## HEALTH SELECT COMMISSION

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

**Date:** **Thursday, 23rd January, 2014**

**Time:** **9.30 a.m.**

## A G E N D A

1. To determine whether the following items should be considered under the categories suggested in accordance with Part 1 of Schedule 12A (as amended March 2006) to the Local Government Act 1972

2. To determine any item the Chairman is of the opinion should be considered later in the agenda as a matter of urgency

3. Apologies for Absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Communications

7. Minutes of the Previous Meeting (Pages 1 - 11)

8. Health and Wellbeing Board (Pages 12 - 22)
   - Minutes of meetings held on 27th November and 18th December, 2013

9. Sexual Health Services (Pages 23 - 30)
   Gill Harrison, Public Health Specialist to present

10. Scrutiny Review - Information for Carers (Pages 31 - 57)
    Deborah Fellowes, Scrutiny Manager to present

11. Public Health Outcomes Framework (Pages 58 - 77)
    Dr. John Radford to present

12. Residential Care Scrutiny Review - Monitoring Report (Pages 78 - 83)
    Shona McFarlane, Director of Health and Wellbeing, to report

13. Integrated Health, Education and Social Care Service for Children, Young People and their Families (Pages 84 - 89)
Dorothy Smith, Director of Schools and Lifelong Learning to report

14. Date and Time of Next Meeting
    - Thursday, 13th March, 2014 at 9.30 a.m.

## HEALTH SELECT COMMISSION
## 5th December, 2013

Present:- Councillor Steele (in the Chair); Councillors Beaumont, Dalton, Goulty, Hoddinott, Kaye, Middleton, Roche, Sims, Watson and Wootton; together with co-opted members Victoria Farnsworth (Speak Up), Peter Scholey and Russell Wells (National Autism Society).

Also in attendance: Councillor Wyatt (Cabinet Member for Health and Wellbeing) for items 48 and 49.

Apologies for absence were received from Councillor Havenhand and from co-opted member Robert Parkin.

**44. DECLARATIONS OF INTEREST**

There were no declarations of interest made at this meeting.

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

A member of the public spoke about the work of the 'Speak up for Autism' Group which, in association with the Sheffield Hallam University, was undertaking a study of the stress levels experienced by people who suffer Autism.

**46. COMMUNICATIONS**

Members noted that the agenda item about Children's Continuing Healthcare has been deferred from the next meeting of the Health Select Commission (23rd January 2014) and will be considered at a later date.

**47. MINUTES OF THE PREVIOUS MEETING**

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on Thursday 24th October, 2013.

Resolved:- That the minutes of the previous meeting be agreed as a correct record for signature by the Chairman.

**48. HEALTH AND WELLBEING BOARD**

Consideration was given to the minutes of the meeting of the Health and Wellbeing Board held on 16th October, 2013.

The Select Commission noted that:-

: (Minute S44) - the Joint Strategic Needs Assessment continues to be a priority for consideration by the Health and Wellbeing Board. New information is being suggested for inclusion, for example, the impact of domestic abuse, as a recommendation from the recent scrutiny review.

: (Minute S45) – the Health and Wellbeing Board had not yet expressed a definitive view concerning the presence of fast-food outlets near schools and within deprived areas – officers within the Planning Service and the Public Health Service are developing a policy on this matter for consideration by Elected Members.

Resolved:- That the minutes be received and the contents noted.

**49. HEALTH AND WELLBEING STRATEGY**

Councillor Wyatt (Cabinet Member for Health and Wellbeing) presented a progress report about the Health and Wellbeing Strategy, which was twelve months into implementation. The six strategic priorities of the Strategy were being delivered through a set of workstreams, each with an identified lead officer who had attended the Health and Wellbeing Board to present their action plan. The new outcomes framework to measure progress on the priorities is being developed, linked to the national Public Health Outcomes Framework.

The workstreams and progress to date were as follows:-

Workstream 1: Prevention and Early Intervention

- Individual commissioning plans for the locally determined priorities (smoking, alcohol and obesity) being developed ensuring they had a focus on Prevention and Early Intervention;
- An increase in the number of adults screened and offered brief intervention within Primary Care in relation to alcohol;
- The Clinical Commissioning Group's Strategy was delivering more alternatives to hospital admission, treating people with the same needs more consistently and dealing with more problems by offering care at home or close to home;
- Remained 1 of the best performing Health Check Programmes, with 57% of people in Rotherham having completed a first Health Check since 2006. There will need to be a step change in performance to achieve the 20% annual target of eligible people screened;
- The 'Making Every Contact Count' model had been agreed in principle at the previous Health and Wellbeing Board;
- The Suicide Review Group had been established and had reviewed all suicide deaths and looked to support actions to improve mental health and wellbeing, including the development of active bereavement support to reduce the risk of suicide in family members.

Workstream 2: Expectations and Aspirations

- Development of a customer pledge which was currently proceeding through the final agreement stage, but not progressing as well as hoped;
- Complaints baselines had been collated to enable monitoring of performance against numbers and types of complaints in relation to Customer Service;
- Practitioner Information Sharing events had taken place for a number of the deprived areas, with the purpose of looking at how to tackle some of the challenges in relation to poverty and deprivation;
- A single set of Customer Standards had been consulted upon at the Rotherham Show in September and was now being developed by the Council with the intention of rolling out further and seeking sign-up from other partners.

Workstream 3: Dependence to Independence

- Formal review process being undertaken - to validate that this element of the Strategy was embedded and resulted in effective outcomes;
- Workforce Strategy Group established and a draft Workforce Strategy now in place;
- Risk Strategy Task and Finish Group, Terms of Reference and action plan are in place;
- Shared decision making framework has been agreed;
- Presentation made to Shaping the Future Provider Forum on 9th July 2013, with presentations to be made to future Crossroads and Age UK Annual General Meetings;
- Voluntary sector representation on workstream group;
- Joint Telehealth Strategy agreed;
- Progress made towards Personal Health Budgets – will be in place by 31st March, 2014;
- Netherfield Court staff tasked with developing an approach that looked beyond people's physical rehabilitation, to a more holistic approach.

Workstream 4: Healthy Lifestyles

- Strong focus on delivery of health behaviour change activity across the Borough, focussing specifically on deprived neighbourhoods and attendance at community events by Services to raise awareness and referrals;
- Adoption of the Smokefree Charter, followed by roll-out and promotion through voluntary and community organisations, businesses and educational establishments;
- Commissioned training for agencies providing support to members of the public affected by Welfare Reform, with particular focus on mental health and support services;
- the 'Making Every Contact Count' workshop has been held;
- http://www.youtube.com/watch?v=FVeUHT1s714 and forward plan in development;

- Refresh of Rotherham Active Partnership and engagement of Elected Member as Chair;
- Work had continued on the review of number of Behaviour Change Services and development of new Service specifications, prior to re-tendering or transfer of commissioning responsibility to the Council;
- Weight management providers actively seeking to extend their reach into Children's Centres, Schools and Colleges;
- Obesity and Tobacco Control programme activity presented to the Public Health England Conference in September 2013.

Workstream 5: Long-term Conditions

- Plans in place to extend personal health budgets to a wider cohort of patients during pilot period, working in partnership with the Council to 1st April, 2014; Sub-groups formed with agreed Terms of Reference;
- Self-management strategy agreed by the Urgent Care Management Committee;
- the Rotherham Clinical Commissioning Group had developed a practitioner skills programme on self-management and is currently trying to identify GP practices willing to utilise the programme;
- Intermediate care facilities fully operational and Winter-ready, providing an alternative level of care for people with long term conditions who could not remain at home;
- Joint Commissioning Team identified high intensity users of Social Care Services with the next step being to match them against high users of health services and establishing whether there was a correlation;
- Specialist psychological support was now being provided to all stroke survivors as part of the Integrated Stroke Care Pathway. This process now needed to be rolled out to other care pathways
- Winter Plan included the process for identifying those with long term conditions who were vulnerable.

Workstream 6: Poverty

- Nine of the eleven deprived neighbourhoods had identified health as a key priority area and actions to address it were embedded into Neighbourhood Plans, where appropriate;
- Actions included learning about healthy lifestyles, improving access to Health Support Services and reducing alcohol consumption on the streets;
- Adult Skills had been identified as a key priority in eight of the eleven deprived neighbourhoods, therefore, actions had been included in plans to address this issue;
- Workshop planned for Service providers with the objective to determine what a strategy would look like to get those people, who are away from the labour market, 'work ready';
- Mapping exercises completed to ascertain the extent of poverty alleviation work currently being undertaken in Rotherham and also to capture national best practice in anti-poverty work; discussions taking place to map out what a building resilience strategy would look like;

– Limited capacity to achieve the Priority around actively working with every household in deprived areas to maximise benefit take-up; a Corporate review was being considered which would examine the appropriateness of Welfare Advice Services.

After the presentation, Members raised the following questions:-

: the key aims and the expected impact of the 'Customer Pledge' – the starting point is that the Pledge should be an expression of basic standards of health and social care to be provided for customers and patients;

: involvement of people who have learning disabilities in projects such as the 'quit smoking' and the 'stop smoking in pregnancy' campaigns; it was noted that there are specialist support services, including specialist midwifery and tailored support for women who are trying to stop smoking;

: the wide-ranging nature and contents of the Health and Wellbeing Strategy; it was noted that the Strategy is in place for a period of three years and intends to encompass all life stages (and age ranges); an explanation was provided of the monitoring arrangements for the Strategy's workstreams and actions (via the multi-agency Health and Wellbeing Steering Group); it was acknowledged that local and national priorities may change over time;

: issues concerning mental health and the waiting lists for assessment;

: funding for Winter pressures;

: the transfer of funding for Public Health services, from NHS England and from NHS Rotherham to this Council;

: progress with the actions to reduce the incidence of people drinking alcohol in the street; the complexity and seriousness of problems concerning alcohol were acknowledged;

: the incidence of obesity in young children – Rotherham is recognised nationally for its creation of the 'Healthy Weight' framework;

: auditing and monitoring of the Health and Wellbeing Strategy; one of the functions of the Health and Wellbeing Board is to hold the Council and partner organisations to account in the delivery of the services in accordance with the Strategy's priorities;

: poverty and the impact upon the Rotherham economy of the coalition Government's welfare reforms;

: the role and impact of the Deprived Neighbourhood Co-ordinators.

Resolved:- (1) That the contents of the report and the progress of each of the workstreams be noted.

(2) That a progress report be submitted to a meeting of the Health Select Commission, in six months' time, detailing the progress of two of the workstreams of the Health and Wellbeing Strategy and the Chairman and the Vice-Chairman of this Select Commission shall choose the two workstreams.

**50. SCRUTINY REVIEW - AUTISTIC SPECTRUM DISORDER**

Further to Minute No. 19 of the meeting of the Health Select Commission held on 11th July, 2013, Steve Mulligan (Principal Educational Psychologist) gave a presentation about the progress of the implementation of the actions arising from the scrutiny review of autistic spectrum disorder (ASD). The various issues highlighted were:-

Scrutiny Review: September-November, 2012
Objectives of the Review

- The reasons for the higher diagnosis rates
- Services required at diagnosis stage and after
- 16plus (pupils leaving school) support and transition
- Budget implications

Final Recommendations

- That the Autism Communication Team (ACT) continue to co-ordinate the monitoring and intelligence of ASD rates of diagnosis in Rotherham and partner agencies be requested to share information to facilitate this being done accurately. ACT should also ensure that partner agencies have access to this compiled information;
  Local and regional data continued to be collected and shared across Education and Health. CAMHS and the Local Authority have improved their dialogue via regular meetings during the past four months. The most recent figures, collated to October, 2013, were:-

  | | |
  |---|---|
  | Mainstream | 1,015 |
  | Special | 192 |
  | Total | 1,207 |

- That the Rotherham Child Development Centre (CDC) and the Child and Adolescent Mental Health Services (CAMHS) bring forward proposals to streamline their assessment processes and reduce waiting lists. In particular, transition referrals at age 5 years should be the subject of a clearly documented care plan that is shared with all partners and the family
  CDC/CAMHS are physically located in the same building and complied with Diagnostic and Statistical Manual version5. Waiting times are being reviewed and both CDC/CAMHS were examining pathways for the Autism Spectrum conditions, working with the Education Psychology Service.

- That the Special Educational Needs reform project group is being asked to implement a pilot project for the development of Education, Health and Care plans for children with a diagnosis of ASD with a view to ensuring that in the future all children with a diagnosis will have a multi-agency care plan with a lead worker allocated
  Education, Health and Care plans were being developed by the Local Authority group looking at Support and Aspiration under strategic leadership within the Council. Pilot Education, Health and Care plans were being formulated in compliance with the new Code of Practice and the Children and Families Bill 2013

- That proposals are brought forward to develop more wrap around family support to assist with the transition between different services (particularly post-5) and at different life stages. This Service should recognise the vital role that parents and carers need to play in working with and influencing Service providers and should be developed in line with the commitments in the Partner and Child Charter
  Continued work regarding the development and understanding of multi-element planning. The principles of the Parent and Child Charter continue to be implemented and rolled out. Development of the Early Years Charter

- That the hierarchy of support within a mainstream setting with ACT and Educational Psychology concentrating on children with more complex needs, be formalised and further developed, including exploring the potential role of special schools to support mainstream schools with support for children with less complex needs
  The ACT Team has been aligned to the Learning Support Service. The funding of all the targeted Services was under a four-way review – High Needs Block, Learners First Review, Development of Integrated Pupil Services and Service Transformation; proposal to appoint a staff member to build capacity as part of Service Transformation and a commissioning process to meet need, should enable progress to be made quickly.

- That the Joint Strategic Needs Assessment include a detailed and thorough assessment of the needs of children and adults with autism including the identification of any gap in services
  The ASC Scrutiny report would form the basis of the JSNA around autism. Discussions at CAMHS planning meetings and a meeting to discuss joint commissioning on 19th December, 2013.

- In line with the JSNA, that commissioners consider the commissioning of Rotherham-based service for young people (16+) with ASD over the next 5 years, building on the good practice that already exists. This would result in a reduction of out-of-authority placements
  Continued work regarding post-16 provision included building capacity at local college, bespoke packages and joint venture partnerships with

independent service providers. The Director of Safeguarding was leading on work regarding out-of-authority placements

- That a local care pathway for the management of ASD in adults should be developed in line with appropriate NICE guidelines
  Discussions had taken place with Adult Services regarding Autism with Adults paper/pathways linked to the ASC Strategy Group

- That RMBC identifies a ‘senior leader’ for the autism agenda who is able to challenge provision and raise the status of the condition. The work should then be channelled through the Autism Strategy Group
  Appropriate senior staff of the Council now fulfil these roles.

- That commissioners should look at how a pathway of care can be resourced effectively and the CCG specifically whether a single diagnostic route would be more appropriate
  Children and young people were diagnosed at different stages of their development. All systems must be NICE compliant. Joint work EPS/CAMHS continued around pathways to reduce “noise” in the system.

As a consequence of the scrutiny review and the work of the local Autism Society, there is now greater awareness in Rotherham, improved communications and increased confidence in schools and services.

After the presentation, Members asked questions about the following matters:-

: the impact of CAMHS services (Members requested additional information about this matter);

: post-diagnosis treatment;

: 5 to 7 years age group;

: post-diagnostic support for families – the Rotherham Clinical Commissioning Group will ultimately be asked to provide funding for such support services;

: support for pupils with high functioning Asperger syndrome in schools.

Resolved:- (1) That the report be received and its contents noted.

(2) That a further progress report explaining the implementation of the actions arising from the scrutiny review of autistic spectrum disorder be submitted to a meeting of this Select Commission in six months’ time.

## 51. YORKSHIRE AMBULANCE SERVICE QUALITY ACCOUNTS 2013-14

Further to Minute No. 42 of the meeting of the Health Select Commission held on 24th October, 2013, Members welcomed Hester Rowell, David Bannister, Steve Rendi and Amanda Best (representing the Yorkshire Ambulance Service)

Hester Rowell, Head of Quality and Patient Experience, Yorkshire Ambulance Service, and Steve Rendi, Locality Manager (Rotherham), reported on the Quality Accounts which would be published in June, 2014 and would provide information on Service performance in the period between April, 2013 and March, 2014. The Service was inviting comments from partner organisations and from the public on the contents of the Quality Accounts report, with a deadline for submission of responses of 31st December, 2013.

Members received a presentation which highlighted the following issues:-

Clinical Quality Strategy
- Key part of the Integrated Business Plan
- Sets out key clinical quality priorities for 2012-2015
- Focus on evidence based practice and national priorities
- Focus on most important issues for the people who use the service

What influences the Yorkshire Ambulance Service Clinical Quality Strategy?
- Learning from the outcome of the Inquiry by Lord Francis into care failings at the Mid-Staffordshire NHS Trust

Quality Accounts 2012-13
- Accountability
- Transparency
- Consultation

Current Priorities
- Improving the experience and outcomes for patients in rural areas
- Working with care and residential homes
- Achieving a reduction in harm to patients (when being transported by ambulance) through the implementation of a safety thermometer tool – it was acknowledged that the incidence of such harm was extremely rare
- Public education
- Patient Transport Service improvement

Progress
- NHS safety thermometer
  Increased awareness raising across staff on safety thermometer and harms
  Review of Patient Transport Service booking process

Review of dynamic risk assessments
Audit of equipment on vehicles
Standardisation of procedures
Education and training review
Regional Falls Network

- Public Education
  Choose well
  : Accident and Emergency (A&E) and the '999' ambulance services are intended for people with life-threatening or serious conditions which need immediate attention, such as heart attacks, strokes, breathing problems or severe bleeding
  : if someone needs treatment or advice for a minor illness, ailment or injury, there are a number of services available – self-care, pharmacy, NHS Direct, GPs, walk-in centre, minor injuries unit;
  : Pharmacists provide an easily accessible service on the high street and at many supermarkets and can give confidential, expert, free advice;
  : by choosing the most appropriate service, people can help to ensure that emergency services such as A&E and '999' are available for those who really need them.

- Working with care and residential homes
  Working in partnership to ascertain reasons for '999' emergency calls, because a high percentage are received from care homes.

- Patient Transport Service for routine appointments
  Patient Transport Service and recruitment
  Restructuring the management team
  Reviewing how the communication function operates
  Re-assessing how work is planned and scheduled
  Reviewing rotas to ensure better links between the service and patient needs
  Improving how the Service listens and responds to patient and staff feedback
  Reviewing fleet and estate requirements

- The Yorkshire Ambulance Service may not achieve Foundation Trust status until 2015, although the Service continues to act, report and engage with communities as a Foundation Trust.

- Next steps
  Roadshow launch – "Spring into Safety"
  Multiple communication channels – Yorkshire Ambulance Service television, social media sites, face to face;
  Steering Group to sustain improvements
  Review structure of clinical supervision
  Review of education and training
  Patient safety culture work

Consultation
- Listening to members, communities and staff

Rotherham Accident and Emergency (A&E)
- Preparing for Winter
- A&E operational re-design
- Incidence of priority 'red' emergency calls and response times
- Collaborative working in Yorkshire and the clinical leadership framework were highlighted.

After the presentation, Members asked questions about the following matters:-

: financial savings to be made by the Yorkshire Ambulance Service, during the next five years and the public consultation process concerning the budget reductions and service targets; it was noted that the Service is recruiting staff throughout Yorkshire;

: service performance targets and whether there is any impact on mortality rates;

: provision of specialist responses with different vehicles to different types of patient (eg: bariatric (obese) patients);

: ambulance 'turn-around' times at hospital A&E departments;

: the possible impact (eg: on ambulance journey distances and times) of the coalition Government's proposed reform of A&E services.

Resolved:- (1) That the information provided in the presentation be noted.

(2) That the Health Select Commission shall provide a response to the Yorkshire Ambulance Service Quality Accounts report 2013/2014, as now indicated and the Chairman and the Vice-Chairman shall approve the details of the response.

**52. DATE AND TIME OF NEXT MEETING**

Resolved:- (1) That a special meeting of the Health Select Commission be held on Thursday, 9th January, 2014, commencing at 9.30 a.m.

(2) That the next scheduled meeting of the Health Select Commission be held on Thursday, 23rd January, 2014, commencing at 9.30 a.m.

**HEALTH AND WELLBEING BOARD**
**27th November, 2013**

**Present:-**

| | |
|---|---|
| Councillor Ken Wyatt | Cabinet Member, Health and Wellbeing **(in the Chair)** |
| Louise Barnett | Rotherham Foundation Trust |
| Karl Battersby | Strategic Director, Environment and Development Services |
| Tom Cray | Strategic Director, Neighbourhoods and Adult Services |
| Councillor John Doyle | Cabinet Member, Adult Social Care |
| Chris Edwards | CCG |
| Ian Jerrams | RDaSH |
| Naveen Judah | Rotherham Healthwatch |
| Martin Kimber | Chief Executive, RMBC |
| Julie Kitlowski | CCG |
| Councillor Paul Lakin | Cabinet Member, Children, Young People and Families Services |
| Acting CI Paul McCurry | South Yorkshire Police |
| Shona McFarlane | Director of Health and Wellbeing |
| Dr. David Polkinghorn | CCG |
| Dr. John Radford | Director of Public Health |
| Laura Sherburn | NHS England |
| Joyce Thacker | Strategic Director, Children, Young People and Families |
| Janet Wheatley | VAR |

**Also Present:-**

| | |
|---|---|
| Kate Green | Policy Officer, RMBC |
| Tracy Holmes | Communications and Marketing, RMBC |
| Sarah Whittle | CC |
| Chrissy Wright | Commissioning, RMBC |

Apologies for absence were submitted from Chris Bain, Jason Harwin and Brian Hughes.

**S51. MINUTES OF PREVIOUS MEETING AND MATTERS ARISING**

Resolved:- That the minutes be approved as a true record.

Arising from Minute No. S47(4) (Healthwatch Rotherham), Naveen Judah reported that 7 responses had been received of which 2 had met the criteria.

1 project was the Development of an Integrated Health, Social Care and Education Service for Children with Disabilities and/or Special Educational Needs sponsored by Joyce Thacker.

The second project was a proposal by the CCG to identify methods of getting care leavers to access services in a more constructive manner.

Updates would be submitted to the Board as well as the work being performance managed and quality assured as part of the contract arrangements.

**S52. COMMUNICATIONS**

The Chairman reported receipt of the following correspondence:-

"Think Pharmacy" – following on from the 2 successful events held in September, information packs were available.

Derbyshire Advocacy Service had submitted a funding application to the Big Lottery Fund.

Shaping our Lives – a partnership with Disability Rights UK and Change which included a brief guide to commissioning user-led services. It was agreed that the letter be forwarded to the Health and Wellbeing Steering Group for consideration.

**S53. INTEGRATION TRANSFORMATION FUND**

Tom Cray presented information that had been received from NHS England with regard to the above Fund.

Planning guidance would be issued on 16th December, 2013, but 10 key points had been highlighted:-

- Improving outcomes
- Strategic and operational plans
- Allocations for CCGs
- Tariff
- Integration Transformation Fund
- Developing integration plans
- Working together
- Competition
- Local innovation
- Immediate actions

There was a real opportunity to create a shared plan for the totality of health and social care activity and expenditure that would have benefits beyond the effective use of the mandated pooled fund. The plan would start in 2014 and form part of a 5 year strategy. The £3.8B national pool brought together NHS and Local Authority resources that were already committed to existing core activity. The Council and CCG would, therefore, have to redirect funds from the activities to shared programmes that delivered better outcomes for individuals.

Discussion ensued with the following issues raised:-

- Discussions had commenced looking at how the Council and CCG could agree an intervention approach to transform services to keep people out of hospital and early discharge

- Of the £3.8B national fund Rotherham would receive approximately £20M, £10M of which was mandated funding streams. The remaining £10M would be for the CCG to identify, and agree with the Council, services that should be decommissioned and a plan developed to decommission and transformation

- A number of conditions attached to the Fund that had to be satisfied some of which gave clear indications as to what areas change and intervention was expected depending upon local conditions

- The Cabinet had agreed that a simple local vision be developed supporting the delivery of locally determined priorities and was consistent with the national definition

- Adopt a programme management approach with NHS Commissioners to produce a 5 year strategic plan informed by the priorities set out in the JSNA

- Joint review of the existing pooled budget arrangements to help agree a 2 year operational plan

- Develop a single framework that ensured the views of providers from the health and social care economy drove change

- Synchronicity of planning and commissioning arrangements that operated to similar timetables

- Understanding the operation of the different markets and developing a single market position statement to provide clarity on how the needs of the local population were met

- Development of a shared risk register

- All had to be consistent with the work of the JSNA and Health and Wellbeing Strategy

- Initial draft strategic plan had to be submitted by 14th February, 2014

- Other health communities in the region were at the same position as Rotherham

Laura Sherburn reported that NHS England would be responsible for the overall governance and assurance role. If agreement was not reached, NHS England would likely be put into a dispute resolution role so,

therefore, should not be involved in any Steering Group established but would need to see its Terms of Reference.

Resolved:- (1) That a Task and Finish Group, comprising 3 representatives from the CCG and 3 from the Local Authority, be established and meet as a matter of urgency.

(2) That NHS England be provided with a copy of the Task and Finish Group's Terms of Reference.

(3) That a Risk Register be developed and submitted to the December Board meeting.

## S54. PUBLIC HEALTH OUTCOMES FRAMEWORK

Dr. John Radford reported that Public Health England monitored the Council's new statutory functions, including health protection and health improvement, through the Public Health Outcomes Framework (PHOF) which focussed on the causes of premature mortality. Rotherham's Health and Wellbeing strategy supported early intervention and prevention as part of improving performance against the PHOF and the key lifestyle factors that influenced avoidable mortality.

The Framework needed to be reviewed quarterly to drive improvements in performance. Public Health would lead the agenda and report to Cabinet by exception and agree with partners action plans to address under performance. Where indicators were significantly underperforming, discussion would take place at the Health and Wellbeing Board followed by a performance clinic to develop a remedial action plan to engage action by partners.

66 indicators had been identified, grouped into 4 domains to deliver the 2 high level incomes of increased healthy life expectancy and reduced differences in life expectancy and healthy life expectancy between communities:-

- Improving the wider determinants of health (19)
- Health improvement (24)
- Health protection (7)
- Healthcare public health and preventing premature mortality (16)

Current performance against the England average had highlighted several areas where there was under performance and a downward trend. There needed to be an agreed reporting structure to ensure performance was monitored effectively.

There would be a comprehensive monitoring process initiated for those indicators off track including performance clinics to review change. The process would be directed by the multi-agency Health and Wellbeing Steering Group.

Discussion ensued with the following issues raised/clarified:-

- Public Health would examine each indicators and produce a report setting out where there were clear performance issues to be escalated to the Steering Group/performance clinic for action

- Should also consider if/what the trends were within the priorities

- Was the data compared against England data or other areas that Rotherham was always compared against?

- Were there areas that could be "quick wins?"

- Need to focus on issues that would make a difference in the 6 Priority areas

Resolved:- (1) That the proposed Framework to address under performance be approved.

(2) That mechanism to deliver the Health and Wellbeing Strategy aim of moving to Prevention and Early Intervention be supported.

(3) That the proposed Framework be submitted to the Cabinet for consideration.

**S55. FLU VACCINATION PROGRAMME**

Discussion ensued on the flu vaccination uptake this Winter as follows:-

- The Council had a programme for offering vaccination to all staff in high risk categories/customer facing - much better uptake this year to the offer which had been co-ordinated by Public Health
- Vaccination of pregnant women was above the national average but could be better – some general practices offered the vaccination alongside Midwifery and some were not
- 54.2% of RFT staff had taken up the vaccination – second highest in the region

Laura Sherburn reported that the first data collection (vaccines given in September and October) showed:-

| | |
|---|---|
| Over 65s | 63.6% |
| Under 65 at risk | 41.8% |
| All pregnant women | 31.6% |
| All 2 year olds | 31.9% |
| TRFT Staff | 54.2% |

Rotherham had the best figures in South Yorkshire and Bassetlaw region currently for patient vaccination uptake and second best in the region for Trust staff uptake.

The Primary Care information was:-

| | |
|---|---|
| GPs | 55% |
| PNs | 68% |
| Non-Qualified Clinical Support | 65% |
| Other Qualified Healthcare Professionals/AHPs | 14% |
| Admin/Reception | 58% |
| Number of staff reported as Declined | 101 |

Resolved:- That the report be noted.

## S56. FREQUENCY AND FORMAT OF BOARD MEETINGS

Further to the discussion at the previous meeting (Minute No. S42 refers), it was felt that, due to the workload of the Board, that the Board continue to meet on a monthly basis. However, the Board would shortly be reviewing its governance arrangements when frequency of meetings would be considered.

It was felt that a reflective meeting would be useful and that there should be an annual public event.

Resolved:- That the Board’s work programme and governance arrangements be submitted to the next meeting.

## S57. MATTERS ARISING FROM INFORMATION ITEMS CIRCULATED

It was noted that the following items had been circulated for information prior to the meeting:-

Cost of Alcohol
Autism Self Evaluation
National Energy Action
Woodlands Trust – Healthy Woods-Health Lives

## S58. DATE OF NEXT MEETING

Resolved:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 18th December, 2013, commencing at 1.00 p.m. in the Rotherham Town Hall.

**HEALTH AND WELLBEING BOARD**
**18th December, 2013**

**Present**
**Members:-**

| | |
|---|---|
| Councillor Ken Wyatt | Cabinet Member, Health and Wellbeing **(In the Chair)** |
| Tom Cray | Strategic Director, Neighbourhoods and Adult Services |
| Councillor John Doyle | Cabinet Member, Adult Social Care |
| Chris Edwards | Chief Commissioning Officer, Rotherham CCG |
| Naveen Judah | Healthwatch Rotherham |
| Martin Kimber | Chief Executive, RMBC |
| Councillor Paul Lakin | Cabinet Member, Children, Young People and Families Services |
| Acting CI Paul McCurry | South Yorkshire Police (rep Jason Harwin) |
| Dr. David Polkinghorn | Rotherham CCG |
| Dr. John Radford | Director of Public Health |
| Joyce Thacker | Strategic Director, Children, Young People and Families |

**Also in Attendance:-**

| | |
|---|---|
| Dr. Gunasekera | Rotherham CCG |
| David Hicks | RFT (rep Louise Barnett) |
| Brian Hughes | NHS England |
| Ian Jerrams | RDaSH |
| Gordon Laidlaw | Communications, Rotherham CCG |
| Shona McFarlane | Director of Health and Wellbeing, RMBC |
| Janet Wheatley | VAR |
| Chrissy Wright | Strategic Commissioning Manager, RMBC |

Apologies for absence were submitted by Chris Bain, Louise Barnett, Karl Battersby, Jason Harwin and Tracy Holmes.

**S59. MINUTES OF PREVIOUS MEETING AND MATTERS ARISING**

Resolved:- That the minutes of the meeting held on 27th November, 2013, be approved as a true record.

Arising from Minute No. S55 (Flu Vaccination Programme), Dr. John Radford reported that he had attended a meeting regarding 2014's Flu Vaccination Programme. The JCVI was proposing that the United Kingdom be the first country in the world to stop the transmission of flu. Over the last 10-15 years flu vaccination uptake in the elderly had been running at 60-70% and 50% in the at risk group. Although best performing country, it was not sufficient to interrupt the transmission. It was proposed to vaccinate all secondary aged children from September-December, 2014.

This would be a logistical challenge in terms of commissioning and delivery across the network.

Arising from Minute No. 56 (Frequency and Format of Meetings), it was noted that the work programme and review would be submitted to the January meeting.

**S60. COMMUNICATIONS**

(a) Obesity Strategy Group
The minutes of the above Strategy Group, held on 23rd October, 2013, were noted.

(b) Winter Pressures Grant
Correspondence had been received from Sir David Nicholson, Chief Executive, NHS England, with regard to additional Winter Pressures monies that was being made available to the NHS to support effective delivery of Winter Plans. The Rotherham CCG would be receiving £1,228M.

The additional resources should be used to secure resilient delivery of the services to patients through the winter and would involve:-

- Schemes to minimise A&E attendance and hospital admissions
- Improvements to system flow through 7 day working across hospital, community, primary and social care with innovative solutions to tackle delayed discharges
- Specific plans to support high risk groups

It was noted that the Urgent Care Board had met that morning and considered bids submitted by the Local Authority, RFT and the Ambulance Service. All bids had been successful and funding secured.

(c) Yorkshire and the Humber Clinical Senate
An update was provided on the development of the above Senate. In accordance with the national guidance, it would need to provide a broad, strategic view on the totality of healthcare with Yorkshire and the Humber, bringing together experts to understand the impact of any 1 single initiative, or group of initiatives, upon the wider geographical area. The aim was for it to be a well-respected organisation whose judgements were trusted by commissioners who would call upon the Senate on issues ranging from quality standards and inconsistencies, the development of care pathways or reconfiguration proposals.

The Yorkshire and the Humber was following the national proposed structure of a Senate Council and a Senate Assembly; the Council being a core multi-disciplinary group to oversee Senate business, receive objective data/information and co-ordinate the formation of advice and the Assembly being a diverse multi-professional forum providing perspectives, ideas and expert opinions encompassing the birth to death spectrum and providing a source of experts for the Senate Council to draw upon.

Interviews for the Senate Chair had been held on 10th December, 2013 with the successful appointment being announced shortly.

A nursing representative and a clinical commissioner from within South Yorkshire and Bassetlaw was being sought and would be encouraged to apply for a position on the Senate Council.

It was felt that consideration should be given to a South Yorkshire-wide Health and Wellbeing Board meeting be held in 2014 once the Senate was established.

(d) Award
The Chair reported that Rotherham had been listed for an award by a national organisation.

(e) 111 Centre
The Chair reported that he was to visit to the 111 Centre the following day.

**S61. JOINT STRATEGIC NEEDS ASSESSMENT - REFRESH**

Chrissy Wright, Strategic Commissioning Manager, submitted the final draft of the JSNA Refresh which included sections on user perspective and a Directory of Assets consisting of community assets, physical infrastructure and individuals and met the latest Government guidance on JSNA content

A web-based approach had been adopted – www.rotherham.gov.uk/jsna/site - a presentation of which was given at the meeting. During 2014, as part of the Council's website refresh, the technology would be utilised to improve and enhance the JSNA website including the use of images.

There were 7 main headings, accessed via the tabs along the top of the page – People, Places, Economy, Staying Safe, Healthy Living, Ill Health and Services. In consultation with subject matter experts, analysis of the available information focussed on answering 3 key questions:-

- Why was this an issue?
- What was the local picture and how did we compare?
- What was the trend and what could we predict would happen over time?

This approach would enable the Board to easily identify and prioritise the key current and emerging issues affect health and wellbeing in the Borough.

If approved by the Board, there would then be a period of consultation with stakeholders from 30th December for 6 weeks. Any comments/amendments would be made with the final version submitted to the February Board meeting.

Discussion ensued on the document and the consultation that was to take place with the following issues raised/clarified:-

- Work would take place with the Communications Team with regard to the consultation
- The consultation questions would be appropriate to the audience concerned
- VAR was to help facilitate a consultation session with the voluntary and community sector
- The document needed to illustrate on the issues that now impacted on family life and how the population now presented with more complex needs

Resolved:- (1) That the draft JSNA be approved for consultation.

(2) That the final version be submitted to the February Board meeting.

**S62. INTEGRATION TRANSFORMATION FUND**

Kate Green, Policy Officer, submitted the proposed Terms of Reference for the Task Group established at Minute No. S53 of the meeting held on 27th November, 2013 and Risk Register.

Brian Hughes, NHS England, reported that the draft guidance was expected the following day containing the funding allocations. It was a very detailed document setting out the expectations of what was now known as the “Better Care Fund”.

The proposed Terms of Reference appeared to be in accordance with the guidance.

The completed Better Care template, as an integral part of the CCG’s Strategic and Operational Plans, should be submitted to NHS England by 14th February, 2014. They would be aggregated to provide a composite report and any areas identified where it had proved challenging to agree plans for the Fund. The revised version of the Plan should be submitted, as an integral part of the CCG’s Strategic and Operational Plans, by 4th April, 2014.

The guidance was not clear as to what happened if the Local Authority and CCG could not agree on the joint plan and who would be the arbitrator.

It was noted that the guidance was very prescriptive in terms of approval and the timeline would be quite challenging.

Resolved:- (1) That a special Board meeting be held in February to approve the joint plan for submission to NHS England.

(2) That the Better Care Fund be included on the agenda for the January meeting.

**S63. DATE OF NEXT MEETING**

Resolved:- That further meetings of the Health and Wellbeing Board be held as follows:-

Wednesday, 22nd January, 2014, commencing at 9.30 a.m.
Wednesday, 19th February, 2014, commencing at 1.00 p.m.
Wednesday, 26th March, 2014, commencing at 9.30 a.m.
Wednesday, 23rd April, 2014, commencing at 1.00 p.m.

in the Rotherham Town Hall.

Agenda Item 9

**ROTHERHAM BOROUGH COUNCIL – REPORT HEALTH SELECT COMMISSION**

| | | |
|---|---|---|
| **1.** | **Meeting** | **Health Select Commission** |
| **2.** | **Date** | **23 January 2014** |
| **3.** | **Title** | **Sexual Health Services** |
| **4.** | **Directorate** | **Public Health** |

## 5. Summary

This paper summarises the sexual health services commissioning responsibilities of Local Authorities in relation to the expected delivery measures as outlined in the Public Health outcomes framework for England, 2013-2016. The paper also outlines the responsibility Local Authorities have in relation to the Health Protection of the population by the development of local plans and capacity to monitor and manage acute incidents to help prevent transmission of sexually transmitted infections (STIs) and to foster improvements in sexual health.

This paper also summarises the latest sexual health data from the Health Protection Report tables published by Public Health England, 5 June 2013 (http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/STIs/STIsAnnualDataTables/#1._STI_Report) and outlines the implications for Rotherham. This data is now being used in the development of a new Strategy for Sexual Health in Rotherham, taking into account the statutory duty of Local Authorities to ensure open access to sexual health services for the population.

## 6. Recommendations

**Members note and support the statutory responsibilities of Rotherham Metropolitan Borough Council (RMBC) in the commissioning of sexual health services.**

**Members support the development of a new strategy for sexual health services in Rotherham.**

## 7. Proposals and details

From 1st April 2013 Local Authorities have been mandated to ensure that their local populations receive effective provision of contraception and appropriate access to sexual health services. Furthermore, they are also mandated to ensure that there are plans in place to protect the health of the population (for example, in relation to STI outbreak). There are also three outcome delivery measures for Local Authorities in relation to sexual health outlined in the Public Health outcomes framework for England, 2013-2016 which have been included as markers to give an overall picture of the level of sexual infection, unprotected sexual activity and general sexual health within the population. The delivery measures are:

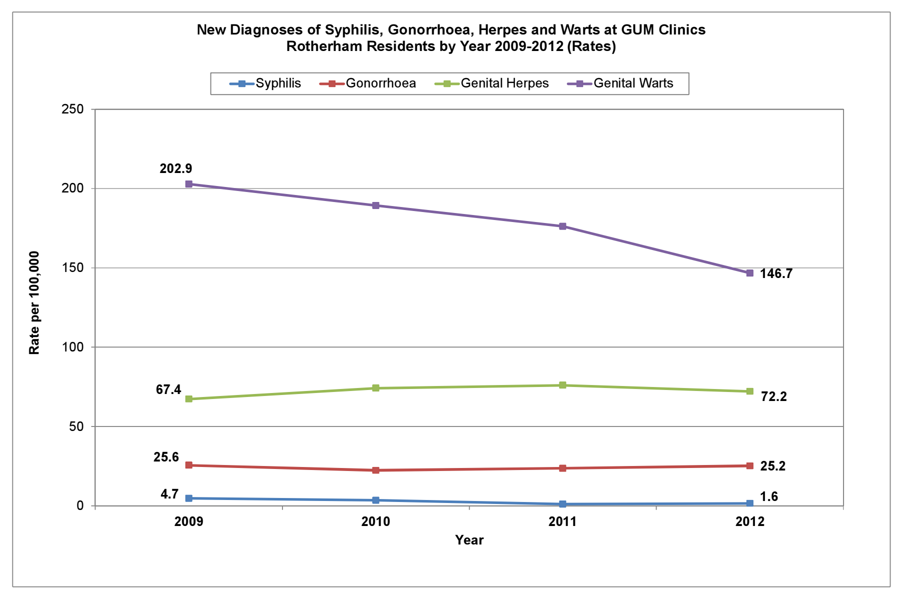
- to work towards achieving a diagnosis rate for Chlamydia of 2,400 – 3,000 cases per 100,000 population (adults aged 15-24)
- to work towards a reduction in the proportion of persons presenting with HIV at a late stage of infection (based on a CD4 count of less than 350 cells/mm3)
- to work towards a reduction in teenage conceptions

**Health protection data**

The Health Protection Report tables published by Public Health England, 5 June 2013 use a variety of data to give an overall picture of STI prevalence across the population of Rotherham. Overall, Rotherham has a significantly higher rate for STIs than that for England.

**2012 data**

| | Diagnosis Rate per 100,000 | | Significance | Rank of 152 | Quintile |
|---|---|---|---|---|---|
| Diagnosis | Rotherham | England | (at 95% level) | Upper Tier LAs | (1=highest) |
| Chlamydia 15-24 | 3,375.9 | 1,979.1 | higher | 13 | 1 |
| Chlamydia 25+ | 251.0 | 160.0 | higher | 25 | 1 |
| Chlamydia All Ages | 592.1 | 371.6 | higher | 20 | 1 |
| Syphilis | 1.6 | 5.4 | lower | 127 | 5 |
| Gonorrhoea | 25.2 | 45.9 | lower | 90 | 3 |
| Genital Herpes | 72.2 | 58.4 | higher | 37 | 1 |
| Genital Warts | 146.7 | 134.6 | similar | 50 | 2 |
| All Acute STIs | 949.5 | 803.7 | higher | 44 | 2 |



**Chlamydia**
Chlamydia is an important cause of infertility, pelvic sepsis in women and orchitis in men and acts as a co-factor in transmission for sexually transmitted infections such as HIV.

Chlamydia is the most common Sexually Transmitted Infection (STI) among Rotherham residents in 2012 (65% of total). The diagnosis rate indicates that Rotherham has an effective screening programme in place but that there is a considerable level of unprotected sexual activity and, thus, high levels of the infection circulating, within the targeted population of young people aged between 15 and 24 years of age.

Chlamydia diagnosis rate was introduced in 2011 as a performance indicator. Chlamydia infection rate is a useful marker for the overall level of sexually transmitted infections and, thus unprotected sexual activity occurring within a population. The initial target, for effective intervention, is 2,400 positive tests per 100,000 eligible population. The 2012 diagnosis rate for Chlamydia in Rotherham is 3,376 cases per 100,000 which is well above the Public Health Outcomes Framework recommendation. Continuing high levels of unprotected sexual activity mean that these high levels of detection are only just keeping pace with the disease. Our relatively high percentage of positive tests show that testing in Rotherham is targeted towards the populations most at risk, however, as testing is predominantly from the core services of GUM, CaSH and Primary Care we need to ensure access to testing is adequate for all young people, especially the more vulnerable who would not necessarily access such services.

**Genital Warts and Genital Herpes**
Rates for Genital Warts have decreased each year between 2009 and 2012 whilst rates for Genital Herpes have remained relatively static and statistically higher than those found in Yorkshire and Humber, North of England and England. Rates for Warts, whilst still being significantly higher than those in the Yorkshire and Humber region, are similar to those seen in the North of England and England. These figures, once again, indicate a high level of unprotected sexual activity occurring within the population.

**Gonorrhoea**
Gonorrhoea numbers are lower for Rotherham residents compared to England although rates have increased slightly between 2010 and 2012. In 2012, rates were similar to those for Yorkshire and Humber but statistically lower than North of England Region and England.

**HIV**
The most recent data for HIV new diagnosis shows an overall increase in cases from 2001 to 2011 by 47% but we are seeing a decrease over the last twelve month period. Most of these cases have contracted HIV outside the UK. Rotherham does not see many late diagnoses of HIV but we do, at present, fund a locally based support group to help people to access services which impacts on our figures. Overall the trend in new diagnosis of HIV (mirrored throughout Yorkshire and Humber) is for a decrease in women diagnosed and an increase in men. We are now seeing new cases predominantly in men, aged between 25-44 years old where the transmission is man

to man. A local survey undertaken by a voluntary group working with young gay men in Rotherham shows a trend against the use of condoms and a low level of awareness in relation to HIV transmission.

**Teenage Pregnancy**
Teenage pregnancy has fallen over the past few years due, in part, to the success of Long Acting Reversible Contraception (LARC) but this may have led to a decrease in the use of barrier contraception thus leading to an increase in STIs. This highlights the need for an updated comprehensive Sexual Health Strategy for Rotherham which incorporates both teenage pregnancy and health protection.

**Other Clinical Services**
GU Medicine and contraceptive services are core NHS clinical services commissioned by RMBC. In addition to sexually transmitted infections and conditions a number of systemic diseases can present with genito-urinary symptoms or signs. These can range from skin conditions such as psoriasis to cancer.

**Commissioning arrangements**
At present RMBC commissions integrated sexual health services, in association with Rotherham Clinical Commissioning Group (CCG), from well managed, successful local providers and it is proposed that for the first few years of transfer of responsibility/budget from NHS Rotherham that these contracts are maintained. In addition RMBC commissions directly with local General Practitioners, Pharmacies and the Voluntary sector.

Commissioning of the sexual health services is managed by Public Health within RMBC.

All services perform an early intervention Public Health function in the prevention of spread of infection and unwanted teenage pregnancy.

The Rotherham Sexual Health Strategy Group has been reformed and is tasked with the production of an updated, comprehensive strategy for Rotherham which takes into account the mandated duties of the Local Authority, the Public Health outcome delivery measures and the needs of the local population. The first draft of the strategy will be presented to the group in January 2013.

All the sexual health contract service level agreements are in the process of being reviewed in relation to efficiency, effectiveness, relevance to local need and performance against Public Health outcome measures. Budgets have been looked at in relation to service level agreements and substantial savings have been made.

Following the development of the strategy RMBC will need to consider how it wishes to contract for the service.

**Safeguarding**
Service providers and commissioners are in the process of harmonising protocols and reviewing care pathways and safeguarding reporting mechanisms for all young people accessing sexual health services in Rotherham.

Care pathways are being developed to allow for the extension of the Emergency Hormonal Contraception (EHC) service in Pharmacies to young women aged 14 to16 which will include an automatic referral for all under 16 year olds to a named team within IYSS to address any safeguarding or possible exploitation concerns. Public Health are working with both IYSS and Pharmacy representatives to agree the necessary protocols and pathways prior to the extension being agreed. An electronic recording system (similar to that already in use for supervised consumption of drugs at Pharmacies) is being introduced which will immediately alert any Pharmacist to the pathway.

Protocols in relation to under 16 year old children attending the GUM and CaSH services already include screening for sexual exploitation and these protocols are being developed further to raise the profile of CSE and enhance the capture of concerns in relation to possible sexual exploitation and to ensure that they contain appropriate referral mechanisms.

GUM and CaSH are moving to an integrated service where the protocols and referral criteria should now be harmonised. These protocols are currently being worked on and an algorithm for referral to the newly appointed sexual exploitation nurse is being developed. Once this work is completed these specialist protocols will be developed for use in general practice.

## 8. Finance

The following services are currently under contract representing an overall spend of £3,000,000*:
All providers offer, quality, value for money, services and contribute to the detection and prevention of sexual ill health. The Genitourinary Medicine Clinic Activity Dataset version 2 (GUMCADv2), an anonymised dataset collecting information on diagnoses made and services provided by GUM clinics and other commissioned sexual health services is an approved mandatory dataset collected by Public Health England. This data on STI testing, vaccination, diagnosis and management provides robust analyses of STI-related trends and service provision.

1. **Genito-Urinary Medicine (GUM)/Contraception and Sexual Health (CaSH) services**

   These services are currently provided by The Rotherham Foundation Trust (TRFT). The commissioned service is based on an integrated model of service delivery to allow easy access to confidential, non-judgemental sexual health services. The services are supported by currenty accredited training programmes and guidance. The services include the following elements:

   Level 1 (basic care)

   - Sexual history taking and risk assessment (including assessment of need for emergency contraception and HIV post-exposure prophylaxis following sexual exposure)
   - Chlamydia screening (opportunistic screening in asymptomatic sexually active males and females under the age of 25)
   - Asymptomatic STI screening and treatment of asymptomatic infections

in men (except MSM) and women

- Partner notification
- HIV testing (including pre-test discussion and giving results)
- Hepatitis A and B vaccination – focusing on key target groups
- Provision of verbal and written sexual health promotion information
- Supply condoms and lubricant
- Assessment and referral for psychosexual problems
- Pregnancy testing and referrals to appropriate services
- Full range of contraception information and services
- Assessment and referral for brief alcoholic interventions
- Urgent and routine referral pathways to and from social care

Level 2 (intermediate care)
Incorporates Level 1 plus

- STI testing and treatment of syptomatic but uncomplicated infections in men (except MSM) and women
- IUD insertion and removal
- Contracetive implant insertion and removal

Level 3 (complex care)
Incorporates Level 1 & 2 plus

- STI testing and treatment of MSM
- STI tresting and treatment of men with dysuria and genital discharge
- Testing and treatment of STIs at extra-genital sites
- STIs in pregnant women
- Recurrent conditions
- Management of Syphilis and blood borne viruses
- Tropical STIs
- Outreach clinical services for high risk groups
- Interface with specialised HIV services as commissioned by NHS England
- Contraceptive services within maternity (as part of teenage parents care pathway for under 18s)
- Management of complex contraceptive problems

2. **Chlamydia Screening Programme**
   These services are currently provided by TRFT within the Rotherham CaSH service.

Rotherham CaSH service manages and co-ordinates the Rotherham Chlamydia Screening Programme and routinely offers Chlamydia screening to all clients aged 15-24 years. The service is an integral part of the National Screening Programme for England. Providers are required to deliver services to nationally agreed standards.

The service includes the following elements:

- Management of the programme (locally) – including screening within Primary Care, outreach programmes and postal kits
- Co-ordination of results and treatment
- Robust failsafe procedure to ensure the accuracy and timeliness of test results
- Data collection and quality assurance

3. **Out of area services** – as from April 2013 the funding of Rotherham residents to access sexual health services in a variety of neighbouring areas (payment by residency – part of the 'choice' agenda) has been transferred to the Local Authority. These contractural arrangements are now managed by Public Health. Charges are based on a nationally agreed tarriff and are accompanied by relevant data.

4. **GP Local Public Health Service contracts** – Locally negotiated contracts for specific services that are additional to the GP National Core contract. The contract value is negotiated with the Local Medical Committee. Individual contracts are held with individual general practices. At present we have the following contracts in place: the fitting of sub-dermal implants, fitting of Intrauterine Coils and Chlamydia testing

   The aims of the contracted services are to ensure that a full range of contraceptive options are available to practice patients, to increase the uptake of long acting reversible contraception and to increase access to the Chlamydia screening programme.

   All practices are expected to provide essential and those additional services that they are contracted to provide to all their patients. The specifications of these services are designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. These specific contracts outline the more specialised services to be provided within Primary Care.

5. **Health Improvement** - including HIV prevention work, contraception out reach and social marketing. RMBC also commissions directly with a voluntary organisation to provide sexual health awareness sessions in schools and to provide support to newly diagnosed HIV positive individuals to access services.

6. **Pharmacy Local Public Health Contracts** - Locally negotiated contract for specific services that are additional to the Pharmacy National Core contract.

The contract value is negotiated with the Local Pharmaceutical Committee. Individual contracts are held with each general pharmacy. At present we have a contract in relation to the provision of Emergency Hormonal Contraception (EHC).

(*excludes spend on teenage pregnancy)

## 9. Risks and uncertainties

Developing a comprehensive strategic approach to the commissioning and delivering of sexual health services can help minimise risk in relation to control of infection and in tackling unintended teenage pregnancy.

Following contract review any tendering processes must consider continuity of care.

## 10. Policy and Performance Agenda Implications

The Public Health Outcomes Framework for England, 2013-2016 expects Local Authorities to deliver on sexual health indicators in relation to Chlamydia screening, HIV detection and teenage pregnancy. Local Authorities also have a statutory requirement to protect the health of their geographical population from threats such as those from outbreaks of infection.

The commissioning of effective sexual health services is one of the mandated areas of work transferred to Local Authorities as the Government sees STI testing and treatment services as a central part of protecting health and believes that high-quality services must be available in all areas, tailored to meet local needs. Analysis of local data and the subsequent development of a comprehensive strategy will enable the council to fulfil its obligations in relation to the sexual health needs of the population of Rotherham.

## 11. Background Papers and Consultation

Public Health Outcomes Framework for England, 2013 – 2016
Public Health in Local Government, 2011
Health Protection Report Tables (published by Public Health England, 5th June 2013)

**12.** Gill Harrison, Public Health Specialist, tel:55868 , email: gill.harrison@rotherham.gov.uk
Jo Abbott, Consultant in Public Health, tel:55846, email: Jo.abbott@rotherham.gov.uk

| **Keywords:** [Keywords] | Sexual health; commissioning; services; genito-urinary medicine; chlamydia; contraception |
|---|---|
| **Officer: Harrison, Gill** | Gill Harrison |
| **Director:** [Manager] | John Radford |

**ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS**

| | | |
|---|---|---|
| 7. | Meeting: | Health Select Commission |
| 8. | Date: | 23 January 2014 |
| 9. | Title: | Scrutiny Review of Support for Carers |
| 10. | Directorate: | Resources |

**5. Summary**

This report sets out the main findings and recommendations of the scrutiny review of support for carers in Rotherham. The draft review report is attached as Appendix 1 for consideration by Members.

**6. Recommendations**

**That the Health Select Commission:**

**6.1 Endorse the findings and recommendations of the report and make any amendments as necessary**

**6.2 Agree for the report to be forwarded to the Overview and Scrutiny Management Board and then Cabinet.**

## 7. Proposals and Details

7.1 Following a Member seminar on dementia and ensuing discussion about the important role and contribution of carers in Rotherham, the Health Select Commission and the Improving Lives Select Commission agreed to undertake a joint spotlight scrutiny review of support for carers.

7.2 The key focus of Elected Members' attention was to ensure carers have access to the right information to enable them to access the support and services they require to assist them in the caring role and to maintain their own quality of life and health and wellbeing. As such it was very important to consider this from the perspective of carers, especially adult carers of adults with long term conditions.

7.3 The following definition of a carer was used for the review:

"A carer is an adult or young person who provides unpaid care for a partner, relative, friend, an older person or someone who has a disability or long term illness, including people with alcohol/substance misuse and mental illness."

7.4 There were six main aims of the review, which were to establish:

- if carers generally identify themselves as carers in line with the definition above
- the degree to which carers access support or consider they need support to assist them in their caring role
- who carers go to for initial support when they first become a carer
- where carers usually go for ongoing support
- key factors necessary for ensuring carers receive good and timely information
- any areas for improvement in current information provision

7.5 Members also wished to complement and add value to the review carried out by Neighbourhoods and Adult Services of current support services for carers, which focused on how support is currently provided to carers and how this may be improved.

7.6 A spotlight review was carried out, chaired by Cllr Brian Steele, and evidence gathering commenced in October 2013, concluding in December 2013. This comprised an on-line survey for carers supplemented by direct engagement with carers at two events, followed by two small discussion groups. Further evidence was provided by Council officers and witnesses from partner agencies in health and the voluntary and community sector.

7.7 Members recognised the large number of "hidden" carers in Rotherham, who are key to the effective provision of social care. There is a very strong case, both morally and financially, to ensure that carers are provided with the most effective support possible as it is estimated that nationally, carers save the country an estimated £119billion in care costs. The review group consider that any resources invested within the carers community in Rotherham, therefore represents an invest to save opportunity, particularly with the demographic pressures created by an ageing population.

7.8 There are ten recommendations and in summary these focus on:

- increasing the number of people recognising themselves as carers and willing to seek support for this vital role they carry out;

- ensuring that support for carers adequately includes emotional support and counselling;
- providing a multi agency "carers pathway" that recognises the journey that carers are on and provides them with the correct support and information at the right time and in the right place on that journey;
- increasing the number of carers receiving a fit for purpose carers assessment, which is reviewed on an annual basis.

**Recommendations**:
1 – That Rotherham CCG and Rotherham Council consider how this first line of support for carers to help them identify themselves, is commissioned, in partnership with GPs.

2 – In looking at recommendation 1 above, the partners consider whether the positive assumption that a relative or friend is a carer unless told otherwise can be built into this process, and what information resources are required to back this up.

3 – That Rotherham Council investigates further with the Advice in Rotherham partnership (AiR) and the Department of Work and Pensions, what specific information carers need to access benefits that are available to them. This may also help to identify more carers.

4 – That Rotherham Clinical Commissioning Group and Rotherham Council, work with its VCS and other partners to create the carers pathway of support. This should include the effective multi agency use of carers assessments and crucially allocation of a "buddy" or "lead worker" to ensure that support is accessed consistently and according to the identified needs of the carer. This lead worker could come from the most appropriate agency identified for individual needs.

5 – That Rotherham Council considers via its review of services to carers; the use of a new single contact number, a combination of Carers Corner and outreach facilities; and the replication of the carers card in schools for adult carers.

6 – That the "triangle of care" presented by RDaSH be considered as part of this process as something that could be adapted and rolled out to all partners providing support to carers.

7 – That Rotherham Council reviews its carers assessment tool in the light of the Care Bill to ensure it is fit for purpose. This should involve considering whether it could be less onerous and more appropriately named to reflect that it is an enabling process rather than an "assessment", whilst complying with statutory frameworks.

8 – That Rotherham Council looks to set more stretching targets for former NI 135.

9 – That a full review is undertaken of the Joint Action Plan for Carers to ensure that it meets the recommendations of this review and is more accountable in terms of its delivery.

10 – The review group recognises that these recommendations have resource implications but consider that the "invest to save" case for the Council and NHS is strong enough to warrant this. It therefore recommends that the £500,000 provisionally allocated to carers support in the Better Care Fund is allocated to implementing the recommendations of this review.

**8. Finance**

The recommendations from the Select Commissions will require further exploration by Cabinet, the Strategic Leadership Team and Partner agencies on the cost, risks and benefits of their implementation, taking into account the invest to save potential over the longer term.

**9. Risks and Uncertainties**

Rotherham has a significant number of carers, many of whom are older people who may themselves have underlying health conditions, and with an ageing population it is vital that support is in place to ensure that carers maintain their own health and wellbeing and are supported in their caring role.

**10. Policy and Performance Agenda Implications**

Children and Young People's Plan 2010-2013
Corporate Plan
Ensuring care and protection are available for those people who need it most.
- Carers get the help and support they need
- People in need get help earlier before reaching crisis
- People in need of support and care have more choice and control to help them live at home

The Care Bill 2013-2014, which will reform the law relating to care and support for adults and the law relating to support for carers, is currently progressing through parliament and will impose new duties once enacted.

**11. Background Papers and Consultation**

See Section 8 of the review report and Appendices 1 and 2.

**12. Contacts**

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Sharon Crook, Scrutiny Support Officer (x 22776)
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# Scrutiny review: Support for Carers

## Joint Review of the Health Select Commission and the Improving Lives Select Commission

*October – December 2013*

**Scrutiny Review Group:**

Cllr Brian Steele (Chair)
Cllr Colin Barron
Cllr Christine Beaumont
Cllr Jane Hamilton
Cllr Denise Lelliott
Cllr Lyndsay Pitchley

*V3 January 2014*

## CONTENTS

| | Page No. |
|---|---|
| **Executive Summary** | **1** |
| **1. Why Members wanted to undertake this review** | **3** |
| **2. Method** | **3** |
| **3. Background** | **4** |
| 3.1 Census data | 4 |
| 3.2 Lifestyle Survey | 5 |
| **4. Carers' Charter** | **5** |
| **5. Findings** | **5** |
| 5.1 If carers generally identify themselves as carers | 5 |
| 5.2 Accessing support | 6 |
| 5.3 Who carers go to for initial support when they become a carer | 8 |
| 5.4 Where carers usually go for ongoing support | 8 |
| 5.5 Key factors for ensuring carers receive good and timely information | 9 |
| 5.6 Areas for improvement in current information provision | 11 |
| **6. Conclusions and recommendations** | **12** |
| **7. Thanks** | **14** |
| **8. Background papers** | **14** |
| **Appendices** | **15** |
| 1 "Are you a carer?" survey | 15 |
| 2 Summary of survey results | 18 |
| 3 Table 1 - Percentage of Rotherham people providing care | 20 |
| Table 2 - Corporate Plan outcome 17 (former NI 135) | 20 |
| 4 Key elements to achieving a Triangle of Care | 21 |

**The aim of the review:**

The review group was made up of the following members:

Health Select Commission
- Cllr Brian Steele (Chair)
- Cllr Colin Barron
- Cllr Christine Beaumont

Improving Lives Select Commission
- Cllr Jane Hamilton
- Cllr Denise Lelliott
- Cllr Lyndsay Pitchley

**Summary of findings and recommendations**

The six stated objectives of the review were to consider, as follows:

1. if carers generally identify themselves as carers
2. the degree to which carers access support or consider they need support to assist them in their caring role
3. who carers go to for initial support when they first become a carer
4. where carers usually go for ongoing support
5. the key factors necessary for ensuring carers receive good and timely information
6. any areas for improvement in current information provision

The review was therefore structured around these six objectives through engagement with carers at two events and through an on-line survey, followed by discussions with two small groups of carers to explore issues in more depth. Further evidence was provided by Council officers and partner agencies in health and the voluntary and community sectors.

Key messages that came out of the review are as follows:

Although many carers do access support there are a large number of “hidden” carers in Rotherham, who are key to the effective provision of social care. There is no doubt that should this hidden support system not exist, the cost burden to the main service providers would be huge. There is a very strong case, both morally and financially, to ensure that carers are provided with the most effective support possible.

Carers praised a number of organisations across all sectors, including some excellent work by named individuals, but also raised areas where their experiences had been less positive. The review discussed a number of good examples and noted recent work through pilot initiatives with scope for further development, but there are still some core areas requiring improvement in order to support carers.

It is the view of the members of the review group, therefore, that these carers represent a vital unpaid workforce within the Borough, and like all workforces they need investing in to get the best out of them. It is estimated that nationally, carers save the country an estimated £119billion in care costs. The review group consider that any resources invested within the carers community in Rotherham, therefore represents an invest to save opportunity, particularly with the demographic pressures created by an ageing population.

There are ten recommendations and in summary these focus on:

- increasing the number of people recognising themselves as carers and willing to seek support for this vital role they carry out;
- ensuring that support for carers adequately includes emotional support and counselling;

- providing a multi agency "carers pathway" that recognises the journey that carers are on and provides them with the correct support and information at the right time and in the right place on that journey;
- increasing the number of carers receiving a fit for purpose carers assessment, which is reviewed on an annual basis.

Recommendations:

1. That Rotherham CCG and Rotherham Council consider how this first line of support for carers to help them identify themselves, is commissioned, in partnership with GPs.

2. In looking at recommendation 1 above, the partners consider whether the positive assumption that a relative or friend is a carer unless told otherwise can be built into this process, and what information resources are required to back this up.

3. That Rotherham Council investigates further with the Advice in Rotherham partnership (AiR) and the Department of Work and Pensions, what specific information carers need to access benefits that are available to them. This may also help to identify more carers.

4. That Rotherham Clinical Commissioning Group and Rotherham Council, work with its VCS and other partners to create the carers pathway of support. This should include the effective multi agency use of carers assessments and crucially allocation of a "buddy" or "lead worker" to ensure that support is accessed consistently and according to the identified needs of the carer. This lead worker could come from the most appropriate agency identified for individual needs.

5. That Rotherham Council considers via its review of services to carers; the use of a new single contact number, a combination of Carers Corner and outreach facilities; and the replication of the carers card in schools for adult carers.

6. That the "triangle of care" presented by RDaSH be considered as part of this process as something that could be adapted and rolled out to all partners providing support to carers.

7. That Rotherham Council reviews its carers assessment tool in the light of the Care Bill to ensure it is fit for purpose. This should involve considering whether it could be less onerous and more appropriately named to reflect that it is an enabling process rather than an "assessment", whilst complying with statutory frameworks.

8. That Rotherham Council looks to set more stretching targets for former NI 135.

9. That a full review is undertaken of the Joint Action Plan for Carers to ensure that it meets the recommendations of this review and is more accountable in terms of its delivery.

10. The review group recognises that these recommendations have resource implications but consider that the "invest to save" case for the Council and NHS is strong enough to warrant this. It therefore recommends that the £500,000 provisionally allocated to carers support in the Better Care Fund is allocated to implementing the recommendations of this review.

## 1. Why Members wanted to undertake this review

Following a Member seminar on dementia and ensuing discussion about the vital role and contribution of carers in Rotherham, at the request of the Leader, Cllr Roger Stone, Overview and Scrutiny Management Board agreed to initiate a review of support for carers. The purpose of the review was to establish the extent to which carers in Rotherham are able to access timely and appropriate information, which helps them to access support and services that meet any specific needs they have as carers.

There were six main aims of the review, which were to establish:

1. if carers generally identify themselves as carers
2. the degree to which carers access support or consider they need support to assist them in their caring role
3. who carers go to for initial support when they first become a carer
4. where carers usually go for ongoing support
5. the key factors necessary for ensuring carers receive good and timely information
6. any areas for improvement in current information provision

## 2. Method

A joint spotlight scrutiny review was carried out by a sub-group of the Health Select Commission and Improving Lives Select Commission, consisting of Cllrs Barron, Beaumont, J Hamilton, Lelliott, Pitchley and Steele (Chair).

An initial report to both commissions provided an introduction and set the local context - including the definition of a carer; a profile of carers in Rotherham based on the 2011 census; and an overview of current work to support carers through the Rotherham Carers' Charter and Joint Action Plan for Carers 2013-16.

For the purposes of this scrutiny review a carer was defined as:

> "A carer is an adult or young person who provides unpaid care for a partner, relative, friend, an older person or someone who has a disability or long term illness, including people with alcohol/substance misuse and mental illness."

Evidence for the review was gathered through the following means:

- An anonymous on-line survey on the Council website from 17 October to 15 November 2013 asking carers about their experiences of accessing information and support.
- Posters and a small number hard copies of the survey in Carers Corner and Healthwatch Rotherham.
- Direct consultation with carers at Fair's Fayre on 30 October 2013 and at the Dementia Café at Davies Court on 5 November 2013.
- Two informal discussion sessions with small groups of carers to explore issues from the survey in greater depth.
- Round table discussions with RMBC officers and partners from health and the voluntary and community sector (VCS).

Appendix 1 is a copy of the survey and Appendix 2 has a summary of the results and the equality monitoring information about the carers who took part.

Neighbourhoods and Adult Services (NAS) have also undertaken a recent review of current support services for carers, focusing on how support is currently provided to carers and how this may be improved. The intention is that the scrutiny spotlight review

complements the NAS review and adds value by looking at available support from the perspective of carers, focusing on access to information.

Members would like to thank everyone who gave evidence for the review and in particular the carers who gave up their time to participate in the discussion sessions. They would also like to thank Carers Corner and partner agencies in the voluntary and community sector, especially Alzheimer's Society, Carers for Carers, Crossroads and Healthwatch, who helped to publicise the survey and encouraged carers to take part in the review.

## 3. Background

In Rotherham and throughout the UK carers underpin the statutory services saving the country a vast sum in care costs annually; quite simply without their support the welfare system would fail. Estimates in 2011 by Carers UK and the University of Leeds calculated the value of care provided by friends and family members to ill, frail or disabled relatives at £119 billion every year nationally or £326 million per day. Further calculations estimated each carer saved the state on average over £18,000 a year. Here in Rotherham the role and value of carers has long been acknowledged, however forthcoming changes in the legislation will have implications for carers and the support they are entitled to receive.

Rotherham has a significant number of carers, many of whom are older people who may themselves have underlying health conditions. Having information widely available that is easy to understand and relevant is a key factor in ensuring carers are able to access services and support and maintain a good quality of life and their own health and wellbeing if they are to continue in their caring role.

The difficulty with supporting carers is that many of them are “hidden” to the various agencies that offer services to them. This has been found to be of particular concern to Members of the review group and their focus therefore has very much been about how effective information is targeted at this hidden and unpaid workforce.

### 3.1 Census data

The 2011 census data showed that although both women and men are carers proportionately there are more women carers than men in England and Wales - 57.7% compared with 42.3%. The share of unpaid care provision fell most heavily on women aged 50-64; but the gender inequality diminished among retired people, with men slightly more likely to be providing care than women.

Rotherham continues to have a higher rate of people with limiting long-term illness than the national average of 17.6% - 56,588 (21.9% of the population). The census also revealed that Rotherham's population is ageing faster than the national average with a 16% increase in the number of people aged over 65 (from 2001 – 2011). Those aged over 85 increased at over twice this rate (+34.6%). This population profile has implications for the number of people needing care now and potentially in the future.

In 2011, 31,001 people in Rotherham said that they provided unpaid care to family members, friends or neighbours with either long-term physical or mental ill-health/disability or problems related to old age. The number of carers has increased only slightly from 30,284 in 2001 but still equates to 12% of the population and is higher then the national average of 10%. One noticeable change is that compared to 2001 fewer people are now providing 1 to 19 hours of care a week (19,069 in 2001 down to 17,400 in 2011) but more are providing care for 20 or more hours per week. The number of people providing 20 to 49 hours care has increased (3,828 to 4,736), as has the number providing 50 or more hours (7,387 to 8,865). See graph in Appendix 3.

Carers were more likely to report their general health as 'Not Good', compared with people providing no unpaid care. 'Not Good' health was derived from those who answered 'fair', 'bad' and 'very bad' to the health question in the 2011 Census. The general health of carers deteriorated incrementally as the number of hours of care provided increased, up to the age of 65, across all economic positions. Providing 50 hours or more unpaid care per week appears to have the greatest impact on the general health of young carers under 24.

**3.2 Lifestyle Survey**
The Young People's Lifestyle Survey carried out annually with local schools also shows a large number of young people who identify themselves as carers. In the most recent survey 27% of pupils consider themselves to be young carers (up from 25% last year). Most are caring for their parents (57%) or siblings (60%). Around 20% were aware of the Young Carers Service (down from 24% the previous year).

## 4. Carers' Charter

The Council and Rotherham Clinical Commissioning Group jointly agreed a Rotherham Carers' Charter in 2013 which provides a clear commitment to all carers in Rotherham, replacing the previous Joint Carers' Strategy. Over the period 2013-2016 work is focusing on a set of four priority outcomes, based on the views and experiences of carers gathered through a range of consultation activities. These priorities are linked to the six priorities in the Health and Wellbeing Strategy.

- Priority 1 - Health and Wellbeing: all carers will be supported to make positive choices about their mental and physical health and wellbeing

- Priority 2 - Access to information: accessible information about the services and support available will be provided for all carers in Rotherham

- Priority 3 - Access to services: all carers will be offered and supported to access a range of flexible services that are appropriate to their needs

- Priority 4 - Employment and Skills: all carers will be able to take part in education, employment and training if they wish to

The charter contains various commitments linked to the four priority outcomes and each commitment is underpinned by a number of actions and measures which comprise the Joint Action Plan for Carers 2013-16. This was approved in March 2013 and in order to build on previous successes and achieve further improvements for carers, effective performance management is necessary to ensure meaningful and measurable outcomes.

## 5. Findings

**5.1 If carers generally identify themselves as carers**
A very strong issue emerging from the survey, consultation with carers themselves and with the professionals who work to support them was that for many the transition from family member/friend to carer is a gradual one. This means that they don't often see themselves as 'carers' with a common description being that it "creeps up". However for other carers the change to becoming a carer is an overnight one, for example following an accident, brain injury or stroke. Most carers see themselves in terms of their relationship to the person being cared first and foremost.

The implications of this are around how carers are identified in the first place and how support services work to support carers in these circumstances – what is provided and how. Members considered carefully how this might most effectively be addressed and

drew on experience from other areas. For example, in Swansea, professionals work on the presumption that the close family member is a carer and are encouraged to ask questions to determine if this is the case. This removes the need for the carer to self identify in order to receive support. Members felt very strongly that the onus should be on the professionals working with the person being cared for to identify the carer and to provide them with the information they need to firstly recognise their role, and secondly to access the support they need. It was considered that the point of diagnosis for the person being cared for is key, making health services paramount to this process, and thus in many circumstances is likely to be a GP. Further work with GPs on maintaining carer registers is required and this will be raised at the Practice Managers Forum as not all practices use and update them regularly as yet.

"Your details be taken at time of diagnosis and someone to contact you (shortly after) and send you more information and explain what will be available to you"
"There are plenty of posters etc in GP surgeries which ask you to register if you care for people. Not sure how registering actually benefits someone"
" …..Information should be available at discharge from hospital"
"More promotion needed through community corner at TRFT"
"Overall GPs are very important, doctors surgeries should have more information"

Positive work is taking place as shown by the Integrated Case Management pilot where GPs lead a multi-disciplinary team of health and social care professionals working with a group of patients with long term conditions and their carers to signpost them to early support. Linked to this is the Social Prescribing Service pilot which enables a link from GPs through a number of VCS Advisors into the VCS sector and the various alternative support options to help meet non-clinical needs of patients and to support carers.

Members also noted evidence received about the emotional impact on carers of coming to terms with this change in relationship and agreed that services need to aim to support them in this process.

"I don't think of myself as a carer but he calls me his carer."
"I am a mother not a carer".
"Didn't realize – it was the mental health team that said 'You are a carer'."
"A nurse at the doctors said 'You are a carer'."
"Just creeps up."
" …… I think getting people to acknowledge they are carers is the first step."
"Hard to recognise when you've reached your limit."
"Changes the relationship with the cared for person, they can often become difficult …."

### 5.2 Accessing support

**Carers**

As a result of 5.1 above, there are a large number of carers who are not accessing support. In section 3.1 it is reported that there are over 31,000 carers in Rotherham, however, the Council's Neighbourhoods and Adult Services are providing services to only a percentage of these.

The number of people receiving adult social care services was 5,229 in November 2013. So with 31,000 carers locally this suggests a significant volume of family members and/or friends providing care for people, who although not all meeting the Fair Access to Care Services (FACS) criteria, currently at substantial level, still require help and support. Thus it is important that this wider group of carers knows how to access support to help them in their caring role.

Carers praised a number of organisations across all sectors, including some excellent work by named individuals, but also noted areas where their experiences had been less positive. Of those who took part in the survey and who are accessing services or support (approximately two thirds of respondents), the majority had found this to be easy or very easy - a very positive finding for the services targeted at carers in Rotherham. There is, however, a significant number who find it difficult and anecdotal evidence from the consultation shows that at least some of those people accessing services did so because of a family member or friend having prior knowledge, or as a result of a chance comment from someone they have met. It is also clear from the survey that Council employees who are also carers do not necessarily know how to access services, despite being already "linked in" to one of the major service providers.

The two direct consultation locations were Fair's Fayre (31 people) and Davies Court café (18) who were more likely to be people with contacts and links to information. Nevertheless ten respondents at Fair's Fayre answered that was very difficult/difficult to find out about services or support and two at Davies Court.

Although the consultation was carefully targeted to encourage new or recent carers to respond, and those who do not self identify as carers, it should be noted that most of the consultees had accessed local agencies for support. This further emphasises the difficulties in reaching "hidden carers".

The implications of this, considered by members of the review group, are around how to promote and make services more accessible when people have recognised themselves as carers and need/want support. This is considered in more detail in the following sections looking at initial and ongoing support needs.

> "I am unaware of any support I could get to assist with the caring I provide."
> "I don't know, I have never received help so not sure what is available."
> "I was lucky as I know about Carers through family links however if I had not been in this position I would have struggled."

**Emotional support**
Discussions took place with carers around support that they may consider they need. Many carers mentioned the difficulty of the decision to send someone into full-time care and the ensuing guilt; coping with the mental aspects of seeing the decline in the person you love; and anxiety when people go for respite, worrying about how they are doing so not switching off.

> "It would be good to have someone to speak to such as counsellor ….."
> "Support later in progression of illness, own wellbeing."
> "They give you plenty of literature but our experience is that none has ever materialised."

**Framework Agreement**
In terms of provision of adult social care, members of the review group heard about the Council's Framework Agreement and how services are commissioned from a range of providers within this framework. Assessment Direct, a direct phone number, is the route via which needs are assessed and referrals made if appropriate. This all depends on whether the person being cared for meets the eligibility criteria, currently set at substantial. If they do, then a brokerage service will refer the person to the relevant service provider.

Concern was expressed, however, that Carers Support Officers who carry out the majority of carers assessments[1], are unable to refer carers through to brokerage for a respite service in their own home (particularly appropriate for people with dementia as routine is key to maintaining equilibrium). This means that carers who are assessed as requiring a break have then to be referred through to Assessment Direct for a social worker to undertake a further assessment. This is time consuming, costly and confusing. Members therefore raised the question of where carers of people who may not meet the FACS criteria (substantial level) actually receive support to prevent a breakdown in their ability to provide care. Witnesses who provided evidence felt very strongly that having a single point of contact for carers was very important and may help to overcome some of these issues. The Council used to have a dedicated Carers Officer who worked proactively to develop such relationships with partners and providers; however, this post was lost during a recent re-structure.

**5.3 Who carers go to for initial support when they become a carer**

The survey showed that the most frequently used sources of initial support were split fairly evenly across GPs, the Council, Carers Corner (which opened in May 2010) and "other". Hospital services and VCS were lower in numbers for initial support. In considering this information members of the review group felt that it is important that all support services are equipped to recognise carers and to have the right information to be able to link them to support and other agencies. However it was felt that GPs are critical to this early identification and referral process.

Stag Medical Centre was the first GP practice to establish a virtual carers corner (June 2013) and is pro-active in signposting people, holding drop-ins and providing information, with an area set aside in both surgeries. The practice has a good patient participation group which includes some carers and which ran with the idea of setting it up. The demographic profile of their patients has above average numbers of over 65s (23%) and 51% are over 45.

Members therefore considered the potential for further development of working in partnership with GPs on early identification of carers' needs, building on the pilot initiatives referred to above and the establishment of a clear carers pathway, including earlier referral to VCS partners. This carers pathway should include a well publicised clear entry point for all carers, commencing with a fit-for-purpose detailed assessment and including reviews at key stages. The review carried out by NAS also seeks to maximise the benefits of partnership working.

It was noted that in the evidence received from VCS partners they have to limit the promotion of their services due to capacity issues. More effective use of the VCS contributes to preventing crises and implies potential cost savings further down the line for statutory partners, such as reducing admissions to residential and hospital care. Therefore a multi-agency approach to the resourcing of the carers pathway is required.

**5.4 Where carers usually go for ongoing support**

With follow on support services, according to the survey, the VCS and hospital services come much higher, with VCS being the highest number. It should also be noted that although access to benefit advice is identified as an issue in both the survey and separate consultation, being described as a "minefield" and a "battle", only one respondent commented that they went directly to the Department of Work and Pensions for support and/or advice. Unfortunately the review was unable to carry out any further investigations around this agenda, in particular looking at benefits advice, however, this is something they considered to be an important issue.

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[1] Carers assessments is the term used but the document is the "Carer's Needs Form and Care Plan".

Members considered this information carefully as it showed that carers use a wide range of services, being equally comfortable with seeking support from formal providers such as GPs, hospitals and the Council and informal services via the VCS. It also shows that carers needs are not met by just one or two key services. The implications of this is that they could be moving around between services and potentially be missing out on support or not receiving consistently high quality support. Some of this was supported by evidence from both the VCS and Council and NHS service providers, in that communication and referrals between the agencies don't work as effectively as they probably should. Members considered during their discussions how to ensure that a clear pathway of support exists for carers and who the key partners might be in achieving this, particularly focusing on the use of a carers assessment tool. This should also include an allocated "buddy" or "lead worker" from the most appropriate agency to ensure that support is accessed consistently and according to the identified needs of the carer.

Evidence from the sessions suggested that carers assessments were not being used consistently, with some carers saying they had never received one, and those who had reported varying experiences of how successful they had been in identifying their needs or in actually helping them on a practical level. Few of the carers who took part in the discussion groups have an updated assessment review on an annual basis.

This was considered to be very important given the fact that members of the review group had already established that carers are very often on a journey and therefore their needs change considerably over time, often requiring referral between a number of partner agencies. Members were not convinced that the carers assessment process was facilitating this adequately.

The statutory duty to carry out carers assessments will form part of the new legal framework when the Care Bill is enacted. However, of equal importance is the need to carry out regular reviews and to ensure assessments result in tangible outcomes for the carer.

> "Although 'Carer's Assessments' in theory are an excellent way of identifying problems/potential 'crisis' points, help required etc., …. they do not seem to follow through as being a particularly helpful tool in so far as people do not seem to feel that they have been of any use."
>
> "… led to overnight respite"

## 5.5 Key factors for ensuring carers receive good and timely information

**Volume and timing of information**

Overall the general consensus is that there is a lack of information and that difficulties exist in accessing information. Some carers mentioned overload of information at early stages, with some information only being required later on in the progression of the person they are caring for's condition, however, it was noted that this may be particularly pertinent to those caring for patients with Alzheimer's or dementia. VCS partners mentioned the need for earlier referrals from social care to help prevention of crisis.

> "Carers need the right information at the right time – NOT masses of info when first diagnosed"

**Accessible information**

Accessibility of information was felt to be key. It needs to be accessible in equalities terms – plain English and simple easy to understand messages. Members also

considered the need for better advertising and circulation of leaflets. A well publicised single point of access was also considered, via a telephone line.

| “Information in plain English for everyone, including health and wellbeing information”<br>“Less bureaucracy on application forms, simpler on–line screens”<br>“Simplified internet searches”<br>“Don’t use big posh words in leaflets”<br>“Office staff don’t explain things properly to carers” |
|---|

**Where to go for information**
Consultation with carers highlighted the need for a range of communication methods to ensure carers are able to access information in a way that best suits their needs. Preferences for the best way to receive information varied demonstrating the need to give people options including face to face communication, telephone, leaflets and electronic communication via social media and dedicated webpages. ICT barriers were cited for some groups, especially many older carers and those without computers and internet access at home.

| “Someone to speak to face to face”<br>“Ring the person more often to keep them up to date”<br>“Using local media and social media, as most carers do not have time to visit walk in centres and seek advice, you just get on with it and try to maintain your own life.”<br>“Ok if know where to go but need good signposting”<br>“I found out about Crossroads from my husband's GP waiting room - leaflets displayed in a way that makes you want to go and read them i.e. tidy, well stocked”.<br>“Golden phone number – staffed”<br>“Keep Carers Corner. Introduce and fund outreach services. Look at development and provision of Carers Corner.”<br>“More community based support required. Rather than all resources being Rotherham centrally based”<br>“1 point of call – one-stop shop”<br>“Include carers round the borough”<br>“an information hub” |
|---|

As part of the review by NAS snapshot monitoring of people specifically going to Carers Corners to request help or information was carried out. During the four month period from June to September 2013 126 people went in to request help or information, an average of 1.5 enquiries per working day. 20% of these resulted in signposting to either Assessment Direct or another organisation for information and advice and the other 80% related to issues including benefits enquiries, housing advice, blue badge scheme, TV licensing and debt related advice. This monitoring does not include people who attended for other purposes, including drop-ins or services provided by other organisations.

The NAS review also identified the success of outreach workshops run to date with workers going out to meet carers in different venues across the borough such as GP surgeries and at the hospital, reflecting some of the comments above.

The implications for discussions around Carers Corner and the NAS review of how this service is delivered are clear. Members considered that Carers Corner emerged as very popular in the survey with some very positive feed back received. It is also clear, however, that more focused outreach would also help to address some of the issues being raised in terms of accessing “hidden” carers and getting the right information to them.

**Information for young carers**
The review did look at information needs for all carers, including young carers, however, it was apparent that how young carers are referred into support services works very differently than for adults. Members spoke to representatives from Barnardo's and heard how the referral process works. An initiative being developed with young carers around a carers card in schools, was received very well and members of the review group considered how this could be adapted to adult carers too. This has been considered but resource implications have precluded its implementation to date.

**Triangle of Care**
Rotherham, Doncaster and South Humber NHS Trust (RDaSH) brought to Members' attention their work towards the Triangle of Care, a three way partnership between the staff, the patient and the carer. Members received this information positively and considered whether it could be adapted for other partners too. This approach encompasses six standards necessary to improve partnership working in mental health services. One standard highlights the essential role of carers who should be identified at first contact and another covers training for staff to become "carer aware". More details about the standards are in Appendix 4.

*Extract from RDaSH Carers Information Leaflet at Swallownest Court*

**5.6 Areas for improvement in current information provision**
Less than half of the survey respondents (44 people) answered yes to the question: "Do you think you receive information at the right time?", showing that there are issues to address to make it easier to access help and support at the right time. In their responses to the survey and in the ensuing discussion sessions carers made some thoughtful and interesting comments and suggestions for improvements as well as highlighting examples that work well. These suggestions (summarised under 12 broad headings in Appendix 2 question 7) focused primarily on operational issues and will be fed back to the relevant agencies.

In terms of helping to plan for information provision the survey also asked about the topics that carers found most useful and the clear top five answers were:

| | |
|---|---|
| Welfare and benefits | 45 |
| Local groups | 39 |
| Health | 38 |
| Respite | 21 |
| Council services | 21 |

The need for information is ongoing and changing over time, also there are many new carers being identified, therefore one-off information campaigns are not sufficient. It was agreed across all witnesses that there will always be a large number of carers who are "hidden" to the support agencies. This is identified in the Joint Action Plan for Carers, but it is not clear whose responsibility this is and it is not a smart action.

It was noted that many of the actions in the Joint Action Plan for Carers would cover some of the issues that have arisen in this review, however, as with the point above Members expressed some concern that arrangements for clear targets, monitoring and accountability to key officers, were missing from many of them.

**Corporate Plan outcome 17 - former NI 135** (see Appendix 3 Table 2)
Monitoring of indicator former NI 135 (one of the corporate plan outcomes) is carried out by NAS, and it measures the number of carers known to Social Services being assessed. Members were concerned to see a seeming lack of ambitious growth targets around this, both in terms of increasing the number of carers being assessed (of those known to Social Services) or to increase the overall number of carers being supported. Under current arrangements most assessments are carried out by the four Carers Support Officers whilst reviews are carried out by the Planning and Reviewing team. This review has considered ways to widen the pool of assessors.

**Flexible working**
Time and work pressures were raised by several carers in paid employment showing the importance of flexible working policies. Members wished to re-iterate the Council's support in terms of flexible working and access to support for its own employees who are carers.

"I often feel that assisting my mum to attend appointments is the most difficult as I can not take time out of work."

## 6. Conclusions and recommendations

Although many carers do access support there are a large number of "hidden" carers in Rotherham, who are key to the effective provision of social care. There is no doubt that should this hidden support system not exist, the cost burden to the main service providers would be huge. There is a very strong case, both morally and financially, to ensure that carers are provided with the most effective support possible.

It is the view of the members of the review group, therefore, that these carers represent a vital unpaid workforce within the Borough, and like all workforces they need investing in to get the best out of them. It is estimated that nationally, carers save the country an estimated £119billion in care costs. The review group consider that any resources invested within the carers community in Rotherham, therefore represents an invest to save opportunity, particularly with the demographic pressures created by an ageing population.

The Council and its partners should therefore seek to:

6.1 Increase the number of people recognising themselves as carers and willing to seek support for this vital role they carry out.

Recommendation 1 – That Rotherham CCG and Rotherham Council consider how this first line of support for carers to help them identify themselves, is commissioned, in partnership with GPs.

Recommendation 2 – In looking at recommendation 1 above, the partners consider whether the positive assumption that a relative or friend is a carer unless told otherwise can be built into this process, and what information resources are required to back this up.

Recommendation 3 – That Rotherham Council investigates further with the Advice in Rotherham partnership (AiR) and the Department of Work and Pensions, what specific information carers need to access benefits that are available to them. This may also help to identify more carers.

6.2 Ensure that support for carers adequately includes emotional support and counselling.

6.3 Provide a multi agency “carers pathway” that recognises the journey that carers are on and provides them with the correct support and information at the right time and in the right place on that journey.

Recommendation 4 – That Rotherham Clinical Commissioning Group and Rotherham Council, work with its VCS and other partners to create the carers pathway of support. This should include the effective multi agency use of carers assessments and crucially allocation of a “buddy” or “lead worker” to ensure that support is accessed consistently and according to the identified needs of the carer. This lead worker could come from the most appropriate agency identified for individual needs.

Recommendation 5 – That Rotherham Council considers via its review of services to carers; the use of a new single contact number, a combination of Carers Corner and outreach facilities; and the replication of the carers card in schools for adult carers.

Recommendation 6 – That the “triangle of care” presented by RDaSH be considered as part of this process as something that could be adapted and rolled out to all partners providing support to carers.

6.4 Significantly increase the number of carers receiving a fit for purpose carers assessment, which is reviewed on an annual basis. This links to the point made previously of widening the pool of assessors.

Recommendation 7 – That Rotherham Council reviews its carers assessment tool in the light of the Care Bill to ensure it is fit for purpose. This should involve considering whether it could be less onerous and more appropriately named to reflect that it is an enabling process rather than an “assessment”, whilst complying with statutory frameworks.

Recommendation 8 – That Rotherham Council looks to set more stretching targets for former NI 135.

Recommendation 9 – That a full review is undertaken of the Joint Action Plan for Carers to ensure that it meets the recommendations of this review and is more accountable in terms of its delivery.

Recommendation 10 – The review group recognises that these recommendations have resource implications but consider that the “invest to save” case for the Council and NHS is strong enough to warrant this. It therefore recommends that the £500,000 provisionally allocated to carers support in the Better Care Fund is allocated to implementing the recommendations of this review.

## 7. Thanks

**Our thanks go to the following for their contributions to our review:**

Cllr Roger Stone, Leader of the Council

**Partners**
Helen Cryan – Crossroads
Lesley Dabell – Age UK
Jacky Fairfax – Rotherham Foundation Trust
Lyndsey Hallatt – Barnardo's
Liz Hopkinson – Alzheimer's Society
Chris Thompson – Stag Medical Centre
Jane Whaley – Barnardo's
Helen Wyatt – Rotherham Clinical Commissioning Group

**RMBC Officers**
Jenny Greaves – Rotherham, Doncaster and South Humber NHS Trust/RMBC
David Stevenson
Richard Waring

## 8. Background papers

Report to Health Select Commission 12 September 2013
Report to Improving Lives Select Commission 18 September 2013

Notes of evidence sessions on 19 November 2013 and29 November 2013

Results of "Are You a Carer?" Survey

Young People's Lifestyle Survey

2011 Census data

*Full story: The gender gap in unpaid care provision: is there an impact on health and economic position?* Office of National Statistics May 2013

*The Triangle of Care Carers included: A Guide to Best Practice in Mental Health Care in England Second Edition* Carers Trust 2013

*Valuing Carers (2011)* Carers UK and University of Leeds

Joint Action Plan for Carers 2013-16

Rotherham Carers' Charter

Terms of reference for NAS carers review

Scrutiny review reports:
- Swansea
- York

## Are you a carer?

The Council is carrying out a short scrutiny review to look at information for carers. We want to hear about your recent experiences of finding out where to go, or who to ask, for information to help you in your caring role.

We are particularly interested in hearing from you if you who have become a carer in the last two years.

For the purpose of the review we are using the definition of a carer as someone who provides unpaid care for a partner, relative, neighbour or friend who is an adult who has a long term illness or condition, including people with alcohol/substance misuse and mental illness.

We would be grateful if you could assist us by completing the questionnaire, which should only take a few minutes.

Your responses will be completely confidential and the information you provide will help us to identify any areas for improvement.

---

**1. Have you used any services or had any support specifically for carers?**

☐ Yes

☐ No (if No please go to straight to Question 7)

**2. How easy was it to find out about services and support available for carers?**

| very easy | easy | difficult | very difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

**3. Who did you speak to or where did you go for support when you first became a carer?** (please tick ONE)

☐ GP

☐ Carers Corner

☐ Council Services

☐ Voluntary & Community Group

☐ Hospital Services

☐ Other (please let us know)

**4. Where else have you been for support since becoming a carer?**
(please tick all that apply)

- GP
- Carers Corner
- Council Services
- Voluntary & Community Group
- Hospital Services
- Other (please let us know)

**5. Do you think you receive information at the right time?**

- Yes
- No

**6. Which information do you find most useful?** (please tick all that apply)

- Welfare and benefits
- Local Groups
- Council Services
- Health
- Housing
- Respite
- Leisure
- Employment and training
- Other (please let us know)

**7. How do you think information about support for carers could be improved?**

**Could you please tell us about you to help us with our evaluation**

**8. Are you male or female?**

- Male
- Female

Please continue

**9. Please select an age range**

- ☐ under 20 years
- ☐ 20 – 29 years
- ☐ 30 – 39 years
- ☐ 40 – 49 years
- ☐ 50 – 59 years
- ☐ 60 – 69 years
- ☐ 70+ years

**10. How do you describe your ethnic origin?**

- ☐ White
- ☐ Black or Black British
- ☐ Asian or Asian British
- ☐ Gypsy or Traveller
- ☐ Multiple Heritage
- ☐ Chinese, Yemeni, Arab
- ☐ Other Ethnic Group

**If you want to take part in the discussion please continue below**

11. Would you like to take part in a small informal discussion?

- ☐ Yes
- ☐ No

12. If yes, please let us know how to contact you **(Please print clearly)**

Name:

Email:

Telephone:

If you would like more information please contact us:
Email: scrutiny.works@rotherham.gov.uk
Telephone: 01709 822776 (Sharon Crook) or 01709 254421 (Janet Spurling)

For advice and support about being a carer contact Carers Corner:
Email: carerscorner@rotherham.gov.uk
Telephone: 01709 254809
Call in – located in the town centre on the corner of Drummond Street and Effingham Square, Rotherham

Please seal your completed form in the envelope provided and leave it with a member of staff at Healthwatch or Carers Corner.

**Appendix 2 – Summary of survey results**

**Total responses – 95** (note that not all respondents answered all questions)

**1. Have you used any services or had any support specifically for carers?**

| | |
|---|---|
| Yes | 61 |
| No | 28 (19 people were directed straight to question 7, see note at end) |

**2. How easy was it to find out about services and support available for carers?**

| | |
|---|---|
| very easy | 17 |
| easy | 32 |
| neutral | 1 |
| difficult | 17 |
| very difficult | 5 |

**3. Who did you speak to or where did you go for support when you first became a carer?**

| | |
|---|---|
| GP | 13 |
| Council Services | 13 |
| Voluntary & Community Group | 7 |
| Hospital Services | 9 |
| Carers Corner | 14 |
| Other | 14 |

Other where more detail given or more than one chosen:

| | |
|---|---|
| GP and Council services | |
| Carers Corner and Voluntary/Community group | 2 |
| Carers Corner, Council services, Voluntary/Community group | |
| GP, Carers Corner, Voluntary/Community group | |
| GP and Carers Corner | |
| Private Company | |
| Rotherham | |
| Macmillan | |
| Adult social care/Social services | 2 |
| Howarth House | |
| Alzheimer's Society | 4 |

**4. Where else have you been for support since becoming a carer?**

| | |
|---|---|
| GP | 26 |
| Council Services | 19 |
| Voluntary & Community Group | 26 |
| Hospital Services | 19 |
| Carers Corner | 17 |
| Other | 12 |

Other where more detail given:
Family member who works for a charity
DWP
Macmillan cancer support hospital
Mencap
Victim Support
Red Cross
Memory Cafe/Singing for Brain groups
Memory service have provided best support
Most useful support from Alzheimer's Society
Crossroads Care x2
HealthWatch

**5. Do you think you receive information at the right time?**

Yes 44 Sometimes 4 No 21

**6. Which information do you find most useful?** (please tick all that apply)

| | | | |
|---|---|---|---|
| Welfare and benefits | 45 | Housing | 8 |
| Local Groups | 39 | Employment and training | 3 |
| Health | 38 | Training | 8 |
| Respite | 21 | Employment | 1 |
| Council Services | 21 | Other | 6 |
| Leisure | 13 | | |

Other where more detail given:
Day care/Day care services 2
Financial
Mobility aids
How to access the right funding for residential services
Information and support when someone has been sectioned
I needed support
Alzheimer's Society

**7. How do you think information about support for carers could be improved?**

Responses may be summarised under 12 headings, as follows:

1. Identifying self as a carer
2. Not knowing how to access support
3. Wanting support
4. Time and work pressures
5. More advertising/signposting/information
6. Making information easier/more accessible
7. Specialist information
8. Welfare information
9. Single point of contact v More outreach/community
10. Carers' Corner
11. Suggestions for service providers
12. Suggestions for where to get more information/advertise more

**Equality monitoring:**

**Gender:**
Female 71 Male 19

**Age**

| | |
|---|---|
| under 20 years 0 | 50 – 59 years 24 |
| 20 – 29 years 1 | 60 – 69 years 15 |
| 30 – 39 years 14 | 70+ years 13 |
| 40 – 49 years 21 | |

**Ethnic origin:**
White 80 Asian or Asian British 6 Other 1

The carers cared for people with a range of conditions – learning disability, autism, Alzheimer's, mental illness and physical disability. Some are caring for more than one person, such as two adult children or both parents.

Note:
Respondents who answered "no" to question 1 on-line were directed straight to question 7, whereas those responding "no" through other methods often did answer questions 2-6.

**Appendix 3**

**Table 1**

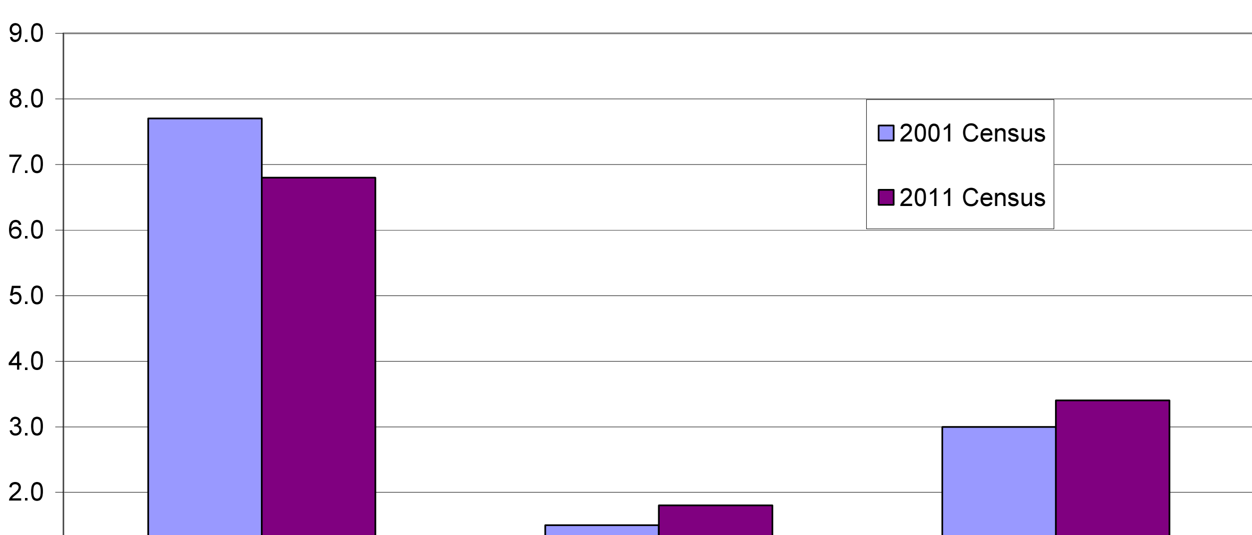


**Table 2**

**Corporate Plan indicator 17 - Carers get the help and support they need**
(former national indicator NI 135)

| **Indicator Title** | **11/12 Actual or baseline** | 12/13 Q1 | 12/13 Q2 | 12/13 Q3 | 12/13 Q4 | **12/13 Year end** | **13/14 Target** | **Performance as at 5/11/13** |
|---|---|---|---|---|---|---|---|---|
| Number of carers receiving needs assessment or review and a specific carer's service, or advice and information. | **41.51%** | 12.05% | 18.77% | 25.38% | 42.02% | **42.02%**<br>Target was 42% | **43%** | **27%** |

This measure accumulates throughout year and is on track to hit the marginal continuous improvement target set at 43%. Latest figures for 2013/14 performance at 5th November 2013 was 1412/5229 = 27%. The denominator is based on the number of people receiving adult social care in the year.

**Appendix 4 The key elements to achieving a Triangle of Care:**

**1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter.**

- Carers' views and knowledge are sought, shared, used and regularly updated as overall care plans and strategies to support treatment and recovery take place.

**2) Staff are "carer aware" and trained in carer engagement strategies.**

- Staff need to be aware of and welcome the valuable contribution carers can make and be mindful of carers' own needs.
- Staff need knowledge, training and support to become carer aware.

**3) Policy and practice protocols re: confidentiality and sharing information are in place.**

- To ensure proactive engagement carers need to be part of the care planning and treatment process across the care pathway, that is, for inpatient, home treatment and community, the service should have clear policies and mechanisms and ensure these are routinely used, including:

- Guidelines on confidentiality and for sharing information – a three-way process between services users, carers and professionals.
- Information release forms and protocols.
- Advance statement forms and protocols.

**4) Defined post(s) responsible for carers are in place, including:**

- Carers lead or champion for all wards and teams irrespective of which service.
- Carers links delegated for each shift/team.

**5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway, including:**

- An introductory letter from the team or ward explaining the nature of the service provided and who to contact, including out of hours.
- An appointment with a named member of the team to discuss their views and involvement.
- Ward orientation/induction procedure and leaflet.
- Carer information packs
- Discharge planning and aftercare support.

**6) A range of carer support services is available, including:**

- Carer support
- Carer needs assessment
- Family interventions

**There also needs to be regular assessing and auditing to ensure the six key standards of carer engagement exist and remain in place.**

*Source: The Triangle of Care Carers included: A Guide to Best Practice in Mental Health Care in England Second Edition Carers Trust 2013*

Agenda Item 11

**ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS**

| | | |
|---|---|---|
| 1. | Meeting | Health Select Commission |
| 2. | Date | 23/01/2014 |
| 3. | Title | Public Health Outcomes Framework |
| 4. | Directorate | Public Health |

## 5. Summary

The Council has new statutory functions that include health protection and health improvement. Public Health England monitors these responsibilities through the Public Health Outcomes Framework (PHOF). Members require assurance that the Framework is being monitored and appropriate action is being taken to address the outcomes.

The Council's wider responsibilities for population health require a coordinated approach, including all partners. The PHOF focuses on the causes of premature mortality. The Rotherham Health and Wellbeing Strategy (HWBS) supports early intervention and prevention as part of improving performance against the PHOF and the key lifestyle factors that influence avoidable mortality. The Outcomes Framework needs to be reviewed quarterly to drive improvements in performance. Public Health will lead this agenda and report to Cabinet by exception. Priority measures include those for avoidable mortality, which also features a as key outcome for the Integrated Transformation Fund.

Public Health will agree with partner's action plans to address under performance and complete a report card on each indicator. Where the Indicator is an outlier the report card will be reported to the appropriate planning or commissioning group.

Agreement needs to be reached on which performance measures are regularly reported to the Health and Wellbeing Board. These should be indicators that are closely linked to the six locally determined priorities which follow our Health and Well Being Strategy. If these high level indicators show no improvement or are significantly underperforming the Board will agree actions to be taken or hold a performance clinic with partners to develop a remedial action plan to engage action. Where a performance clinic is held this will report to Cabinet. The emphasis of the performance clinics will be on innovation and doing things differently to drive improvement and change.

Indicators outside of these top six strategic issues will be addressed elsewhere within the local performance framework. The actions will refocus activity on early intervention and prevention agenda for long term and sustainable impact. The report provides a framework for this process and an initial progress report.

**6. Recommendations**

- **That Health Select Commission note the proposed framework and reporting structures to address performance on the Public Health Outcomes Framework.**

- **That Health Select Commission note this is a mechanism to deliver the Health and Wellbeing Strategy aim of moving services to prevention and early intervention.**

**7. Proposals and details**

In November 2012 the Public Health Outcomes Framework, Improving outcomes and supporting transparency was released (Department of Health, 2012a). The framework focused on the two high-level outcomes, which were intended to be achieved across the public health system and beyond. These two outcomes are:

1. Increased healthy life expectancy.
2. Reduced differences in life expectancy and healthy life expectancy between communities.

There are 66 indicators identified, that are grouped into four domains to deliver the two high level outcomes:

- improving the wider determinants of health (19)
- health improvement (24)
- health protection (7)
- healthcare public health and preventing premature mortality (16)

To improve the two high level outcomes will require the collective efforts from all parts of the public health system, and across public services and wider society. The framework focuses on the respective role of local government, the NHS and Public Health England, and their delivery of improved health and wellbeing outcomes for the people and communities they serve. It requires a robust partnership approach, which includes identifying leadership for each indicator.

The performance framework has a clear link to the Health and Wellbeing Strategy and the Integrated Health and Social Care Fund (IHSCF). The effectiveness of the local management of the IHSCF will be judged against impact on avoidable mortality as measured in the PHOF.

We propose public health work with key partners to address areas of underperformance. This approach is aimed to be clear and transparent to all partners, to help the RMBC performance team with the development of the management and accountability structure for the indicator sets. In Appendix 1 the table outlines the performance management lead and where there are cross overs with the current performance management of social care and children's services (boxes shaded in grey).

The current performance against the England average has highlighted several areas where there is under performance and a downward trend. This information is shown in Appendix 2. There needs to be an agreed reporting structure to ensure performance is monitored effectively.

The wide range of indicators requires feedback to a range of Directorate Leadership Teams in RMBC. The DLT teams will receive exceptions reports will be submitted are highlighted on Appendix 1. There will be a comprehensive monitoring process initiated tor those outcomes off track, including performance clinics to review change. This process will be directed by multiagency the Health and Wellbeing Steering group. The performance clinic will involve all the key partners and will use the Friedman (2009) outcome based accountability approach to develop remedial

actions which will make long term sustainable change. There will be a strong focus on addressing the prevention and early intervention opportunities within the remedial action plan to make long term impact (see appendix 3). It is recognised that population based indicators are slow and challenging to change. The PHOF should be used to drive forwards the priorities in the Health and Wellbeing Strategy.

**Commentary on Public Health Outcomes – Current Performance by domain:**

1. **Improving the Wider Determinants**

    - The child poverty continues to be a significant challenge for the Borough
    - The Safer Rotherham Partnership need to consider the link between high admission rates for violent crime and the apparently low crime rates in Rotherham.

2. **Health Improvement**

    - Breastfeeding rates are poor and smoking at delivery remains high. Both indicators impact on the health of mother and infant including long term issues such as school performance and obesity.
    - Hospital admissions for unintentional injury need to be reviewed.
    - The number of adults who are inactive and/or smoke continue to be high.
    - Performance is poor on diabetic retinopathy screening (the major cause of avoidable blindness).
    - Self-reported measures for wellbeing as a mental health and wellbeing indicators appears to be low. This is of concern particularly in relation to the increase in local suicides.
    - Injuries to older people from falls are a concern.

3. **Health Protection**

    - Rotherham has high rates of chlamydia infection which results in infertility. Chlamydia is used as a marker of other sexually transmitted diseases.
    - HPA vaccination uptake has recently been improved.
    - Although the completion of TB treatment appears low the number of TB cases in Rotherham is very small.

**4. Healthcare Public Health**

- The position on infant mortality is good considering the performance on breastfeeding and smoking at delivery
- Under 75s mortality for all the avoidable causes (except liver disease are significantly above the national average.
- Emergency admissions and readmissions are a continuing problem.
- Preventable sight loss is a concern.

All of the above issues will be subject to an action plan to explore the reasons for under performance and identify measurable outputs. Some may also require a performance clinic.

**8. Finance**

There will be some activity funded by the Public Health budget, however many of the wider determinant elements will be funded by a range of partner organisations and from other Directorates within the Council. There will be be opportunities for Integrated Health and Social Care Fund to be delivering prevention activity which addresses avoidable mortality outcomes which is a key objective of the Fund.

**9. Risks and uncertainties**

There are currently a number of new indicators which have new data collection methods being developed. The full outline of the indicators is available in the Public Health Outcomes Framework, Improving outcomes and supporting transparency Part 2 document (Department of Health 2012b).

Premature mortality reflects social disadvantage and societal and individual behaviours that put people at increased risk.

**10. Policy and Performance Agenda Implications**

The framework will deliver the ambitions of the Health and wellbeing Strategy and the Public Health White paper, Healthy Lives Healthy People: Our strategy for public health in England.

Regional and national comparisons can be found on http://www.phoutcomes.info/

## 11. Background Papers and Consultation

Department of Health (November 2012a) Improving outcomes and supporting transparency: Part 1A Public Health Outcomes Framework for England 2013 -16. HMSO: London

Department of Health (November 2012b) Improving outcomes and supporting transparency: Part 2 – summary technical specifications of public health indicators. HMSO: London

Friedman, M. (2009). Trying hard is not good enough: How to produce measurable improvements for customers and communities. FPSI Publishing: Charleston.

## 12. Keywords: Performance framework, Outcomes, Public Health, Early Intervention and Prevention

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Appendix 1 – Public Health Outcome – PH leads, Partners and reporting structure

Appendix 2 – Public Health Outcomes Framework Report card – October 2013

Appendix 3 – Performance Clinic Framework

Appendix 4 - Friedman (2009) Performance Management Effort and Effect Matrix

### Appendix 1: Public Health Outcomes Framework – PH leads, Partners and reporting structure

| Domain | Indicator | Reported to | Partner organisations | Public Health lead |
|---|---|---|---|---|
| Improving wider determinants of health | Health and Wellbeing – Prevention and Early Intervention | | | John Radford (with the support of Public Health Specialists) |
| Improving the wider determinants of | Children in Poverty | CYPS | RMBC CYPS<br>CVS<br>Schools | |

| Domain | Indicator | Reported to | Partner organisations | Public Health lead |
|---|---|---|---|---|
| health | | | Job Centre | |
| | School readiness | CYPS | RMBC CYPS<br>Schools<br>RFT (HV/SN) | |
| | Pupil Absence | CYPS (monitored and managed by SW team) | RMBC CYPS<br>RFT (HV/SN)<br>Schools<br>GPs | |
| | First Time Entrants Into Youth Justice System | CYPS (monitored and managed by SW team) | SY Police<br>RMBC IYSS<br>RDaSH | |
| | 16-18 NEETS | CYPS (monitored and managed by SW team) | RMBC IYSS<br>Job Centre plus | |
| | People with mental illness or disability in settled accommodation | NAS (in ASCOF monitored and managed by DR team) | RMBC NAS<br>RDaSH<br>CCG<br>Job Centre | |
| | People in prison who have a mental illness | NAS | RMBC<br>CCG<br>RDaSH<br>SY Police | |
| | Employment for those with LT health conditions including those with learning difficulties/disability or mental illness | NAS (in ASCOF monitored and managed by DR team) | CCG<br>RMBC NAS<br>Job centre<br>RDaSH | |
| | Sickness absence rate | Resources<br>NAS | All partners | |
| | Killed or seriously injured casualties on England's roads | EDS | RMBC EDS<br>SY Police<br>Schools | |
| | Domestic abuse | NAS | RMBC NAS<br>SY Police<br>All Health partners<br>CVS | |
| | Violent crime (including sexual violence) | NAS | RMBC PH<br>SY Police<br>RFT<br>CCG | |
| | Re-offending | NAS | SY Police<br>RMBC NAS | |
| | The percentage of | NAS | RMBC NAS | |

| Domain | Indicator | Reported to | Partner organisations | Public Health lead |
|---|---|---|---|---|
| | the population affected by noise | | | |
| | Statutory homelessness | NAS | RMBC NAS<br>CVS | |
| | Utilisation of green spaces for exercise/health reasons | EDS | RMBC EDS<br>RMBC NAS<br>CVS | |
| | Fuel poverty | EDS | RMBC EDS<br>RMBC NAS<br>CVS | |
| | Social connectedness | NAS<br>(in ASCOF monitored and managed by DR team) | RMBC NAS<br>CVS | |
| | Older people's perception of community safety | NAS<br>(in ASCOF monitored and managed by DR team) | RMBC NAS<br>SY Police | |

| Domain | Indicator | Reported to | Partner organisations | Public Health lead |
|---|---|---|---|---|
| Health Improvement | Health and Wellbeing – healthy lifestyles | | | Joanna Saunders (with the support of Public Health Specialists) |
| Health Improvement | Low birth weight of term babies | CYPS | RMBC CYPS<br>RMBC NAS<br>CCG<br>RFT | |
| | Breastfeeding | CYPS (monitored by SW team – performance managed by PH) | RMBC CYPS<br>RMBC NAS<br>CCG<br>RFT | |
| | Smoking status at time of delivery | CYPS | RMBC CYPS<br>RMBC NAS<br>CCG<br>RFT | |
| | Under 18 conceptions | CYPS | RMBC CYPS<br>RMBC NAS<br>CCG<br>RFT | |
| | Child development at 2-2.5 years | CYPS | RMBC CYPS<br>RMBC NAS<br>CCG<br>RFT | |
| | Excess weight at 4-5 and 10-11 year olds | CYPS (monitored by SW team – performance managed by PH) | RMBC CYPS<br>RMBC NAS<br>CCG<br>RFT | |
| | Hospital admissions caused by unintentional and deliberate injuries in under 18s | CYPS | RMBC CYPS<br>RDaSH<br>CCG<br>RFT | |
| | Emotional wellbeing of LAC | CYPS | RMBC CYPS<br>RMBC NAS<br>CCG<br>RFT | |
| | Smoking prevalence – 15 year olds | CYPS | RMBC CYPS<br>RMBC NAS<br>RMBC EDS<br>Schools | |
| | Hospital admissions as a result of self-harm | CYPS | RMBC CYPS<br>RMBC NAS<br>CCG<br>RFT<br>RDaSH | |
| | Diet | CYPS<br>NAS | RMBC NAS<br>RMBC CYPS<br>CVS | |
| | Excess weight in adults | NAS | RMBC NAS<br>CCG | |

| Domain | Indicator | Reported to | Partner organisations | Public Health lead |
|---|---|---|---|---|
| | | | RFT<br>Weight Management Providers | |
| | Proportion of physically active and inactive adults | EDS | RMBC EDS<br>RMBC NAS<br>CVS<br>DC Leisure | |
| | Smoking prevalence – adult (over 18s) | NAS | RMBC NAS<br>Stop Smoking services | |
| | Successful completion of drug treatment | NAS | RMBC NAS<br>Drug treatment providers | |
| | People entering prison with substance dependence issues who are previously not known to community treatment | NAS | RMBC NAS<br>Prison Serrvice | |
| | Recorded diabetes | NAS | RMBC NASA<br>CCG<br>RFT<br>GP Practices | |
| | Alcohol related hospital admissions | NAS | RMBC NAS<br>RFT | |
| | Cancer diagnosed at Stage 1 and 2 | NAS | RMBC<br>RFT | |
| | Cancer screening coverage | NAS | RMBC NAS<br>NHS England<br>RFT | |
| | Access to non- cancer screening programmes | NAS | RMBC NAS<br>NHS England<br>RFT | |
| | Take up of the NHS Health Check Programme | NAS | RMBC NAS<br>GP Practices | |
| | Self-reported wellbeing | NAS | RMBC NAS | |
| | Falls and injuries in the over 65s | NAS | RMBC NAS<br>CCG<br>RFT – Falls service<br>RMBC EDS<br>Providers | |

| Domain | Indicator | Reported to | Partner organisations | Public Health lead / contact |
|---|---|---|---|---|
| Health Protection | Health and Wellbeing – Prevention and early intervention | | | Jo Abbott (with the support of Public Health Specialists) |
| Health Protection | Air pollution | EDS<br>NAS | RMBC EDS<br>RMBC NAS | |
| | Chlamydia diagnoses (15-24 year olds) | CYPS | RMBC CYPS<br>RFT<br>Schools | |
| | Population vaccination coverage | NAS | RMBC NAS<br>NHS England<br>PH England<br>CCG | |
| | People presenting with HIV at a late stage of infection | NAS | RMBC NAS<br>CCG<br>RFT<br>GP Providers | |
| | Treatment completion for tuberculosis | NAS | RMBC NAS<br>CCG<br>RFT | |
| | Public sector organisations with board approved sustainable development management plan | EDS | All partners | |
| | Comprehensive agreed interagency plans for responding to public health incidents | NAS<br>EDS | RMBC NAS<br>RMBC EDS<br>RFT<br>CCG | |

| Domain | Indicator | Reported to | Partner organisations | Public Health lead / contact |
|---|---|---|---|---|
| Healthcare public health and preventing premature mortality | Health and Wellbeing – Long term conditions | | | Nagpal Hoysal (with the support of Public Health Specialists) |
| Healthcare public health and preventing premature mortality | Infant Mortality | CYPS | RMBC CYPS<br>RMBC NAS<br>RFT<br>CCG | |
| | Tooth decay in children aged 5 | CYPS | RMBC CYPS<br>RMBC NAS<br>RFT | |
| | Mortality from causes considered preventable | NAS | RMBC NAS<br>RFT<br>CCG | |
| | Mortality from all cardiovascular diseases (including heart disease and stroke) | NAS | RMBC NAS<br>RFT<br>CCG | |
| | Mortality from cancer | NAS | RMBC NAS<br>RFT<br>CCG | |
| | Mortality from liver disease | NAS | RMBC NAS<br>RFT<br>CCG | |
| | Mortality from respiratory diseases | NAS | RMBC NAS<br>RFT<br>CCG | |
| | Mortality from communicable diseases | NAS | RMBC NAS<br>RFT<br>CCG | |
| | Excess under 75 mortality in adults with serious mental illness | NAS | RMBC NAS<br>RFT<br>CCG | |
| | Suicide | NAS<br>CYPS | RMBC NAS<br>RMBC CYPS<br>RFT<br>CCG<br>SY Police<br>CVS (Samaritans) | |
| | Emergency admissions within 30 days of discharge from hospital | NAS | RMBC NAS<br>RFT<br>CCG | |
| | Health related quality of life for older people | NAS | RMBC NAS<br>RFT<br>CCG | |
| | Hip fractures in over 65s | NAS | RMBC NAS<br>RFT<br>CCG | |
| | Excess winter deaths | EDS<br>NAS | RMBC NAS<br>RFT | |

| Domain | Indicator | Reported to | Partner organisations | Public Health lead / contact |
|---|---|---|---|---|
| | | | CCG | |
| | Dementia and its impacts | NAS | RMBC NAS<br>RFT<br>CCG<br>RDaSH<br>CVS | |

## Appendix 2 – Public Health Outcomes Framework scorecard – October 2013

### Public Health Outcomes

**Report date:** 28-Oct-13

| **Position Key:** | | **Trend key:** | |
|---|---|---|---|
| 🟢 | Better | ▲ | Improving |
| 🟡 | Average | ▬ | Stable |
| 🔴 | Worse | ▼ | Worsening |
| ⚫ | Not compared | | |

| Indicator | Time Period | Value | Lower CI | Upper CI | Count | Denominator | Sex | Age | Position | Trend |
|---|---|---|---|---|---|---|---|---|---|---|
| 1.01 - Children in poverty | 2010 | 23.14 | 22.77 | 23.51 | 11480.00 | 49610.00 | Persons | <16 yrs | 🟢 | |
| 1.03 - Pupil absence | 2011/12 | 5.57 | 5.34 | 5.81 | 616514.00 | 11065292.00 | Persons | 5-15 yrs | 🟢 | ▲ |
| 1.04i - First time entrants to the youth justice system | 2012 | 434.88 | 356.08 | 521.72 | 110.97 | 25517.00 | Persons | 10-17 yrs | 🟢 | ▲ |
| 1.05 - 16-18 year olds not in education employment or training | 2012 | 7.40 | 6.94 | 7.98 | 730.00 | 9802.33 | Persons | 16-18 yrs | 🔴 | ▬ |
| 1.06i - Adults with a learning disability who live in stable and appropriate accommodation | 2011/12 | 76.40 | | | 545.00 | 715.00 | Persons | 18-64 yrs | ⚫ | |
| 1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation | 2010/11 | 63.40 | | | 620.00 | 980.00 | Persons | 18-69 yrs | ⚫ | |
| 1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate | 2012 | 6.00 | | | | | Persons | 16-64 yrs | ⚫ | |
| 1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate | 2011/12 | 61.30 | | | | | Persons | 18-64 yrs | ⚫ | |
| 1.09i - Sickness absence - The percentage of employees who had at least one day off in the previous week | 2009 - 11 | 2.92 | 2.13 | 3.98 | | 1367.00 | Persons | 16+ yrs | 🟡 | |
| 1.09ii - Sickness absence - The percent of working days lost due to sickness absence | 2009 - 11 | 2.34 | 1.71 | 3.19 | | 5612.00 | Persons | 16+ yrs | 🔴 | |
| 1.10 - Killed and seriously injured casualties on England's roads | 2009 - 11 | 30.75 | 26.96 | 34.93 | 237.00 | 770679.00 | Persons | All ages | 🟢 | |
| 1.12i - Violent crime (including sexual violence) - hospital admissions for violence | 2009/10 - 11/12 | 86.93 | 80.08 | 94.20 | 603.00 | 763069.00 | Persons | All ages | 🔴 | |
| 1.12ii - Violent crime (including sexual violence) - violence offences | 2011/12 | 8.95 | 8.58 | 9.32 | 2278.00 | 254600.00 | Persons | All ages | 🟢 | |
| 1.13i - Re-offending levels - percentage of offenders who re-offend | 2010 | 25.79 | 24.23 | 27.41 | 746.00 | 2893.00 | Persons | All ages | 🟡 | |
| 1.13ii - Re-offending levels - average number of re-offences per offender | 2010 | .65 | .62 | .68 | 1885.00 | 2893.00 | Persons | All ages | 🟢 | |
| 1.14i - The percentage of the population affected by noise - Number of complaints about noise | 2011/12 | 8.71 | 8.35 | 9.08 | 2245.00 | 257716.00 | Persons | All ages | 🔴 | |
| 1.15i - Statutory homelessness - homelessness acceptances | 2011/12 | 1.10 | .91 | 1.32 | 117.00 | 106000.00 | Undefined | Undefined | 🟢 | ▼ |
| 1.15ii - Statutory homelessness - households in temporary accommodation | 2011/12 | .32 | .22 | .45 | 34.00 | 106000.00 | Persons | All ages | 🟢 | ▼ |
| 1.16 - Utilisation of outdoor space for exercise/health reasons | Mar 2009 - Feb 2012 | 13.70 | 7.76 | 19.63 | | | Persons | 16+ yrs | 🟡 | |
| 1.18i - Social Isolation: % of adult social care users who have as much social contact as they would like | 2011/12 | 41.80 | 38.20 | 45.40 | | 595.00 | Persons | 18+ yrs | 🟡 | ▼ |

# Public Health Outcomes

**Report date:** 28-Oct-13

**Position Key:** (green) Better; (yellow) Average; (red) Worse; (black) Not compared

**Trend key:** (up) Improving; (dash) Stable; (down) Worsening

| Indicator | Time Period | Value | Lower CI | Upper CI | Count | Denominator | Sex | Age | Position | Trend |
|---|---|---|---|---|---|---|---|---|---|---|
| 2.01 - Low birth weight of term babies | 2010 | 3.32 | 2.74 | 4.03 | 99.00 | 2978.00 | Persons | >=37 weeks gestational age at birth | Average | |
| 2.02i - Breastfeeding - Breastfeeding initiation | 2011/12 | 61.46 | 59.68 | 63.21 | 1794.00 | 2919.00 | Female | All ages | Worse | Improving |
| 2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth | 2011/12 | 30.20 | 28.58 | 31.86 | 911.00 | 3017.00 | Persons | 6-8 weeks | Worse | Improving |
| 2.03 - Smoking status at time of delivery | 2010/11 | 22.36 | 20.89 | 23.90 | 659.00 | 2947.00 | Female | All ages | Worse | |
| 2.04 - Under 18 conceptions | 2011 | 40.91 | 35.45 | 46.98 | 201.00 | 4913.00 | Female | <18 yrs | Worse | Improving |
| 2.06i - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds | 2011/12 | 16.10 | 14.84 | 17.44 | 494.00 | 3068.00 | Persons | 4-5 yrs | Better | Improving |
| 2.06ii - Excess weight in 4-5 and 10-11 year olds - 10-11 year olds | 2011/12 | 33.03 | 31.29 | 34.81 | 902.00 | 2731.00 | Persons | 10-11 yrs | Average | Stable |
| 2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) | 2011/12 | 130.68 | 120.45 | 141.55 | 602.00 | 46066.00 | Persons | <15 yrs | Worse | Worsening |
| 2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24) | 2011/12 | 157.88 | 144.33 | 172.36 | 499.00 | 31606.00 | Persons | 15-24 yrs | Average | Stable |
| 2.08 - Emotional well-being of looked after children | 2011/12 | 15.30 | | | | 175.00 | Persons | 4-16 | Not compared | Improving |
| 2.13i - Percentage of physically active and inactive adults - active adults | 2012 | 52.38 | 47.58 | 57.18 | | 416.00 | Persons | 16+ yrs | Average | |
| 2.13ii - Percentage of active and inactive adults - inactive adults | 2012 | 33.57 | 29.03 | 38.11 | | 416.00 | Persons | 16+ yrs | Worse | |
| 2.14 - Smoking prevalence - adults (over 18s) | 2011/12 | 23.31 | 21.21 | 25.40 | | 1563.00 | Persons | 18+ yrs | Worse | Stable |
| 2.15i - Successful completion of drug treatment - opiate users | 2011 | 7.85 | 6.47 | 9.49 | 96.00 | 1223.00 | Persons | 18-75 yrs | Average | Improving |
| 2.15ii - Successful completion of drug treatment - non-opiate users | 2011 | 50.48 | 43.77 | 57.17 | 106.00 | 210.00 | Persons | 18-75 yrs | Better | Improving |
| 2.17 - Recorded diabetes | 2011/12 | 6.21 | 6.10 | 6.31 | 12715.00 | 204899.00 | Persons | 17+ yrs | Better | Improving |
| 2.20i - Cancer screening coverage - breast cancer | 2012 | 80.83 | 80.37 | 81.29 | 22854.00 | 28273.00 | Female | 53-70 yrs | Better | Stable |
| 2.20ii - Cancer screening coverage - cervical cancer | 2012 | 77.48 | 77.15 | 77.80 | 49536.00 | 63934.00 | Female | 25-64 yrs | Better | Stable |
| 2.21vii - Access to non-cancer screening programmes - diabetic retinopathy | 2011/12 | 66.65 | 65.72 | 67.57 | 6660.00 | 9992.00 | Persons | 12+ yrs | Worse | Stable |
| 2.22i - Take up of NHS Health Check Programme by those eligible - health check offered | 2012/13 | 17.87 | 17.60 | 18.14 | 13694.00 | 76637.00 | Persons | 40-74 yrs | Better | Improving |
| 2.22ii - Take up of NHS Health Check programme by those eligible - health check take up | 2012/13 | 51.60 | 50.76 | 52.44 | 7066.00 | 13694.00 | Persons | 40-74 yrs | Better | Worsening |
| 2.23i - Self-reported well-being - people with a low satisfaction score | 2011/12 | 26.09 | 24.29 | 27.89 | | 3681.00 | Persons | 16+ yrs | Worse | |
| 2.23ii - Self-reported well-being - people with a low worthwhile score | 2011/12 | 21.13 | 19.44 | 22.82 | | 3657.00 | Persons | 16+ yrs | Average | |
| 2.23iii - Self-reported well-being - people with a low happiness score | 2011/12 | 31.33 | 29.36 | 33.30 | | 3681.00 | Persons | 16+ yrs | Worse | |
| 2.23iv - Self-reported well-being - people with a high anxiety score | 2011/12 | 42.27 | 40.21 | 44.33 | | 3657.00 | Persons | 16+ yrs | Worse | |
| 2.24i - Injuries due to falls in people aged 65 and over (Persons) | 2011/12 | 1833.17 | 1717.42 | 1954.36 | 1039.00 | 45130.00 | Persons | 65+ yrs | Worse | Improving |
| 2.24i - Injuries due to falls in people aged 65 and over (males/females) | 2011/12 | 1409.12 | 1251.17 | 1581.36 | 293.00 | 20085.00 | Male | 65+ yrs | Average | Improving |
| 2.24i - Injuries due to falls in people aged 65 and over (males/females) | 2011/12 | 2257.22 | 2090.51 | 2433.23 | 746.00 | 25045.00 | Female | 65+ yrs | Worse | Improving |
| 2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 | 2011/12 | 996.46 | 894.52 | 1106.77 | 353.00 | 33513.00 | Persons | 65-79 yrs | Average | Improving |
| 2.24iii - Injuries due to falls in people aged 65 and over - aged 80+ | 2011/12 | 5598.37 | 5163.89 | 6058.12 | 686.00 | 11617.00 | Persons | 80+ yrs | Worse | Improving |

# Public Health Outcomes

**Report date:** 28-Oct-13

**Position Key:** (green) Better; (amber) Average; (red) Worse; (black) Not compared

**Trend key:** (up) Improving; (dash) Stable; (down) Worsening

| Indicator | Time Period | Value | Lower CI | Upper CI | Count | Denominator | Sex | Age | Position | Trend |
|---|---|---|---|---|---|---|---|---|---|---|
| 3.01 - Fraction of mortality attributable to particulate air pollution | 2010 | 5.70 | | | | | Persons | 30+ yrs | Not compared | |
| 3.02i - Chlamydia diagnoses (15-24 year olds) - Old NCSP data | 2011 | 2554.98 | 2382.97 | 2736.13 | 819.00 | 32055.00 | Persons | 15-24 yrs | Worse | Improving |
| 3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD | 2012 | 3375.94 | 3176.39 | 3584.74 | 1067.00 | 31606.00 | Persons | 15-24 yrs | Worse | |
| 3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old) | 2011/12 | 96.15 | 95.41 | 96.77 | 2971.00 | 3090.00 | Persons | 1 yr | Better | Improving |
| 3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old) | 2011/12 | 96.72 | 96.03 | 97.29 | 3004.00 | 3106.00 | Persons | 2 yrs | Average | Worsening |
| 3.03iv - Population vaccination coverage - MenC | 2011/12 | 95.44 | 94.64 | 96.12 | 2949.00 | 3090.00 | Persons | 1 yr | Better | Stable |
| 3.03v - Population vaccination coverage - PCV | 2011/12 | 95.86 | 95.10 | 96.51 | 2962.00 | 3090.00 | Persons | 1 yr | Better | Improving |
| 3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old) | 2011/12 | 95.30 | 94.50 | 95.99 | 2960.00 | 3106.00 | Persons | 2 yrs | Better | Stable |
| 3.03vi - Population vaccination coverage - Hib / Men C booster (5 years) | 2011/12 | 90.15 | 89.03 | 91.17 | 2692.00 | 2986.00 | Persons | 5 yrs | Better | |
| 3.03vii - Population vaccination coverage - PCV booster | 2011/12 | 93.75 | 92.85 | 94.55 | 2912.00 | 3106.00 | Persons | 2 yrs | Better | Improving |
| 3.03viii - Population vaccination coverage - MMR for one dose (2 years old) | 2011/12 | 92.92 | 91.96 | 93.77 | 2886.00 | 3106.00 | Persons | 2 yrs | Better | Improving |
| 3.03ix - Population vaccination coverage - MMR for one dose (5 years old) | 2011/12 | 93.50 | 92.56 | 94.33 | 2792.00 | 2986.00 | Persons | 5 yrs | Average | Worsening |
| 3.03x - Population vaccination coverage - MMR for two doses (5 years old) | 2011/12 | 89.48 | 88.33 | 90.53 | 2672.00 | 2986.00 | Persons | 5 yrs | Better | Improving |
| 3.03xii - Population vaccination coverage - HPV | 2011/12 | 82.10 | 80.23 | 83.84 | 1422.00 | 1732.00 | Female | 12-13 yrs | Worse | Worsening |
| 3.03xiii - Population vaccination coverage - PPV | 2011/12 | 74.61 | 74.21 | 75.02 | 33013.00 | 44245.00 | Persons | 65+ yrs | Better | Stable |
| 3.03xiv - Population vaccination coverage - Flu (aged 65+) | 2011/12 | 76.02 | 75.62 | 76.42 | 33756.00 | 44402.00 | Persons | 65+ yrs | Better | Improving |
| 3.03xv - Population vaccination coverage - Flu (at risk individuals) | 2011/12 | 53.62 | 53.04 | 54.21 | 15075.00 | 28112.00 | Persons | 6 months-64 yrs | Better | Improving |
| 3.04 - People presenting with HIV at a late stage of infection | 2009 - 11 | 58.62 | 38.94 | 76.48 | 17.00 | 29.00 | Persons | 15+ yrs | Average | |
| 3.05i - Treatment completion for TB | 2011 | 78.95 | 56.67 | 91.49 | | | Persons | All ages | Average | |
| 3.05ii - Treatment completion for TB - TB incidence | 2009 - 11 | 8.51 | 5.26 | 12.85 | 21.67 | 254605.00 | Persons | All ages | Worse | |
| 3.06 - Public sector organisations with a board approved sustainable development management plan | 2011/12 | 100.00 | | | 5.00 | 5.00 | Undefined | Undefined | Not compared | |

# Public Health Outcomes

**Report date:** 28-Oct-13

**Position Key:** Better / Average / Worse / Not compared

**Trend key:** Improving / Stable / Worsening

| Indicator | Time Period | Value | Lower CI | Upper CI | Count | Denominator | Sex | Age | Position | Trend |
|---|---|---|---|---|---|---|---|---|---|---|
| 4.01 - Infant mortality | 2009 - 11 | 4.48 | 3.23 | 6.05 | 42.00 | 9379.00 | Persons | < 1 yr | Average | |
| 4.03 - Mortality rate from causes considered preventable (provisional) | 2009 - 11 | 159.76 | 151.70 | 168.12 | 1529.00 | 773148.00 | Persons | All ages | Worse | |
| 4.04i - Under 75 mortality rate from all cardiovascular diseases (provisional) | 2009 - 11 | 72.02 | 66.53 | 77.84 | 652.49 | 711417.00 | Persons | <75 yrs | Worse | |
| 4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (provisional) | 2009 - 11 | 51.24 | 46.68 | 56.13 | 474.00 | 712608.00 | Persons | <75 yrs | Worse | |
| 4.05i - Under 75 mortality rate from cancer (provisional) | 2009 - 11 | 124.09 | 116.89 | 131.62 | 1132.00 | 711417.00 | Persons | <75 yrs | Worse | |
| 4.05ii - Under 75 mortality rate from cancer considered preventable (provisional) | 2009 - 11 | 71.18 | 65.77 | 76.90 | 656.00 | 712608.00 | Persons | <75 yrs | Worse | |
| 4.06i - Under 75 mortality rate from liver disease (provisional) | 2009 - 11 | 15.67 | 13.10 | 18.60 | 134.00 | 712608.00 | Persons | <75 yrs | Average | |
| 4.06ii - Under 75 mortality rate from liver disease considered preventable (provisional) | 2009 - 11 | 13.65 | 11.25 | 16.41 | 116.00 | 712608.00 | Persons | <75 yrs | Average | |
| 4.07i - Under 75 mortality rate from respiratory disease (provisional) | 2009 - 11 | 30.39 | 26.94 | 34.15 | 288.00 | 712608.00 | Persons | <75 yrs | Worse | |
| 4.07ii - Under 75 mortality rate from respiratory disease considered preventable (provisional) | 2009 - 11 | 12.39 | 10.26 | 14.82 | 121.00 | 712608.00 | Persons | <75 yrs | Average | |
| 4.08 - Mortality from communicable diseases (provisional) | 2009 - 11 | 39.75 | 36.42 | 43.29 | 572.00 | 773148.00 | Persons | All ages | Worse | |
| 4.10 - Suicide rate (provisional) | 2009 - 11 | 4.27 | 2.92 | 6.02 | 34.00 | 773148.00 | Persons | All ages | Better | |
| 4.11 - Emergency readmissions within 30 days of discharge from hospital | 2010/11 | 12.78 | 12.41 | 13.16 | 4417.00 | 33255.00 | Persons | All ages | Worse | |
| 4.11 - Emergency readmissions within 30 days of discharge from hospital | 2010/11 | 13.58 | 13.01 | 14.17 | 2117.00 | 15492.00 | Male | All ages | Worse | |
| 4.11 - Emergency readmissions within 30 days of discharge from hospital | 2010/11 | 12.07 | 11.58 | 12.57 | 2300.00 | 17763.00 | Female | All ages | Worse | |
| 4.12i - Preventable sight loss - age related macular degeneration (AMD) | 2011/12 | 144.03 | 111.16 | 183.58 | 65.00 | 45130.00 | Persons | 65+ yrs | Worse | Worsening |
| 4.12ii - Preventable sight loss - glaucoma | 2011/12 | 12.66 | 7.38 | 20.28 | 17.00 | 134234.00 | Persons | 40+ yrs | Average | Improving |
| 4.12iii - Preventable sight loss - diabetic eye disease | 2011/12 | 3.16 | 1.27 | 6.52 | 7.00 | 221216.00 | Persons | 12+ yrs | Average | Improving |
| 4.12iv - Preventable sight loss - sight loss certifications | 2011/12 | 58.20 | 49.26 | 68.30 | 150.00 | 257716.00 | Persons | All ages | Worse | Worsening |
| 4.14i - Hip fractures in people aged 65 and over | 2011/12 | 465.86 | 408.64 | 528.50 | 268.00 | 45130.00 | Persons | 65+ yrs | Average | Worsening |
| 4.14ii - Hip fractures in people aged 65 and over - aged 65-79 | 2011/12 | 213.41 | 167.85 | 267.47 | 76.00 | 33513.00 | Persons | 65-79 yrs | Average | Worsening |
| 4.14iii - Hip fractures in people aged 65 and over - aged 80+ | 2011/12 | 1601.86 | 1369.59 | 1860.42 | 192.00 | 11617.00 | Persons | 80+ yrs | Average | Stable |

**Appendix 3 – Performance clinic structure and process**

Each indicator will have a current performance assessment and list of preventative activities developed to monitor preventative activity and actions on a report card.

Where the Indicator is an outlier the report card will be reported to the appropriate planning or commissioning group

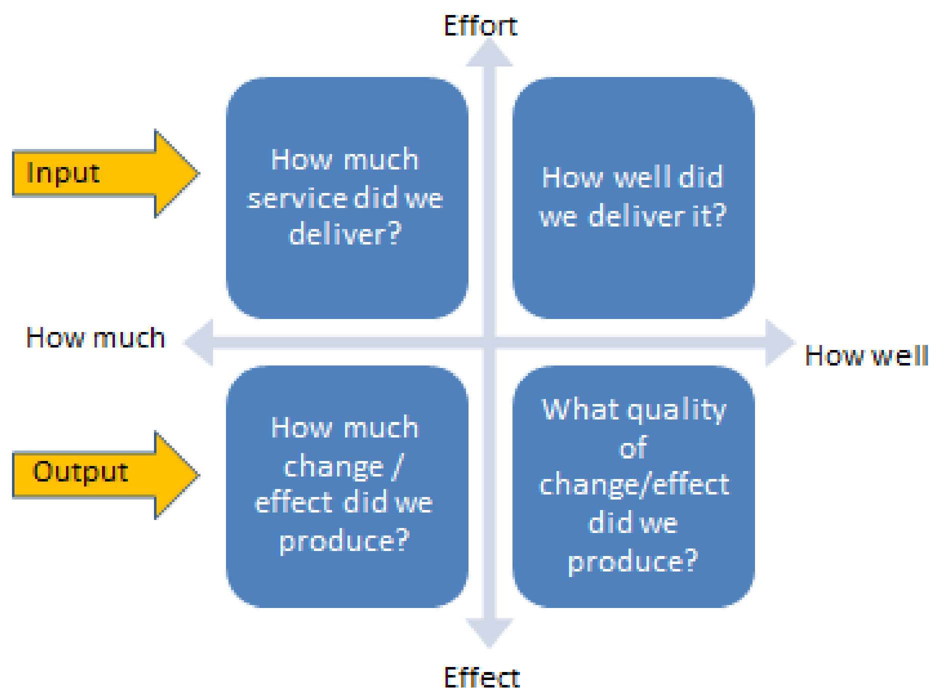
Public Health Outcomes that are significantly off target will have a performance clinic to develop an action plan which aims to reverse the current trend. The performance clinic will bring together partners (Commissioners and Providers) to explore advantages and challenges. We will use the Effort and Effect matrix (Appendix 4) along with additional tools from the Friedman (2009) outcome based accountability. This approach should be completed within 2 hours, creating a robust action plan that ensures efforts result in improved outcomes.

# Report Card

| **4.3 Mortality from causes considered preventable** | |
|---|---|
| Rationale | Preventable mortality can be defined in terms of causes that are considered to be preventable through individual behaviour or public health measures limiting individual exposure to harmful substances or conditions. Examples include lung cancer, illicit drug use disorders, land transport accidents and certain infectious diseases. |
| Indicator | **Age-standardised rate of mortality from causes considered preventable per 100,000 population.** |
| Current performance and trend | Higher than England average<br>Rated – RED by PH England<br>Rotherham 159.76 per 100,000 (2009/11)<br>National 146.1 per 100,000 (2009/11)<br>Rotherham's performance compared to other comparable areas is improving.<br>Doncaster 175.0 per 100,000 (2009/11)<br>Barnsley 167.4 per 100,000 (2009/11)<br>Sheffield 155.3 per 100,000 (2009/11) |

| | |
|---|---|
| Prevention activity | Mental health first Aid<br>Tobacco Control<br>Weight Management Framework<br>Safe alcohol use<br>NHS Health Check programme and lifestyle support<br>Affordable Warmth Strategy<br>Public Health England's Screening programmes<br>Early access to health services<br>Flu vaccination programme<br>11 Disadvantaged area work<br>Safer Rotherham Partnership |
| Remedial Actions | To be determined as part of a performance clinic<br>e.g. Make Every Contact Count |
| Review Date | |

**Appendix 4: Friedman (2009) Performance Management Effort and Effect Matrix**



**ROTHERHAM BOROUGH COUNCIL – HEALTH SELECT COMMISSION**

| | | |
|---|---|---|
| 1 | **Meeting:** | **Health Select Commission** |
| 2 | **Date:** | **23 January 2014** |
| 3 | **Title:** | **Scrutiny Review of RMBC Residential Homes** |
| 4 | **Directorate:** | **Neighbourhoods and Adult Services** |

5 **Summary**

This report sets out a brief outline of the progress that has been made by Senior Management, Residential Managers and Human Resources Business Partner in line with recommendations from the Scrutiny Review of RMBC residential homes, following receipt of the report and action plan by Cabinet on 4 September 2013.

6 **Recommendations**

- **That the Health Select Commission receives and notes the report.**

## 7 Proposals and Details

The scrutiny review was undertaken from September to December 2012 by Scrutiny members and Cabinet Member for Adult Social Care. It was held in the context of the significant budget pressures being faced by the Council and the need to identify further efficiencies. Previous Value for Money analysis has demonstrated that the homes are higher cost than the equivalent services provided in the independent sector, and reduce the cost effectiveness of Adult Social Care.

The review enabled the Senior Management, Residential Managers and Staff within the service to take a critical look at previous and current expenditure and to achieve an understanding of value for money, outcomes and quality of service provision and in particular, the potential impact of budget cuts on this area and the risks associated. The homes are registered with and regulated by the Care Quality Commission; as a result there are essential standards of care which have to be maintained, and have to be clearly factored into the plans to ensure compliance.

The actions taken include:-

- Restructure of all Staffing within the homes, including a review of Terms and Conditions for staff, to achieve some of the budget savings proposals.
- Revise and review shift patterns for all staff, to ensure staffing requirements and service provision is carried out safely to meet essential standards and service user assessed needs.
- A change to the management structure in the homes.
- Review of quality assurance systems in the homes.
- Residential Managers worked with Procurement Officers to look at options to utilise different suppliers and contract to ensure value for money and address potential savings in this area.
- Both homes have a structured and varied social and activities programme which presently meets individual need, promotes wellbeing, and provides the service users with a range of options both in the home and community. To achieve the budget savings proposed for the homes, this area has been considered wit positive outcomes.
- Options to be considered for lease arrangements to generate some income related benefits, i.e. The Café and the Hairdressing / Beauty Salon.
- The Service has now employed a Handy Person at each home, which will reduce some of the expenditure on minor repairs and maintenance. The Residential Managers are working with EDS Building Manager to look at other ways of how to use this role and where some savings can be

achieved immediately, i.e. To train the Handy Person and purchase the equipment to undertake Electrical PAT Testing requirements which would reduce costs on contracting from the present Council Contractor in place, Wilmot Dixons.

**8 Finance**

The review recommendations have contributed to an agreed in-year saving of £870,000. As the saving was only agreed formally in March 2013, there was insufficient time to implement the changes in order to achieve full year delivery of the savings target. However good progress was made and the changes are now fully implemented and will result in full year savings in 2014/15.

**9 Risks and Uncertainties**

There is a risk that a reduction in staffing will result in poorer quality care. To prevent this, quality monitoring and audit processes are continued to be used to identify gaps and areas for development.

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E-mail: shona.mcfarlane@rotherham.gov.uk

## *Scrutiny Review RMBC Residential Homes - Update*

| Recommendation | | Update | Officer Responsible | *Status* |
|---|---|---|---|---|
| 1. That RMBC corporately agrees to review the terms and conditions of the staff to address issues of out of hour's enhancements and sickness absence payments. | | Terms and Conditions of staff were addressed under the review of the residential homes. Average hours paid for annual leave and sickness were removed at the recruitment process within the new structure for the homes. This was implemented on 1.11.13. This brings the homes in line with other services within NAS.<br><br>Out of Hours enhancements and sickness payments are a corporate area of responsibility and would need to be addressed by Corporate HR. | HR Business Partner<br>O Stringwell | Complete<br><br>Ongoing |
| 2. That Human Resources and NAS Management consider urgently whether the permanent recruitment freeze could be lifted for the two homes, enabling them to take more control of some of the staffing costs. | | A Recruitment Freeze had been in place from October 2013, due to the Review. There is no longer a recruitment freeze in place. Staff were appointed to the new roles in October and there are a small number of vacancies, which are being actively recruited.<br><br>Recruitment was and remains ongoing with casual bank of staff at both homes, to ensure consistency of care delivery | Service Manager<br>R Brown<br>Registered Managers<br>L Sykes<br>Todd | Complete |
| 3. That the hard work and commitment of the staff and managers of both homes be recognised and the achievements made in enhancing the dignity of residents. | | The recruitment process has ensured that staff have been allocated to appropriate roles. NAS have Reward and Recognition schemes in place including the STAR awards and also take an active part in corporate schemes such as young person of the year. Service Manager and Director visit on a regular basis and recognise the hard work and commitment of staff. | Service Manager<br>R Brown<br>HR Business Partner<br>O Stringwell HR Officers<br>Union Representation<br>Registered Managers,<br>L Todd L Sykes | Complete |

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| 4. To provide the opportunity for the teams to explore this further and to generate independent income for the homes to enhance the experience for residents and to ensure that quality of provision is maintained as far as possible. This might also include some independent management of procurement for food and catering items. | | A corporate task group has commenced working, looking at all catering arrangements including the residential services and will report elsewhere.<br><br>No work has yet commenced on scoping the potential for generating additional income as the teams have been focusing on the implementation of the new management and staffing structures which commenced on 15.11.13. | Service Leader Simon Bradley Procurement Officers Registered Managers L Todd L Sykes Service Manager R Brown Registered Managers | Ongoing |
| 5. That further work is done with the procurement team of the Council to look at value for money in the current contractual arrangements and a review of how the food budgets are spent in carried out in conjunction with the managers of the homes. | | Following work undertaken with Procurement colleagues, standard menus have been produced and implemented and product lists have been rationalised ensuring a balance of quality and cost. No impact has been felt by customers. | Service Leaders Simon Bradley Procurement Officers<br><br>Registered Managers | Complete |
| 6. That consideration is given to the extent to which the handyman service or another internal employee could be trained to carry out some of the maintenance services that are currently causing the homes to go over their repairs and maintenance budgets. | | Since commencing the Handyperson role, there has been an improvement in the fabric of the homes, as small repairs can be undertaken immediate they are needed. There has been a reduction in spend on repairs as a result. | EDS Building Manager D Wilde Registered Managers L Todd, L Sykes | Complete |
| 7. That the same review contained within recommendation 5 for food procurement is carried out regard to procurement of cleaning, repairs and maintenance services. | | A Rotherham MBC framework agreement for repairs and maintenance services has recently been let for all Council buildings. This agreement has been awarded following a robust procurement process and advertised through the Official Journal of the European Union, this agreement is delivering huge benefits and cost savings to Rotherham MBC. | Simon Bradley Service Leader Procurement Officers Registered Managers | Complete |
| 8. That Cabinet do not cut staff hours per resident below 25 as it is felt this will be to the detriment of the quality of other service provided. | | The budget hours allocated per week per resident for care delivery remains at 25 hours. This has been planned in to the revised structure for the care delivery and to ensure that Essential Standards are maintained. | Budget Support Officer Viv Ford Service Manager R Brown | Complete |

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| 9. That Cabinet re-consider the proposal to reduce the number of managers within the homes, as this is likely to result in re-deployment and payment protection costs which could outweigh the savings being made. | | The Team Leader role has been reviewed to achieve a balance between cost and safety/quality of care. Sufficient leadership role are in place within the new structure. There were no compulsory redundancies as a result of the proposals and payment protection arrangements were minimal. | Hr Business Partner<br>O Stringwell<br>Service Manager<br>R Brown<br>Registered Managers<br>L Todd, Sykes | Complete |
| 10. That the Council looks at alternative ways to manage the capital costs and borrowing associated with this, which potential review the burden from the revenue budgets of the homes. | | Finance to review the treatment of borrowing costs in accordance with Standard Accounting practices. This will ensure comparative treatment with the independent sector. The work is ongoing as part of the council's review of capital costs. | Finance Manager<br>Mark Scarrott | Ongoing |

# Agenda Item 13

**ROTHERHAM BOROUGH COUNCIL – Report to Members**

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|---|---|---|
| 1 | **Meeting:** | **Health Select Commission** |
| 2 | **Date:** | **23 January 2014** |
| 3 | **Title:** | **Integrated Health, Education and Social Care Service for Children, Young People and their families** |
| 4 | **Directorate:** | **RMBC CYPS**<br>**Rotherham Clinical Commissioning Group** |

## 5. Summary

This report is a joint report from RMBC CYPS and RCCG. The purpose of this paper is to inform Members of the proposal to integrate services across Social Care, Education and Health for children with a Special Educational Need or Disability (SEND) in Rotherham. This proposal is in line with the government requirements for reforms in commissioning and provision for SEND across Education, Health, Social Care and wider partners as set out in the Department of Health's (DH) SEN Green Paper 'Support and Aspirations; a New Approach to Special Educational Needs and Disability and with joint commissioning as set out in the Children and Families Bill (DfE).

This report sets out the improved outcomes for children and their families, legislative requirements for the council, key principles, benefits and potential risks of this integrated approach and that the proposal is in line with the joint Health and Wellbeing Strategy for Starting Well, Developing Well and Living and Working Well. It is stated here that changes will take place in services to meet the required reductions in revenue as demanded by central government.

Cabinet were asked to endorse the proposal for consultation which will be of the maximum required 45 day period so that the reconfigured joint approach service and the required revenue reductions be implemented from April 2014.

## 6. Recommendations

**That Members:**

**6.1 Note the proposals to integrate services across Social Care, Education and Health for children with a Special Educational Need or Disability (SEND)**

## 7. Background

### 7.1 National Context:

The SEN Green Paper 'Support and Aspirations; a New Approach to Special Educational Needs and Disability set out the following vision:

- **Early Identification** – Streamlining assessment processes and development of the Education, Health and Care Plan.
- **Giving Parents Control** – Creation of a 'Local Offer' covering including the choice for families to opt for a "Personal Budget".
- **Improved Learning and Achieving** – improved outcomes for children and young people across schools and colleges.
- **Preparing for Adulthood** – Seamless service 0-25 years with smooth transition
- **Services Working Together for Families** – development and expansion of joint commissioning arrangements

The required timeline for these reforms to be in place is September 2014.

**Definition of Disability**

The 2013 Draft Code of Practice for Special Educational Need (SEN) (Department of Education) defines disability as:

*A child is disabled if he is blind, deaf or dumb or suffers from a mental disorder of any kind or is substantially and permanently handicapped by illness, injury or congenital deformity or such other disability as may be prescribed. Children Act 1989*

*A person has a disability for the purposes of this Act if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. Equality Act 2010*

### 7.2 Current Provision

Currently Social Care and Education provider management responsibilities services relating to SEND in CYPS are shared across the Director for Schools and Lifelong Learning and the Director for Safeguarding Children and Families and between different M3 and M2 managers. There are also health colleagues working alongside the teams but with a different management structure and terms and conditions. The majority of the teams are co located at Kimberworth Place and a move to greater integration is the natural next step. However, there is still 'silo' working with little or no integration with partner agencies. Duplication exists and there is no overall strategic approach. There is evidence that documents confusion in the special schools about which team does what.

Most often the first engagement with services for parents or carers of a child with a special educational need or a disability is through health services or educational services separate from social care services.

These services are all seen as separate and relationships need to be developed across all services by families or carers to navigate the labyrinth of

services this does not meet any criteria for a high quality service. There should be one access point and a '*one stop shop*' service.
There are isolated examples of joint working currently and these include:

- Co-location of services at Kimberworth Place – a hub for Health (TRFT and RDASH/CAMHS); education and social care teams including: Child Development Centre; Physiotherapy, Occupational Therapy, Speech and Language Therapy, Complex Care Nursing Team, HI and VI service, Psychology, Social Care and Aiming High for Disabled Children Short Breaks for both under and over 8s.
- **Specialist equipment provision** - Specialist Equipment panel for high cost specialist bespoke equipment. Funding is split across TRFT and RMBC (Education, Early Years and Social Care).
- **Team around the Child meetings** - joint meetings across Early Years services and SEND services **(Early Years SEN)**
- **The Rotherham Charter for Parent and Child Voice** – Furtherance of the charter implementation
- **CAMHS** - Development of Autistic Spectrum Disorder pathway working with the Child Development Centre

**SEND services**
Services across SEND are funded by a combination of revenue and Dedicated Schools Grant (DSG); these services are RMBC unless indicated otherwise and include:

- SEN Assessment team
- Children with disabilities outreach team
- Social Care Disabilities team
- Families together
- Orchard Centre
- Early Years Inclusion Outreach Team
- Parent Partnership
- Parent Carer Forum – RMBC commissioned and VCS is provider
- Portage
- Learning Support Service including the Inclusion Outreach Team and Autism Communication Team
- Visual Impairment Team and Hearing Impairment Team
- Education Psychology
- Aiming High for Disabled Children
- Special Schools x 6
- Child Development Centre – RCCG commissioned and RFT is provider
- CAMHs – Tier 2 and 3 RCCG commissioned (RMBC contribution) and RDaSH is provider
- CAMHs – Tier 4 NHS England Commissioned
- Moving and Handling service
- Health Therapy services (SALT, OTs, & Physiotherapy) – RCCG commissioned and RFT is provider
- Complex Care Team – RCCG commissioned and RFT is provider
- School Nurses

**7.3 Integrated Social Care, Education and Health approach**

The approach to deliver improvement in outcomes for children and their families and against the legislative requirements is a service and structural redesign to improve outcomes for all children with additional needs. The approach will be the implementation of an integrated multi-agency, multi-disciplinary, social care, education and health team... This approach will support the implementation of integration in the Green Paper, *Support and Aspiration* and the joint commissioning requirement in the Children and Families Bill.

The key principles enshrined in the legislation are:

- Team around the Child
- Lead Working
- Personalisation agenda
- Birth to 25 years streamlining of CYPS and Adult services
- Rotherham's "Local Offer"

Funding for an interim appointment of a Strategic Lead has been secured and the post is to be jointly recruited with RMBC, CCG and Learners First to lead this critical work over the next 18 months through a robust programme and project management approach. A number of options will be developed to identify the best way forward learning from best practice.

An impact assessment will be completed.

**7.4 Outcomes for Children, Young People and their families**

A tried and tested integrated approach will deliver against the key principles set out above and improve outcomes through the development of a single pathway of care across Social Care, Education and Health for children into services with less confusion across the professional boundaries for the service user and their families. There will also be efficiencies achieved through reduction of duplicated resources.

A multi agency, multi disciplinary integrated Social Care, Education and Health team would deliver improved outcomes for service users and their families through a one stop shop access model. A joint commissioning approach would enable a strategic approach to the delivery of the SEND reforms including the development of Personal Budgets.

Implementing this approach will deliver the following:

- Improved outcomes for children and their families
- System change with increased VfM and efficiencies
- Mapping pathways from Portage (0-5 years) through to adult services
- Structural change with streamlined, effective and efficient service delivery with reduced resources
- Stronger governance arrangements
- Strategic approach to future delivery against legislation requirements
- The Council and Health partners are able to set a realistic budget within the identified available resources across a pooled budget and achieve efficiencies

The implementation of Personal budgets will be built on the excellent practice established in NAS; this will include the Resources Allocation System (RAS).

The development of a multi agency multi disciplinary SEND team will require:

- Alignment of priorities across each service
- Joint /integrated commissioning
- Agreed information and data sharing protocols
- Actual or virtual pooled budgets
- An agreed Performance Management Framework
- Strategic consultation and engagement protocol
- Identified governance, decision making and reporting ,arrangements

**7.5 Consultation**

Cabinet were asked to endorse the proposal for consultation which will be of the maximum required 45 day period so that the reconfigured joint approach service and the required revenue reductions be implemented from April 2014.

Extensive consultation has taken place with the Rotherham Parent Carer Forum, parents, the VCS, our colleagues in Health and other forums to arrive at this integrated and joint approach to improving outcomes for children and their families and to meet the legislative requirements. Further consultation will take place once the integrated service model has been developed.

It is to be noted that this report is presented on behalf of both RMBC CYPS and RCCG to inform Members of the joint approach to commissioning and providing of services going forward.

One of the priorities of an integrated approach will be co-production and it will be ensured that customers including children, young people and their families, schools and other stakeholders contribute to the re-design and delivery of any new service from the outset, including the recruitment of the strategic lead.

An impact equalities assessment will be completed.

**8. Finance**

Work to deliver the SEND reforms will be delivered within existing resources. It is anticipated that joint commissioning and integrated provision will achieve financial and resource efficiencies for all partners.

Personal budgets will have an impact across services as well as being a significant change for families.

**9 Risks and Uncertainties**

1. Any decisions made about the progress of the outlined approach will need to consider that partner organisations will also need to meet governance requirements

2. That any efficiency gains achieved will need to be proportionate across the council and health partners
3. Any potential pooled or virtual budget will need to be quantified
4. That the opportunity to transform services to improve outcomes is not grasped with enough vigor to make the necessary changes happen and achieve the service transformation and efficiencies.
5. That the capacity to deliver a high quality IYSS will be reduced by the need to achieve the reduction in revenue

## 10. Background papers


- Rewiring Public Services, Children's Services, LGA, 2013
- Evidence for the Frontline, Alliance for Useful Evidence, Dr. Jonathan Sharples, 2013
- Integrated Commissioning Strategy for Early Years services for children with additional needs 2008-2011, Devon County Council, 2008
- The Tail, How our schools fail one child in five: what can be done, Marshall, 2013
- Strategic toolkit for planning integrated working, 4 Children, 2010
- Bright Futures: local children local approaches, LGA, 2013
- Report of the Children and Young Peoples Health Outcomes Forum, The CYP Forum, 2012
- The State of the State 2013, In Search of Affordable Government, Deloitte and Reform, 2013
- Support and aspiration: A new approach to special educational needs and disability, DH, 2012
- Children and Families Bill, DfE, February 2013
- Draft SEND Code of Practice Formal Consultation, DH, 2013


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