You are hereby summoned to a meeting of the Health Select Commission to be held on:-

Date:- **Thursday, 9 July 2015** **Venue:-** **Town Hall, Moorgate Street, Rotherham S60 2TH**

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

HEALTH SELECT COMMISSION AGENDA

1. To consider whether the press and public should be excluded from the meeting during consideration of any part of the agenda.

2. To consider any item which the Chairman is of the opinion should be considered as a matter of urgency

3. Apologies for Absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Communications

7. Minutes of the Previous Meeting (Pages 1 - 16)

8. Health and Wellbeing Board (Pages 17 - 32)
   Minutes of meeting held on 18th May, 2015

9. Community Transformation (Pages 33 - 44)
   Chris Holt, Chief Operating Officer, Rotherham Foundation Trust

10. Hospital Discharges (Pages 45 - 50)
    Chris Holt, Chief Operating Officer, Rotherham Foundation Trust

11. Scrutiny Review Monitoring Report - Urinary Incontinence (Pages 51 - 58)
    Rebecca Atchinson, Public Health Principal (Healthcare Public Health)

12. Health and Wellbeing Strategy Refresh (Pages 59 - 70)
    Joanna Saunders, Head of Health Improvement, and Michael Holmes, Policy Partnership Officer

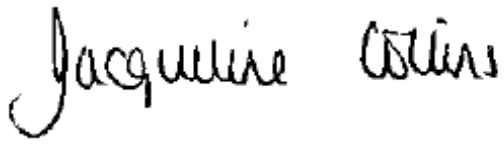
13. Scrutiny Review Monitoring Repair - Childhood Obesity (Pages 71 - 77)
Joanna Saunders, Head of Health Improvement

14. Provisional Sub-Groups for Quality Accounts

15. Healthwatch Rotherham - Issues

16. Date of Future Meetings
Thursday,

10th September, 2015	9.30 a.m.
22nd October	3.00 p.m.
3rd December	9.30 a.m.
21st January, 2016	3.00 p.m.
17th March	9.30 a.m.
14th April	9.30 a.m.



J. COLLINS,
Director of Legal and Democratic Services.

HEALTH SELECT COMMISSION
11th June, 2015

Present:- Councillor Mallinder (in the Chair); Councillors Alam, Burton, Elliot, Evans, Fleming, Hunter, Khan, Reeder and Smith.

Apologies for absence:- Apologies were received from Ellis, Godfrey, Rushforth, Sansome, M. Vines, Victoria and Robert.

1. DECLARATIONS OF INTEREST

Cllr Fleming raised his employment with the NHS in Sheffield.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

3. COMMUNICATIONS

The Chair welcomed everyone to the first meeting of the Health Select Commission in the 2015/16 Municipal Year.

Information pack
In addition to the Agenda papers for the meeting, a separate information pack with other documents of interest to the Commission which may not need discussion in the meeting may be circulated. If any Member wanted to raise an issue or ask a question in relation to any of the papers in the pack they should be raised under Communications. It included information on the Health and Wellbeing Strategy which was being refreshed and would be on the July agenda.

GP Limited Liability Partnership (GP LLP)
All of the Rotherham GP practices (now reduced from 36 to 35 following a recent merger) had formed a GP LLP which was registered at Companies House. Currently the LLP was not conducting any business but possible future actions could be to benefit from economies of scale or as a means of attracting investment which had happened elsewhere.

Treeton Medical Practice
This was a long running issue with regard to securing new premises as the present surgery premises were too small for the practice which had a growing patient list and likely to increase substantially with new housing developments close by. Originally it had been hoped to have a new building near their present site but this had stalled. Discussions had now commenced with Howarth Estates regarding the medical centre the developer was building at Waverley. A business plan application form had been submitted to NHS England on 11th May, 2015. The practice has not had a response as yet.

Care Quality Commission Inspection of the Rotherham Foundation Trust

It was standard practice after a CQC inspection to hold a Quality Summit with the Hospital, Health commissioners and stakeholders to discuss the findings and improvement plans. This had been due to take place on 12th June but had been postponed with a new date to be agreed. The Chairman, Interim Director of Adult Social Care and Interim Strategic Director Children and Young People's Services would be invited.

Joint Health and Overview Scrutiny Committee

(1) Representation

In keeping with previous years, the Select Commission was requested to consider representation on the JHOSC.

Resolved:- That Councillor Sansome and Councillor Mallinder (substitute) represent Rotherham on the Joint Health and Overview Scrutiny Committee.

(2) Yorkshire Ambulance Service

The Joint Health and Overview Scrutiny Committee, through Wakefield Council, was also being represented at the Care Quality Commission Quality Summit for the Yorkshire Ambulance Service on 15th June, 2015.

Health and Wellbeing Board

Councillor Roche, Advisory Cabinet Member, reported that a meeting had taken place with some of the key players to look at how the Board was going to run in the future, membership, agenda items, roles of the Chair and Vice-Chair and integration as much as possible. The Board would meet at various locations around the Borough and not in the Town Hall. A report would go to the Board's July meeting following by a report to the Select Commission.

Councillor Roche reported that Alison Iliff, Public Health, had been awarded a British Heart Foundation Hero Award for her work in promoting Rotherham as a Heart Town.

The Board had also held a special meeting in May to discuss Rotherham's Suicide Prevention Action Plan. The Plan had been agreed and would be sent to all the relevant partners.

It was also reported that central funding to local authorities for Smoking Cessation Services and Sexual Health Services was likely to be reduced.

4. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the Health Select Commission held on 16th April, 2015, were noted.

Further to Minute Nos. 87 and 89 (Rotherham Foundation Trust Quality Accounts and RDaSH Quality Accounts), it was noted that the Select Commission had submitted its statements for the Quality Accounts for the Foundation Trust, RDaSH and the Yorkshire Ambulance Service in accordance with the deadlines.

It was noted that a progress report on the Continence Review was to be submitted to the July meeting. Incontinence was often a key factor for people going into residential care but it was not inevitable with age and many forms such as stress and urge incontinence could be treated. It was also relevant to falls prevention.

Further to Minute No. 88 (Nurses in Special Schools), Tracey McErlain-Burns (Chief Nurse) had spoken with members of the Family Health Directorate regarding the query raised with respect of the level of support that might be provided when a young person leaves education.

The current position was that School Nurses would provide support to young people leaving school/education if requested by that young person or parents or if another partner agency requested it provided the School Nursing Service had accessed their ability to provide ongoing support. That was provided on a 1:1 ad hoc basis.

Further to Minute No. 90 (Scrutiny Review – RDaSH CAMHS), it was noted that the CAMHS report and the updated response to the Access to GPs review had been approved by the Overview and Scrutiny Management Board. They would be submitted to Commissioner Manzie and the Health and Wellbeing Board.

5. HEALTH SELECT COMMISSION WORK PROGRAMME

Janet Spurling, Scrutiny Officer, presented a report setting out the priorities for Scrutiny and the specific work programme for the Select Commission in light of the changes to the Executive decision making arrangements of the Council.

Since their appointment in March, 2015, the Commissioners had engaged with Elected Members to determine a realistic and focussed Scrutiny programme for 2015/16 clearly identifying the areas they would like Members to prioritise. It had been discussed and agreed by the Overview and Scrutiny Management Board at its meeting on 24th April and approved by Council on 22nd May, 2015 as follows:-

Budget plus statutory work	Overview and Management Scrutiny Board
Task and Finish work on Litter/Waste	Improving Places Select Commission
Scrutiny of Child Sexual Exploitation	Improving Lives Select Commission
Health/Social Care Integration	Health Select Commission

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

Initial overviews of Health Services and Adult Social Services
Better Care Fund and the Fund Finances
The Care Act including support for carers
Updates on previous Scrutiny Reviews
Capturing Service User/Patient Feedback and Experience
Children and Young People
Quality Accounts
Year End Performance
Visits to other local authorities and/or Health bodies
Monitoring Previous Scrutiny Reviews

The Commission's amended Terms of Reference were also submitted for information.

Discussion ensued on the proposed programme and the new way of working with most of the indepth scrutiny being carried out in the meetings by the full Commission rather than in smaller review sub-groups. The exception would be the Quality Accounts where it was proposed to have three sub-groups for Rotherham Hospital, RDaSH and Yorkshire Ambulance Service respectively.

Resolved:- (1) That the overall priorities for Scrutiny for 2015/16 and the focus for Health Select Commission on Health and Social Care integration be noted.

(2) That the Select Commission's 2015/16 proposed work programme be approved.

(3) That the Health Select Commission's Terms of Reference, as outlined in Appendix C submitted, be noted.

6. PRIMARY CARE UPDATE

Jacqui Tuffnell, Head of Co-Commissioning, Rotherham Clinical Commissioning Group (RCCG), gave a powerpoint presentation on the Primary Care update:-

- From April, 2015, the RCCG had taken on delegated responsibility for GP practices but not for the whole of Primary Care. There was the potential for conflicts of interests

- The Primary Care Sub-Committee met in public on a monthly basis, the meeting papers for which were available on the website. The Sub-Committee was Chaired by a Lay Member and was made up of members of the RCCG and 3 GPs who were elected to sit on the Sub-Committee to provide advice. At the point of making a decision, the GPs would leave the room

- A big piece of work that needed to take place was to set the GP Strategy for Rotherham. There would only be 1 plan which would align with other strategies such as the Health and Wellbeing Strategy and the Commissioning Strategy. There were 10 key priorities

  – Quality Driven Services
  Services were "RAG" rated so a warning would be received as to which practice's performance was raising concern. This was the first time this had been seen and Rotherham was paving the way. It enabled bench marking of practices as well as the sharing of good practice with others. The LLP gave practices the opportunity to look at working together rather than in silos. Work was starting on looking at new models of delivery regarding the integration of Health and Social Care and what possible models could look like

  – Services as local possible
  There were a number of challenges associated with this priority. Rotherham was around the national benchmark level for Doctors but new ways of managing patients were being explored including a new role of associate physician to support GPs in practice and looking at the wider health workforce including pharmacists and therapists.

  The RCCG was also looking at using IT and technology such as Skype. The Emergency Centre would integrate urgent care and out of hours care seamlessly.

  – Equality of Service Provision
  Dependent upon where you lived and the size of your practice, there could be real inequality in relation to the Services provided. Encouragement was being given to having "baskets" of Services through co-operation between practices so that if a practice did not deliver a particular Service it may be that the practice down the road could do so on their behalf thereby ensuring everyone received the same service. Some of the commissioning arrangements around Public Health were due to the way it had been divided up; the RCCG wanted to stop those barriers and all

work together and avoid whose responsibility for commissioning services

- Increasing Capacity and Capability
  It was hoped that there would be 5,000 more GPs nationally. Currently once trained, many Doctors opted not to go into GP practice. It was felt that it should be made easier for those coming back into the country to start practising again as currently you had to retrain to certain degree. There was a ten point national plan to attract and retain GPs. Rotherham would have its own local workforce plan associated with that. Sheffield Hallam University and Sheffield University were now running courses for associate physicians with Sheffield Hallam already having an oversubscribed allocation. Rotherham had managed to fill its cohort for GP training as it had a really good reputation but it was hoped to secure associate physicians to support GPs. Associate physicians would free up GPs to deal with the more complex issues and enable successful succession planning. Work was also taking place on a Recruitment Strategy, finding out what attracted people to Rotherham, what it could do to keep them in Rotherham and improve the profile as a place to work and achieve an improved fill rate.

- Primary Care Access
  Questions asked at a recently held Health event had revealed:-

  89% would be happy with telephone consultations
  87% wanted an allocated appointment time and wanted to be seen very close to that appointment time
  35% wanted Saturday opening
  24% wanted 7.30 a.m. opening
  41% wanted the surgery to be open until 8.00 p.m.
  19% wanted to use technology to self-care (mainly older people)
  80% supported usage of the extended workforce as they felt confident in the nurses and the advice they received from them

  Approximately 70% of the audience were the more mature of those who attended the event. The feedback derived from the event would be fed into the Strategy which would be subject to a number of engagement events, with the Patient Participation Groups as well as localities

- New Models of Care
  Currently 1 of the barriers was the contractual complexity which the formation of the GP Limited Liability Partnership would help with. Work had started on collaboration and engaging with GPs to get the right services within a catchment area to support the whole of the population. The opportunity of the Emergency Centre would be exploited.

- Self-Care
  There had been significant developments in health care resulting in people living longer as their health was better, but that had led to increased demand on Services which were not seeing an increase in the same way. There would need to be a real focus on educating the public on way services were available because for some time the message has been if you could not get in to see your GP you would be seen within 4 hours at A&E. There was some good work being carried out on social prescribing. The CQC on their recent visits to practices had commended the case management work – the report would be on their website soon

- Robust Performance Management
  Practices were far more robustly performance managed than ever before. This gave the ability to spot where there may be a problem with a practice. An intelligence system known as Radar had been developed by the North East which 10 practices were currently piloting which would also give information. Satisfaction surveys were also used

- Improving Medicines Management
  Significant steps had been made but the Service redesign would continue. Prescriber was also used which focused practices' attention on ensuring patients were on the right medication and had regular medication reviews

- Engaging Patients to Optimise Pathways
  It was known that those that are experiencing the pathway were the ones you would get the best information from and the best routes for that were being explored. There were Patient Participation Groups and Healthwatch Rotherham had been engaged to help with the 30% that were less successful and looking at what was right for that particular population 1 size did not fit all in how patients were engaged

Discussion ensued on the presentation with the following issues raised/clarified:-

- **Had there been any progress on matching computers between the Hospital and GPs?**
  It had been hoped to move to 1 system but it had been agreed to move to inter-operability between the 2 systems. Given the new Emergency Centre would be opening later in the year, everyone would be able to see the same medical record for a patient. The governance arrangements were being worked upon so that a patient understood that their record was being shared across the Services.

- **Had the issue of budgets been resolved i.e. did all the Services/agencies share 1 budget?**
  It had not been completed resolved but steps had been made with the Better Care Fund and agencies were looking at increasing that so as to prevent silos. Primary Care and GPs had been subject to the Equitable Funding Review so everyone would get paid the same amount for a patient. The setting up of the GP Limited Liability Partnership would be able to help, once the contracting arrangements were in place, either to deliver it or be responsible to ensure patients received delivery of the services so the contract would be internally between the GP practices

- **If a GP did not provide a particular Service had any consideration been given to accessing the Service across boundary?**
  Work had commenced on this issue. Barnsley had opted for co-commissioning and, therefore had delegated responsibility. It was not easy but there was a network working together as there was a similar with Sheffield. It would not be helpful having different levels of service so plans were being shared to understand the impact of where there was an issue. The intention was to try and work closely but it would be for Barnsley to decide what it did with its own Strategy

- **A number of senior GPs are retiring and we are struggling to recruit. Was there succession planning so have part-time GPs. Need to look at this**
  Work was taking place, but would be really hard to achieve, what that a patient would always see the same doctor. However, work was taking place within the workforce plan that, instead of having locum agency staff, a bank of trainees that did not want to base themselves in a particular practice but wanted to remain in Rotherham would be developed in an attempt to reduce the need to bring in outside help and utilise our own GPs. There were more Rotherham GPs involved in the Out of Hours facility so when doctors were away our own workforce was utilised so it was the same people seeing patients across Rotherham

- **How do we develop more understanding about disability including learning disability in practices?**
  It was difficult to achieve that a patient always saw the same doctor. However, work was taking place within the workforce plan that; instead of having locum agency staff, a bank of trainees that did not want to base themselves in a particular practice but wanted to remain in Rotherham would be developed in an attempt to reduce the need to bring in outside help and utilise our own GPs. There were more Rotherham GPs involved in the Out of Hours facility so when doctors were away our own workforce was utilised so it was the same people seeing patients across Rotherham.

- **How would you ensure patients with Mental Health issues are getting access to Services?**
  1 size did not fit all. GPs had expressed the need for additional Mental Health training for themselves and their staff or resources to support practices and it was the development around the pharmacies and how to direct patients in the right way. 1 practice was using telephone consultations but some patients did not want to feel they were being triaged by a receptionist. 1 practice was trialling triage by a GP. That would not work in every surgery but it was working for that particular practice

- **With regard to the CQC Duty of Candour, would the CCG take the role of moderator?**
  Currently complaints and incidents were still managed by NHS England and that responsibility had not been delegated. Work was taking place with NHS England but it was felt that it would remain with them as statutory body but issues with practices would be dealt with by the CCG.

- **How easy or difficult was it to keep all the GPs on side? What were the sort of issues that came up from GPs? Were some issues more difficult to deal with?**
  Some practices had been significantly affected by the Equitable Funding Review and work was taking place with them to achieve sustainability. There were some practices that were GP-led with very little practice nursing input when it was known that some tasks could be done with a different workforce. Practices were worried about their funding and their recruitment at the same time as wanting to deliver good services to their patients. Work was taking place on gaining an understanding on what "extras" practices were paying for and what were the right services to provide for the whole population and not just across GMS and PMS so there was no difference

- **Was Rotherham working towards 7 day access to GPs?**
  It could be argued that Rotherham already had it due to the availability of the Walk-in Centre 7 days a week. Barnsley did not have such a facility open 7 days. Events had been run with health professionals who had expressed concern with regard to capacity issues as there was no additional funding associated with it. Investigation was taking place on what access meant, what the need was rather than the want and ensure the need was addressed

Jacqui was thanked for her attendance and presentation.

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

(2) That the Select Commission receives further information from the Rotherham Clinical Commissioning Group on the final Strategy in September.

7. OVERVIEW OF ADULT SOCIAL CARE

Profession Graeme Betts, Interim Director of Adult Social Services, gave the following powerpoint presentation on Adult Social Care Services:-

Changes in Adult Social Care Nationally – from Dependency to Resilience

- From institutions to community and home-based services
- Improvements in supporting people to live their lives independently
- Greater use of information and advice, one-off interventions and advocacy
- Greater focus on prevention, early intervention, rehabilitation, recovery and reablement and enablement
- Greater use of housing-based support, telecare and other technologies
- Focus on supporting carers
- Greater use of personal budgets to increase choice and control
- Better joint working with the NHS

The Challenges facing Adult Social Care

- Demography
  In Health there was a gradual increase in the spending on people as they got older
  In Care, the costs were reasonably low until the age of 85 when the costs then soared
  Rotherham's population was declining with regards to its younger adults – these were the ones that provided informal care to older people

- Expectations

- Quality Standards
  There had been an incredible rise in the standards of residential care but it came at a cost

- Safeguarding
  Agencies were better at identifying the level of emotional, physical and financial abuse – again at an increased cost

- Resources
  Net expenditure of approximately £70M
  Over the past 3 years the Authority had had to make £14M savings
  Rotherham Adult Social Care Services was a high spender

Headline Figures 2014/15

- Over 6,400 people had received a Service during the year (excluding Occupational Therapy only Services)
- Approximately 4,000 Social Care Assessments or re-assessments were undertaken during the year
- 90% of Service users on Service for more than a year received a review of their needs
- 1,700 adults and older people placed in residential and nursing care

Pyramid of Care

- Contact received during the year with the outcome
  Service Cost £371,517
  Age 18-64 – 889
  Age 65+ - 1,828

- In long term Community-based Service
  Service Cost £22,399,007
  Age 18-64 – 2,051
  Age 65+ - 2,204

- Residential/Nursing Service
  Service Cost £22,139,903
  Age 18-64 – 234 (Residential 195 and Nursing 39)
  Age 65+ - 1,462 (Residential 1,090 and Nursing 372)

Connect to Support Rotherham

- A website for adults in Rotherham who needed support to live independently
- The website offered information and advice and was also an e-marketplace offering 1,905 products and 414 services
- Generated an average 800 hits a month
- www.connectosupport.org/rotherham
- Self-serve and channel shift
- Dependence to Independence
- Preventative
- Supported the Care Act through advice and information
- Had the potential to be further developed to provide personalised guidance, self-assessment, financial assessment, care accounts, support planning and more

Shared Lives

- Shared Lives offered opportunities for vulnerable adults to live or spend time with approved carers and their families
- This could be for a few hours or a few days a week (befriending), short stays in the home of the Shared Lives carer or living as a member of their family
- There were over 50 users of the Service. Currently all long term and respite users had a learning disability. Befriending was mostly used by older people and/or people with dementia or physical difficulties

- Carers were approved and supported by Shared Lives Workers and received fees and expenses. Shared Lives was registered with the Care Quality Commission
- Person-centred and was cost effective

Changes to Eligibility Criteria
- A new national Eligibility Framework – a single, consistent route to determining people's entitlement to care and support
- Based on principles of wellbeing
- Assessment to be based on 'strengths' instead of deficits and to be asset based
- Portability of assessments
- National consultation being undertaken by the Department of Health
- Shift from Dependence to Independence

Delivering Adult Social Care in the Future
- Resilient residents accessing mainstream services
- Focus on prevention, enablement and support for carers
- Personalised services with high use of direct payments
- Strong commissioning function
- Well-developed market for social care maximising choice and control
- Wide range of micro-enterprises, Personal Assistants and Shared Lives Schemes
- Strong partnerships with Health and the third sector
- Well-developed co-production and co-delivery with users, carers and residents underpinning all of this

Discussion ensued with the following issues raised/clarified:-

- The Integrated Mental Health Services was not operating as well as it should and work was taking place with Doncaster and North Lincolnshire who worked with RDaSH.

- The Learning Disability Service was an area that was being looked at in more detail particularly with regard to integration.

- **Following Winterbourne, were there any safeguards in place to ensure people with learning disabilities or mental health issues were protected and supported?**
  An assurance was given that Winterbourne was taken very seriously in Rotherham and there was a whole programme to ensure Services knew where people were in the system and what the plans were for them. That is being handled well .

- **There was no mention of dignity which was something that quite often was omitted?**
  Dignity went hand in hand with independence and was at the heart of everything the Service did.

- **As the criteria had changed nationally and was now based on substantial and critical needs, an individual's needs may increase which have an effect on Services. Was an increase anticipated?**
  As a result of the Care Act, it was anticipated that the introduction of assessments for carers would see an increase in the workload together with self-funders being able to now request an assessment even though they may not get access to funding from Rotherham.

- **More people were living longer and encouraging them to stay in their own homes caused a housing problem further down the line. However, if they moved into more appropriate housing that was not solving the problem as you would wish them to stay in an environment that was familiar to them**
  Housing was a challenge. The Authority had a Housing Strategy for Older People which we Adult Social Care would be feeding into. It needed to take account of the fact that people were living longer and on their own more. There was a project called "happy" project which basically looked at housing suitable for older people rather than older people's housing and the idea that people moved much earlier in their lives.

- **The Shared Lives Scheme was a great initiative but had not really been very successful in Rotherham**
  The Project Manager had been requested to draw up a 3 year growth plan. It was felt that Rotherham had huge potential for Shared Lives.

- **If Shared Lives was successful it would result in significant financial savings. Would they be reinvested in the Adult Social Care budget?**
  There were areas that needed to be reinvestment. Overall the Council would have to meet its budget responsibility as well as careful consideration given to what was invested in.

- **There was an issue around the transition of young people into Adult Social Care particularly within the wider integration agenda. What current work was taking place?**
  The Director of Children's Services had attended a meeting of the Adult Social Care Management Team to discuss how to improve integration. A meeting was to take place shortly with Commissioner Manzie regarding the overall commissioning and the issue of whether there should be commissioning and Service provision across the lifecourse and a much more integrated approach from cradle to grave. Work was taking place on making Services more integrated and giving residents a better service.

- **Personal budgets in terms of independence were really great but what were they based on? Were there any statistics?**
  A number of residents had been met who had personal budgets, Direct Payments etc. to discuss the quality of services. The feedback

was that the Authority needed to do more but the message was very much that Direct Payments had given them their lives back. Quite often it was the most complex cases that a Direct Payment could make sense of how they ran their lives. However, the Service did not do enough and needed to look at why.

- **The Connect to Shared Lives website received 800 hits a month but how did that translate into takeups?**
  It was not known at the present time but it would be looked into.

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

(2) That further liaison with Adult Social Care take place to assist in developing the work programme.

8. UPDATE FROM CONTINUING HEALTH CARE REVIEW

Janet Spurling, Scrutiny Officer, presented an update on the progress to date on the final outstanding recommendations of the joint Scrutiny Review.

Since the review was undertaken, NHS restructuring had seen responsibility for Continuing Health Care (CHC), including the budget, transfer to the Rotherham Clinical Commissioning Group (RCCG) who had commissioned the Commissioning Support Unit to carry out assessments and manage the budget. There was also now greater focus on personalisation of Health and Social Care Services and the development of personal health budgets.

A Senior Management Working Group of both Council and NHS staff had agreed a set of actions to ensure effective multi-disciplinary working and delivering better outcomes for people.

CHC and Social Care Assessments were completed by Health and Social Care staff presently or recently involved in assessing, reviewing, treating and supporting the individual. A better working relationship now existed together with a greater understanding of each professional's role in participating in multi-disciplinary assessments and completing the Decision Support Tool. Improved engagement had been achieved through attendance at CHC Panels and it was now routine that the Council's CHC Champions attend ratification panel meetings as part of the Multi-Disciplinary Team and implement joint actions. The Champions also ensured issues were addressed in a timely manner.

RCCG and Council staff also met regularly to progress work regarding CHC for children with complex needs in relation to assessments and the timing of payments for care packages for children agreed as eligible for CHC funding.

Resolved:- That the progress on joint working on Continuing Healthcare be noted.

9. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

10. REPRESENTATIVE ON WORKING PANELS

Resolved:- (1) That Councillor Sansome and Councillor Mallinder (substitute) represent the Health Select Commission on the Health, Welfare and Safety Panel for the 2015/16 Municipal Year.

(2) That Councillor Sansome represent the Health Select Commission on the Rotherham Local Plan Steering Group for the 2015/16 Municipal Year.

11. FUTURE MEETING TIMES

Discussion on the future meeting times took place. The opinion of those Members present was split on a morning (9.30 a.m.) and afternoon (3.00 p.m.) starting time.

However, it was noted that a number of apologies had been received for the meeting.

Resolved:- That an e-mail be sent to the full membership of the Commission seeking the preferred starting time of the Health Select Commission for the 2015/16 Municipal Year.

12. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 9th July, 2015, commencing at 9.30 a.m.

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HEALTH AND WELLBEING BOARD
18th May, 2015

Present:-

RMBC	
Councillor David Roche	Advisory Cabinet Member (Adult Social Care and Health) **(Chair)**
Councillor Gordon Watson	Advisory Cabinet Member (Deputy Leader)
Stella Manzie	Commissioner and Managing Director
Ian Thomas	Strategic Director, Children and Young People's Services
Jo Abbott	Acting Director of Public Health
Ruth Fletcher-Brown	Public Health Specialist
Professor Graeme Betts	Interim Director of Adult Social Services
Michael Holmes	Policy Officer
Mandy Atkinson	Corporate Communications
Julie Kitlowski	Chair, Rotherham Clinical Commissioning Group
Chris Edwards	Chief Operating Officer, Rotherham CCG
Sue Cassin	Chief Nurse, Rotherham CCG
Tracey McErlain-Burns	Chief Nurse, Rotherham Foundation Trust
Dr. Deborah Wildgoose	Chief Nurse, RDaSH
Chief Superintendent J. Harwin	Rotherham District Commander, South Yorkshire Police
Tony Clabby	Chief Executive, Healthwatch Rotherham
Shafiq Hussain	Voluntary Action Rotherham
Carole Lavelle	NHS England

Also in attendance were Councillor Sue Ellis (Ward Councillor) and five parents (including Frances McCormack, Jimmy Allen, Brian Kiernan and Adrian King), Deborah Cunningham (student of Sheffield Hallam University) as well as a reporter and a photographer from the Rotherham Advertiser newspaper.

Apologies for Absence:-

Steve Ashley	Chair, Rotherham Local Safeguarding Children Board
Janet Wheatley	Voluntary Action Rotherham
Chrissy Wright	Policy and Performance, RMBC

81. SUICIDE - INDEPENDENT REVIEW OF ACTIONS AND FUTURE STRATEGY

1. Introduction

The Chair welcomed everyone to the meeting and introductions were made.

2. Purpose of the Meeting

Councillor Roche, in his opening statement :-

i) explained that there was only one item on this agenda, which was the specific purpose of considering the independent review of actions taken following a group of suicide events in Rotherham and the future strategy in tackling the risk of suicides.

ii) stated that the thoughts of everyone at the meeting went out to all parents affected by these tragedies and that those present shared the deep sorrow. The key was to take action and do as much as possible to make sure that such incidents did not happen again. The purpose of the meeting was to look at the work done and determine how it could be performed better by a number of different agencies.

iii) expressed thanks to the Councillors of the Wickersley electoral Ward, who had originally brought the issues formally to the attention of the agencies and had worked hard on ways of moving the issues forward.

iv) stated that the agencies must look back, learn the lessons and acknowledge that things must be better. Actions, strategies and processes had to be put in place to make improvements, intervene at an earlier stage and prevent suicide happening. Support needed to be provided for the bereaved families and friends, which would be straightforward to access. The aim was to take forward an effective suicide prevention strategy, with the co-operation of all agencies and schools.

3. Suicide in Rotherham - Independent Review of Actions and Future Strategy

Introducing both the covering report, the report of the Independent Review (NB: executive summary) and the supporting documents submitted to the meeting, Jo Abbott offered condolences to the families, stating that she had met family members previously. She was aware that the pain and grief were tremendous. People in the agencies wanted to do what they could to prevent suicide and incidents of self-harm from happening again.

The purpose of the submitted report was :-

(1) to report formally the key findings of the independent report commissioned by the Council to examine circumstances surrounding the four deaths by suicide of boys and young men in Rotherham, aged between 15 and 19 years of age, since 5th November 2011 and two identified self-harm incidents as late as March 2014. Two of those who died by suicide and one of the self-harm incidents were students attending School A; and

(2) to present Rotherham's Suicide Prevention Action Plan and its model Rotherham Suicide and Serious Self-Harm Community Response Plan for consideration and approval by the Health and Wellbeing Board.

Attached to the report were three appendices:-

a) Executive Summary of An Independent Review of Actions Taken Following a Group of Suicide events in Rotherham; (nb: the full document is available on the Council's website);

b) Draft Rotherham Suicide Prevention and Self-Harm Action Plan;

c) Rotherham Suicide and Serious Self-Harm Community Response Plan.

There were five key aims to the independent review:-

1) To provide a supportive critique to the work undertaken to date in relation to prevention measures and response plans in the event of future suicides/unexpected deaths.

2) To determine whether there was an appropriate response to assessing and meeting the needs of the specified cohort of young people who have been identified as being closely affected by the events.

3) To identify areas of work that has been undertaken to date, which requires redesign or additional specific interventions.

4) To develop a plan for a whole system approach to prevention of young people suicides and self-harm in Rotherham and ways in which any barriers could be overcome.

5) To recommend governance and reporting arrangements for the performance management of the Suicide Prevention and Self-Harm Strategy and the Community Plan

The Health and Wellbeing Board noted that the updated Rotherham Suicide and Serious Self-Harm Community Response Plan was developed during the response to the incidents referred to above. This Plan had subsequently been used in schools across Rotherham who have had incidents of serious self-harm amongst their pupils. The schools involved had provided positive feedback about using the plan which addresses a wider community response through 'circles of vulnerability'.

This aspect did not replace the support that the NHS, Social Care and the South Yorkshire Police may be providing for individuals and their families.

The submitted Rotherham Suicide Prevention and Self-Harm Action Plan incorporated the recommendations from the independent review, as well as the six areas for action as outlined in the Department of Health Suicide Prevention Strategy 2012.

The Board noted that the Child Death Overview Panel had discussed the common issues affecting the incidents. After discussions with Public Health England, it was confirmed that there were no United Kingdom national guidelines for dealing with teenage suicides, although The Samaritans have produced comprehensive guidance for use in schools. Instead, use was being made of the 'Melbourne guidelines' from Australia.

In order to increase the national knowledge about teenage suicides, Public Health England recommended independent authors who could write a review of lessons learned. Rotherham Borough Council subsequently commissioned the independent review, the report of which was being submitted that day.

The draft Rotherham Suicide Prevention and Self-Harm Action Plan included the lessons learned from the independent review, plus the six areas for action, identified in the Department of Health Suicide Prevention Strategy 2012 and built on best practice. There was also the Mental Health Crisis Care Concordat, which partners of the Health and Wellbeing Board has signed up to. The Concordat included identifying people in crisis and signposting them to Services.

Since the series of incidents of suicide and self-harm, various initiatives had been implemented, including:-

- a bereavement pathway for children bereaved by suicide;
- a suicide prevention conference aimed at front line workers;
- suicide prevention training such as Applied Suicide Intervention Skills Training (ASIST) and Mental Health First Aid (for front line staff);
- CARE about suicide cards for front line staff (Concern, Ask, Respond, Explain);
- work with the Rotherham Youth Cabinet on self-harm (focus on mental health issues);
- GPs 'top tips' in suicide prevention had been developed;
- Rotherham guidance on self-harm (recognition that there was more work to do).

Alongside the development of these initiatives, the All Party Parliamentary Group on Suicide and Self-Harm published an "Inquiry into Local Suicide Prevention Plans in England" during January 2015. Bench-marking showed that Rotherham performed well against other local authorities in Yorkshire and the Humber. Examples of Rotherham's work were included as good practice, eg: CARE cards and the Suicide Conference.

Ruth Fletcher-Brown referred to the 'Melbourne guidelines', which led to the development of the Rotherham Suicide and Serious Self-Harm Community Response Plan. The latter was a partnership response plan, including representation from all of the various agencies.

The response to the 'circles of vulnerability' was a model used in the Rotherham Suicide and Serious Self-Harm Community Response Plan to identify all groups which may be at risk. Good practice suggested flooding the school community with advice and support, etc., as well as information about the ways of noticing the signs that someone was in distress. The situation in schools would be monitored to ascertain whether any specific staff training should be provided. Schools which had actively engaged in the community response work had been pleased with the support being provided. It was the responsibility of all agencies to be involved in the prevention work. The Community Response Plan was an evolving document. Any recommendations formulated nationally would be incorporated into the Community Response Plan.

The intention was to report on progress to future meetings of the Health and Wellbeing Board, as well as the provision of workforce development and support for staff in the various agencies. The Suicide Prevention and Self-Harm Group was accountable to the Health and Wellbeing Board.

Ruth Fletcher-Brown informed the Board that Rotherham was part of the South Yorkshire Real Time Suicide Surveillance pilot scheme. In the event of a suicide happening, agencies should be informed within 24 to 48 hours. This allowed for a fast response both to support families in their bereavement and also to prevent the contagion (spread) of suicides. Traditionally, agencies had to wait for the Coroner's verdict which may take up to 18 months after a death. This delay was too late for work to be carried out in supporting families and communities and to offer "post-vention" to prevent further suicides.

Questions by members of the Health and Wellbeing Board

(a) Councillor Roche referred to the use of the word 'clusters' (for several incidents of suicide) and asked whether the definition or use of the word was accurate in this context?

Response – Public Health England had advised that agencies should exercise a great deal of caution in the use of this term. There had been several suicides in Bridgend (Wales) but, after lengthy analysis using a specialist IT system, they had not been deemed to be a 'cluster'. The 'Melbourne guidelines' included a definition of "having more than you would expect." There could be an increasing incidence of 'copycat' suicides. Again, it was vital that agencies responded quickly and prevented any more incidents. Rather than talking about 'clusters', the preference was to refer to 'multiple suicides'. Rotherham instead addressed unusual and complex multiple suicides.

(b) Councillor Roche asked whether all schools and academies were engaging with agencies and with the implementation of the Community Response Plan?

Response – There had been a good response from most schools. School A (referred to in the report) had not responded initially and used a targeted approach. The Community Response Plan followed best practice and advocated a whole community response.

(c) Councillor Roche – did the draft Rotherham Suicide Prevention and Self-Harm Action Plan include all the points contained within the Independent Review report (eg: on the provision of counselling)?

Response - Yes, all of the recommendations were dealt within the Action Plan (and officers would check that this was the case).

With regard to the specific issue of the Rotherham Borough Council Chief Executive writing to the Secretary of State for Education and to the Secretary of State for Health, concerning the engagement of School A in the multi-agency response, together with this Council's Strategic Director of Children and Young People's Services, Commissioner Manzie stated that there would be further dialogue with the Head Teacher and the Governing Body of School A on this matter. The reference to Government Ministers would be a last resort, to be used only if the dialogue with School A did not result in satisfactory progress being made.

Chief Superintendent Jason Harwin extended the sympathies of the South Yorkshire Police to the families present. He explained that the South Yorkshire Police were learning the necessary lessons, especially in respect of faster communications and the timeliness of investigations. The safeguarding of people was the first priority, including the need to keep vulnerable people safe. The South Yorkshire Police service structures had changed as a consequence of the lessons learned.

The Members of the Health and Wellbeing Board referred to the recommendation concerning the reporting of progress on the implementation of the Rotherham Suicide Prevention and Self-Harm Action Plan and agreed that the first progress report must be submitted to a meeting of the Board within three months.

The Council's Strategic Director of Children and Young People's Services, Ian Thomas, also expressed sympathy for the families present. He said that whether a school was an academy or a local authority-maintained school, the engagement in the process was necessary and the Authority would intervene with both types of school. All schools had the responsibility of responding effectively. The Regional Schools Commissioner for East Midlands Yorkshire and Humber, Jenny Bexon-Smith, was also available to hold schools to account in this important matter.

The Board noted that most schools welcomed the provision of guidance. Schools also now had representation on the Rotherham Local Safeguarding Children Board and it was intended that schools would be represented on the new Children's Trust arrangements.

The Board noted that discussions at the Council's Health Select Commission (Autumn 2014) had highlighted the lack of Mental Health Services for children and also the lack of Early Help Services. Workforce development would ensure that staff would develop the skills to identify, at an early stage, any signs of suicide tendencies; and also understand the need to put in place help for parents at an earlier stage.

(d) Councillor Roche asked about the availability of Mental Health Nurses in schools.

Response – Chris Edwards extended the sympathies of NHS Rotherham to the families present. He confirmed that the School Nurses should be able to refer pupils immediately to the Mental Health Services available within NHS Rotherham.

Mr. Tony Clabby (Chief Executive, Healthwatch Rotherham) referred to recent experiences and staff undertaking the Applied Suicide Intervention Skills Training (ASIST). Training was being provided within the community as well, it was not only a matter of workforce development.

The Board acknowledged that Rotherham has a good track record of providing Adult and Youth Mental Health First Aid, with service delivery reaching a high standard. Ruth Fletcher-Brown reported that the National Youth Mental Health First Aid course had not yet been developed as a peer-to-peer course. The Rotherham Youth Cabinet appeared to be keen to keep its focus on mental health as one of its main issues. All agencies should be prepared to be involved in this work. This approach should include an investigation of the scope of peer group support and how to train young people to deliver this sort of first aid. The Kirklees Council area (Huddersfield) and areas of London had also developed this approach.

The Health and Wellbeing Board agreed that peer-to-peer approaches should be included in the Rotherham Suicide Prevention and Self-Harm Action Plan.

Mr. Tony Clabby stated that all agencies ought to be smarter and more flexible in what they did. 80 young people had signed up to participate in peer group activity at Wales High School. They would require training because young people preferred speaking to their age group peers.

Julie Kitlowski agreed that the Rotherham Youth Cabinet was already undertaking some very good work. The NHS commissioning process ensured that there was investment in some Mental Health and Support

Services, yet there were sometimes too many services, causing confusion for parents and children. More work should be done to simplify this matter.

(e) Councillor Roche asked about the bi-monthly meetings of the Rotherham Suicide Prevention and Self-Harm Group and whether the meetings occurred frequently enough.

Response – Ruth Fletcher-Brown replied that Rotherham was a real-time suicide prevention pilot area. Information gathered by the South Yorkshire Police and from the Rotherham Clinical Commissioning Group (CCG) was shared with the Suicide Audit Group. This Group, which included Public Health, CCG, RDaSH and the South Yorkshire Police, met bi-monthly. There might at times be a need to have more frequent meetings, although the bi-monthly pattern was considered to be sufficient at the present time. The information provided by the Police and by the CCG was carefully assessed by the Public Health service, upon receipt.

(f) Councillor Roche pointed out that the flowchart of contacts, within the Community Response Plan, ought to include Public Health alerting the Leader of the Borough Council, as well as the Advisory Cabinet Members for Public Health and for Children's Services, in the 'Partners Activated' section.

(g) Councillor Roche stated that any reporting to the Regional Schools Commissioner for East Midlands, Yorkshire and the Humber should refer not only to schools, but also to the academies as well.

Response – it was agreed that the reporting to the Regional Schools Commissioner would include issues concerning schools, academies and colleges.

It was noted that future meetings of the Health and Wellbeing Board would take place on Wednesday, 8th July, 2015 (morning), Wednesday, 26th August 2015 and on Wednesday, 30th September 2015. The initial progress report on the implementation of the Rotherham Suicide Prevention and Self Harm Action Plan should be submitted to a Board meeting no later than Wednesday, 30th September, 2015.

Councillor Roche commented that the Health and Wellbeing Board must keep this issue to the forefront of its agenda and maintain a system of monitoring the progress and work of the Rotherham Suicide Prevention and Self-Harm Group.

Chief Superintendent Harwin commented that, whilst the focus of this discussion was correctly on children and young people, there must also be consideration of the incidence of suicide amongst adults.

Mr. Tony Clabby commented that the speed of information being made available by agencies was good, enabling the prevention work to begin at an earlier stage. Often, it was necessary to have to wait for the result of an inquest, which did not always deliver a verdict of suicide.

Comments and Questions by parents present at the meeting

Q1) Almost without exception, all individuals I met after Oliver's death were well-intentioned and helpful. But it was apparent that the systems and policies served to form barriers between the different organisations. The initial Police response and investigation was very good and the Police officers on the ground were supportive. Even though it was a known fact that it was an apparent suicide, assumptions were made. The Police ought to be better and faster at what they have to do. It seemed that the Police were subservient to the Coroner's Office in the remit of their investigations. That remit looked at four points, but they did not include investigating any connection between the various deaths. Therefore the investigation could not have been sufficiently thorough. Did the Coroner set the terms of the Police investigation? This aspect ought to be checked.

Response - Commissioner Manzie confirmed that the parent's comments would be passed on to the Coroner (it was also noted that the parent had sent an e mail message to the Coroner, in similar vein, in 2013).

Chief Superintendent Harwin commented on the point about the assumption of the death being suicide. The CID would undertake an investigation because suicide was treated as a suspicious death. However, Police Officers had received training so as not to make that type of assumption in the future. The Police were obliged to report any death to the Coroner. The terms of an investigation, as decreed by the Coroner, ought to be told to parents. As responsible agencies, we have to ensure we prevent other deaths happening.

Q2) The situation in Bridgend, Wales, was a cluster of deaths by suicide. What was the downside of not using the term 'cluster'. Should the term 'cluster' be used to ensure that families had better and faster access to services?

Response - The Samaritans provided good guidance to the media about reports of suicide. There were fears that the use of the term 'cluster' in a widespread way could be inflammatory and might encourage more suicides.

Q3) Was the issue treated differently when it was known as a cluster ?

Response - Jo Abbott replied that no, agencies would not do that. The starting point had to be from the position of preventing suicide and preventing others from copying a suicide. It could be difficult to ascertain whether there were connections between cases. It was always hard to

find out exactly what the reasons were for any one case of suicide, as it was often the end point of a complex history of risk factors. Further national guidance was being published by Public Health England, during 2015, to help agencies respond to suicide. Whether the term 'cluster' was used, or whether it was called a series of multiple suicides, the imperative was to support family and friends and prevent further incidents by protecting vulnerable people.

Q4) The Director of Public Health did not identify a connection between the two suicide cases initially. The Director, at the time, did raise the matter with the Child Death Overview Panel (of which he was the Chair). There was initial contact between the two mothers, using social media. I was later contacted myself, from my former wife. I had also known Joyce Thacker because I had been a school governor. The matter had been raised in March of that year (2013) and Joyce Thacker had said that she would contact the Director of Public Health.

Response – The Child Death Overview Panel (CDOP) procedure did note the circumstances of the suicides, occurring 18 months apart and the two deaths being connected to School A.

Commissioner Manzie explained that the new appointee to the post of Director of Public Health would begin work on Monday, 29th June, 2015. An important initial task would be to focus on work with schools. The intention was to ensure the rapid identification of commonalities between cases, such as geography, institution attended, whatever the detail may be. The events over the period in question were horrible and much work had since taken place to ensure that, in future, there would be a much higher chance of making connections. The South Yorkshire pilot scheme concerning 'real-time' suicide surveillance was one such improvement. The Community Response Plan would contain everything together and, within a short space of time, all factors would be in place.

A parent also commented that agencies need to be quicker with their actions, even with 'real time' surveillance.

Q5) The concentric circles model ought to be included in the 'real-time' surveillance model and firmly embedded in it.

Q6) The assumption in the prevention plan and elsewhere was that the circumstances of a suicide case were unique. How did the agencies know that?

Response - The national advice available informed agencies that each suicide was driven by a unique set of circumstances, due to the age range, proximity, link to a school etc.

A parent commented that enough monitoring had taken place for the agencies to be able to say the case was unique. Perhaps there was a national vacuum (of information provision) on this. Agencies must not be complacent when they made their assumptions.

Another parent referred to the Police response and the involvement of a paediatric doctor. Advice had been given to contact School A. On telephoning the school the next day, we had asked the Police why it had been necessary to contact the school. The Police had referred to a 'spate' of suicides at School A.

Q7) Father of Jack - Young people preferred talking to young people of the same age. Jack used Facebook a lot, sometimes early in the morning. There were conversations about X-box and Playstation games. Jack's brothers and friends had not yet come to terms with his loss. It was important not to expect every young person always to communicate about every issue, even with their closest friends.

Response – Communication (and the lack of it) was the key point to make here.

A parent commented that, as parents, we would not always look for preventative support until something awful happens.

Another parent (mum) commented that there was not always accountability in schools.

Q8) The incidence of online bullying was not properly monitored. Jack was linked to different groups via X-box games, Facebook, etc.

Response – Jo Abbott replied that the recommendations contained within the independent review report asked the Health and Wellbeing Board to make public mental health and resilience for young people priorities in the re-fresh of the Strategy. Youngsters needed to be both happy and resilient.

Q9) One father thanked the Authority and other agencies for making parents feel welcome at today's meeting. He said that it was good that preventative work will be undertaken. Agencies must engage with the young people and get them on board with the work on prevention of suicide. As a parent, it had been a nightmare to go through this. We must make improvements in the future. Funding for Mental Health Services would be vital. Suicide was the biggest killer of young people, so it was important to get the issue sorted out. Parents would not always know how to cope. You go through counselling and find a way of dealing with it. You have to do so, to be able to move forward. There was another tragedy because his best friend was involved. Perhaps that may have been a factor. The other tragedies had not just been suicide. It was good for agencies to involve parents. We appreciate the invitation to come and

speak to officials. Some of us had not seen a copy of the report and the other documents.

Response – A full set of reports and supporting documents, considered by the Health and Wellbeing Board, would be provided for all parents. Details of appropriate agencies and officials had been given to all parents identified within the report.

Jo Abbott confirmed that the agencies now had a pathway of support for children and young people, up to the age of 18 years, if people in that age group were bereaved as a result of suicide, or some other traumatic event. Schools would know the individual circumstances and generally have faster access to the Mental Health Services (CAMHS). There would be help for siblings. The feedback from families using this support pathway had been positive, with families agreeing that the service was a good one. It was helpful for everyone to know that the support was there. The Rotherham Suicide Prevention and Self-Harm Group was investigating the possible establishment of a similar pathway of support for adults. It was very helpful for agencies to receive the parents' feedback and their views on the support available at the time of the incidents.

The advice provided by the South Yorkshire Police was specific to the investigation of incidents. But, there also needed to be a balanced approach taken to the range of support services known to be helpful to parents. The provision of emotional support was especially important.

Tony Clabby commented that the information available from the CAMHS Mental Health Services had improved. However, the timely access to Mental Health Services had not. The transition from the CAMHS Service to the Adult Mental Health Services was a very vulnerable time for any person.

Q10) A parent stated that it was helpful to have a single point of contact for families across the whole period of time until the inquest was closed. This was an intense need. Families would not be bothered where that contact person was based.

Q11) A parent referred to the report's references to School A and the interventions made in that School. Did the report address those children and young people who were not pupils of School A, but may still have suffered some level of impact (eg: young people from primary schools or youth clubs)?

Response – Ruth Fletcher-Brown replied that the Community Response Plan would include circles of vulnerability, for example: faith schools, children and young people in other establishments and elsewhere. Agencies must look beyond an immediate area for any contacts there may be with other children and young people. A comprehensive improvement

plan was being put into place. The timeliness of access to appropriate support services was also improving.

Q12) A parent commented that it was good that lessons were being learned and agencies were moving forward on this difficult matter. Prevention and post-incident intervention were important. If these response and improvement plans were all put in place, would this all achieve the outcomes we want? We have to look back at the tragic incidents with that objective in mind. We must ask – has the appropriate action been taken.

A parent thanked the agencies for the invitation to this meeting.

General discussion

Councillor Ellis commented that the language of suicide and self-harm was very difficult to cope with. The careful monitoring of the improvement action plans must be thorough. When the boxes were ticked for the 'red-amber-green' ratings, was there sufficient notice taken of timescales? Was there the correct investigation of the individual circumstances of any incident? The necessary budget details were not included in the improvement and action plans. The budget situation was known to be difficult, yet it was important that all of the different agencies want to be a part of this. There would probably be an impact because of reductions in the budgets for some Health Services and for some schools.

A 'whole community approach' was essential in dealing with loss. Councillor Ellis had become aware because her own children were of similar age to the individuals and they had found out by using social media. It would not be easy to take a 'whole school approach' when dealing with the various academies and types of school. There was now not such strong contact between the academies and the Local Authority, so a heavy-handed approach may sometimes have to be used. The risk or even fear of reputational damage should not prevent people (and agencies) getting involved to do good work.

Councillor Roche stated that the Community Response Plan had to be a 'living' plan and the Health and Wellbeing Board must keep it under continual review. Actions were more important than plans on paper. It was difficult to comment on the budget issues.

There followed a discussion involving Councillor Ellis and Chris Edwards (CCG) about NHS Rotherham's budget of £200,000 for Children's Mental Health Services in the 2015/16 financial year. The plan was for the Services to be a big area of investment, not a budget cut. Councillor Ellis asked about the measurement of success and how much money would be invested in prevention?

There was a discussion about schools and academies, with an emphasis on the importance of the whole community approach. This included a statement from a parent who was critical of an apparent lack of co-operation from academies and schools. They should all be co-operating when it was the lives of young people which were at stake. It should not be a difficult issue (to co-operate) because the safety of children and young people was so important

It was emphasised that most schools had regular Safeguarding meetings held at the Rockingham Professional Development Centre, Kimberworth Park. Schools were making good progress with this issue and appreciated the help they would receive from the range of agencies. The Strategic Director, Ian Thomas, stated that the Borough Council was working hard to strengthen the partnerships with schools, via the arrangements of the Children's Trust Board. There was a process of escalation to the Regional Schools Commissioner if the academies did not want to join in. The Borough Council had that commitment.

Tony Clabby referred to the cases of young people's engagement with the Mental Health Services. What happened in situations where they were sectioned or admitted to a hospital away from the Rotherham Borough area? The Board was informed that there would have to be an investigation of any serious incident which had taken place. All health providers were accountable to the Clinical Commissioning Group, which would ultimately give its independent view on an individual case.

Another parent commented that it was hard to understand why it (suicide) had happened. As parents, they had not seen it coming. Other parents would go through this in the future and you did not get any warning. Self-harm was different, because you could see some of the signs. But it could still be very hard for parents to pick up on it.

Decisions of the Health and Wellbeing Board

Resolved:- (1) To approve the recommendations contained within the submitted report and as set out at (a) to (c) below and with the amendment to recommendation (c) from "at least annually" (suggested in the independent report) to the timescales below :-

(a) That the Health and Wellbeing Board notes the Executive Summary of the Independent Review.

(b) That the Health and Wellbeing Board accepts and endorses the Rotherham Suicide Prevention and Self-Harm Action Plan and tasks the Rotherham Suicide Prevention and Self-Harm Group to implement it.

(c) That the Rotherham Suicide Prevention and Self-Harm Group is tasked to provide a minimum of a quarterly update to the Health and Wellbeing Board about progress made in implementing the plan (frequency increased from the suggested annual update).

(d) That the Health and Wellbeing Board accepts and endorses the Rotherham Suicide and Serious Self-Harm Community Response Plan, the use of which will be promoted by the Director of Public Health in the case of any future incidents.

(2) To support the seven recommendations listed in the report of the Independent Review:-

i) Local stakeholders, led by an agreed lead agency, should agree procedures for the ongoing development of the Community Response Plan and the associated Action Plan (with clear timescales and identified leads) ensuring the Action Plan remains an ongoing and up to date plan.

ii) The Rotherham School Incident Plan should be updated alongside the community response plan to include available support services for suicide/self-harm within Rotherham.

iii) The current Rotherham Suicide Prevention Strategy Action Plan should be updated and thereafter re-updated annually and include the use of suicide audit to inform its redrafting.

iv) The Rotherham Health and Wellbeing Board should develop a Public Health Mental Health and Wellbeing Strategy within which the emotional needs of young people are clearly addressed and are prioritised at Cabinet level in the Council.

v) A clear communications strategy should be developed between Rotherham MBC and its strategic partners. This should proactively promote suicide prevention approaches.

vi) The Rotherham Police and Coroner's Office should consider some of their specific roles and responses to deaths by suicide in light of this report.

vii) Primary Care and Mental Health Service commissioners should review their relevant commissioning strategies in light of this report.

(3) To approve the additional items, as discussed at the meeting and listed below:

a) All agencies must learn the appropriate lessons from these incidents and ensure the long-term focus on appropriate preventative measures being in place.

b) To investigate thoroughly the possibility of establishing one single point of contact for parents' wishing to seek help and access support services.

c) The reports and documents, including appropriate contact details, to be provided for parents attending this meeting.

d) The implementation of a whole school approach to preventative work and ensuring the participation of all academies and schools.

e) To ensure the engagement of all academies and schools in the implementation of the Action Plan and the Community Response Plan and, if necessary, to refer those unwilling to participate to the Regional Schools Commissioner for East Midlands, Yorkshire and the Humber.

f) To ensure that pupils have fast access to the School Nursing Services.

g) The investigations of suicide incidents must include the examination of any links to other, earlier suicides, because an individual's difficulties may develop over a long period of time.

h) To provide the impetus which will ensure the improvement of the focus of a range of partner agencies involved with CAMHS (Child and Adolescent Mental Health Services), noting that the transition from CAMHS to Adult Support Services is a particular issue.

i) To ensure that agencies do not make too narrow an assessment of the needs of young people or parents who were seeking help and support; there may be a diverse range of options for the provision of the necessary support, available from a wide variety of organisations.

j) To investigate, with the Rotherham Youth Cabinet, the possibility of a system of peer group support being available for young people.

k) To have further dialogue with the Governing Body and the Head Teacher of School A on the issue of suicide and self-harm, with reference to Government Ministers only as a last resort, if satisfactory progress was not made.

(l) The Director of Public Health to consider sharing the learning with a wider audience, including Public Health England, NHS England and other local authorities.

The Chair, Councillor Roche, thanked everyone for their participation in and contributions to this meeting.

82. DATES OF FUTURE MEETINGS

Resolved:- That future meetings of the Health and Wellbeing Board take place on:-
Wednesday, 8th July, 2015
Wednesday 26th August 2015
Wednesday 30th September 2015

Transforming Unscheduled Care

The story so far

The Rotherham NHS
NHS Foundation Trust

- Community Transformation launched
- A focus on 5 key priorities
  - A Better Community Nursing Service
  - Integrating Services in Health and Social Care
  - An Enhanced Care Coordination Centre
  - Utilisation of Alternative Levels of Care
  - Better Governance and Performance Management
- 'Input' and milestone focus
- Secured successfully – need stage 2
- Acute was delivering, but recently struggled

The story so far

The Rotherham NHS
NHS Foundation Trust

Priority	Successes
A Better Community Nursing Service	• Reconfigured around locality teams • Better leadership, clinical supervision and governance • Additional nurses (14 WTE) against 14/15 establishment • New IT equipment, full connectivity
Integrating Services	• Developed new IRR (merging Fast Response, ANP's) • Respiratory care pathway agreed • Investment in integrated falls and bone health care pathway • New service model for neuro rehab
Enhanced Care Coordination Centre	• Resourced to provide 24/7 cover • Hub for new supported discharge and admit prevent pathways • Develop single point of access for community nursing referrals
Utilisation of Alternative Levels of Care	• Agreed model for Community Unit to target Frail / Elderly • Discharge to Assess beds commissioned at Waterside Grange • 3 supported discharge and admission prevention pathways
Better Governance and Performance Management	• Performance framework established across all community teams • Reporting mechanisms and indicators agreed with teams • Bi-monthly meetings held between CCG and Community Teams

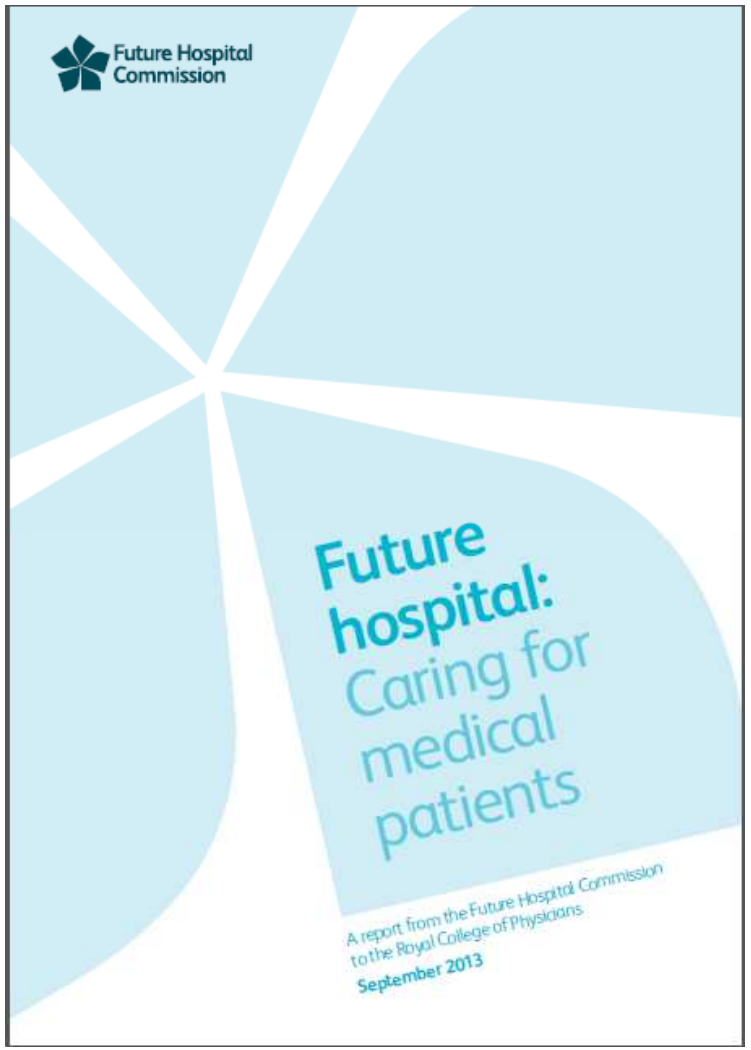
Current situation – an opportunity

The Rotherham NHS
NHS Foundation Trust

- Provider of Acute and Community services
- Community Transformation enablers
- A focus to improve within Acute
- Take a 2 to 3 year view
- Address other key enablers (Emergency Centre, 7/7 Services)
- Outcome and performance driven

Origins of the programme

The Rotherham NHS
NHS Foundation Trust



A future model of care

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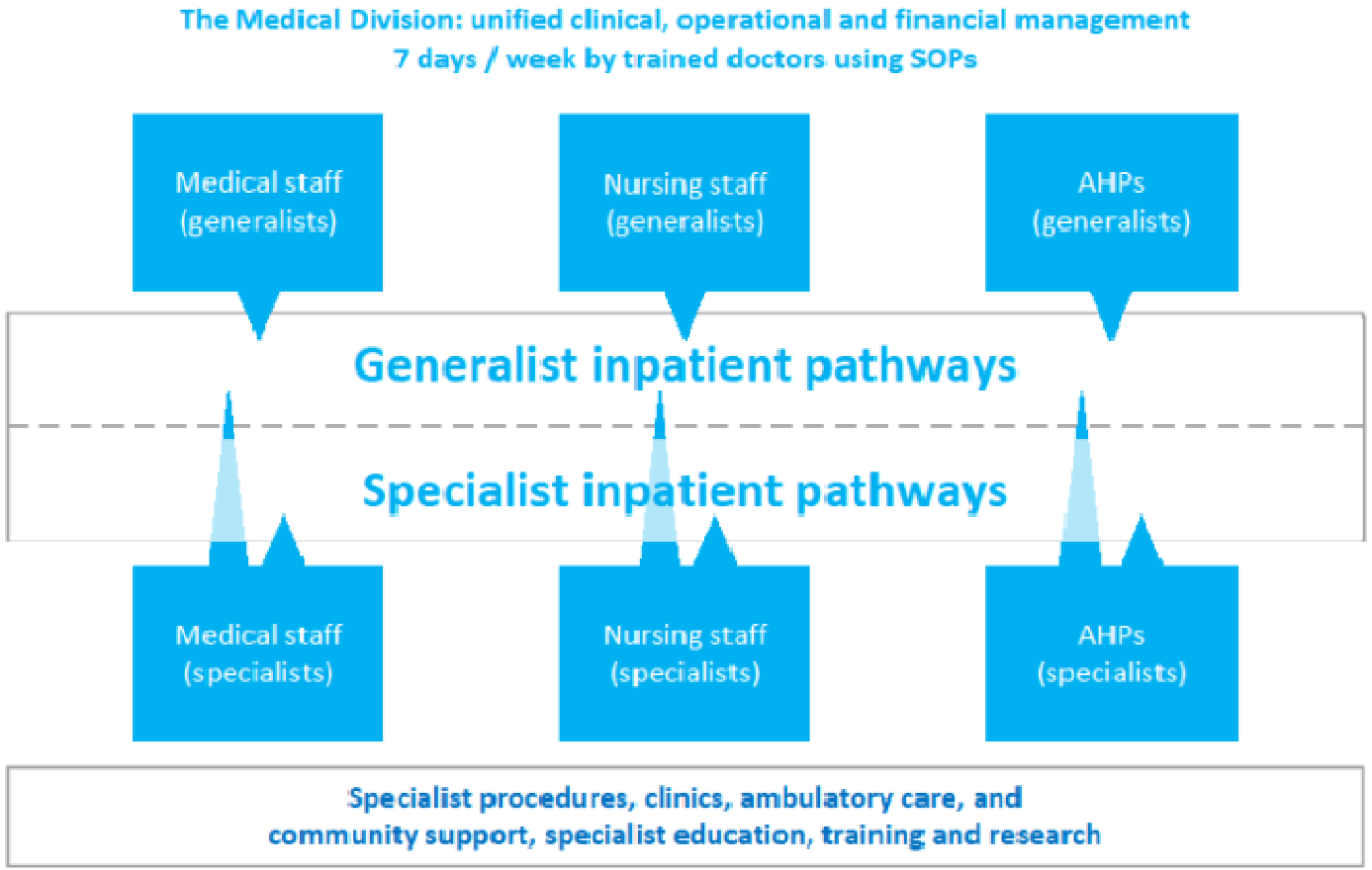

A future model of care

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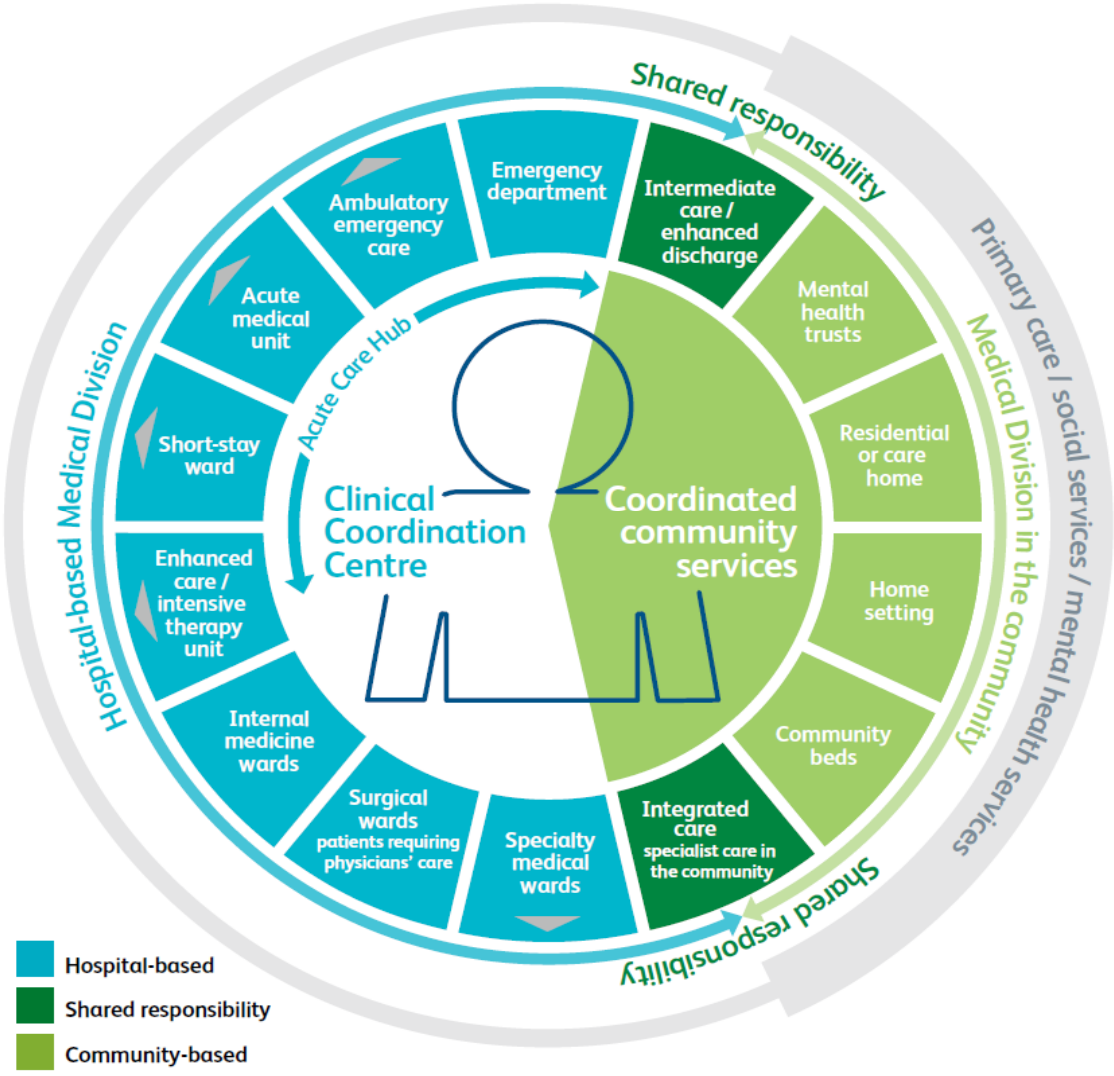

A proposed future state

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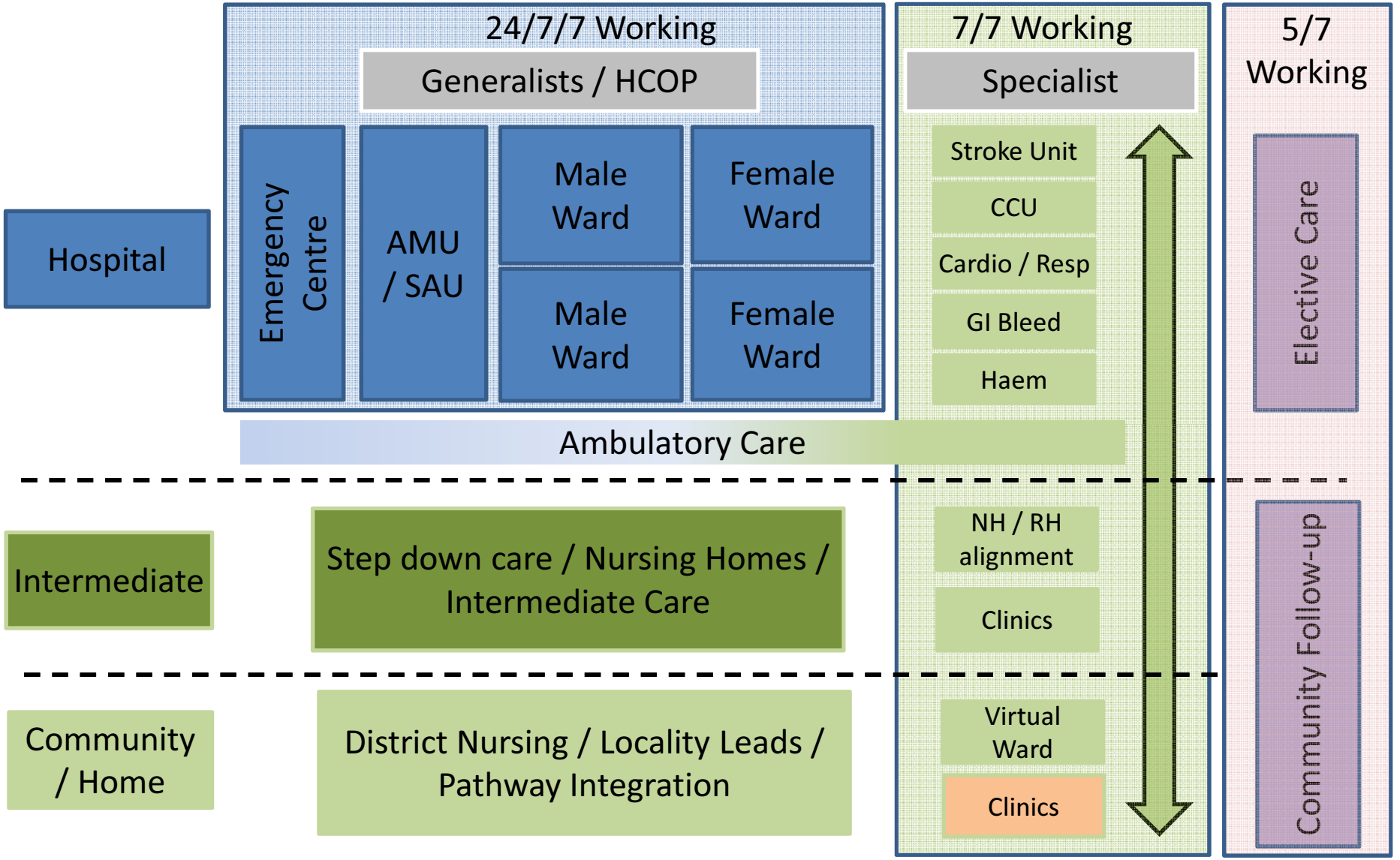

The ambition

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- Strengthened acute take and ambulatory care
- Ward reconfiguration and reduced bed base
- 7 day assessment of appropriate patients
- Community physician support for localities
- Reduction in acute length of stay
- LOS at home / UPOR to be main indicator
- Primary, secondary and community partnerships

5 key priorities

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1. Emergency access and admissions
2. Structured and systematic management of in-patient beds (acute and intermediate)
3. Embedding admission prevention and supported discharge pathways
4. Integration of Acute & Community Care Pathways
5. Partnerships with social care, mental health, voluntary sector partners

Year 1 Priorities

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NHS Foundation Trust

Priority	Focus	Outcomes
Emergency Access & Admissions	- Frail Elderly Assessment Unit - Alignment of A&E / GP services - Redesign of Acute Take (24/7/365) - Redesign of AMU	- No. of patients seen by GP - No. of admissions >65yrs - Increase in the number of ambulatory patients
Inpatient Bed Management	- Programme of 'Perfect Ward' - Management of Outliers - Ward re-configuration (Medicine, MAU, SAU, B3) - 7/7 services - Site coordination, site team & CCC	- No. of weekend discharges - No. of acute beds - Reduction in number of long stay patients
Admission & Discharge Pathways	- Implement IRR and Frail Elderly Unit - EMI Step down provision - Embed pathways 1, 2 and 3 with acute - Nursing home alignment by locality and formal alliance	- No. of GP admissions to MAU - Utilisation of ALOC beds - No. of attends from care homes

Year 1 Priorities

The Rotherham NHS
NHS Foundation Trust

Priority	Focus	Outcomes
Integration of Acute & Community Pathways	- Embed 7 locality physicians - Implement integrated pathways from Community Transformation (Neuro, Falls / Bones, Respiratory) - Priority and visibility of care plans	- Admits for respiratory patients - LOS for Neuro patients - No. of >55 years with fragility fracture
Partnership Working	- Develop protocols with Social Care for Community Beds - Develop arrangements for EMI patients with RDASH - Align community nursing teams with care homes - Integration of Voluntary Sector within acute	- No. of DTOC's - LOS for dementia patients - Hospital LOS for care home residents

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**9 July 2015**
3.	**Title:**	**Hospital Discharges**
4.	**Directorate:**	**The Rotherham Foundation Trust**

5. Summary

The report provides Members with the additional information requested following the update on the Hospital Discharges scrutiny review recommendations in October 2014.

6. Recommendation

That Members:

- **Note and discuss the contents of the report and the positive changes made to support patients with discharge from hospital.**

7. Proposals and Details

As part of its work programme in 2013-14 the Health Select Commission (HSC) carried out a spotlight review of Hospital Discharges. This review was undertaken due to a perception, based on anecdotal evidence, of a problem with out of hours discharges (late at night or weekends) and patients being discharged without adequate support arrangements in place. Factual evidence did not support the perceived problems about discharges but Members recognised the potential impact that an unsafe discharge could have for patients and their families.

The HSC received a monitoring report on the recommendations at its meeting on 23 October 2014 and Members noted the progress made through effective joint work between the hospital and the Council, with the majority of actions completed It was agreed to have a future agenda item on Community Transformation (separate powerpoint presentation) as this evolved from the business process review that had followed the scrutiny review. Members also requested additional information, which is included in the appendices as follows:

Appendix A - Figures for delayed discharges and complaints relating to discharges
Appendix B - Details about the work of the Care Co-ordination Centre
Appendix C - Information about the SAFER care bundle

8. Finance

There are no direct financial implications from this report, but there are financial and budgetary implications for the Council and health partners in working towards greater integration of health and social care.

9. Risks and Uncertainties

There are various reasons why patients may have a delayed transfer of care from hospital but closer integration of health and social care and between acute and community services will help to ensure people are in the most appropriate care environment.

10. Policy and Performance Agenda Implications

- RMBC Corporate Plan Priorities:
  - Helping to create safe and healthy communities
  - Ensuring care and protection are available for those people who need it most.
- Health and Wellbeing Strategy
- Better Care Fund Plan

11. Background Papers and Consultation

Scrutiny Review of Hospital Discharges Report (September 2013)
Scrutiny Review of Hospital Discharges Monitoring Report (October 2014)

Contact Names:
Maxine Dennis Director of Operations, The Rotherham Foundation Trust
Chris Holt Chief Operating Officer, The Rotherham Foundation Trust

The Rotherham Foundation Trust - Discharge Update
Reporting Period: May-2015 - Snapshot Position

Delayed Discharges

Year	Total
2013/14	416
2014/15	595

Complaints re Discharge

Year	Total
2013/14	44
2014/15	37

Delayed Transfers of Care

	w/e 03/05	w/e 10/05	w/e 17/05	w/e 24/05	w/e 31/05
Acute - DTOC	9	9	6	11	9
No. of Bed Days occupied by DTOC	57	56	31	64	58

Reasons for DTOC

Delay NHS assessments	26
Delay IMC bed availability	1
Delay patient choice.	4
Delay family choice	7
Delay joint SW and health assessments	2
Delay completion of DST	4

Medically Fit for Discharge	39
Within DST Process	6
Awaiting transfer to DTA beds	3
Ongoing SW Assessments	7
Awaiting SW Allocation	10
Ongoing therapy issues	3
Issues from Ward Staff	5
Discharge Planned	3
Other (Family Choice, CCG Funding)	2

The Rotherham NHS
NHS Foundation Trust

The way our wards work

S Senior Review, all patients will have a Consultant Review before 12 noon

A All patients will have a Planned Discharge Date (that patients are made aware of) based on the medically suitable for discharge status

F Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. All wards to pull one patient from assessment by 10am

E Early discharge, 35% of our patients will be discharged from base inpatient wards before midday. TTOs (medication to take home) for planned discharges should be prescribed and with pharmacy by 3pm the day prior to discharge

R Review, a weekly systematic review of patients with extended lengths of stay (14 days +) to identify issues and actions required for discharge.

SAFER enhances patient flow and ensures patients get the right care in a safe and timely way

SAFER Bundle

Embedding SAFER as part of TRFT's ongoing Perfect Week Programme

Your health, your life, your choice, our passion

The Rotherham NHS
NHS Foundation Trust

Care Co-ordination Centre

The Care Co-ordination Centre provides the following services:

- **GP Support Service** – Access point for GPs to gain advice and guidance in relation to the range of health care services available within TRFT. The service also provides a referral service, arranges placements and co-ordinates patient transport.
  Navigation service provided also to other health care professionals.
  A community pathway for suspected DVT is also provided.

- **Hospital Discharge** – A follow-up service for patients at risk of hospital re-admission. The service contacts all patients that have been discharged within a 3 day period to ascertain if their condition is stable and that they have integrated back into home life. Appropriate checks are made to ensure patients are receiving effective support packages.

  A community pathway for intravenous therapy at home provided by District Nursing and/or Fast Response Team aimed to reduce length of stay (LOS) and enhance patient experience.

- **Urgent Response Service** – Single point of access for NHS 111 and 999 ambulance service into alternative levels of care. CCC forms part of the YAS Pathfinder Project which supports ambulance crews when patients do not require Emergency Department (ED) services.

- **Acute Oncology Service** - Patients who are referred via the CCC for a healthcare need who are known to the Acute Oncology Service (AOS), have a notification of pathway management / new condition / ongoing healthcare need highlighted for appropriate follow up by the AOS.

- **Oakwood Community Unit** - All referrals for patients who require step up beds are currently taken by the CCC

Supported Discharge Care Pathway and Supporting Case Management

- The CCC hold a register of patients in acute beds, whose medical episode are complete and will proactively liaise with in-patient wards on a daily basis to facilitate discharge and update the register

- Supporting case management function is for patients who have been identified by their GP or by the CCC team (during a repeat admission to hospital), as people who require additional support to allow them to self-manage their long term condition and treatment(s)

- **Discharge to Assess** - The CCC liaise wards to identify patients who have a residual nursing need who are likely to require a decision support tool and facilitate discharge. This ensures that the patient is at their optimum prior to assessment in a more conducive environment.

24/7 & Single Point of Access

- **24/7 Service** – The service will receive out-of-hours calls from patients and health professionals who require access to community health services or have an urgent health need commencing the 31st July 2015.

- **Single Point of Access for Community Nursing Referrals** – The service receives all hospital based referrals for community nursing services

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ROTHERHAM BOROUGH COUNCIL – HEALTH SELECT COMMISSION

1.	**Meeting**	**Health Select Commission**
2.	**Date**	**09/07/2015**
3.	**Title**	**Urinary Incontinence Scrutiny Review Response**
4.	**Directorate**	**Public Health**

5. Summary

Rotherham's Health Select Commission completed a scrutiny review of urinary incontinence services in May – June 2014. This review identified a series of recommendations which cut across the Council's directorates. This report provides the Health Select Commission with a six month progress review of the report recommendations. This has been coordinated by Public Health.

6. Recommendations

The Health Select Committee are asked to consider;

- **The recommendations and responses to the urinary incontinence review**
- **The progress made over the past six months and review next steps.**

7. Proposals and details

Background to the review

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.

Summary of findings and recommendations in the report

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, including doing pelvic floor exercises as a preventive measure is essential. It is recognised that this 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 Streetpride and partner agencies such as SYPTE 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 RMBC Sport and Leisure team should establish greater links with the Community Continence Service in order to support people to participate in appropriate sport and physical activity.

3 RMBC Sport and Leisure team should liaise with other sport and leisure activity providers to consider building more pelvic floor exercises into the Active Always programme and wider leisure classes

4 There should be greater publicity by partner agencies, coordinated through the Health and Wellbeing Board, to reduce stigma associated with incontinence and 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

d) the need to include the impact of incontinence due to medication, such as diuretics, within a patient's care

5 RMBC Neighbourhoods and Adult Services should work with care homes to encourage more 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 from Rotherham Clinical Commissioning Group in 2015 on the outcomes of the project considering future service development of the Community Continence Service.

The lead officers were contacted in November 2014 and again in June 2015 to discuss progress against each recommendation. The progress is outlined in the response table in Appendix 1. Progress has been slower than anticipated and this may need to be considered by the Committee. It is recognised that developments including the additional funding in to physical activity should result in more opportunities in the future.

The challenges of addressing urinary incontinence in isolation from wider health and wellbeing issues may have resulted in it not receiving the profile it needs to fully implement the recommendations formulated by the Review. There may also be a need to identify at risk groups for the physical activity recommendations e.g. mothers, older people, as it is recognised that their needs may be different. It may be advisable to review the recommendations and to consider the similar conditions/issues to help to raise the profile of the issue further.

8. Finance

The responses which require additional resources are either low or no cost. The integration of the recommendations into ongoing activities will ensure that financial commitments are minimal and activities are joined up to maximise impact.

9. Risks and uncertainties

There is currently uncertainty regarding the need for incontinence training within care homes and other community settings. This will need to be further explored before training is offered to reduce risk of wasted resources. It is expected that any changes to services should consider the needs of people with urinary incontinence.

10. Policy and Performance Agenda Implications

Health and Wellbeing

11. Background Papers and Consultation

Scrutiny review: Urinary Incontinence**:** Review of the Health Select Commission *May – July 2014*

SLT paper – 9.12.14

Cabinet paper – 14.1.15

12. Keywords: Urinary incontinence, healthy lifestyles, care homes

Officer: Rebecca Atchinson, Public Health Principal

Cabinet's Response to Scrutiny Review Urinary Incontinence – update June 2015

Recommendation	**Cabinet Decision** *(Accepted/ Rejected/ Deferred)*	**Cabinet Response** *(detailing proposed action if accepted, rationale for rejection, and why and when issue will be reconsidered if deferred)* *Update June 2015*	**Officer Responsible**	**Action by** ***(Date)***
1. RMBC Streetpride and partner agencies such as SYPTE 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.		Response - SYPTE have confirmed that the toilet facilities provided by SYPTE at its Interchanges meet the requirements recommended in Urinary Incontinence Scrutiny review. All SYPTEs toilet facilities are appropriately maintained, regularly cleaned and re provisioned with consumable products throughout the day including weekends to ensure a pleasant customer experience. *No further information* Response - Streetpride have confirmed that toilet facilities in Rotherham have suitable waste disposal systems are cleaned regularly to meet the needs of people with urinary incontinence. *No further information*	Kim Phillips Kim Phillips	June 2015
2. RMBC Sport and Leisure team should establish greater links with the Community Continence Service in order to support people to participate in appropriate sport and physical activity.		Response – Active Rotherham agree to work more closely with the Community Continence Service and take further guidance on how to improve the pathways to physical activity from the service. Suggestions include literature for patients and information on suitable exercises for pelvic floor to be added the new Get Active Rotherham website which is currently under development. *Outstanding action – website is still under development.*	Steve Hallsworth	June 2015

3. RMBC Sport and Leisure team should liaise with other sport and leisure activity providers to consider building more pelvic floor exercises into the Active Always programme and wider leisure classes		Response – Active Rotherham will include pelvic floor exercises into their existing "active always" provision. Public Health will also raise the importance of pelvic floor exercises at the next Rotherham Active Partnership meeting and long term conditions subgroup which covers most activity providers across the Borough. If there are any training requirements identified, these will be considered and delivered to the Rotherham Active Partnership members to ensure the exercises are embedded in all services. *Recently Public Health has received £500K of funding from Sport England to develop a Long Term Condition physical activity programmes which will include pelvic floor exercises, where it is deemed appropriate.*	Steve Hallsworth	January 2015
4. There should be greater publicity by partner agencies, coordinated through the Health and Wellbeing Board, to reduce stigma associated with incontinence and 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)		Responses – SYPTE offered the opportunity to use Rotherham Interchange to promote health issues in either road show or poster display format. Public Health offer the opportunity for key messages to be included on our Public Health TV screens as well as encouraging Pharmacies to consider prioritising incontinence as one of their Public Health Campaigns for 2015. Information will also be included on the Get Active Rotherham website to raise awareness and confidence of patients with urinary incontinence. It is recognised that the wide distribution of this review should also result in an increase in awareness of the needs of those experiencing urinary incontinence. *Public health to contact incontinence service for a*		

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 d) the need to include the impact of incontinence due to medication, such as diuretics, within a patient's care		*short strapline for PHTV. Physical activity website still under development.*		
5. RMBC Neighbourhoods and Adult Services should work with care homes to encourage more 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		Response – NAS Neighbourhood and Adult services have previously offered incontinence training to care home staff but this was not taken up and as a consequence the training was cancelled. It is unclear if there was a need for training or if this is already being met by the Community Continence service support to Care Homes. Further information is being sought and NAS Learning and Development Team are happy to provide further training if necessary. *2 short training sessions were delivered in March 2015 at Queens Care Centre Maltby to promote continence products by a representative of the LA's*		

		current provider. This was widely advertised but only moderately attended. Care Homes however did request the need for repeated training but for this to be delivered on site with each provider. *All requests were forwarded directly on to Stephen Skelton in the Continence Service to determine if the Service has the capacity to deliver on site.*		
6. That the Health Select Commission receives a report from Rotherham Clinical Commissioning Group in 2015 on the outcomes of the project considering future service development of the Community Continence Service.		Response – The CCG have been forwarded the Health Select Commission report and will be invited directly to attend the Commission and report back their findings. *The CCG from money released from the continence contract has funded two nurses (not full time posts) to undertake audit/research in the following areas* *o Catheter related infections* *o Referral pathways for continence issues* *o A\E attendances for continence issues* *This work is now complete and will be presented to the CCG shortly, the CCG will consider the outcomes and recommendations that arise from this work stream and this will inform future commissioning decisions/intentions.*		

Rotherham Metropolitan Borough Council
Where Everyone Matters

Rotherham Health & Wellbeing Strategy

Health Select Commission – 9th July 2015

Health and Wellbeing Board

Rotherham Metropolitan Borough Council
Where Everyone Matters

- Established by Health and Social Care Act 2012
- Brings together council, CCG and other key partners, including Healthwatch and service providers
- Produce joint strategic needs assessment (JSNA) – evidence base for health needs
- Develop strategy to improve health and wellbeing
- Ensure partners' spending plans are geared towards achieving the strategy's aims and objectives

Health and social care integration

- Better Care Fund (BCF) – pooled funding to transform health and social care services
- Critically it is about person-centred care:

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

- Rotherham BCF plan approved Jan 2015; key target to reduce hospital admissions

What does the evidence tell us?

- Life expectancy below England average and significant gap between the borough's most and least deprived areas
- Population changes – ageing population and people living longer with poorer health
- 28.5% of adults are classified as obese, worse than the England average
- Relatively high rate of hospital stays for alcohol related harm
- Higher than average adult smoking levels and smoking related deaths
- Rate of sexually transmitted infections is worse than average
- Rates of death from cardiovascular disease and cancer are worse than the England average

Key health challenges: children and young people

- Child poverty is worse than the England average with 22.8% of under 16s living in (relative) poverty
- 9.8% of children aged 4-5 and 23.4% of children aged 10-11 are classified as obese
- The rate of diagnosis of sexually transmitted infections in young people aged 15-24 years is above the England average
- Relatively high rates of smoking in pregnancy, contributing to increased risk of stillbirth, low birth weight and neonatal deaths
- Rotherham's breastfeeding rate is amongst the lowest in the region – contributing to levels of childhood obesity

The strategy – current thinking

- Explicit focus on children and young people
- Increased emphasis on mental health
- Help people to take responsibility for their health
- Principles of prevention and early intervention
- Work with communities – asset-based approach
- Build on good practice in Rotherham and elsewhere
- Meaningful indicators to measure progress

Feedback from VCS

- Increase emphasis on and investment in prevention and early intervention
- Holistic approach to H&Wb, utilising expertise from a range of organisations
- Recognise key transition points rather than waiting for people to hit crisis
- Real commitment to “asset-based” approach - not just as a cover for cuts
- Make the H&Wb “system” easier for people to access, understand and navigate
- Target the most disadvantaged regardless of age, including a renewed focus on healthy ageing

For Sept 2015…

- Health and Wellbeing Board approve strategy, including long-term strategic outcomes
- Outcomes inform partners' emerging commissioning plans

After September…

- Annual delivery plan, informed by outcomes and indicators, with associated performance measures
- Detailed plans for specific themes/programmes, with linkages to wider partnership strategies and objectives
- Further consultation

Refresh of Health and Wellbeing Strategy

Introduction

This paper provides Members with the outcomes from a consultation session on 24 June 2015 with local voluntary and community sector (VCS) organisations that will inform the development of the refreshed strategy. Questions asked covered:

- What are your aspirations for health and wellbeing in Rotherham?
- What help do you/your service users need to be healthier?
- What can we do differently?
- For the strategy to have been successful, what will have changed in: 1 year; 3 years; 10 years?
- Is there any relevant data, research, consultation feedback that we should take into account?
- How can we best keep in touch with and involve you/your users on an ongoing basis?

Health and wellbeing strategy – VCS consultation session at Voluntary Action Rotherham (VAR)

<u>General</u>

- Need for improved local media coverage of issues
- Health profile stats don't necessarily reflect situation on the ground (e.g. on children's mental health, homelessness) so won't always be the most appropriate progress measure
- Where problems are hidden and not reflected in the stats, how do we ensure commissioners of services and HWbB are aware so that resources can be targeted appropriately?
- Noted that winter deaths improvement was largely achieved through external funding. Can it be sustained now funding has reduced?
- Don't tackle problems in isolation (e.g. physical/mental health inextricably linked, which should be explicit in the strategy)
- Some providers seen as "gatekeepers" preventing wider involvement from potential delivery bodies. Services also seen to concentrate on clinical solutions rather than holistic support. Need for a wider range of providers to be involved, including VCS/community-based organisations.
- Need to be able to take funding away when services are failing and/or ensure – through better commissioning/contracting – that services focus on prevention
- Difficulties in understanding and navigating the system. Some people only able to get effective support due to their personal contacts or professional knowledge.
- Higher support thresholds for adult social care increasingly leading to interventions occurring only when crisis is reached. Again, VCS can play a vital role in shifting focus to effective preventative support – "upstream" investment.
- Need to invest health money in tackling wider determinants – as per Marmot.
- The problems aren't new, but we don't seem to be making much headway – do we need to think more radically?
- Community assets based approach can't just be dumping problem on the VCS because of budget cuts. Need a constructive dialogue and appropriate

investment/incentives. Also address disproportionate scrutiny of non-mainstream spend.
- Pick people up when they "wobble" – invest in the right areas at the right time.
- Danger that health and wellbeing board is actually focused on existing ill health rather than prevention and wider wellbeing

Response to questions

- Ensure we focus on reducing inequality and helping those who are most disadvantaged or excluded
- More preventative and joined up approach
- Can't lose focus on older people 50+ and particularly look to intervene at transition points (e.g. losing a job or partner, onset of major health problem) to prevent isolation and deterioration of physical and mental health. Ageing well is part of current strategy, but hasn't delivered sufficiently. Needs renewed focus in new strategy.
- Specific focus on social isolation as this is major cause of physical and mental health problems
- Consultation like this raises expectations, but then often nothing seems to happen or change as a result. Need to feedback and for this to be an ongoing dialogue.
- Transparency of decision-making and ability to challenge.
- Understanding system and where to go for help. Digital/online services can be impersonal and not appropriate for everyone, particularly older people. Often a lack of empathy from service providers.
- Felt that some service problems were HR issues – i.e. high staff turnover so lack of continuity and understanding of issues/context.
- Transition from children to adult services is an issue, particularly for mental health services
- Provide support when and where people need it. Allow people to self-refer – increased choice. Invest in information, advice and advocacy. Right services, right place, right time.
- People can often ping-pong between services – referrals/connectivity within the system need to improve – help people to navigate their way through.
- Sharing info between agencies is vital. For example, SYF&R identify health risks / vulnerable people and signpost to other agencies. "First contact counts" approach.
- Refer people to more cost effective (VCS) services when appropriate – commissioning pathway that recognises varying support is needed from a range of organisations at different stages. Ultimately provide more holistic support that is more likely to prevent problems from recurring.
- May need a leap of faith, accepting that some organisations/sectors can do certain things better, so invest in them.
- To promote healthy behaviour and better understand how we can improve health and wellbeing, need to speak to people about their real life experiences and use this to inform the way services are designed and commissioned.
- Will personal health budgets, especially for people with learning difficulties or disabilities, be specifically addressed in the strategy?

Summary / key themes

- There should be increased emphasis on and – crucially – investment in prevention and early intervention
- The health and wellbeing strategy and board should promote a holistic approach rather than a narrow clinical focus, with clear support pathways that utilise expertise from a range of organisations at the appropriate stage.
- Decision making should be transparent and driven by the needs of service users rather than maintaining the status quo, with services clearly held to account for poor performance.
- Partners need to recognise key transition points for people, across all age groups, and address the consequent support needs as they arise rather than waiting for people to reach crisis point.
- Whilst recognising the importance of children's health and wellbeing, the strategy must focus on supporting the most disadvantaged and excluded people regardless of age, and should include a renewed focus on healthy ageing.
- For consultation to be meaningful, we should commit to an ongoing dialogue and be able to clearly demonstrate that feedback is used to inform the strategy and the wider work of the board and its partner organisations.

Next steps

- Attendees asked to send in case studies or further relevant information (via: michael.holmes@rotherham.gov.uk)
- More detailed discussions to be arranged around specific service areas / pathways as the strategy develops
- Arrange a similar session when there's a draft strategy to consider

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ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**9th July 2015**
3.	**Title:**	**Childhood Obesity Update Report**
4.	**Directorate:**	**Public Health**

5. Summary

5.1 A detailed report of the workshops held by a sub-group of the Health Select Commission was presented to Cabinet in October 2013. An update was received in November 2014, when Members requested a further update following the reprocurement of Rotherham's Healthy Weight Framework.

5.2 Services in Rotherham's Healthy Weight Framework (tiered weight management services) were recommissioned with new contracts effective from April 2015, following approval from Cabinet in March 2014. Contracts for three "lots" of child obesity services have been awarded to two providers. Places for People Leisure will deliver the tier two programme (MoreLife clubs) and MoreLife Ltd will be delivering tier three (MoreLife clubs with 1:1 support) and tier four (MoreLife residential camp).

5.3 The majority of the recommendations in this update report focus on the prevention of overweight and obesity within the community and the promotion of weight management programmes to support children locally.

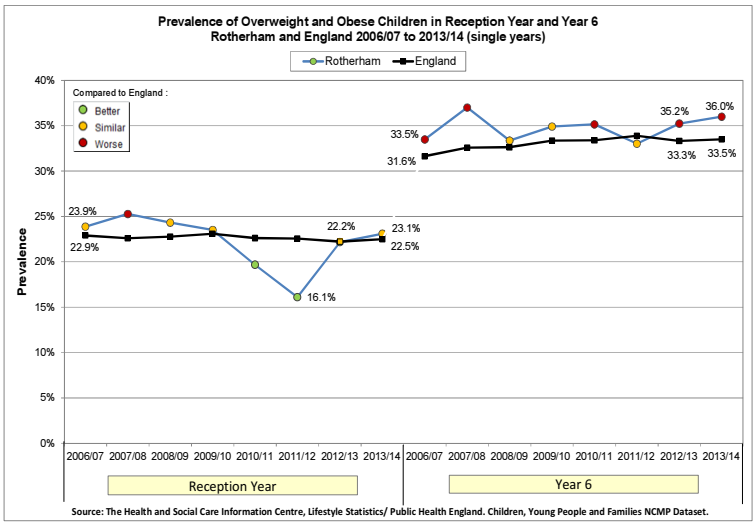
6. Recommendations

6.1 **That members of the HSC note the progress being made against the recommendations identified in the original review and the resources being deployed to reduce levels of childhood obesity.**

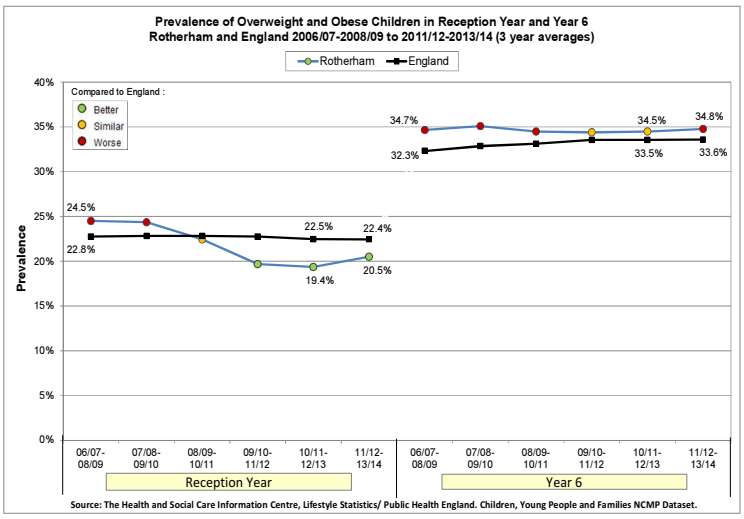
7. Proposals and Details

7.1 This paper summarises the current position with regard to the recommendations in the original report. A detailed update of activity contributing to reducing levels of excess weight in children across the borough can be found in Appendix A.

7.2 Progress has been made with work completed or underway on a number of the recommendations. Levels of childhood overweight and obesity continue to be of concern in Rotherham, with 2013/14 data from the National Child Measurement Programme (NCMP) showing that levels of overweight and obese are above the England average in both Reception (22.5% England, 23.1% Rotherham), and Year 6 (33.5% England, 36% Rotherham).



7.3 The trend of overweight and obesity using a 3 year average shows that Rotherham's level in Reception is below the England average. However the trend in Year 6 shows increasing levels of overweight and obesity and a widening of the gap between England and Rotherham.



7.4 The Healthy Weight Framework services have been recommissioned with updated specifications which are consistent with national guidance and evidenced best practice. Contracts were awarded with effect from April 2015 for

three years. A single point of access have also been established which help to ensure all children are assessed and referred into the correct service and monitored effectively. The DCRS data system allows commissioners access to live service data and enables improved targeting, contract monitoring and equity audit information.

7.5 The national policy introducing free school meals to reception and KS1 children has increased meals served per day.

7.6 Stakeholders continue to meet quarterly at the Obesity Strategy Group to drive obesity prevention and treatment work across the borough

7.7 Childhood obesity service performance April 2015 to date:

Service	Commenced in programme	Ready to commence programme	No. of completers achieving weight loss
Children Tier Two *Places for People / More Life*	57	36	No data available until end July 2015
Children Tier Three *MoreLife*	36	38	No data available until end July 2015
Children Tier Four *MoreLife Camps*	Recruitment underway 20 confirmed places July 2015		No data available until September 2015

8. Finance

8.1 The total cost of the Healthy Weight Framework totals £844k. Of which the children's services comprise: tier 2 - £170K, tier 3 - £128K and tier 4 - £76K.

8.2 Additional external funding relating to increasing levels of physical activity may have an impact on the prevention of overweight and obesity however there is no way of evidencing that this impact will be seen.

9 Risks and Uncertainties

9.1 Lack of referrals from health care professionals and front line practitioners could impact on target outcomes.

9.2 Weight reduction requires motivation and commitment from individuals and families. If motivation is not appropriately assessed there is a higher risk of attrition from the programme.

9.3 Whilst the Obesity Strategy Group provides the overarching framework for partnership work, the factors influencing childhood obesity are outside the control of the commissioned weight management services. Continued commitment from all partners is required to impact on the obesogenic environment e.g. address levels of and opportunities for physical activity, access

to healthy food, support from education and health partners, continued lobbying for legislative change on food and physical activity policy.

10. Policy and Performance Agenda Implication

10.1 The local weight management services are subject to compliance with national guidance and ongoing performance management.

Rotherham Child Health Profile 2015 (HSCIC)
Joint Strategic Needs Assessment for Rotherham
NICE Guidance (NG 7, CG43, PH6, PH25, PH27, PH35, PH38 PH42 and PH47)
Healthy Lives: Healthy People – a call to action on Obesity (2011, Department of Health)
Foresight Report (2007, Government Obesity Unit)
Public Health Outcomes Framework for England 2013-2016 (Department of Health)
Developing a specification for lifestyle weight management services (2013, Department of Health)
Clinical Commissioning Policy: Complex and Specialised Obesity Surgery (2013, NHS Commissioning Board)

11. Background Papers and Consultation

4th December 2014 Health Select Committee report on Childhood Obesity
12th September 2013 Health Select Committee report on Childhood Obesity

12. Contact

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13. Appendix A: Cabinet's Response to the Scrutiny Recommendations

Cabinet's Response to Scrutiny Review Childhood Obesity

Recommendation	**Cabinet Decision** *(Accepted/ Rejected/ Deferred)*	**Cabinet Response** *(detailing proposed action if accepted, rationale for rejection, and why and when issue will be reconsidered if deferred)*	**Officer Responsible**	**Action by** ***(Date)***	**Update July 2015**
Recommendation 1 The balance of activities commissioned for children between clubs and RIO should be reviewed as there appears to be an expressed preference for attendance at the clubs.	Accepted	The specifications for services are being reviewed and the referral pathways strengthened to ensure that children are triaged into the most appropriate service at their referral. The service pathway specifies the most appropriate service for each child's weight and height to maximise success in the services	Catherine Homer	End January 2014	The children's services now operate using a single evidence based pathway – delivered collaboratively by MoreLife Ltd and Places for People Leisure which offers a family friendly focus. The MoreLife programme is internationally recognised as best practice for the delivery of tier 2-4 interventions.
Recommendation 2 Establish interim contract monitoring and improved data management for obesity services once recommissioned.	Accepted	There is already ongoing performance management of all the services including performance and service quality. A single bespoke data management system will be commissioned as part of the service re-procurement for the range of obesity services to enable better quality performance monitoring.	Catherine Homer	End April 2014	The data is managing through the web based data management system (DCRS). DCRS is a Nationally developed tool with bespoke features tailored for the Rotherham service. Services provide updates on their contractual performance on a monthly basis using live data accessed through DCRS.
Recommendation 3 Promote more individual success stories of children and young people who have done well on the programmes to encourage others.	Accepted	Media releases and promotions are undertaken by individual services and collectively in response to specific opportunities such as National Obesity Week, Summer Camp etc. Programme currently being developed for National Obesity Week 2014 (13-19 January)	Catherine Homer plus service providers	Ongoing	Case studies and success stories are routinely collected by the service providers. These case studies are shared with performance and quality (P&Q) and communications colleagues for RMBC reports and media interest. Case studies are also showcased in

					conference presentations.
Recommendation 4 Consider including targets for referrals to weight management programmes as part of the new specification for school nurses.	Accepted	The specification had already included active referral and signposting to weight management programmes and is being updated to strengthen this process. The specification/contract will be monitored for referrals to services through the performance management process. Ongoing updates provided to a wide range of service providers through Healthy Schools Network and protected learning time for clinical staff.	Alison Iliff	Ongoing	Rotherham's school nursing specification has been reviewed and the DCRS system will allow monitoring of the numbers of referrals form the school nursing service.
Recommendation 5 Provide more information about services and encourage greater engagement with parents through schools, particularly in primaries, to reach children at a younger age.	Accepted	Information is already provided as part of the National Child Measurement Programme process. Healthy Schools Coordinator promoting services on an ongoing basis to schools. Information about services is available in children's centres, schools, libraries, leisure services, general practices and other public places.	Catherine Homer / Service providers	Ongoing	Information is provided as part of NCMP feedback to parents. Healthy Schools Coordinator and providers promoting services on an ongoing basis to schools. Information about weight management services is available in children's centres, youth work settings and public libraries.
Recommendation 6 Continue to promote whole family interventions and free activities such as walking initiatives and park runs.	Accepted	Promoted through Obesity Strategy Group, Rotherham Active Partnership (RAP), Heart Town initiative, social media. Local weight management services already promote such activities. Opportunity to enhance promotion through review of website.	Rebecca Atchinson/ Service providers	Ongoing	Promoted through Obesity Strategy Group, Rotherham Active Partnership (RAP), Heart Town initiative, social media. The weight management services already promote such activities.
Recommendation 7 Promote Rothercard more extensively to encourage increased participation in activities.	Deferred	Promoted at local venues but scheme requires review (the scheme was SY wide – there is no local performance data and the scheme is under review as part of local offer by RAP.	Chris Siddall/ Rebecca Atchinson	No timescale agreed	Promoted at local venues but scheme requires review (SY wide – no local performance data). For review as part of local offer by RAP.

Recommendation 8 Explore the feasibility of introducing a healthy vending policy in PfP leisure centres.	Accepted	The majority of the goods offered in vending and café facilities within Leisure Centres would be considered to be healthy in moderation.	Joanna Saunders/ Steve Hallsworth	To be negotiated	Discussed with provider. Current vending policy is company wide.
Recommendation 9 Introduce a 400m exclusion zone for new fast food takeaway businesses near schools in Rotherham.	Accepted	Under discussion with planning colleagues – part of consultation on Local Development Plan. Meetings with planning colleagues are scheduled in January 2014.	Joanna Saunders/Helen Sleigh	Ongoing	Included in Local Development Plan. Only relevant to new applications, not current businesses.
Recommendation 10 Strengthen the requirement for report authors to show awareness of the health implications of their proposals.	Deferred	For consideration by Admin and Legal – would require development of framework for assessment and potential training. Lead commissioner to discuss with Admin and Legal.	Joanna Saunders/Admin & Legal	To be negotiated	Continues to be under discussion.
Recommendation 11 That Cabinet be asked to support the regional and national lobby for legislation to support work on healthy weight and reductions in obese and overweight people.	Accepted	Contributing to NICE guidance consultation and attending the regional Obesity group which links directly to Public Health England.	Joanna Saunders	Ongoing	Public Health professional organisations including the Faculty of Public Health and the Royal Society for Public Health continue to lobby for legislative changes to reduce levels of sugar, salt and fat in food and drink products and for clear and consistent labelling to enable the public to make informed choices
Recommendation 12 Forward the points relating to schools to CYPS DLT for information and consideration.	Accepted	Already discussed at CYPS DLT – further discussion with Healthy Schools Lead ongoing.	Joanna Saunders/Kay Denton-Tarn	Ongoing	Discussions continue with CYPS DLT on a regular basis. DLT continue to monitor the take up of school meals which meet nutritional standards.