Rotherham Prevention and Health Inequalities Strategy and Action Plan:

March 2022-December 2025

‘People in Rotherham live well for longer’

Contents

Introduction

As a partnership, we want more people in Rotherham to live well for longer. Focussing on preventing problems from arising in the first place and intervening early will not only lead to better health outcomes for local people but is also vital to ensure a sustainable future for our services. Where problems do arise, we want to focus on preventing them from escalating further, so that people can live happy, healthy, and fulfilling lives for as long as possible. We also know that there are significant health inequalities between different groups in Rotherham, which means we need to support communities at a level that is proportionate to the degree of need – taking a universal approach where appropriate whilst also providing targeted support to those who most need it.

The ambition to focus on prevention and address health inequalities is outlined within both Rotherham's Health and Wellbeing Strategy 2018-2025 and Rotherham's ICP Place Plan 2020-2022. This plan will help to deliver on the commitments made within each of those strategies, with a focus on the role of the health and social care system in the prevention and health inequalities agenda.

The priorities and outcomes outlined within this document will run from March 2022-December 2025, which aligns with the timelines within Rotherham's Health and Wellbeing Strategy. However, it may be necessary to review these at an earlier stage to align with national and regional developments, including work taking place through the South Yorkshire Integrated Care System. Additionally, as we build our understanding of health inequalities in Rotherham, we may seek to adjust our strategy.

This document also includes an action plan to oversee delivery against these priorities; this will be a 'live' plan which will be formally reviewed yearly. To monitor progress against the action plan, regular updates will be presented at the Prevention and Health Inequalities Enabler Group meeting. All Place partners will be collectively responsible for assuring delivery.

The development of this plan has been informed by data and intelligence. Additionally, it has been shaped by engagement with members of the Prevention and Health Inequalities Enabler Group and wider stakeholders. The priorities set out within this plan are based on an understanding

that the impacts of the coronavirus pandemic continue to be felt across local communities and within partner organisations. Therefore, our approach as a partnership will need to remain flexible and responsive to emerging needs and pressures.

What do we mean by prevention?

Prevention is about promoting good health and wellbeing and stopping illnesses from escalating further – enabling people to live happy and healthy lives for longer. Our definition of prevention focusses on the whole pathway and is broken down into three categories:

Primary prevention

Primary prevention is taking action to reduce ill-health and disease within the population before it occurs. This is achieved through universal measures that reduce lifestyle risks or by targeting high-risk groups. Such measures include immunisation programmes, which may be open to all or targeted to high-risk groups, or healthy diet, fitness, and smoking cessation campaigns.

Secondary prevention

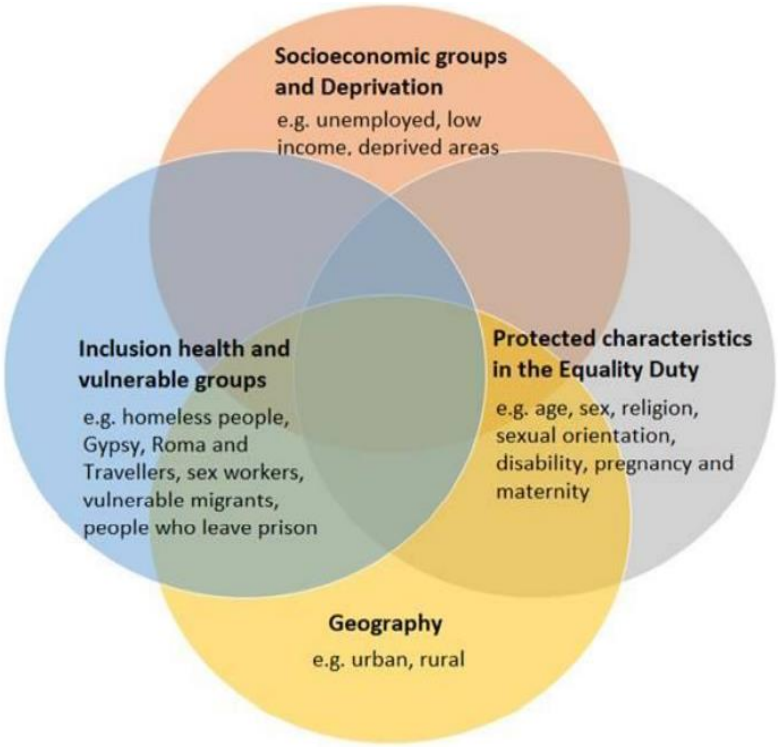
Secondary prevention aims to reduce the impact of disease or poor health, by detecting and treating it as early as possible in its course. The intervention is often during the asymptomatic phase, in an effort to delay or reduce symptoms and negative effects. This can be implemented through screening programmes, which aim to identify pre-symptomatic disease for early treatment, or through measures such as diet and exercise programmes or daily low-dose aspirin to prevent further heart attacks.

Tertiary prevention

Tertiary prevention is undertaken to reduce the negative impact of established disease or ill-health, aiming to minimise the impact on life quality and life expectancy. This is done by reducing complications and disability, through interventions such as cardiac or stroke rehabilitation programmes.

What do we mean by health inequalities?

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health as well as our physical health and wellbeing.



Health inequalities are multi-factorial and vary depending on the specific health outcome or risk factor. Evidence shows that some of the factors that increase the risk of experiencing health inequalities include:

- Socioeconomic deprivation
- Protected characteristics
- Geographical factors
- Other vulnerabilities (e.g., homelessness, sex work)

These different dimensions of health inequalities often intersect and can lead to multiple disadvantage. This strategy will include consideration of all four categories.

Why do we need a prevention and health inequalities strategy for Rotherham?

Our aim is for people in Rotherham to live well for longer.

In Rotherham, both life expectancy and healthy life expectancy are lower than the national average. This means that local people not only live shorter lives than the England average, but they can expect to live for a longer proportion of their lives in poor health. There are also considerable inequalities in health outcomes across the borough. Men in the most deprived areas of Rotherham can expect to live an average of 52.3 healthy years, compared with 70.7 healthy years for those living in the least deprived communities. In comparison, women in the most deprived areas of Rotherham can expect to live an average of 51.4 healthy years compared with 71.2 years for those in the least deprived areas. (2017-2019 data)

The evidence shows that the factors driving these health outcomes are largely amenable to prevention. The Global Burden of Disease Study 2019 shows that behavioural, metabolic, and environmental risk factors significantly contribute to disability-adjusted life years (DALYs) in the borough, (which refers to the number of years lost due to ill-health, disability, or early death.) For example, the following table sets out the five leading causes, which between them contribute over 25% of DALYs in Rotherham and the estimated percentage of DALYs which were attributable to risk.

Condition	% risk factor attribution	% of total DALYs in Rotherham
Ischemic heart disease	94.87%	8.9%
Tracheal, bronchus and lung cancer	86.5%	5.03%
Stroke	83.18%	3.69%
Chronic obstructive pulmonary disease	72.9%	5.04%
Lower back pain	41.73%	4.5%

Therefore, by focussing on prevention, there is the potential to have a significant impact on the health of our population. Additionally, as the leading causes and risk factors associated with DALYs disproportionately affect certain groups, focussing on prevention is also a vital component of addressing health inequalities.

Focussing on prevention has benefits not only for the individual, but also for the sustainability of the health and social care system. The population is ageing, and across the UK, advances in life expectancy over the last century have not been matched by improvements in 'healthy life expectancy' – (or the years an individual lives in good health.) This means that people are living for longer periods in poor health and spending more years in the 'window of need', contributing towards demand pressures for health and social care.

Linked to this, there is a strong economic case for prevention. Ill-health amongst working age people costs the UK economy approximately £100 billion per year. A systematic review of cost-effectiveness evidence produced to support the development of public health guidance at the National Institute of Health and Clinical Excellence (NICE) found that most public health interventions reviewed were cost-effective. (Owen et al., 2018) Another review found an estimated median return on investment from public health interventions of 14.3 to 1. (Masters et al., 2017)

In summary, there is a need to focus on prevention-led approaches in Rotherham in order to:

- Improve the overall health and wellbeing of the Rotherham population when compared with the England average.
- Reduce health inequalities within Rotherham, including within our most deprived communities as well as between protected characteristic and other inclusion groups.
- Manage, delay, and prevent future demand for our health and social care services.
- Support the delivery of other agendas, including our economic strategy for the borough, by ensuring more people in Rotherham are healthy and empowered.

Policy context

National context

There is a national policy drive relating to prevention and health inequalities. As well as delivering against locally agreed priorities, this strategy seeks to deliver against several national policy imperatives.

This includes the NHS Long Term Plan (2019) which committed to 'more NHS action on prevention and health inequalities' and was subsequently reinforced by the prevention green paper. (2019)

Additionally, the NHS operational planning guidance for 2022/23 included a renewed commitment to the five strategic actions to prevent and manage ill-health in groups that experience health inequalities:

1. Restoring NHS services inclusively
2. Mitigating digital exclusion
3. Ensuring datasets are complete and timely
4. Accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes
5. Strengthening leadership and accountability

Additionally, NHS England has published the CORE 20 PLUS 5 Strategy. This strategy focusses on the most deprived 20% of the national population, plus any locally identified priority groups, and delivery across the following five key clinical areas: maternity, annual health checks for people with severe mental illness, chronic respiratory disease, early cancer diagnoses and hypertension case finding. These priorities have informed the development of this plan (further detail is outlined on page 10.)

In addition to a policy drive within the NHS around inequalities, there is also a broader focus nationally on tackling socioeconomic inequality and the wider determinants of health. This includes the Government's Levelling Up White Paper, which includes a focus on healthy life expectancy, health inequalities and wellbeing. A white paper on health disparities is also anticipated in 2022.

This strategy seeks to strengthen our approach to prevention and health inequalities in Rotherham and support our response to these national policy drivers at a local level.

Local context

In terms of the local strategic context, this strategy forms part of the delivery of the ICP Place Plan and is owned by ICP Place Board.

It also supports the delivery of Rotherham's Health and Wellbeing Strategy, 2018-2025 and the four key aims, which are:

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

Additionally, maintaining strong links with the South Yorkshire Integrated Care System is a priority, ensuring that activity relating to prevention and health inequalities is joined up at a subregional level where it is beneficial to do so.

CORE20 PLUS 5 in Rotherham

This strategy has drawn from the CORE20 PLUS 5 approach to identify and address health inequalities. This means focussing on:

- The most deprived **20**% of the national population;
- **Plus** any locally identified priority groups, and;
- Delivery across the following **5** key clinical areas.

Further context relating to Rotherham's 'CORE20 PLUS 5' is set out below.

CORE20

According to the IMD (2019), 36% of the Rotherham population live in the 20% most deprived areas of England. As outlined on page 6, there are significant inequalities in health outcomes for the most and least deprived communities in Rotherham, and we know that deprivation also influences the way that people access and experience our services. In line with our principle to embed proportionate universalism, targeted action to support our most deprived communities will be a key part of our strategy.

PLUS

In addition to deprivation, as outlined on page 5, we know that there are other factors that drive health inequalities. In the development of this strategy, several inclusion groups for Rotherham have been identified:

- *Ethnic minority communities* – a rapid review undertaken by the NHS Race and Health Observatory found that ethnic inequalities in access to, experiences of, and outcomes of healthcare are longstanding problems in the NHS, and are rooted in experiences of structural, institutional and interpersonal racism. In Rotherham, ethnic minority communities are highly concentrated within the inner

areas of the town, which are some of the most deprived areas of Rotherham, leading to multiple disadvantage.

- *Roma and traveller communities* – Roma and traveller communities face significant inequalities and are more likely to describe their health as 'bad' or 'very bad.' This cohort is also less likely to be satisfied with the care that they receive.

- *People with severe mental illnesses (SMIs)* – people with SMIs are at a greater risk of premature mortality than the general population and recent data reviews undertaken locally (such as the smoking health needs assessment) have found evidence that some health outcomes are poorer for Rotherham people with SMIs compared with the national average.

- *People with learning disabilities and autistic people* – evidence shows that these two cohorts have a lower life expectancy and healthy life expectancy when compared with the rest of the population.

- *Carers* – we know that carers play an integral role in helping others to live well for longer but are twice as likely to experience poor health. Supporting carers' wellbeing and reducing inequalities for this group is vital for the sustainability of the health and social care system.

- *Asylum seekers and refugees* – asylum seekers and refugees face greater risks of mortality and morbidity compared with the general population. Evidence shows that this group also faces barriers in accessing care, including language, cultural and socioeconomic barriers.

- *Those in contact with the criminal justice system* – evidence shows that people that are in contact with the criminal justice system experience worse health outcomes, are more likely to be suffering from mental illness and are more likely to smoke. Although there are no prisons in Rotherham, this elevated risk is also true for those serving community sentences and those in contact with the criminal justice system on suspicion of committing a criminal offence.

It should be noted that this list is far from comprehensive, and other inclusion groups will be of particular import for certain pathways and health concerns. Moreover, the identification of 'plus' inclusion groups for Rotherham will be an iterative and ongoing process. The Health Inequalities

Data Subgroup will be considering this as part of building our local approach to population health management and the development of an outcomes framework, which will be used to monitor the successful delivery of the strategy.

Partners also have duties under the Equality Act (2010), which will be considered as part of delivery.

'5'

All five clinical areas identified within the national strategy are feeding into the Rotherham ICP Place Board. The table below shows the lead delivery group for each of the five areas.

CORE20PLUS5 – 5 clinical areas	**Lead delivery group in Rotherham**
Maternity – ensuring continuity of care for 75% of women from BAME communities and the most deprived groups	Prevention and Health Inequalities Enabler Group *(with links to the Children and Young People's Transformation Workstream/First 1001 days group)*
Severe Mental Illness – ensuring annual health checks for 60% of those living with SMI	Mental Health, Learning Disability and Neurodevelopmental Group
Chronic Respiratory Disease – a clear focus on COPD, driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions	Prevention and Health Inequalities Enabler Group
Early Cancer Diagnosis – 75% of cases diagnosed at stage 1 or 2 by 2028	Prevention and Health Inequalities Enabler Group
Hypertension Case Finding – to allow for interventions to optimise blood pressure and minimise the risk of MI and stroke	Prevention and Health Inequalities Enabler Group *(Health Inequalities Data Subgroup)*

Principles of the strategy

In delivery of the Prevention and Health Inequalities Strategy, partners have committed to the following principles:

- Embedding proportionate universalism by delivering interventions at a scale and intensity that is proportionate to the degree of need.
- Adopting a whole pathway approach, considering opportunities for primary, secondary and tertiary prevention.
- Drawing from research, data and intelligence to develop evidence-based interventions.
- Working with local people and involving them in decisions about their health and care.
- Taking a compassionate approach to health promotion.
- Making every contact count to maximise opportunities for prevention.
- Advocating for prevention within the wider system, including work to tackle the 'causes of the causes.'
- Challenging clinical variation to raise the bar of the management of risk factors and chronic conditions across all communities.
- Acting at the earliest possible stage to prevent and reduce the burden of ill-health.

The programme will also adhere to the overarching principles set out within the ICP Place Plan.

Our plan on a page

Our aim

People in Rotherham live well for longer

Five priorities

Strengthen our understanding of health inequalities	Develop the healthy lifestyles prevention pathway	Support the prevention and early diagnosis of chronic conditions	Tackle clinical variation and promote equity of access and care	Harness partners' roles as anchor institutions
20 outcomes / objectives with work targeted at a scale and intensity that is proportionate to the degree of need				
Improve the understanding of health inequalities in Rotherham Ensure that partners have access to bespoke data products Ensure that data around health inequalities informs commissioning, decision-making and service-delivery	Reduce the prevalence of smoking in Rotherham and narrow the gap between population groups Increase the proportion of people in Rotherham who are a healthy weight Reduce alcohol-related harm for people in Rotherham Support older people in Rotherham to retain their independence and age well	Reduce the health burden of cardiovascular disease in Rotherham Improve the management of diabetes Reduce the health burden of chronic respiratory disease in Rotherham Increase the proportion of cancer diagnoses made at stage 1 or stage 2 Ensure people get support with their mental health at the earliest possible stage	Narrow the gap in maternity outcomes for ethnic minority women and women from deprived communities Reduce premature mortality for people with learning disabilities, autistic people and those with severe mental illnesses Improve access to social prescribing for ethnic minority communities Mitigate against digital exclusion	Improve the health and wellbeing of our workforce across the place partnership Employ people from deprived communities and inclusion groups in Rotherham Increase our local spend to support Rotherham's economy Reduce our environmental impact

Underpinned by work to

Advocate for prevention across the wider system

Our priorities

Priority 1: Strengthen our understanding of health inequalities

Why is this important?

To make a compelling impact on health inequalities, we must act based on a strong understanding of the needs and experiences of our communities. This includes having a clear understanding of who are target groups are, to enable us to take a proactive approach and make the biggest difference to population health. Work to build our understanding of health inequalities will inform the entire programme; the intention is that our action plan and strategy will evolve as we build our understanding of the data and intelligence, ensuring we are responsive to the best evidence available and emerging needs. We will also share the data and intelligence we collate more widely to influence across the wider system.

Integral to this work will be the inclusion of community intelligence and the voice of local people. Listening to and acting on what people tell us is essential to addressing inequalities in our communities, including identifying any barriers to accessing care and disparities in the experiences and outcomes of different groups.

As well as building our understanding of our local communities, we will draw from the best academic and research evidence available to identify effective interventions to tackle health inequalities.

Where do we want to be?

We want to have a strong understanding of health inequalities in Rotherham, with partners acting on this data and intelligence to shape service-delivery and inform decision-making.

How will we get there?

To deliver on this, we will:

- Develop our approach to population health management to improve our understanding of patient and population needs. This will include defining a long-term plan for a sustainable population health management resource in Rotherham.
- Analyse waiting lists, inequalities in access to services and performance differentials across demographic groups.
- Ensure that our approach to population health management includes community voice and insights garnered through engagement activity.
- Ensure that partners have access to bespoke data products to support action on health inequalities.
- Promote the insights gathered through our data and intelligence work to inform commissioning, decision-making and service-delivery. This will include reshaping this strategy when necessary to act on our findings but will also involve sharing our insights more widely across the system.

Priority 2: Develop the healthy lifestyles prevention pathway

Why is this important?

Smoking, alcohol, and obesity are all leading modifiable risk factors associated with disability adjusted life-years in Rotherham. This association is partly driven by the fact that Rotherham has higher rates of smoking, obesity and alcohol-related harm when compared with the England average:

- 17.8% of the Rotherham population smokes compares with 13.9% of England (2019)
- 72.9% of adults in Rotherham are considered to be overweight or obese compared with 62.8% in England (2019/20)
- There were 583 admission episodes for alcohol-related conditions per 100,000 people in Rotherham in 2019/20, compared with 519 per 100,000 in England

There are also significant disparities in the prevalence of these issues between the most and least affluent communities and for specific groups, meaning that focussing on these preventable risk factors is an important part of addressing inequalities in the borough.

Rotherham also has an ageing population, and as healthy life expectancy in Rotherham is lower than average, many people are living for long periods in poor health. Supporting people to age well and remain healthy for as long as possible is an important priority.

Where do we want to be?

We want:

- Local people to feel supported and empowered to lead happy and healthy lives.
- Fewer people in Rotherham to smoke and the gap in smoking prevalence to narrow between our most and least deprived communities.
- More people in Rotherham to be a healthy weight, with an increased focus on prevention and improved access to advice and support.
- To reduce alcohol-related harm for people in Rotherham.

- Older people in Rotherham to retain their independence and age well.

How will we get there?

We will:

- Ensure that commissioned services operate within a person-centred, joined-up and effective partnership pathway.
- Develop and deliver local plans focussed on smoking, healthy weight, and alcohol as some of the leading risk factors associated with disability-adjusted life years in Rotherham.
- Increase upstream prevention messaging, drawing from behavioural insights and engagement with local people.
- Develop our approach to providing low-level advice and support to older people in the community.

Priority 3: Support the prevention and early diagnosis of chronic conditions

Why is this important?

Rotherham is significantly worse than national average for preventable mortality and is also worse than national average for under 75 mortality for numerous conditions, including:

- Cardiovascular disease – Rotherham 83.8 per 100,000, England average 70.4
- Cancer – Rotherham 155.7 per 100,000, England average 129.2
- Respiratory disease – Rotherham 49.9, England average 33.6

The estimated prevalence of those aged 16 and over with common mental health disorders is also higher than the England average at 18.6% (compared with 16.9% England average.)

It is estimated that two thirds of premature deaths could be avoided through improved prevention, early detection, and better treatment, meaning that focussing on prevention and early diagnosis of chronic conditions has the potential to have a significant impact on mortality in Rotherham.

Where do we want to be?

We want:

- The health burden of cardiovascular disease in Rotherham to be reduced, improving performance against national CVD prevent targets.
- The management of diabetes for people in Rotherham to improve.
- The health burden of chronic respiratory disease in Rotherham to be reduced.
- More cancer diagnoses to be made earlier, and particularly at stage 1 or stage 2.

- People to get support with their mental health at the earliest possible stage.

How will we get there?

We will:

- Manage long-term conditions and health inequalities through QOF.
- Review long-term conditions pathways to identify opportunities for prevention, improvements in care and a strengthened focus on health inequalities.
- Progress the population health place development programme, with a focus on CVD/diabetes.
- Undertake work to increase early cancer diagnosis, including the lung health checks programme, recruiting clinical cancer champions and undertaking a behavioural insights project focussed on early diagnosis.
- Work with the Mental Health, Learning Disabilities and Neurodevelopmental Workstream to address inequalities in mental health, including building consideration of mental health into pathways for long-term conditions.

Priority 4: Tackle clinical variation and promote equity of access and care

Why is this important?

COVID-19 has shone a harsh light on some of the health and wider inequalities that persist in our society, and we know that everyone does not access services on an equal footing. For example:

- Analysis from The King's Fund shows that people living in the most-deprived areas in England are nearly twice (1.8 times) as likely to experience a wait of more than one year for hospital care than those who live in the least-deprived areas. (2021)
- According to analysis from the Health Foundation, after accounting for different levels of need, a GP working in a practice serving the most deprived patients will on average be responsible for the care of almost 10% more patients than a GP serving patients in more affluent areas. (2018)

There are also disparities in the outcomes people experience from the care they receive. For example:

- Women from Black ethnic groups are four times more likely to die in pregnancy than women from White groups. Women from Asian ethnic backgrounds are almost twice as likely to die in pregnancy compared to White women. (2017-2019)
- General practices serving patients living in the most deprived areas have the lowest overall patient satisfaction scores. Patient satisfaction increases as deprivation decreases, and patients living in the wealthiest areas are most satisfied with the care they receive. (2018)

Ensuring that every person in Rotherham has access to quality care is a key component to addressing health inequalities across the borough. This will often require a tailored and targeted approach to meet the needs of specific communities.

Where do we want to be?

We want:

- Ethnic minority women and women from deprived communities to experience better maternity outcomes, with the gap narrowing between these cohorts and the rest of the population.
- People with learning disabilities, autistic people, and those with severe mental illness to experience better health outcomes and to narrow the gap in life expectancy for these groups.
- More people from ethnic minority communities to access social prescribing and experience positive outcomes.
- Digitally excluded people to have fair and equitable access to services, advice, and support.

How will we get there?

We will:

- Work towards continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups, including working with the Maternity Voices Partnership to learn from the experiences of women in these groups.
- Review the health section of the Learning Disability Strategy and develop action plans to reduce premature mortality for people with learning disabilities and autistic people.
- Explore opportunities to build mental health support into long-term conditions pathways.
- Deliver a programme to promote social prescribing amongst ethnic minority communities and increase referrals from clinicians.
- Collaborate with the Digital Enabler Group to identify and deliver against shared priorities.

Priority 5: Harness partners' collective roles as anchor institutions

Why is this important?

The term 'anchor institutions' is used to refer to organisations which have an important presence in a place, usually through a combination of being largescale employers; the largest purchasers of goods and services in the locality; controlling large areas of land; and/or having relatively fixed assets.

Members of the ICP are anchor institutions; place partners collectively spend in the order of £650m per year across the health and social care system. Being such large institutions within Rotherham means that we have the potential to improve population health by addressing the socioeconomic and environmental conditions that influence health outcomes.

There is also an opportunity to make a difference to population health through supporting our own workforce, as staff working within the health and social care system make up a significant proportion of our local population. Supporting them to achieve and maintain good health delivers business and population health benefits.

Where do we want to be?

We want:

- Our workforce across the partnership to experience good health and wellbeing.
- More people from deprived communities and inclusion groups to be in employment, including within our own organisations.
- A higher proportion of our collective spend to be local in support of Rotherham's economy.
- Our collective impact on the environment to be lower.

How will we get there?

We will:

- Work towards a shared understanding of our role as ‘anchor institutions’ and the key drivers and outcomes our organisations are working towards.
- Agree partnership commitments to act as anchor institutions to reduce health inequalities in Rotherham.

Underpinning priority: Advocate for prevention across the system

Why is this important?

Health is influenced by a broad range of factors. The wider determinants of health include socioeconomic factors, environmental conditions, and the social and community networks people have access too. Evidence indicates that these wider determinants have a greater influence on health than the healthcare people receive.

In Rotherham:

- 36% of the population lives in the 20% most deprived areas of England (2019)
- 21.3% of children are in absolute low-income families and 25.6% in relative low-income families (2019/20)
- 57.5% of the population is qualified to NVQ3 level or above compared with 61.3% of the British population.

Whilst this partnership programme and strategy is focussed primarily on the health and social care system, it will be important to use partners' collective influence and the intelligence we gather to shape action to address the wider determinants of health.

Where do we want to be?

We want organisations across Rotherham and beyond to prioritise action to prevent ill-health and reduce health inequalities, informed by a strong understanding of our local communities.

How will we get there?

To support this, we will:

- Provide evidence to key stakeholders and partnership forums such as the Health and Wellbeing Board to influence action on the wider determinants of health.
- Advocate for prevention within each of our own organisations.

Governance and monitoring

Governance arrangements

This strategy and action plan is owned by the ICP Prevention and Health Inequalities Enabler Group. This group is chaired by the Director of Public Health and is comprised of members across the Rotherham Place partnership including:

- Rotherham Metropolitan Borough Council, including representation from Public Health, Adult Social Care and Children and Young People's Services
- Rotherham Clinical Commissioning Group
- The Rotherham Hospital Foundation Trust
- The voluntary and community sector
- Rotherham Doncaster and South Humber NHS Trust
- Connect Healthcare Rotherham Ltd (Rotherham GP Federation)

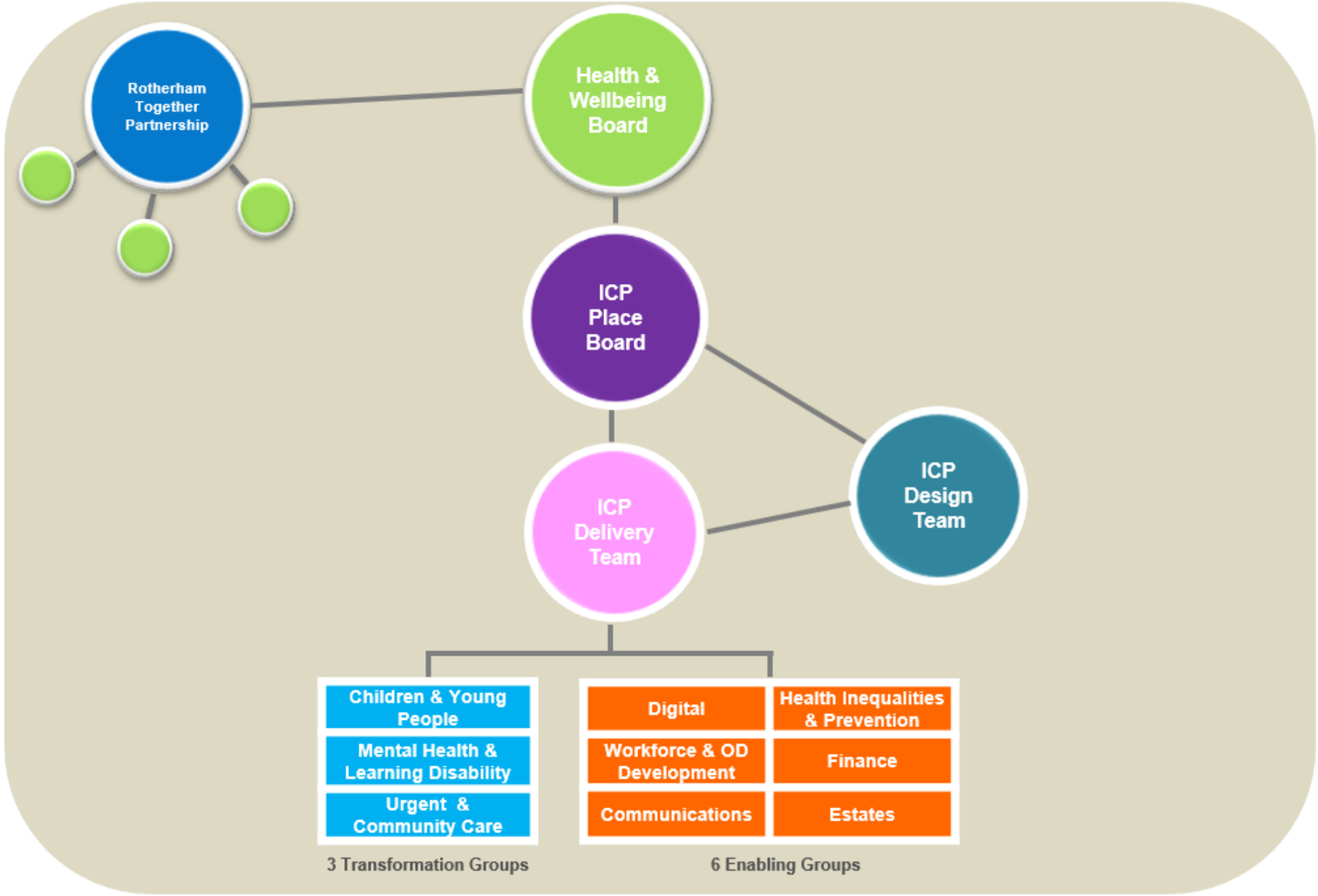
This group feeds into the Rotherham ICP Place Board, as well as Rotherham's Health and Wellbeing Board allowing for strategic oversight of the work. The named executive leads for health inequalities across the Rotherham Place will also have a role in steering the agenda and ensuring the strategy is delivered within each organisation.

Subgroups will be established where required, including the Health Inequalities Data Sub-group which will take a leading role in delivering on priority one.

Monitoring delivery

Progress will be reported into the Prevention and Health Inequalities Enabler Group on a monthly basis, with issues escalated to the Place Board and the Health and Wellbeing Board where necessary. All Place partners will be responsible for assuring the delivery of the plan.

The action plan that is appended to this strategy will be refreshed annually in consultation with all partners. An outcomes framework will also be developed, which will identify targets, key inclusion groups and will seek to measure the longer-term success of the strategy.


Rotherham Together Partnership
Health & Wellbeing Board
ICP Place Board
ICP Delivery Team
ICP Design Team
Children & Young People
Mental Health & Learning Disability
Urgent & Community Care
Digital
Health Inequalities & Prevention
Workforce & OD Development
Finance
Communications
Estates
3 Transformation Groups
6 Enabling Groups

Action Plan – 2022/23

This action plan will be formally reviewed on an annual basis and will be reported through to the ICP Place Board as part of performance monitoring for the Prevention and Health Inequalities Enabler Group.

Priority 1: Strengthen our understanding of health inequalities through data and intelligence

Outcomes	#	Action	Timescale	Delivery group/ lead organisation	Lead(s)	Alignment with NHS 5 strategic actions
Improve the understanding of health inequalities in Rotherham (1A) Ensure that partners have access to bespoke data products (1B) Ensure that data around health	1.1	Develop our approach to population health management including a focus on: • The RODA work programme • Hypertension case findings • Small area-level data to identify prevalence of smoking and obesity at a ward level and split down by protected characteristic	Q4 2023 TBC based on resources Q1	Health Inequalities Data Subgroup	Alex Henderson-Dunk	Ensuring datasets are complete and timely

inequalities informs commissioning, decision-making and service-delivery (1C)	1.2	Analyse waiting lists, inequalities in access to services and performance differentials across demographic groups.	Q2	Health Inequalities Data Subgroup	Alex Henderson-Dunk, Elizabeth Wardle and Ray Hennessey	Restoring NHS services inclusively Ensuring datasets are complete and timely
	1.3	Develop the first draft of an outcomes framework and dashboard to support the delivery of the prevention and health inequalities plan and identify key inclusion groups.	Q1	Health Inequalities Data Subgroup	Becky Woolley and Alex Henderson-Dunk	Ensuring datasets are complete and timely

Priority 2: Develop the prevention pathway to reduce the harms from smoking, obesity and alcohol and support healthy ageing

Outcomes	#	Action	Timescale	Delivery group/ lead organisation	Lead(s)	Alignment with NHS 5 strategic actions
Reduce the overall prevalence of smoking in Rotherham and narrow the gap between population groups (2A) Increase the proportion of Rotherham people who are a healthy weight (2B) Reduce alcohol-related harm for people in Rotherham (2C) Support older people in Rotherham to retain	2.1	Develop our partnership action plans focussed on tobacco, healthy weight, and alcohol.	Tobacco – end of Q3 Alcohol – Q3 Healthy weight – TBC	Partnership task and finish groups to be established by Public Health	Catherine Heffernan and Jacqui Wiltschinsky	Accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes
	2.2	Identify and treat inpatient smokers as part of the QUIT programme.	Q4 - 2023	TRFT and RDaSH	Healthy Hospitals Manager (TRFT) And Olha Hodgson (RDaSH)	
	2.3	Develop a prevention 'brand' and communications campaign with a focus on upstream prevention messages.	Q4 - 2023	ICP Prevention and Health Inequalities Enabler Group	Ben Anderson, Gordon Laidlaw and Aidan Melville	

their independence and age well (2D)				working with the Communications Enabler Group		
	2.4	Recommission the healthy lifestyles services and NHS health checks as part of a broader partnership pathway, informed by coproduction work.	Cabinet decision about model and timeline – Q1 2022	Public Health	Anne Charlesworth	
	2.5	Develop our approach to providing low-level advice and support to older people in the community, using learning from the Active Solutions pilot.	Q2	RMBC Adult Social Care and voluntary sector partners	Jo Hinchliffe and Lesley Dabell	
	2.6	Launch and promote the NHS England resource pack to support carers with their health and wellbeing.	Q1	RMBC Adult Social Care	Jo Hinchliffe	

Priority 3: Support the prevention and early diagnosis of chronic conditions

Outcomes	#	Action	Timescale	Delivery group/ lead organisation	Lead(s)	Alignment with NHS 5 strategic actions
Reduce the health burden of cardiovascular disease in Rotherham (3A) Improve the management of diabetes (3B) Reduce the health burden of chronic respiratory disease in Rotherham (3C) Increase the proportion of cancer diagnoses made at	3.1	Restore diagnosis, monitoring and management to pre-pandemic levels in 2022/23, as per the Quality and Outcomes Framework (QOF), Integrated Investment Fund and Direct Enhanced Service targets for: • Hypertension • Atrial fibrillation • High cholesterol • Diabetes • Asthma registers and spirometry checks for adults and children • COPD registers and spirometry checks for adults and children	Q4 – 2023	Primary Care Networks	PCN Clinical Directors	Restoring NHS services inclusively Accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes
	3.2	Progress the population health place development programme, with a focus on CVD/diabetes.	Q2	Population Health Place Development Programme Group	Ben Anderson and Ian Atkinson	Accelerating preventative programmes that

stage 1 or stage 2 (3D) Ensure people get support with their mental health at the earliest possible stage (3E)	3.3	Review the engagement methods of the healthy engagement team.	Q4 – 2022	Voluntary Action Rotherham	Julie Adamson	proactively engage those at greatest risk of poor health outcomes
	3.5	Review Rotherham's respiratory pathway in the context of the national Right Care pathway.	Q1 (TBC)	Rotherham CCG and Public Health	Jacqui Tuffnell and Catherine Heffernan	
	3.6	Undertake work to increase early cancer diagnosis, including: • Delivering the lung health checks programme • Recruiting clinical cancer champions using funding from Yorkshire Cancer Research. • Undertaking a behavioural insights project focussed on early cancer diagnosis.	Q3 Q1	Primary Care Networks	Dr Jason Page PCN Clinical Directors	
	3.7	Providing prevention and health inequalities support to mental health transformation work, including: • Three OHID-funded prevention projects • A communications campaign to promote 'self-	Ongoing	Prevention and Health Inequalities Group providing support to the Mental Health, Learning Disabilities and Neurodevelopmental Workstream	Ruth Fletcher-Brown Gordon Laidlaw Kate Tufnell	

		help', early intervention, and prevention • The community mental health transformation programme • Health checks for those with SMIs				

Priority 4: Tackle clinical variation and promote equity of access and care for underserved groups

Outcomes	#	Action	Timescale	Delivery group/ lead organisation	Lead(s)	Alignment with NHS 5 strategic actions
Narrow the gap in maternal outcomes for ethnic minority women and women from deprived communities (4A) Reduce premature mortality for people with severe mental illness, learning	4.1	Ensure continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.	2024	TRFT	Sarah Petty	Restoring NHS services inclusively Accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes
	4.2	Review the health section of the Learning Disability Strategy and develop action plans to reduce premature mortality for people with learning disabilities and autistic people.	Q1	Subgroup (TBC)	Garry Parvin	
	4.3	Review opportunities to build mental health support into long-term conditions pathways.	Q4	Prevention and Health	CCG and TRFT leads TBC	

disabilities and autistic people (4B) Improve access to social prescribing for ethnic minority communities (4C) Mitigate against digital exclusion (4D)		*(Also relates to outcome 3E)*		Inequalities Group		
	4.4	Deliver a programme to promote social prescribing amongst ethnic minority communities and increase referrals from clinicians.	Q4 – 2022	Voluntary Action Rotherham	Julie Adamson	
	4.5	Identify shared priorities with the digital enabler group	Q1	ICP Prevention and Health Inequalities Enabler Group and the Digital Enabler Group	Becky Woolley	Mitigating digital exclusion

Priority 5: Harness partners' collective roles as anchor institutions to address health inequalities

Outcomes	#	Action	Timescale	Delivery group/ lead organisation	Lead(s)	Alignment with NHS 5 strategic actions

Improve the health and wellbeing of our workforce across the place partnership (5A) Employ more people from deprived communities and inclusion groups in Rotherham (5B) Increase our local spend to support Rotherham's economy (5C) Reduce our environmental impact (5D)	5.1	Hold a workshop to start working towards a common understanding and focus for the anchor institution agenda.	Q4 2022	ICP Prevention and Health Inequalities Enabler Group	Ben Anderson and Becky Woolley	Leadership and accountability
	5.2	Agree partnership commitments to act as anchor institutions to reduce health inequalities in Rotherham.	Q2	ICP Prevention and Health Inequalities Enabler Group	All partners	