR project will be the primary focus of the Urgent and Community Care workstream through 2019/20 and early 2020/21. In 19/20 all affected place partners supported an Outline Business Case (OBC) which set out the ambitions for ICR. The OBC set out the case to rationalise seven disparate, separate and overlapping ICR pathways across health and care into three integrated pathways delivered as a single service across Rotherham.

Our Plan

Investment will be made in our home based teams to increase the capacity and capability enabling more patients to be supported at home and reduce the need for some of our community reablement bed base capacity. This will support the 'home first' ethos which is a key part of the Rotherham Place Plan.

Key Outcomes

- Increase in the number of patients who are supported at home following an urgent episode
- Reduced admission into hospital or community bed base
- Reduced length of stay for patient where admission is unavoidable
- Reduction in the demand for community beds for intermediate care services

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- Start to implement the home based pathways for Intermediate Care and Reablement - Q1 20/21
- Reduction in the community bed base – Q2 20/21
- Evaluation of the Therapy Led Intermediate Care Beds – Q3 20/21

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- Proportion of new clients who receive short term (enablement) service in year with an outcome of no further requests made for support - *ASCOF 2d 2B7*
- Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Number of emergency re-admissions within 28 days of hospital discharge to Intermediate Care Beds
- Number of patients discharged to their usual place of residence from Intermediate Care Beds
- Average length of stay to below national intermediate care target
- Average length of stay to below national intermediate care target
- Proportion of therapy led Step Up / Step Down beds which are utilised for patients on a Step Up pathway
- The number of people seen within their usual place of residence for their intermediate care needs
- The % of patients admitted to Intermediate Care beds who are discharged on or before their pathway expected length of stay

Priority 3: Development of a coordinated approach to care homes support

The Enhanced Care in Care Homes framework set out a clear vision for working with care homes to provide joined up primary, community and social care to residents of care and nursing homes.

We are committed to developing a network of relationships to actively promote good health in care homes rather than a reactive response to ill health. We want to pursue the development of technology to link homes to services and the improved access points.

We will continue to implement our response to Enhanced Health in Care Homes. Current care home support activity will be mapped to identify opportunities to further integrate and streamline out services and training offer. We will continue to explore opportunities for the use of assistive technology and will roll our NHS mail to all care homes to enable service information sharing.

Key Outcomes

- Greater focus on prevention and recovery to support greater independence for longer
- Holistic, patient centred care which reduces duplication
- Increased use of assistive technology to upskill staff and reduce A&E attendances and admissions

Milestones ***(note: final milestones will be confirmed for the performance report and appear in the published version of the plan)***

- Roll out of ECHO in Residential/Nursing Care Homes via a hub supported by the Hospice – Q2 20/21
- Development of robust plan for integration of Care Home provision across the Health and Social Care – Q3 20/21

KPIs ***(note: final KPIs will be confirmed for the performance report and appear in the published version of the plan)***

- New permanent admissions to residential nursing care for adults – 65+ *BCF/ASCOF 2a (2)/ BCF (per100,000)*
- Number of A&E attendances from care home residents (local)
- Number of unscheduled hospital admissions Care Homes

10 Governance to Support Delivery

10.1 Governance Structure

The ICP Place Board is the group responsible for directing and leading the ICP, reporting to the H&WB Board for progress against the Place Plan.

In addition, with the exception of RMBC as they are not formal partners to the ICS, the Place Board will liaise, where appropriate, with:

- the South Yorkshire and Bassetlaw ICS to communicate the views of the ICP on ICS level matters; and
- national stakeholders (including NHS England and NHS Improvement) to communicate the views of the ICP on national matters relating to integrated care.

Partners represented at the Place Board have developed and agreed an ICP Agreement for how we will work together. The Agreement is based on a Memorandum of Understanding (MoU) approach to provide an overarching arrangement which governs the development of integrated multi-party solutions for health, care and support across the geographical area of Rotherham. The format is designed to work alongside the NHS Standard Contract and arrangements for the delivery of non-NHS care, support, and community services via RMBC.

The Agreement is not intended to be legally binding except for specific elements, but encompasses the spirit by which the ICP partners have and will continue to collaborate in supporting work towards the transformation and better integration of health, care, support and community services for local people. The Agreement reflects the differing position RMBC has with the ICS. This will be further strengthened by the development and implementation of a Provider Alliance agreement during 2020/21. Key benefits of the agreement will be; a more formal forum for partners to deliver targeted outcomes; the development and implementation of joint incentives; and ability for more rapid escalation and resolution of issues.

Final Draft 3.0
Final Draft 3.0

Collectively the ICP has worked towards an agreed governance structure and have agreed a shared vision and a set of principles by which the Rotherham Place Board, and sub-groups will adhere to. These can be found in section 2.2.

The Place Board will act in accordance with its Terms of Reference and will:

- promote and encourage commitment to the Place Plan and ICP Principles amongst all partners;
- formulate, agree and implement the transformational priorities of the Place Plan;
- ensure alignment of all organisations to facilitate sustainable and better care which is able to meet the needs of the population;
- review performance of partners against the Place Plan and the ICP outcomes and determine strategies to improve performance or rectify poor performance;
- agree policy as required, including values to be adopted and annual and short-term performance outcomes/targets;
- report on progress against the Place Plan to the H&WB Board as required;
- communicate the collective interests and views of the ICP at meetings of, or when liaising with, the ICS and national stakeholders;
- oversee the implementation of the Place Plan in line with the ICP Principles.

The ICP Delivery Team is the group responsible for managing the collaborative operation of partners and the delivery of the Place Plan and will:

- make recommendations to the Place Board for its approval or rejection as to how the services should be delivered in a more integrated and best for Rotherham way so as to deliver the Place Plan; and
- provide clinical and professional leadership with regard to the services.

The diagram on page 67 shows the governance structure for the Place Board, setting out the relationship to the H&WB Board.

10.2 Performance Management

A quarterly report is produced on the delivery of this Place Plan so that the ICP Place Board can be assured on its delivery and can be sighted on any potential opportunities or risks to delivery.

The Performance Report includes key milestones and key performance indicators (KPIs) for each of the priorities beneath the five areas of transformation. The milestones provide a way of measuring that the actions and pace set for each of the priorities is being met. The KPIs have been chosen from existing metrics that are already collected and where there is baseline information and associated targets.

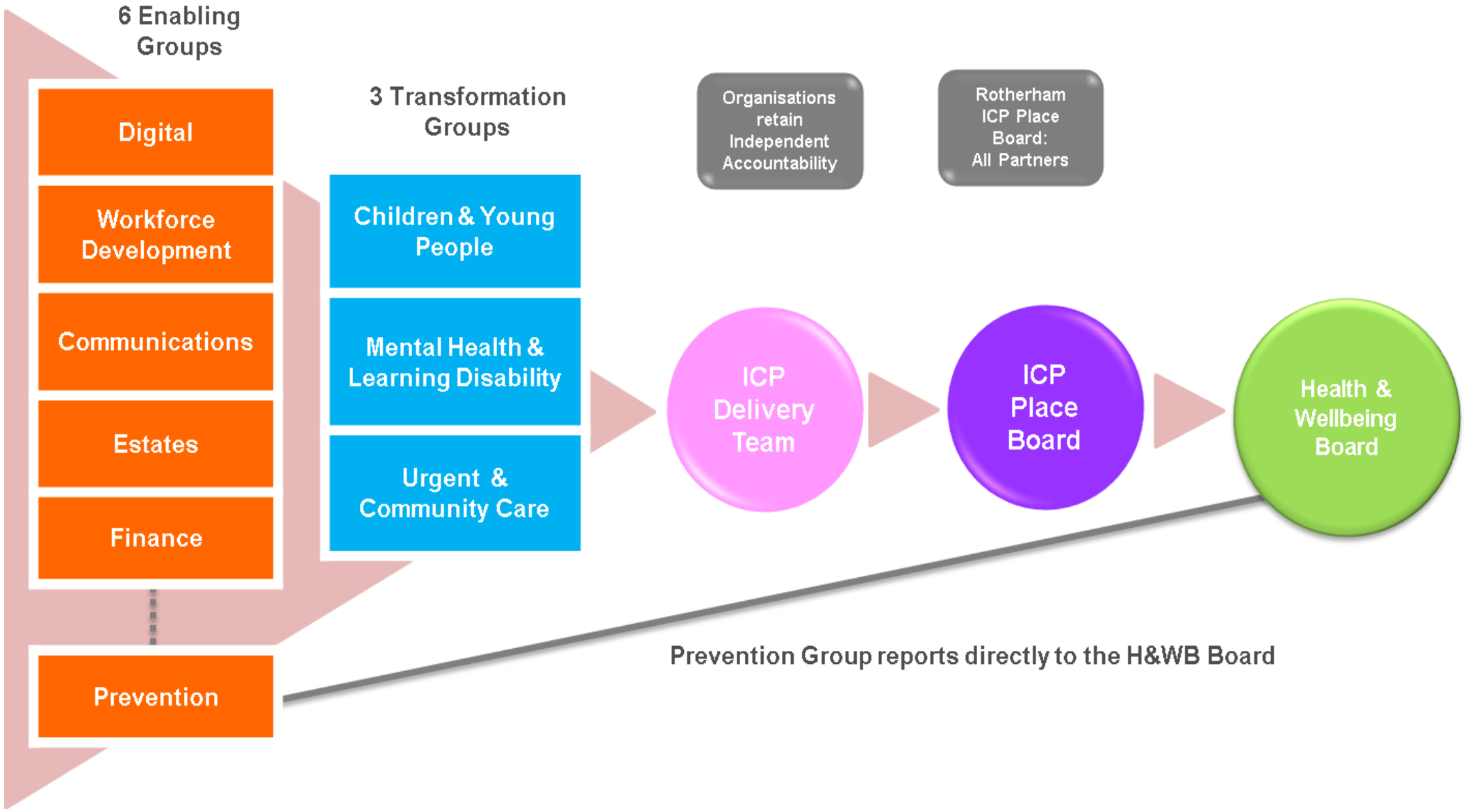
In section 9 where we have described each of the transformation workstreams and priorities we have also documented the associated milestones and KPIs.

10.3 High Level Risks

In addition to the robust governance arrangements and structure established to deliver this plan, we have considered the potential risks and mitigations.

Potential Risk		Mitigation
Organisational behaviour – potential impact of individual organisations financial and delivery targets on the overall system wide delivery of plan	→	• Open and transparent discussions. • Robust governance arrangements. • System wide commitment to joint planning
Capacity to deliver the Plan – risk of organisations not having the capacity/workforce within existing resources to deliver the plan.	→	• Realistic implementation plans, aligned to partners organisational goals and objectives. • Robust performance monitoring arrangements. • Make best use of joint working arrangements and shared resources. • Joint workforce strategy, aligned to the requirements of the plan and • Joint Organisational Development Plan.
Capability to deliver the Plan - risk of organisations not having sufficient capability / skills within existing workforce to deliver the plan.	→	• Skills gaps analysis/ competency Framework / training plan. • Effective change management / culture change. • Joint Organisational Development Plan.
Impact of national policy / regulations – unknown impact of national policies and changes to business rules	→	• Robust governance arrangements. • Work with statutory and regulatory bodies to inform development of revised policy / regulations.
Public opinion – risk of not undertaking relevant public consultation on the key initiatives of our plan.	→	• Open and transparent discussions. • Robust governance arrangements. • Use existing consultations and ensure robust consultation is continued to be undertaken on future developments. • Make best use of joint working arrangements and shared resources.
Impact on organisational reputation - risk of adverse publicity in relation to the plan and its objectives.	→	• Open and transparent discussions. • Utilise collective communication and engagement resources to ensure robust approach continues.
Resident Behaviour – risk that current behaviour in terms of access and use of services is not changed as a result of the plan.	→	• Open and transparent discussions. • Effective public education. • Effective communication plan. • Insight into local behaviour and create environments for healthy lifestyle choices.
IT Infrastructure – impact of not successfully integrating health and social care systems and not driving forward IT solutions to support self-management.	→	• Joint Interoperability group and partner sign up. • Effective training. • One provider for Health IT.
Wise use of current resources – use of current funding and impact of not being successful in securing additional funding to deliver the place plan at pace and scale.	→	• Development of robust implementation plan, agreed by partners. • Upfront agreement on how potential funding is prioritised, agreed by partners. • Ability to mobilise plans quickly to attract any potential additional funding announcements.

Rotherham ICP Governance Structure



11 Glossary

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

Appendix 1: Prevention in detail

11.1 Tobacco Addition

Tobacco addiction is the single biggest cause of preventable illness and avoidable death in the world. It kills about half of all lifetime users, and is the leading cause of socioeconomic inequalities in health in the UK, accounting for around half the difference in life expectancy between the richest and poorest groups. In the UK, adults from deprived backgrounds are more likely to smoke and therefore bear the burden of health impacts disproportionately. Conditions where smoking has been identified as a causative agent include coronary heart disease and stroke, cancers of the lung, stomach, mouth, throat, larynx, oesophagus, bladder, bowel, cervix, kidney, liver and pancreas, asthma and Chronic Obstructive Pulmonary Disease (COPD), and osteoporosis. The harms are not just limited to the individual smoker, as the second hand smoke impacts on the health of their partners and children.

While overall the prevalence rate for smoking in adults in Rotherham has fallen overall in the last decade, unfortunately it has recently increased and is currently 18.9%, the highest since 2015, and it is higher than the England average of 14.4%. The number of women smoking at time of delivery (SATOD) has fallen to 17.6% compared to 19.9% in 2018, though this is higher than the England average of 10.8%. Tackling tobacco addiction is a major part of tackling health inequalities, as rates for routine and manual workers are much higher than the rest of the population at 29.9%. In the most deprived communities where smoking may still be perceived as a social norm, levels of tobacco addiction are higher. High rates are also seen in individuals with mental health conditions and learning disabilities, where it is a substantial contributor to the higher rates of premature death observed amongst them. In 2018 the costs to society of smoking in Rotherham were estimated to be around £64.2 million (2016) compared to £12.6 billion for England (http://ash.lelan.co.uk)

What we are doing

Public Health has commissioned a smoking cessation service for adults within the Get Healthy Rotherham (GHR) Integrated Lifestyle wellness service. The service supports people to quit using evidence-based practice, which involves a combination of pharmacotherapy and support from a trained stop smoking advisor. In people can also chose to use e-cigarettes as a quit smoking aid alongside the advisor support. Work is ongoing to increase the number of referrals to Get Healthy Rotherham from primary care to reach the target numbers of residents for 4 week smoking cessation quits.

The Maternity Transformation Plan has SATOD as a priority with work focused on bringing the high local rate down towards the England average. Public Health are working in partnership with The Rotherham Foundation Trust (TRFT) and supporting the work of the Rotherham Maternity Better Births group to reduce the prevalence of women smoking at time of delivery to 16% or less by end of 2022. All women smoking during pregnancy are offered specialist midwifery smoking cessation support. The SATOD midwifery led service ensures every pregnant woman has their carbon monoxide level tested regularly which gives an accurate local picture of women who are smoking; a robust opt out system is in place to support these women to give up.

The QUIT programme is the systematic implementation of the treatment of tobacco dependency in secondary care (acute and mental health trusts) and the provision of ongoing support for people from community stop smoking services or the specialist mental health stop smoking advisors. It is based on the Ottawa and London Senate Models, NICE Public Health Guidance and has four comprehensive steps:

Q	Ask all hospital patients about their smoking status
U	Understand their addiction and record CO monitor results for all hospital patients
I	Inform them that the hospital site is smokefree and provide support for nicotine replacement
T	Initiate treatment as soon as possible by referral to smoking cessation support

The QUIT programme is a priority within the NHS Long Term Plan, and

recognises that tobacco dependence is a chronic, relapsing clinical condition that prematurely kills at least half of people who smoke, with smoking being seen as a medical condition that can be treated rather than as a lifestyle choice. The CURE programme in Greater Manchester has shown that it is possible to implement the Ottawa model in NHS acute trusts with impressive results. A business case written by South Yorkshire ICS details the plans and funding now agreed to expand routine tobacco dependence treatment to all patients at TRFT and RDaSH.

Work across communities in Rotherham includes that done with schools and by trading standards. A smokefree toolkit will be launched in September 2019, which will strengthen efforts to stop young people taking up smoking. There are also regional and national tobacco control campaigns such as Breathe 2025. Trading standards work across Rotherham to enforce smokefree legislation in public places and for standardised packaging, ensure reduction of access to illicit tobacco and prevent sale of tobacco products to children and children.

Expected outcomes / benefits

Reducing the prevalence of smoking across all sections of the Rotherham population would have a major impact on morbidity and premature mortality, improve quality of life, ensure a healthier, more productive workforce and help ensure sustainability of the health and social care system. Supporting people to stop smoking is the quickest and most effective thing to support a reduction in health inequalities, as it accounts for half of the health gap between the poorest and most affluent communities and is a major contributor to the 15 – 20 years gap in life expectancy between people with a severe mental health illness and the general population.

The British Thoracic Society has estimated that 25% of patients admitted to acute hospital are smokers, with even higher rates for people admitted to or using mental health secondary care. Reducing the prevalence of smoking is one of the most effective demand management measures for the NHS since the risk of hospital admission falls as soon as someone stops smoking; evidence from the Ottawa model suggests individuals are 50% less likely to be re-admitted to the hospital for any cause and 30% less likely to visit an emergency department within 30 days. It is also one of the key actions that the NHS can do to reduce the incidence of cancer

It has been estimated that implementing QUIT in Rotherham would lead to:

- 383 lives saved at one year, 460 lives in two years
- 396 readmissions to acute trusts within 30 days prevented
- 747 readmissions to acute trusts within a year prevented
- 958 six month quits
- Around £1.2 million saving from acute trust readmissions alone within a year
- £46,000 savings from A&E attendances within 30 days

11.2 Obesity

The problem

Tackling the high levels of overweight or obesity in our society is important for preventing a number of serious and potentially life-threatening conditions, such as type 2 diabetes, coronary heart disease, stroke and some types of cancer, including breast and bowel cancer. Obesity does not just affect physical health as it can also have an impact on quality of life and lead to psychological problems, such as depression and low self-esteem. Income, social deprivation and ethnicity all have a big impact on the chances of becoming obese, and there is a strong relationship between deprivation and childhood obesity (Marmot Review, National Child Measurement Programme).

In Rotherham 25.5% of 4-5 year olds and 36.1% of 10-11 year olds are overweight or obese (NHS Digital, National Child Measurement Programme). Obesity levels are much higher in our most deprived communities: the three most deprived wards (Rotherham East, Rotherham West and Valley) have some of the highest rates for obese children at Reception and Year 6 (2015/16 – 2017/18 combined) (NHS Digital, National Child Measurement Programme). Recent adult obesity levels were significantly higher than the England average. However, Rotherham improved dramatically between 2016/17 and 2017/18 from 71.2% to 62.7%. Therefore nearly two-thirds of Rotherham adults aged over 18 years are now overweight or obese, similar to the England

average (62.0%). These levels of obesity cost the local economy an estimated £23.7 million and reducing obesity will be an important contributor to achieving sustainability in the health and social care.

What we are doing

Reducing the high prevalence of overweight and obesity in Rotherham requires a whole-system approach across the borough. A local 'Healthy Weight for All' Plan to promote healthy weight and reduce obesity across all ages is being developed, led by Public Health. The contribution and engagement of all NHS partners and council directorates will be needed for it to be effective. Steps are also being taken towards adopting the Local Authority Declaration on Weight. This involves looking at opportunities across the whole council, as well as working with partners, to create healthy environments for local people, including areas such as planning, licensing, green spaces, and catering.

The Rotherham Activity Partnership (RAP) is developing a local plan which focuses on getting the population of Rotherham, particularly the least active, children and families, and older people more engaged in physical activity. Currently only 13.5% of the Rotherham population use outdoor space for exercise or health reasons, which is lower than elsewhere in South Yorkshire and Bassetlaw. The Cultural Strategy for Rotherham 2018-2025: Things to Do, Places to Go (available here: Like Rotherham) has also been launched which helps tackle this, supporting good levels of physical activity to become the norm as a result of encouraging people to get active, more creative and get outdoors more often; this will need to be linked to active travel plans for all partners. Rotherham has accessed Sheffield City Region sustainable travel access funding in 2017 -18 for a range of walking and cycling projects to encourage people to be more active, and there is an active travel working group in the Council incorporating Members from multiple areas of responsibility.

Public Health has recently commissioned a new child weight management service, being delivered by the 0-19 Service at the Rotherham Foundation Trust (TRFT) called WHAM (weight, health and attitude management service). This provides tailored support to children, young people and their families who have been identified with a weight concern (over 91st centile) via the National Child Measurement Programme (NCMP), a health professional or by self-referral. WHAM has links with a range of professionals including school nurses, dietetics, paediatricians and general practitioners (GPs), as well as with community organisations such as Rotherham United Community Sports Trust. The service is also developing a training package for staff across the council and the NHS who work with children and young people, which will aim to raise their confidence andskills in talking to people about weight and provide information about where to sign-post or refer children and families onto.

Further discussions now need to take place to explore what more could be done in early years (children under 5) to promote healthy weight messages and identify children with weight concerns before they reach school. If children over 96th centile were flagged early (during the standard 2 year check) and families provided with support, this could help reduce the numbers of children being identified as obese at reception (via NCMP).

Get Healthy Rotherham offers weight management support and also helps those individuals attending for a Health Check identified as overweight or obese to make lifestyle changes to address their weight issues in partnership with Slimming World. Those who are identified non-diabetic hyperglycaemia or raised fasting plasma glucose as part of their Health Check are referred to the National Diabetes Prevention Programme (NDPP).

New Supplementary Planning Document (SPD) has been developed for health and inequalities. This includes a restriction on new fast-food takeaways within a 400-metre radius of schools and colleges.

Although SPDs are non-statutory, it forms part of the local plan and can be used as guidance when processing planning applications. The SPD also includes a checklist for any prospective developers to help ensure they consider health and wellbeing issues.

In addition to using planning to ensure provision of healthier, affordable food for the general population, there are a number of opportunities

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available to improve the local food environment. These include looking at food provision in council buildings, hospitals, leisure centres and schools. All partners have a role to play in this, to ensure consistent healthy weight messages are given in all settings for the public as well as the workforce.

In line with this and the aspirations of the NHS long term plan hospital premises should adopt hospital food standards on healthy nutrition for both patients and staff to limit the proportion, placement and promotion of foods and beverages high in fat, salt and sugar. In addition the promotion of physical activity within clinical services and for staff, and the use of active travel plans for both patients and staff will also be conducive to the promotion of healthier weight

Expected outcomes / benefits

The strategic vision is for Rotherham to be a place where healthy weight is the norm and making healthy choices around nutrition and physical activity is easy for everyone. As obesity is the major modifiable risk factor for diabetes, reducing obesity levels would have an impact on the prevalence of diabetes, which is currently rising and therefore its associated costs. As well as improving the quality of life for individuals with obesity, reducing obesity levels would make an impact on levels of cancer, cardiovascular disease, and maternity outcomes. It would also make a contribution to tackling health inequalities, given the association between obesity and deprivation.

11.3 Alcohol

The problem

Long-term alcohol misuse in particular affects the brain and nervous system, heart, liver and pancreas, and is associated with an increased risk of high blood pressure, stroke, liver disease and cancer, pancreatitis, cancers of the mouth, head and neck, breast, bowel, depression and dementia, sexual and infertility problems. The effects of alcohol are not limited to health, and also include harms from accidents and violence, antisocial behaviour, impacts on education and employment, family break-up and divorce, domestic abuse, financial problems and homelessness.

While people in the most socioeconomically deprived neighbourhoods of the UK do not drink more alcohol, they are more likely to experience more alcohol-related health problems than those drinking equivalent amounts living in more affluent neighbourhoods (the alcohol harm paradox). Rotherham's rate of hospital admissions related to alcohol is significantly higher than England with over 1,800 people admitted in 2017/18.

What we are doing

Actions to tackle excess alcohol consumption and treat alcohol dependence are being undertaken by the local NHS and the Council. Several alcohol partnership events have recently been held to identify the key issues and discuss what the next priorities for action should be. A rapid alcohol health needs assessment has been carried out that will also inform these priorities.

The Challenging, Leadership and Results (CLeaR) assessment for responsible drinking has been completed and will inform work on responsible drinking and the licensing process. Public Health have worked closely with licensing as a Responsible Authority and contribute meaningful intelligence and advice into the alcohol licensing process.

Get Healthy Rotherham is identifying individuals with high levels of alcohol consumption and providing a brief intervention which allows such individuals to understand alcohol limit guidelines and how they can reduce their drinking. They also refer on those individuals identified as being problem drinkers to Change Grow Live (CGL). Referrals to the CGL service for problem drinking from GPs and the Get Healthy Rotherham service are low (in line with a Public Health England reported national trend), and work is needed to address this. An Alcohol Care Team is in place in TRFT to reduce emergency attendances and admissions bed days, readmissions and ambulance call-outs, with a referral service for problem drinking from Get Healthy Rotherham. This is another element of the Healthy Hospital Programme that will encompass the other prevention priorities within the Long Term Plan that relate to Trusts, such QUIT, healthy hospital food standards, active transport and air pollution.

CGL also deliver the opiate and non-opiate treatment service for adults. Public health continue to monitor any changes in patterns of substance misuse.

Expected outcomes / benefits

Reducing excess alcohol consumption in Rotherham would contribute substantially to the sustainability of the health and social care system, for example more than 1 in 10 visits to accident and emergency departments in England are due to alcohol-related illnesses, as well as to reducing the burden on the public sectors outside of health, for example more than 1.2 million violent incidents are linked to alcohol misuse each year in England.

11.4 Air Pollution

The problem

Air pollution is a mixture of particles and gases that can have an adverse effect on human health. The black smog which once shrouded British cities has now cleared but it is estimated that invisible air pollution still produces an effect equivalent to 28,000 to 38,000 deaths in the UK annually (Health Protection Profile, PHE, 2018). Although air pollution has improved over recent decades, there are still significant public health challenges mainly related to Particulate Matter ($PM_{2.5}$ and PM_{10}) and nitrogen dioxide (NO_2) in ambient air. It is now regarded as the largest environmental risk linked to deaths in the United Kingdom and a significant source of ill-health. Tackling air pollution is a government priority, as demonstrated through the Governments latest Clean Air Strategy https://www.gov.uk/government/publications/clean-air-strategy-2019 and will feed into the wider work to tackle the climate emergency'

There are strong associations between air pollution and major diseases that pose a great health and economic burden, including childhood asthma, coronary heart disease, stroke, and lung cancer. Poor air quality can have an impact on health at all stages of life, from being associated with low birth weight, lung function development in children, an increased risk of chronic respiratory disease and acute exacerbations, and premature death, and is estimated to be responsible for 4.1% of mortality in Rotherham. Recent evidence suggests air pollution can affect cognitive function. All these may have an impact upon the quality of life, with the most vulnerable being the young and the old. It is often the case that the most deprived communities where there is less car ownership bear the brunt of air pollution from vehicle emissions.

In most of Rotherham, air quality is good, but Rotherham, along with most urban areas in England, has areas of elevated air pollution which have been declared as Air Quality Management Areas (AQMA) Rotherham Air Quality monitoring. Whilst traffic emissions continue to impact on the quality of air in Rotherham, air quality in the Wellgate AQMA has improved sufficiently for the AQMA to be revoked.

What we are doing

Local authorities are required to declare an AQMA where both exceedances of air quality targets occur (averaged over a period) and where people are exposed. The current air quality management areas for Rotherham cover those locations where exceedance of objectives for NO_2 has been measured and relevant exposure to this pollution occurs. The Council has implemented a range of measures as part of Air Quality Action Plans to work towards achieving compliance with the air quality objectives identified in the AQMAs.

- ***Clean Air Zone***

The National Air Quality Plan, published by Department for Environment, Food and Rural Affairs (DEFRA) in July 2017, identified those Local Authorities with areas that are not compliant with the European Union (EU) Ambient Air Quality Directive through national air quality modelling. 28 Local Authorities were included ('mandated') in the plan, including Rotherham Metropolitan Borough Council (RMBC). Following the completion of a joint feasibility study across Sheffield and Rotherham, a Plan will be produced which will include a range of targeted measures to be implemented locally to reduce emissions from vehicles and achieve compliance in the shortest possible time as required by the Government.

- ***Planning***

The Rotherham Local Plan supports the provision of local health facilities but also influences health directly by supporting strategies for

improvements to air quality and promoting a healthier lifestyle through walking, cycling and the provision of open spaces and recreation facilities. Aspects of the plan which aim to improve air quality and reduce inequalities in health by the end of the plan period (Rotherham Local Plan Core Strategy 2013-2028) include:

- An increased proportion of trips made by walking and cycling
- Improved public transport interchanges and bus services between local communities
- Initiatives to secure improved information technology networks to enable increased "teleworking", along with the development of live/work housing and mixed use schemes in appropriate locations.

➢ ***Electric transport***

The Government has provided funding for the rollout of public Electric Vehicle (EV) Charging Points throughout Rotherham borough during 2018. These public charging points have been installed in Rotherham's main town centre car parks, our country parks, and at our leisure centres. Many of the public EV Charging Points have been installed in conjunction with solar panels and battery storage which will also increase public awareness to alternatives to petrol and particularly diesel vehicles. This is in parallel with the South Yorkshire Care4air campaigns 'Fuelling Change' https://fuellingchange.co.uk/ and https://drivingcleanair.care4air.org/

The Council has started to move towards increasing use of Ultra Low Emission Vehicles, with the purchase of some electric cars and installation of electric vehicle charging facilities at the Transport Depot. In the near future, electric vans will start replacing conventionally fuelled ones for undertaking Council business.

➢ **The Rotherham Activity Partnership** (obesity section 5.2.2) supports work to tackle air pollution by encouraging active travel as part of being more physically active through schemes to:

- Improve accessibility to walking and cycling
- Local road safety, e.g. new crossings

➢ **NHS Partners** will also need to assist local government in the reduction of air pollution. Actions suggested in the NHS long term plan which should be adopted locally include: reducing business mileages from redesigned care and greater use of virtual appointments, minimising the need for patient and staff travel; and reducing air pollution by ensuring that at least 90% of the local NHS fleet use low-emissions engines (including 25% Ultra Low Emissions) by 2028, and that primary heating from coal and oil fuel in NHS sites is fully phased out. Adoption of active travel plans for patients and staff will also help reduce air pollution

Expected outcomes/benefits

Shifting from motorised to active forms of transport, such as walking and cycling, can reduce the levels of particulate matter (PM) and nitrogen dioxide (NO2) while also contributing to reducing the burden of obesity and non-communicable diseases; this is known as the 'co-benefits'. This approach can lead to substantial benefits for public health and reduce healthcare costs in addition to reducing health inequalities.

In 2017, the total NHS and social care cost due to $PM_{2.5}$ and NO_2 was estimated to be £42.9 million in England. If no action to improve air quality is taken and trends continue, costs could accumulate to £5.3 billion between 2017 and 2035.
https://publichealthmatters.blog.gov.uk/2018/05/22/enabling-local-authorities-to-tackle-air-pollution/

Air pollution is an international problem that affects everyone, but almost always the most socioeconomically disadvantaged suffer most from the health effects of pollution. Other groups disproportionately affected include older people, children, pregnant women, individuals with existing medical conditions, and communities in areas of higher pollution.

11.5 Antimicrobial Resistance

The problem

The overuse of antimicrobials in clinical and other settings (e.g. in animal health) is leading to increasing resistance to antibiotics that is spreading worldwide. A particular concern globally is the spread of

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carbapenemase-producing gram-negative infections (CPE) which are resistant to carbapenem antibiotics which are often the last line of treatment in severe bacterial infections. Antimicrobial resistance (AMR) to carbapenems is currently at low levels in England. However, there is considerable variation across Europe. In 2017, there was less than 1% resistance in most of northern Europe, including the UK, in contrast to 8.6% in Portugal, 31.4% in Romania, 22.5% in Italy and 64.7% in Greece (European Centres for Disease Prevention and Control, 2018, Surveillance Atlas of Infectious Diseases).
https://atlas.ecdc.europa.eu/public/index.aspx

AMR makes treating infections caused by multi-drug resistant organisms increasingly difficult, which is both costly and a safety risk. Of particular concern is the potential for levels of AMR to rise quickly. For example, Italy had 1% to 2% resistance from 2006 to 2009 but by 2014 this had increased to 33% at which point control efforts became expensive and challenging. This reinforces the need for proactive control measures which are vital to prevent the rapid development of resistance.

What we are doing
The government has published a five-year action plan which sets out actions to slow the development and spread of antimicrobial resistance. Part of this strategy includes national voluntary point prevalence surveillance for Healthcare Associated Infections (HCAI) and antimicrobial stewardship to benchmark performance and to be able to compare primary care prescribing rates for co-amoxiclav, cephalosporins, and quinolones. The Rotherham Foundation Trust (TRFT) and Rotherham CCG have been active participants although the full report for the National and European results has not yet been published.

Good infection prevention and control, and appropriate antimicrobial use are essential in ensuring safe and effective care for those receiving health and social care and in managing and controlling the spread of communicable diseases. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone (Health and Social Care Act: Code of Practice, DH 2008).

The Council, CCG commissioners and the CQC continually monitor and seek assurance that patient safety and service quality are maintained for Infection Prevention and Control in the public and independent sectors who deliver regulated services.
Through medicines management actions are being undertaken to optimise the use of antibiotics, reduce unintentional exposure to them and the requirement for them. Particularly challenging areas remain in the community to ensure that policies are implemented on appropriate prescribing and review. In the coming year CCG and TRFT will therefore be working on the following areas:

- Long term Urinary Tract Infection (UTI) management, including use of non- antibiotic treatment e.g. promoting hydration
- Review of prophylactic antibiotic regimens in primary care in terms of length of course and appropriateness of treatment choice, in conjunction with microbiology at TRFT to inform future joint actions.
- Review of long term and repeated ‘rescue medication’ in Chronic Obstructive Pulmonary Disease (COPD) management.
- Review of prophylactic antibiotic regimens in primary care in terms of appropriateness of treatment choice and frequency of repeat courses in conjunction with microbiology at TRFT.
- Review of topical antifungals for fungal nail infection
- Review of acne treatment pathway/ de-prescribing of topical antibiotics for acne
- Implementing aspects of TARGET Antibiotic Tool kit.

The UK wide Antibiotic Guardian campaign to raise awareness and to stimulate behaviour change in members of the public, healthcare professionals and other local stakeholders are encouraged to sign up to these national aspirations.

Expected outcomes/benefits
With an aging population, increased co-morbidities and surgery, it is important to reduce unnecessary and inappropriate antibiotic use in both the community and hospital. This will avoid unnecessary costs across the health and social care system.

11.6 Stronger Action on Health Inequalities

The problem

'There can be no more important task for those concerned with the health of the population than to reduce health inequalities' (Sir Michael Marmot 2019)

Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs (NHS and Public Health England).

The overarching indicators of health inequalities are life expectancy and health life expectancy for men and women. Life expectancy at birth in Rotherham is still below the England average: currently for men in Rotherham it is 77.9 years compared to 79.5 years for the England average, and for women in Rotherham it is 81.6 years compared to 83.1 years for the England average. Within Rotherham inequalities are even more striking, a baby boy born in the poorest areas can expect to live on average 10.8 years less than one born in the richest areas, and for a baby girl this difference is 8.4 years. People are more likely to live in poor health with multiple long-term conditions in Rotherham, and as a result they are likely to have substantial health and social care needs. Healthy life expectancy in Rotherham for men is 59.8 years compared to the England average of 63.3 years, and for women 55.7 years compared to the England average of 63.9 years. This means that on average men in Rotherham spend 24% of their life in poor health and women 30%.

While life expectancy for men and women improved overall in the last decade, more recently it shows signs of having levelled off or to be declining. Moreover the gap in life expectancy between Rotherham and the England average has been getting steadily wider. The reason for this is not completely clear but inequalities in the underlying social determinants of health play a large part. The green paper on prevention references evidence to suggest that these are responsible for 15-20% of premature mortality. These wider determinants of health that encompass a range of social, economic and environmental factors account for 80% of population health outcomes but do not receive an equivalent amount of dedicated NHS funding to tackle them; healthcare accounts for 20% of population health outcomes, though the relative proportions could be altered if services were to be better targeted and more attuned to the needs of the most marginalised and the underlying social determinants addressed. The adapted Dahlgren and Whitehead model (Figure 1) highlights how the health of the people of Rotherham is affected by a wide range of factors throughout the life course:

Rotherham is more deprived compared to the rest of England on average, and people with lower incomes have significantly worse physical and mental health than those with higher incomes. In 2018, 18.9% of children in Rotherham were living in workless households, the highest number in Yorkshire and Humber; in 2016, 21.8% of Rotherham children under 16 were living in poverty (low income families) compared to 17% for England. Stable employment in a quality job is usually associated with greater income and better health. Employment rates have improved in Rotherham, but not for vulnerable groups such as those with learning disabilities or in contact with secondary mental health services. Moreover, many of those in work are still living in poverty as a result of short term or zero hours contracts.

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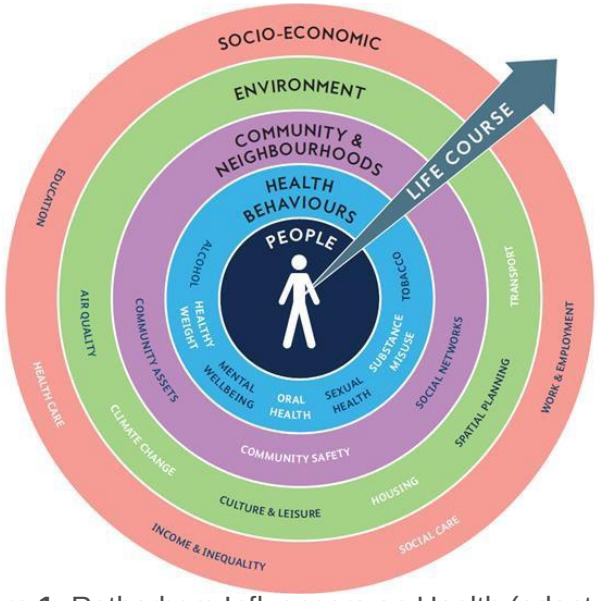

Figure 1: Rotherham Influencers on Health (adapted from Dahlgren-Whitehead, 1991)

In addition to where people work, where they live and play has an impact on their health; therefore a consistent and sustained commitment across place needs to be developed to address the resulting health inequalities. Poor quality housing, a contributor to excess winter deaths, is an issue for Rotherham particularly in the private rented sector, where 16% of properties have category 1 Housing Health and Safety Rating System hazards and 4.2% have an Energy Performance Certificate rating below band E. The housing in many deprived communities tends to be closer to busier roads and therefore more prone to the effects of particulate air pollution (section 5.2.4).

The physical and social environment around homes and workplaces is also important. Good access to green spaces is associated with better physical and mental health, but this is not equal across Rotherham where only 13.5% of the population use outdoor space for exercise or health reasons, which is lower than elsewhere in South Yorkshire and Bassetlaw. Cohesive communities and good social links support mental health, resilience, and overall happiness; currently 11.2 % of people in Rotherham have a self-reported low happiness score in the annual wellbeing survey compared to the national average of 8.2%, and less than half of both adult social care users and carers have as much social contact as they would like (47.5% for adult social care users and 37.3% for adult carers).

The impact of these wider determinants becomes apparent when the pattern of preventable ill health and premature death across Rotherham is considered. Rates for tobacco dependence (section 5.2.1), cancer, cardiovascular disease, respiratory disease (sections 5.9.1, 2 & 5) and suicide (section 3.3.2) are all above the England average. Of particular concern locally is respiratory disease where the rate is increasing faster than the England average. These conditions are more prevalent in deprived communities where the underlying risk factors of tobacco dependence, obesity (section 5.2.2), high blood pressure, diabetes (section 5.9.4) and high cholesterol occur more often and tend to cluster.

What we are doing

The 2010 Marmot Review identified six areas for action in order to address health inequalities:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

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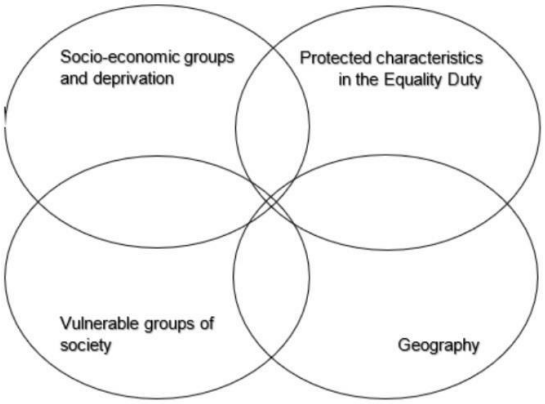
This recognises that reduction of health inequalities requires action from all partners across the life course; specific actions to address health inequalities in maternity and children's services are addressed elsewhere in this plan (section 3.3.1). The NHS Long Term Plan (NHS LTP) and associated NHS LTP Implementation Framework (NHS LTP IF) emphasise a commitment to progressively increase the NHS focus on prevention and ensure that reducing health inequalities is central to any local system plans. The NHS LTP highlights that such plans should be developed between NHS and Local Authorities partners and include consideration of the need to integrate relevant services.

Health bodies have a duty (Health and Social Care Act 2012) to reduce health inequalities; all public sector bodies also need to give consideration to achieving equality (The Equality Act 2010) for the most vulnerable in society, including but not exclusively those disadvantaged due to age, sexuality and gender, deprivation, ethnicity, mental health status, physical or learning disability (section 3.3.2), caring responsibility, or housing status. This applies to all endeavours to improve life expectancy and healthy life expectancy across society, so reducing the disparity in outcomes is a vital part of them. Those enduring health inequalities may do so for more than one reason (Figure 2). One of the requirements of the NHS LTP IF will be to demonstrate how additional funding will address the health inequalities experienced by these groups. Actions to address health inequalities should be at both the individual level, such as improvements to knowledge around services and self-management abilities, and at the community or population level, such as those to address the social determinants of health; they should work across the life-course to address the most significant health inequalities in Rotherham but care needs to be taken to ensure that any actions do not unintentionally widen health inequalities.

Figure 2: Overlapping dimensions of health inequalities (PHE, 2019)
For the purposes of reducing health inequalities and improving population health, a framework centred on four pillars has been identified (King's Fund 2018):



- Wider determinants of health
- Behaviours and lifestyles
- Places and communities
- Integrated health and care systems

➢ **Wider determinants of health**

The wider determinants of health are being addressed in Rotherham through actions for education and employment, housing, use of green spaces and to reduce air pollution.

The employment and skills plan is an essential part of improving the opportunities for good, well paid, sustainable employment in Rotherham. In line with the Strategic Economic Plan, individuals with health issues are being supported to gain or remain in employment by primary care and workplace health. The Working Win health-led employment trial has now supported 4,000 people living with a physical or mental health condition to stay in or get into employment across the Sheffield City Region; for Rotherham the target number is 1,375. The South Yorkshire wide Bewell@work scheme was also launched in March 2019 to improve physical and mental health in the workplace. Having access to benefits and welfare advice within healthcare settings would further support this work.

Improving health through housing is one of the four key themes of the new Housing Strategy. The Council has 21,000 council homes, of which 99.7% reach decent homes standards. As part of the Sheffield

City Region, Rotherham is involved in work to tackle excess winter deaths. This will be focused on affordable warmth and improvements to the thermal efficiency of the housing stock, which will also help combat climate change. In addition a Tenancy Health Check Form has been developed to support identification of health issues in council housing tenants. Asking about housing in healthcare appointments and signposting on to support when issues are identified would further strengthen this work.

The council is developing plans for investment and development of the major parks and is in process of finalizing a new library strategy which will have an important role in the wellbeing of communities, in particular supporting mental wellbeing. The Cultural strategy for Rotherham has also been launched to encourage people to get active, more creative and get outdoors more often, making best use of natural resources to promote health in the wider sense.

- **Behaviours and lifestyles**

The local NHS and council have key roles in promoting healthy lifestyles and behaviours as a result of the contact the public has with their services. The Get Healthy Rotherham integrated lifestyle service helps the people of Rotherham to stop smoking, reduce their alcohol consumption, get more active, lose weight, and improve their overall health, in addition to carrying out an NHS Health Checks. Increased referral and uptake of these services would help meet health inequalities objectives particularly as all these services are targeted to individuals, groups and communities where health outcomes are worse. Other services commissioned by public health that address behaviours are the sexual health and alcohol and substance misuse services. For problem gambling a comprehensive awareness raising programme for front line staff within Rotherham Council and wider partner services has also been developed and rolled out to council staff. Extension of this awareness programme to healthcare would support appropriate signposting to relevant sources of help and support including the planned NHS specialist clinics for people with serious gambling problems.

In addition to specific interventions and programmes, the local NHS and council need to maximise opportunities that arise for prevention and lifestyle change arising from their contact with the public and those using their services, through Making Every Contact Count (MECC). Furthermore, they need to take on the role as champions of reducing inequalities by improving their workforce health (section 4.2), ensuring healthy estates and premises (section 4.5), further enhancing social value in their commissioning and contracting processes, and acting as anchor institutions.

In Rotherham in 2017/18 the proportion of 0-19s having a hospital episode for an extraction was 1.55% of 0-19s (62,543 hospital episodes in one year), which was the highest of all lower tier local authorities in England, with Doncaster a close second at 1.54%, followed by Sheffield (1.35%) and Barnsley (1.23%), meaning that this an issue of particular concern both to Rotherham and to South Yorkshire as a sub-region. Oral health is a striking indicator of health inequality: tooth decay in young children tends to follow a social gradient, meaning that children living in more deprived areas are more likely to experience tooth decay. Hospital dental extractions are a significant cost burden to the local NHS system. Alongside other oral health interventions, South Yorkshire will work together to assess the feasibility of community water fluoridation, which would be a very effective means of reducing health inequalities.

- **Places and communities**

While individual behaviour change is an important part of prevention in Rotherham, there needs to be an increased focus on changing the environments in which individuals live, work and play, and making the healthiest choice the easiest choice.

The Thriving Neighbourhoods Strategy has been developed by the Council to enable residents, members and partners to work together using an asset based approach at ward level to find solutions in order to achieve three key outcomes: safe and welcoming neighbourhoods; residents happy, healthy and loving were they live: residents using their skills and assets to contribute to the outcomes that matter to them. Facilitated by this strategy, healthcare needs to link with existing community assets to support healthier lifestyles and reduce health inequalities.

The "Five Ways To Wellbeing" is being promoted across Rotherham, a social prescribing scheme is in operation for individuals with long term and mental health conditions, and a pilot is in place to tackle loneliness in the south of the borough which will be extended more widely. Discussions are underway to determine the best local means of extending social prescribing to a wider population as part of the NHS LTP offer (section 5.1.2). This needs to avoid placing undue burden on the voluntary sector and to identify the best fit with the developing primary care networks. The latter should also link in with existing community assets to support healthier lifestyles and reduce health inequalities, supported by the Thriving Neighbourhoods Strategy. Other opportunities to commission, partner with and champion local charities, social enterprises and community interest companies to provide services and support to vulnerable and at-risk groups need to be explored.

- **Integrated health and care systems**

Prevention is a key focus of the Health and Wellbeing Strategy though actions need to be further developed and implemented. The refresh of the Joint Strategic Needs Assessment (JSNA) alongside development of the Rotherham Health Care Record and population health management approaches such as segmentation by deprivation (section 4.4.1 & 2) will support Health and Wellbeing Board strategies to tackle the leading causes of morbidity and mortality, and create sustainable, place-based health and care across partners in Rotherham and reduce inequalities for all ages.

Better use and analysis of existing datasets will enable links to be identified between health, wider determinants of health and the services outside of health, and help shift the focus from treatment to prevention and early intervention. It should also allow for the planning of more joined up care across the health and social care system, which would minimise duplication from the user end and make it easier for all individuals to access and engage with (section 5.5). Services should also aim to work with communities differently, taking into account cultural variation to achieve equality of outcomes. This will be an important part of improving the overall quality of and access to care, and reduce unwarranted variation compared to peers and within local areas.

Expected outcomes /benefits

Upscaling prevention by focusing on the environments in which individuals live and work will add years to life and life to years and allow inclusive economic growth through a healthier workforce.
In addition to the moral imperative to tackle health inequalities, reducing them would bring about substantial socioeconomic benefits; it has been estimated that the consequent burden of illness and disability accounted for around £60-70 billion per year in 2010 in the UK due to productivity losses, lost taxes, higher welfare payments and additional NHS healthcare costs (Marmot Review, 2010).
Tackling health inequalities is a key part of ensuring sustainability across health and social care as the poorer health outcomes observed in the disadvantaged communities lead to a higher demand on services.

Furthermore improving the health of the worst off in society and reducing co-morbidities as a result of tackling the underlying causes of ill health, will help reduce the overall burden on the health and social care system. Across the UK, of all the potential years of life lost due to inequality, half come from the most deprived fifth of the population but a further quarter come from people in middle socioeconomic deciles. Improving inequalities across the whole of society will therefore lead to better outcomes for all.