HEALTH SELECT COMMISSION

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

Date: Thursday, 13th March, 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 Meetings (Pages 1 - 11)
   - Meetings held on 9th and 23rd January 2014

8. Health and Wellbeing Board (Pages 12 - 25)
   - Minutes of meetings held on 22nd January, 2014 and on 11th February 2014

9. Pharmaceutical and Medicines Waste (Pages 26 - 34)

10. School Nurses Service (Pages 35 - 67)

11. Better Care Fund (Pages 68 - 111)

12. Scrutiny Review of Continuing Healthcare (Pages 112 - 119)

13. Joint Health Overview and Scrutiny Committee (Pages 120 - 128)

14. Date and Time of Next Meeting
    - Thursday, 17th April, 2014 at 9.30 a.m.

HEALTH SELECT COMMISSION
Thursday, 9th January, 2014

Present:- Councillor Steele (in the Chair); Councillors Dalton, Goulty, Hoddinott, Roche, Wootton, Watson and Beaumont, Victoria Farnsworth (Speak Up), Robert Parkin (Speak Up) and Peter Scholey.

Apologies for absence were received from Councillors Barron, Kaye, Havenhand, Middleton and Sims; Richard Wells (National Autistic Society).

53. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

54. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There no members of the public or press present at the meeting.

55. EXCLUSION OF THE PRESS AND PUBLIC

Resolved: - That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972 (information relating to the financial/business affairs of any person (including the Council)).

56. ROTHERHAM FOUNDATION TRUST - UPDATE ON FUTURE PLANS

Louise Barnett, Interim Chief Executive, and Christopher Langley, Interim Chairman, Rotherham Foundation Trust, gave a powerpoint presentation setting out:-

- The background
- NHS financial challenge
- Key strategic principles
- The 3 Strategic options
- The preferred option, its financial challenge and clinical sustainability
- Delivering the preferred option
- Summary of forthcoming actions

The following additional information, incorporating questions by Select Commission Members, was given:-

Monitor
- 5 year financial plan and strategic options submitted by the 31st December, 2013, deadline
- The proposals had not been considered by the Trust's Governors as

yet

- The next step was to set the detail of the vision in conjunction with commissioners and the community

Financial Situation

- Challenges and risks faced by the Trust
- Organisation now on a more stable footing
- Clarification with regard to the Trust's forecasted financial position at the end of 2013/14 financial year and the 2014/15 budget
- Inflationary pressures and continuing reduction in Government funding

Transformation Programme

- Financial situation improved by Bolt Partners through reduced corporate functions
- Involvement of workforce in finding efficiencies – key staff identified to lead on change
- Set of priorities agreed with commissioners to look at opportunities to work together across the region i.e. procurement for any potential efficiencies through economies of scale
- Need to ensure the best interests of the patient
- Clinically led systematic speciality based reviews would commence to understand what services were being provided and how
- Assessment of clinics and whether they were meeting patients' needs
- Important that through general partnership working, there was a shared view with regard to the way forward – there was support for the preferred option

Workforce

- There were a number of vacancies where high cost locum and agency staff were used
- Assessment of clinics and whether they were meeting patients' needs
- 7 day working would have implications for staffing
- Smarter use of rotas to anticipate absences and reduce the need for agency staff
- Continued commitment to recruit the extra nurses identified previously
- Important to have the right skills mix of staff such as qualified nurses and health care assistants

Governance

- Interviews for the position of Board Chair would be held shortly
- The recruitment process was to start for the Chief Executive Officer

Communication

- There would be a series of communications issued
- Patient groups would be targeted
- Communications Strategy being drawn up

Louise and Christopher were thanked for their attendance.

Resolved:- (1) That the Chief Executive Officer and Chair of the Rotherham Foundation Trust attend the 14th April meeting of the Health Select Commission to give a further update.

(2) That, once known, the Health Select Commission be informed of any comments by Monitor on the 5 year financial plan and strategic options.

57. DATE AND TIME OF NEXT MEETING

Resolved:- That a further meeting of the Health Select Commission be held on Thursday, 23rd January, 2014, commencing at 9.30 a.m.

HEALTH SELECT COMMISSION
23rd January, 2014

Present:- Councillor Steele (in the Chair); Councillors Doyle, Dalton, Goulty, Hoddinott, Kaye, Middleton, Roche, Wootton, Havenhand, Sims and Beaumont.

Apologies for absence:- Apologies were received from Wyatt, Barron and Watson.

58. DECLARATIONS OF INTEREST

There were no declarations of interest made at this meeting.

59. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no questions from members of the public or the press.

60. COMMUNICATIONS

(1) With regard to the proposed Urgent Care Centre the Vice Chair had received a response from NHS Rotherham Clinical Commissioning Group in relation to the issues raised by the review group. It was noted that design work has now commenced in respect of the proposed building which is scheduled for completion during 2015.

(2) The Chairman clarified the issues which are included in the 2013/14 Work Programme of the Health Select Commission : priority has been given to the scrutiny reviews of (i) support for carers in Rotherham; (ii) services provided by GPs in Rotherham; and (iii) the provision of Incontinence Services. Members also noted that the scrutiny review of Mental Health Services was to take place during the 2014/2015 Municipal Year.

61. MINUTES OF THE PREVIOUS MEETING

Consideration was given to the minutes of the meeting of the Health Select Commission held on Thursday 5th December, 2013.

Resolved:- (1) That the minutes of the meeting held on 5th December, 2013, be agreed as a correct record for signature by the Chairman.

(2) That, with regard to Minute No. 50 (Scrutiny Review – Autistic Spectrum Disorder), the requested details of the impact of the CAMHS services be reported to the next meeting of the Health Select Commission.

62. HEALTH AND WELLBEING BOARD

Consideration was given to the minutes of the meetings of the Health and Wellbeing Board held on (i) 27th November, 2013 and (ii) 18th December, 2013.

The Select Commission referred to the following items:-

- (Minute S53 and Minute S62) Integration Transformation Fund (Better Care Fund) – the Health Select Commission requested that a report on this matter, detailing the financial resources, the terms of reference and the operational plan be submitted to the next meeting, to be held on 13th March 2014.

- (Minute S54) – the Public Health Outcomes Framework has been approved by the Cabinet at its meeting held on 15th January 2014.

- (Minute S55) Flu Vaccination Programme – Members noted that no new national guidance had yet been issued.

- (Minute S60) Communications – Members requested details of the bids for funding considered and approved by the Urgent Care Board.

- (Minute S61) Joint Strategic Needs Assessment – Refresh – the consultation process on the draft, revised document has begun and there will be a seminar for all Members of the Council, scheduled to take place on Tuesday 18th February, 2014.

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

63. SEXUAL HEALTH SERVICES

Consideration was given to a report presented by Public Health Specialist Gill Harrison, summarising 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 report also outlined the responsibility which local authorities had 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 the transmission of sexually transmitted infections and to foster improvements in sexual health.

The submitted report also summarised the most recent sexual health data from the Health Protection Report tables, published by Public Health England on 5th June 2013
(http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/STIs/STIsAnnualDataTables/#1._STI_Report)
and outlined the implications for Rotherham. This data was 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.

Members were informed that there were three outcome delivery measures for local authorities, in relation to sexual health, outlined in the Public Health Outcomes Framework for England, 2013-2016. These measures had 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 were:-

- to work towards achieving a diagnosis rate for Chlamydia of 2,400 – 3,000 cases per 100,000 population (adults aged 15-24 years);
- 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/mm^3); and
- to work towards a reduction in teenage conceptions.

Specific reference was made to:-

- commissioning and reporting arrangements for sexual health services – enabling the assessment of the effectiveness and value for money of these services;

- the effectiveness of sexual health screening programmes and the management of patient contacts;

- the funding of ‘out-of-area’ services, as patients may themselves choose where they accessed treatment services;

- comparisons of the incidence of sexually transmitted infections in Rotherham and around the country;

- the role and function of the Rotherham Sexual Health Strategy Group;

- the provision of sexual health education in schools;

- specific treatments e.g. contraception services;

- the measures in place to reduce the incidence of teenage pregnancy;

- safeguarding and protocols;

- examination of trends, over many years, in respect of sexually transmitted infections e.g. rates of Chlamydia are relatively high, but are reducing;

  - the need for early intervention and prevention of infection (e.g. the Chlamydia screening programme, work with schools, colleges and VCS groups);

- the overall use of the finance and resources available for Sexual Health Services, including the commissioning of services;

- ensuring that adequate advice about the prevention of infection was provided to patients;

- local Public Health services provided by GPs.

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

(2) That the statutory responsibilities of this Council in the commissioning of Sexual Health Services be noted.

(3) That the Health Select Commission supports the development of a new strategy for Sexual Health Services in Rotherham.

64. SCRUTINY REVIEW - INFORMATION FOR CARERS

Further to Minute No. 30 of the meeting of the Health Select Commission held on 12th September, 2013, consideration was given to a report presented by the Scrutiny Manager setting out the main findings and recommendations of the scrutiny review of support for carers in Rotherham. The draft review report was submitted for consideration by the Health Select Commission.

The report and discussion highlighted the following salient issues:-

- the recommendations for future actions, arising from this scrutiny review; Members noted that some of the issues raised are resource-intensive and their implementation may depend upon the allocation of limited resources;

- the review of performance targets;

- partnership working with GPs in the provision of services;

- the importance of providing emotional support for carers – including the creation of a multi-agency ‘carers’ pathway’;

- the availability of the Better Care Fund, which ultimately did not provide additional funding for the delivery of local authority services (details of this Fund are to be reported to the next meeting of this Select Commission).

Members placed on record their appreciation of the work undertaken by the scrutiny review group.

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

(2) That, subject to appropriate amendments being made to the review report and its recommendations, as now discussed, the Health Select Commission endorses the findings and recommendations of the scrutiny review of support for carers in Rotherham.

(3) That the report and recommendations of this scrutiny review, as amended in accordance with resolution (2) above, be forwarded to the Overview and Scrutiny Management Board and to the Cabinet for further consideration.

65. PUBLIC HEALTH OUTCOMES FRAMEWORK

Further to Minute No. 165 of the meeting of the Cabinet held on 15th January, 2014, consideration was given to a report presented by the Director of Public Health concerning the Council's statutory functions for health protection and health improvement. Public Health England monitored the responsibilities through the Public Health Outcomes Framework (PHOF). Members were informed of arrangements for monitoring of the Framework and the action being taken to address the outcomes.

The Council's wider responsibilities for population health required a co-ordinated approach, involving all partner organisations. The PHOF focused on the causes of premature mortality. The Rotherham 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 Outcomes Framework had to be reviewed quarterly to monitor improvements in performance. Public Health would lead this agenda and report to Cabinet by exception. Priority measures included those for avoidable mortality, which also featured as a key outcome for the Integrated Transformation Fund.

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

It was noted that agreement needed to be reached on which performance measures were regularly reported to the Health and Wellbeing Board. These should be indicators which were closely linked to the six locally determined priorities which followed the Health and Wellbeing Strategy. If these high level indicators showed no improvement or were significantly underperforming, the Health and Wellbeing Board would 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 was held, the issue would be reported to Cabinet. The emphasis of the performance clinics would be on innovation and doing things differently, to facilitate improvement and change.

The Indicators not included in the top six strategic issues would be addressed elsewhere within the local performance framework. The actions would re-focus activity on the early intervention and prevention agenda for long term and sustainable impact. The submitted report provided a framework for this process and summarised the early progress being made.

Specific reference was made to:-

- life expectancy and healthy life expectancy – causes of mortality and disability:

- reward grant in 2015-16 to local authorities being most successful regarding health inequalities, based on the outcomes framework

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

(2) That the proposed framework and reporting structures to address performance on the Public Health Outcomes Framework, as described in the report now submitted, be noted.

(3) That the use of the Public Health Outcomes Framework as a mechanism to deliver the Health and Wellbeing Strategy's aim of moving services to prevention and early intervention be noted.

66. RESIDENTIAL CARE SCRUTINY REVIEW - MONITORING REPORT

Further to Minute No. 64 of the meeting of the Cabinet held on 4th September 2013, consideration was given to a report presented by the Director of Health and Wellbeing describing the progress being made by Senior Management, Residential Managers and Human Resources Business Partner in line with recommendations from the Scrutiny Review of the Council's residential homes. The report included details of progress with the proposed restructure of the homes and service, in accordance with the budget savings and proposals for 2013/2014.

Reference was made to the following salient issues:-

- value for money, the use of limited resources and the requirement for financial savings; Members noted that the recruitment of staff was continuing and there had also been issues relating to the level of staff sickness absence;

- efficiencies made in respect of specific budgets (eg: revised procurement for the food budget, facilitating individual choice of meals from a wider-ranging menu);

- the quality of care services being provided.

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

67. INTEGRATED HEALTH, EDUCATION AND SOCIAL CARE SERVICE FOR CHILDREN, YOUNG PEOPLE AND THEIR FAMILIES

Consideration was given to a joint report presented by the Director of Schools and Lifelong Learning describing 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 was in line with 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 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 2013.

The submitted report described the improved outcomes for children and their families, legislative requirements for the Council, key principles, benefits and potential risks of this integrated approach. Members noted that the proposal was in line with the joint Health and Wellbeing Strategy for Starting Well, Developing Well and Living and Working Well. The Strategy stated that changes would take place in services to meet the reductions in revenue as demanded by the coalition Government.

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 from birth to 25 years, with smooth transition;
- Services Working Together for Families – development and expansion of joint commissioning arrangements.

The official timeline required the reforms to be in place by September 2014.

The report also outlined current service provision (including SEND services), the proposed integrated approach and the importance of improving outcomes for children, young people and their families.

It was noted that the Cabinet had endorsed the proposal for consultation, which would last for the maximum required period of 45 days. This action would enable the reconfigured joint approach service and the required revenue spending reductions to be implemented from April 2014 (Minute No. 168 of the meeting of the Cabinet held on 15th January 2014 refers).

Members referred to the following salient issues:-

- the pooled budget arrangements (local authority and health services) and the need to ensure value for money;

- the development of a project plan, for eventual submission to Members;

- the role and function of the Young Adult Transition Team;

- the provision of equipment for children and young people with Special Educational Needs (e.g. Rotherham Equipment Store);

- the process of consultation in respect of the new arrangements, which would be the subject of future reports to Elected Members;

- the requirement to achieve reductions in revenue spending on the integrated health, education and social care services.

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

(2) That the proposals to integrate services across Social Care, Education and Health for children with a Special Educational Need or Disability, as detailed in the report now submitted, be noted.

(3) That a further report be submitted to a future meeting of the Health Select Commission, during the Autumn 2014, detailing the proposals for the new arrangements for integrated health, education and social care services for children, young people and their families.

68. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 13th March, 2014, commencing at 9.30 a.m.

HEALTH AND WELLBEING BOARD
22nd January, 2014

Present:-

Councillor Ken Wyatt	Cabinet Member, Health and Wellbeing **(in the Chair)**
Chris Bain	RDaSH
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	Chief Commissioning Officer, Rotherham CCG
Jason Harwin	South Yorkshire Police
Julie Kitlowski	Rotherham CCG
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families Services
Dr. David Polkinghorn	Rotherham CCG
Joyce Thacker	Strategic Director, Children, Young People and Families
Janet Wheatley	Voluntary Action Rotherham

Also in attendance:-

Robin Carlisle	Rotherham CCG
Kate Green	Policy Officer, RMBC
Melanie Hall	Healthwatch Rotherham (rep. Naveen Judah)
Pete Hudson	Chief Finance Manager, RMBC
Shona McFarlane	Director of Health and Wellbeing, RMBC
Phil Morris	Rotherham Local Safeguarding board
Joanna Saunders	Department of Public Health (rep. Dr. Radford)
Chrissy Wright	Strategic Commissioning Manager, RMBC

Apologies for absence were submitted by Brian Hughes, Naveen Judah, Martin Kimber and Tracy Holmes.

S64. MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

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

Arising from Minute No. S59 (Flu Vaccination Programme), Joanna Saunders reported that there was no further national information. There was a national meeting convened for the following week from which feedback would be received.

Arising from Minute No. 61 (Joint Strategic Needs Assessment), Chrissy Wright gave clarification of the website address. A report would be submitted in due course on uptake.

Janet Wheatley reported that a consultation event was to take place on 27th January at the Unity Centre for the voluntary and community sector.

S65. COMMUNICATIONS

The following were reported:-

(1) Attendance at a meeting of specialist commissioners by Councillor Dalton.

(2) NHS England's Commissioning intentions had been received and would be circulated.

(3) Rotherham was 1 of 6 areas in the country that had successfully secured funding from the local area CCG and the Police and Crime Commissioner for a pilot initiative for mental health patients in custody. There would be mental health practitioners working alongside the Police and Council employees to identify those with possible mental health issues. An update would be submitted in due course.

(4) "Ramp up the Red" – a national Heart Town initiative – would run though the month of February.

S66. RMBC BUDGET - MEETING THE CHALLENGE

Pete Hudson, Chief Finance Manager, gave the following powerpoint presentation:-

The Financial Challenge
- The scale of financial challenges/risks facing local government was set to continue at least until 2017 (possibly a decade)
- From 2013/14 there had been increased financial risk transferred to local councils through the Local Government Finance and Welfare Reform challenges and restrictions on finances e.g. Council Tax Referenda
- Sustainable medium/long term financial planning was now even more critical

What this meant for Rotherham
- 2010/11 £5M (emergency budget)
- 2011/12 £30M
- 2012/13 £20M
- 2013/14 £20M
- 2014/15 £23M
- 2015/16 £23M (estimate)

Old Budget Principles
- Previous budget principles served the Council well in the past, however, in the context of the Government's Finance and Welfare Reform changes, a new approach was essential to meet future financial challenges:-
  Support Services pared to a minimum

Staff headcount reduced by over 1,000 and management posts reduced by 19%
Lean Council
No longer 'salami slice' services

New Budget Principles
The Council's budget had been developed to:-
- Focus on the things most important to local people
- Help people to help themselves wherever possible
- Provide early support to prevent needs becoming more serious
- Shift scarce resources to areas of greatest need including targeting services and rationing services to a greater extent than at present

What this meant for Rotherham
- Need to create an Investment Fund to focus on delivering Business Growth
- Not doing everything, providing fewer services directly and supporting more people needing help through forging partnerships with other public sector stakeholders, communities, businesses and citizens to help them to do more for themselves
- Using the limited and shrinking resources to tackle the biggest problems for the most needy, focussing on the 11 most deprived areas, accepting some would need to get less or less frequently
- Achieving the best quality, safest, most reliable outcome via the most affordable service delivery method
- Direct provision of service only where the Council was the cheapest/best quality solution to meet the critical needs of its citizens

Rotherham's 2014/15 Budget Challenge
Initial Funding Gap in Medium Term Financial Strategy
£19.1M
- June Spending Round adjustments
  +1.0M
- July Technical Consultation adjustments
  £0.4M

Additional Pressures
- New Government announcements
  +0.7M
  (reduced Housing Benefit grant/reduced Education Support Grant)
- Pensions Triennial Revaluation
  +1.5M
- Undelivered savings target 2013/14
  +0.3M

Revised Funding Gap
£23.0M

Meeting the Challenge: Savings Proposals 2014/15

- Directorate Savings Proposals
  £15.6M
- Central Savings Proposals
  £5.3M
- Revisions to Planning Assumptions
  £2.1M
- Total
  £23.0M

It was noted that the budget proposals were to be considered by Cabinet 5th March, 2014.

Discussion ensued on the presentation with the following comments made:-

- Important for all parties to share their budget proposals to enable collaborative working and achieve maximum impact for the funding available – also to ensure partners did not make budget cuts in the same areas
- Once the full list of all the saving proposals had been compiled Impact Assessments would be worked up to accompany the report to Cabinet to enable Members to be aware of the effect of the savings

Pete was thanked for his presentation.

S67. RMBC COMMISSIONING INTENTIONS FOR ADULTS AND CHILDREN'S SERVICES

Chrissy Wright, Strategic Commissioning Manager, gave the following powerpoint presentation:-

The Big Things – Adult Social Care and CYPS
- Early Intervention and Prevention
- Dependence to Independence
- Joint Commissioning and Integration
- Achieving Financial Efficiencies

Alignment with Health and Wellbeing Strategic Priorities
- Priority 1 – Prevention and Early Intervention
- Priority 2 – Expectations and Aspirations
- Priority 3 – Dependence to Independence
- Priority 4 – Healthy Lifestyles
- Priority 5 – Long Term Conditions
- Priority 6 – Poverty

Adult Social Care – Priority Activities
- Early Intervention and Prevention
  Growth of Connect to Support
- Dependence to Independence

Disinvest in residential care placements and invest in community-based services
- Joint Commissioning and Integration
  Better Care Fund identify current joint work and opportunities for a pooled budget with alignment with RCCG
- Achieving Financial Efficiencies
  Delivering the identified savings in the budget matrix

CYPS Social Care – Priority Activities
- Early Intervention and Prevention
  Partnership with Public Health on breast feeding and smoking cessation in pregnancy
- Dependence to Independence
  Deliver Support and Aspiration SEND reforms
- Joint Commissioning and Integration
  Building transition into the Better Care Fund programme
- Achieving Financial Efficiencies
  Deliver the strategic transformation intentions e.g. reconfiguration of Children's Centres

Discussion ensued on the presentation with the following comments made:-

- Children's Centres had been a flagship for the previous Government, however, the current Government had not provided funding for them. Due to the critical financial challenges faced by the Council, there was only funding for 1 more year
- Given the support for the 11 most deprived areas, many of which had Children's Centres and were a model of good practice, it was felt that closing them would be disastrous
- Just working in the 11 most deprived areas would not achieve the aims/aspirations across the board

Chrissy was thanked for her presentation.

S68. ROTHERHAM CCG PLAN 2014/2015

Robin Carlisle, Deputy Chief Officer, Rotherham CCG, presented the CCG's 5 year commissioning plan for endorsement prior to submission to NHS England on 14th February, 2014.

The plan had been developed in discussion with member GP practices, other Rotherham commissioners (RMBC and NHS England) and providers of health services in Rotherham (including TRFT and RDASH) and circulated to stakeholders. Comments received and the requirements of the planning guidance "Everyone Counts" had been incorporated into the draft.

Comments by Board members would be welcomed particularly on the following:-

- 5 year vision
- Plan on a page
- QIPP (Quality, Innovation, Productivity and Prevention) both Provider and System Wide

There was still work required by the February deadline with regard to financial implications, levels of ambition for outcome measures and Rotherham's approach to the Better Care Fund.

Discussion ensued on the document with the following comments made:-

- Important for all Service providers to understand/know the detail of what the implications were for their particular services and the chance to be involved
- Need to ensure all the plans being submitted to the various bodies all aligned and did not forget the transformational time required to make the plans happen

Resolved:- (1) That any comments on the plan be submitted to the CCG as a matter of urgency to enable the plan to be submitted to NHS England by the 14th February, 2014, deadline.

(2) That the Council and NHS England, as co-commissioners, confirm that the plan was complementary with their own commissioning plans.

(3) That TRFT and RDASH, as substantial providers of health services within Rotherham, confirm that the financial, activity and strategic vision in the plan triangulated with their 5 year organisational plans.

S69. BETTER CARE FUND

Tom Cray, Strategic Director Neighbourhoods and Adult Services, gave the following powerpoint presentation;-

Task Group Terms of Reference
- To work with members of the Health and Wellbeing Board to understand and interpret the requirements of the Better Care Fund
- To develop a local jointly agreed vision for integration
- To develop a plan to be signed off by the Health and Wellbeing Board and submitted to NHS England by 14th February
- To do any necessary further work to ensure the plan was adopted and being monitored by April, 2014

We Are Here:-
- The Health and Wellbeing Board has developed good relationships across the new health and care landscape
- Already agreed the joint priorities through the Health and Wellbeing Strategy informed by the JSNA

- The Health and Wellbeing Board have made a commitment to integration through the local Strategy
- Clear links to what needs to be delivered as part of the Better Care Fund
- Better Care Fund Plan would help deliver the Health and Wellbeing Strategy

Definition of Integration
- Adopt the nationally recognised definition of Integration:
  "I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me" ('National Voices')

Vision
- Ovearching vision of Health and Wellbeing Board: To improve health and reduce health inequalities across the whole of Rotherham
- The Better Care Fund would contribute to 4 of the strategic outcomes of the Health and Wellbeing Strategy:
  - Prevention and Early Intervention – Rotherham people will get help early to stay health and increase their independence
  - Expectations and Aspirations – all Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community
  - Dependence to Independence – Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances
  - Long-term Conditions – Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life

Measuring Success
- Develop 'I statements' as a common narrative to help us
  - Keep the voice of Rotherham people at the heart
  - Understand what integration feels like for service users/patients/carers
- Based on what people tell us – way of 'making it real'
- Influencing change through people's experiences
- Adopt this as a principle with aim to implement at a later date (drawing on lessons learned from national consultation)

Criteria for Selection of One Local Measure
Must have:-
- A clear, demonstrable link with the Joint Health and Wellbeing Strategy
- Data which was robust and reliable with no major data quality issues (e.g. not subject to small numbers – see "statistical significance" in next section)
- An established, reliable (ideally published) source
- Timely data available, in line with requirements for pay for

performance – this meant that baseline data must be available in 2013-14 and that the data must be collected more frequently than annually
- A numerator and a meaningful denominator available to allow the metric to be produced as a meaningful proportion or a rate
- A challenging locally set plan for achievement
- A metric which created the right incentives

Local Measure (choose 1 from 9 or select own)
- NHS Outcome Framework
  - Proportion of people feeling supported to manage their (long term) condition
  - Diagnosis rate for people with Dementia
  - Proportion of patients with fragility fractures recovering to their previous levels of mobility/walking ability at 120 days
- Adult Social Care Outcomes Framework
  - Social care related quality of life
  - Carer reported quality of life
  - Proportion of adults in contact with secondary, mental health services living independently, with or without support
- Public Health Outcomes Framework
  - Proportion of adult social care users who have as much social contacts as they would like
  - Proportion of adults classified as inactive
  - Injuries due to falls in people aged 65 or over (Persons)

Does the Local Measure meet the Better Care Fund Criteria?

Local Measure – suggested option
- NHS Outcome Framework
  - Possible new local measure
    Health Related Quality of Life for people with long term conditions, Indicator E.A.2 from the "Everyone Counts"
  - Proportion of people feeling supported to manage their (long term) condition

Next Steps
- To have a clear commitment from all partners to provide data and information as and when required
- To agree the local measure for pay-for-performance element
- Joint offer working group (LA/CCG/NHSE) to ensure we are meeting all national conditions
- Consultation with user/patients/providers
- Next Task Group meeting 31st January to look at:-
  - What is currently commissioned that does not improve Better Care Fund measures
  - What needs to be commissioned to meet the Better Care Fund measures and estimated costs
  - First draft of Better Care Fund Plan

Discussion ensued with the following points raised/clarified:-

- The task group comprised of Martin Kimber, Chris Edwards, Julie Kitlowski, Councillor John Doyle, John Radford and Tom Cray
- It was not new money but the funding currently allocated to the Local Authority and the CCG for Services provided to patients and the citizens of Rotherham
- A regional event had shown that Rotherham had made similar levels of progress as others with regard to the submission
- Challenge was to ascertain which Services met the outcomes and then how to prioritise to meet the Services currently commissioned

Tom was thanked for his presentation.

S70. JOINT PROTOCOL BETWEEN HEALTH AND WELLBEING BOARD AND CHILDREN'S SAFEGUARDING BOARD

Phil Morris, Rotherham Local Safeguarding Children Board (RLSB), submitted a proposed Protocol which outlined and confirmed the functions and responsibilities of Rotherham's key strategic partnerships i.e. the RLSB, the Children, Young People and Families Partnership (CYPFSP) and the Health and Wellbeing Board. It also set out the relationship between them, providing clarity and ensuring that the needs of children and young people in the Borough were identified and addressed at a strategic level:-

- The CYPFSP will formally report to the HWBB on the progress update against the relevant priorities (in line with the Health and Wellbeing Strategy) of both the CYPFSP and the key milestones and targets within the Children and Young People's Commissioning Plan

- The RLSCB will submit its Annual Report of the Health and Wellbeing Board

- The Health and Wellbeing Board will ensure that:
  The Joint Strategic Needs Assessment takes account of key areas for vulnerable children identified via the RLSCB Annual Report and the CYPFSP key priorities. The Director of Public Health had specific responsibility for this

- The Health and Wellbeing Board may also request that the CYPFSP and/or the RLSCB to consider issues for development, action or scrutiny

Resolved:- That the Protocol be approved and be put into operation with immediate effect.

S71. DATE OF NEXT MEETING

Resolved:- That a Special meeting of the Health and Wellbeing Board be held on Tuesday, 11th February, 2014, commencing at 9.30 a.m. in the Rotherham Town Hall.

HEALTH AND WELLBEING BOARD
11th February, 2014

Present:-

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
Jason Harwin	South Yorkshire Police
Brian Hughes	NHS England
Naveen Judah	Healthwatch Rotherham
Martin Kimber	Chief Executive, RMBC
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families Services
Dr. John Radford	Director of Public Health
Janet Wheatley	Voluntary Action Rotherham

Also in attendance:-

Helen Dabbs	RDaSH
Kate Green	Policy Officer, RMBC
Shona McFarlane	Director of Health and Wellbeing
Clair Pyper	Director of Safeguarding
Chrissy Wright	Strategic Commissioning Manager, RMBC
Keely Firth	CCG

Apologies for absence were received from Chris Bain, Louise Barnett, Karl Battersby, Tracy Holmes, Julie Kitlowski, Dr. David Polkinghorn and Joyce Thacker.

S72. BETTER CARE FUND

Kate Green, Policy Officer, presented Rotherham's Better Care Fund plan for approval by the Board, prior to submission to NHS England by 14th February. The documents to be submitted included:-

Planning Template Part 1 –
Planning Template Part 2
Appendix 1 - Summary of consultation
Appendix 2 - Rotherham Better Care fund Action Plan
Appendix 3 – Health and Wellbeing Strategy
Appendix 4 – Joint Strategic Needs Assessment
Appendix 5 – Overarching Information Sharing Protocol

Kate drew attention to the following:-

- A huge amount of work had been put in by officers from all agencies

- The work had been developed by a multi-agency officer group overseen by the Task Group which provided the strategic overview of the work

- Negotiations had taken place by both the Local Authority and CCG in order to produce a plan and action plan that both partners were fully signed up and committed to

- A range of consultation activity and engagement had taken place as well as collating information from previous consultation. This had included:-
  - Commissioning of Healthwatch Rotherham to conduct consultation with the local community on the envisaged transformation of services. The survey had been completed by 42 people between 31st December, 2014 and 14th January, 2014
  - 12 Council Customer Inspectors were asked a series of questions focussed around the proposed vision including the 4 Health and Wellbeing priorities
  - Emails sent to 305 social care providers in Rotherham inviting them to take part in a survey
  - The results from the Health and Wellbeing Strategy consultation that took place between July-August, 2012 to help shape the priorities
  - Patient Participation Network
  - Mystery shopper volunteers looking at the prevision vision, priorities and seeking their advice on Health and Wellbeing activities
  - Discussions at the Adult Partnership Board

- The findings from the consultation activity were used to develop a set of "I" statements , which demonstrate outcomes that local people want from integrated working:
  - I am in control of my care
  - I only have to tell my story once
  - I feel part of my community which helps me to stay healthy and independent
  - I am listened to and supported at an early stage to avoid a crisis
  - I am able to access information, advice and support early that helps me to make choices about my health and wellbeing
  - I feel safe and am able to live independently where I choose

- The vision for the plan had been based on the local Health and Wellbeing Strategy, A lot of work had gone into developing the local strategy which was being used to influence the plans of a range of partner organisations. The Better Care Fund, if used effectively, should contribute significantly to delivering against the Strategy's outcomes:
  - Prevention and Early Intervention
  - Expectations and Aspirations
  - Dependence to Independence
  - Long term Conditions

- The 12 schemes in the action plan (appendix 2) had been divided under the above 4 themes and the plan demonstrated which BCF outcome measures the schemes would help achieve

- Much more work was now required to add detail to the plan before final submission on 4th April, but the first draft provided the foundation to work from

Finance and Measures (Template 2)

- The funding information mapped directly to the action plan

- For each Metric other than patient experience, it detailed the expected outcomes and benefits of the scheme and how they would be measured

- There were 5 nationally prescribed metrics and one locally agreed measure:-
  - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population
  - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
  - Delayed transfer of care from hospital per 100,000 population (average per month)
  - Avoidable emergency admissions
  - Patient/service user experience
  - Emergency re-admissions (local measure)

- Targets had been set based on the national guidance provided. Further work would be required on them before the final submission in April

Next Steps

- The documents would be submitted to NHS England in accordance with the 14th February deadline with feedback expected by the end of February

- The officer group would continue to meet on a regular basis to further develop the plan and look specifically at the schemes, developing an action and delivery plan for each, identification of leads and timescales.

- The Task Group would also meet to give a strategic overview of the work and the financial plan which had to be submitted by 4th April

Brian Hughes, NHS England, stated that the process followed by Rotherham was what would have been expected. The assessment process was currently in the process of being finalised and once complete, he would ensure that Rotherham received it.

Every bid would have an initial assessment and then subject to a thorough assessment. Brian stated that he would give feedback by 28th February on Rotherham's submission. The bid may not have gone through the national or regional peer process by that date but it would have been subject to the joint assessment by ADAS and NHS England.

Discussion ensued on the presentation with the following issues highlighted:-

- Careful consideration should be given to the emergency readmission measure. It was noted that nationally a lot of Services were taken out of the metric. This has been highlighted on the Risk Register
- Monitoring of the action plan

The Chairman emphasised that it was not new money but money that was already in the system.

He thanked Healthwatch Rotherham, the mystery shoppers and the Patient Participation Group for their assistance in the consultation.

Resolved:- (1) That the Better Care Fund application and supporting documentation be approved for submission to NHS England in accordance with their 14th February deadline.

(2) That Councillor Wyatt, Martin Kimber and Chris Edwards sign off the submission.

(3) That an All Members Seminar be convened to ensure Members were fully informed with regard to the Better Care Fund.

(4) That consideration be given to monitoring of the action plan be given at the next Health and Wellbeing Board.

(5) That a press release be issued on Rotherham's submission.

S73. DATE OF NEXT MEETING

Resolved:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 19th February, 2014, commencing at 1.00 p.m. in the Rotherham Town Hall.

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**Thursday 13 March 2014**
3.	**Title:**	**Pharmaceutical and Medicines Waste**
4.	**Directorate:**	**Rotherham Clinical Commissioning Group**

5. Summary

The report updates Members on work in Rotherham to reduce pharmaceutical and medical waste.

6. Recommendation

That Members:

- **Note the contents of the report and the progress made in Rotherham in reducing costs.**
- **Note the proposed actions to work towards further reductions in waste.**
- **Agree to receive a future update on the progress of the actions outlined in Appendix 1.**

7. Proposals and Details

The Health Select Commission identified excess medication as an area to consider in the work programme for 2013-14. Appendix 1 provides an overview of current work in Rotherham to reduce waste and covers the following areas:

- Extent of the issue
- Savings achieved through service redesign
- Reducing waste in other areas of prescribing
    - Patients
    - Practices
    - Pharmacists
    - Residential and Nursing Care Homes

8. Finance

No direct financial implications from this report, but by reducing unnecessary waste the CCG and ultimately GPs can create savings which can be invested in other areas of healthcare.

9. Risks and Uncertainties

Past work to reduce waste has resulted in challenges from interested parties and it is anticipated that this would also be the case for any future measures to manage medicines waste more actively.

10. Policy and Performance Agenda Implications

Any policies developed to manage medicines waste must be patient focused and improve the patient experience and safety.

As for finance.

11. Background Papers and Consultation

Anecdotal evidence from patients and future engagment are referred to in Appendix 1.

Contact Name:
Stuart Lakin, Head of Medicines Management
NHS Rotherham Clinical Commissioning Group
Stuart.Lakin@rotherhamccg.nhs.uk

Appendix 1

Pharmaceutical and Medicines Waste

1. Key questions

How much is there?

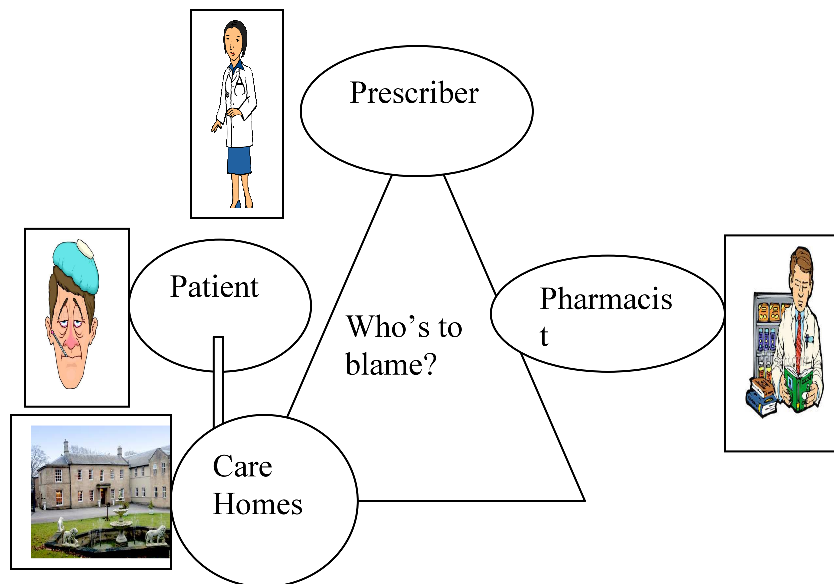
Whose fault is it?

What can we do about it?

2. Background

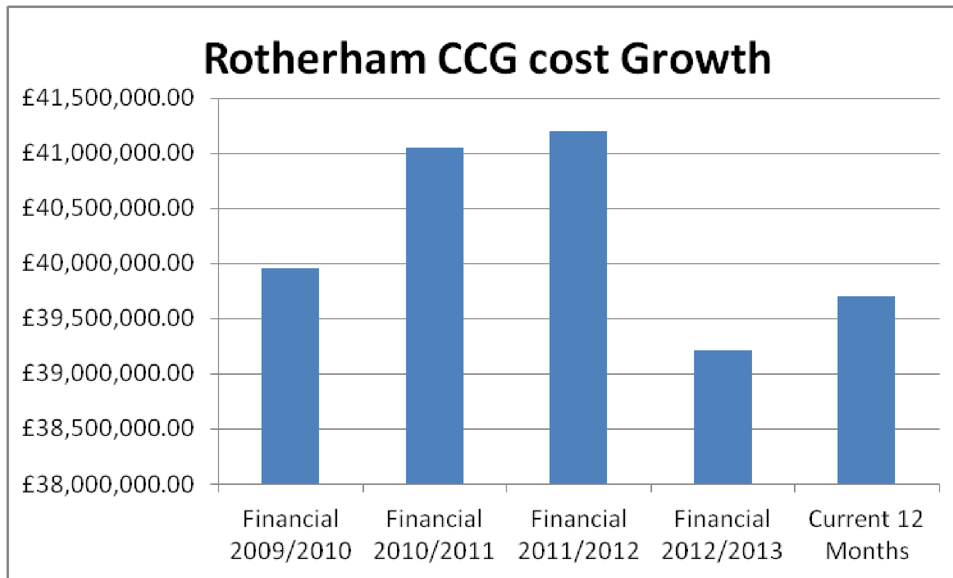
Medicines waste is a well documented problem, it is estimated that in England £300m of medicines are wasted each year, and that half of this is avoidable (Lin-Nam Wang The Pharmaceutical Journal Feb 2012).

That would equate to 1.5 million in Rotherham every year. However, it is not just about patients over ordering or patients requesting medication that they do not require, it is more complicated than that.



3. What's been achieved?

a Prescribing Costs



Five year prescribing cost growth = -0.63%

b Service redesign projects

Nationally 10.7% (£831,292,864.99/annum) of prescribing expenditure is on appliances (continence\stoma), nutritional supplements and wound care products.

In this area Rotherham has managed to significantly decrease the cost of prescribing whilst improving the patient experience.

Prescribing area	Management transferred to	Date
Nutrition Supplements & tube feeds	Dieticians	April 2006
Continence appliances	Continence advisor	April 2009
Gluten Free/Low Protein Products	Dieticians	September 2009
Stoma appliances	Expanded continence service	April 2012
Wound Care	District Nursing	Project ongoing

Summary of savings

Nutrition
It is estimated that if NHS Rotherham's nutritional expenditure had increased in line with national cost growth trends since the service redesign, then expenditure in 2012/13 would have been 89% higher resulting in a potential saving of £468,125/annum.

Continence
In the four years since the project started continence prescribing costs in England increased by 21.56% whereas in Rotherham costs decreased by -8.99%.

It is estimated that if NHS Rotherham's continence expenditure had increased in line with national cost growth trends, costs in 2012/13 would have been 30% higher resulting in a potential saving of £239,591.

Gluten Free
The management of the prescribing of gluten free products by the dietician resulted in a decrease in expenditure of - 19.61%, whereas nationally costs have increased by 20.63% resulting in a saving in 2012/13 of £107,998.

Stoma Prescribing
During 2012/13 in Rotherham stoma prescribing costs decreased from £964,687 in 2011/12 to £748,159 in 2012/13, a cost reduction £216,528, -22.45%, and average monthly expenditure was still trending strongly downwards at the end of the project. Whereas, across England EPACT data suggests cost increased by 6.48% over the same period.

If Rotherham costs had increased in line with those of England then expenditure for 2012/13 is predicted to have been £1,027,198 compared to the actual expenditure of £748,159 a potential saving of £279,039 27%.

Service redesign summary

These savings have been achieved by the improved management of prescriptions. In the case of appliances the GPs had lost control of the prescribing to the Direct Appliance Contractors (DACs). By regaining control considerable savings have been made which have been reinvested into service development. There is no restriction on product choice; in Rotherham patients get the product that is most suitable for them. Patient choice has probably been widened as patients now have access to a wider range of products by utilising the knowledge base of the continence nurses. In the case of nutrition the issue was inappropriate prescribing with patients not being appropriately assessed or reviewed. With dieticians managing the caseload these issues have been resolved.

It is estimated that these projects achieved savings totally £1,094,753 against Rotherham's 2012/13 prescribing costs.

4 Going forward - reducing waste in the remaining 90% of prescribing

a Patients

There is plenty of anecdotal evidence from health care professionals and pharmacy returns of patients stockpiling medication in their own homes.

The literature is full of articles that have counted, photographed and weighed this waste but there is next to nothing published on successful interventions that have effected a change in patient behaviour to prevent over ordering.
There are a number of advertising agencies that are selling CCGs medicines waste campaigns, but these campaigns lack outcome data. They can demonstrate that

patient awareness of the campaign and the issues of medicines waste as been raised. But they are unable to demonstrate that they have changed patient behaviour to prevent waste occurring.

But are patients solely to blame?

Patients understand that medicines waste is a waste of NHS resources; the majority of patients want the NHS to work well, patients are tax payers too.

Approximately 300 patient questionnaires were sent directly to patients in 2012. The returns did not reveal waste as an extensive problem and neither did it identify any causes of waste.

Continence and stoma patients reported that they were often in receipt of products that they did not require or in quantities that they did not need, but they were powerless to stop it, as requests to practices to change the prescription or to appliance companies not to order went unheeded.

Patients also report similar issues with pharmacists ordering medication but again requests to the pharmacist not to order or the practice to remove it from prescription are not acted upon.

Patients are also genuinely resistant to tell their doctor that they are not taking a particular medication; this mindset needs to be addressed.

This is however, all anecdotal evidence, work needs to be undertaken to ascertain how we can engage with patients in order to develop systems that will reduce the amount of medication that is wasted.

Action

- Working with NHS Rotherham's Patient Engagement lead it is intended to canvass patients views to get an understanding from the patient's perspective how and why waste happened.
- To plan a local communication campaign, to raise awareness about the problem and to encourage patients to report to practices medicines that they are receiving but not using.
- To ensure that practices are ready to act, if a patient informs them of medicines that they are not taking, will the practice.
    - Remove the item from the patient's prescription.
    - Have all "PRN" medication (pro re nata – as required) on the acute medicines screen to be ordered by the patient only.
    - Instigate a medication review with the patient if the medication that they report they are not taking is deemed important for their well-being.
- Establish a CCG helpline and e-mail where patients can report medicines waste in confidence, enabling them to enlist help from the Medicines Management Team (MMT) if they have been unable to prevent waste from occurring.

b Practices

The only intervention demonstrated to reduce medicines waste is the adoption of a 28 day prescription policy.

Research conducted in 2007 by the National Audit Office has shown home excess medicine stock values for patients who were prescribed a 28 day supply of a medicine to be one third less than those for patients receiving prescriptions to cover 56 days. By reducing unnecessary waste, the CCG and ultimately GPs can create savings which can be invested in other areas of healthcare.

Several schemes which have shown drug cost savings when 28 day dispensing has been introduced – Grampian (16% cost savings), East Surrey (13% cost savings) and New Zealand which saved NZ$44m in 1995/96 based on 85% of prescriptions dispensed monthly.

A further study conducted by Bradford University in 1995 looked at waste medication returned to 30 out of a possible 76 community pharmacies in the Kirklees (Huddersfield) area over one month. It revealed that there was a linear correlation between mean values of returns and prescription length. It was estimated that there would be a reduction of 34% in the cost of waste medication by changing the prescription duration to 28 days. On extrapolation of the total cost of returned waste medication, it was concluded that the total waste per annum throughout Kirklees would be in the region of £80k and if extrapolated through the region would amount to in excess of £4.2m. The cost of returns was shown to increase exponentially with the duration of the prescription, in other words the longer the prescription length the greater the amount of waste.
(Source: Hawksworth, Wright & Chrystyn; Journal of Social & Administrative Pharmacy: Vol 13, No. 4 1996.)

34 of Rotherham's 36 GP practices have a 28 day prescribing policy.

Are practices repeat prescribing systems robust enough to prevent waste?

Patients have reported that when they inform a practice that they are no longer taking a particular medication it still keeps coming. Clearly if we are successful in empowering patients to report waste practices must have systems in place to respond.

Action

- MMT to work with practices to review repeat prescribing policies to ensure
    - They do not encourage waste
    - As required medication is not issued regularly
    - If patients report waste if can be acted upon

c Pharmacists

Pharmacies' ordering on behalf of the patient has become widespread over recent years.

Pharmacies promote this as a convenience for the patient and will defend the patient's choice to allow them to order their medication.

The advantage to the pharmacy is that they have guaranteed custom. As the patient no longer sees their prescription it is difficult for them to take back control once it has been surrendered.

Anecdotally patients report

- That they never requested for the pharmacy to start ordering their medication.
- They signed up for a service that was not explained to them.
- Pharmacies fighting over patients each claiming that the patient is theirs.
- Receiving of medication that they do not require.

Practices report the same issues but in addition

- Pharmacies requesting prescriptions for items no longer on the patient's prescription due to a medication change, because the prescription had been dispensed in advance in anticipation of the prescription.
- Problems occurring with pharmacies not ordering medication that has been recently initiated as it is not present on the right hand side of the original prescription.

The MMT have audited pharmacy ordering across six Rotherham practices. The issues uncovered are.

- Pharmacists failing to contact the patient before ordering to clarify what is required.
- Pharmacists regularly keeping the right hand side of the prescription, resulting in the patient missing practice messages and failing to make appointments.
- Prescriptions being ordered 28 days in advance of when required.
- Medicines waste due to the regular ordering of as required medication.
- Patients complaining of a loss ownership over their medication.

These failings were not consistent across pharmacies; some demonstrated more robust ordering systems that others.

However, pharmacy patient ordering systems have been developed independently of GP practice repeat prescribing systems and these together are not always serving the patents well.

One Rotherham practice has stopped pharmacies ordering for patients. The MMT is working with this practice to ascertain the effect this policy has on;

- Patients, the practice has requested details from the pharmacy of any vulnerable patients that may require assistance in ordering their medicines.
- Impact on waste
- Patient's opinion on not allowing pharmacy's to order medication.
- Impact on the practice workload.

Action

- Evaluate the outcomes of the practice that has taking back patient medicines ordering.
- To undertake a patient engagement exercise with patients to ascertain how they value pharmacists ordering medication for them
- Develop with practices and pharmacies "A Pharmacy patient ordering policy" that is patient centred.
- Develop an audit process to ensure adherence to any future NHS Rotherham CCG pharmacy patient ordering policy

d Residential and Nursing Homes

Most care homes order a complete new prescription for every item on a patient's prescription each month. Any unused medication, sometimes even unopened medication, is returned to the pharmacy for disposal. Such systems have developed for ease and often patient safety is cited, with medication dispensed in a monitored dosage system (MDS). These practices can be very wasteful but there is no incentive for care homes to invest resources into managing or reducing medicines waste and CCGs have no mechanisms available to them to insist that care homes manage medicines differently.

5 Barriers

The English community pharmacy contract and the funding mechanism for care homes and carers provide no incentives for reducing medicines waste.

The work that NHS Rotherham CCG has undertaken on nutrition, appliances and wound care faced a number of challenges from interested parties and the threat of legal action was made by several commercial companies and a trade association.

Any measures to manage medicines waste more actively would likewise be challenged by interested parties.

NHS Rotherham CCG to take this work forward must;

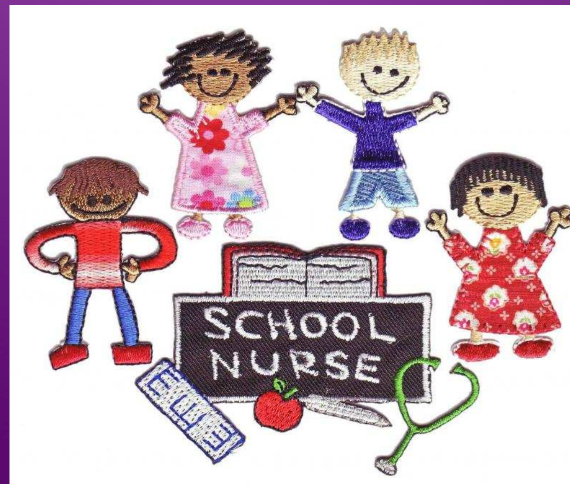
- Actively engage with patients and seek their opinion and ensure that any polices developed to manage medicines waste are patient focused and improve the patient experience and safety.
- Ensure that prescriptions are not directed to any particular pharmacy, all contractors must be treated with equity.

Stuart Lakin
Head of Medicines Management
NHS Rotherham CCG **February 2014**

Rotherham Public Health

Changes to the Rotherham School Nursing Service

Anna Clack



Rotherham Metropolitan Borough Council
Where Everyone Matters

Purpose of the presentation

- To support the progress in updating the Rotherham School Nursing Service specification
- To understand the national drivers and requirements
- To understand the role of the school nursing service and expectations

Rotherham Public Health
Rotherham Metropolitan Borough Council
C2 Riverside House, Main Street Rotherham S60 1AE
Telephone: 01709 255840 • Email: publichealth@rotherham.gov.uk • Web: rotherhampublichealth.co.uk

Healthy Child Programme 5-19

Core ambition to have children and young people who are happier, healthier and ready to take advantage of positive opportunities and reach their full potential…

- **Framework for universal and progressive services for prevention and early intervention.**
- **Key role is to identify children with high risk and low protective factors**
- **Partnership working to develop high quality services.**
- **Effective use of resources informed by a local needs assessment**
- **Delivered to local population regardless of school status- academy's, educated at home**
- **Evidence based programmes.**

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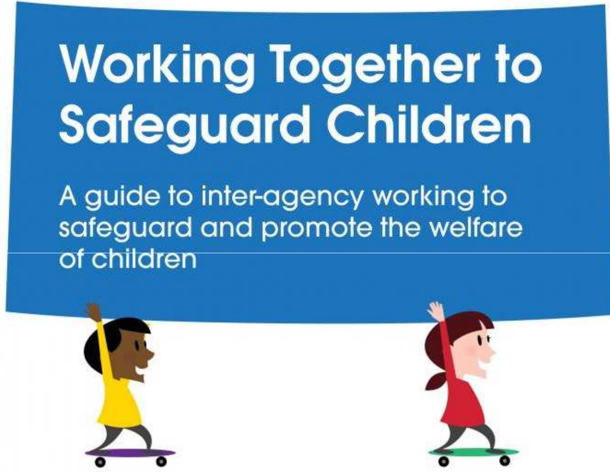
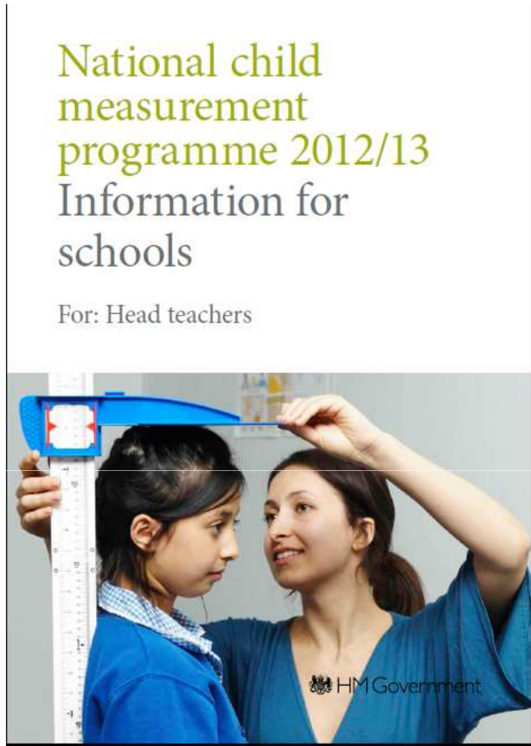
National Guidance



March 2010

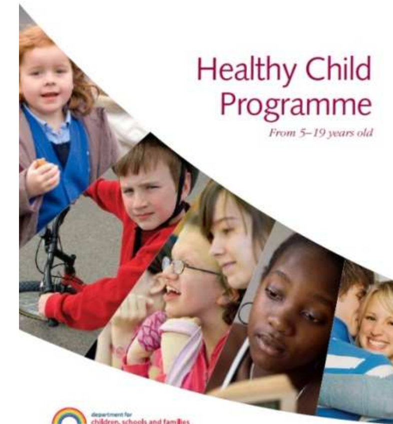
National child measurement programme 2012/13 Information for schools

For: Head teachers



You're Welcome
Approved

Healthy Child Programme
From 5–19 years old



Getting it right for children, young people and families

Maximising the contribution of the school nursing team: Vision and Call to Action

Rotherham Public Health
Rotherham Metropolitan Borough Council
C2 Riverside House, Main Street Rotherham S60 1AE
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Where Everyone Matters

Getting it right for children and families-

an opportunity to…

- **revitalise the profession**
- **review and revise local services**
- **reaffirm School Nurses as leaders and key deliverers on public health**
- **develop a framework for local service delivery**
- **involve children & young people in service development**
- **provide a service that is 'in synch with the way young people live their lives'**

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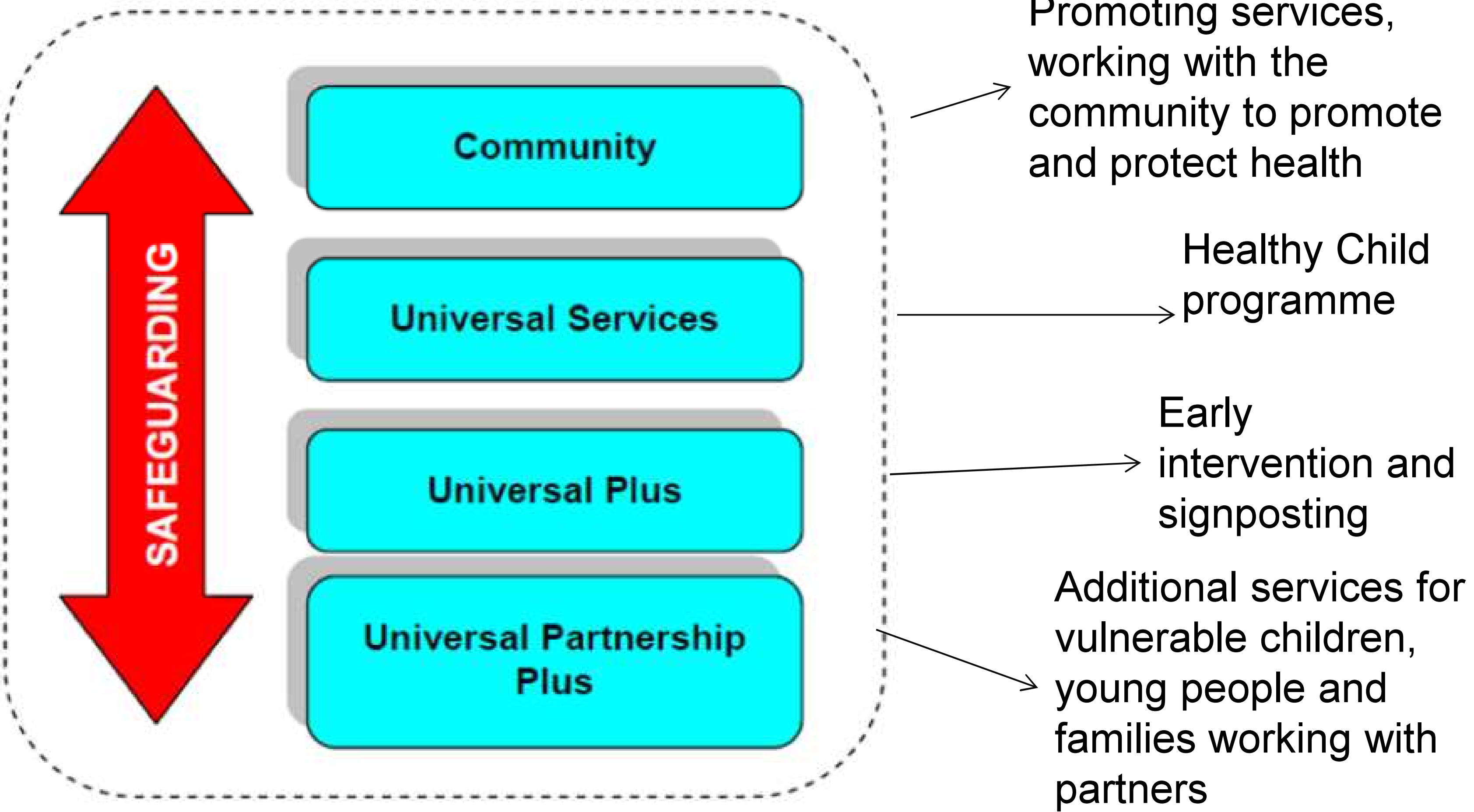
Getting it right for children, young people and families



Promoting services, working with the community to promote and protect health

Healthy Child programme

Early intervention and signposting

Additional services for vulnerable children, young people and families working with partners

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Outcomes measures for Children, Young people & families

- **Improved emotional wellbeing of looked after children**
- **Reduced School absences**
- **Reduced excess weight**
- **Reduced under 18 conceptions**
- **Reduced chlamydia prevalence in 15-24 year olds**
- **Reduced smoking prevalence**
- **Reduced alcohol and drug mis-use.**
- **Reduced tooth decay in 5 year olds**
- **Population vaccine cover**

Public health outcomes framework (DH 2012).

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Rotherham Metropolitan Borough Council
Where Everyone Matters

Where we are now…

Some examples of how the Rotherham School Nursing Service is achieving elements of the national vision…

- Delivering elements of Healthy child programme
- Key professionals in safeguarding children and young people
- **NCMP- offering targeted advice and support**
- Integrated HV and SN team to support seamless transition
- **Delivery of efficient and effective vaccination programmes**
- Use of system one to evidence outcomes.
- Working in partnership on early help strategies
- Offering and coordinating targeted support for children and families- CAF's
- Use of the 4 level service model to categorise need in caseloads on SystmOne e.g. universal plus
- Working with agencies to promote emotional health at tier 1.
- Offering sign posting and support on sexual health
- 'Brief interventions' to promote healthy lifestyles.

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What does a good Service look like?…

- A high quality evidence based service
- An appropriately skilled School health team.
- Efficient delivery of our local service model
- Involvement of children, young people & families and stakeholders in development, review and evaluation.
- All children & young people from School entry age have access to a skilled public health nursing service.
- Working in partnership to get best outcomes.
- School Nursing recognised as a career opportunity.

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Rotherham Metropolitan Borough Council
Where Everyone Matters

The updated Rotherham Service Specification

- Focuses on quality health improvement (outcome measures)
- Is detailed and more prescriptive than the previous specifications
- Has to acknowledge the intense work of the vaccination programme and National Child Measuring Programme.
- Recognises the separate commissioning of the vaccination programme (NHS England responsibility)
- Ensures children & young people from School entry age have access to a skilled public health nursing service
- Will deliver the specification (still subject to contract negotiations) with a 10% reduction in the service contract budget

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Rotherham Metropolitan Borough Council
C2 Riverside House, Main Street Rotherham S60 1AE
Telephone: 01709 255840 • Email: publichealth@rotherham.gov.uk • Web: rotherhampublichealth.co.uk

Any Questions

Rotherham Public Health
Rotherham Metropolitan Borough Council
C2 Riverside House, Main Street Rotherham S60 1AE
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Rotherham Metropolitan Borough Council
Where Everyone Matters

SERVICE SPECIFICATION

Service	Rotherham School Nursing Service
Commissioner Lead	Rotherham Metropolitan Borough Council (Director of Public Health)
Accountable Lead Provider	The Rotherham NHS Foundation Trust
Period	1st of July 2014 – 30th June 2017
Date of Review	July 2015
Version	Version 9

1. PURPOSE

The Rotherham School Nursing Service aims to provide high quality community based services for all children, young people and their families and carer's who are resident in the Borough of Rotherham and attend a Rotherham School up to age of 18, with the aim of helping them to achieve their optimum health and well-being.

The Service will deliver the national Healthy Child Programme 5 – 19 years. This good practice guidance sets out a framework of universal and targeted services for children and young people. It has established the context for the emphasis of the school nursing provision to be on using holistic health assessment skills to establish where early intervention and preventative (or "early help") public health skills should be directed, enabling a more responsive service to be delivered based on need and in partnership with health visiting, schools, primary care and others. In addition, the Service will contribute to early help working, child protection and safeguarding of children in accordance with the policies and procedures of the Rotherham Local Safeguarding Children Board.

The School Nursing Service is to be strongly integrated with the Health Visiting Service, the Family Nurse Partnership Programme and multi-agency Early Help services led by the local authority (including the Families for Change initiative); will ensure a seamless level of care and multi-agency teams to strengthen integrated working across the Healthy Child Programme 0 – 19 pathway of care.

The fundamental role of the School Nurse is to improve children and young people's health and wellbeing, providing a health response that is appropriate to their identified health needs, by:

- Leading, delivering and evaluating preventative health services and universal public health programmes, as set out in the Healthy Child Programme 5-19, for school aged children and young people both within school and community settings.
- Supporting and where appropriate delivering evidence based approaches and cost effective programmes or interventions that contribute to children and young people's health and well being e.g. Supporting Tier 1 CAMHS work e.g. behaviour and parenting support where appropriate, contributing to a reduction in childhood obesity, under 18 conception rates, delay onset and problematic use of alcohol and prevention of sexually transmitted infections. Using a care pathway approach, School Nurses where appropriate will co-ordinate relevant services, support young carers, refer to other agencies and where necessary delegate within the team to maximise resources and utilise the expertise of other skilled professionals.
- Supporting the interface between primary and secondary care to ensure a seamless transition into school, from primary to secondary school and transition into adulthood (as appropriate).
- Interacting with education regarding the child or young person's health and wellbeing, including emotional health and wellbeing which are important for the achievement of optimal education. Principally this will be achieved by contributing to a robust assessment to ensure that the

commissioning of more complex acute interventions is proportionate, timely and achievable. In partnership with Special Schools' Nurses, School Nurses provide health support for children and young people who have complex and/or additional needs and long term conditions including providing support to improve their life chances.

- Preventing abuse and neglect. This will include participation in safeguarding procedures or the Family CAF process where specific health needs have been identified, either both physical/ and emotional or both.
- Playing an active role in supporting the health needs of Looked After Children (LAC). School Nurses will work closely with LAC Healthcare team ensuring that health assessments are timely, effective and of sufficient quality to support the child/young person. Their work may involve supporting or signposting to evidence based parenting programmes to sustain improvement for children and young people.
- Utilising a variety of technology and media to enhance (not replace) existing service provision including SMS texting facilities to support drop-in and appointment delivery

In summary, the School Nursing Service is a service for all children between the ages of 5 and 19 which aims to increase the health, well-being and safety of children and young people in Rotherham. This will be achieved by working in partnership with children and their families offering a range of interventions that include, parenting advice, advocacy and public health promotion.

2. Scope

Rotherham Metropolitan Borough Council (RMBC) is committed to ensuring that a high quality, comprehensive, integrated, community based Child Public Health Service is available that ensures the early detection and treatment of relevant conditions and issues that impact upon children. The Child Public Health Service will directly influence the achievement of the strategic objectives set out in Rotherham's Early Help Strategy. These are:

- To identify the health needs of children, young people and their families and carers (across the continuum of need).
- To understand and respond quickly to the health needs of children and young people and families and carers (across the continuum of need).
- To support the re-focusing of resources from crisis intervention to prevention (from find and fix to predict and prevent), including working with partner schools to support children who may be at risk of sexual exploitation.
- To mitigate the effects of child poverty (including health inequalities focussing on the 11 deprived communities –see Appendix A), particularly in vulnerable groups such as Looked After Children or children with additional health needs by supporting families and carers to fulfil the child or young person's potential.
- To provide the context for multi-agency partnerships to work together to improve outcomes for children, young people and families for generations to come.

The scope of this approach will support the achievement of better health outcomes for children and families as outlined in the Rotherham Children and Young People's Plan. In addition it will lead to a reduction in health inequalities (Health and Well-Being Strategy) and improved life chances by ensuring that children and young people are given the best opportunity to reach their full potential through a focus on the 5 Every Child Matters Outcomes of:

- Being healthy
- Staying safe
- Enjoying and achieving

- Making a positive contribution
- Achieving economic well-being

This service specification is intended to provide the framework for a modernised School Nursing Service to deliver the national vision set out in the School Nurse Development Programme (DH, 2012 Getting it Right for Children, Young People and Families: maximising the contribution of the school nursing team vision and call to action) and describes the service which the Commissioner expects to be delivered and maintained throughout the period of the contract. It follows that the Provider should notify the Commissioner promptly of any in year failure to deliver the services as specified or any capacity and demand issues arising from the implementation of this service specification. Significant changes in service will be subject to a formal agreement to vary the contract.

2.1 Aims and Objectives of Service

2.1.1 Aim:
The overall aim is to ensure children, young people, families and carers are offered a core programme of evidence based preventative health care with progressive care and support for those who need it.

2.1.2 Objectives:
The Service will:

- Review children at school entry, Year 7 and when they move into Rotherham, by gathering information from children, parents, teachers and health professionals e.g. Health Visitors. Invite any child where concerns have been expressed around development, ill health or safety for a face-to-face contact and assessment of need.
- Undertake the National Childhood Measurement Programme with children in Reception and Year 6 class groups.
- Identify children who are overweight or underweight, offer targeted support to achieve a healthy weight and signpost or refer to specialist services and weight management programmes.
- Participate in the delivery of the Rotherham Looked After Children (LAC) and Care Leavers (CL) Service by undertaking health assessments of children aged 5 to 19 in accordance with statutory guidance and the requirements set out in the separate Looked After Children and Care Leavers Service Specification 2012-2015.
- LAC and CL review health assessments will be in line with local and national expectations with health plan being agreed and shared with relevant partner agencies, the young person and the carer.
- Provide school and teaching staff with the information they require to appropriately manage children in school with health care plans relating to identified needs e.g. allergies, asthma, medical conditions.
- Offer universal hearing screening of all children in reception year class groups.
- Support children presenting with nocturnal enuresis through simple interventions.
- Provide school and teaching staff with information and appropriate support to deliver Sex and Relationships Education in school

Monitor children in mainstream schools with additional/special needs and support communication between the school and the relevant health provider regarding health assessments and any multi-agency Family CAF that is instigated (leading if appropriate) as a consequence.

- Work with the designated school safeguarding lead and local authority services with regard to children with a Family CAF, Child in Need or Child Protection Plan and young people at risk of sexual exploitation, providing health assessment and reports if appropriate, to inform progress. As appropriate direct work with families providing support, as detailed in the Plan to reduce the vulnerability of children.

- Support the early identification of children with additional needs and develop and implement early

intervention strategies as part of a 'Team Around the Family' to improve outcomes and prevent further escalation of issues through the use of the Family Common Assessment Framework (FCAF) and support for multi-agency Team Around the Child/Family processes.

- Provide information, guidance and support on a one to one basis, where required, to children and young people, their parents and carers, to promote a healthy lifestyle. This will include emotional health and wellbeing, including: Tier 1 CAMHS (identification and referral), stopping smoking advice, drugs and alcohol advice, promoting physical activity, healthy eating, sexual health advice and services including C-Card (Hardwear), signposting for Chlamydia screening, pregnancy testing and emergency contraception. The School Nurse Service will refer to specialist services as appropriate.

2.2 Expected Outcomes including improving prevention
The Service will support the delivery of public health outcomes set out in the national Public Health Outcomes Framework:
Improved:
- Readiness for School
- Emotional wellbeing of looked after children

Reduced:
- School absences (by working in partnership with the Education Welfare Officer)
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions due to intentional or deliberate injuries
- Under 18 conception rates
- Chlamydia in 15-24 year olds
- Smoking prevalence in 15 year olds
- Alcohol misuse
- Substance misuse

Further work will be undertaken on outcome measures linked to the Joint Health and Well-Being Strategy and Rotherham Children and Young People's Plan.

Domain 1	Preventing people from dying prematurely	Y
Domain 2	Enhancing quality of life for people with long-term conditions	Y
Domain 3	Helping people to recover from episodes of ill-health or following injury	Y
Domain 4	Ensuring people have a positive experience of care	Y
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	Y

2.3 Evidence Base
The strong evidence for the Healthy Child Programme is set out in Health for All Children (Hall and Elliman, 2006) and underpins the core programme which has been supplemented by NICE guidance. The list below is not exhaustive and the service is expected to demonstrate that it has systems and processes in place to take account of emerging published evidence and best practice guidance.

- Getting it Right for Children, young people and Families: Maximising the contribution of the school nursing team: Vision and call to action (DH, 2012).
- Healthy Child Programme 5 – 19 years (DH & DCSF, 2009)
- Rotherham Children and Young People's Plan (2013-2016)
- Rotherham Early Help Strategy (2012-2015)
- Rotherham Health & Wellbeing Strategy (2012-2015)
- Rotherham Families for Change Delivery Plan (April 2012-2015)

- No Health Without Mental Health (DH, 2011)
- Healthy Lives, Healthy People: Our Strategy for Public Health in England (DH, 2010)
- National Child Measurement Programme Guidance for Primary Care Trusts (updated annually)
- "You're Welcome" Quality Criteria for Young People Friendly Health Services (DH, 2011).
- Green Paper Support and Aspiration: a New Approach to Special Educational Needs and Disability (DfE, 2011)
- Working Together to Safeguard Children (DfE, 2013)
- Statutory Guidance on Promoting the Health and Wellbeing of Looked After Children (DH 2010)
- Healthy Lives Healthy People: A call to Action on Obesity in England (DH 2011)

2.4 Service Description

The School Nursing Service is the core Public Health service for school age children in Rotherham, guiding parents/carers and helping to give all children a healthy start in life. The School Nursing Service will deliver the Healthy Child Programme 5 – 19 years through needs led universal and targeted provision working with children young people and their families, including children who are subject to school exclusion, home tutored and children not in a school setting, together with Looked After Children.

"Getting it right for children, young people and families" (DoH 2012) sets out a four level model with safeguarding as a theme through all levels. These levels outlined below describe the continuum of support children and young people in Rotherham can expect to receive through the School Nursing Services and multi-disciplinary working and are listed below.

Your School – Your Community

- School Nursing will, act as "*local leaders for health for the school aged population and their families"* work as part of the school and family of schools and the wider health, local authority and voluntary services to improve the health and wellbeing of the school aged population and their families.

Universal Provision

- The School Nursing Service will lead and co-ordinate the delivery of the Healthy Child Programme for the health and wellbeing of the school and community within a defined school cluster area.
- **The Universal provision is:**
    - To undertake holistic health assessments, promote health and contribute to safeguarding the school age population.
    - To offer advice and support to individuals and groups of children, young people and the adults who care for them ensuring they are referred to the appropriate health and social care provision; or receive effective health management support from the School Nursing Service.
    - To use the 'Make Every Contact Count (MECC) philosophy, Support Practitioners should be able to demonstrate level one competency, School Nurses level 2, in line with the local framework.
- **All Schools irrespective of need receive a core offer:**
    - Health leadership for the school, and learning community provision.
    - A formal handover of care from the Health Visiting service for children who have identified health or social care needs to ensure an integrated and seamless level of care.
    - School Entry, Year 7 and on moving into Rotherham, Holistic Health questionnaire and targeted intervention should the needs indicate this.
    - Where there is a health specialist service involved with a school child the School Nurse will respond by completing a holistic health review as appropriate and liaise with the school and specialist agency.
    - Children with health needs that impact upon their ability to learn will be supported through health assessment and reviews to manage their health condition.
    - Development of coordinated actions in response to Public Health priorities as identified in the school health profile with particular emphasis to support the school in their responsibilities to promote health.

A response to Public Health Priorities as they arise (there is an acknowledgement that Commissioners/Providers would agree priorities for core work if the public health priorities were to be sustained over a period of time)

Universal Plus (Health only response)

- The School Nursing Service will respond to the identified health needs in a timely and organised way to minimise the impact of the health condition and improve the child's ability to actively participate in school life and increase attainment.
- The School Nursing Service will support public health initiatives within schools for example reducing teenage pregnancies and the prevention of sexual exploitation.
- The Universal Plus provision is for children who have a health need that can be responded to by the School Nursing Service or the wider health provision.

Universal Partnership Plus (Vulnerable or Complex Families on Rotherham's Continuum of Need)

- The School Nurse will provide health *leadership* and work in partnership with the school, learning community, other health and wider early help and social care provision to ensure that a child has their health and wider social care needs met. There will be a named School Nurse for each School Learning Community with team coverage for absence.
- The *Universal Partnership Plus* provision is for children and families that have complex health and wellbeing needs that warrant a multi-agency response; this may include families that are identified as part of the Families for Change cohort
- Where the needs are predominantly health-related the School Nurse can act as lead professional for the Family CAF process if they are deemed the most appropriate.

2.5 Safeguarding

- The School Nursing Service is responsible for their contribution to the safeguarding process, and will follow the guidance and pathways developed through the Rotherham's Local Safeguarding Children Board.
- It is recommended that further work is undertaken with the wider safeguarding team, including TRFT, Named Professionals for safeguarding to utilise a holistic health assessment tool for children subject to a Child In Need or Child Protection Plan that can be used for evidence in terms of quantifying the child's health needs, and associated care plans that will follow. It is assumed that this documentation will release the School Nurse from attending unnecessary core group and other meetings if there are no current identified health concerns. The School Nurse will always be expected to attend initial and first review child protection case conferences.
- If health needs are identified the School Nurse will assist in the development of a care plan and in the assessment and review process, until such health needs are met.
- If further referrals are made to the School Nurse re health issues, the School Nurse will complete a new assessment and assist the care planning process as part of the overall child protection/child in need plan. This will be part of a time limited (evidenced based) intervention.
- The School Nursing Service will support the identification of any Private Fostering arrangements and ensure these are referred into social care as a matter of urgency.
- Where a case is being stepped-down from social care led support to multi-agency Early Help services the School Nurse will participate in the Family CAF process, leading if appropriate

2.6 Looked After Children and Care Leavers

- The School Nursing Service has a responsibility to support the delivery of the Looked After Children and Care Leavers Service Specification by undertaking local health assessments within statutory guidance for children aged 5 to 19.
- The School Nurse will be a proactive health advocate for LAC ensuring that their identified health needs are met within the health system and escalating any barriers efficiently and effectively.
- The Schools Nurse will be expected to engage with the Independent Reviewing Officer (IRO) for a LAC, including contributing to the review process.

2.7 Accessibility / Acceptability

The School Nursing Service aims to provide high quality community based services for all children, young people and their families and carer's who are resident in the Borough of Rotherham and attend a Rotherham School, with the aim of helping them to achieve their optimum health and well-being. The Service will liaise with further education providers to ensure effective communication/transition for

vulnerable young people.

The School Nursing Service is offered to all children and young people who are a resident in the Borough of Rotherham and attend a Rotherham School up to the age of 18 years. The Service has to be flexible and delivered in the most appropriate setting dependent on the needs of the child / young person including schools, the home, clinic and GP practice settings and other community based settings as appropriate.

RMBC has a single equality scheme which ensures that people are not treated less favourably on the basis of their age, disability, gender, racial group, sexual orientation, religion or belief

- The Service will work in partnership with parents and carers and in an integrated way with other agencies
- The Service will be flexible and responsive, adapting to the individual needs of children and families in terms of their circumstances, e.g. strengths, level of risk, culture, ethnicity, language and disability.
- The Service will be required to evidence effective working arrangements with a range of local services to deliver evidence based progressive interventions.

2.8 Whole System Relationships and Interdependencies with other services

The School Nursing Service is linked to other Children's Services (Community and Hospital), Child and Adolescent Mental Health Service (CAMHS), Public Health, Sexual Health Services, Local Authority Services, Schools, Primary Care and the Healthy Settings Team and representatives from:-

- NHS Rotherham Clinical Commissioning Group (CCG)
- The Rotherham NHS Foundation Trust
- GPs, Community Paediatricians, Health Visiting Teams, other Primary and Secondary Care Staff
- Extended Schools, Teachers and support staff, Children's Centres and Nurseries
- Rotherham Metropolitan Borough Council – adults' and children's services, Integrated Youth Support Services, Housing Services and Early Help Services, including Educational Psychologists and Behavioural Support Staff
- The local voluntary and community sector

Working together across all these services is important for disadvantaged children and those with additional needs. Wherever possible consideration should be given to the co-location of services and the use of one multi-agency plan (Family CAF) for families where the threshold is met.

The service will ensure that policies and procedures relating to safeguarding are adhered to and that the School Nursing workforce has undertaken training appropriate for their professional role. All School Nursing staff working with children and young people are required to have a Disclosure and Barring Scheme check undertaken by their employer.

2.9 Relevant Networks and Screening Programmes

Healthy Child Programme 5 to 19
National Child Measurement Programme
Rotherham and Young People Partnership
Think Family Partnership
Early Support Panel
Child Health Programme Board
Children's Health Services Professional Forum
Rotherham LAC Quality Assurance Group

This is not intended to be a complete list.

3. Service Delivery

- The Service is equitable in provision and responsive to varying patterns of need across the Borough to help address health inequalities and early identification and intervention.
- The School Nursing team will comprise members who have the competency to provide a service that covers all the key priorities (see also 2.4 Service Description). The service will cover all children and young people aged 5-19 who are resident in the borough of Rotherham and attend a Rotherham school up to the age of 18 and includes children being home schooled, and children placed in Rotherham from other areas e.g. LAC.
- The Service will develop strong working relationships with nurses working in Special Schools, the Looked After Children's nurse, Child Sexual Exploitation nurse, the Youth Offending Services Nurse Practitioner and Specialist Nurses supporting those with Long Term Conditions and disability, thus enabling all children and young people to fully engage and access services and provision.

Care and Referral Pathways will be developed to outline the appropriate involvement of the School Nursing Service and will include:

- Primary Care - for referral to and from primary care and to identify those children who

have consistently defaulted and not completed the childhood immunisation schedule including school booster and HPV vaccination.
- Schools – including referral pathway for repeated school absence due to ill health, (this will be in partnership with the Education Welfare service), and a referral pathway for families who meet the criteria for the Families for Change initiative.
- Cascading training within the service to ensure all staff are familiar with pathway and referral processes including; weight management, substance misuse, sexual health, continence management, bereavement support, emotional and mental health, asthma, eczema and for young people with disabilities and complex needs.
- The Health Visitor to School Nurse handover of care to be to be used to identify those children who have health needs, or who are vulnerable with an effective verbal handover and transfer of information to ensure a smooth transition.

All GP Practices and each school learning community to be supplied with the contact details of the School Nursing Service to facilitate effective and timely communication.

The following clarifies the key priorities of work:

Health Leadership (Your School Your Community)	
Activity	**Action**
Provide health leadership at a learning community level to ensure the health needs of the school age population becomes a priority and is addressed through the new school health and wellbeing responsibilities.	• Through analysing the health reviews, and the locality health profiles work in partnership to include health needs within school planning. • Identify health themes and needs to enable the school to prioritise health actions. • Support the school to fulfil their health duties through the provision of appropriate information.
Promoting the School Nursing Service	• As part of the transition process to secondary school the School Nurse will actively promote the School Nursing Service to the school and pupils through universal means. A brief description of the role of the School Nursing Service and contact details to be displayed on notice boards in schools
Identifying Health Needs ***(Universal Provision)***	
Activity	**Action**
Completing Rotherham wide School Entry and Year 7 Health Review pathway and to develop a pathway for all children and young people to be identified for a health assessment.	• Undertake a standardised holistic health assessment through the school entry review including targeted hearing test if there is an identified concern. • SNs will implement a holistic health assessment pathway for all Year 7 children to establish their health and needs at this transition point. The assessment will commence at the start of secondary school provision and if appropriate a health management plan should be in place. • Pathways for identifying children and young people who may require a health review and/or further support should be identified and promoted to other health professionals, practitioners and schools. • Identify those children who will require additional support in managing their health condition and provide support as appropriate.

National Child Measurement Programme	• SN team will book the NCMP measurement schedule with the school to enable the school to plan. • SN team will deliver the NCMP according to the NCMP delivery requirements • SN team will provide advice and support to children and parents following the results letter and signposting or refer to weight management services as appropriate
Provide health input to support children who have health conditions that will affect their ability to participate in school life.	• SN in partnership with the school, the child and their parents will consider the best approach to support the family. • SN will ensure that there is a personalised health care plan in place to improve school participation, working in partnership with the multi-agency health care team as appropriate. • SN will participate in the transition reviews.
Reactive and Responsive *(Universal Plus)* and *(Universal Partnership Plus)*	
Activity	**Action Pathways Guidance**
Provide health input to manage and respond to all identified health needs. Instigate Partnership working as appropriate to the needs of the child/family.	• Ensure that the early identification of vulnerable families is clearly identified through the transfer of care from HV to SN, and the School Nurse acquaints herself with the family either prior or as soon as the child enters school • Follow appropriate guidance and pathways where in place. Be involved in the development of pathways and referral systems to ensure that the health needs are met and managed in a timely and appropriate way, using the Family CAF tool to coordinate multi-agency interventions.
Specific Health Issues/Conditions the School Nurse will respond to:	
Follow-up on A&E attendance.	• All Children & Young People's A&E attendances and admissions to TRFT are notified to the School Nursing Service and this information is included in the Child's SystmOne record. Any attendance or admission that gives cause for concern will be reviewed by the School Nursing Service in line with agreed procedures. • Where appropriate the School Nurse will act as liaison between health providers, the family and the school to provide appropriate support in the school setting.
Drug and alcohol misuse	School Nurses: • provide brief intervention and appropriate signposting for personal alcohol and drug prevention advice. • offer support for the Child/Young Person following TRFT admission. • use the agreed alcohol pathway for young people under the age of 16 years attending A&E as a result of alcohol misuse. • to make full use of the 'Where are you at' Screening Tool.
Smoking Prevalence	• provide brief intervention for stop smoking • provide stop smoking support to children and young people wishing to stop smoking • refer young people to local stop smoking services where appropriate • promote social norms messages to prevent uptake of

	smoking by children and young people
Domestic Abuse	• SN Team to identify and support children and young people who are exposed to domestic abuse. • To follow safeguarding procedures in relation to domestic abuse including assessing for Child Sexual Exploitation (CSE). • To refer the case on (e.g. to Multi Agency Risk Assessment Conference in high risk cases). • Refer high risk domestic abuse cases involving 16/17 years olds to MARAC
Emotional Well-Being	• SN to provide Tier 1 mental health and emotional support e.g. self-harm, anxiety and low mood (where appropriate) and the identification and referral for children and young people requiring more specialist support to CAMHS • Where bullying is an issue ensure children receive support through partnership working with the school and the local authority. Influencing the school undertaking preventative actions that promote positive emotional wellbeing and positive mental health for children and their families • Specific emphasis to ensure that there is an understanding of the Looked After Children's specific needs and the school are sensitive to this. • Identify and signpost children and young people who have been bereaved by suicide for support

Sexual Health and reducing teenage conceptions.	• Ensure Teenage Pregnancy Pathway is followed
	• Enhanced School Provision –
	  ○ Following *"The Young People Friendly"* principles
	  ○ Instruction on condom use and distribution
	  ○ Assessing for risk of CSE
	  ○ Access to emergency contraception
	• Refer/or where appropriate provide:
	  ○ Instruction on condom use and distribution
	  ○ Pregnancy testing
	  ○ Chlamydia screening
	• To be delivered in partnership with Contraceptive & Sexual Health Services and Genito-urinary Medicine Service, as appropriate to need.
	• Encouraging use of community provision e.g. Youth Start

Looked After Children (LAC)	• SN to work proactively in conjunction with the LAC Health team to support the implementation of the health plan relative to a child's needs in school.
	• LAC pathway - SN to be proactive in working with the school to ensure that LAC specific needs are responded to in the school setting. This includes:
	  ○ Alcohol/ Substance misuse (including smoking)
	  ○ Promote uptake of immunisations as appropriate
	  ○ Physical health and well being
	  ○ Mental health and emotional wellbeing,

	particularly bullying and integration ○ Promoting positive sexual health and appropriate risk assessment for CSE • School Nurse to undertake health needs assessments on request in accordance with statutory guidance *(Please refer to Looked After Children and Care Leavers Service Specification Jan 2013 to 2015)*
Young Carers	• SN to identify young carers who require/want additional support (as appropriate) • SN to provide additional and ongoing support (as appropriate) to identified young carers in Rotherham Schools • SN to liaise with Barnardo's Rotherham Young Carers Service and schools to support young carers. • To promote the Rotherham Young Carers Card within all Rotherham Schools
Promoting the uptake and completion of immunisations.	• Develop communication and pathways between Primary Care and SN team to enable proactive follow-up of children and young people with incomplete immunisation status. • Promote the benefits of immunisations through innovative approaches. • Ensure children and young people with associated risk factors are offered appropriate vaccinations including HepB, BCG and influenza. • Signpost children and young people who have missed immunisation to their GP practice.
Underweight and Obesity	• Follow the Healthy Weight Framework for overweight and obese Children and Young People. • Refer children identified to be under the 3rd BMI centile to their GP and follow-up as appropriate. • SN service to have appropriate training to enable them to identify and respond to issues of under and overweight children and young people. • School Nurse to influence school to prioritise healthy lifestyle as part of the school curriculum.
School Absence – SN to follow up on children who are recurrently absent due to ill health or children who are excluded who may have health problems.	• Support clear referral pathways to and from Primary Care to ensure children who are recurrently ill and are of school age are followed up and the GP is aware of school absence history to support the child and maintain school attendance • SN to contribute to the holistic assessment of C&YP who miss school due to ill health. which may lead to the development of health management plans by the relevant health provider. These health plans will require appropriate monitoring and review. • Work with EWOs to identify school absence levels due to poor health and contribute to the development of suitable plans to increase support for the child/family to improve attendance.
Public Health –	• The SN service will respond to local public

• As a PH provision the SN will respond to a PH crisis as emergency planning procedures require. • Promote PH actions as appropriate to the need. E.g. TB risks screening etc	health needs as identified in the health profiles and respond accordingly. • Facilitate an appropriate (regular) drop-in offer in every secondary school, this will require close monitoring to assess usage and outcomes and assessment of effectiveness • The SN Service will prioritise and respond to PH needs as required, including in response to vaccine preventable disease outbreaks • Use TB guidance to *assess* risk according to national guidelines and refer for vaccination according to agreed local pathways.
Safeguarding & Early Help	
Vulnerability and Safeguarding across the continuum of need to include vulnerable, complex and acute. This will include children subject to statutory plans (Child Protection Plan and Child in Need Plan) as well as the Family CAF (non-statutory): Identify children who are vulnerable/at risk or respond to referrals. These children will require the completion of a holistic health assessment, with an associated care plan in place and subsequent evaluation. Each case will be closed at the end of each episode of statutory intervention (an episode of Care includes the timeframe from initial assessment to successful completion of health need). The SN will work in partnership with the family and provide health expertise.	• Follow Rotherham Local Safeguarding Children policies and procedures. • All SN to be trained to agreed level 3 of Intercollegiate Doc 2010 in line with Royal College of Nursing expectations. • All SN Teams to be trained in the effective use of Family CAF and BAAF documentation • SN to contribute to the standardised holistic multi-agency assessment of children identified with social care needs). This is to be used for the basis of joint case reviews and other planning reviews. If there are health problems the SN will coordinate actions from relevant health providers aimed at improving the child's health outcomes New referrals for health needs for the same child will come from case reviews • Provide reports following agreed standards.
Integrated Working *(Universal Professional Plus)*	
Activity	**Action / Pathways / Guidance**
The School Nurse will work as part of a multi-agency whole team approach, delivering the Healthy Child Programme to support the development of a seamless and responsive service to maximise the level of support a child and family needs at a time most appropriate to the need. Integrated working requires the sharing of relevant health information to enable the multi-agency team to inform its work and that of the school and other agencies, so that they can respond effectively to the health needs of the school and community.	• Where possible the SN should be co-located with the Health Visiting Service and other early help providers, or have access to "hot desk" facilities to improve the sharing of information and communication processes. • The SN will attend the school leadership meetings, as appropriate to provide the specialist health input. • The SN will attend Family CAF Lead Worker meetings where appropriate. • Where a case is being worked via Family CAF and is deemed to be 'stuck' a referral will be made to the Early Help Support Panel.

4. Referral, Access and Acceptance Criteria

4.1 Geographic Coverage/Boundaries
All children and young people aged 5 to 19 and resident in Rotherham and attending a Rotherham school.
4.2 Location(s) of Service Delivery
School Nursing provision will be provided in accessible venues throughout the Borough, and where possible will be co-located with Health Visiting services and Early Help Providers.
4.3 Days/Hours of Operation
The service will operate from 9am-5pm Monday to Friday, 52 weeks a year, but will be flexible to meet the needs of service users).
4.4 Inclusion Criteria

- Where children are attending schools within Rotherham but live in another area, it is the School Nurse's responsibility to respond to the child's needs within the school setting, but liaise with cross boundary health practitioners where there are health and social care issues within the home setting.
- The School Nursing Service covers all Rotherham Children, including LAC and Young People who are placed in Rotherham by another Local Authority. These placing Local Authorities will be invoiced according to national tariff and local agreement for Initial and Review Health Assessments that are undertaken by the Rotherham School Nursing Service. Rotherham LAC placed out of area will have their statutory health assessments undertaken by the most appropriate and effective means, the management of these health assessments will be undertaken by TRFT LAC Team who will utilise the DoH LAC Checklist Tool.

4.5 Location of Provider Premises

- Premises used by the Service Provider will be fit for purpose
- Premises must meet the requirements of the Health and Safety at Work Act (1974), the Disability Discrimination Act (1995) and if necessary the Health and Social Care Act (2008):code of practice for the prevention and control of healthcare associated infections

5. Continual Service Improvement/Innovation Plan

5.1 Monitoring and Evaluation
The Commissioner and Provider will meet at Quarterly Performance Monitoring Meetings. One of these meetings will be an annual service review meeting. Reports on the Service are required at each monitoring meeting and should be submitted at least 5 working days before the meeting. The required format will be agreed with the Commissioner over the initial contract period and will be based on the national Child Health Information Service schedule.
The Provider will be expected to adhere to reporting against the quality requirements set out in the national Local Authority Standard Contract for the delivery of Public Health services.
The Service will identify a plan and agree a methodology with the Commissioner for measuring the outputs of the Service being offered and for ensuring that any unmet need is both identified and brought to the attention of the lead Commissioner.
5.2 Surge Capacity
The Service will be expected to provide mutual aid in times of crisis e.g. pandemic flu, requirement for mass vaccination.
5.3 Workforce Development
The Provider must have in place a detailed staffing plan that describes the staffing arrangements that will enable the delivery of the service for the duration of the specification and make this available to the Commissioner on request. This should be underpinned by a workforce strategy including training

requirements, consideration of staff retirements and succession planning.
The staff will need to develop their knowledge and skills to deliver the core programme. The Service will be required to have in place clear policies for:

- Clinical and child protection supervision.
- Staff appraisal
- Individual professional development plans.

As a minimum the Provider must ensure that all clinical staff engaged in delivery of the Service are registered with the appropriate regulatory body and have achieved the expected level of safeguarding training as agreed by RLSCB.

6. Key Service Outcomes

See section 2.

7. Baseline Performance Targets – Quality, Performance and Productivity

Performance Indicator	***Indicator***	***Threshold***	***Method of Measurement***	***Frequency of Monitoring***
1.1 Service User Experience	Overall client satisfaction is positive	80%	Service evaluations Children and Young people's Lifestyle Survey	Annually
1.2 Workforce Plan developed to include recruitment & retention of qualified School Nurse workforce, skills & training needs analysis of existing workforce & trajectory for training and development to meet competency gaps	Improved quality and competency of provision	Baseline analysis of workforce to be completed by May 2014. End of year annual report.	Baseline report May 2014 Annual management report March 2015	Annually
1.3 Development of shared protocols and pathways with training in place to reflect it	Number of shared protocols and pathways	Gap analysis completed by March 2014 with trajectory and timeline for care pathways and guidelines to be completed	Quarterly management report	Quarterly

8. Activity

The Provider is required to participate in the new national ISB 1069 Children and Young People Secondary Uses Dataset which becomes mandatory in April 2013. Please see http://www.ic.nhs.uk/maternityandchildren for further information.

The table below (8a) lists activity for monitoring only and aims to inform the future development of key performance indicators:

Table 8a

Activity Monitoring	Method of Measurement	Frequency of monitoring
1. Number of care plans initiated	School Nursing data	Quarterly
2. Number of care plans closed	School Nursing data	Quarterly
3. Number of family CAFs initiated by the School Nursing Service	Early Help Performance Dashbaord	Quarterly
4. Family CAFs led by the School Nursing Service.	Early Help Performance Dashbaord	Quarterly
5. % of **initial** case conferences attended	School nursing data	Quarterly
6. % of case conferences attended with ongoing school nursing input	School nursing data	Quarterly
7. Safeguarding supervision uptake (as per TRFT policy)	% and number of staff School health collected data	Quarterly
8. Number of children and young people identified with self-harm behaviour	School nursing data	Quarterly
9. Number of 16/17 year olds referred to MARAC (as part of the vulnerable child and young people caseload)	Number of children referred School nursing data	Quarterly
10. Staff attending the Multi-agency Domestic Abuse Training at level 2 and 3	% of school nurse workforce	Quarterly

Table 8b

Key Performance Activity Indicator	Method of Measurement	Threshold	Frequency of Monitoring
1. Your School - Your Community			
1.1 Two targeted school nurse delivered community public health campaigns delivered annually in each school learning community (evidence based)	Number of campaigns delivered School Nursing data	100%	Annually
1.2 A minimum of one monthly drop in sessions delivered in each secondary school	Number of drop-ins delivered	80% (year on year stretch target to be agreed)	Quarterly
1.3 All schools are provided with details of their named school nurse ad know who they are	Audit of schools	100%	Every 6 months

1.4 The service actively promotes their role and the service core offer	Audit of schools Young People's Lifestyle Survey	Threshold to be determined	Annually
2. Identifying Health needs			
2.1 98% of school entry (Reception year) health reviews completed annually in order to identify those requiring additional support.	Number and % of reviews completed Number and %of those identified as requiring further support School Nursing data	100% offered a health review 90% to be reviewed as part of first year roll out.	Quarterly
2.2 Pathway for identifying children at Year 7 requiring a holistic health review as part of transition support	Number and % of reviews completed Number and % of those identified as requiring further/ongoing support Number and % of referrals for specialist support School Nursing data	100% offered a review % take-up target to be established following first year roll out	Quarterly
2.3 98% coverage of NCMP in reception year (3335 total for 2012/13)	NCMP national dataset	98% of eligible children	Annual review
2.4 92% minimum coverage of NCMP in year 6 (3045 total for Y5 (2012/13)	NCMP national dataset	92% of eligible children	Annual review
3. Health Care Plans			
3.1 100% of eligible Looked After Children Health Assessments to be completed within timescale set out in statutory guidance (children 5 to 19)[1]	School nursing data	100% of referrals for health assessments received	Quarterly
4. Specific Health Issues the School Nurse will respond to:			
4.1 Improving mental and emotional health and well-being			
4.1a % of young people assessed for mental and emotional ill-health are supported and/or appropriately referred e.g. CAMHS, MIND ,Youth Start	Number for young people assessed for emotional and mental ill health Number supported through the school nursing service Number referred for specialist support	100%	Quarterly

4.1b % of Looked After Children who are assessed for mental and emotional health are supported and/or appropriately referred e.g. CAMHS, MIND, Youth Start	Number of Looked After Children Assessed for emotional and mental ill-health Number supported by the school nursing service Number referred	100%	Quarterly
5. Improving sex health and reducing teenage pregnancy			
5.2a Provide sex and relationships education support to all primary schools as part of the SRE curriculum	Number of schools provided with support School Nursing data	90%	Quarterly
5.2b % of young people who are given contraceptive advice and provided access to appropriate contraception including EHC	Number of young people given advice and number referred School nursing data	90%	Quarterly
5.2c % of young people who may be at risk of becoming a teenage parent and given advice and support and/or referred to services e.g. IYSS	Number identified and number of referrals School nursing data	90%	Quarterly
5.2d % young people who receive sexual health advice and support are assessed for risk of Child sexual Exploitation	Number of young people given sexual health advice and support Number of referrals to the CSE Specialist Nurse	To be determined	Quarterly
6. Smoking Prevalence: to reduce smoking among children and young people			
6.1a % of children and young people offered advice and/or support or referred to Rotherham stop Smoking Service	Number of young people offered advice Number of young people given school nurse support Number of young people referred to Rotherham Stop Smoking Service	90%	Quarterly
7. ***Weight Management: to increase the number of children and young people who are a healthy weight***			

7.1a % of children and young people identified as on or under the 3rd BMI centile (very underweight) are referred to their GP with school nurse follow-up	Number of children identified (including those identified and referred to the school nursing service)	100%	Quarterly
7.1b All children and young people on or above the 98th BMI centile are referred to Tier 2 or Tier 3 weight management services (as appropriate) with school nurse follow-up	Number of children identified and number referred	90%	Quarterly
7.1c Referring 200 Children annually to weight management service (including both tier 2 and 3 provision)	Number of children referred	200	Quarterly
8. **Drug/Alcohol misuse: reducing the harm caused by alcohol**			
8.1a % of young people identified as using drugs and/or alcohol are screened using the 'Where you are at' screening tool and given advice and/or appropriate referral to 'know the Score'.	Number of children and young people screened and given advice Number of children and young people referred	100% of young people identified are screened	Quarterly
9. ***Self Harm: to reduce self-harming behaviour among children and young people***			
9.1a % of children and young people who are identified as self-harming are referred for specialist support (flowing the self-harm pathway) are assessed	Number referred to specialist support	100%	Quarterly

8.1 Activity Plan / Activity Management Plan

Plans need to be in place for current provider, The Rotherham NHS Foundation Trust (TRFT) and the Rotherham Metropolitan Borough Council (RMBC) Public Health Directorate, to work together on:

- The development of the School Nursing Service workforce plan
- Staff training and continuing professional development
- Arrangements for effective clinical, professional competency and safeguarding supervision

- Development of data collection and reporting systems to enable effective performance and monitoring of outcomes
- Serious incident reporting and root cause analysis
- Development of holistic health assessment tool for children subject to child protection plan to as evidence base for School Nurse involvement
- Enhancement of the protocol, care pathway and guidelines for health assessments of Children in Care / Looked After Children aged 5 to 19
- Ensure up to date, evidence based protocols, care pathways and clinical guidelines are used in connection with:
- Alcohol/Substance misuse
- Teenage pregnancy
- Unhealthy weight – underweight as well as overweight and obesity
- GP to School Nurse referral
- Referral and management of continence
- School Nurse follow up of A&E attendances and hospital admissions
- Provision of input only on STIs and contraception as part of school based delivery of PSHE programmes relating to sexual health and relationships
- Proactively promote school health drop-ins to maximise access to sexual health and contraceptive advice and support for young people
- Development of programme for clinical audit to be shared with the Commissioner

A timeline for the production of these plans and the plans themselves need to be agreed with the Commissioner.

8.2 Capacity Review

The Provider is required to undertake a capacity review and gap analysis, in partnership with the Commissioner, to establish an appropriate allocation of school nursing capacity to schools and an appropriate level of skills mix, including any requirement for specialist skills and competencies and additional training. An action plan to address any gaps should be provided to commissioners and reported on a quarterly basis.

Appendix A Rotherham 11 Deprived Communities

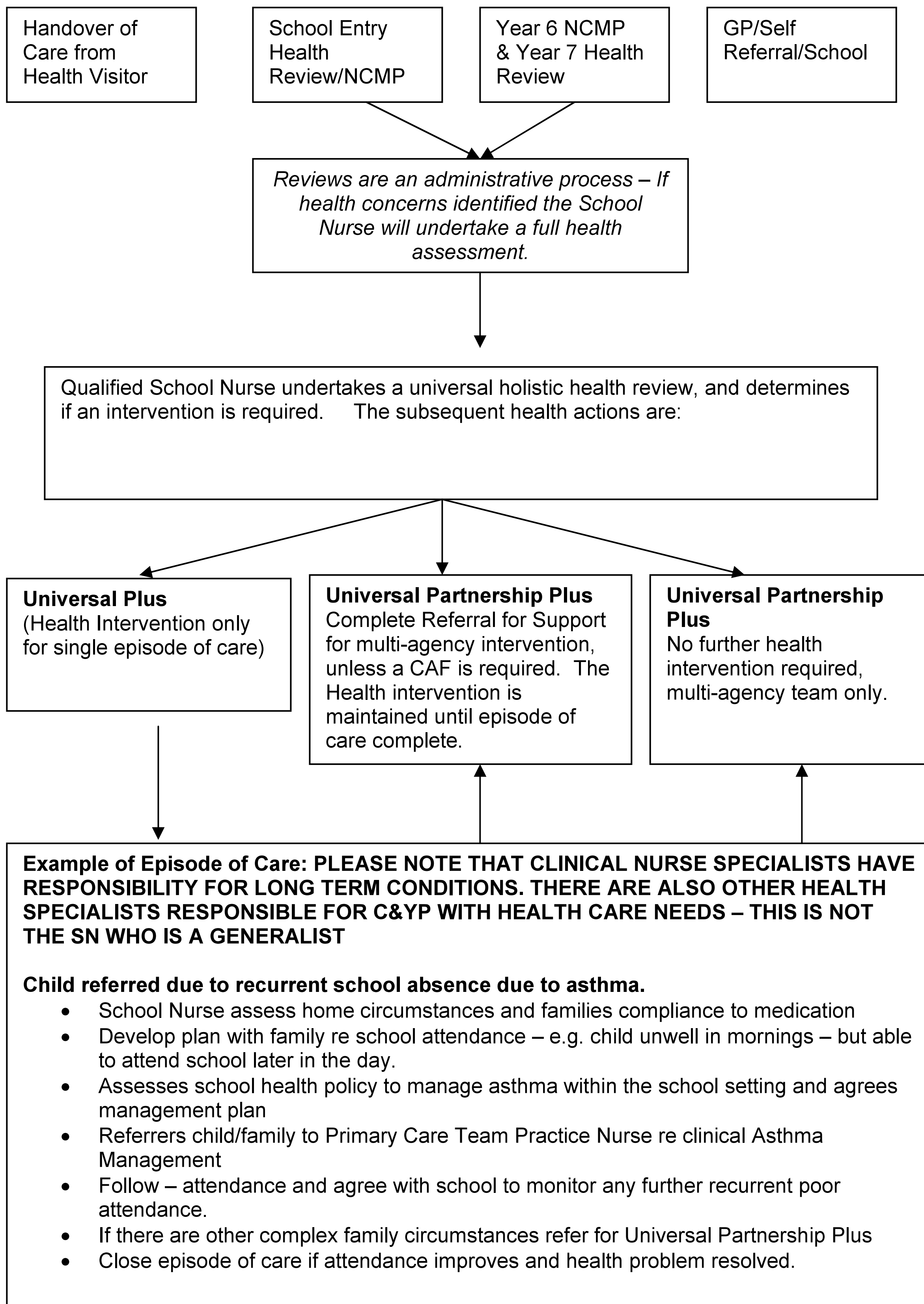
The Rotherham 11 deprived neighbourhoods comprise of areas within:

1. East Herringthorpe
2. East Dene
3. Eastwood
4. Canklow
5. Town Centre
6. Dalton Thrybergh
7. Ferham Masborough
8. Rawmarsh
9. Dinnington
10. Maltby South
11. Aston North

For the key postcodes please see the excel sheet attached below

Copy of Disad areas postcodes.xlsx

Appendix B Core Contact and Pathway



ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**Thursday 13 March 2014**
3.	**Title:**	**Better Care Fund**
4.	**Directorate:**	**Neighbourhoods and Adult Services**

5. Summary

The £3.8bn Better Care Fund was announced by government in the June 2013 spending round, providing a catalyst for local authorities and Clinical Commissioning Groups to transform and integrate health and social care.

The Better Care Fund does not offer any new money, but provides a single pooled budget made up from money already in the system, to support health and social care services to work more closely together in local areas.

This report outlines the requirements of the fund and describes how Rotherham has developed a local plan to meet these.

6. Recommendations

That the Health Select Commission:

- Notes the work undertaken to develop a local Better Care Fund plan and the agreed actions
- Receives the final Better Care Fund plan once submitted in April 2014

7. Background

The £3.8bn Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas.

The BCF does not offer any new money to local authorities or Clinical Commissioning Groups. The purpose of this fund is to provide an opportunity to improve lives of some of the most vulnerable people in our communities, by giving them more control, placing them at the centre of their care and ensuring services are integrated and working together for the benefit of the person.

7.1 National Conditions

The funding must be used to support adult social care services in each local authority, which also has a health benefit. Local authorities and clinical commissioning groups will need to demonstrate how the funding transfer will make a positive difference to social care services and outcomes for service users. However, beyond this broad condition there is some flexibility for local areas to determine how the investment in social care services is best used.

Other than protecting social care services, plans should:

- Be jointly agreed between the council and CCG, and in agreeing plans, areas should engage with local providers likely to be affected by the fund
- Demonstrate how 7-day services will be provided to support patients being discharged and prevent unnecessary admissions
- Demonstrate how local areas will improve data sharing between health and social care, based on use of the NHS number
- Demonstrate a joint approach to assessments and care planning, and identify which proportion of the population will receive case-management and a lead accountable professional, and which will receive self-management support
- Identify what the impact will be on the acute sector

The Health and wellbeing board has responsibility for signing off the local plan.

7.2 Developing the Rotherham BCF Plan

The local BCF plan has been developed by a small multi-agency task group of the Health and Wellbeing Board (HWB), supported by an officer group.

The terms of reference of the task group were:

- To work with members of the HWB to understand and interpret the requirements of the BCF
- To develop a local jointly agreed vision for integration
- To develop the first draft plan to be signed–off by the HWB and submitted to NHS England by 14 February
- To do any necessary further work to ensure the final plan is adopted by April 2014

7.3 Local definition, vision and principles

Definition

The Health and Wellbeing Board agreed to adopt the nationally recognised definition of integration (developed by 'National Voices'):

"*I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me"*

Vision

The Rotherham BCF Plan contributes to achieving the overarching vision of the Health and Wellbeing Board: *To improve health and reduce health inequalities across the whole of Rotherham*.

More specifically, the actions in the BCF plan contribute to 4 of the strategic outcomes of the Health and Wellbeing Strategy:
- **Prevention and early intervention**: Rotherham people will get help early to stay healthy and increase their independence
- **Expectations and aspirations**: All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community
- **Dependence to independence**: Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances
- **Long-term conditions**: Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life

The local vision for integration is based on the experiences, values and needs of our service users, patients and carers. Through mapping these and understanding the journeys people take in and out of health and social care, a number of 'I statements' have been identified which demonstrate the outcomes local people want from integrated, person-centred services. These statements will be monitored to ensure the plan is achieving them; specifically how this will be undertaken is currently being developed ('I statements' are outlined on page 6 of the BCF Template part 1).

Principles

The principles of the BCF are also taken from the local Health and Wellbeing Strategy, demonstrating how the BCF actions will contribute towards the wider local vision.

In the strategy, under each of the strategic outcomes, there are a set of 'principles' which the BCF actions are aligned to, for example:

To deliver our vision on 'Prevention and Early Intervention' -
- We will coordinate a planned shift of resources from high dependency services to early intervention and prevention, and;
- Services will be delivered in the right place at the right time by the right people

How they align can be seen in Appendix 2 - BCF Action Plan.

7.4 Consultation

In developing a plan, there was a requirement to demonstrate how service users, patients and providers had been engaged in the planning process, and in developing the local priorities. A number of methods were used:

- Healthwatch Rotherham were commissioned by the Health and Wellbeing Board to consult with the local community and engage them in the envisaged transformation of services
- Rotherham council consulted with a group of mystery shopper volunteers regarding the proposed vision, priorities and their views of health and social care services
- Responses from a range of consultation exercises and surveys previously completed were collated, and used to help shape the local vision and priorities, including; Joint Health and Wellbeing Strategy consultation, Adult Social Care User Survey, Annual Survey of Adult Carers in England, health inequalities consultation and staff consultation regarding the hospital admission to discharge process
- The Rotherham CCG Patient Participation Network undertook a consultation exercise as part of developing their 5 year plan, through this they identified a number of priorities that could be addressed as part of the Better Care Fund
- Full discussions on the BCF have taken place at The Adults Partnership Board and Urgent Care Board, and local health providers understand that Rotherham CCG has identified a range of services which will be transferred into the Better Care Fund, and that the commissioning arrangements for these services are going to change significantly
- The Rotherham Health and Wellbeing Board also includes the main local health providers (Acute and Community Foundation Trust and Mental Health Trust) as well as representation from the voluntary sector (Voluntary Action Rotherham), this has ensured that they are fully signed up to the principles and vision of the BCF and are aware of the potential impact on services and the local community

Further detail on the consultation activity can be found in Appendix 1 – findings from consultations.

7.5 BCF Action Plan and Measures

The action plan (Appendix 2) demonstrates the specific actions that will be delivered locally as part of the BCF. These actions are shown aligned to 4 strategic outcomes from the Health and Wellbeing Strategy, demonstrating how they will help achieve these. The actions in the plan also demonstrate how locally these contribute to the 6 national conditions.

Measures

Local plans have to deliver against 5 nationally determined measures:

- **Admissions into residential care -** Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000
- **Effectiveness of reablement** - Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services
- **Delayed transfers of care** - Delayed transfers of care from hospital per 100,000 population (average per month)
- **Avoidable emergency admissions**
- **Patient and service user experience**

Plus one locally agreed measure, which meets specific criteria. Rotherham has chosen 'emergency readmissions' for this purpose.

BCF Template 2 outlines the detail and metrics submitted as part of the plan. These metrics are based on the national guidance which provides a statistically significant target. Further detail on these are currently being considered by the task group and supporting officers ready for the final April submission.

7.6 Next steps

The first draft plan was submitted to NHS England on 14 February 2014. Formal feedback will be received shortly after the 28 February.

The task group and officer group will continue to meet throughout March to develop the plan further, based on feedback received. A final plan will need to be submitted 4 April.

8. Finance

The BCF does not offer any new money to the council or CCG. It is made up of already allocated spend, which has been identified for including in the pooled budget.

The Rotherham BCF minimum requirement for 2015/16 is **£20,318,000.00.**

The total amount agreed by the council and CCG is **£22,055,000.00.**

Detail of how this money is being used to deliver the BCF actions is shown in BCF Template 2.

9. Risks and Uncertainties

The timescale for producing a strategic plan to deliver the BCF has been tight, however, the CCG, local authority and providers need to work collaboratively within the timescale to ensure the plan is right for the Rotherham population,

Not working quickly on this, and having a final agreed plan by 4 April, which the Health and Wellbeing Board signs up to, will result in us not being in a position to meet the requirements of the BCF.

10. Policy and Performance Agenda Implications

The NHS together with local authorities face an unprecedented level of future pressures, driven most importantly by an ageing population and increase in those with long-term conditions. Locally the JSNA tells us that the number of people aged over 65 will increase from 45,100 (2011) to 54,100 in 2021, and the number of people over 85 will increase from 5,500 to 7,100. Although people will tend to remain healthy for longer than they do now, over 65s with a limiting life-long illness or disability is higher in Rotherham than the England average (61% compared with 53%), and this is projected to rise.

These factors present major challenges and implications for health and social care services within a changing financial environment. Locally the Health and Wellbeing Strategy sets out the Health and Wellbeing Board's joint priorities, which includes 'prevention and early intervention', 'dependence to independence', 'expectations and aspirations' and 'long-term conditions', all of which have a crucial role in ensuring actions are delivered to deal with some of these challenges.

The HWB will play a leading role in developing the strategic plan for integration and will therefore need to ensure its priorities, as set out in the HWB strategy, continue to drive the work needed to deliver the expected outcomes of the BCF.

11. Background Papers

BCF Template part 1 **(attached with report)**

BCF Template part 2 **(attached with report)**

Appendix 1 – findings from consultations **(attached with report)**

Appendix 2 – BCF action plan **(attached with report)**

Appendix 3 – Health and Wellbeing Strategy

Appendix 4 – Rotherham Joint Strategic Needs Assessment
http://www.rotherham.gov.uk/jsna/

Appendix 5 – information sharing protocol

11. Contacts

Tom Cray
Strategic Director, RMBC
tom.cray@rotherham,gov.uk

Kate Green
Policy Officer, RMBC
Kate.green@rotherham.gov.uk

Rotherham Better Care Fund

Planning template – Part 1

Local Authority
Rotherham Metropolitan Borough Council

Clinical Commissioning Group
Rotherham Clinical Commissioning Group

No boundary differences

Date agreed at Health and Wellbeing Board
11 February 2014

Date submitted
14 February 2014

Minimum required value of ITF pooled budget	2014/15	**£20,101,000.00**
	2015/16	**£20,318,000.00**
Total agreed value of pooled budget:	2014/15	**£21,838,000.00**
	2015/16	**£22,055,000.00**

Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**Rotherham Clinical Commissioning group**
By	Chris Edwards
Position	Chief Operating Officer
Date	11 February 2014

Signed on behalf of the Council	**Rotherham MBC**
By	Martin Kimber
Position	Chief Executive
Date	11 February 2014

Signed on behalf of the Health and Wellbeing Board	**Rotherham Health and Wellbeing Board**
By Chair of Health and Wellbeing Board	Cllr Ken Wyatt
Date	11 February 2014

Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

This first draft submission reflects a number of ways in which health and social care providers have been engaged in the planning process for the Better Care Fund (BCF), and in developing our local priorities.

The Rotherham Health and Wellbeing Board includes the main local health providers (Acute and Community Foundation Trust and Mental Health Trust) as well as representation from the voluntary sector (Voluntary Action Rotherham), this has ensured that they are fully signed up to the principles and vision of the BCF and are aware of the potential impact on services and the local community.

In addition to this, full discussions on the BCF have taken place at The Adults Partnership Board, which acts as a commissioner / provider interface on jointly commissioned services. The board is coordinated jointly by the council and Rotherham CCG and includes representation from Rotherham Foundation Trust, RDASH and the voluntary/community sector. The board agrees commissioning plans which address outcomes identified in the local Health and Wellbeing Strategy, makes recommendations about commissioning priorities to the Health and Wellbeing Board, and oversees performance on jointly commissioned services. The Rotherham urgent care working group, which has cross system membership, has also reviewed the BCF outline plans. We intend to have further detailed discussions with providers before the final submission in April.

Local health providers understand that Rotherham CCG has identified a range of services which will be transferred into the Better Care Fund, and that the commissioning arrangements for these services are going to change significantly. Locally the BCF will affect services delivered by Rotherham Foundation Trust (RFT) and key voluntary sector partners and all provider organisations have expressed a willingness to work under the

new commissioning framework, recognising the potential opportunities. RFT is committed to delivering integrated health and social care pathways and regard the BCF as a vehicle through which these can be achieved. Voluntary sector partners have already developed services which form part of integrated care pathways in stroke and dementia care, and we see the BCF as an enabler to embed voluntary sector services into other condition specific care pathways.

We have engaged with social care providers to raise awareness of the implications of the BCF and to better understand some of the issues and good practices already taking place. This has been done through an online survey and round-table discussion, using their experiences to explore potential solutions. A number of common themes have been identified which have informed the plan:

- There needs to be a greater focus on prevention and early intervention, with appropriate information and signposting to community-based services at a much earlier stage
- Better communication between agencies is needed to identify individuals who are most vulnerable and at risk of crisis (particularly in relation to mental health)
- Equipment, adaptations and support services need to be provided quickly before cases become critical and people reach crisis point
- Better 7-day (weekend) provision is needed to support discharge from hospital and transition between services
- We need more step up and step down beds to support transition between services
- Carers and workers need to have the right skills to deal with changes in care packages
- We need to reduce bureaucracy and make it easier for all providers to link up and work together
- GPs are often the first point of contact for people and commissioners need to work with GPs to ensure that preventative solutions are utilised
- Commissioners of health and social care need to communicate more and see the whole person (not just single issues in isolation) as well as the whole system, avoiding duplication
- We need more opportunities for people to engage in their community; reducing the reliance on more formal 'services' for social interaction

Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Our Better Care Fund vision is based on what Rotherham people have told us is most important to them.

We have used a variety of methods to involve service users and the public in the development of the plan including:

- Better Care Fund consultation– Healthwatch Rotherham was commissioned by the Health and Wellbeing Board to consult with the local community and engage them in the envisaged transformation of services between December 2013 - January 2014
- RMBC Customer Inspection Group – During January 2014 Rotherham Council consulted with a group of mystery shopper volunteers regarding the proposed vision, priorities and their views of health and social care services

We have also collated responses from a range of consultation exercises and surveys previously completed, and used these to help shape our vision and priorities, including; Joint Health and Wellbeing Strategy consultation July – August 2012, ASCOF Adult Social Care User Survey 2011/2, Personal Social Services annual Survey of Adult Carers in England 2012/13, Health Inequalities consultation 2011 and staff consultation regarding the hospital admission to discharge process. In addition, the council continually works to improve services through customer insight activities and learning from customer complaints, ensuring that service users are at the heart of service delivery. The annual Local Account is also used to inform members of the public how the council is meeting the needs of service users and improving outcomes.

Rotherham CCG co-ordinates a Patient Participation Network that brings together patient representatives from GP Practices across Rotherham. Patient Participation Groups have been meeting throughout the year, providing feedback on local health services. The Patient Participation Network meets on a quarterly basis, bringing together patients' views from across the local health economy. As part of an exercise to develop the patients' view of the CCG's five year strategy, the network identified a number of priorities that could be addressed as part of the Better Care Fund Plan.

Through service user, patient and public engagement, we have been able to identify a number of common areas for improvement including:

- Patients and service users do not always feel central to decision making, they want to be in the driving seat when it comes to their own care
- Services, local groups and organisations are not accessible due to a lack of information and advice, availability 7 days a week and long waiting times
- There needs to be better education and information available for people, particularly those with long term conditions
- People often feel unclear of expectations regarding the service they should receive and customer pathways due to a lack of advice and support and conflicting information. They are also not always signposted to appropriate services. Better staff training and education is required
- There is a lack of communication and information sharing resulting in poor joined up working between patient/service user, family and carers, health and social care services, GP, hospital, providers and partners
- Service users feel that they have to chase health and social care professionals, causing delay in the delivery of care and support
- Service users and patients would like an allocated key worker/professional; inconsistency of workers makes individuals feel unsafe
- There needs to be more of a focus on preventative, community/home-based services to reduce the number of people going into hospital and residential and nursing care. Nursing services are also critical for home-based support.
- Better after care is required. Examples provided included people felt alone, socially isolated, found it difficult to access services, no support for carers who are left behind
- Service users have a level of distrust using external health and social care providers

Further information regarding the consultation can be found in Appendix 1.

Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Ref.	Document or information title	Synopsis and links
A1	**Findings from consultations**	A summary of all the consultations which have taken place as part of the BCF planning and wider health and wellbeing agenda.
A2	**Rotherham Better Care Fund action plan**	Includes the detail and intended outcomes (including related 'I Statements') of the schemes to be delivered through the BCF, and shows how these align with the local health and wellbeing strategy priorities and objectives,
A3	**Health and Wellbeing Strategy**	The joint strategy which sets out the priorities of the health and wellbeing board for 2013 – 2015.
A4	**Joint Strategic Needs Assessment**	Assessment of the health and social needs of the Rotherham population. http://www.rotherham.gov.uk/jsna/
A5	**Overarching information sharing protocol**	This protocol complements and supports wider national guidance, professional body guidance and local policies and procedures to improve information sharing across services in Rotherham. Signed up to by HWB September 2012.

1) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- *What changes will have been delivered in the pattern and configuration of services over the next five years?*
- *What difference will this make to patient and service user outcomes?*

The Rotherham Health and Wellbeing Strategy sets out our overarching vision to improve health and reduce health inequalities in the borough. Through the strategy, the Health and Wellbeing Board has made a commitment to more integrated, person-centred working, to improve health outcomes for local people.

The Better Care Fund plan will contribute to 4 of the strategic outcomes of the local Health and Wellbeing Strategy:

- **Prevention and early intervention**: Rotherham people will get help early to stay healthy and increase their independence

- **Expectations and aspirations**: All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community

- **Dependence to independence**: Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances

- **Long-term conditions**: Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life

Our vision for integration is based on the experiences, values and needs of our service users, patients and carers. Through mapping these and understanding the journeys people take in and out of health and social care, we have identified a number of 'I statements' which demonstrate the outcomes local people want from better integrated, person-centred services. From 2015/16 our Better Care Fund plan will work towards the following:

'I am in control of my care'
People want to feel central to decision making and development of their care plans, they want all professionals and services to communicate with each other to understand their care needs and ensure they receive the most appropriate care for their circumstances, and they want to be provided with the right information to help them to manage their conditions and make informed choices about their own health and wellbeing.

'I only have to tell my story once'
Service users, patients and carers want all organisations and services to talk to each other and share access to their information, so that they only ever have to tell their story once.

'I feel part of my community, which helps me to stay healthy and independent'
People want to feel independent and part of their community and want organisations to provide better information and support to help them to do this, understanding that this reduces social isolation and avoids the need for more formal care services later on.

'I am listened to and supported at an early stage to avoid a crisis'
People want support, advice and information at an early stage to help them look after their mental health and wellbeing, avoiding the need for more intense, high-level services when they reach crisis point.

'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing'
People want a greater focus on preventative services and an increased capacity in community activity to prevent high intensity use of services and more formal care, and to help them better manage their conditions. They also want services to be available 7 days a week and information and advice to be more accessible. Understanding the journeys that people take into health and care services will help us to provide more appropriate information and support at times when people need it most.

'I feel safe and am able to live independently where I choose'
People want to stay independent and in their own home or community for as long as possible. They want to feel safe to do this and know that the right support is available when and where they need it.

As a result of the changes we will make, all service users, patients and their carers will have confidence in the care they receive and feel supported to live independently, manage their conditions and participate in their community. They will feel well and less likely to rely on acute services, resulting in a reduction in overall pressure on the hospital and health budgets. Although, when acute care is the best option for people, they are helped to move quickly back into their community when they are ready to do so. We will see a greater shift from high cost reactive care, to lower cost, high impact preventative activity.

To achieve this, we have agreed a number of actions that will begin this journey and result in changes short and medium term. However our longer term, 5 year plan, will see health and social care teams working in an increasingly integrated way. We will move to a whole-system commissioning model, which has services commissioned in line with our health and wellbeing strategy principles that are coordinated across all agencies to ensure they are person-centred and we maximise local spend. We will explore the benefits and efficiencies that can be made through having joint approaches to call centres, including an increased use of assistive technologies, and joint teams for commissioning and assurance.

b) Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- *What are the aims and objectives of your integrated system?*
- *How will you measure these aims and objectives?*
- *What measures of health gain will you apply to your population?*

Our aim is for an integrated system, that provides care and support to people in their home or community, which focuses on prevention, early intervention and maximising independence. To do this, we have identified a number of key objectives set out in our health and wellbeing strategy which have been used to inform our plan. We have demonstrated below where these will impact on the specific outcome measures of the BCF:

To deliver our vision on Prevention and Early Intervention (PE)	
What we will do	**Related measures**
We will coordinate a planned shift of resources from high dependency services to early intervention and prevention	N1, N2, N4, N5, L1
Service will be delivered in the right place at the right time by the right people	N1, N2, N3, N4, N5, L1

To deliver our vision on Expectations and Aspirations (EA)	
What we will do	**Related measures**
We will ensure all our workforce routinely prompt, help and signpost people to key services and programmes	N1, N2, N3, N4, N5, L1
We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions	N1, N2, N3, N4, N5, L1

To deliver our vision on Dependence to Independence (DI)	
What we will do	**Related measures**
We will change the culture of staff from simply 'doing' things for people to encouraging and prolonging independence and self-care	N1, N2, N3, N4, N5, L1
We will support and enable people to step up and step down through a range of statutory, voluntary and community services, appropriate to their needs	N1, N2, N3, N4, N5, L1

To deliver our vision on Long-term Conditions (LC)	
What we will do	**Related measures**
We will adopt a coordinated approach to help people manage their conditions	N1, N2, N3, N4, N5, L1
We will develop a common approach to data sharing so we can provide better support across agencies and put in place a long-term plan for the life of the individual	N3, N4, N5, L1

Outcome measures (key):

- **N1 Admissions into residential care -** Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000
- **N2 Effectiveness of reablement** - Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services
- **N3 Delayed transfers of care** - Delayed transfers of care from hospital per 100,000 population (average per month)
- **N4 Avoidable emergency admissions** - Avoidable emergency admissions
- **N5 Patient and service user experience**
- L1 Emergency readmissions

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- *The key success factors including an outline of processes, end points and time frames for delivery*
- *How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care*

Achieving our vision will mean significant change across the whole of our current health and care landscape. Commissioners and providers will need to adapt and change the way they do things. The following actions demonstrate the commitment both the council and CCG have made to transforming services and working in a more integrated way for the benefit of Rotherham people.

A more detailed action plan is attached as Appendix 2.

What we want to achieve: Rotherham people will get help early to stay healthy and increase their independence

We will use the BCF to:
- Commission mental health liaison provision, ensuring it is aligned to health and social care priorities for prevention and early intervention.
- Review the falls service to ensure its primary focus is delivering a preventive community-based service
- Implement a joint approach to an integrated rapid response service, including out of hours, capable of meeting holistic needs of identified individuals to reduce hospital admission.
- Review and evaluate existing arrangements against potential increase in demand arising from 7 day working across the community, social care and mental health.

What we want to achieve: All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community

We will use the BCF to:
- Review the social prescribing pilot to ensure it is delivering on prevention, avoidance and delaying access to formal care services, and commit to mainstreaming this service subject to findings.
- Undertaken a deep dive exercise conducted on cases of high social care and health users, to identify opportunities to improve pathways, and explore where better preventative action earlier on may help avoid or delay access to health and care services in the future.
- Carry out a full evaluation of Rotherham's risk stratification tool, and develop a mechanism for identifying high intensity users of health and social care services.

Want we want to achieve: Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances

We will use the BCF to:
- Commit to giving personal budgets to as many people as possible
- Develop self-care and self-management, working with voluntary and community groups to co-design, co-develop and co-produce improved health and care outcomes,
- Develop and implement a person centred, person held plan, in partnership with key stakeholders.
- Identify the cost and activity pressures resulting from the implementation of the care bill and develop a plan to meet these pressures.

Want we want to achieve: Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life

We will use the BCF to:
- Undertake a project to review all existing S75 and S256 agreements and pooled budget arrangements.
- Develop portal technology to share data in a secure way that is in the best interest of people who use care and support. Use of the NHS number as a unique identifier across health and social care will create the starting point for the development of shared IT capacity.

Aligning to other plans

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities.

Timeline

Feb – April 14: We will further develop our BCF action plan, setting out timescales, delivery leads and the specific governance arrangements for each scheme.

April 14 – March 15: We will undertake detailed planning to ensure the schemes in the action plan are implemented.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

NHS Rotherham CCG's share of the national efficiency challenge is around £80 million over five years and is referred to as QIPP (Quality, Innovation, Productivity and Prevention). QIPP has two components:

Provider QIPP; Efficiencies passed onto health service providers. For the last three years and for the foreseeable future, providers have been expected to provide the same services with less funding. For example in 2014/15 providers will be given 2.1% uplift for inflation but are then expected to make 4% efficiencies. The efficiency requirement is **£8.8m**.

System Wide QIPP; NHS financial allocations are expected to rise by around 1-2% each year over the next 5 years. The underlying rate of growth in health service activity and costs prior to 2010 was around 6%. Without QIPP we anticipate growth will continue at around 6% a year because of the ageing population, rising expectations and new medical technologies. System wide QIPP programmes are the actions required to keep overall growth at an affordable 1-2% level rather than the historical 6%.

The Unscheduled Care QIPP target will be partially reliant upon the success of the BCF. The initiatives will provide more alternatives to hospital admission, treat people with the same needs more consistently and deal with more problems by offering care at home or close to home - value is **£2.5m**.

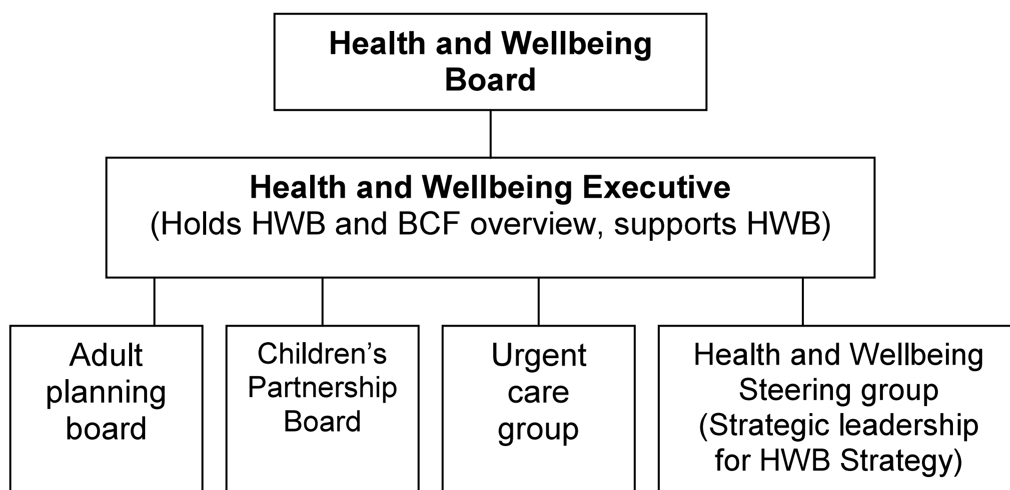
e) Governance

Please provide details of the arrangements in place for oversight and governance for progress and outcomes

The CCG and RMBC have co-terminus boundaries and already have a layer of governance and delivery mechanisms in place. There is clear agreement to the need to maintain a simple clear governance framework which does not add to the burden of any of the agencies or partnership mechanisms.

The delivery of the BCF will be fully integrated with the delivery of the Health and Wellbeing Strategy and as a result, the existing mechanisms with some adaptation should be fit for purpose to ensure effective governance, accountability and delivery.

The framework outlined below brings together the existing partnership and single agency arrangements into a coherent whole system approach and integrates the existing mechanisms to ensure that there remains a clear focus on the health and wellbeing strategy.



The Health and Wellbeing Board will:

- Monitor performance against the BCF Metrics (National/ Local) and receive exception reports on the BCF action plan
- Ratify the Better Care Fund Commissioning Strategy
- Ratify decisions on commissioning or decommissioning of services, in relation to the BCF

The HWB executive provides support to the board and holds the overview role for delivery of the BCF through the 4 key groups below.

Our final submission will include more detailed information about how the 4 groups will deliver the actions in the BCF plan.

Audit

The use of the funds and other finance issues arising will be audited with the final scope to be agreed by RCCG Chief Finance Officer and RMBC Finance Director.

2) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Key to the delivery of integrated person centred services, in the context of reduced revenue and increased demand for health and social care services, is a core offer of social care services including:

- Advice, guidance and information sharing
- Preventive services such as telecare/assistive technology, reablement, intermediate care – all designed to support independence
- Ongoing care provision including personalised services which offer choice and control to the individual to enable them to lead as independent a life as possible
- Good quality domiciliary and residential care

It is known that cuts to social care services increase pressure on the NHS, and protecting the NHS is a key priority for central government. Without the support that is achieved through the Better Care Fund, social care reductions will negatively impact on the local NHS community. RMBC has taken the following actions to date:

- A rational approach to setting reasonable fees for provider services, including tackling high cost fees for learning disability residential placements and supporting the quality of care in older people's residential care services
- Increases in charges for care
- A greater use of reablement services that offer support to people to enable them to remain independent
- Implementation of personalised support, alongside effective commissioning of services

To date it is clear that these efforts have enabled the council to manage increasing demand due to demographic pressures – these approaches cannot be effective indefinitely, and in 2013/14 there are indications that demand, despite the actions taken to reduce demand through reablement etc, is beginning to increase significantly.

In order to prevent further cuts to services, it is essential that the Better Care Fund is used to support those care services which in turn protect the NHS.

Please explain how local social care services will be protected within your plans

The fund itself does not address the financial pressures faced by local authorities and CCGs. The Better Care Fund brings together the NHS and local authority resources that are already committed to existing core activity. The Better Care Fund will be used in the first instance to protect the funding to existing services, allowing the local council to maintain its current eligibility criteria, under Fairer Access to Care Services (FACS). Current services will be reviewed and evaluated to ensure that they address the key aims of the Better Care Fund. Where they are not seen to be delivering against this, they will be recommissioned or decommissioned and the funding reinvested in services that support improvements in health and wellbeing, independence, and prevents admission to care services or hospital, as well as information and signposting services for people who are not eligible for services, to prevent or delay their need for such services. Assessment, care management, and commissioned support for those who meet eligibility criteria needs to be maintained at current level, with the potential that this investment will need to increase to maintain the offer in the light of developing 7 day services and additional responsibilities that the Care Bill will bring when enacted in 2015.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

There is a commitment in our plan to the achievement of 7 day working in all parts of the health service, parity of esteem for people living with mental health issues and better care for people requiring integrated health and social care services. This is a key element in our contract negotiations with providers.

There is also a commitment from the CCG to support GP practices in transforming the care of patients aged over 75 in line with national planning guidance. This is being developed in year to compliment our strategy for vulnerable people which is also included in our plan.

Existing services, including out of hours support by social workers, access to enabling care and intermediate care, will be reviewed and strengthened where necessary in response to emerging patterns of demand.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All Rotherham NHS correspondence uses NHS number as primary identifier.

RMBC does not currently use the NHS number as primary identifier.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

The NHS Number can be recorded in SWIFT/AIS as a specific ‘Other Reference’ which then appears in the person’s context banner in the most commonly used screens.

From May 2014, we will begin a piece of work with Northgate to use a facility provided by them to batch load NHS numbers into SWIFT/AIS. Steps in the process are as follows:

A script will be provided to extract all clients without a validated NHS number into the correct csv file format for submission. SWIFT Identifiers will be provided with names, address, data of birth and gender for matching purposes. This will initially be used for a bulk update and can then be run on an automated regular basis to pick up new clients or clients where the initial match attempt has failed (since their SWIFT details may be updated to achieve a match eg as part of data quality work). The file will be encrypted and transferred from the local authority server to the secure Northgate server via secure ftp.

Northgate has a secure server with an N3 connection to the NHS Spine who will run the client software on that server to submit each customer’s clients in an encrypted file to the Demographics Batch Service. The returned file will then be transferred back to the local authority by sftp. Northgate will automate this process to run on a nightly basis and keep

records of runs. The returned file will identify those Persons for whom no match was found. We will have in place a process for dealing with those cases, eg checking & amending the demographic details and re-submitting.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

All Rotherham NHS platforms are Information Governance Toolkit compliant.

RMBC is committed to adopting systems that are based upon open APIs.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

All Rotherham NHS Organisations use the IG toolkit and provide annual assurance on this.

Rotherham CCG will complete assurance on Caldicott 2 compliance by 31 March 2014

The Rotherham Health and Wellbeing Board has jointly approved and signed up to an overarching information sharing protocol (appendix 5).

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

There is an initiative in place to improve the case management of the 5% (12,000) of patients at risk of hospitalisation which is key to our unscheduled care efficiency plan. In 2013/14 the pilot was solely for patients identified by a computer tool as being at the highest risk of admission to hospital. In 2014/15 the tool will still be used to identify the first 3% of patients eligible to be on the scheme. An additional 2% of each practices population will be eligible for the scheme, this will also include all patients in nursing and residential homes and other patients selected on the basis of clinical judgment.

In light of the planning guidance requirement to provide addition GP services for patients over the age of 75 the CCG will add an additional component to the LES to provide services for all 20,000 people in Rotherham over 75. The CCG will make the case management and over 75 services funding recurrent so that practices can make permanent appointments as the current shortage of locums is affecting the stability of current services.

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	**Risk rating**	**Mitigating Actions**
Governance is deemed by NHS England not to meet requirements to deliver the BCF change	Medium	Task group to agree the most appropriate governance structure for BCF, which includes the HWB as the accountable body.
A lack of detailed data / baseline data means finance and performance targets are unachievable	High	Validated financial data from both organisations enabling interpretation and auditing of information. Performance Management Framework that includes SMART measures to evidence progress against improving outcomes
Shifting of resources could destabilise current service providers.	High	Joint working with stakeholders to develop implementation plans and timelines that include contingency planning. Assessment of the potential impacts on the provider to be collated as integral to the implementation plan
Unintended consequences of achieving savings in one area of the system could result in higher costs elsewhere.	High	All partners have made a commitment to ensure that if evidence of these consequences is seen, cash will flow to the right place across the system that all partners will benefit from.
Failure to receive 50% of the pay-for-performance element at the beginning of 2015/16 due to the HWBB not adopting a plan that meets the national conditions by April 2014	High	HWB to ensure plan meets the national requirements and is fully adopted by April. Performance management framework in place to monitor progress throughout 2014/15 to ensure meet agreed targets.
Failure to receive the remaining 50% of the pay-for-performance element mid 2015/16 due to not meeting the in-year performance targets.	High	Performance management process in place, accountable the HWB
Introduction of the Care Bill resulting in an increase in cost of care provision from April 2015, impacting on social care services and funding	High	Working group established and initial impact assessment undertaken of the potential effects of the Care Bill.

Local Government Association

NHS England

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Rotherham MBC	Y	3,453	1,968	3,670
NHS Rotherham CCG	Y	18,385	18,350	18,385
BCF Total		**21,838**	**20,318**	**22,055**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this

The BCF plans are based on robust methods of working which will be further enhanced by targeted investment to deliver the outcomes. Failure to reduce emergency admissions or social care costs will be mitigated in the first instance by any underspends in the BCF funds and CCG/RMBC contingency plans thereafter.

Contingency plan:		2015/16	Ongoing
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population	Planned savings (if targets fully	TBC	TBC
	Maximum support needed for other services (if targets not achieved)		
Proportion of older people (65 & over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Planned savings (if targets fully achieved)	TBC	TBC
	Maximum support needed for other		
Delayed transfers of care from hospital per 100,000 population (average per month)	Planned savings (if targets fully achieved)	TBC	TBC
	Maximum support needed for other		
Avoidable emergency admissions	Planned savings (if targets fully achieved)	2,000	TBC
	Maximum support needed for other	600	
Patient / service user experience	Planned savings (if targets fully achieved)	208	TBC
	Maximum support needed for other	62	
Reduced Emergency Re-admissions	Planned savings (if targets fully achieved)	310	TBC
	Maximum support needed for other	93	

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
BCF01 - Mental Health Service	MH FT	1479		507		1479		507	
BCF02 - Falls prevention	RFT	903		310		914		310	
BCF03 - Integrated rapid response team	RFT/RMBC	610		209		610		209	
BCF04 - 7 day community social care and mental health provision to support discharge and reduce delays	RFT/RMBC	4186				4186			
BCF05 - Social Prescribing	Voluntary Sector	605		208		605		208	
BCF06 - Learn from experiences to improve pathways and enable a greater focus on prevention	RFT/RMBC	27				27			
BCF07 - Personal health and care budgets	RMBC	1268				1268			
BCF08 - Self-care and self management	RFT	50				50			
BCF09 - Person-centred services	Primary Care	3739		1283		3739		1283	
BCF10 - Care Bill preparation	RMBC	1351				1351			
BCF011 - Review existing jointly commissioned integrated services	RMBC	6607				6607			
BCF12 - Data sharing bewteen health and social care		0				0			
Disabled Facilities Grant	RMBC	1013				1219			
Total		**21838**	0	**2517**	0	**22055**	0	**2517**	0

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population - We plan to reduce admissions by 12%
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services - We plan to increase these services by 6%.
Delayed transfers of care from hospital per 100,000 population (average per month) We plan to reduce delayed transfers by 14%
Avoidable emergency admissions (composite measure). We plan to reduce avoidable admissions by 15% over the 5yr strategic planning period which equates to an average of 3% per annum.
Emergency readmissions - there is a plan to reduce the rate of emergency readmissions where clinically appropriate. This is supported by community services which are currently being reviewed to ensure that seven day and locally designed services are in place.

A range of outcomes and benefits from our schemes will be provided via our action plans. All measures will benefit from aspects of :
- Integrated rapid response team - will provide a joint approach to an integrated rapid response service, ensuring a coordinated response is provided to individuals' needs, which supports them to remain independent while reducing admissions to residential care and hospital.
- 7-day community, social care and mental health provision to support discharge and reduce delays, ensuring appropriate services are available 7 days a week to enable timely discharge from hospital, and avoid unnecessary admissions to hospital or residential/nursing care.
- Social Prescribing pilot findings that deliver on prevention, avoidance and delaying access to formal care services with the outcomes of the need for more formal care services being reduced.
- Learning from experiences (of high social care and health users) to improve pathways and enable a greater focus on prevention that sustains users within the community.
- Care Bill preparations, will result in Rotherham adult social care being able to meet the increased demand and maintain / protect the existing level of service.
- Review existing jointly commissioned integrated services (S75 and S256 agreements and pooled budget arrangements) will deliver value for money for customers and provide effective services through de-commissioning/re-commissioning as appropriate.

In addition other actions will impact on specific metrics from the six national and local suite including outcomes resulting from our actions regarding:
- Review of Mental Health provision resulting in greater investment in community based and primary care preventative activity which addresses mental health issues much earlier.
- Falls prevention service improvements identify that where a person is more at risk of a fall, they are provided with the right advice and guidance to help them prevent it.
- Personal health and care budgetsprovision will be maximised to individuals so they are provided with the right information and feel empowered to make informed decisions about their care.
- Self-care and self-management working with voluntary and community groups to co-design, co-develop and co-produce improved health and care outcomes, so that Individuals are provided with the right information and support to help them self-manage their condition/s.
- Person-centred services recorded on a person held plan (using NHS number) will mean individuals will only need to tell their story once and key details are available (in home and on shared portal initially, building to shared IT capacity) which enables integrated, person-centred service delivery.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

National metric to be used

Each metric will have a performance management and assurance process in place. The overall performance management will take place at the Health and Wellbeing Executive (Holds HWB and BCF overview, supports HWB) and will be monitored by the Health and Well Being Board.

Each metric will have:

A designated senior lead ASC/Health operational manager, who will be responsible for delivery of the overall measure performance and has the 'power' to direct available resource to meet service demands within agreed limits.
An agreed action plan, with milestones and target delivery profiles
An appropriate frequency of reporting to Senior Management Teams/Executives/Boards etc
An agreed quality assurance of reported performance
An agreed remedial action plan process when a 'trigger' is activated
An agreed escalation process with sufficient 'power' to direct available resource to meet service demands within agreed limits
Satisfaction testing of outcomes achieved, which when coupled with any complaints learning will lead as appropriate to further improvements being factored into on-going arrangements

Permanent admissions - Delivery of this metric will be lead by Rotherham MBC
Reablement - Delivery of this metric will be lead by Rotherham MBC
Delayed Transfers - Delivery of this metric will be lead by Rotherham NHS
Avoidable emergency admissions - Delivery of this metric will be lead by Rotherham NHS
Emergency readmissions - Delivery of this local metric will be lead by Rotherham NHS

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Not applicable

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	739.6	N/A	650.7
	Numerator	345		317
	Denominator	46645		48720
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	86.7	N/A	91.5%
	Numerator	110		119
	Denominator	130		130
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	126.6	109.1	104.7
	Numerator	256	223	215
	Denominator	202200	204480	205444
		(insert time period Apr 13 - Nov 13 [8 months]	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	499	484	528
	Numerator	2994	2,904	3169
	Denominator	6	6	6
		(April - September 2013)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]		National to be used	N/A	National measure not yet available - data for October 2015 to be provided.
		(insert time period)		*(insert time period)*
Emergency readmissions within 30 days of discharge from hospital (all ages) PHOF 4.11 NHSOF 3b - Note this is a local variation to national measure, and calculates from patients registered with a Rotherham GP, not local authority population.	*Metric Value*	12.10%	11.86%	11.60%
	Numerator	2290	2995	2934
	Denominator	18932	25250	25250
		April - December 2013	*April 2014 - March 2015*	*April 2015 - March 2016*

Appendix 1

Better Care Fund consultation – service user, public and provider engagement

1. Better Care Fund consultation conducted by Healthwatch December 2013 – January 2014

Healthwatch Rotherham was commissioned by Rotherham Health and Wellbeing Board to conduct consultation to undertake consultation with the local community and engage the community in the envisaged transformation of services.

The aim of the consultation was to:

- Seek views on how local people think things are working at the moment
- Get views and ideas on how we could do things better
- Ensure local people in Rotherham know about this activity

The survey was completed by 42 people between 31st December 2013 and 14th January 2014.

Of the surveys completed:

- 25.6% strongly disagreed and 18.6% disagreed some of the time, that there needs as a person were assessed and taken into account. The results show that the participants views were evenly spread across agreeing and disagreeing.
- 27.9% strongly disagreed and 18.6% disagreed some of the time, that professionals involved did not talk to each other and work as a team
- 32.6% strongly disagreed and 30.2% disagreed some of the time, that they were told about other services available and local and national organisations
- 32.6% strongly disagreed and 16.3% disagreed some of the time, that when something was planned, it happened without chasing it up
- 27.9% strongly disagreed and 14.0% disagreed some of the time, that when moved between service there was a plan in place for what happened next
- 27.9% strongly disagreed and 23.3% disagreed some of the time, that they had systems in place so that they could get help at an early stage to avoid crisis

The survey demonstrated that:

- Services are not co-ordinated around a person or family – users and carers do not feel central to decision making and assumptions are made regarding an individual's needs based on previous diagnosis
- People do not talk to each other and there are problems with communication between the patient/service user, family and carers, health and social care services, GP, private companies, housing and all services involved in the persons care. No evidence of joined up care. Good examples of joined up care mentioned included Lifeline, Mental Health Crisis Team and Portage services
- People believe that services require chasing up and agreed actions are not completed – in some cases uncertainty about referrals and what happens next
- Customers and service users are unclear of expectations regarding the service they should receive
- Lack of information provided about local and national services and organisations
- Information and education needs to be improved:
    - People feel trapped in the system falling between services
    - People are given conflicting information

  - No clarity on who the person or the department is that is looking after their health and social care needs
  - Not having their needs been looked at as a whole person or assumptions being made due to a diagnosis
  - Waiting for services/referral to respond with appointments taking too long
- Individuals have a good experience of services when there has been a dedicated key worker or professional
- Level of distrust regarding providers in health and social care
- More nurses and better community care are required to prevent the number of people going into residential and nursing care

Recommended areas for improvement:

- Communication:
  - Service contracts to be drawn up with the service user and carer regarding what is expected by each party and the consequences of failure to keep to the contract
  - Extended usage of emails from professional to professional including service users and carers
  - Health and social care staff working within the same teams with same leadership
  - Key workers to stay involved in a person's care when needed to hand over to a new team/service until the service user/carers needs are fully understood
  - Carers to write their own daily notes on their observations in an everyday setting. This can be used when care is reviewed
  - Acceptance of private assessments to avoid duplication, this should be accepted by statutory services
  - From the beginning of journey consent to share a customer's details should be sought. This could be included in a service contract
  - Decision makers to encourage challenges and to provide a clear rationale for decisions
- Reduce the number of people going into hospital and residential care:
  - Provide information on local and national services, with a quality indicator – extend home from home to provide signposting to private providers on how they get quality checked
  - Use community, family and friends to help
  - Extend roles eg porters to handover patients between wards, community nurses to monitor IV drips
  - Specialist teams to work with GPs to raise awareness and support them to understand the effects of specialist issues
  - After care to be provided for carers eg help to arrange funeral and coming to terms with adapting to not supporting the person they cared for

2. Views of the Customer Inspectors – January 2014

During January 2014 12 RMBC customer inspectors were asked a series of questions focussed around the proposed vision health and wellbeing vision including the 4 priorities, experiences of health and social care services and views on what needs to change to make services better. Key headlines are as follows:

- Do you agree with the vision? 100% of customers surveyed said Yes it is very needed

- Do you think the 4 priorities are the right ones to focus on? 100% of customers surveyed said Yes

- What is your experience of health and social care services?
    - There has been a long wait for hospital appointments. They have cancelled on me three times and then I have had to chase things up myself
    - From my experience departments do not speak to each other
    - Communication is poor eg between GP's, district nurses and the hospital. There has been lots of confusion between appointments and information being faxed from one department to another has caused me a lot of upset
    - I can't fault my home care. It is brilliant and they communicate with each other
    - The Council needs to provide the care again, rather than contracting out. If it wasn't for carers I would be in a home.
    - I am not an unwell person, but when I have needed medical assistance it was there and quickly
    - Direct payments difficult to manage eg timesheets, paying for carers etc.
    - I have a friend who has had a need for social care and has been involved in making all the necessary decisions about her care and she was happy.
    - My sister was in a care home. The care she received was very good. They were brilliant. I think you need to know that your staff are people that really care and not just in it for the money. Can't fault the private home care or the council residential home care at all

- What needs to change to make services better?
    - Some people are too proud to admit they need care when they are having a tough time so they refuse it. We need to be able to put care in place for a person even when they say no. the council need more power to be able to do this
    - Better communication between all services to ensure joined up working. Customer should not have to chase services up. More focus needed on the client eg better training and better communication within the NHS particularly your own doctors.
    - Better care services available in the home and more staff to cope with demands so people can remain independent
    - Better after care is needed. You are just left to it once services are put in place. There needs to be more support available for people. Services are just too difficult to access
    - More accessible information needs to be available to people. I had to find out about what services were available to me, no one told me
    - So much care is external to Council and they don't know what is happening most of the time
    - There needs to be consistency of same workers. Too many services are cut back which means people have different workers and feel unsafe
    - Long waiting times for GP's - It's at least 2-3 weeks before you can get into the doctors and you can get worse in that time

3. **Better Care Fund provider consultation – January 2014**

Emails were sent to 305 social care providers in Rotherham inviting them to take part in a survey around issues related to the Better Care Fund. 7 questions were asked:

- How do you think that the Council and Health could work together better?
- How could the Council and Health work together to offer more support to people to help them live independently in their own homes and communities and keep people out of hospital?
- How could the Council and Health together better support local organisations to provide services that prevent people from reaching crisis point and having to be admitted to hospital?
- What services should the Council and Health stop commissioning and/or start commissioning to support people to live independently in their own homes, manage their own care and keep out of hospital?
- Given the opportunity, how could your business / service better support people to remain independent in their own homes?
- How might your organisation support a 7 day redesigned service to support patients being discharged at weekends and prevent unnecessary hospital admissions at weekends or "out of hours"?
- Given the opportunity, how might your organisation improve the patient or service user experience?

See embedded below the responses to the questionnaire:

Results of questionnaire.xls

The questionnaire also asked providers if they wanted to attend a round table discussion on the Better Care Fund. 9 providers responded positively and the meeting took place 28th January 2014 at Riverside House.

Following a presentation that explained the Better Care Fund, the attendees were asked to discuss the following questions:

- We need to shift resources from acute to prevention, how do you as providers see this working?
- What practically could be done to prevent people going into hospital / staying too long in hospital?
- How do you want us as commissioners to change?
- What are the gaps / what does the future look like?

Below are the notes taken to capture comments on each of the questions:

- We need to shift resources from acute to prevention, how do you as providers see this working?
  - Equipment is key – much lower cost than acute services and prevents people from deteriorating mentally and physically and getting into a downward spiral where they then need an acute service. But equipment and adaptations need to be provided quickly before cases become critical.
  - There are some great funds / grants already in existence but not always marketed and fully utilised. Eg Motability Scheme where people can trade in their Mobility Allowance for a car which can then be driven by the SU, or parents, carers, PA etc. Eg Disabled Facilities Grant which is used to adapt properties. Eg NHS Costs to help people access hospital appointments.

- More information should be given at assessment stage – even when people don't fit the criteria or eligibility. Signposting to community services at this point would be key to preventative action.
- Crisis (mental health) often occurs at night, when a person may call an ambulance – need to have mechanisms in place to support this person without the need for hospital.

- What practically could be done to prevent people going into hospital / staying too long in hospital?
  - Better identification of people at risk. With better communication between agencies it will be easier to identify people who are vulnerable but not currently in receipt of any support
  - Not enough manpower at weekends. All work is geared towards a Mon- Fri week. There is no point in any one organisation working out of hours – the whole system needs to change as all the links need to be in place.
  - More step up and step down beds would be useful. Can we not work with our better performing care homes to provide this?
  - Meal service available as part of care package for a short period of time, would provide a proper meal, and a visit to help a person settle back at home after a time in hospital.
  - Not having appropriate equipment/services/medication support in place often delays discharge, but most services (for equipment etc) close at 5pm – there needs to be more out of hour services, not just 7 days.
  - Carers need to feel confident about the care package and support which the person requires after being in hospital
  - All support services (that provide equipment/social care/dom care etc) need to communicate and work better together.

- How do you want us as commissioners to change?
  - Reduce bureaucracy – example given of it being very common to experience delays in receiving a commode. People have to talk to different agencies, repeating their story and experiencing delay. In the meantime they reduce their liquid intake, find themselves dehydrated. This can result in illness and/or a fall which then leads to acute services being required.
  - Help organisations link up and work together. Eg an LD provider did not know about Community Transport.
  - GPs are often first point of contact – commissioners need to work with GPs to ensure that preventative solutions are utilised eg Social Prescribing Service.
  - Transport is not always taken into consideration when planning DP packages – rendering the package useless.
  - Commissioners of health and social care currently work separately, need them to work more joined up and see the whole person (not just single issues in isolation).
  - Savings that could be made in acute/health sector through more focused prevention/social care support should be realised by all commissioners and money could be reinvested appropriately.
  - People often deteriorate quicker in hospital than if they were at home, if social care/support provision is put in place earlier they could be prevented from going into hospital – which then has a knock-on effect, because is a person does go into hospital their social care needs may be greater when they come out
  - In dom care, when a person is assessed as needing continuing healthcare, the dom care provider loses the person because the contracts are different for

CHC, this can cause distress for a person who is familiar with their carer and comfortable with their care package – change can be difficult.

- What are the gaps / what does the future look like?
  - There should be better education around health and social care. Don't wait until people are in crisis as then they are unable to take all the information on board. People should be taught to plan their health care in the same way that people plan their finances – early on and proactively. Awareness should begin in schools
  - People use A&E/hospital for the wrong reasons – need to raise awareness about the services/support available for people when hospital is not the most appropriate place e.g. people may call 999 as they know someone will pick up the phone – and there may be a stigma to other support, such as charity organisations
  - Marketing about support organisations needs to be targeted to those most likely to use hospitals inappropriately – often if they are lonely/want some company
  - There is no longer a sense of community – people's social needs are not met in their community. People often reply on things like day centres, and when they are gone, they lose touch with other people – people need to have this social interaction in another way.
  - People attending mental health day centres, don't want to get this interaction elsewhere, as through a day centre they meet with people they are familiar with and likeminded.
  - How do we engage people more in their community – it is cheaper to fund and support community groups to establish themselves and reach out to people in the area, than a social care/health care package or hospital.
  - We have created a dependent society, where things/services are provided to people, we need to encourage independence more and help people to engage in their community.

4. Health and Wellbeing consultation – July – August 2012

Consultation on the Rotherham Joint Health and Wellbeing Strategy took place between July – August 2012 to help shape the priorities. In addition a summary of the outcomes of the consultation were fed back at a VAR/LINk hosted event which took place on 24th July 2012.

The consultation was focussed around the proposed vision and priorities, how the priorities would be achieved and barriers to achieving these.

A summary of the findings from the consultation were as follows:

- The vision and 6 priorities were the right ones, however the following suggestions were made regarding what needs to happen and change:
  - Priority 1 Prevention and early intervention:
    - Commissioning process to redirect services to prevention
    - Collaborative working and investment needs to be made into the VCS
    - Face to face/person centred approaches are important
    - Requires a shift and pooling of resources
    - Consideration to be given regarding how people who need services are reached
  - Priority 2 Expectations and aspirations:
    - Need to be clear - tailored standards required and communicated

- Although this priority is important it should be cross cutting across the strategy
- Training of staff required to ensure they know what is available
- Improve partnership working
- Develop different ways of getting information out to people
- Priority 3 Dependence to independence:
  - Collaborative working and investment needs to be made into the VCS
  - Better promotion and use of community transport to help people access services
  - All staff need to be aware of services available to signpost individuals
  - Simpler patient pathways required
  - Support which an individual receives should decrease as an individual becomes more dependent
  - Use of telecare is crucial to support independence
- Priority 4 Healthy lifestyles:
  - Accessible information is required in different formats
  - Small pots of funding required to make things happen
  - Better sharing of resources is required
  - Motivation is different for different people, need to look at behavioural changes
- Priority 5 Long term conditions:
  - Protocols required to share information from VCS
  - People are not always aware of voluntary and community groups available
  - End of treatment can lead to a feeling of abandonment, need to consider transition
- Priority 6 Poverty:
  - Need to improve job creation/entrepreneurship and improve take up of European funding
  - Carers often give up employment to provide care – flexible support is required
  - Workers need to be aware of what facilities are available to support people and improve skills
  - Funding needs to be more accessible

- Issues raised regarding some of the language used, suggested that some areas needed to be reviewed to ensure clarity regarding what was to be achieved and by when including priority 2 (Expectations and aspirations) and what this meant
- Felt that good partnership working would be required to achieve the outcomes
- Strong view that the shift from high dependency to early intervention was the right approach, however disappointed that the draft strategy did not refer to the VCS
- Concerns that not everyone could be treated through early intervention and enablement and that there should be plans in place for those that need acute care
- Comment made in relation to measuring success and whether any consideration had been given to what an undesirable outcome would be, if the outcomes were not achieved. Suggested that this needed to be built into the PMF.

5. Learning from customer complaints

Rotherham Council received a number of complaints between 2012-13 relating to Assessment and Care Management and Health and Wellbeing.

Strategic outcome	Service	Complaint
Prevention and early intervention, Dependence to Independence and	Home Enabling	Customer is not happy that their mother has to change care provider after 10 years. From in house domiciliary care to a private provider.

expectations and aspirations		
Expectations and aspirations	Hospital Social Work Team / Home Enabling	Customer was charged for care on discharge / assessment by Hospital Social Work Team as care was arranged via private provider rather than enabling care.
Expectations and aspirations	ACM – Older people	It was apparent that customer misunderstood information provided to them at assessment. This led to their care being reduced and for them to complain and challenge the assessment.
Prevention and early intervention, Dependence to Independence and expectations and aspirations	Assessment Direct/Enabling	Not happy with the assessment of their family member, how it was completed and the outcome as it left them without care. They did not want to go from 4 enabling calls to 0.
Prevention and early intervention, expectations and aspirations	Assistive Technology	Customer complained about the delay in equipment being ordered due to backlog of work caused by annual leave
Expectations and aspirations	Intermediate Care Netherfield Court	Customer complained that they had not been informed of falls suffered by a relative while in Intermediate Care
Expectations and aspirations	Unplanned Review	Customer complained about delays in assessment and submission to resource panel for a request to increase for customers mother
Expectations and aspirations	Home enabling	Customer complained about a missed call and the way a carer handled her mother
Expectations and aspirations	Unplanned Review	Customer complained about repeated unkept promises from a Social Worker to keep in contact regarding money owed for care
Expectations and aspirations, prevention and early intervention	Home Enabling	Customer complained about Missed calls from Home Enablers, the delay in sending out complaints leaflets and the lack of apology from the office in respect of a missed call

6. Customer Insight and service improvement (Continuous activities)

Rotherham Council has a strong, customer focussed performance management framework which tests services through customer experience on an ongoing basis. Techniques to gain customer insight and reality check services include:

- The Customer Inspection Service
- Customer Journey Mapping
- Customer Insight (quality checking calls, testing web pages)
- Mystery Shopping

This information regularly informs service improvements and helps to identify priorities for the council. For example, a recent Customer Insight Report which involved listening in to calls made by customers to the *Rothercare Service* identified that 4 out of 10 customers were not able to access the out-of-hours social care service due to no social worker being on duty. This highlights the need to improve our arrangements to ensure customers are provided with appropriate support out-of-hours and has fed in to our Better Care Fund Plan for action.

7. Local Account 2012/13

Customer insight is shared with the general public annually through our Local Account. This summarises how adult social care services performed in the previous year and sets out key priorities for the year ahead. The customer voice is prevalent in the account through '*you said; we did'* statements and customer case studies. The account gives a balanced view of both achievements and areas for improvement.

Last year's account celebrates the Home Enabling Service which improved the customer's experience and outcomes during 2012-13. A total of 892 people were referred to the service, of these customers 42.8% resulted in being fully enabled to live in the community.

This was achieved by joining up more effectively with our partners (Hospitals, Social Workers and Therapists) to speed up the support provided for the customer. We have improved the national measure of how effective enablement services are with the numbers of people still living independently at home 91 days after discharge, from 85.5% to 86.7% which is well above national (81.5%) and similar council comparator average of 77.7%.

Customer quotes:

- *"Very satisfied helped me to get on my feet again. Thank you very much". "The service you all gave was amazing - we were so very grateful. Please pass on my thanks.*
- *"Very pleased with the care I received"*
- *"Very useful and a godsend under the circumstances. The carers have proved themselves cheerful, helpful and very obliging"*

Last year's account also evidences where existing integrated services have worked well together, for example Intermediate Care Services are integrated step-up, step-down facilities which support people to re-gain their independence and live in the community.

Customer quotes:

- *'This is a very good place, I have had a*
- *lot of help from pleasant people; I cannot fault it'* (Lord Hardy Court)
- *"I enjoyed my stay at Netherfield Court and would recommend it to anyone. Thank you" (RICC)*
- *"The service has given me confidence" (RICC)*

The account also sets out our future intentions to support more people to live independently in the community, by:

- reducing spend on residential care by a total of £4.880m
- decommissioning 30% of residential care and commissioning community based alternatives such as Extra Care Housing and Supported Living
- increasing the amount of joint funding into intermediate care - step up step down beds

The account evidences what progress has been made on this so far; In 2012/13 we placed 78 less people in permanent residential accommodation by expanding what works - our preventative intermediate care services.

Further intentions for 213/14 included in the Local Account, which support the delivery of the BCF include:

- Support more people to live in their own homes and reduce the number of people who need to go into a residential home
- Improve the experience of customers who want to access services and need advice and information, including out of hours
- Speed up the way we assess people when their needs have changed.
- Increase the number of services and support for carers

8. ASCOF Adult Social Care User Survey 2011-12

An annual national survey carried out by the NHS Information Centre for health and social care and all local authorities with Social Services Responsibilities are required to take part. The survey asks service users about their quality of life and their experiences of the services they receive.

The survey is sent to those receiving services including service users in residential care, those who have a learning disability and those who use mental health services.

388 surveys were completed and returned.

- **Quality of life -** ASCOF Score 19.2 (Improved from 19.1 in 2011/12)

Overall the results are positive and RMBC are in the top quartile nationally however:

- 3.9% (15 out of 388) of people felt they had no control over their daily lives
- 7% felt socially isolated
- 5.8% felt they did not do anything valuable with their time
- 3.7% found it very difficult and 10.1% found it fairly difficult to find information and advice about support, services and benefits
- 2.6% don't feel safe and 18.7% do not feel that the care and support services which they receive make them feel safe

9. Personal Social Services Survey of Adult Carers in England 2012-13

An annual national survey carried out by the NHS Information Centre for health and social care and all local authorities with Social Services responsibilities. The survey asks carers of service users about their quality of life and their experiences of services they receive.

336 surveys in total were completed and returned.

- **Carer reported quality of life** – ASCOF Score 8.8 (Improved from 8.4 in 2009/10)

Overall the results are positive and RMBC are in the top quartile nationally. The majority of carers were also satisfied with the support/services they received however:

- 62.9% said that they did some things they valued with their time but not enough and 5.5% said that they don't do anything they value or enjoy with their time
- 56.8% said that they have some control over their life but not enough and 7% said that they have no control over their daily life
- 16.6% said that they have some worries about their personal safety and 2.1% said they were worried about their personal safety
- 36.5% have some social contact with people but not enough and 10.3% have little social contact with people and feel socially isolated
- 33.3% feel that they have some encouragement and support but not enough and 13.7% felt they have no encouragement and support
- 17.6% said that they had not been consulted in the last 12 months

10. Health Inequalities consultation – September 2011

The RMBC Public Health Team conducted health inequalities consultation with 426 people in September at the Rotherham Show. Key headline included:

- 41.3% of people felt that health in Rotherham had got worse and that the main contributors to this were unemployment, less money and increased costs of weekly

shops. Only 9.7% said that this was as a result of lack of health services and 20.9% as a lack of health choices.

- 52.5% of people thought that the NHS and Council should provide more information about eating healthy and 52.3% think that people should be encouraged to do more physical activity to improve people's health. However, only 29.6% of people thought that there needed to be easier access health services.

In addition a number of consultation focus groups were held and the problems and solutions suggested were as follows:

- Cost of living
  - Raise awareness of food schemes
  - Provide budgeting advice and support
  - Employers to offer flexible working arrangements
  - Teach people to cook from scratch
- Skills for life
  - Life skills are required not just employment eg cooking, budgeting
  - Provide parenting support
  - Provide opportunities for all abilities
  - Wider awareness needed regarding what is available
- Look and feel of Rotherham
  - Basic standard of housing and code of conduct for private landlords
  - Community engagement in town centre regeneration
  - Increased opening hours of shops and cafes
  - Presence in Town Centre – people, police, community wardens
- Health
  - There are confusing messages across services. Direct clear advice and support is required
  - Increase awareness of good health and prevention as there is a lack of self-awareness which impacts on behaviours
  - Standard core offer from GPs eg opening times and services
  - Offer support groups and raise awareness of what is available
  - Use of co-ops eg food crisis
  - Improve access to services
- Communities
  - Communities need to work better together/community integration
  - Improve communication about community groups and the value of these

11. **Staff Consultation**

A number of workshops were held in autumn 2013 to map out the process from point of admission in to hospital to discharge to recognise where the points of interface are between health and social care and identify improvements to provide the patient with a better experience.

The workshops had good joint representation from health and social care, and a number of issues were raised about the way the current system operates. The key themes emerging were as follows:

Prevention:

- 'Patients circumstances and needs can change after the pre-assessment takes place (for scheduled care) resulting in patients requiring a bed following day surgery'
- 'A&E is a fall-back position for crisis teams'

- ‘Criteria for services is not being applied flexibly resulting in patients being refused access’
- ‘Lack of capacity in the community can result in (avoidable) admission in to an acute bed’

Delay in the system – delaying discharges

- ‘Out of hours causes inappropriate admission and delayed discharges’
- ‘Patients are referred to the Hospital Social Work Team inappropriately’
- ‘Discharge planning is often not commenced until the day of discharge’

These issues will be fed in to the BCF Plan.

***12.* Patient Participation Network**

Rotherham CCG co-ordinates a Patient Participation Network that brings together patient representatives from GP Practices across Rotherham. Patient Participation Groups have been meeting throughout the year, providing feedback on local health services. The Patient Participation Network meets on a quarterly basis, bringing together patients’ views from across the local health economy. As part of an exercise to develop the patients’ view of the CCG’s five year strategy, the Network has identified the following priorities that could be addressed as part of the Better Care Fund Plan.

- Patients should be in the driving seat when it comes to their own care
- Services should be available 7 days/week
- There should be better education and information for people with long term conditions
- Social care, healthcare and voluntary services should work closely together
- More people should be treated at home Invest in community nursing services which are critical to home-based support

Appendix 2. ROTHERHAM BETTER CARE FUND ACTION PLAN

Ref.	Scheme	Action	Outcome	Measure/s
HWB Strategy: (PE) prevention and early intervention – Rotherham people will get help early to stay health and increase their independence				
PE1 – We will co-ordinate a planned shift of resources to high dependency services to early intervention and prevention				
BCF01	Mental Health Service	Commission mental health liaison provision, ensuring it is aligned to health and social care priorities for prevention and early intervention.	A jointly agreed plan which results in a reduction in formal, high intensity use of services (including acute services and police intervention) and a greater investment in community-based and primary care preventative activity which addresses mental health issues much earlier on. *'I am listened to and supported at an early stage to avoid a crisis'*	Admissions to residential and care homes Avoidable emergency admissions Patient/service user experience Emergency readmissions
BCF02	Falls prevention	Review the falls service to ensure its primary focus is delivering a preventive community-based service, as well as targeting those most vulnerable, who are most at risk of fracture neck of femur.	Older people are aware of the risks of falls and have opportunities to remain active and healthy in their community. Where a person is more at risk of a fall, they are provided with the right advice and guidance to help prevent them. *'I feel safe and am able to live independently where I choose'*	Admissions to residential and care homes Effectiveness of reablement Avoidable emergency admissions Patient/service user experience

				Emergency readmissions
PE2 – services will be delivered in the right place, at the right time, by the right people				
BCF03	Integrated rapid response team	Implement a joint approach to an integrated rapid response service, including out of hours, capable of meeting holistic needs of identified individuals to reduce hospital admission. Incorporate community nursing, enabling and commissioned domiciliary care.	A coordinated response is provided to individuals' needs, which supports them to remain independent while reducing admissions to residential care and hospital. *'I feel safe and able to live independently where I choose'*	Admissions to residential and care homes Effectiveness of reablement Delayed transfer of care Avoidable emergency admissions Patient/service user experience Emergency readmissions
BCF04	7-day community, social care and mental health provision to support discharge and reduce delays	Review and evaluate existing arrangements against potential increase in demand arising from 7 day working across the community, social care and mental health.	Appropriate services are available 7 days a week to enable timely discharge from hospital, and avoid unnecessary admissions to hospital or residential/nursing care. *'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing'*	Admissions to residential and care homes Effectiveness of reablement Delayed transfer of care Avoidable emergency admissions

				Patient/service user experience Emergency readmissions
HWB Strategy: (EA) All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community				
EA1 – We will ensure our workforce routinely prompt, help and signpost people to key services and programmes				
BCF05	Social Prescribing	Review social prescribing pilot to ensure it is delivering on prevention, avoidance and delaying access to formal care services, and commit to mainstream this service subject to findings.	The need for more formal care services is reduced, creating an opportunity to shift investment into community activity that fosters independence and encourages local people to participate in their community. *'I feel part of my community, which helps me to stay healthy and independent'*	Admissions to residential and care homes Effectiveness of reablement Delayed transfers of care Avoidable emergency admissions Patient/service user experience Emergency readmissions
EA2 – We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions				
BCF06	Learn from experiences to improve pathways and enable a greater focus on	Undertaken a deep dive exercise conducted on cases of high social care and health users. Map the journey through health and social care services to identify opportunities to improve pathways and explore where better	A shift in investment from high-cost, high-intensity users of health and social care, to low cost high impact community initiatives which focus on prevention. A co-produced (between health, public health and	Admissions to residential and care homes Effectiveness of reablement

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	prevention	preventative action earlier on may help avoid or delay access to health and care services in the future. Carry out a full evaluation of Rotherham's risk stratification tool, and develop a mechanism for identifying high intensity users of health and social care services.	social care) risk stratification tool to identify high intensity users. *'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing'*	Delayed transfers of care Avoidable emergency admissions Patient/service user experience Emergency readmissions
HWB Strategy: (DI) Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances				
DI1 – We will change the culture of staff from simply 'doing' things for people to encouraging and prolonging independence and self-care				
BCF07	Personal health and care budgets	Commitment to giving personal budgets to as many people as possible, and will develop our plans to do this. Extend our current plans for personal health budgets, working with patients, service users and professionals.	Individuals are provided with the right information and feel empowered to make informed decisions about their care. *'I am in control of my care'*	Admissions to residential and care homes Effectiveness of reablement Patient/service user experience
BCF08	Self-care and self-management	Develop self-care and self-management, working with voluntary and community groups to co-design, co-develop and co-produce improved health and care outcomes, including the areas of transitions from young people's services into adult care. Develop patients and practitioner skills programmes that can be implemented across health and social care.	Individuals are provided with the right information and support to help them self-manage their condition/s. Professionals are equipped with the right skills to enable self-care / self-management and promote independence. *'I am in control of my care'*	Admissions to residential and care homes Effectiveness of reablement Avoidable emergency admissions

		Development of integrated workforce development programmes and risk management courses aimed at promoting an ethos of self-management. Develop specialised psychological support services for people with long term conditions so that they are better able to self-manage their condition.		Patient/service user experience Emergency readmissions
DI2 – We will support and enable people to step up and step down through a range of statutory, voluntary and community services, appropriate to their needs				
BCF09	Person-centred services	Develop and implement a person centred, person held plan, in partnership with key stakeholders.	Each individual has a single, holistic, co-produced assessment, meaning they only need to tell their story once and key details are available (in home and on shared portal initially, building to shared IT capacity) which enables integrated, person-centred service delivery. *'I am in control of my care'* *'I only have to tell my story once'*	Patient/service user experience
BCF10	Care Bill preparation	Identify the cost and activity pressures resulting from the implementation of the care bill, including increased assessments, carers assessment and support, information advice and guidance capacity, and resulting administrative and operational costs. Develop a plan to meet these pressures.	Rotherham adult social care is able to meet the increased demand and maintain / protect the existing level of service.	The Care Bill will impact on all BCF outcome measures
HWB Strategy: (LC) Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life				
LC1 – We will adopt a co-ordinated approach to help people manage long term conditions				
BCF11	Review existing jointly	Undertake a project to review all existing S75 and S256 agreements and pooled	All jointly commissioned services provide value for money and are aligned with the BCF vision	All integrated services impact

	commissioned integrated services	budget arrangements.	and principles. Where services are not efficient and effective, a plan is developed to de-commission/re-commission as appropriate.	on BCF outcome measure/s
LC2 – We will develop a common approach to data sharing so we can provide better support across agencies and put in place a long-term plan for the life of the individual				
BCF12	Data sharing between health and social care	Develop portal technology to share data in a secure way that is in the best interest of people who use care and support. Use of the NHS number as a unique identifier across health and social care will create the starting point for the development of shared IT capacity.	All providers have access to integrated person-held records, which include all health and social care plans, records and information for every individual. *'I only have to tell my story once'*	Delayed transfer of care Avoidable emergency admissions Patient/service user experience Emergency readmissions

Agenda Item 12

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1	Meeting:	Health Select Commission
2	Date:	Thursday 13 March 2014
3	Title:	Response to Scrutiny Review of Continuing Healthcare
4	Directorate:	Neighbourhoods and Adult Services

5 Summary

Continuing Health Care (CHC) relates to NHS funding which is allocated to people whose health care needs meets a nationally agreed threshold. Following concerns that citizens in Rotherham were not being served well due to CHC spend being lower than nearby and statistical neighbours; a Review of Continuing Health Care was led by the Joint Health and Improving Lives Select Commissions in 2012. A number of recommendations were made which it is intended will improve the experience of citizens and ensure that a fairer share of CHC funding is received within Rotherham.

Following receipt of the report, a senior management working group consisting of both RMBC and NHSR staff agreed a set of actions to ensure effective multi disciplinary working and deliver better outcomes for customers. This report provides a further update to Cabinet regarding progress made against the action plan.

CHC and social care assessments are completed by health and social care staff presently or recently involved in assessing, reviewing, treating and supporting the customer. In terms of highlights from the process, a better working relationship exists and understanding of each professional's role in participating in a multi disciplinary assessment and completing the Decision Support Tool (DST), however, it is yet to be seen whether this will impact on the financial position as positively as is required.

6 Recommendations

- **Health Select Commission update on progress and issues arising from scrutiny review of Continuing Healthcare.**

7 Proposals and Details

7.1 The recommendations of the Joint Select Commissions have been addressed through joint work between NHS Rotherham and RMBC. Good progress has been made in addressing the recommendations, as can be seen from the attached plan, which has been reviewed. Unfortunately significant changes in the NHS, including the transfer of responsibilities to the Clinical Commissioning Group and the local National Commissioning Board did result in some delays in agreeing the devised joint protocol, which reflects the National Guidance for NHS Continuing Healthcare and NHS Funded Nursing Care and which addresses local issues identified by the Select Commission.

This piece of work has been delayed following the restructure and the move of CHC team over to CCG/Commissioning Support Unit, along with the actions required to drive Personalisation of services in Rotherham forward across Health and Social Services.

7.2 Attempts to ensure that this process continued were made and a joint leadership meeting took place between the CCG and RMBC to discuss progress. At this meeting, the progress that had been made by Adult Services was noted; however it became clear that there were a number of issues relating to assessment, decision making and access to CHC (Continuing Health Care) for children with complex needs. It became apparent that for children and young people with significant needs, there are two main areas which need to be improved: first, reviews of current cases and consideration of a number of new cases which have yet to be assessed and considered by the Panel; and second, an improved system of decision making through a revised Continuing Care Panel which complies with national guidance on Children's Continuing Healthcare and 'Who Pays'. At this meeting there was a commitment to address the backlog by the end of March 2014. However, it has become apparent that the CCG and CSU are unable to meet these deadlines. As a result, the Chief Executive raised this as a concern with the CCG in writing. The commitment which has now been made is that the CCG will backdate their financial commitment for cases in 2013-4 to the date from which the package of care started for children and young people agreed as eligible for CHC funding; and that they are seeking clinical assessment support to carry out the work. A group of CCG and LA staff are meeting fortnightly to progress the agreed programme of work.

7.3 With regards to the joint protocol, it has been drafted and work has commenced with continuing healthcare manager/staff and RMBC CHC champions now CHC lead is in post. Specific training for those working in children's services will be based on regional advice, following the National Guidance on CHC, and take account of the new Panel arrangements. The protocol will include how to resolve disputes, and written guidance for staff will be produced to ensure consistency and compliance once it has been issued.

7.4 It has been agreed that training will be delivered jointly by CHC/LA leads and rolled out across hospital, community health and social care teams. As recommended, examples of local case studies, with examples of completed and anonymised Decision Support Tools will be used, ensuring that staff can learn from the experience of Rotherham customers. Progress on the delivery of the training has been delayed and we now require the CCG to provide information regarding the start date for that training.

7.5 The RMBC/CHC Senior Management group, Personalisation Workstream will continue to meet and consider budget issues and to develop cost effective delivery of personal health budgets by 1st April 2014 based on a pilot project implemented from 1st April 2013.

7.6 Improved engagement has been achieved through the attendance at CHC panels. It is now routine that RMBC CHC champions attend ratification panel meetings as part of the Multi Disciplinary Team and implement joint actions. CHC Champions ensure that issues are addressed in a timely manner.

8 Finance

The latest Yorkshire and Humberside CHC benchmarking information for the final quarter ending 31 March 2013, Rotherham is ranked 7 out of 15 in terms of the number of people receiving CHC funding. In terms of actual expenditure Rotherham is ranked 10th and therefore still below the average spend per person within the region.

9 Risks and Uncertainties

9.1 The following actions have been taken forward by RMBC/CHC strategic leads to implement Scrutiny's recommendations and minimise risk to the council

9.1.1 Monthly meetings are held between strategic leads to consider budget issues, address joint protocols, transitions between funding streams and services etc.

9.1.2 Operational leads continue to meet weekly to address day to day issues and improve communication.

9.1.3 Written protocols – work has commenced and a joint training plan is in place, and plans are in plan to disseminate to health and social care professionals.

10 Background Papers and Consultation

Review of Continuing Health Care in Rotherham – Joint Report of the Health and Improving lives Select Commissions

National Framework for Continuing Health Care – Department of Health

Contact Name: Michaela Cox, Service Manager
Telephone: ext 55982
E-Mail michaela.cox@rotherham.gov.uk

Cabinet's Response to Joint Select Commission Review of Continuing Healthcare

Recommendation	Response *(detailing proposed action if accepted, rationale for rejection, and why and when issue will be reconsidered if deferred)*	Officer Responsible	Action by *(Date)*
1. Assessments: 1a) To consider options for ensuring the CHC and social care assessments are undertaken together and develop an agreed protocol for how this should be delivered	Requirement within the National Framework to conduct reviews in a timely manner and work with RMBC through Joint Working Group. Work has commenced to devise a joint local CHC/LA protocol which reflects the National guidance for NHS Continuing Healthcare & NHS Funded Nursing Care which addresses local issues. This piece of work will continue following the restructure and the move of CHC team over to CCG/CSU and changes within CHC team have been fully implemented. **UPDATE** This piece of work is delayed and needs to be progressed 2/7/2013 Following the restructure of the NHS, CHC has now successfully moved over to be part of the CSU. The implementation of the National Framework for NHS Continuing Health Care and NHS Funded Nursing care December 2012 was implemented from 1st April 2013. CHC continues to follow the National Framework for NHS Continuing Health Care and NHS Funded Nursing Care December 2012 to ensure that reviews are conducted with in a timely manner and work with RMBC. Any issues to be flagged through the joint working Group	**MC** **SMc/SL**	Ongoing
1b) To consider options for utilising the use of step up/step down units much more widely, and enable assessments to be undertaken in this setting	Community hospital now in operation providing a degree of step up/down care. Additional Step Up Step Down beds in Intermediate Care Service have 89% occupancy rate. Impact of community hospital to be monitored	**DB**	Complete

2. Training: 2a) To refresh the CHC training package, ensuring it is up to date, appropriate for the different staff involved and rolled out to all relevant staff periodically	Refreshed National Framework released for implementation April 2013 CSU nominated lead to develop an appropriate CHC training package to be rolled out locally across SY&B area 2/7/2013 The CSU has appointed an individual who is in post to develop an appropriate CHC training package to be rolled out locally across SY&B area. The training will be accessible to all health professionals and Social workers and Social services officers 24/10/2013 CHC have developed a CHC training package for Health and Social Care professionals. The Package as been discussed with LA Paula Brown and Lyndsay Bishop. A meeting has been arranged with Paula Brown on the 31st October to discuss an plan for dissemination the training package **UPDATE** Implementation is delayed, CHC to be required to provide a deadline for completion.	**DM/SM**	Complete Ongoing
2b) To ensure the training package incorporates local case studies and opportunities for feedback to relevant workers on completing the assessment process to enable shared learning	CHC training package incorporate case studies to assist in application and learning CSU operational lead with responsibilities for training to undertake training delivery Examples of local case studies, completed and anonymised DST will be used and feedback given. 2/7/2013 The CSU has appointed an individual to develop an appropriate training package to be rolled out across SY&B. All training will incorporate case studies 24/10/2013 CHC have developed a CHC training package for Health and Social Care professionals. The Package has been discussed with LA Paula Brown and Lyndsay Bishop. A meeting has been arranged with Paula Brown on the 31st October to discuss an plan for dissemination the training package Scenario has been included in the training package	**DM/SM**	Complete Complete

3. Written Protocols:	As per National framework		
3a) To clarify issues in relation to who should be the lead worker for individual cases and how to resolve disputes by producing written, agreed guidance for all to adhere to	Work to be undertaken through Joint Working Group Joint protocol, work will re commence with continuing healthcare manager/staff and RMBC CHC champions. Protocol is drafted – includes how to resolve disputes, written guidance will be produced. 2/7/2013 Work to be undertaken through the joint working group to revisit the local resolution/ dispute process which is currently in place and to develop a protocol to include a written guidance to include and resolve disputes with agreement with all parties involved – CSU,CCG and LA **UPDATE** **This work to be completed by 28.2.14**	**SMc/SL**	28.2.14
3b) To put in place written agreement regarding the backdating of funding when a person is admitted to a nursing unit based on a fast track or checklist, pending a full DST being completed (protocols for weekends/holidays etc)	As per Framework. Any issues to be discussed through Joint Working Group. Guidance will be provided within the joint protocol. 2/7/2013 The National Framework For NHS Continuing Healthcare and NHS Funded nursing Care December 2012 and Refund Guidance will be followed with regards backdating of funding when a person is admitted to a nursing unit based on a fast track or checklist - pending a DST being completed	**SMc/SL**	Ongoing
3c) To agree and put in place an appropriate joint 'exit strategy' for people moving from high level of care to lower level (within and across service providers)	Agreed 14 day turnaround in principle with LA - agreed	**SMc/SL**	Complete
3d) To agree joint protocols for engaging with service users to gather their experience and views for the purpose of service improvement	Currently patient feedback sought for Domiciliary care packages and captured in service user/customers survey. Outcomes are fed through to Joint Working Group. Customer Outcomes also to be monitored through new Personal Health Budgets pilot . 22/8/2013 - the current process continues. CHC nurses continue to use Quality of Domiciliary care proforma each time a review is completed – these allows any issues/ compliments to be discussed with care providers therefore improving the service provided to our patients.	**SMc/SL**	30/8/2013 Ongoing

4. Joint Working 4a) To ensure the continuation of MDT meetings on a regular basis to improve joint working and communication across agencies	Currently meeting are organised by RMBC . To continue with inclusion of the identified CHC leads within the CSU. RMBC CHC champions to continue to attend eligibility panel as part of the MDT.	**DM & Op lead**	Complete
4b) To put in place joint strategic liaison meetings on a twice yearly basis, to allow for issues to be raised across agencies in an open and honest forum (including budget issues, transition planning and implementing the proposals within the Care and Support Bill)	Joint approach between RMBC & CCG agreed to take place alternate months with input from CHC nominated lead. RMBC/CHC working group to continue to meet and address budget issues and implementing the proposals within the Care and Support Bill.	**SMc/SL & CHC lead**	Complete
4c) For the NHS and Local Authority to agree appropriate arrangements to consider discharge planning to avoid delays	Work has been undertaken through discharge strategy group which includes LA and CHC members NHS and Local Authority consider a customer's needs and start planning for discharge on admission. Guidance will be given in the joint protocol.	**SMc/SL & CHC lead**	Complete
4d) To consider options in relation to closer working across agencies, based on examples of good practice e.g Maltby Service Centre	RCCG commissioned integrated Health & Social care teams across Rotherham as part of the wider strategy to improve the care of patients with long term conditions	**SMc/SL & CHC lead**	Complete
5. Panels and Appeals 5a) To address concerns in relation to the lack of representation from the Local Authority at CHC panel meetings	CHC ratification panel undertaken daily LA reps now attending Tuesday and Thursday.	**LB/PB & SM**	Complete
5b) To ensure there is expert knowledge via an appropriate worker (such as a learning disabilities representative) on future CHC and Dispute Panels	Currently distinct LD panel runs monthly. CHC rep present on appeal panels also attended by LD service leads. John Williams Service Manager Learning disability Service attends.	**DM & Op lead**	Complete

5c) To review the current Dispute Panel, and take action to ensure this is an independent, multi-disciplinary panel which includes representation from the Local Authority	Appeals & disputes currently handled by central CSU retrospective team who organise MDT panel inclusive of a LA rep. Any revision to be taken forward through Joint Working Group	**DM & op lead**	Complete
5d) To review the decision making process and look to streamline panels where possible to reduce delays and inconsistencies	Ratification of applications as per the principles of the National Framework. Any issues to be discussed through Joint Working Group	**DM & op lead**	Complete
5e) To ensure that all workers are routinely giving service users information leaflets and that the appeals process and their right to appeal is clearly explained at the beginning of the process	Principles of National Framework followed - information and/or leaflets supplied routinely. Staffs have access to information, leaflets and explain the appeals process at the offset when assessments are completed and the CHC process explained.	**DM & op lead**	Complete
Reviewing Recommendations: 6) For the Health Select Commission to receive a report from the CHC manager 6 months from the recommendations being approved, to ensure they are being implemented and making progress to improve this service in Rotherham.	Progress has/is being made to improve services in Rotherham. These are contained within this report and any further requests for updates to be discussed through Joint Working Group	**SMc/SL**	Complete

Key to named individuals:

MC – Michaela Cox DM – Debbie Morton DB – Dominic Blaydon SM – Sheena Moreton
SMc – Shona McFarlane SL – Sarah Lever LB – Lindsay Bishop PB- Paula Brown

Agenda Item 13

ROTHERHAM BOROUGH COUNCIL - REPORT TO MEMBERS

1.	**Meeting:**	Health Select Commission
2.	**Date:**	Thursday 13 March 2014
3.	**Title:**	Support for Joint Health Overview and Scrutiny Committee
4.	**Directorate:**	Resources

5. Summary

The report provides the background to the new review of congenital heart disease services and seeks to reaffirm support for the establishment of a Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) in relation to the review.

6. Recommendations

That the Health Select Commission:

6.1 Notes the contents of the report.

6.2 Confirms the Chair of the commission as its nominee to sit on the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) in relation to the new review of Congenital Heart Disease services, in line with the attached terms of reference.

6.3 Makes the following recommendations to full Council.

a) That Council reaffirms its support for the establishment of a Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber); in relation to the new review of Congenital Heart Disease services, as set out in the attached terms of reference.

b) That Council agrees that the relevant functions (in relation to the Council) set out in the attached terms of reference for the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) shall be exercisable by that Committee, subject to the terms and conditions set out in the attached terms of reference.

c) That Council agrees to appoint the Chair of the Health Select Commission to the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber).

d) That any necessary amendments are made to the Council Constitution.

7. Proposals and details

The purpose of this report is to provide the background to the new review of congenital heart disease services and to ask the Health Select Commission to consider and make recommendations to Council regarding reaffirming support for the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) [JHOSC] in relation to this new review.

The previous work of the JHOSC with regard to the Safe and Sustainable Review of Children's Congenital Cardiac Services in England (SSR) is well known and well recorded. There is clear support from the constituent authorities for the work of the JHOSC to continue and for the new review of congenital heart disease services to benefit from similar robust scrutiny arrangements.

7.1 Background information

A JHOSC was initially established in March 2011 to consider the SSR – the associated proposals and the impact on children and families across Yorkshire and the Humber. The JHOSC also acted as the appropriate scrutiny body across Yorkshire and the Humber in providing a response to the proposals and reconfiguration options presented for public consultation.

Leeds City Council (through its Scrutiny Support Unit) led the process to establish the JHOSC during the second half of 2010 and has been the administering authority since it was formally established in March 2011.

The membership of the JHOSC comprised a single representative from each of the following 15 top-tier local authorities (i.e. those with specific health scrutiny powers) across Yorkshire and the Humber:

- Barnsley MBC
- Calderdale Council
- City of Bradford MDC
- City of York Council
- Doncaster MBC
- East Riding of Yorkshire Council
- Hull City Council
- Kirklees Council
- Leeds City Council
- North East Lincolnshire Council
- North Lincolnshire Council
- North Yorkshire County Council
- Rotherham MBC
- Sheffield City Council
- Wakefield Council

At that time, the terms of reference identified that the JHOSC's work would specifically include consideration of the:

- Review process and formulation of options presented for consultation;
- Projected improvements in patient outcomes and experience;
- Likely impact on children and their families (in the short, medium and longer term), in particular in terms of access to services and travel times;
- Views of local service users and/or their representatives;
- Potential implications and impact on the health economy and the economy in general, on a local and regional basis;
- Any other pertinent matters that arise as part of the Committee's inquiry.

Following a decision on the proposed future model of care and designation of surgical centres in July 2012, the JHOSC made a referral to the Secretary of State for Health in

November 2012. This referral was made on the basis that the proposed changes would not be in the best interests of local NHS services and was subsequently passed to the Independent Reconfiguration Panel (IRP) for consideration and advice. On 12 June 2013, an announcement from the Secretary of State for Health accepted the IRP's report and recommendations in full and called a halt to the SSR.

The Secretary of State then invited NHS England, as the new body responsible for commissioning specialised services from 1 April 2013, to report how it intended to proceed by the end of July 2013.

7.2 New review of congenital heart disease services

Following the decision to halt the SSR the JHOSC has continued to meet and at its meeting in September 2013 considered the Secretary of State's decision alongside the report of the Independent Reconfiguration Panel (IRP). The committee was also made aware of NHS England intentions for the new review to consider the whole lifetime pathway of care for people with congenital heart disease (CHD) i.e. covering services to both children and adults.

At the meeting Members of the JHOSC expressed support for the work of the JHOSC to continue, insofar as it relates to the new CHD review, and specifically highlighted a number of points, including:

- The strength of joint scrutiny arrangements across Yorkshire and the Humber, vis-à-vis the Safe and Sustainable review and proposals, was clearly evident in the Secretary of State's announcement in June 2013.

- That the new CHD review would benefit from similar robust scrutiny arrangements as those in place for the Safe and Sustainable review.

- Concern regarding the likely timescales for the new review and the processes necessary for agreeing revised terms of reference across fifteen constituent local authorities.

It was also clarified that while it would not be necessary to formally dissolve the JHOSC, the existing terms of reference would need to be revised to reflect the changed approach and scope of the new review of CHD services. This would also place the governance arrangements for the committee's work in relation to the CHD review on a firmer footing.

Revised terms of reference associated with the new review of CHD services were agreed at the JHOSC's meeting in December 2013 (see Appendix 1).

Nonetheless, as it is likely that the JHOSC will make recommendations to NHS England and other interested parties, which may include the Secretary of State for Health; it is advisable to provide Council with an opportunity to reaffirm its support for the JHOSC and its refocused terms of reference in relation to the new review of CHD services. It is also recommended that any necessary amendments be made to the Council's Constitution.

8. Finance

Leeds City Council is the administering authority and their Scrutiny Support Unit will continue to provide day-to-day support for the work of the JHOSC. However, in recognition of the level of support already provided and the view from JHOSC members

that the new CHD review would benefit from similar robust scrutiny arrangements to those in place for the SSR, all constituent authorities have been requested to make a financial contribution of £1000 per authority for the financial year 2014/15.

9. Risks and Uncertainties

There is still uncertainty as to the timeframe for consultation on the draft national standards that are currently being developed and which will set a consistent national expectation for patients.

10. Policy and Performance Agenda Implications

Equality and communities
The JHOSC will consider the impact of any future reconfiguration and future service model proposals on specific populations and communities across Yorkshire and the Humber. This will be alongside the general health and equality impacts arising from the new review and in particular, the comparison with existing provision and service configuration. This was a key feature of the JHOSC's previous work.

Legal Implications
Under Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, two or more local authorities may appoint a joint overview and scrutiny committee of those authorities and arrange for relevant functions to be exercisable by the joint committee, subject to such terms and conditions as the authorities may consider appropriate. As the proposed terms of reference below for the JHOSC include discharging the authorities' functions under Regulation 23, this means that the authorities cannot report to the Secretary of State themselves if they are dissatisfied with the consultation on the new review of CHD services or if they consider the proposals are not in the interests of the health service in their areas.

Where a health body is required to consult with more than one authority in relation to a proposal for a substantial development of the health service or for a substantial variation in the provision of such a service, those authorities must appoint a joint overview and scrutiny committee for those purposes, and the powers to make comments on proposals consulted on, require information, and require witnesses can only be exercised by that joint committee.

Subject to the matters mentioned above, the usual statutory rules relating to overview and scrutiny committees will apply to the JHOSC.

11. Background Papers and Consultation
Leeds City Council Report to General Purposes Committee 4 March 2014

12. Contact
Janet Spurling, Scrutiny Officer, Resources Directorate
email: janet.spurling@rotherham.gov.uk Tel: 01709 254421

Appendix 1

THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (YORKSHIRE AND THE HUMBER)

INQUIRY INTO THE NEW REVIEW OF CONGENITAL HEART DISEASE (CHD) SERVICES IN ENGLAND

TERMS OF REFERENCE

1.0 Introduction

1.1 In March 2011, a Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) – the JHOSC, was established to consider the emerging proposals from the Safe and Sustainable Review of Children's Congenital Cardiac Services in England and the options for public consultation agreed by the Joint Committee of Primary Care Trusts (JCPCT).

1.2 The membership for the JHOSC shall made in accordance with the Joint Health Scrutiny Protocol (Yorkshire and the Humber) and drawn from the following constituent local authorities:

- Barnsley MBC
- Calderdale Council
- City of Bradford MDC
- City of York Council
- Doncaster MBC
- East Riding of Yorkshire Council
- Hull City Council
- Kirklees Council
- Leeds City Council (Chair)
- North East Lincolnshire Council
- North Lincolnshire Council
- North Yorkshire County Council
- Rotherham MBC
- Sheffield City Council
- Wakefield Council

1.3 The JHOSC submitted a formal response to the options presented for public consultation in October 2011.

1.4 Following the JCPCT's decision on the proposed future model of care and designation of surgical centres on 4 July 2012, the JHOSC referred the JCPCT's decision to the Secretary of State for Health in November 2012. This was subsequently passed to the Independent Reconfiguration Panel (IRP) for consideration and advice.

1.5 1.5 The IRP's findings and recommendations were set out in its report to the Secretary of State for Health at the end of April 2013. A summary of the IRP's recommendations is attached at Appendix 1 (available on request).

1.6 On 12 June 2013, an announcement from the Secretary of State for Health accepted the IRP's report and recommendations in full and called a halt to the Safe and Sustainable Review of Children's Congenital Cardiac Services in England and asked NHS England – as the new body responsible for commissioning specialised services following the restructuring arrangements across the NHS that came into force from 1 April 2013, to report how it proposed to proceed by the end of July 2013.

1.7 NHS England's response to the Secretary of State for Health, which included a report presented to the NHS England Board on 18 July 2013, is attached at Appendix 2 (available on request).

2.0 Scope of the inquiry

2.1 The overall purpose of this inquiry is to consider the arrangements and outcomes associated with the new review of congenial heart disease (CHD) services in England.

2.2 As such, specifically in relation (but not limited) to the population of the constituent authorities' areas, the JHOSC may:

<u>Part 1</u>

- Consider the findings and recommendations of the Independent Reconfiguration Panel (IRP) associated with its assessment of the previous Safe and Sustainable review of Children's Congenital Heart Services in England, and make an assessment of the extent to which they have been acted upon as part of the new CHD review;
- Consider and make an assessment of the new CHD review processes and any associated formulation of proposed options for reconfiguration and future service models, presented for public consultation;
- Consider the views and involvement of local service users, patient groups and/or charity organisation as part of the new CHD review;

<u>Part 2</u>

- Examine the projected service improvements arising from the new CHD review and any proposed reconfiguration and future service model including, but not limited to, the basis of projected improvements to patient outcomes and experience;
- Consider the likely impact arising from the new CHD review on patients and their families accessing services in the short, medium and longer- term, particularly in terms of access to services and travel times;
- Consider the health and equality impacts arising from the new CHD review and any associated reconfiguration and future service model proposals and, in particular, the comparison with existing provision and service configuration;

- Consider other potential implications of any reconfiguration options arising from the new CHD review and presented for consultation, including the impact on the local and regional health and general economy.

Part 3

- Formally respond to the findings of the new CHD review and any reconfiguration options or proposed future service models arising from the new CHD review and presented for public consultation.

Part 4

- Consider and maintain an overview of any plans for implementation associated with the agreed future service model and reconfiguration of services arising from the new CHD review.

2.3 In addition, the JHOSC may generally:

- Consider any other pertinent matters that may arise as part of the Committee's inquiry (as agreed by the JHOSC).

- Make any recommendations deemed appropriate in relation to any or all of the above matters.

- Review and scrutinise the effects of the new CHD review on the planning, provision and operation of the health service in the constituent authorities' areas pursuant to Regulation 21 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, and make reports and recommendations on such matters pursuant to Regulation 22.

- Act as consultee and discharge the constituent authorities' functions under Regulation 26 in relation to the new CHD review.

- Discharge the constituent authorities' functions under Regulation 26 and Regulation 27.

2.4 As the administering authority, arrangements for the JHOSC shall be in accordance with Leeds City Council's Scrutiny Procedural Rules.

3.0 Desired Outcomes and Measures of Success

3.1 The decision to undertake this inquiry has been based on the JHOSC's previous consideration and reports relating to the Safe and Sustainable Review of Children's Congenital Cardiac Services in England.

3.2 In conducting this inquiry and responding to any future proposals presented for public consultation, the JHOSC wishes to secure high quality, accessible services for patients suffering congenital heart disease (CHD) and their families across Yorkshire and the Humber in the immediate and longer-term.

3.3 It is also important to consider how the JHOSC will deem if its inquiry has been successful in making a difference to local people across Yorkshire and the Humber.

3.4 Some measures of success may be obvious at the initial stages of an inquiry and can be included in these terms of reference. Other measures of success may become apparent as the inquiry progresses and discussions take place.

3.5 Some initial measures of success are:

- Ensuring the recommendations identified by the Independent Reconfiguration Panel (IRP) have been appropriately acted upon as part of the new CHD review.
- Ensuring the new CHD review processes are rigorous and fit for purpose.
- Ensuring the involvement, engagement and consultation arrangements associated with the new CHD review are appropriate and fit for purpose.
- Ensuring any proposed future service model will deliver improved or enhanced services for patients and families across Yorkshire and the Humber.
- Ensuring any projected service improvements arising from the new CHD review are realistic and have a high prospect for success.

4.0 Comments of the relevant Director and Executive Member

4.1 In line with Leeds City Council's Scrutiny Board Procedure Rule 12.1, the relevant Director(s) and Executive Member(s) shall be consulted on these terms of reference.

5.0 Timetable for the inquiry

5.1 NHS England is currently working toward securing 'an implementable solution' by the end on June 2014. As such, the timetable of this inquiry will broadly reflect NHS England's review timetable.

5.2 The length of the inquiry may be subject to change.

6.0 Submission of evidence

6.1 NHS England is currently working toward securing 'an implementable solution' by the end on June 2014. The timetable of this inquiry and the submission of evidence will broadly reflect NHS England's review timetable.

6.2 The JHOSC will determine the evidence it 'reasonably requires' to discharge its statutory functions and advise those bodies responsible accordingly.

7.0 Witnesses

7.1 The JHOSC will determine those witnesses it may 'reasonably require' and/or may wish to invite to attend its meetings, in order that it may discharge its statutory functions.

7.2 The JHOSC will advise any identified witnesses accordingly.

8.0 Equality and Diversity / Cohesion and Integration

8.1 The Equality Improvement Priorities 2011 to 2015 have been developed to ensure Leeds City Council's legal duties are met under the Equality Act 2010. The priorities will help ensure work takes place to reduce disadvantage, discrimination and inequalities of opportunity.

8.2 Equality and diversity will be a consideration throughout the inquiry and due regard will be given to equality through the use of evidence, written and verbal, outcomes from consultation and engagement activities.

8.3 The JHOSC may engage and involve interested groups and individuals to inform any recommendations.

8.4 Where an impact has been identified this will be reflected in any inquiry report and associated recommendations and the body responsible for implementation or delivery should give due regard to equality and diversity, conducting impact assessments where it is deemed appropriate.

9.0 Post inquiry report monitoring arrangements

9.1 Following the completion of this inquiry and the publication of any inquiry report and recommendations, the initial response and subsequent progress against such recommendations will be monitored.

9.2 Any inquiry report will include information on the arrangements for monitoring the implementation of any recommendations.