HEALTH SELECT COMMISSION

Venue: **Moorgate Crofts Business Centre, South Grove, Rotherham, S60 2DH**

Date: **Thursday, 11th September, 2014**

Time: **9.30 a.m.**

A G E N D A

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

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

3. Apologies for absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Communications

7. Minutes of the previous meeting held on 11th July, 2014 (Pages 1 - 11)

8. Issues from Healthwatch

9. Representation on Panels and Sub-Groups

   To appoint one representative to the Environment and Climate Change Steering Group

10. Progress on plans for new Emergency Centre (Pages 12 - 20)
    - Joanne Martin and Dr David Clitherow, RCCG

11. Minutes of meeting with Rotherham Foundation Trust (Pages 21 - 24)

12. Scrutiny Review: Urinary Incontinence (Pages 25 - 38)
    - Councillor Dalton to report

13. Mental Health Scrutiny Reviews (Pages 39 - 45)

14. Health Scrutiny Guidance (Pages 46 - 49)

15. Draft Local Health Protocols (Pages 50 - 54)

16. Date of Next Meeting
    - 23rd October, 2014 at 9.30 a.m.

HEALTH SELECT COMMISSION
11th July, 2014

Present:- Councillor Steele (in the Chair); Councillors Hoddinott, Hunter, Jepson, Kaye, Swift, Vines, Whysall and Wootton.

Apologies for absence were received from Councillors Dalton and Havenhand.

19. DECLARATIONS OF INTEREST

There were no declarations of interest made at this meeting.

20. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no members of the public and press present at the meeting.

21. COMMUNICATIONS

It was noted that the DoH had issued guidance around Health Scrutiny following the 2013 Regulations. A briefing would be circulated to the Health Select Commission.

22. MINUTES OF THE PREVIOUS MEETINGS

Consideration was given to the minutes of the meeting of the Health Select Commission held on 12th and 25th June, 2014.

Resolved:- That the minutes of the meetings held on 12th and 25th June, 2014, be agreed as a correct record for signature by the Chairman.

Arising from Minute No. 3 (Support for Carers Review), it was noted that the response from the Overview and Scrutiny Management Board would be circulated to Select Commission Members.

Arising from Minute No. 10 (Scrutiny Review: Urinary Incontinence), it was noted that the spotlight review had taken place. A report would be submitted to the September Select Commission meeting.

Arising from Minute No. 17(2) (Rotherham Foundation Trust), it was noted a schedule had been drawn up for meetings with the Chairman, Vice-Chair and the Trust Chief Executive. Notes of the meetings would be submitted to the Select Commission.

23. HEALTH AND WELLBEING BOARD

Consideration was given to the minutes of the meeting of the Health and Wellbeing Board held on 4th June, 2014.

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

Arising from Minute No. S108 (Sector Led Improvement), it was noted that as requested information from the performance clinics had been supplied to the Chairman and Vice-Chair. A number of the actions mirrored the recommendations from the Childhood Obesity Scrutiny Review carried out by the Select Commission.

24. ISSUES FROM HEALTHWATCH

Further to Minute No. 6 (Hear to Help Service) of the meeting held on 12th June, 2014, Melanie Hall, Rotherham Healthwatch Manager, reported that, thanks to the support of Councillors, Voluntary Action Rotherham and John Healey, MP, the CCG had given the Foundation Trust funding to re-commission the Service and reinstate drop-in sessions.

25. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

Dr. John Radford, Director of Public Health, presented the first annual report since the 2012 Health and Social Care Act placed the responsibility for Public Health within local authorities.

The report focussed on an analysis of the causes of death and disability in the Borough and the health inequalities that existed between Rotherham and the rest of England.

It was split into the following sections:-

- Overview
- Public Health Outcomes Framework
- Children and Young People's Health
- Life Expectancy and Cause of Death
- Heart Disease and Stroke
- Cancer
- Liver Disease and Other Digestive Disease
- Mental Wellbeing
- Respiratory Disease
- Mortality from Infectious Disease

Discussion ensued on the document with the following highlighted:-

- Rotherham was doing a lot better than other parts of North England in respect of health inequalities.

- Approximately 70% of health inequalities was due to other determinants of health.

- Maternal and infant health was an issue across the Borough.

- Maternal mental health was a big issue with large numbers of mothers living in poverty, unemployed, using drugs and/or alcohol and depressed. This had a knock on effect on the next generation.

- As the Health Visiting Service transferred into the Local Authority there was a need to look at more innovative methods of working to support young mothers and engage them in society.

- Work was taking place with Planning with regard to incorporating conditions in Planning Policy in connection with takeaways near to schools, as recommended by the Commission.

- Approximately 1/3 of the premature deaths in Rotherham were due to heart disease and stroke. A number of those were preventable in terms of lifestyle interventions e.g. increasing exercise, stop smoking.

- The importance of exercise and healthy lifestyles and how Members can promote activities locally to encourage people to become more active, as well as influencing through policies.

- Encouraging on-site policies in secondary schools.

- Approximately 1/3 of Rotherham's health inequalities was due to smoking related Cancer.

- A number of the respiratory causes of death were linked to historical industries and Pneumonia.

- As a whole, GPs in Rotherham were late in referring patients to hospital with symptoms of Cancer and work was required to improve the referral rate. Some Cancers could be helped by surgery but early detection was imperative and it is important to get out to the public information about the early signs of cancer.

- 1 in 20 respiratory deaths were due to air pollution and was known as the silent killer. There were issues around the M1 corridor but also traffic hotspots - Rotherham was no different from the rest of the country.

- E-cigarettes and trying to ban them in schools and on non-Council sites.

- Importance to increasing uptake of Healthchecks.

- There had been an increase nationally in Liver disease and Liver cirrhosis. There were 3 main causes – alcohol cirrhosis, fat due to obesity and Hepatitis B. Rotherham had very good vaccination

programmes against Hepatitis B in terms of “at risk” groups including occupational groups.

- There was an epidemic of Hepatitis C which was largely found in intravenous drug users who were at high risk of cirrhosis.

- Late referrals to the Stop Drinking Service.

- The Hospital reported a rising trend of young women with significant issues with alcohol

- Real challenge with regard to mental ill health and the upsurge in the last 12-18 months of suicide in Rotherham plus growing awareness of the issues of mental wellbeing in the elderly, especially those who lived alone unsupported.

- It was a major cause for people being off work, not only those who had severe mental illness, but those who felt anxious, low and had difficulties in coping with day-to-day life.

- Research had discovered social networks that discussed self harm and suicide and almost normalised it. How agencies should respond and intervene to support young people change their attitudes was extremely difficult and complex.

- Making Every Contact Count – about discussing mental health openly and being aware that it was extremely common. Work had taken place with front line staff to try and identify those who may be at risk and get access to services to support them. Gender differences with regard to suicide and seeking support were noted.

- Work had taken place with the Youth Cabinet with regard to self-harm and support offered to address self-harm issues. The Safeguarding Board had also worked with schools to respond to the issue.

- Quite often self-harm was a way of staying alive and remaining in control, however, it did put people at risk and may result in permanent disability or death.

- It was not a case of pushing people to do something they did not want to do but provide them with the environment that allowed them to do things that were more healthy.

- At risk groups were 4-20 times more likely to die from influenza than non-risk groups. Currently in Rotherham GPs managed to vaccinate 60% of those in the at risk group. Rotherham was 1 of the national pilots to introduce a School Influenza Vaccination Programme for Y7/8 pupils in the attempt to stop transmission home.

- The recommendations from this year's annual report will be reported in next year's report.

Resolved:- (1) That the report be noted.

(2) That an update be submitted on progress in reducing health inequalities.

26. HEALTHWATCH ANNUAL REPORT AND ESCALATION POLICY

Melanie Hall, Manager, Rotherham Healthwatch, presented Healthwatch's annual report and Escalation Policy and Procedure.

The report included:-

- Summary
- Our Work
- Changes that had happened this year
- Gathering local people's views and making them known
- Enabling local people to monitor the standard of local care services
- The involvement of local people in the Commissioning and Scrutiny of local services
- Making reports and recommendations about local care services
- Providing advice and information about access to care services
- Working with The Care Quality Commission and escalations of good practice
- Sharing views with Healthwatch England
- Working with the people of Rotherham
- Engagement methods and activities
- Who are our members
- Our volunteers
- Our Board and governance

Rotherham Healthwatch's Mission was to be the first point of contact for all of Rotherham's communities and individuals, to help them to have a means of improving their own and others quality of health, wellbeing and social care by promoting the local people's following rights:-

- The right to essential services
- The right of access
- The right to a safe, dignified and quality service
- The right to information and education
- The right to choose
- The right to be listened to
- The right to be involved
- The right to live in a healthy environment

Discussion ensued on the report with the following highlighted:-

- An area for improvement was the collection of data with regard to information and advice given
- Examples of where Healthwatch had made a positive impact
- Healthwatch worked with NHS England and had escalated a number of complaints to them
- Rotherham Healthwatch was held in high esteem and had won a national award for its work
- Currently the Healthwatch contract was held by Parkwood Healthcare but as from 1st September, 2014, Rotherham Healthwatch would be run by Rotherham people and become a social enterprise

Discussion then ensued on the Escalation Policy and Procedure the aim of which was to ensure safe and uniform standards of reporting on the quality of health and social care providers were delivered. It provided clarity to the public, providers and stakeholders as to when Healthwatch would escalate concerns/complaints/compliments/comments.

One comment on its own may not indicate risk or the quality of a service, however, many comments of the same nature/regard to the same service would. The criteria set out in the Escalation Policy indicated what could be an indicator or risk, poor or good quality service, along with timeframes for services to take action.

The report set out in full details of the Policy and Procedure.

It was noted that:-

- In the last 3 weeks there had been 2 “urgent” level of escalation but only 3 in total
- Healthwatch had the power of “Enter and View” which was considered at the low level of the escalation process. This would be appropriate where further information was required from the people using a Health or Social Care service and/or to satisfy Healthwatch that a change had been made following issues they had received. It had not been used in Rotherham
- Rotherham Healthwatch had tried to ensure that they were seen as different from the Care Quality Commission
- Healthwatch England were very keen that all Healthwatch’s implemented Rotherham’s Escalation Policy

Resolved:- (1) That the Healthwatch annual report be noted.

(2) That the Escalation Policy and Procedure for handling comments and concerns be noted.

(3) That the Select Commission receive 6 monthly updates.

27. HEALTHWATCH - CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Melanie Hall, Manager, Healthwatch Rotherham, presented the report produced in partnership with a group of local parents into the work of the Children and Adolescent Mental Health Services

Nationally, health and social care provision was being evaluated in light of the Francis report as well as a national review of CAMHS as part of the Children's Plan.

In Rotherham stakeholders had come together to produce and deliver the Rotherham Emotional Wellbeing and Mental Health Strategy for children and young people. The Strategy would inform service planning and commissioning for the next 5 years. The aims of the investigation were to:-

- Seek views on how local people believed the culture of CAMHS was affecting Service delivery
- Obtain views and ideas as to how things could be done better
- To share the views of local people with the provider and commissioners of CAMHS
- Ensure local people in Rotherham knew about the activity

To enable Healthwatch to achieve the above, 3 methodologies were used:-

- A purpose designed survey
- A public 2 day event gathering views on themed topics
- A review of the Healthwatch Rotherham Database

From all the statements made it could be concluded:-

- that there was a high level of dissatisfaction with the Service provided
- parents/carers did not feel listened to
- felt blamed for the problems they and their child were experiencing
- did not feel included or able to participate
- no clarity on what to expect from CAMHS and what services they provided
- difficult to make a complaint
- complaints were not handled consistently or in a timely manner
- waiting times to be seen were too long leaving families feeling unsupported
- when children were discharged from the service it did not always include families and they were unaware they had been discharged
- no crisis planning leaving families feeling unsupported and not sure what to do

Discussion ensued on the report with the following issues clarified:-

Discussion ensued on the report with the following issues clarified:-

- This issue was moderate on the escalation policy
- A good response to the report had been received from RDaSH and a meeting between the participants and RDaSH was to be held
- It was accepted that the numbers of people with concerns was quite small but they had had negative experiences and the challenge to RDaSH was to prove that these were the exceptions and not the rule
- Healthwatch had looked into CAMHS because it did not meet the needs of Rotherham's young people. It was acknowledged that it was mainly the voice of the young people's parents who, although very vocal, were still not getting anywhere due to the mechanisms they were using.
- They were not being asked to change clinical practices but to be very clear about their customer services, how they treated the families and that they acknowledged the skills the families had
- The Health and Wellbeing Board Customer Charter that partners were asked to sign up stated how every individual should be treat as well as the NHS Constitution

Resolved:- (1) That the report be noted.

(2) That CAMHS be included as part of the Select Commission's work on Mental Health and Wellbeing during 2014/15.

28. EMOTIONAL WELLBEING AND MENTAL HEALTH STRATEGY FOR CHILDREN AND YOUNG PEOPLE 2014-19

Paul Theaker, Operational Commissioner, and Ruth Fletcher-Brown, Public Health Specialist, gave the following powerpoint presentation:-

CAMHS Commissioning
- More providers than just RDaSH
- More commissioners than just Rotherham CCG

CAMHS Tiered Model of Provision
- Commissioners
  NHS England
  Rotherham CCG
  RMBC
- Providers
  Private Sector
  RDaSH CAMHS (Sheffield Health and Social Care, Nottinghamshire Healthcare)
  RMBC
  Voluntary Sector
  GPs, RFT

Where key services fit in the Tiered Model

Tier 1

- Health Services - School Nurses, Family Nurse Partnership, Midwives, Accident and Emergency, LAC Nurse, Health Visitors, GPs, Dieticians, Sexual Abuse Referral Centre, Rotherham Institute of Obesity and Parenting Support Advisory Service
- Social Care – Youth Offending, Parent Support Advisory Service and Family Recovery Programme
- Education – Rowan Centre
- Voluntary Sector - Barnardos

Tier 2

- Health Services - RDASH CAMHS, Child Development Centre, Paediatricians
- Social Care – Youth Start, Looked After and Adopted Children
- Education - MIND

Tier 3

- Health Services - RDASH CAMHS, Child Development Centre, Early Intervention in Psychosis, Paediatricians
- Social Care – Youth Start, Looked After and Adopted Children
- Education – MIND, Educational Psychology

Tier 4

- Health Services – NHS England
- Social Care – Disability Service, Custody
- Education – Educational Psychology

Background

- May/June, 2013 – Issues with RDaSH CAMHS Service
- 'Contract Query' process October, 2013
- GP Surveys – September and December, 2014, May, 2014
- Universal Workers Survey January, 2014
- 'Top Tips', Directory of Services, locality workers, GP events and IYSS conference

CAMHS Strategy

- Draft format
- Informed by National Guidance and local feedback
- Formalisation of some ongoing work
- From issues raised by families, carers, referrers and services

Draft Recommendations

- Ensure patient/parents/carers input into developing services
- Develop multi-agency care pathways
- Develop family focussed services which were easily accessible and delivered in appropriate locations
- Best value for money for the people of Rotherham
- Flexible working times – not restricted to normal operating hours
- Appropriate training and support for staff

- Transition from Child and Adolescent Mental Health Services to Adult Services
- Multi-agency single point of access (SPA) to Mental Health Services
- Services that demonstrate improved outcomes for children and young people
- Promote the prevention of mental ill health
- Reduce the stigma of mental illness
- Reduce waiting times and improve access

Next Steps
- Engagement of parents, carers and young people
- Finalisation of Strategy
- Continuing joint commissioner/provider improvement work
- Opportunities for engagement
- Pathways event

Discussion ensued with the following issues raised/clarified:-

- Improvement Notice served on CAMHS last year
- GP Surveys had revealed 20% satisfaction rate
- A lot of work and improvement had taken place over the last year
- The Local Authority put funding into the contract but no monies had been realised until receipt of a draft Strategy. Said Strategy had been produced on 31st March, 2014. A CAMHS Strategy was now also a requirement of Ofsted
- A meeting had taken place with parents at which the same issues had been raised as they had with Healthwatch
- Meeting with Youth Cabinet to ascertain how they wished to be involved in the future
- The Strategy would be considered by the Health and Wellbeing Board in September
- It was confusing with regard to the people involved in the CAMHS process – RDaSH CAMHS work should be time limited but there would still be a Social Worker/IYSW/Key Worker working alongside CAMHS.
- Entry to the Service was by referral at present and could be via any agency involved with the young person e.g. Youth Start, Rotherham Mind, GP, Hospital

Resolved:- That the report be noted.

29. HEALTH SELECT COMMISSION WORK PROGRAMME UPDATE 2014-15

Janet Spurling, Scrutiny Officer, presented a report that was to be considered by all the Select Commissions and by the Overview and Scrutiny Management Board with regard to the 2014/15 work programme.

The proposed programme for the Health Select Commission was as follows:-

Continence Services
Child and Adolescent Mental Health Services (CAMHS)
Other Mental Health Services
Nurses in Special Schools
Commissioning Support Unit – Continuing Health Care
Improving Health Outcomes in Rotherham
Quality Accounts
Monitoring Previous Scrutiny Reviews

Also set out in the report, for information, was the Select Commission's terms of reference and the role of the Overview and Scrutiny Management Board

Discussion ensued on the proposed programme:-

- Each Select Commission was to conduct 1 full Scrutiny Review and 1 Spotlight Review a municipal year
- Mental Health and Wellbeing was the Select Commission's focus for 2014/15
- Add Maternity Mental Health

It was noted that Select Commission's work programmes would be discussed by the Overview and Scrutiny Management Board on 18th July.

Resolved:- (1) That the Select Commission's terms and reference and the role of the Overview and scrutiny Management Board be noted.

(2) That the Select Commission's 2014/15 proposed work programme be noted.

30. DATE AND TIME OF NEXT MEETING

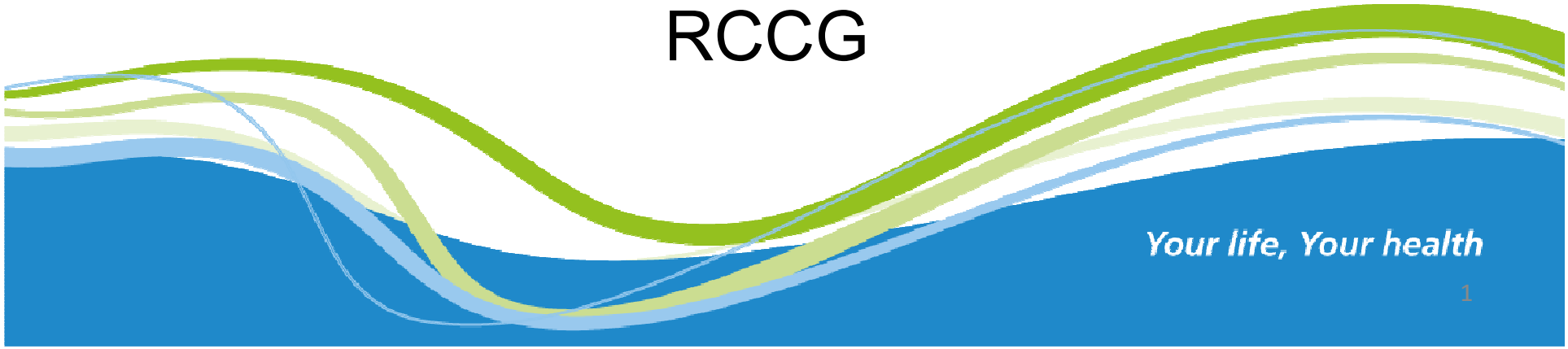
Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 11th September, 2014, commencing at 9.30 a.m.

The Emergency Centre: Right Care, First Time

Dr David Clitherow

Lead GP for Unscheduled Care

RCCG



Recap - our proposal

To redesign our urgent and emergency care system to ensure :

1. *Patients receive the right care first time*
   – one place to go to if you have an emergency or urgent care need

2. *Patients receive quality care*
   – bringing together the skills of primary care with the skills of accident and emergency in a modern facility

3. *Rotherham's emergency and urgent care services are sustainable for the future*
   - more and more patients need and will need urgent care.
   - Re-investing in this area will make the whole NHS in Rotherham work better

Why do we need to change?

- Rotherham patients told us that the existing system is confusing and they don't know where to go to when they have an urgent care need. Sometimes they go to more than one service.

- We know that sometimes patients can wait a long time when they access urgent care, we want to improve this.

- We know that demand for urgent and emergency care services continues to rise. The existing services may struggle to meet the demand in the future, especially with an ageing population.

- We know that patients are sometimes admitted to hospital unnecessarily creating pressure on services.

- Nationally, the evidence base states that 30% of A&E attendances are for conditions which could be treated by primary care.

- Nationally the direction of travel is to develop emergency centres.

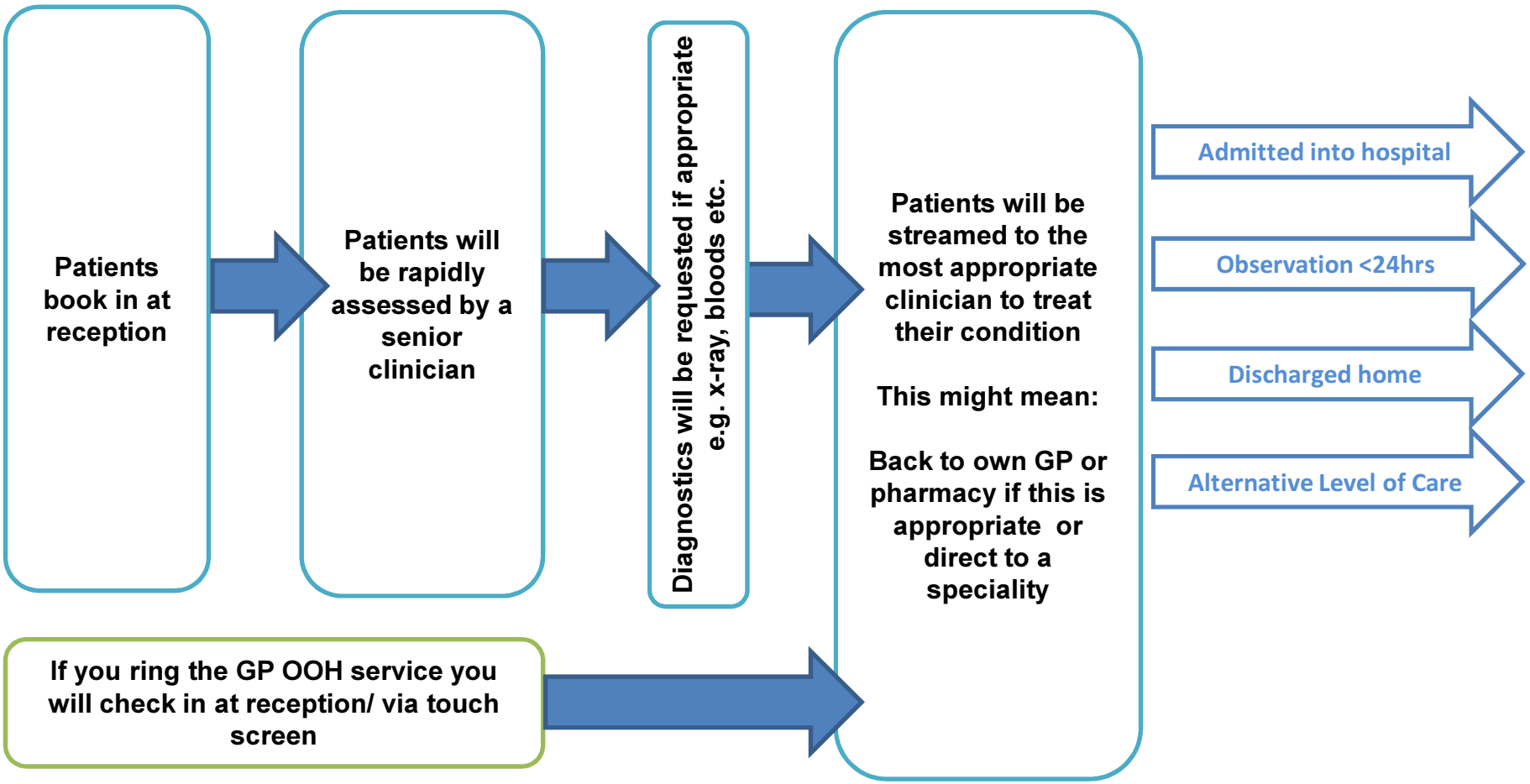
The Vision

To have one **Emergency Centre** to provide a single urgent and emergency care system for the people of Rotherham, located at the hospital.

This means:

- Emergency Department staff and Primary Care staff working together to provide a multi-skilled workforce fully equipped to meet the patients needs
- The GP OOH service and care coordination centre will be based there so all urgent care services are together in one place
- It will have better links with mental health services
- It will have better links with social care services
- Enhanced facilities to meet future demand

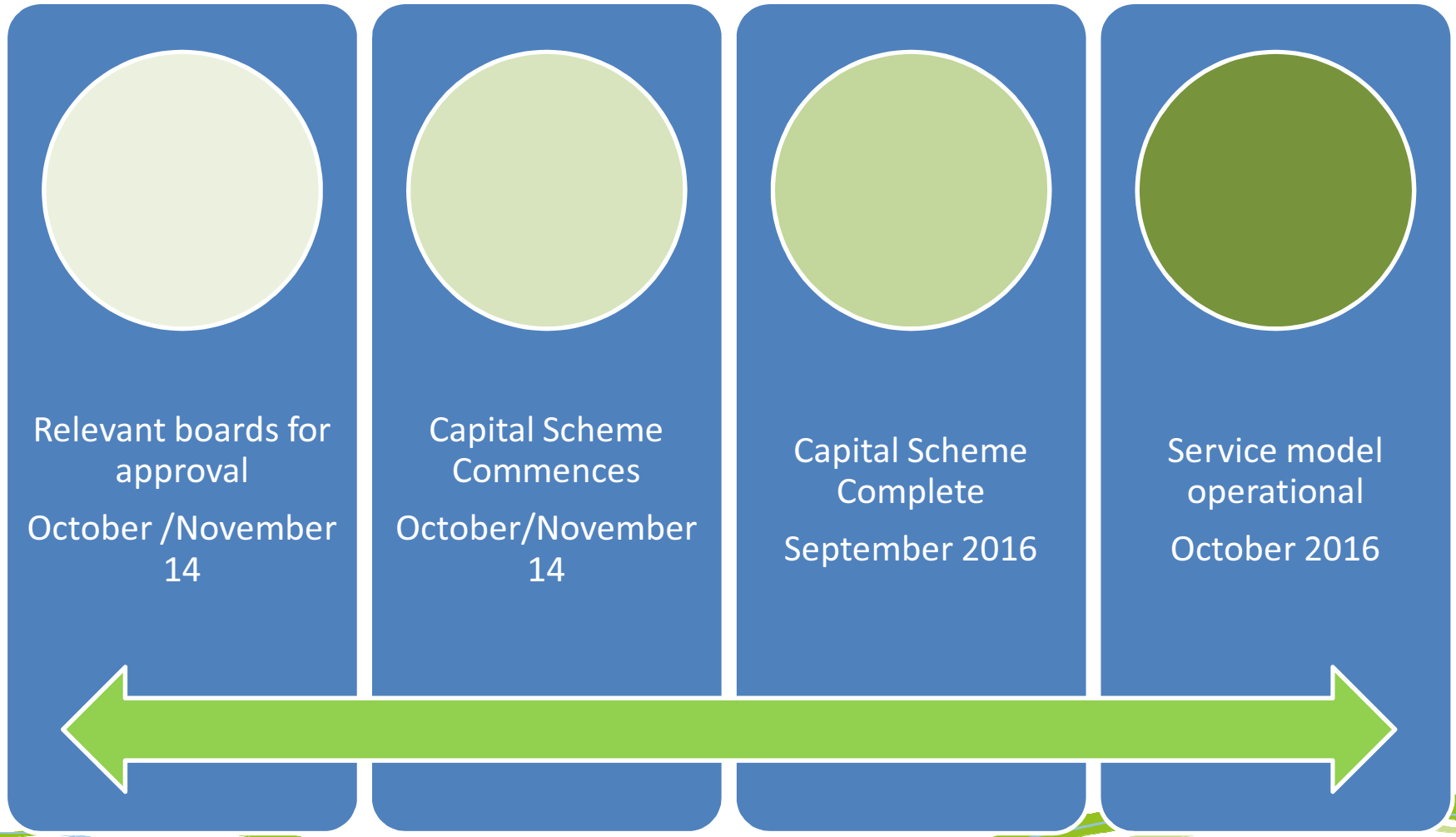
How will it work – service model



What difference will it make to the people of Rotherham?

- **It will ensure patients see the right clinician first time.**
  - Patients no longer have to make a decision about which service to use if their condition is urgent, they can go to one place and be rapidly assessed to the most appropriate clinician.
- **Improved waiting times**
  - Having more experienced physicians at the start of patients journey means people see the right clinician, first time and reduces the time patients are waiting.
  - The ability in the model to flex capacity depending where the demand is the highest follows the latest thinking around patient flow and will help to reduce waiting times.
- **Quality, safe care**
  - This model has been developed by Rotherham Clinicians, following consultation with Rotherham residents and is based on local and national evidence.
  - It is clinically beneficial for both patients and staff
- **More sustainable services for the future**
  - The new model is focused on what is best for Rotherham patients and staff. It truly meets the needs of Rotherham now *and* for the future
  - The new model focused on developing a diverse

Timescales


Relevant boards for approval
October /November 14
Capital Scheme Commences
October/November 14
Capital Scheme Complete
September 2016
Service model operational
October 2016

Frequently Asked Questions

Q. Will the whole of Rotherham Community Health Centre will be closing after the Walk-in-Centre leaves the building.

A. The centre currently provides health services to patients other than the Walk-in-Centre. There will still be health services provided in the building after the walk-in service leaves.

Q. Is A&E closing, where do I go if I have an emergency?

A. We are not closing the A&E department, we are bringing together all emergency and urgent care services under one roof to make it easier to know where to go when you have an emergency or urgent condition.

Q. What's happing about parking?

A. We recognise that parking is an concern. We know staff park in the patients car park. As part of the scheme we will be building an additional 122 spaces to move staff out of the patient car park, which will free up car parking spaces for the public.

Q. Will I have to pay for parking?

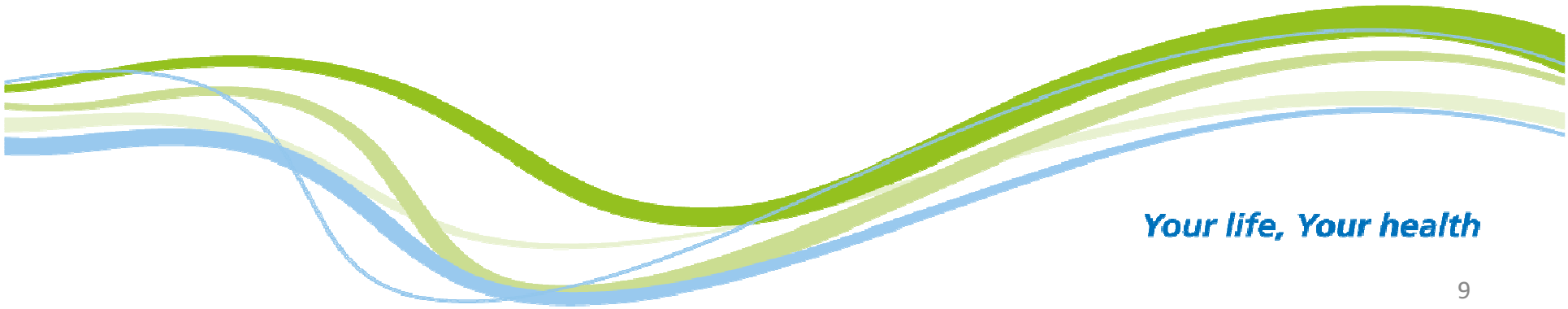
A. Yes. Patients who access A&E now pay for parking. When the emergency centre opens this will not change.

Q. What is going into the health centre when the WIC moves out?

A. We are currently in the process of looking at what services could be better delivered from the community health centre.

Thank you for listening

Comments and Questions



Notes from meeting 11 August 2014
Health Select Commission and The Rotherham NHS Foundation Trust

Present:
TRFT - Louise Barnett, Chief Executive and Anna Milanec, Director of Corporate Affairs/Company Secretary

HSC - Cllr Brian Steele, Chair and Cllr Emma Hoddinott, Vice Chair

Notes: Janet Spurling, Scrutiny Officer, RMBC

Purpose of the meeting

As agreed at HSC on 25 June 2014 this would be the first of a series of monthly meetings to discuss progress on Rotherham Foundation Trust's Five Year Strategic Plan. Key issues to discuss in these meetings are likely to be finance, staffing, quality, performance, Cost Improvement Programme (CIP) and the regional Working Together partnership.

Discussion points

Monitor and Five year plan – the final version has been submitted to Monitor and was very similar to the version HSC received in June. Monitor have contacted TRFT by 'phone to clarify some points and a performance review meeting (PRM) is scheduled for 9 September in London. A formal response is expected regarding the breaches for governance and finance in due course. Enforcement regarding the Electronic Patient Records (EPR) has now been lifted, save for a generic point which relates to governance in general which cannot be lifted until the governance breach itself is lifted.

Finance – on track at the end of month 3 with the June deficit of £303k being £175k less than expected at this stage. The quarter 1 deficit in £1,663k is also better than plan and the aim is to have £662k surplus at year end. Income and spending were both higher than plan in quarter 1. Savings of £10.9m are to be made for 2014-15, of which £ 9.1m have been identified and approved following quality impact assessment; the £9.1m excludes some proposals which have been rejected at this stage. There are still further savings possible in corporate functions through reorganisation, which will protect the front line, and some vacancies have not been filled having balanced this against risk to quality.

£12.9m CIP target for 2015-16 will be very stretching and any implications for the proposed Emergency Centre have to be considered.

In terms of the financial position non-recurrent funding obscures the actual bottom line so it is important to be clear about the true financial picture.

Mandatory training is being introduced for all budget holders.

A new team of internal auditors is in place.

Benchmarking – the benchmarking exercise to review overall costs at TRFT and compare them with peer organisations is ongoing

Service Line Reporting – this had been introduced to improve financial information and looks at all the costs for a specialty and compares them with income to identify areas of

surplus/deficit which will help to inform the strategic clinical specialty plans. The first reports are due in October.

Specialty reviews – dialogue has taken place with the doctors to get them on board and a methodology has been agreed that will be piloted in ENT and then be refined prior to roll out. Initially it was hoped to complete the reviews by November 2014 but it is more likely to be March and this will then feed in to the business planning cycle. Patients will be asked for their feedback. A prioritised timetable for the reviews will be drawn up.

Emergency Centre – TRFT board will receive the business case for the new model in September and the decision will be made. The impact of changes was not included in the Five Year Plan as it was not definite at the time of submission. Staff will be involved in the plans.

Board – a Chief Operating Officer, Director of Finance and interim Director of Workforce and Transformation have all been appointed. Recruitment for a permanent DWT is underway so TRFT anticipate having a full board by November which should facilitate progress.

CQC Risk rating – TRFT risk banding has moved from 4 to 2 (higher risk) so there is an increased likelihood of visits, although the expectation is that the risk will return to a 3 or a 4 within the next year. This current rating is due to having four 'elevated risks' and four 'risks', based on a range of data both recent and historical, with use of the latter being an issue for TRFT.

- Complaints – many were in relation to EPR and this data is included even though it is now two years old
- Pneumonia – should be closed
- Ratio of staff : beds was triggered as a risk, yet the ratio is better than average so TRFT intends to liaise with CQC about the calculation because of the impact of community staff.

Risk categories have been altered with Monitor risk now one of the factors taken into account by CQC whereas it was not included previously – the Trust is either 'red' orr 'green' rated for governance so any enforcement action leads to a red rating. Members questioned if there might be care quality concerns not only financial. TRFT will look at measures next time with more up-to-date data and a team are checking if any are likely to be worse.

A mock CQC inspection led by the Chief Nurse, also involving community services, had been a good exercise

Risk Management Strategy – agreed by the Trust Management Committee in July 2014 with a clear timetable to establish a golden thread with training and structures to deliver a consistent approach.

Safeguarding – TRFT is likely to locate one staff member to the Multi-Agency Safeguarding Hub (MASH) and has designated officers to liaise with the Local Authority Designated Officer (LADO) regarding any allegations against professionals working with children and young people.

Nurses – 87 posts have been offered to newly qualified nurses, with around 40 accepting. There are still gaps and a national shortage so international recruitment is likely. If people

want to do more specialised nursing they would tend to go to Sheffield rather than Rotherham as it is very different working at a teaching hospital to a district. There is less opportunity for progression so less need for as many nurses at higher grades. Nursing figures are looked at and reported on monthly.

Staffing costs - £3m was spent on temporary staff in quarter 1 so recruiting permanent staff more quickly is a priority to save money and improve care quality. TRFT cannot have clinical staffing gaps so there is reliance on temporary staff and they are trying to get agency staff more cheaply through the national framework.

Staff turnover – this has reduced and a more detailed breakdown has been requested to identify any issues or trends in a particular area. All leavers have the opportunity to have an exit interview (not with their line manager).

Seven day working – TRFT is working with the CCG to develop both hospital and community seven day services that meet NHSE Clinical Standards. There will be £3m non-recurrent funding in Sept for acute/community.

Staff appraisals – 79% completion at the end of July with the process being much more meaningful and linked to the organisational priorities and plans.

Excellent service ratings – the Primary Ear Care and Audiology Service has been rated as “better than green” in a national audit of children’s hearing services.

Targets (quarter 1 performance)

- 4-hour A&E target was achieved and year to date (as at 23.07.14) is 95.77% against a significant increase in activity. Extra resources are still being put in but staff are also working in a different way now.
- All cancer targets achieved subject to validation and a focus group was held.
- All 18 week pathway targets achieved bar the admitted pathway for Trauma and Orthopaedics (due to high volume)
- Service improvement works continues in the stroke service (CQC two metrics) and breast services as TRFT is not yet achieving all the quality metrics.

“Perfect Week” programme – planning is underway for a ‘perfect month’ in Sept/Oct with staff acting as ward liaison officers to champion their wards and to identify any issues.

Winter plan review – revised plans to the Board in August and to be shared with Monitor at the PRM meeting in September.

Staff engagement – It was agreed that previously there had been engagement problems but TRFT view staff relations as good with more partnership working. Staff governors are a point of contact and there are staff champions. The trust is revamping its whistleblowing policy and engaging with the RCN Speak Out Safely campaign and any similar initiatives trade unions might also have.

“Listening into Action” - staff engagement initiative has ten people at the centre cascading out to 100. A short “pulse check” survey with 15 questions has been sent out with 1642 responses and results will be shared with staff. Results are better than average for TRFT’s cohort of trusts. A series of events for over 800 staff are being held in Sept to be able to share their views with the CX (in booked slots) and TRFT want people to feel listened to and valued. They hope to survey everyone in the organisation. This staff survey data will

set the baseline from which to measure change, although it is uncertain if enough time has elapsed since changes commenced for this to be reflected in survey responses.

Patient and public engagement – as the commissioner and decision maker it would be the CCG's responsibility to undertake public engagement if they had any plans to discontinue a particular service at the hospital. TRFT is obliged to provide services according to its licence and also has to work with its governors with regard to any service changes. Work is ongoing through the regional Working Together partnership with providers on potential models for vulnerable services.

Holistic approach of scrutiny – Members reiterated that health scrutiny considers wider issues such as patient experience and access to services, transport and parking and ease of family and friends being able to visit people in hospital as well as the clinical and financial case for any service changes.

Additional car parking spaces have been earmarked for the Emergency Centre following clearance of the area where the crèche used to be situated.

Changes to bus routes were noted with some areas losing their direct link to the hospital. TRFT mentioned that they had been notified that the leaflet showing all the bus routes to the hospital had unhelpfully been withdrawn.

Agreed actions:

1 TRFT to send the following information to HSC Chair and Vice Chair:
- final version of the Five Year Strategic Plan
- prioritised list of Specialty Reviews once drawn up

2 TRFT to attend HSC on 11 September for the Emergency Centre agenda item.

3 TRFT to look into an issue raised regarding charges for damage to hearing aids.

4 Members to follow up the withdrawal of the leaflet advertising all bus routes to the hospital.

Date and time of next meeting:

Monday 29 September 3:30pm at TRFT

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meetings:**	**Health Select Commission**
2.	**Dates:**	**11 September 2014**
3.	**Title:**	**Scrutiny review: Urinary Incontinence**
4.	**Directorate:**	**Resources** **All wards**

5. Summary

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

6. Recommendations

That the Health Select Commission:

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

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

7. Proposals and details

This review was requested by the Health Select Commission as part of its work programme and the key focus of Members' attention was to establish the extent to which preventive measures are promoted in Rotherham to reduce urinary incontinence, given the impact it has on people's quality of life.

There were three aims of the review, which were to:

- ascertain the prevalence of urinary incontinence in the borough and the impact it has on people's independence and quality of life
- establish an overview of current continence services and costs, and plans for future service development.
- identify any areas for improvement in promoting preventive measures and encouraging people to have healthy lifestyles

A spotlight scrutiny review was carried out, chaired by Cllr Judy Dalton and evidence gathering began in May 2014, concluding in July 2014. This comprised desktop research and a round table discussion with health partners and the Council's Sport and Leisure Team.

Urinary incontinence affects all age groups and should not be viewed as inevitable as people get older. Many forms may be treated or cured and it is vital to expand preventative work and continence promotion to try and reduce the numbers of people becoming incontinent. It is also important to ensure more people are having an assessment of the cause of the problem rather than coping as best they can with off the shelf products or struggling because they are too embarrassed to seek professional help.

Members recognised the good services provided by the award winning Community Continence Service (CCS) and that Rotherham Clinical Commissioning Group has been unique in reducing expenditure on continence products in the last five years yet delivering improved outcomes for service users. The CCS does engage in preventative work and plans for future service development include greater focus on this area. One workstream will be to consider developing an integrated continence care pathway, with a single point of access.

General awareness raising with both the public and health and care professionals is needed to emphasise the importance of good bladder and bowel health and how healthy lifestyle choices can help to prevent incontinence. Pelvic floor muscle training has been proved to relieve symptoms and may reduce the risk of developing stress incontinence. More people could be encouraged to do these exercises as a preventative measure and there is scope to consider if they could be incorporated more widely within sports and fitness activities.

Recommendations

1 RMBC and partner agencies should ensure all public toilets in the borough are clean and well equipped to meet the needs of people who have urinary incontinence, including suitable bins for the disposal of equipment and disposable products.

2 Greater links should be established between the Community Continence Service and Rotherham MBC Sport and Leisure team to support people to participate in appropriate sport and physical activity.

3 Rotherham MBC and other sport and leisure activity providers should consider building more pelvic floor exercises into the Active Always programme and wider leisure classes.

4 There should be greater publicity by partner agencies to raise public and provider awareness of:

a) the importance of maintaining good bladder and bowel health and habits at all life stages (through media such as screens in leisure centres and GP surgeries, further website development, VAR ebulletin and a campaign during World Continence Week from 22-28 June 2015)

b) healthy lifestyle choices having a positive impact on general health but also helping to prevent incontinence, such as diet, fluid intake and being active

c) the positive benefits of pelvic floor exercises as a preventive measure for urinary incontinence, including the use of phone apps for support

5 More work should take place with care homes to encourage staff to participate in the training offered by the Community Continence Service and to increase staff understanding of the impact of mobility, diet and fluid intake on continence.

6 That the Health Select Commission receives a report in 2015 on the outcomes of the project considering future service development of the Community Continence Service.

8. Finance

Any recommendations from the Select Commission would require further exploration by the Strategic Leadership Team and partner agencies on the cost, risks and benefits of their implementation.

9. Risks and Uncertainties

It is important that people have access to health services and the right advice and information to help them maintain a good quality of life at all life stages. Incontinence can have a significant negative impact on a person's life and stigma about incontinence may deter people from seeking professional help. More continence promotion and educative work about healthy lifestyles could help to reduce the number of people having preventable incontinence, resulting over time in lower demand for services.

10. Policy and Performance Agenda Implications

Corporate Plan priority - Helping people from all communities to have opportunities to improve their health and wellbeing.
Health and Wellbeing Strategy

11. Background Papers

See section 7 of the review report.

12. Author

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Appendix 1

Rotherham Metropolitan Borough Council
Where Everyone Matters

Scrutiny review: Urinary Incontinence

Review of the Health Select Commission

May – July 2014

Version 2 HSC 110914

Contents

Executive Summary

The aim of the review:

The review group consisted of the following members:

Cllr Judy Dalton (Chair) Cllr Maureen Vines

There were three main aims of the review which were:

- To ascertain the prevalence of urinary incontinence in the borough and the impact it has on people's independence and quality of life.
- To establish an overview of current continence services and costs, and plans for future service development.
- To identify any areas for improvement in promoting preventive measures and encouraging people to have healthy lifestyles.

It would also aim to support the following Council priority from the Corporate Plan:- Helping people from all communities to have opportunities to improve their health and wellbeing.

Summary of findings and recommendations

The review focused primarily on prevention rather than the costs of current service provision, but recognised that preventative work contributes towards achieving savings for services, for example by reducing admissions to hospital or residential care. Centralisation of continence prescribing has improved outcomes for service users and future service development with greater emphasis on prevention should also produce both further savings and better outcomes. Awareness raising of the importance of good bladder and bowel health and being physically active, plus doing pelvic floor exercises as a preventive measure, could lead to fewer people having their quality of life diminished through urinary incontinence and result in lower future demand for services.

The review conducted was a spotlight review and formulated six recommendations as follows:

1. RMBC and partner agencies should ensure all public toilets in the borough are clean and well equipped to meet the needs of people who have urinary incontinence, including suitable bins for the disposal of equipment and disposable products.

2. Greater links should be established between the Community Continence Service and Rotherham MBC Sport and Leisure team to support people to participate in appropriate sport and physical activity.

3. RMBC and other sport and leisure activity providers should consider building more pelvic floor exercises into the Active Always programme and wider leisure classes.

4. There should be greater publicity by partner agencies to raise public and provider awareness of:
   a) healthy lifestyle choices having a positive impact – diet, fluid intake and being active
   b) the importance of maintaining good bladder and bowel health and habits
   c) the benefits of pelvic floor exercises as a preventive measure for urinary incontinence.

5. More work should take place with care homes to encourage staff to participate in the training offered by the Community Continence Service and to increase staff understanding of the impact of immobility, diet and fluid intake on continence.

6. That the Health Select Commission receives a report in 2015 on the outcomes of the project considering future service development of the Community Continence Service.

1. Why members wanted to undertake this review?

This review was requested by the Health Select Commission and as such an initial report was received at its meeting in June 2014. The key focus of Members' attention was to establish the extent to which preventive measures are promoted in Rotherham to reduce urinary incontinence, given the impact it has on people's quality of life.

There were three aims of the review, which were to:

- ascertain the prevalence of urinary incontinence in the borough and the impact it has on people's independence and quality of life
- establish an overview of current continence services and costs, and plans for future service development
- identify any areas for improvement in promoting preventive measures and encouraging people to have healthy lifestyles

2. Method

A spotlight scrutiny review was carried out by a sub-group of the Health Select Commission consisting of Cllrs Dalton (Chair) and M. Vines. Following background research an initial report to the Commission provided an introduction and set the context. Evidence for the review was then gathered through a focused round table discussion with health partners and the Council's Sport and Leisure Team.

Members would like to thank the following officers who provided the review with evidence:

Stuart Lakin – Head of Medicines Management, Rotherham Clinical Commissioning Group
Joanne Mangnall – Continence Advisor, Community Continence Services
Chris Siddall – Sport & Leisure Manager, Leisure and Green Spaces, RMBC

3. Background

An article in the Nursing Times in 2013 highlighted that around 14 million people in the UK have a bladder control problem. Causes of urinary incontinence can be physical or neurological; resulting from injury, illness or disability, but many forms can be cured, improved or managed. Good continence care and assessment helps to reduce hospital and residential care admissions and may reduce the need for continence products through interventions such as physiotherapy or medication. When continence products are required a good service ensures people have the most appropriate products, with their needs periodically reviewed.

Lower Urinary Tract Symptoms include problems storing or passing urine, which may lead to urinary incontinence. There are several types of urinary incontinence with varying symptoms, but stress incontinence and urge incontinence are the most common, thought to be responsible for over 90% of cases, and people may have symptoms of both. Stress incontinence is when urine leaks if the bladder is under pressure, for example when coughing, sneezing or laughing, usually as a result of weakness or damage to the muscles that are used to prevent urination, such as the pelvic floor muscles and urethral sphincter. Urge incontinence occurs when people feel an intense urge to pass urine and urine leaks before they reach a toilet. It is usually due to over activity of the detrusor muscles that control the bladder.

Continence is typically achieved during early childhood; however both men and women are at risk of developing urinary incontinence at any stage of their life. Women can develop problems following pregnancy and childbirth and research tells us urinary incontinence affects about twice as many women as men. Whilst urinary incontinence

does become more common with age it should not be viewed as an inevitable consequence of ageing.

4. Findings

4.1 Prevalence of urinary incontinence

The Joint Strategic Needs Assessment shows that incontinence affects 19% of people over 65, rising to a third of those aged over 85 years. Rotherham has an ageing population, ageing faster than the national average, with the number of over 65s projected to increase by 7,500 (16%) by 2021 and the number aged 85+ by 1,500 (27%). This suggests a significant potential increase in future demand for continence services, unless more preventative work takes place across all age groups.

Based on data from the Royal College of Physicians the number of people in Rotherham with a continence problem would be estimated to be 12,500, but statistics show the Community Continence Service (CCS) is aware of or working with approximately half this projected number.

- The present clinical caseload the service is actively working with numbers around 1600 people.
- The caseload for stress/urge incontinence and bladder problems is approximately 220, mainly women (which is the norm) plus 54 with mental health problems such as dementia.
- 528 people with indwelling catheterisation and 618 with intermittent catheterisation (following conditions such as MS, stroke, spina bifida, post childbirth or detrusor muscle failure).
- 4276 are prescribed pads, 2884 of whom are female and mainly aged over 50 (see table below for detailed breakdown).
- 1 in 100 adults wets the bed.
- Rotherham has no paediatric continence service, although there is a children's service in Sheffield. School nurses deal with bed wetting and the Child Development Centre with toilet training.
- More boys than girls aged under 18 use pads, for example due to disability or developmental delay.

Members were provided with a snapshot profile by age and gender of current Community Continence Service users who are prescribed pads (all data is as at 8 July 2014).

	0 - 18		19 - 34		35 - 50		51 - 66		67+	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Community	257	145	46	57	39	113	120	253	662	1432
Residential			3	6	3	8	9	13	126	557
Nursing Bed (Self-funded)			2	2	7	5	11	40	107	253
Total	**257**	**145**	**51**	**65**	**49**	**126**	**140**	**306**	**895**	**2242**

Total Males: 1392 **Total Females: 2884** **Overall total: 4276 people**

4.2 Impact of urinary incontinence

Health, wellbeing and participation
Incontinence is likely to have significant health and emotional impacts and to affect people's ability to take part in paid employment, education, or social and leisure activities. It may also damage family and intimate relationships. Social isolation, depression, low self-esteem and self-confidence and/or reduced independence are commonplace in many cases. Members heard anecdotally how some people plan their lives around the location of public toilets so they feel confident enough to leave home and go out.

"I've recently been using the continence service after experiencing issues, and I have to say it has been marvelous, absolutely life-changing. I can use the toilet normally again, and feel like I'm alive again!" *Service user on patient opinion website*

Stigma
Embarrassment is a significant barrier that deters people from seeking professional help. On average people wait two to three years before they do so and often elderly people will not admit to having a problem. It may also mean many people either cope with the problem as best they can or purchase off the shelf products, rather than having an assessment to find out the cause of the incontinence and how best to treat or manage it.

"The first time I went to continence specialists nursing, Rotherham Community Centre, I felt nervous and embarrassed to talk about my condition, but within minutes I felt really at ease. The staff were so caring, polite and happy…" *Service user on patient opinion website*

Disturbed sleep and falls
Incontinence may lead to disturbed sleep and/or increased risk of falls and injury if people are making frequent urgent trips to the toilet, especially at night. People with balance problems, people who are less mobile and/or lack physical strength or dexterity are more likely to fall if they get up to rush to the toilet. Identifying and treating incontinence may help to reduce the risk of falls and fractures amongst older people, but continence as a factor can get overlooked in assessing them.

"I have prostate cancer, and before using this service was getting up in the night up to 6 times to relieve myself. The continence prescription service was recommended by my district nurse, and after seeing them and being fitted up, things have been great ever since." *Service user on patient opinion website*

4.3 Community Continence Service

General Service and Prescribing Service
The award winning CCS provides clinical advice, support and treatment to people in Rotherham who experience problems with bladder and bowel dysfunction. The service is responsible for supplying disposable absorbent products and prescribing all continence related equipment such as urinary catheters and drainage bags, using a standardised triage template to facilitate safe product ordering.

For the Prescribing Service people are seen within 48 hours and for the General Service the longest wait is four weeks. Once people are on the caseload they can self-refer in. Service users have the opportunity to discuss any product related problems with staff who will make home visits or hold telephone consultations. Annual reviews of patient needs

take place to check the suitability of their products and to spot any changes in clinical need.

In addition to support and product prescribing the service is also involved in preventative work:

- preventing catheter related A&E attendances and hospital admissions
- preventing patients from requiring long term catheterisation
- working with infection control to prevent catheter associated urinary tract infections

The General Service is staffed by the Continence Advisor plus a 0.6fte band 6 nurse, support worker and administrative worker. The Prescribing Service has 2.4fte band 6 nurses and support staff who cross over with the stoma service.

Referrals derive from GPs and other health care professionals, through self-referral and also from people learning about the CCS from other service users. The CCS works closely with the physiotherapist running the women's health clinic with two-way referrals in place. Publicity about the service is included on the TRFT website and in directories of local services and the CCG website contains detailed information and advice.

Centralised prescribing

Rotherham transferred the prescribing responsibility for continence products from GPs to the existing nurse-led CCS in 2009, together with the financial responsibility for the prescribing budget. It is the only Clinical Commissioning Group (CCG)/Primary Care Trust to demonstrate a decrease in continence expenditure over the last five years. From 2009-2013 continence prescribing costs in England increased by 21.56% whereas in Rotherham costs decreased by 8.99%. The CCG estimates 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, thus resulting in a potential saving of £239,591. The current budget is approximately £670,000 p.a. and cost efficiencies have released resources to improve service provision through additional staff, funded entirely from the savings made from centralisation of prescribing. Members noted that incontinence pads are controversial and with tight savings targets in the NHS many CCGs are trying to ration them or to save money.

The continence service redesign revealed a number of people whose mobility and independence had been compromised due to unsuitable products. The project enabled the CCG to meet this unmet need and improve patients' independence. Feedback on the Patient Opinion website is very positive about the service and choice is probably enhanced through being able to access a wider range of products via the specialist knowledge of the continence nurses. Service users have said they like talking to the expert staff of the CCS rather than someone at their GP practice.

Future service development

Input from the service user group informs service development and funding has been agreed from cost savings for a research/project nurse to continue the continence service re-design, to improve patient outcomes and release further efficiencies. This will develop further the work on preventing catheter associated urinary tract infections and on reducing the number of non-elective hospital admissions.

Another facet of the work that was welcomed by Members will be exploring the opportunity to develop an integrated incontinence referral pathway with the service as the single point of access, signposting people to urology or gynaecology if needed. There are approximately 450 GP referrals to TRFT urology and gynaecology outpatients each month and a number of these patients could be seen and managed in a community based clinic

either by a nurse or physiotherapist. Similar pathways developed elsewhere in the country are improving patient outcomes and reducing consultant referrals.

4.4 Preventative measures

Preventive work may take place on three levels:

- Primary prevention - educational work and promoting wellbeing across the whole community
- Secondary prevention - identifying people more at risk through early intervention
- Tertiary prevention - working to minimise disability or deterioration from an existing health condition

Preventative work currently undertaken and being further developed by the CCS focuses mainly on secondary and tertiary level prevention. Potentially the project/research nurse could also consider more educative work as part of the plans for future service development on prevention. In addition scope exists for wider partner agencies to contribute more to reducing urinary incontinence through primary prevention to support the existing work.

The CCS held some patient facing events five years ago although these were not overly successful and the service has attended Older People's Day and Carer's Day events. Wider awareness raising and education about continence is likely to result in increased demand for services, which could have resource implications in the short term, until the results of greater focus on prevention impact on demand in the longer term.

Lifestyle choices
Healthy lifestyle choices have a positive impact and help to reduce the chance of urinary incontinence developing:

- maintaining a healthy weight;
- reducing alcohol and caffeine consumption (as these are irritants to the bladder) but ensuring an adequate fluid intake;
- having a good diet to avoid constipation as this sometimes exacerbates bladder problems; and
- keeping fit and active.

Healthy Lifestyles is one of the six priorities in the Health and Wellbeing Strategy so there is scope to link in to that workstream in terms of publicity and awareness raising about preventing incontinence, for example during World Continence Week.

Physical activity
Demanding exercise such as heavy lifting or marathon running may actually weaken the pelvic floor muscles and people with stress incontinence may be fearful of taking part in physical activity in case of mishap, with a knock on impact on their overall health and wellbeing. However core strength training targets all muscle groups that stabilize the spine, hips and pelvis, focusing on balance and stability during movement. This is of universal benefit but may particularly be helpful for anyone with reduced mobility or poor balance who experiences incontinence, as mentioned in 4.2.

Active Always is a comprehensive borough wide programme of physical activities for adults, coordinated through RMBC Active Rotherham (formerly Sports Development) in partnership with several NHS Rotherham services and community partners. The

programme offers a range of general activities plus specific ones to support people with a long term condition or after a rehabilitation programme (some by referral only from a GP or health professional). Falls Prevention – Active Otago Strength & Balance exercise sessions take place in seven venues, including Davies Court. Strength, coordination and balance form a key component of the Exercise after a Stroke class and Tai Chi.

The four leisure centres include Active Always activities within their programming as well as the wide range of activities for all age groups, such as workout classes in the studio or the pool, gym classes and sports.

Pelvic Floor Exercises
Supervised intensive pelvic floor muscle training (also known as Kegel exercises) has been proved to relieve symptoms and may reduce the risk of developing stress incontinence. However research shows that the number of women who do the exercises as a preventative measure is quite low according to the CCS. Although exercises may be incorporated into the individual's daily regime, initial support helps to ensure they are done correctly, as research also shows some women experience difficulty with identifying the muscles and doing the exercises. Where people are intensely supported in classes they are also more likely to sustain the exercises. Physiotherapists are able to carry out quick tests to check whether there is an improvement after exercising.

Pelvic floor exercises, which are beneficial for both women and men, could potentially be included more widely within sport and activity programmes as a no-cost preventive measure, subject to staff being trained to deliver them. They are currently included in leisure centre activities such as Pilates and Aqua Pilates and are part of core strength training. Information about classes and activities does not explicitly mention which ones include pelvic floor exercises.

Downloadable apps for mobile phones provide information about how to do pelvic floor exercises. They usually incorporate a timer function to time the muscle contractions and to set as a reminder to undertake them. Detailed information about exercises for both men and women is also available on the internet.

Bladder training
Another helpful method to reduce certain types of urinary incontinence is to retrain the bladder by gradually increasing the time between toilet visits to micturate. "Just in case" toilet trips might make people feel more secure but diminish bladder capacity.

Toilet facilities
Access to clean, well equipped toilets, in schools and workplaces as well as in public spaces, was emphasized by the CCS. Toilets should contain suitable bins for the disposal of equipment and pads for both men and women. The biggest issue for the CCS service user group is clean, accessible public toilets, with some negative views expressed regarding the town centre, including poor design of the accessible toilet.

Nursing and care homes
As stated above mobility, dexterity and core stability are all important as it can cause functional issues if people are not as mobile or are unable to walk or to balance on a toilet. These issues coupled with fluid intake and diet are all relevant in care homes. RMBC's Sport and Leisure team includes a disability officer and engages with care homes for sporting activities, such as New Age Kurling and Boccia in nursing homes and sheltered accommodation. Rotherham United also holds activities in care homes.

Research carried out in Rugby[1] showed the benefit of education for staff as urinary

incontinence was less prevalent in nursing homes where nurses and carers had received continence training. The CCS do offer training to care home staff and in-house product training but take up is low and last year sessions were cancelled due to a lack of participants. Engagement is more difficult with private sector care homes and high staff turnover impacts on training and continuity of care.

Health professionals
Although in general there is greater focus on incontinence management and containment, more attention is starting to be paid to needs assessment and continence promotion. Awareness raising is needed with health care providers to dispel the notion of incontinence being an inevitability due to age or certain conditions and to encourage promotion of continence and preventative measures. Nurses, occupational therapists, physiotherapists, midwives, health visitors and school nurses are all well placed to assist with this. Signposting people for early assessment or support should link in with the future service development plans for an integrated pathway.

5. Conclusions

Rotherham has a good, award-winning community continence service, which is evident from service user feedback. Therefore the question is what more could be done on the preventative side to try and reduce the numbers of people who do become incontinent, particularly in relation to preventable stress and urge incontinence, as well as providing services and support for those who will continue to need continence products.

One such measure is to continue promoting healthy lifestyle choices to all sections of the community, which is already one of the six priority workstreams within the Health and Wellbeing Strategy. Public awareness about the importance of good bladder and bowel health and information to try and counter some of the stigma around incontinence are important. Raising awareness about continence promotion more widely with health professionals and care home staff will help with prevention. However it may well result in more signposting for assessment, rather than management and containment of incontinence, potentially increasing demand for services in the shorter term.

Another measure is to support and encourage people to do pelvic floor exercises and to consider ways to incorporate these more widely or more specifically within Rotherham's sport and leisure activity offer. The general benefits of core strength training were noted as helping with balance and mobility and current provision includes many sessions that focus on this area, including within the Active Always activity programme.

Members welcomed the plans for future service development of the Community Continence Service with greater focus on prevention, especially the workstream to consider developing an integrated continence care pathway, which should link in with services such as physiotherapy and fitness activities. Early assessment of a urinary incontinence problem, to identify its root cause and appropriate treatment should be facilitated by a single point of access, potentially reducing the numbers who are using incontinence products unnecessarily or inappropriate products, improving the quality of life for many people.

6. Recommendations

1 RMBC and partner agencies should ensure all public toilets in the borough are clean and well equipped to meet the needs of people who have urinary incontinence, including suitable bins for the disposal of equipment and disposable products.

2 Greater links should be established between the Community Continence Service and Rotherham MBC Sport and Leisure team to support people to participate in appropriate sport and physical activity.

3 Rotherham MBC and other sport and leisure activity providers should consider building more pelvic floor exercises into the Active Always programme and wider leisure classes.

4 There should be greater publicity by partner agencies to raise public and provider awareness of:

a) the importance of maintaining good bladder and bowel health and habits at all life stages (through media such as screens in leisure centres and GP surgeries, further website development, VAR ebulletin and a campaign during World Continence Week from 22-28 June 2015)

b) healthy lifestyle choices having a positive impact on general health but also helping to prevent incontinence, such as diet, fluid intake and being active

c) the positive benefits of pelvic floor exercises as a preventive measure for urinary incontinence, including the use of phone apps for support

5 More work should take place with care homes to encourage staff to participate in the training offered by the Community Continence Service and to increase staff understanding of the impact of mobility, diet and fluid intake on continence.

6 That the Health Select Commission receives a report in 2015 on the outcomes of the project considering future service development of the Community Continence Service.

7. Background papers and references

Pharmaceutical and Medicines Waste - Report to Health Select Commission 13 March 2014

Scrutiny review: Urinary Incontinence - Report to Health Select Commission 12 June 2014

Joint Strategic Needs Assessment

Ensuring Effective Continence Care - October 2013 Health Scrutiny Panel, North Lincolnshire Council

Warwickshire County Council January 2011 – Report of Adult Social Care Prevention Services Task and Finish Group

Nursing Times Discussion: Continence10.07.13

Frontline magazine, Chartered Society of Physiotherapists 2.10.13

NHS Choices and Patient Opinion websites

Reference
1 - “Is policy translated into action?” National survey by RCN and Continence Foundation

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meetings:**	**Health Select Commission**
2.	**Dates:**	**11 September 2014**
3.	**Title:**	**Mental Health Scrutiny Reviews**
4.	**Directorate:**	**Resources** **All wards**

5. Summary

This report provides a brief overview of local mental health services to inform the work programme in 2014-15. It also provides Members with some potential issues to consider for the scope of the review of Child and Adolescent Mental Health Services.

6. Recommendations

That Members:

6.1 Inform the Chair if they wish to be part of the review group scrutinising Child and Adolescent Mental Health Services.

6.2 Consider and comment on the issues outlined for the potential scope of the CAMHS review.

6.3 Consider the issues outlined in the report and decide which other areas besides CAMHS to prioritise within the work programme.

7. Proposals and details

7.1 Introduction

At its meeting in April 2014, the Health Select Commission (HSC) decided to focus its work around the theme of mental health and wellbeing during the 2014-15 municipal year. Further to this it was agreed in July 2014 that a review of Child and Adolescent Mental Health Services (CAMHS) be included in the work programme following a report from Healthwatch and a presentation from RMBC officers.

Mental health and wellbeing is a vast issue to consider, ranging from loneliness and isolation impacting on mental wellbeing, to depression, stress or anxiety, through to illnesses such as bi-polar disorder and schizophrenia, and cutting across all age groups. As such is it is essential that HSC determines the specific areas to scrutinise during the year and the approach it wishes to take to each – review or initial report with follow up work if desired by Members.

Maintaining good mental health is important for the whole community and as with childhood obesity; wider policies need to support the mental health and wellbeing agenda. It is also essential to ensure that besides health professionals, other officers and workers are more aware of referral pathways and how to signpost people to support. These factors could underpin any review work by the HSC in addition to service specific questions.

Rotherham Joint Strategic Needs Assessment illustrates the prevalence and impact of mental ill health:

- 1 in 4 people in the UK experience a mental health problem in the course of a year
- People with serious mental health problems have their lives shortened by 14-18 years on average
- Mental health problems are often found coexisting with physical health problems

7.2 Strategic framework

National
No health without mental health, a cross-government mental health outcomes strategy for people of all ages was launched by the Government in February 2011, setting out its vision for improving mental health and wellbeing in England in the longer term based on six core objectives:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

This was followed by the *Mental Health Strategy Implementation Framework* and *Suicide Prevention strategy* in 2012. In February this year *Closing the gap: priorities for essential change in mental health* was published by the Department of Health. This “seeks to show how changes in local service planning and delivery will make a difference, in the next two or three years, to the lives of people with mental health problems”. It identifies 25 areas where people can expect to see, and experience, the quickest changes (see Appendix 1).

Local

The Health and Wellbeing Strategy is due for refresh, presenting an opportunity to strengthen the focus on mental health. In his annual report the Director of Public Health recommended:

> "Rotherham MBC should develop a Rotherham Mental Health Strategy outlining local action to promote wellbeing, build resilience and prevent and intervene early in mental health problems."
>
> "Mental health promotion messages should be an agreed theme within Making Every Contact Count (MECC)."

RMBC and Rotherham Clinical Commissioning Group are currently developing an Emotional Wellbeing & Mental Health Strategy for Children and Young People that is due to be signed off in November 2014 by the Health and Wellbeing Board.

Other strategies and initiatives include:

- Dementia Strategy
- Rotherham Less Lonely campaign
- social prescribing
- Mental Health First Aid training
- work on self-harm involving the Youth Cabinet
- work on suicide prevention including the *Care about Suicide* guide which follows the care principles of Concern, Ask, Respond, Explain.

7.3 Rotherham Doncaster and South Humber NHS Foundation Trust

Many organisations are involved in mental health and wellbeing service provision, with RDaSH being a major provider operating services in 200 locations across Rotherham, Doncaster, North and North-East Lincolnshire and Manchester. The trust employs over 3,700 staff and has more than 200 committed volunteers. It provides inpatient and community mental health and learning disability services and other community services, such as district nursing, with around 115,000 people accessing services each year.

The business divisions within the NHS trust are:-

- CAMHS
- Adult MHS
- Older People's MHS (over 65s)
- Learning Disability
- Substance misuse – adults/young people
- Forensic MHS - mainly work with people with a mental illness who have been involved with the criminal justice system
- Doncaster Community Integrated Service – adults/children, young people and families (for information)

Members may wish to look at another business division as well as CAMHS or at a specific service or services within one of the divisions. Other potential issues Members may wish to consider are:

- transition from CAMHS to Adult MHS
- transition from Adult MHS to Older People's MHS
- services for specific groups such as ex-armed forces personnel
- maternal mental health – highlighted in the Rotherham Director of Public Health Annual Report 2014 and currently an area of work for Healthwatch

Improving Access to Psychological Therapies
RDaSH is participating in the national initiative Improving Access to Psychological Therapies (IAPT) to offer people with depression and anxiety disorders more talking treatments. The Rotherham IAPT Service comprises a team of health professionals based in GP surgeries who are skilled in helping people to overcome emotional and mental difficulties, including:

- Depression
- Stress
- Anxiety and sleep problems
- Assertiveness problems
- Confidence and self-esteem problems

7.4 Rotherham Clinical Commissioning Group

The CCG commissions many of the local mental health services and recently engaged an organisation called Attain to carry out reviews of CAMHS, Adult MHS and Learning Disability Services. Potential changes regarding the Learning Disabilities Assessment and Treatment Unit and community services are being consulted on.

It has also worked closely in partnership with RDaSH to address some issues of performance and quality in their CAMHS. Through the implementation of a detailed action plan improvements have been made, with positive feedback from GPs.

7.5 Child and Adolescent Mental Health Services

Definition
The following is the definition of child and adolescent mental health services used in the new strategy:

> Child and Adolescent Mental Health Services is commonly used as a broad concept that embraces all those services that contribute to the mental health care of children and young people, whether provided by health, education, social services or other agencies. As well as specialist services, this definition also includes universal services whose primary function is not mental health care, such as GPs and schools, and explicitly acknowledges that supporting children and young people with mental health problems is not the responsibility of specialist services alone.
>
> Source – http://www.everychildmatters.gov.uk/health/CAMHS/

Scrutiny review
Members of the CAMHS review subgroup will be invited to a presentation and discussion on the findings of the review undertaken by Attain on behalf of the CCG. This should provide an overview of the key findings and recommendations that will be progressed and will assist in finalizing the scope of the scrutiny review.

Given the wide range of mental health and wellbeing services to support and treat children and young people HSC may wish to limit the review to specific services within the wider CAMHS provision, whether delivered by RMBC, RDaSH and/or other providers. Information presented at the HSC meeting in July covering CAMHS is included in Appendix 2 showing the tiered model of provision. Having determined which services will

be the focus of Members' attention, below is an indication of some potential areas to consider within the review, but this is not an exhaustive list.

- Numbers and demographic profile of service users
- Referral mechanisms and pathways
- Waiting times once referred
- 7 day access to services
- Getting support in a crisis
- Service quality
- Experience of service users/patients
- Experience of families and carers
- Complaints and results of satisfaction surveys
- Outcomes for service users
- Financial resources and budget allocation
- Targets and performance
- Access to wider counselling and support
- Awareness raising and breaking down barriers
- Information about services and how to access them

8. Finance

There are no implications arising directly from this report but any future recommendations from the Select Commission would require further exploration by the Strategic Leadership Team and partner agencies on the cost, risks and benefits of their implementation.

9. Risks and Uncertainties

Although mental ill health is very common, with 1 in every 4 people in the UK experiencing a mental health problem in the course of a year, stigma and barriers still persist. Mental ill health impacts on all aspects of people's lives and also has significant resource implications for service providers, hence the importance of early intervention and preventative work.

At borough wide level addressing the wider socio-economic determinants of health is vital but people will still need access to high quality physical and mental health services, information and support to help them maintain good mental health and wellbeing at all life stages.

10. Policy and Performance Agenda Implications

- Corporate Plan priority - Helping people to improve their health and wellbeing and reducing inequalities within the borough
- Health and Wellbeing Strategy

11. Background Papers

RDaSH website and Quality Account 2013-14
Healthwatch CAMHS report 2014
Rotherham Director of Public Health Annual Report 2014
Presentation to HSC July 2014 on draft CAMHS Strategy
Rotherham Joint Strategic Needs Assessment

12. Author

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janet.spurling@rotherham.gov.uk

Appendix 1 ***Closing the gap: priorities for essential change in mental health***

Increasing access to mental health services

1. High-quality mental health services with an emphasis on recovery should be commissioned in all areas, reflecting local need
2. We will lead an information revolution around mental health and wellbeing
3. We will, for the first time, establish clear waiting time limits for mental health services
4. We will tackle inequalities around access to mental health services
5. Over 900,000 people will benefit from psychological therapies every year
6. There will be improved access to psychological therapies for children and young people across the whole of England
7. The most effective services will get the most funding
8. Adults will be given the right to make choices about the mental health care they receive.
9. We will radically reduce the use of all restrictive practices and take action to end the use of high risk restraint, including face down restraint and holding people on the floor
10. We will use the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children's mental health services
11. Poor quality services will be identified sooner and action taken to improve care and where necessary protect patients
12. Carers will be better supported and more closely involved in decisions about mental health service provision

Integrating physical and mental health care

13. Mental health care and physical health care will be better integrated at every level
14. We will change the way frontline health services respond to self-harm
15. No-one experiencing a mental health crisis should ever be turned away from services

Starting early to promote mental wellbeing and prevent mental health problems

16. We will offer better support to new mothers to minimise the risks and impacts of postnatal depression
17. Schools will be supported to identify mental health problems sooner
18. We will end the cliff-edge of lost support as children and young people with mental health needs reach the age of 18

Improving the quality of life of people with mental health problems

19. People with mental health problems will live healthier lives and longer lives.
20. More people with mental health problems will live in homes that support recovery
21. We will introduce a national liaison and diversion service so that the mental health needs of offenders will be identified sooner and appropriate support provided
22. Anyone with a mental health problem who is a victim of crime will be offered enhanced support
23. We will support employers to help more people with mental health problems to remain in or move into work
24. We will develop new approaches to help people with mental health problems who are unemployed to move into work and seek to support them during periods when they are unable to work
25. We will stamp out discrimination around mental health

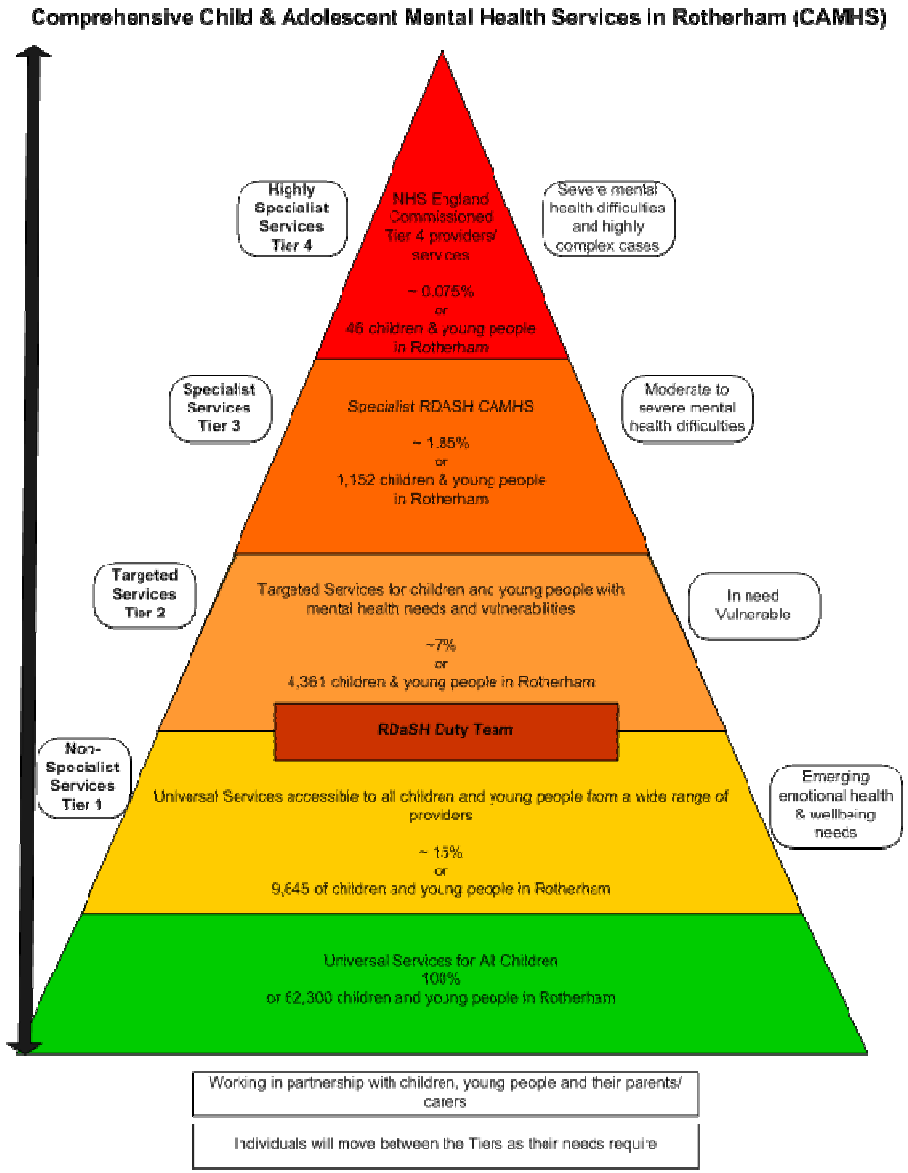
Appendix 2

CAMHS Tiered Model of Provision

<u>Commissioners</u>
NHS England

Rotherham CCG

RMBC



<u>Providers</u>
Private Sector

RDaSH CAMHS
(Sheffield Health & Social Care, Nottinghamshire Healthcare)

RMBC

Voluntary Sector

GPs, RFT.

Health Scrutiny Briefing

This briefing provides Members of the Health Select Commission with an overview of the recent guidance for health scrutiny issued by the Department of Health in June 2014. The purpose of the guidance is to support local authorities, relevant NHS bodies and relevant health service providers (public, private or voluntary sector) in discharging their duties and responsibilities under the relevant regulations, thus supporting effective health scrutiny. The guidance emphasises the holistic, wide ranging role that health scrutiny has beyond focusing on specific health services and holding commissioners and providers to account.

- The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe.
- Health scrutiny should be outcome focused, looking at cross-cutting issues, including general health improvement, wellbeing and how well health inequalities are being addressed, as well as specific treatment services.
- Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working.

1 Health and Social Care Act 2012

The Act established health and wellbeing boards to promote partnerships across the health and social care sector and local Healthwatch organisations to represent the voice of patients, service users and the public. Health scrutiny functions are conferred on a Local Authority through the 2012 Act, allowing it to discharge its health scrutiny function through various mechanisms.

2 Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013

In RMBC, as stated in the Council Constitution, the Health Select Commission performs "the role of the Council's designated scrutiny body for any issue relating to health and the public health agenda, including those functions contained within the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013."

The regulations relate to matters with regard to the health service and include:

- services commissioned by the NHS
- services provided by the NHS
- services provided to the NHS by external non-NHS providers, including local authorities
- public health services commissioned by local authorities

The regulations set up formal relationships between local Healthwatch organisations and local authority health scrutiny, to ensure that the new system reflects the outcomes of involvement and engagement with patients and the public.

3 Powers and duties

a Local authority powers

- Review and scrutinise matters relating to the planning, provision and operation of the health service in the area, which may also include scrutinising finances.
- Require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny.

- Require employees, including non-executive directors, of certain NHS bodies to attend before them to answer questions.
- Make reports and recommendations to certain NHS bodies and responsible persons and request a written response within 28 days.
- Set up joint health scrutiny committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority.
- Refer NHS substantial reconfiguration proposals to the Secretary of State if it considers:
    - The consultation has been inadequate in relation to the content or the amount of time allowed.
    - The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.
    - A proposal would not be in the interests of the health service in its area.

b Local authority requirements

Mechanisms need to be in place to:

- deal with referrals made by Local Healthwatch.
- respond to consultations by relevant NHS bodies/health service providers on substantial reconfiguration proposals.
- determine how their members of a joint health scrutiny committee would be appointed to respond to substantial reconfiguration proposals covering more than one council area.

c Reporting and making recommendations

Regulation 22 enables local authorities and committees to make reports and recommendations to relevant NHS bodies and health service providers. The following information must be included in a report or recommendation:

- An explanation of the matter reviewed or scrutinised.
- A summary of the evidence considered.
- A list of the participants involved in the review or scrutiny.
- An explanation of any recommendations on the matter reviewed or scrutinised.

d Powers and duties for the NHS

A major change for the NHS is the extension of certain duties to providers of health services (commissioned by NHS England, Clinical Commissioning Groups (CCGs) or local authorities) who are not themselves NHS bodies. Together with relevant NHS bodies these providers are known as ‘responsible persons’ and they include:

- CCGs and NHS England
- Local authorities (if providing health services to CCGs, NHS England or other local authorities)
- NHS trusts and NHS foundation trusts
- GP practices and other providers of primary care services (previously they were not subject to specific duties as independent contractors but now subject to them as providers of NHS services)
- Other providers of primary care services to the NHS, such as pharmacists, opticians and dentists
- Private and voluntary sector bodies commissioned to provide NHS or public health services by NHS England, CCGs or local authorities

In line with the local authority powers mentioned above in 3a the corresponding duties are: providing information; attending to answer questions; and responding to reports and recommendations. Consultation and involvement is covered below in paragraph 5.

e Providing information

Information requested and provided will depend on the subject under scrutiny, such as:

- Financial information about the operation of a trust or CCG, for example budget allocations for the care of certain groups of patients or certain conditions, or capital allocations for infrastructure projects, such as community facilities.
- Management information such as commissioning plans for a particular type of service.
- Operational information such as information about performance against targets or quality standards, waiting times.
- Patient information such as patient flows, patient satisfaction surveys, numbers and types of complaints and action taken to address them.
- Any other information relating to the topic of a health scrutiny review which can reasonably be requested.

f Local Healthwatch

Local Healthwatch organisations and contractors have specific roles which complement those of health scrutiny bodies, for example “enter and view” powers for certain premises where health and social care services are provided. Information from the local Healthwatch will supplement and triangulate information provided by service providers to health scrutiny, such as additional information on the quality of services, safety and any issues of concern around specific services and providers.

Statutory activities include making reports and recommendations regarding service improvements to scrutiny bodies, relating to the planning, provision and operation of health services in their area. This could potentially include concerns about local health services or commissioners and providers to local authority health scrutiny bodies.

Regulation 21 sets out duties that apply when an issue is referred to a local authority by a local Healthwatch organisation or contractor. Receipt of referrals must be acknowledged within 20 working days and the local Healthwatch must be kept informed of any action taken in relation to the matter referred.

4 Consultation and involvement on service reconfiguration

a Duty to consult

Under existing legislation the NHS is already required to consult current and potential service users in planning services, on proposals to change how services are provided and on decisions affecting the operation of those services. Similarly there is a duty on relevant NHS bodies and health service providers (now extended to the ‘responsible persons’ outlined above) to consult local health scrutiny bodies on any proposal they have “under consideration for a substantial development of or substantial variation in” the provision of health services in the local authority’s area. However the terms “substantial development” and “substantial variation” are not defined in the legislation. There are also a small number of specific exceptions when consultation with health scrutiny is not required.

Good practice guidance published by NHS England is intended to support commissioners, working with local authorities and providers, to carry out effective service reconfiguration in

a way that puts quality of care first, is clinically evidence-based and which involves patients and the public throughout.

If the substantial development or variation is to services commissioned by the CCG or NHS England then the NHS commissioners are responsible for the consultation not the providers. If providers have a development or variation "under consideration" they need to inform commissioners at a very early stage so that the latter can comply with the requirement to consult as soon as proposals are under consideration.

Regulation 23 requires the proposer of a substantial development or variation to publish clear timescales for consultation in order to inform the public. Health scrutiny bodies should be provided with the timescales, plus a deadline for their comments regarding the consultation and the date when the proposer intends to make a decision on whether or not to proceed with the proposal. Any changes to these dates must be notified to the health scrutiny body and published.

The guidance suggests health scrutiny should be able to receive details of the outcome of the public consultation before making its response, so that the response can be informed by patient and public opinion.

b Responding to consultation

When a health scrutiny body has been consulted on a substantial development or variation it should normally respond in writing to the relevant NHS body or health service provider within the timescale specified after considering the proposals and local evidence. The Health Select Commission acts as the consultee in respect of such matters.

If the health scrutiny body's comments include a recommendation which the consulting organisation disagrees with, that organisation must notify health scrutiny of the disagreement. Both bodies "must take such steps as are reasonably practicable to try to reach agreement". If NHS England or a CCG is acting on behalf of a provider then the health scrutiny body and NHS England/CCG (as the case may be) must involve the provider in the steps they are taking to try to reach agreement.

c Referrals to the Secretary of State

The general circumstances when referrals may be made are covered in 3a. In making a referral certain evidence and information must be included (detailed in the guidance) and health scrutiny will be expected to provide clear evidence based reasons for any referral.

There are also certain limits on when referrals may be made:

- To be able to make a referral in a situation where a health scrutiny body has not commented on a proposal or has commented without making a recommendation, it must notify the consulting organisation of:
    - its decision on whether to refer the matter to the Secretary of State and the date by which it proposes to make the referral; or
    - the date by which it will decide whether to refer the matter to the Secretary of State.

- In circumstances where agreement has not been reached over a scrutiny recommendation a referral cannot be made unless the health scrutiny body is satisfied that:
    - reasonably practicable steps have been taken to try and reach agreement but this has not been achieved within a reasonable time;
    - the relevant NHS body or health provider has failed to take reasonably practicable steps to try and reach agreement within a reasonable time.

Joint Protocol Between Rotherham Health and Wellbeing Board, Health Select Commission and Healthwatch Rotherham

This joint protocol ensures that the local Health and Wellbeing Board (HWB), Health Select Commission (HSC) and Healthwatch Rotherham develop a constructive and productive working relationship with one another. Each body has an independent role and a shared aim to reduce health inequalities and improve health and wellbeing outcomes. The roles are distinctive but complementary and must add value to each other's work, and avoid duplication. This joint protocol details the distinctive roles of each body, and presents examples of working together and reporting arrangements.

Rotherham Health and Wellbeing Board

The HWB is a statutory, sub-committee of the council. Locally, it is the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health and other services directly related to health and wellbeing, in order to secure better health and wellbeing outcomes for the whole Rotherham population, better quality of care for all patients and care users and better value for the taxpayer.

The board brings together key decision makers to address issues of local significance and to seek solutions through integrated and collaborative working, whilst being an advocate and ambassador for Rotherham collectively on regional, national and international forums.

Main functions of the board:

- To enable, advise and support organisations that arrange for the provision of health or social care services to work in an integrated way**,** for the purpose of advancing the health and wellbeing of people in Rotherham
- To ensure that public health functions are discharged in a way that help partner agencies to fully contribute to reducing health inequalities
- To assess the needs of the local population and lead the coordination, development and delivery of the local Joint Strategic needs Assessment (JSNA) and Health and Wellbeing Strategy
- To oversee the development of local commissioning plans, ensuring they take account of the Health and Wellbeing Strategy and are aligned to other policies and plans that have an affect on health and wellbeing
- To hold relevant partners to account for the quality and effectiveness of their commissioning plans and request relevant information from any of its members or agencies represented on the board (cross over with scrutiny function)
- To ensure arrangements are in place to provide assurance that the standards of service provided and quality of services are safe, meet national standards and local expectations

Health Select Commission (health overview and scrutiny)

Legislation sets out that health scrutiny can scrutinise any matter in relation to commissioning or providing health and wellbeing services in the local area. This includes holding to account all local commissioners and providers of publically funded health and social care services (including the HWB, Clinical Commissioning Group, NHS organisations) for the quality and outcomes of services; ensuring they reflect the local Health and Wellbeing Strategy, are accessible and equitable, and meet the needs and aspirations of local people.

Scrutiny can request information from the above bodies/organisations, request that they attend meetings, and make recommendations for service improvement.

The terms of reference for the HSC specifically mention scrutinising the following:

- health services commissioned for the people of Rotherham
- partnerships and commissioning arrangements in relation to health and well-being and their governance arrangements
- measures for achieving health improvements and the promotion of wellbeing for Rotherham's adults and children
- measures designed to address health inequalities
- public health arrangements

It is a requirement for the relevant body/organisation/officer to consider and respond to the recommendations in a timely way following a scrutiny review. This will generally require a full response to all recommendations to be made within two months of the review report being presented to cabinet, as set out in the Council Constitution. However NHS commissioners and service providers do have a duty to respond in writing to a report or recommendation within 28 days if so requested. If the recommendations involve both the council and one or more health partners, or only health partners, they should be presented at the next HWB meeting following presentation at cabinet.

NHS bodies and commissioners, including the Clinical Commissioning Group, are required to consult with scrutiny on substantial developments or variations to local health services. If scrutiny has significant concerns with any proposal, it has the power to make referral to the Secretary of State for Health.

Any referral made to scrutiny by Healthwatch Rotherham must be acknowledged and advised of what action will be taken.

Local Authority Health Scrutiny guidance published by the Department of Health in June 2014 sets out duties and responsibilities for local authorities and health partners to ensure effective scrutiny.

Healthwatch Rotherham

Healthwatch is the new independent consumer champion for both health and social care. It is a vital part of the government's health reform plans to give people a stronger voice and drive improvements in services.

Healthwatch Rotherham will represent the views and experiences of the diverse communities in the borough, ensuring the voices of vulnerable people and hidden communities are heard.

The national vision for local Healthwatch is that it will:

- Act as local consumer champion representing the collective voice of patients, service users, carers and the public
- Support individuals to access information about services
- Provide or signpost people to independent advocacy if they need help to complain about NHS services
- Have real influence with commissioners, providers, regulators and Healthwatch England using their knowledge of what matters to local people

The vision for Rotherham's local Healthwatch was created by the Healthwatch Rotherham Board.

Vision: Healthwatch Rotherham will be known by all communities and individuals as delivering on its promises backed up by robust action and supported by improvements in local services.

Mission: To be the first point of contact for all of Rotherham's communities and individuals, to help them to have a means of improving their own and others quality of health, wellbeing and social care.

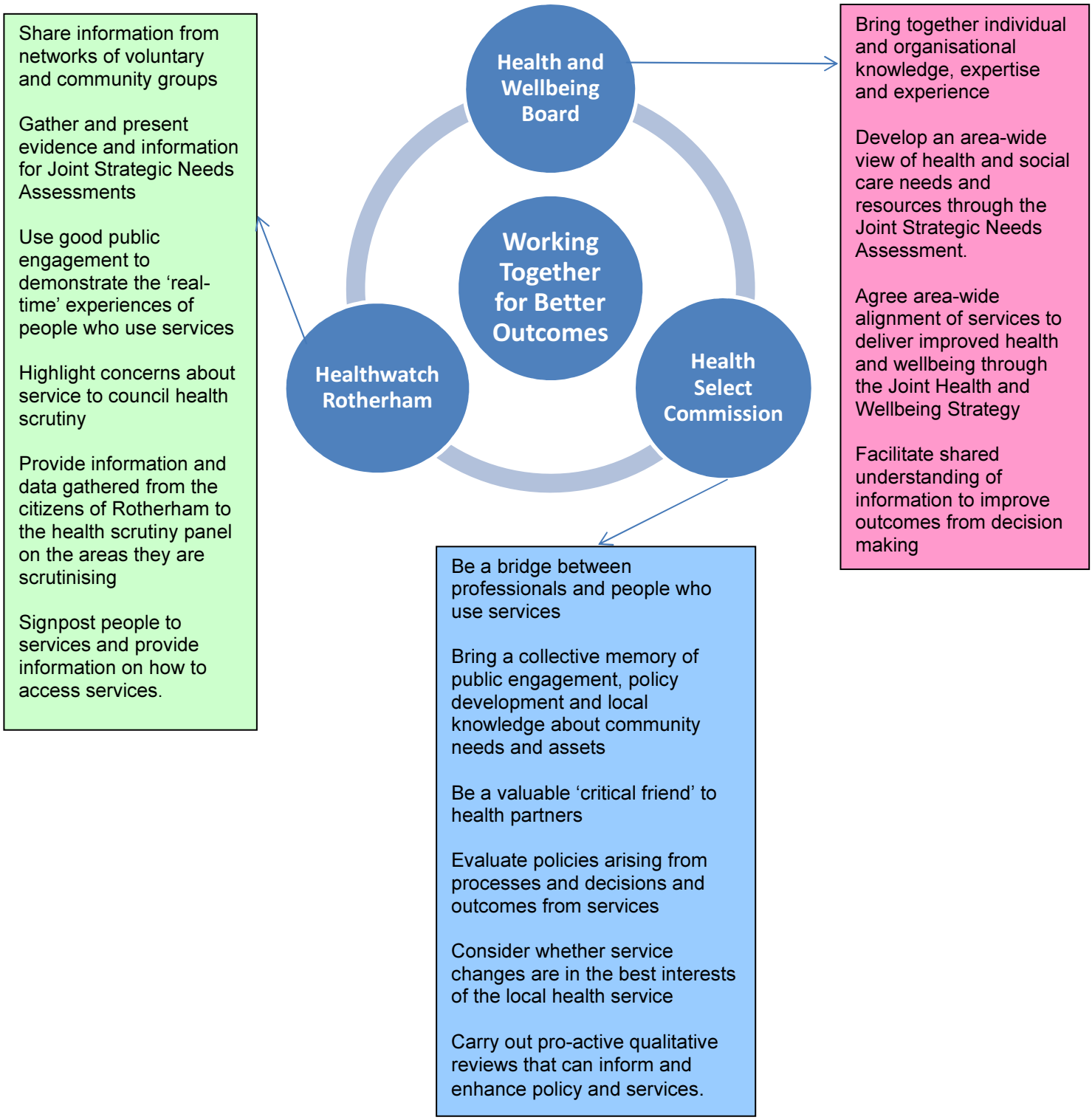
Values: To be an impartial and trusted friend to help communities and individuals to achieve their desired results and be recognised for being a fiercely independent organisation by the citizens of Rotherham.

Healthwatch Rotherham will also influence the development the local JSNA and health and wellbeing priorities, through its seat on the Health and Wellbeing Board.

Working Together

All three bodies recognise they have a role to play in the way that local services are planned and delivered and that how they interact with each other will directly influence and add value to outcomes for local people and communities.

Diagram below adapted from 'Local Healthwatch, health and wellbeing boards and health scrutiny - Roles, relationships and adding value' CfPS http://cfps.org.uk/publications?item=7195



Joint Principles, Actions and Reporting Arrangements

The Rotherham Health and Wellbeing Board, Health Select Commission and Healthwatch Rotherham agree to adhere to the following:

Key Principles:

- To improve health and social care services and reduce health inequalities in Rotherham
- To ensure and enable early and inclusive discussions about key health and wellbeing challenges
- To develop relationships based on openness, honesty and accountability

Actions:

1. To ensure regular and timely sharing of information, including sharing key actions, minutes and work plans as appropriate. As required, update reports to be presented at the respective boards to ensure transparency, provide an early opportunity to comment and to avoid duplication.

2. To coordinate the work plans of each body, ensuring duplication is avoided, cross-cutting issues are managed and clarity is given as to how each body can add value.

3. To ensure the understanding of roles and responsibilities between each body, members of each will have a seat, and/or be invited to attend meetings or joint discussions with regards to work plans and key areas of work:

- Chair of HWB to attend HSC and share minutes of meetings
- Open invitation for scrutiny members to attend HWBB
- Chair of Healthwatch Rotherham to have a formal seat on the HWBB and receive minutes of and attend where appropriate the HSC
- Healthwatch items raised at HWB to be noted through the minutes shared at HSC meetings
- HSC has a standard agenda item enabling Healthwatch to bring issues to their attention
- The chair of each body to attend joint briefings or meetings as required

Reporting Arrangements

The agreement between the HWB and HSC states that scrutiny reviews taking place that have implications for health and wellbeing board partners, should be circulated to the board for information at the early scoping stage.

Once a scrutiny review has taken place, the recommendations should be fed back to the HWB following agreement by cabinet (if implications for the council) and/or the appropriate board or committee (if implications for health partners).

Healthwatch Rotherham, as a formal member of the HWB, are able to raise issues with the board and request reports or information to be presented as appropriate.

Reporting from the HWB to HSC on delivery and performance of the health and wellbeing strategy will be undertaken annually.

Formal Agreement

Rotherham Health and Wellbeing Board, Health Select Commission and Healthwatch Rotherham agree to adhere to the principles, actions and reporting arrangements above in order to work effectively together.

Signed on behalf of the three bodies:

Cllr J Doyle	**Cllr B Steele**	**Naveen Judah**
Chair of the Health and Wellbeing Board	Chair of the Health Select Commission	Chair of Healthwatch Rotherham

Date …...../……/2014