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

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| **Date:-** | **Thursday, 21st January 2016** | **Venue:-** | **Town Hall, Moorgate Street, Rotherham S60 2TH** |
| **Time:-** | **3.00 p.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 Meetings (Pages 1 - 24)
   Minutes of meetings held on 3rd and 17th December, 2015

## For Discussion

8. Overview of Public Health
   Presentation by Terri Roche, Director of Public Health

9. Spending the Public Health Grant in Rotherham (Pages 25 - 43)
   Terri Roche, Director of Public Health, and Alison Iliff, Public Health Specialist, to report

10. Detail of Public Health proposed Efficiency Savings to Public Health Service Providers (Pages 44 - 59)
    Terri Roche, Director of Public Health, and Anne Charlesworth, Commissioning and Quality Manager, to report

**For Information**

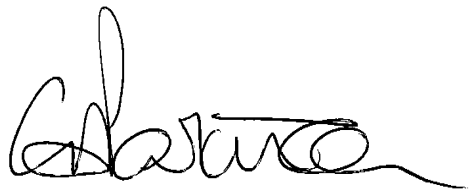
11. Health and Wellbeing Board (Pages 60 - 70)
Minutes of meeting held on 25th November, 2015

12. Updates from Improving Lives Select Commission

13. Healthwatch Rotherham - Issues

14. Date of Future Meetings

| | | |
|---|---|---|
| Thursday, | 17th March | 9.30 a.m. |
| | 14th April | 9.30 a.m. |



**CATHERINE A. PARKINSON,**
Interim Director of Legal and Democratic Services.

**Membership:**

Councillors Sansome (Chair), Mallinder (Vice-Chair), Ahmed, Burton, Elliot, Evans, Fleming, Godfrey, Hunter, Khan, Parker, Price, Rose, Rushforth, John Turner, Smith and M. Vines.
Co-opted Members:
Vicky Farnsworth and Robert Parkin (Rotherham Speak Up) and Peter Scholey.

# HEALTH SELECT COMMISSION
## 3rd December, 2015

Present:- Councillor Sansome (in the Chair); Councillors Ahmed, Alam, Burton, Elliot, Fleming, Khan, Mallinder, Parker, Rose, Smith, John Turner and M. Vines.

Apologies for absence were received from Councillors Godfrey, Hunter and Price.

**46. DECLARATIONS OF INTEREST**

Councillor Fleming declared a personal interest on the range of matters included on this meeting's agenda as he was an employee of the Sheffield Teaching Hospital Trust. He remained in the meeting and spoke and voted on the items.

Councillor Mallinder also declared a personal interest on the range of matters including on this meeting's agenda as she was the Carers Champion. She remained in the meeting and spoke and voted on the items.

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

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

**48. COMMUNICATIONS**

(1) GP Event
The Chairman and Councillor M. Vines had attended the recent GP event which had been based on Health, Care and the whole package around GPs in the Borough. It had been a very interesting event partly due to the individuals who had led on the event.

Councillor Vines had talked to six student doctors about their training and had found it very disappointing that only two wished to become a GP.
*Following the meeting it was established that to become a GP you needed to complete a five year degree course in medicine and a two year foundation programme of general training. You also needed specialist training in general practice which would take three years. Many foundation programmes included placements in general practice – over 40% of FY2 rotations in 2011. These provided useful and invaluable experience even for those who did not intend to train as a GP. Some but not all did* 1/3 of their F2 year in general practice.

(2) RCCG Communication and Consultation Sub-Committee meeting
Councillor Mallinder had attended the meeting as a substitute for the Chairman. Engagement was the priority and the CCG was very keen to know how they could engage and communicate with others. Other issues discussed included the use of bank staff and GP shortages.

Resolved:- That Councillor Mallinder prepare a report on the meeting and circulate to Select Commission Members.

(3) CAMHS

The Scrutiny Review response had been signed off by Commissioner Newsam and was to be discussed at the Overview and Scrutiny Management Board on 10th December. All of the twelve recommendations had been accepted and work was progressing on delivery. Some of the actions linked in with the new CAMHS Transformation Plan.

(4) Visits

Good practice visits had taken place to Wigan and North Lincolnshire with regard to Adult Social Care as part of the Adult Social Care Working Party.

(5) Health and Wellbeing Board

Councillor Roche, Advisory Cabinet Member for Adult Social Care and Health, reported that external funding had been secured from the LGA and Rotherham United for an event to share and showcase good practice that was happening in sports and health. It was to be a South Yorkshire Event held on 13th April, at the New York Stadium. There would be a key note speaker from Birmingham who had done a lot of work promoting physical activity and sport.

The Board was now moving on to developing and implementing its action plans for the Health and Wellbeing Strategy. There would be a sub-group (Engine Room) consisting of practitioners which would drive forward the key parts of the Health and Wellbeing Strategy.

There was to be a report to the February Board meeting from partners as to how they were progressing integration. The report would be submitted to the Health Select Commission.

## 49. MINUTES OF THE PREVIOUS MEETING

Resolved:- That the minutes of the previous meeting of the Health Select Commission held on 3rd December, 2015, be agreed as a correct record.

Further to Minute No. 39 (Health and Wellbeing Board), Councillor Roche, Advisory Cabinet Member for Adult Social Care and Health, reported that the Board's website was being refreshed and had its own Twitter account.

Further to Minute No. 40 (Annual Review of NHS Rotherham Clinical Commissioning Group's Commissioning Plan), it was noted that a letter had been sent to the Yorkshire Ambulance Service and the Commissioning Group highlighting Councillor Parker's concerns with regard to an incident.

## 50. DEVELOPING THE ROTHERHAM CARERS STRATEGY

Sarah Farragher, Change Leader, Adult Social Care, gave the following powerpoint presentation:-

What do we need to do

- The Care Act has a strong focus on carers, recognising the caring role as fundamental to the whole adult social care system. Carers have increased rights and status within the Act with enhanced rights to promotion of wellbeing, earlier support and personalised support

In Rotherham

- We have a mixed picture of carer involvement and support. We need to build stronger collaboration between carers, the Council and other partners
- We want to lay the foundations for achieving these partnerships and set the intention for future working arrangements
- We want to do something that makes a difference now whilst setting up the right co-produced options for the future

Progress to date and timescales

- This is a Rotherham Carers Strategy not a Rotherham Council Carers Strategy. It is a partnership plan
- Hopefully will be taken through the Health and Wellbeing Board

Progress to date and timescales

- The Group has met three times and the first draft of the Strategy has been circulated and comments made. Second draft to be worked up following Carers Rights Day
  Further work being undertaken to strengthen the voice of young carers
  Asking carers "what three things would make a positive difference?" through Crossroads AGM, at Carers Rights Day and through volunteer sector forums

Strategy based around three outcomes

- Outcome One – Carers in Rotherham are resilient
- Outcome Two – The caring role is manageable and sustainable
- Outcome Three – Carers in Rotherham should have their needs understood and their wellbeing promoted

What do we need to do to achieve these outcomes?

- We need to strengthen some things that are already in place to increase the reach and get parts of the system working together better
- We need to view carers as partners when making decisions about care (without losing the voice of the cared for person)
- We need more people doing Carers Assessments including partners in the independent and voluntary sector

- Need to develop a Carers Wellbeing budget and Allocation System (RAS)
- We need whole family assessments to stop duplication of assessments
- We need to target services better and understand who our carers are and what they need
- We need to provide reassurance for carers that a back up is there when they cannot provide the usual care

What three things?
- Information and advice
- A voice
- Consistent support
- Valued
- Time for me
- Involved
- Quality care
- A break
- Financial help
- Understanding

Strategy – who is involved
- Currently being developed through a working group of partner agencies – outcomes came from group and were part of consultation
- Hope was to get some carers onto the group (thirty people expressed an interest at Carers Rights Day event)

Consultation and Engagement
- Carers Forum – event end January/beginning of February organised by Councillor Mallinder
- Plan to do something every four-six months – format to be agreed

Measures and Accountability
- Strategy group will have responsibility for delivery
- There will also be a commissioning plan with specific actions, timescales following on from Strategy

More information about what is going on in Rotherham
- Carers Forum – currently being redeveloped
- Care4Carers – very strong and active as a group
- Alzheimers Café – demand outstripping supply over 200 carers attend four cafes
- Carers Resilience Service – pilot project based in GP surgeries
- Social Prescribing – identifies carers and refers through for support as well as “patient”
- Carers Emergency Scheme – over 1,000 carers registered

What is happening in Rotherham

- Approximately 2,000 hours a month of homecare were provided through the carer specific schemes
- So far thirteen carers have received Care Act assess support as a carer … more to be done

What is going well?
- Good partnership commitment
- Social Workers and Carers Support Officers were meeting carers at the Carers Corner to complete the assessments
- Mental Health Carers Services very strong – craft groups, resilience training etc.
- Increase in referrals to Carers Corner following pro active work with GPs

What is not working well
- Carers Corner out of the way – difficult to find. Footfall at the Centre is low (even after the work)
- Plan to change building name meant difficult to advertise as the information would go out-of-date
- Carers Emergency Scheme was not working for carers of people with mental health difficulties – IT issues
- Generally, services were fragmented based on client groups rather than based on carers – not making the best use of our resources

Information and Advice
- Training for Carers – new training booklet was re-printed by Direction Team and was on display at Carers Corner
- Carers directory was being printed in the New Year (free and would be updated regularly) and also available on Connect to Support
- Voluntary and Community Services directory almost complete – would be put on Connect to Support and printed on request

Other Information
- So far not seen an increase in assessments (was predicted up to 5,357 carers)
- Assessment/recording tracking of carers would be through Liquid Logic (from mid next year) – still to be worked through
- Delegated Carers budget based on RAS (this was a budget pressure) – work to be undertaken on this
- 5,627 clients on Service and 3,192 had an NHS number recorded

Discussion ensued with the following issues raised/clarified:-

- That the recommendations from the Scrutiny Review of Support for Carers will feed in to the development of the Carers Strategy

- Consultation and engagement would take place every 4-6 months to track progress of the Strategy. Once embedded the feedback would be used to ascertain if it was making a difference

- More work was required on the Carers Emergency Scheme as to how carers who had used it were finding the Scheme. It was suggested that a covering letter could be included from RDaSH asking if a carer wanted to join the Council's Scheme

- In terms of how the agencies were joined up, a meeting had taken place recently with the Carers Worker for Mental Health. More work was required to understand what the problem was

- There was a lot of mistrust of the Council and statutory bodies generally by carers especially by those that had fought the system all their lives. However, if a carer trusted a particular organisation and they were able to carry out the assessment and draw down the resources on the back of it, that would increase the numbers. Where there were carers who did not want an assessment, a whole family assessment would pick up on the needs/requirements of the carer

- Work was ongoing to develop a Health and Social Care Portal for Rotherham in terms of getting the different areas and systems working together. At the moment it very much concentrated upon the Foundation Trust systems so the question had been asked about integrating it with the Social Care and RDaSH systems. The plan was to look at it but as there was to be a move to the new Social Care system it was not appropriate to do so at the current time. There had been a discussion regarding the recording of Mental Health data more generally onto Social Care systems; Liquid Logic had been requested to ascertain how other authorities record such information

- There was a section within the Strategy on young carers. The Strategy would focus on people who were caring for an adult regardless of the age of that person doing the caring. It was not looking at parent/carers at the moment to keep it reasonably defined

- The long term view would be holistic family assessment but would start with family assessments for adults and would include young carers

- There would be a separate consultation with young carers as much of the support networks were around adult carers and older persons carers

- The Mental Health Carers Worker had carried out a lot of work going around the Teams and Hospital Wards promoting the work of carers. The idea of Carers Corner had always been to be the central point for all carers in Rotherham and, if that was right, everybody would know about it and have access to the information for all groups

- The Carers Resilience Service, a pilot service, had just started to work in GP practices to provide information from the practice. It was part of the Strategy to get to as many places as possible where people might access the Service

- Liquid Logic would enable members of the public to self-assess and self-provide the information. It was felt that the Liquid Logic portal was the appropriate place as it was a public portal and the information could be fed through to the statistical returns

- Other areas of the country had set up Service Level Agreements to pay other organisations to carry out carers assessments.

- Outreach work would be part of the ongoing work. All the issues with regard to accessing hard to reach groups, engagement, promotion would form part of the regular engagement sessions within the implementation part of the Strategy.

- The Council was now committed to working with carers

- Adult Social Care in Rotherham was not where it should be generally. In terms of implementation of the Care Act, there was a development programme around the need to change Adult Social Care which carers were part of. The Liquid Logic changes were something that had come off the back of the review of Children's Services, which Adult Services had then come on board, and having the one system for the whole Council. The implementation date was July; the existing system was not sufficiently flexible. Carers had been flagged in terms of the Resource Allocation System but care packages would be looked at first and then carers

- Work was also taking place on how the customer journey could be improved with the development of a single point of access for Rotherham – not just for carers but a single number for all Social Care in Rotherham. An initial meeting had taken place with officers from the Council, Foundation Trust, CCG and RDaSH (both Learning Disability and Mental Health) to discuss, in principle, a single point of access for Rotherham. There were different interpretations of a "single point of access" and the meeting had discussed a shared understanding of what it was. The development group would meet again in January, 2016, to work up, ascertain the appetite for and how it might work for a single access point. It would have a positive impact on carers

- The current carers' budget covered Carers Officers who were in Mental Health, the Team at Carers Corner, the building costs of Carers Corner as well as carers' monies that came out of the General Purchasing budget which included items such as home care for carers, Carers Emergency Scheme etc. There was no specific carers' budget. When developing the Resource Allocation System it was one

of the things required but not simple to do. Carers would still potentially need support and breaks for the person they cared for and it was hoped to have a separate Wellbeing budget. It had been flagged in the Adult Social Care internal budget strategy group that it needed to be included as a pressure. It was an invest to save because if a carer was supported to care for longer than would have then it would have a knock on effect on other budgets

- It would be a decision for the Council as to whether to apply the 2% precept increase to support Adult Social Care. The final details were still awaited for analysis

Sarah was thanked for her presentation.

Resolved:- (1) That the information provided about the development of a new Carers Strategy be noted.

(2) That the draft Strategy be submitted to a future meeting of the Health Select Commission.

(3) That further information be submitted before the 17th December, 2015, Select Commission meeting.

## 51. BETTER CARE FUND UPDATE/IMPLICATIONS OF THE AUTUMN STATEMENT FOR SOCIAL CARE AND THE BETTER CARE FUND

Jon Tomlinson, Interim Assistant Director of Adult Commissioning, gave the following powerpoint presentation:-

Better Care Fund Update

- Building on previous presentations – good progress around integration continues to be made
- Robust governance and reporting has enabled Rotherham to comply with national requirement to submit information about progress
- Latest quarterly return (27th November, 2015) approved by Health and Wellbeing Board and submitted
- Regional feedback has been received on the Quarter One Return

Main points from Feedback

- Rotherham is not an outlier in any areas of the BCF
- We are still working towards meeting two of the national conditions:-
  Implementing 7 day working
  - Pilot commenced 1st December
  - Hospital Discharge Team

  NHS Identifier
  - In scope cohort of adults records should be matched by the end of 2015

Moving Forward

- Key lines of enquiry for NHS England for future BCF Integration
- Changing format shifting focus from compliance with national conditions to strategy, pace and development of integration
- Personal health budgets, preventative care and use of integrated records across Health and Social Care are now integration metrics
- Work to rigorously review current projects has been completed
- Clearly the BCF remains a key driver for integration of Health and Social Care
- Target dates and resources have been included within the spending review
- Senior officers will be meeting on 7th December to review the strategic vision and priorities
- A new proposed model at an individual, family and community level will be considered
- This will feed into and inform the review that has been undertaken

Discussion ensued with the followings issues raised/clarified:-

- There was massive pressure on the Council to provide services to help the vision become reality. The Authority needed to ensure that the money was in the right place which was where commissioning and joint commissioning came into its own. There were probably areas that needed careful consideration and redistribution of the resources into the correct places which would then feed into the agenda of prevention and supporting people into not coming into Social Care as a statutory service. The challenge was huge but no different to anywhere else in the country.

- Integration was the first step and critical. Agencies in Rotherham were very close to being on the same page with regard to integration and looking to do the same things i.e. provide the best possible care and outcomes for the citizens of Rotherham

- Joint commissioning was the way forward for Social Care as it reduced duplication and the opportunity for varying rates. Value for money was vital. The citizens would be best placed to determine value for money with the drive to personalisation, personal budgets and individuals buying their own services.

- In terms of commissioning, the Authority had the responsibility for the overall contracting and management of the market and benchmarking would give an indication of whether it was a reasonable rate being charged. The contracting arrangements, reviewing and monitoring what the Authority received for its money ensured it got best value

- Benchmarking was just one discipline that could be used to get a sense of whether the charge was consistent or not. An exercise was currently being undertaken to get an absolute position on what the

cost of care in Rotherham was. That required a proper relationship with the market providers to look at those costs together. That work was in its infancy and was hoped to bring to a conclusion over the next six months

- The Trust was absolutely in tune with the Authority in terms of facing the financial challenges but also in providing first class patient care. The Trust realised that to deliver what it needed to do it had to do something differently and supported what BCF was trying to do

- There were ongoing discussions with NHS England in trying to reduce the tick box matrix that had to be completed. Reports were to be submitted to the Health and Wellbeing Board explaining what was behind the numbers in real terms

- Work was taking place on a proposal to purchase properties into which patients, who no longer required to be in hospital but could not return to their own home, would move into temporarily. A meeting was to take place with the Foundation Trust Chief Executive to further explore the option

- Work and a development programme were underway on how to get Social Workers to think differently and changing the message so that every review should make a difference to someone's life. The professional standards lead was working with the region and the universities about producing academically qualified Social Workers that were fit to practice, as it had been found over the years, and not just in Rotherham, that students coming out of university had the theory but were less well equipped to work with people in reality. The Authority was working with universities to ensure the Social Worker training course was fit for purpose

- The Social Worker training was now generic for both Adults and Children

- The vision would make it clear that absolute integration was the aim but would at least be meeting what was expected nationally

Jon was thanked for his presentation.

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

(2) That the BCF return report be submitted to the Health Select Commission once it had been considered by the Health and Wellbeing Board.

(3) That a report be submitted to the January meeting of the Commission.

## 52. IMPLICATIONS OF THE AUTUMN STATEMENT FOR SOCIAL CARE AND THE BETTER CARE FUND

This was combined with Minute No. 51 above.

## 53. UPDATES FROM IMPROVING LIVES SELECT COMMISSION

Councillor Ahmed gave the following verbal report on the work of the Improving Lives Select Commission:-

- In terms of work with CSE, we were looking at meeting some CSE survivors in December. However, that was to be arranged to ensure that there was a clear process of conducting ourselves and not overloading/overburdening survivors with questions. Hopefully, a further update would be given to the next meeting.

- The Select Commission had had CSE updates from the Police and different partners. There appeared to be a robust system in place within the MASH hub and progress was being made. In a couple of years Rotherham would hope to be seen as one of the best local authorities in providing the most appropriate support for CSE survivors

- A lot of work been done by the newly established Early Help Group which had met in November and was to meet again on 8th December where the Assistant Director was the lead. The Group was considering how the Authority could look at early help and intervention, to intervene at an early stage and prevent any young person becoming a victim of CSE. This included looking at localities, how they were based in schools, how Universal Services would play a far more proactive role in completing FCAFs to provide the assessment opportunity and asking Universal Services to take some responsibility. There would be a lot of emphasis on looked after children which was a key priority in Jay report

- Other potential work could include further audit work to identify specific themes and ensure ongoing good social work practice. Also missing young people, including those missing from the school roll

- It was important to be mindful of looking at things from the whole family perspective and what therapeutic services were in place, from the Health Select Commission point of view - looking at what gaps there were still in terms of support that the whole family can receive and the CAHMS element of it

Councillor Ahmed informed the Commission that the Corporate Parenting Panel had also discussed work that was going on in terms of CSE and a lot of excellent work that was taking place at the moment with the CSE teams and the survivors to look at preventing any young person becoming a victim.

Councillor Rose reported that she had attended a RDaSH meeting as a Governor. They were appointing a full-time CSE Worker and taking every item of any concern very seriously. She had felt very reassured that RDaSH were moving with the Authority on this issue.

## 54. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

## 55. DATES OF FUTURE MEETINGS

Resolved:- That meetings be held as follows:-

Thursday, 17th December, 2015 at 9.30 a.m.
21st January, 2016 at 3.00 p.m.
17th March at 9.30 a.m.
14th April at 9.30 a.m.

# HEALTH SELECT COMMISSION
## 17th December, 2015

Present:- Councillor Sansome (in the Chair); Councillors Ahmed, Khan, Mallinder, Parker and M. Vines and Vicky Farnsworth (Speakup)

Councillor Roche, Advisory Cabinet Member, Adult Social Care and Health, was in attendance at the invitation of the Chairman.

Apologies for absence were received from Councillors Elliot, Godfrey, Hunter, Price, Rose, Rushforth, John Turner and Robert Parkin (Speakup).

**56. DECLARATIONS OF INTEREST**

Vicky Farnsworth declared a personal interest in Minute No. 64 (Developing a Model for the Enabling Service for Older People and Adults with Disabilities in Rotherham) as a user of the Service.

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

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

**58. PROPOSED JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR SOUTH AND MID-YORKSHIRE, NOTTINGHAMSHIRE AND DERBYSHIRE**

The Chair reported that the next phase of the Commissioners Working Together Programme for Health Services across South and Mid-Yorkshire, Nottinghamshire and Derbyshire would include public consultation. As part of informing the work, NHS England were proposing to set up a JHOSC. Members' opinion was sought as to whether the Council should be represented on the Committee.

Resolved:- That Commissioner Manzie be informed that the Health Select Commission felt that Rotherham should be represented on the proposed Joint Health Overview and Scrutiny Committee by the Chair and Vice-Chair as substitute as and when required.

(The Chair authorised consideration of the above item to enable the necessary arrangements to be made.)

**59. COMMUNICATIONS**

**(1) Councillor Alam**

The Chairman thanked Councillor Alam for his work during his membership of the Select Commission and wished him well in his new role as Advisory Cabinet Member.

**(2) Rotherham Foundation Trust Quality Account**

Councillor Mallinder gave a brief verbal report on the meeting held on 3rd December, 2015, to discuss the above which included:-

Quality Ambitions

- Harm Free "Stop Pressure" initiative to reduce pressure sores and ulcers
- Using Dr. Foster to compare performance with other Trusts on mortality indicators
- Clinically led task group looking at missed and delayed diagnosis
- Friends and Family response gathered on line on the Ward and A&E
- "Must Nutrition Score" Food Hostess to monitor food and beakers in a different colour to identify at risk patients

Quality Improvements

- Dementia Care Training is done in-house
- Stroke patients should be at 50% for a scan within 1 hour
- Appropriate training to be delivered on all Wards as identified
- There had been an increase in complaints against Doctors
- Nursing nationally is 1 nurse to 8 patients - in Rotherham it is approximately 1 nurse to 6-7 patients. There are 50,000 nursing vacancies nationally

How are we doing?

- There has been a spike in death rates nationally which is being looked at further
- Discharges are being analysed to see how it is working in Health and Social Care
- MRSA – 0
- CDIF- nationally 24 – Rotherham 14 to date

Discussion ensued on the nursing situation nationally. There were a high number of applications but not enough training places were commissioned by NHS England. Universities were given funding for the number of nursing students they could enrol but the funding was cut which impacted upon the number of places that could be offered.

Resolved:- That the issue of nurses and vacancies be raised with the Foundation Trust with regard to the number of applications for nursing posts in Rotherham to gain an understanding of the number of positions available compared to the number of vacancies.

**(4) CAMHS Scrutiny Review**

The Overview and Scrutiny Management Board had accepted all of the Scrutiny Review recommendations at its meeting on 11th December, 2015. The Board would be working with the Rotherham Youth Cabinet on the Children's Commissioner Take Over Challenge.

Janet Spurling, Scrutiny Officer, would be speaking with RDaSH colleagues in the CAMHS Service with regard to their involvement in the event.

The CQC Quality Summit would take place on 3rd February, 2016.

**(5) Improving Lives Select Commission**

Councillor Ahmed gave the following verbal update from the meeting held on 16th December, 2015:-

- Information regarding CSE and where the Authority was in terms of Service provision together with the analysis and evaluation provided by Salford University
- The low number of referrals made by health partners was highlighted – approximately only 7% of CSE referrals came in via Health. Reassurance had been given that there would be further work with GPs and health professionals in terms of raising awareness and improving referrals
- There would be a further update provided to show how the additional work had impacted on the number of referrals coming through
- From a sample of young people participating in questionnaires it had been evident that there was a very low percentage from vulnerable groups e.g. Roma families, BME communities and LGBT. Reassurance had been given that a lot of work was being carried out engaging with the voluntary sector and BME communities on how engagement could be improved/enhanced

**60. ADULT AND OLDER PEOPLE'S MENTAL HEALTH TRANSFORMATION**

Steph Watt (Programme Lead) and Kerry Booker, RDaSH, gave the following powerpoint presentation:-

Engagement activity

- Six whole system stakeholder events during the Summer
- Multi-agency steering group
- Online and survey questionnaires
- Options paper to Commissioners October, 2015
- Eight engagement events November, 2015-January, 2016
- Formal consultation February-March, 2016
- Implementation from April, 2016

What stakeholders said

- Waiting times are too long for some Services
- Access routes are confusing
- Organising Services around age creates an artificial barrier
- Too many hand offs (Adult Services)
- Improve communication
- Once in Service the Service is good

Financial Constraints
- Year on year 3-4% efficiency savings
- £1.2M in Rotherham for 2016/17
- Change the model to limit cuts in clinical services

Principles
- Integrated partnership working
- Patient focussed/needs driven
- Focus on quality of life (recovery/wellbeing)
- Maintain/improve quality
- Release savings

Proposals
- Cultural change – partnership working, recovery/wellbeing focus, integrated needs driven working and agile working
- A Trust-wide move from cross-Borough business divisions to a place-based Rotherham model
- A new gateway to Services
- Service re-design

Recovery and Wellbeing Focus
Traditional Approach
- Description
- Focus on the disorder
- Illness/deficits-based
- Based on reducing adverse events
- Individual adaptations to the programme
- Rewards passivity and compliance
- Expert Care Co-ordinators
- Service-led goals
- Service-led evaluation
- Fosters dependency
- Pessimism about outcomes

Recovery Approach
- Understanding
- Focus on the person
- Strengths based
- Based on hopes and aspirations
- Provider adaptations to the individual
- Fosters empowerment
- Individual is the expert
- Individual-led goals
- User-led evaluation
- Fosters independent
- Creates hope

Gateway to Services
Taking a phased approach to:-

- A 24/7, all age, single contact number
- Mental Health Gateway
- Rotherham Hub – Health and Social Care, Mental Health and Social Care, Health
- Electronic directory

Adult (18+) Service Options

- Do nothing: not an option
- Community-based ageless service
- All-age service based in 2 localities – Older Peoples Team centrally located or embedded in localities
- Opportunities to co-locate?
- Review and embed Social Care roles

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

- The proposal to release a couple of old Council stock properties for the development into a facility for those released from hospital but did not require care/intermediate care, would be in relation to the Older People agenda and not Mental Health

- RDaSH was presently looking at getting a single system and a different electronic record that should be able to "talk" to other systems. A single systems paper was being developed to take to various companies that, hopefully, would be rolled out in 2017 within the Trust

- RDaSH was developing physical health screening so rather than having to make an appointment for a client for an ECG etc. they had nurses who were trained. This was being rolled out gradually. The physical health screening clinics were initially for high dose prescribing but were then to be rolled out to patients with psychosis. The Early Intervention Services were the first point of contact for somebody with psychosis as a young person who was treatment naïve; they would have all the screening there before being prescribed anything. There were Key Performance Indicators against that to achieve for those patients

- There had been broad support for a Rotherham-wide approach to Access to Support. RDaSH recognised that it was complex and took time; the focus would be on the Mental Health gateway but the relationship between Mental Health and Social Care had come out really loud and clear in the consultation engagement work. RDaSH was also mindful that the Council was changing how it worked and the need to work closely together to avoid patients/service users being

passed from one to the other. The more RDaSH could understand about the bigger picture the more they could help patients and carers

- Currently in Adult Mental Health Services all referrals came through to a reception member of staff who would answer basic questions. From there if it was someone who needed clinical advice or the admin worker felt it was well beyond the basics of what they could answer, it was currently passed to a trained Social Worker who triaged all referrals, including Safeguarding, and linked in with Assessment Direct when required or with the Access Team. RDaSH wanted to maintain and grow that function because they knew from clinicians, patients and the feedback from GPs, that they wanted to speak to someone who knew what they were talking about. That did not mean that the admin staff did not know but in terms of the clinical expertise the triage would have clinically trained staff, nurses and Social Workers. It was hoped to expand it across the board for all ages/services but would not be a call centre type service. Older people's referrals went straight to treatment teams as in CAMHS

- There were a number of initiatives concerning engagement with patients on waiting lists. In those cases where a patient had been waiting longer than one would expect, Team Managers had them on their caseloads and would actively contact them, either by telephone or in writing. A number of RDaSH services now ensured that repeat letters were sent followed up by telephone calls particularly in Primary Mental Health Care and within the Access Teams. An Engagement Policy had been introduced over the last 2 years for those people who were not really engaging with the service or the service was finding it difficult in engaging with them particularly in terms of the Crisis and Access Teams. There was an expectation that those Teams would actively follow clients up rather than just writing to them and discharging them from services if they did not engage. There was a recognition that people who were mentally quite unwell or very vulnerable did not engage for those reasons. In terms of those people with personality disorder and suicide, RDaSH always reviewed suicides within their Service very robustly and action plans developed with the families

- RDaSH currently had an Access Team that conducted the first assessment and then made a decision as to whether to pass them through to a Treatment Team. As part of the transformation, the Access Assessors would be embedded in the Treatment Teams thereby facilitating a closer relationship, easier communication and hopefully address the need for someone not having to repeatedly tell their story

- With regard to the All Age Services based in two localities a piece of work was being conducted across the Trust looking at the demographic of Rotherham, buildings and the volume of referrals. The terms North, South, East and West were being used but the

localities would be divided to enable balanced teams. Consultation would take place with the Council, CAMHS and Primary Care as to how they divided up Rotherham and mirror those as far as possible

- RDaSH Services linked into the multi-agency meetings and arenas as well as the MARAC and MAPPA, particularly for those who were very vulnerable within Rotherham's communities. There would be a lot of work within the transformation to ensure that none of the existing work was disrupted. Development of some new services was taking place within the Criminal Justice arena, working with Early Help, for those young people that were picked up by the Police and were in the Police Custody Suites as well as those young people that were not taken into custody but were arrested

- Work had taken place with the Rotherham CCG and the voluntary and community sector to identify representative groups with regard to consultation. An event had been arranged for January, 2016, which would be publicised through the Trust in an endeavour to get as wide engagement as possible

- RDaSH were interested in a shared directory with the Council and a meeting would be held in the New Year to discuss further

- An electronic directory would be one tool in a range that would be used. There were accessible information standards and guidance so work was taking place with all the different contracts around looking at how information was provided

Steph and Kerry were thanked for their presentation.

Resolved:- (1) That the information provided about Mental Health Transformation be noted.

(2) That Option 3 would be the Health Select Commission's preferred option.

(3) That the Select Commission receive an update on the final approved option.

## 61. DEVELOPING A SINGLE POINT OF ACCESS TO SOCIAL CARE

Sarah Farragher, Interim Change Leader, gave the following powerpoint presentation:-

What are the access points for adults?
- Assessment Direct – Adult Social Care
- Badsley Moor Lane – Learning Disability
- Crisis Team – Mental Health
- Out of Hours Services – RDaSH and RMBC

- Care Co-ordination Centre
- Others?

What should we aspire to?

- Single point of access for health and social care for Rotherham (customer or patient tells us once)
- Covers RMBC, TRFT, RDaSH
- Triage/assessed based on customer outcome not Service provision
- Operates on a 24 hour a day 7 days a week basis
- Does not replace professional to professional contacts

What we need to consider

- Shared vision for what the Service looks like
- Pooled resources
- Integrated/co-located services
- Utilising shared technology
- Provides information, advice and guidance to enable self-management for customer/patient

How we are going to get there

- Initial scoping workshop took place end of October – well attended by partners
- Positive shared desire to achieve this but more work to understand the scope and priorities
- Further working parties were being organised from January to progress the agenda

In advance of this partners have been asked to consider

- What are the must haves?
- What is the financial envelope/constraints for this?
- What are the timescales?
- What are the things we would like to do (in addition to the musts)

Information and Advice Gateway

- Currently use Connect to Support but needs work
- Need to decide whether we develop this system or use Liquid Logic (Social Care system)
- Event planned for early February to talk to both providers to inform decision making

Issues

- Both systems would need investment both in terms of the resources to implement and the ongoing maintenance
- Need to think about impact and interface with Council website
- Connect to Support does not work well locally because we have not invested in this

But

- Some Council were seeing over 90% diversion rate
- Connect to Support was a regional resource and keen to work across Health and Social Care Partnerships

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

- It was accepted that the Connect to Support website needed a lot of work to get where it should be and to maintain it including accessibility issues for those with learning disabilities and the visually impaired plus ensuring access to information for people without computers

- Liquid Logic was a Social Care database in two parts - Adult and Children - where assessments would be generated and stored, commissioned care packages and provided performance data. It had an additional functionality of a self-serve portal which would be where a member of the public might want to search for information and if they logged in that information could potentially come straight into the Directorate. Under the Care Act, the Authority needed to move towards people self-assessing and self-reviewing so that it was not necessarily carried out by a professional but the person themselves telling you what they needed and/or how their packages were going and Liquid Logic had the functionality to do that for those who would be self-assessing. Potentially Connect 2 Support also had the same capability so consideration needed to be given as to the best route

- There was a partnership group of all agencies working on a portal which would provide access from all IT systems into one shared system. Key points were information governance and data sharing. It was quite an innovative piece of work and probably worth having IT representatives attend a meeting to talk further

- If someone used Liquid Logic to self-assess there was an option to have their details sent through to the Directorate. Connect to Support could similarly do the same but it had the advantage of not being a health and social care but a community portal. Connect to Support was independent and if a customer/citizen said they wanted some support, it could potentially be shared because it was being shared at the request of the individual but it was still early days

- Following the scoping workshop held in October, the information had been sent to Children and Young People's Services as it had not been represented at the meeting. The pre-planned questions had been sent out to all representatives with reminders being sent as a follow-up

- All libraries were now wifi enabled and members of the public were able to access Connect to Support. Members of staff were trained to assist members of the public who required assistance in using the portal

- Connect to Support at the moment essentially was information and advice but could do more. Mental Health had been in attendance at the Connect to Support Regional event and there would be a further meeting to discuss local work. RDaSH had in mind using Connect to Support as a starting point and potentially growing it over time (RDaSH)

Resolved:- (1) That the information provided regarding the transformation of a single point of access be noted.

(2) That feedback in terms of the Working Party be shared with the Select Commission at a future meeting.

## 62. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

## 63. EXCLUSION OF THE PRESS AND PUBLIC

Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 and 4 of Part I of Schedule 12A to the Local Government Act 1972 (information relating to financial or business affairs and labour relations matters).

## 64. RESTRUCTURE OF ADULT SOCIAL CARE - PHASE ONE (MANAGEMENT)

Sarah Farragher, Interim Change Leader, presented a report setting out the proposed Phase One of the Adult Social Care restructure.

A significant restructure of Adult Social Care was necessary to deliver an enhanced customer journey and ensure that it was fit for purpose and met the statutory Care Act (2014) requirements. It would provide more accountability and allow the development of improved integration with NHS partners.

The report detailed the first phase (management restructure). A second phase would be required to develop the teams below the structure the detail for which would be worked up through the consultation period.

Discussion ensued on the report with the following salient issues raised:-

- Current structure was unsustainable due to the workload
- The restructure would provide strategy and support
- The skills required of the appointees to the new posts
- Use of agency staff
- Direct Payments and personalisation
- Workload of qualified/unqualified Social Workers
- Supervision and support of staff

Resolved:- (1) That the significant restructure of Adult Social Care Services, necessary to deliver an enhanced customer journey and ensure that Adult Social Care was fit for purpose and met the statutory Care Act (2014) requirements, be noted.

(2) That the Select Commission receive regular updates to gain an understanding of where the pressure points were and how any problems that arose would be mitigated.

## 65. DEVELOPING A MODEL FOR THE ENABLING SERVICE FOR OLDER PEOPLE AND ADULTS WITH DISABILITIES IN ROTHERHAM

Sarah Farragher, Change Leader Adult Social Care, presented a report on the Enabling Service which provided intensive support for a short period to residents who may have lost their ability to live independently or who were at risk of doing so.

Currently Rotherham's Service was unable to accept all referrals and did not accept the more complex cases. Benchmarking indicated that the service was significantly less efficient that other comparable services in the region.

Discussion ensued upon the report and the three proposed options contained therein for the development of the Service:-

- The Enabling Service had emerged from the previous traditional Homecare Service
- The Service coped very well with basic needs
- What facilities would the Authority provide for training of staff to fulfil the roles available
- Consultation and feedback

Resolved:- That the report be noted.

## 66. ADULT SERVICES TRANSPORT FLEET

Sarah Farragher, Interim Change Leader, presented a report on the Adult Services Transport Fleet and the existing vehicle lease arrangement.

At present Adult Services provided transport to approximately 200 customers on a daily basis (Monday to Friday) primarily to and from the existing in-house Learning Disability Day Services with some older provision and ad-hoc arrangements with in-house respite services.

Due to the expiry of the current lease and maintenance arrangements for the vehicles, it was opportune to review the arrangements and service needs in respect to the future fleet. The implementation of the Care Act also created a shift in the thinking around delivering services and moving towards independence and opportunities for customers to take control of their own lives.

Discussion ensued on the report with the following salient points made:-

- Costs of short term vehicle lease arrangements against long term lease
- Financial costs plus different working methods/independent travel
- Use of taxis
- Long term lease arrangements and use of vehicles across the Council as a whole

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

(2) That a further report be submitted detailing the finance to be incurred, value for money and a comparison of short and long term lease terms and agreements.

**67. DATE OF FUTURE MEETINGS**

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 21st January, 2016, commencing at 3.00 p.m.

Rotherham Metropolitan Borough Council

Public/~~Private~~ Report
Council/or Other Formal Meeting

**Summary Sheet**

**Council Report**

**Title: Spending the Public Health Grant in Rotherham**

**Is this a Key Decision and has it been included on the Forward Plan?** No

**Strategic Director Approving Submission of the Report:**
Teresa Roche, Director of Public Health

**Report Author(s):**
Alison Iliff, Public Health Principal
Alison.iliff@rotherham.gov.uk Tel: 01709 255848

**Ward(s) Affected: All**

**Executive Summary**

- The Rotherham population faces significant health challenges, with lower life expectancy and healthy life expectancy than the England average. In addition, the difference in health between different parts of the borough is stark, with life expectancy being 9 years lower for men and 7 years lower for women in our most deprived areas than in the least deprived. These health needs influence local Public Health priorities.
- Despite these health challenges, Rotherham's public health grant is lower per-capita than many of our statistical neighbours and below the target per-capita figure,
- The structure and roles of the Public Health team have been reviewed and revised. The changes to the structure were orientated around a refocusing on the Public Health priorities for Rotherham, the statutory functions of Public Health within the Local Authority and the statutory functions of the Director of Public Health. We also needed to create more capacity to support the Children's and Young People's agenda and the integration of Health and Social Care for Adults. In addition, Public Health is taking a lead role in developing and implementing the Joint Health and Wellbeing Strategy.
- Public Health activity within the local authority is funded through a ring-fenced grant, devolved from the Department of Health. There is a requirement to provide an annual report to the Secretary of State for Health outlining how the grant has been spent to improve population health.

- The Public Health grant represents a small percentage of the overall spend on health and care. The Health and Wellbeing Strategy identifies over £530m invested by RMBC and Rotherham CCG on health and care services. The Public Health grant represents just 3% of this figure.
- Public Health is contributing to RMBC's requirement to find savings to its core budget; the savings have been identified through the All Service Review process. In the June 2015 budget the Chancellor announced an in-year cut of £200m to Public Health grants; this has been applied as a flat percentage cut to all local authorities and has reduced Rotherham's Public Health grant for 15/16 by around £1m. In November 2015's Spending Review the Government announced that Public Health Grants would remain ring-fenced for 16/17 and 17/18, but would be reduced through "delivering average annual real-terms savings of 3.9% over the next 5 years". A letter from Duncan Selbie, Chief Executive of Public Health England , states that PHE does "not yet know the implications for individual local authorities. This will depend on decisions about the funding formula… [and upon] how fast we move from historic spend to the formula based target shares".
- This paper outlines the structural changes within the Public Health team and the increasing pressures upon the ring-fenced Public Health grant in more detail.

**Recommendations**

- That the Health Select Commission note the new structure within Public Health to support delivery of the three pillars of Public Health, the Authority's statutory Public Health functions and RMBC priorities of the child-centred borough and health and social care integration.
- That the Health Select Commission note the emerging pressures being placed on the Public Health Grant as a result of the announcement in the Comprehensive Spending Review
- That the Health Select Commission note the proposed Public Health commissioning programme for 16/17 and 17/18
- That a members' working group be established after the May 2016 local elections to agree the future strategic spend against the Public Health Grant

**List of Appendices Included**

- Appendix 1: paper to SLT outlining proposals for recommissioning Public Health services (dated November 2015)

**Background Papers**

Spending Review and Autumn Statement
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/479749/52229_Blue_Book_PU1865_Web_Accessible.pdf

**Consideration by any other Council Committee, Scrutiny or Advisory Panel**
**N/A**

**Council Approval Required: No**

**Exempt from the Press and Public: No**

**Spending the Public Health Grant in Rotherham**

## 1. Recommendations

1.1 That the Health Select Commission note the new structure within Public Health to support delivery of the three pillars of Public Health, the Authority's statutory Public Health functions and RMBC priorities of the child-centred borough and health and social care integration.

1.2 That the Health Select Commission note the emerging pressures being placed on the Public Health Grant as a result of the announcement in the Comprehensive Spending Review

1.3 That the Health Select Commission note the proposed Public Health commissioning programme for 16/17 and 17/18

1.4 That a members' working group be established after the May 2016 local elections to agree the future strategic spend against the Public Health Grant.

## 2. Background

### Public Health Structure and Roles

2.1 The Rotherham population faces significant health challenges, with lower life expectancy and healthy life expectancy than the England average. In addition, the difference in health between different parts of the borough is stark, with life expectancy being 9 years lower for men and 7 years lower for women in our most deprived areas than in the least deprived. These health needs influence local Public Health priorities.

2.2 Public Health is the science of preventing disease, promoting health, and prolonging life. Its emphasis is on collective responsibility for health and it aims to provide conditions in which people are empowered to make positive health choices regardless of their circumstances. It can be achieved by working with, and within, communities and with partners to protect them from threats to their health, and by building on the skills, knowledge and assets of communities. The Faculty of Public Health identifies three domains of Public Health: Health Protection, Improving Services (Healthcare Public Health) and Health Improvement.

2.3 Local authorities have been given the statutory responsibility for Public Health as part of the health and social care reforms introduced in April 2013, alongside dedicated funding and a new Public Health outcomes framework. The Health & Social Care Act conferred new duties on local authorities to improve the health of their population. The statutory functions for PH in Local Government are:

- Steps to be taken to protect the health of the local population.
- Ensuring NHS commissioners receive the Public Health advice they need (Healthcare Public Health)

- Appropriate access to sexual health services.
- The National Child Measurement Programme.
- NHS Health Check assessment.

2.4 A review of the current structure identified gaps in provision; in particular it was not possible to be fully assured that we were meeting the statutory functions around Health Protection and Healthcare Public Health, and the delivery mechanism for the NHS Health Checks programme needed to be evaluated. We also needed to create more capacity to support the Children's and Young People's agenda and the integration of Health and Social Care for Adults. In addition, Public Health is taking a lead role in developing and implementing the Joint Health and Wellbeing Strategy.

2.5 In order to address the Public Health statutory functions, placed upon the Council as part of the Health & Social Care Act, it made sense to continue to base the structure on the three domains of Public Health. We need to continue to regularly review what activities/functions operate within each domain.

2.6 We currently have 29.05 whole time equivalent Public Health staff, with a relatively flat reporting structure. This establishment includes administrative support for the Director of Public Health and the team, and two 'provider' services: the health trainer team and the workplace health team. The relatively flat structure is typical of highly professionalised organisations that require all of the staff to take personal responsibility for delivering a high quality, effective service, based always on evidence of need and what works and this should remain.

2.7 The ring-fenced Public Health grant also funds a number of posts across the Local Authority that contribute to the delivery of Public Health outcomes within other directorates. These posts were not included in the structural review.

2.8 The changes to the structure were orientated around a refocusing on the Public Health priorities for Rotherham, the statutory functions of Public Health within the Local Authority and the statutory functions of the Director of Public Health[1]. Cost-effectiveness and evidence based interventions must be a cornerstone of Public Health practice.

2.9 The challenge was to ensure that statutory Public Health functions and key priorities were fully met with a shift in emphasis to meet the demands of the Council moving forward and to do this within existing resources. This challenge would only be realised by focusing the work of the Public Health workforce on identified priority areas; a change in emphasis for some existing posts has enabled identified gaps to be filled within the existing workforce.

[1] Directors of Public Health in Local Government. Roles responsibilities and context. DH (2012).

**Commissioning through the Public Health Grant**

2.8 Public Health activity within the Local Authority is funded through a ring-fenced grant, devolved from the Department of Health. There is a requirement to provide an annual report to the Secretary of State for Health outlining how the grant has been spent to improve population health.

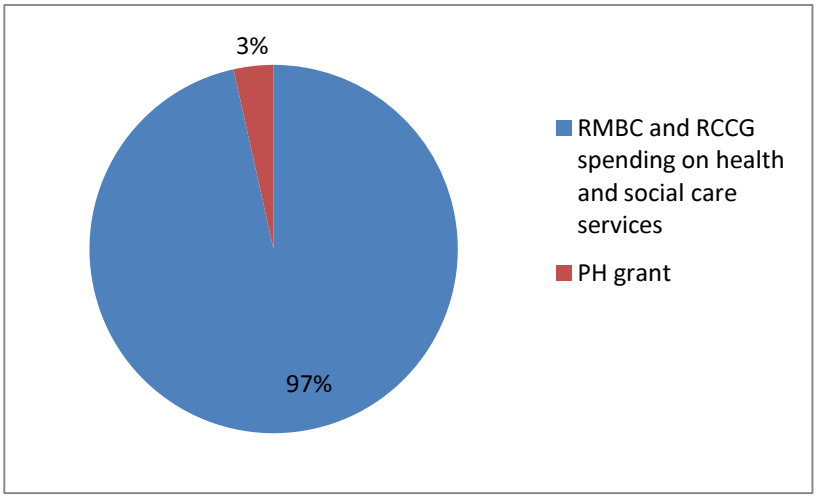
2.9 The amount of the Public Health grant was based on historical spend when Public Health was part of the NHS, and this is mapped against a target per-capita figure determined by an allocation formula. Rotherham's Public Health grant for 15/16 was£14,176,000 or £54 per capita, 1.8% below the target per-capita allocation of £55. The grant is also lower per-capita than many of our statistical neighbours:

**Table 1: Public Health allocation by Local Authority area**

| Area | Grant per head 2013/14 | Uplift 2014/15 | Grant per head 2014/15 | Uplift 2015/16 | Grant per head 2015/16 |
|---|---|---|---|---|---|
| Barnsley | 58 | 4.9% | 60 | 0% | 60 |
| Doncaster | 65 | 2.8% | 66 | 0% | 66 |
| Wakefield | 61 | 2.8% | 62 | 0% | 62 |
| **Rotherham** | **53** | **2.8%** | **54** | 0% | **54** |

2.10 On 1st October responsibilities for commissioning statutory health services for 0-5 year olds (health visiting and family nurse partnership services) transferred from NHS England to Local Authorities, along with the associated budget (£2,150,000 part year for 15/16). This sum is fully committed to commissioned services.

2.11 The Public Health grant represents a small percentage of the overall spend on health and care. The Health and Wellbeing Strategy identifies over £530m invested by RMBC and Rotherham CCG on health and care services. The Public Health grant represents just 3% of this figure.




2.12 Public Health is contributing to RMBC's requirement to find savings to its core budget; the savings have been identified through the All Service Review process. Public Health has found savings of £1m on its ring-

fenced grant, to be delivered over a three-year period (16/17, 17/18 and 18/19). Detail of these proposals are given in a separate paper being submitted to the Health Select Commission.

2.13 Whilst Government has committed to increasing funding for the NHS, Public Health spending is not immune to the current austerity measures. In the June 2015 budget the Chancellor announced an in-year cut of £200m to Public Health grants; this has been applied as a flat percentage cut to all local authorities and has reduced Rotherham's Public Health grant for 15/16 by around £1m,

2.14 In November 2015's Spending Review the Government announced that Public Health Grants would remain ring-fenced for 16/17 and 17/18, but would be reduced through "delivering average annual real-terms savings of 3.9% over the next 5 years" [2]. A letter from Duncan Selbie, Chief Executive of Public Health England , states that "the savings will be phased in at 2.2% in 16/17, 2.5% in 17/18, 2.6% in each of the two following years, and flat cash in 20/21" but that PHE does "not yet know the implications for individual Local Authorities. This will depend on decisions about the funding formula… [and upon] how fast we move from historic spend to the formula based target shares"[3]. At the time of writing, therefore, we are unable to show with certainty the impact of this announcement on the Public Health grant.

2.15 In addition, the Spending Review announced a consultation upon full funding of the Public Health grant from business rates in the future.

2.16 Spend from the Public Health grant can be broadly split into four categories:

- Commissioned services
- Public Health staff salaries
- Overheads
- Funding reallocated to other RMBC services

2.17 Over the coming three years many of our commissioned services will be due for reprocurement. Decisions on future contract values will have to take account of the decrease in the Public Health grant, and balance any spending reduction with impact on delivery of the Public Health Outcomes Framework, the Council's key priorities and the aims of the Health and Wellbeing Strategy.

2.18 More specifically, over the next two financial years Public Health has plans to recommission three major work programmes:

[2] HM Treasury (2015). Spending Review and Autumn Statement 2015. P.88

[3] The letter is attached as an appendix to the paper: Detail of the proposed efficiency savings to Public Health service providers also on the agenda for the meeting on 21 January 2016.

- Health services for children and young people aged 0-19 years
- Sexual Health services
- Drug and alcohol misuse services

The proposals for the commissioning of these three services are outlined in a paper that has been approved at SLT on 24 November 2015 and Commissioner Manzie's Decision Making Meeting on 15 December 2015, and is attached at Appendix 1.

2.17 In addition, a paper is being developed to determine whether some Public Health services currently commissioned from general practice and community pharmacy would be exempt from competitive tender.

## 3. Key Issues

3.1 The pressure on the ring fenced Public Health grant will become more acute over the coming years. The Local Authority Chief Executive or Section 151 Officer and the Director of Public Health is required to return an annual statement to the Department of Health confirming that the grant has been used in line with the conditions set by Government. This is becoming a challenge to justify the redistribution as contributing to Public Health outcomes in other parts of the council.

3.2 The Local Authority has statutory responsibilities for provision of certain Public Health services, but these do not represent the full range of current commissioned services, nor do they necessarily represent the services which best meet RMBC's corporate priorities and those within the Health and Wellbeing Strategy.

3.3 The health challenges for Rotherham people remain and we risk these worsening as a result of the pressures on spending. This is likely to impact on other areas of the health and social care system.

## 4. Options considered and recommended proposal

4.1 This paper is for information only, and therefore contains no specific options appraisal or proposal. When we have clarity from the Spending Review over the level of savings required in 16/17 a further paper will be provided that contains detailed proposals of how the savings can be achieved.

## 5. Consultation

5.1 Consultation is fundamental to the items discussed in this paper.

5.2 Any proposals for recommissioning of services will involve consultation with stakeholders and, where appropriate, the public. This is outlined in the paper at Appendix 1.

5.3 The Spending Review announced a consultation on the proposal to fully fund the Public Health grant from retained business rates. No timescale for this consultation was given.

5.4 Public Health Structure and roles: the proposals were developed following a series of 1-2-1 meetings between the Director of Public Health and staff members. Following publication of the proposed changes a 30-day consultation period was held with staff and unions prior to the final structure being embedded.

## 6. Timetable and Accountability for Implementing this Decision

6.1 The savings announced by the Chancellor in his June 2015 budget will be implemented in-year during 15/16.

6.2 The additional savings announced in the Spending Review will be applied over the coming five years. As mentioned before, the exact details have yet to be confirmed for Local Authorities.

6.3 Public Health will make savings of c.£1m over three years (16/17, 17/18 and 18/19) as part of RMBC's All Service Review programme

6.4 Public Health will propose the establishment of a working group of elected members following the May 2016 election to agree the strategic spend against the Public Health grant for 2017/18 onwards and particularly when the ring-fence is removed, which is currently expected at the end of 2017/18.

6.5 Teresa Roche, Director of Public Health, holds overall accountability for implementation of the proposals in this paper; practical delivery will be carried out by members of the Public Health team.

## 7. Financial and Procurement Implications

7.1 The exact financial implications of the reductions on the Public Health grant will become clearer in early 2016 when allocations for 16/17 are announced. This will lead to in-year pressures to find the additional savings on top of those already identified in the All Service Review process.

7.2 The planned reprocurement of services during 16/17 may provide some opportunity to find these additional savings when setting new contract values. In addition, we will continue to work with existing services to identify efficiencies within current contract terms.

7.3 The procurement process and contract variations necessary to reflect any efficiency savings identified will have an impact on colleagues in finance and procurement.

## 8. Legal Implications

8.1 Negotiations with existing contracted providers to find efficiency savings will need to be carefully managed to ensure processes are completed within the necessary contract terms.

8.2 Under the Health and Social Care Act (2012) Local Authorities are tasked with providing certain statutory Public Health services. The structural review of team roles and responsibilities will ensure that RMBC is able to continue to fulfil these statutory duties.

## 9. Human Resources Implications

9.1 The structural review of the Public Health team was undertaken in conjunction with Human Resources colleagues to ensure any potential implications were addressed at an early stage. Full consultation with staff and unions took place, and where necessary, issues raised were taken back to HR for further advice.

9.2 The additional pressures on the Public Health grant means we will need to look at staff cuts from within the already stretched Public Health team.

## 10. Implications for Children and Young People and Vulnerable Adults

10.1 The Public Health structural review has been carried out in light of RMBC's work to become a child-centred borough and to ensure that roles and responsibilities within the team for work with children and young people, as well as for vulnerable adults, are clearly defined.

10.2 The 0-19 Public Health services that are due to be commissioned will be developed in partnership with RMBC children's services.

## 11 Equalities and Human Rights Implications

11.1 Any proposed changes to services being commissioned will have equality impact assessments conducted. We ask providers to supply equality impact assessments for any reductions in funding we apply.

11.2 Equality impact assessments will be completed for the savings proposed as part of the All Service Review process.

## 12. Implications for Partners and Other Directorates

12.1 The increased pressure on the Public Health grant will inevitably have consequences for partners and other directorates. Reduction of contract values and/or ceasing of some services is likely, which in some cases may impact on frontline delivery.

12.2 Reductions to preventative health services is likely to lead to higher costs elsewhere in the system, as there is strong evidence that Public Health interventions result in reduced costs to NHS and social care services.

12.3 The programme of recommissioning for the three Public Health programmes will require input from colleagues in a number of other RMBC directorates/teams, including procurement, legal, finance, and children's and young people's services.

## 13. Risks and Mitigation

13.1 As stated in 12.2 above, there is a risk that the reduction in the level of Public Health grant may result in increased costs elsewhere in the system and a worsening of health status and health inequalities.

13.2 Decisions on how we adapt our commissioning plans and negotiate budget reductions mid-contract with providers will seek to mitigate these risks by focusing services on the most vulnerable in our community, by adopting a progressive universalism approach and by encouraging more flexible methods of delivery that minimise cost whilst maintaining levels of delivery.

13.3 We will maintain focus on these risks through our directorate risk register and, where appropriate, the RMBC corporate risk register.

## 14. Accountable Officer(s)

Teresa Roche, Director of Public Health

Approvals Obtained from:-

Strategic Director of Finance and Corporate Services:- Nicola Stewart

Director of Legal Services: Ian Gledhill

Head of Procurement (if appropriate): N/A

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**Appendix 1: paper on proposals for recommissioning of public health services**

Rotherham Metropolitan Borough Council

Public/Private Report
Council/or Other Formal Meeting

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**Summary Sheet**

**Council Report**
Senior Leadership Meeting

Public Health Proposals for Re-Commissioning Public Health Services.

**Is this a Key Decision and has it been included on the Forward Plan?**
Yes this is a key decision and is included in the Forward Plan.

**Strategic Director Approving Submission of the Report**
Terri Roche - Director of Public Health

**Report Author(s)**
Anne Charlesworth – Public Health Commissioning and Quality Manager

**Ward(s) Affected**
All

**Executive Summary**

Public health proposes to review and revise the specifications for 3 major areas of the Public Health programme within the next 6 -12 months: sexual health, 0 – 19 children's health services and substance misuse (in 2 stages - recovery and secondary care clinical services).

These services will then be subject to a transparent European Union competitive tendering procurement process. The current providers, including The Rotherham Hospitals NHS Foundation Trust (TRFT) and Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) will be given timely notice of this intention and existing contracts will be extended to fit with the procurement process to ensure, if applicable, a seamless transfer of patient care.

The existing NHS contracts will expire in March 2016 and will require extension until 31st March 2017 for Sexual Health, Substance Misuse Recovery and Children's 0 -19 Health Services and 31st March 2018 for Substance Misuse Secondary Care clinical services. These contracts have operated on a rolling renewal basis as novated from the NHS, and have been extended annually. Public Health will be preparing a number of applications for exemption from section 38 of Rotherham MBC's standing orders and financial regulations and the legal requirement to tender these types of contract across the European Union.

**Recommendations**

1.1 To extend the contracts for sexual health, 0-19 children's health services and substance misuse recovery until 31st March 2017. To extend secondary care substance misuse until March 2018.

1.2 That the service specifications are reviewed and revised by Public Health and partners then shared in summary form across RMBC before they are tendered in order to increase corporate understanding of how the Public Health grant is spent to deliver the Public Health outcomes (services which deliver in support of other directorates, e.g. children's, will be developed in partnership with CYPS colleagues).

1.3 That SLT agrees that Public Health will develop exemption cases for some services to be extended without a tender process: namely the provision of supervised consumption of prescribed medication currently provided by local pharmacists and some services which RMBC purchase from General Practice as a unique provider.

1.4 That the CCG as the main commissioners of TRFT and RDASH are advised of this process before the providers in order to minimise the concerns from Health and Wellbeing Board members and to maximise stakeholder engagement.

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**List of Appendices Included**

None

**Background Papers**

**Consideration by any other Council Committee, Scrutiny or Advisory Panel**

**Council Approval Required**

**Exempt from the Press and Public**

No

**Public Health Proposals for Re-Commissioning Public Health Services.**

## 1. Recommendations

1.1 To extend the contracts for sexual health, 0-19 children's health services and substance misuse recovery until 31st March 2017. To extend secondary care substance misuse until March 2018.

1.2 That the service specifications are reviewed and revised by Public Health and partners then shared in summary form across RMBC before they are tendered in order to maximise corporate understanding of how the Public Health grant is spent to deliver the Public Health outcomes (services which deliver in support of other directorates, e.g. children's, will be developed in partnership with CYPS colleagues).

1.3 That SLT agrees that Public Health will develop exemption cases for some services to be extended without a tender process; namely the provision of supervised consumption of prescribed medication currently provided by local pharmacists and some services which RMBC purchase from General Practice as a unique provider.

1.4 That the CCG as the main commissioners of TRFT and RDASH are advised of this process before the providers in order to minimise the concerns from Health and Wellbeing Board members and to maximise stakeholder engagement.

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## 2. Background

2.1 Public Health transferred into RMBC in April 2013, bringing across from the Primary Care Trust (PCT) a mixture of contracts which had been competitively tendered and some that had been internal NHS contracts. Most of these NHS services have never been tendered as they were part of the structure of the organisation; in the same way that refuse collection or environmental health might be within a council.

2.2 Most Local Authorities have embarked on redesigning and tendering of Public Health services. Some did this as they transferred to Local Authorities. In the main, services were novated at the point of transfer of the function, but this was not the case in Rotherham. Although the Public Health function and funding novated to RMBC the contracts were left with the CCG for 2 years as partnership agreements, RMBC signing the contracts as a co–commissioner. This arrangement ended in 2015, when the 3 year rolling contracts with the providers had a break, and the contracts then became between RMBC and the respective providers. At this point the process was problematic as starting a new contract with a provider that had not been tendered was recognised by RMBC legal as the only option but not without risk of challenge.

2.3 Public Health, with a new Director of Public Health, are now in a position to begin this work, but the contracts will require extensions until March 2017/ 2018 to allow the process to take place. This is because the re-commissioning of these services will be complex and it is important that we allow time for wider

stakeholder engagement, market stimulation and full needs analysis. This will ensure the commissioned services best meet the needs of Rotherham people. Based on a "do it once – do it well" approach, this could take in excess of six months. All the services will be subject the EU tender rules, which lengthens the tender slightly. In the event that the existing providers are not successful 3 months is built in to allow for staff TUPE transfer and the smooth transfer of patient records, which will require patient consent for transfer outside of the NHS. The overriding principle will be the smooth transfer of services for clients, which in many cases are the most vulnerable in our society.

2.4 **Drug and Alcohol Misuse services**

In relation to 'shared care' of drugs and alcohol patients, this service was reviewed in 2014 and is currently part of a consultation exercise to concentrate work into a smaller number of practices to improve the efficiency of the support staff. The support staff are employed by RDASH and would be part of the substance misuse tender process. The model of having most of the dependant drugs and alcohol population with their own GP is nationally recognised best practice, is cost effective for RMBC and works well for both the patient and the community. There is already risk that because Public health has reduced the payment to GPs there is the potential for them to withdraw from provision of the service. RMBC is currently consulting with stakeholders, including GPs, on a model to reduce the number of practices offering this service, again to improve efficiency and to concentrate expense. No further changes are proposed until stakeholders have responded (deadline 30th November 2015). In order to respond to the consultation and re-tender the newly designed recovery services, work needs to be undertaken to ascertain what work in shared care will be part of the recovery agenda, and how much relates to clinical services. Public Health requires an extension to the RDaSH contract until March 2017. The secondary care services are currently provided in part as separate services from the same provider. In order to undertake the next stage of the service remodelling Public Health requires an extension for this element until March 2018.

2.5 **0-19 Children's Health Services**

Public Health commissions the School Nursing service and, from 1 October 2015, is the commissioner of the 0-5 Child Health programme (Health Visiting and Family Nurse Partnership) which transferred from NHS England. The latter has been novated with a 6 month contract and RMBC is required to give the current provider notice of its future commissioning intentions. Public Health has recently reviewed the specification for School Nursing and has begun discussions to incorporate all 0-19 health services into a single specification and contract. This has been agreed in partnership with Children and Young People's Services and supports the RMBC improvement agenda. A similar approach is being taken in a number of other authorities.

In order to take this forward, PH requires approval to extend the novated contract for 0-5 Child Health programme and school nursing service until 31st March 2017 to allow notice to be given to our local provider of our intention to re-specify, market test and retender the 0-19 children's health services.

2.6 **Sexual Health Services**

Local Authorities have a statutory duty to commission confidential, open access services for sexually transmitted infections and contraception.

The responsibility for commissioning sexual health services is complex. Local Authorities are responsible as above, plus HIV prevention and Chlamydia screening. CCGs are responsible for commissioning abortion, sterilisation and contraception for gynaecological purposes. NHS England is responsible for commissioning HIV treatment and care and cervical screening. It is essential therefore that care pathways and contracts are developed collaboratively.

Public Health is redesigning the model of provision for Rotherham and collaborating with stakeholders through market stimulation events to inform a model of best practice. In order to complete this work Public Health requires an extension to this contract until March 2017.

2.7 **Primary Care Provision**

Primary care providers (GPs and Pharmacists) are significant service providers for Public Health. There are 39 practice and 46 pharmacy providers. Together they deliver a range of services. To procure these services from an alternative provider would require care pathways to be redesigned as these providers are in a unique position, and are described within the NHS as “preferred” providers.

The model of primary care delivery reduces duplication within the health system, speeds up referral when conditions are diagnosed and enables streamlined care pathways for subsequent treatment. Services are accessible and community based. The disadvantage is that if one individual provider has performance concerns it is not viable to issue individual notice without reviewing the whole system. This model also needs to be constantly reviewed to ensure that it remains good value in a changing market.

Currently GPs provide the NHS Health Checks (including alcohol screening), a range of sexual health and contraception services and shared care for over 500 dependant drug and alcohol users. Primary care pathways are built into the local pathways with other providers. This is complex to change as patients will still go to their GP for other services and can choose to continue to receive some of these services from their GP. Any change should be managed from the outset with the full co-operation of the GP and pharmacy community. The review of the sexual health pathway includes looking at models of subcontracting for primary care which are being introduced in other areas of England.

**Key Issues**

3.1 Public Health monitor performance on all of these contracts, but performance against contract is not the key driver of this proposal. This will continue with the new specifications.

3.2 Vital to this process is the consideration of impact on partners – the services will still be commissioned but in a different way, possibly from different providers. This is to ensure compliance with procurement requirements. Any proposed changes will be considered for their wider impact. In this instance both NHS Foundation Trusts are service providers as well as partners and the roles should not be confused as this would compromise the procurement exercise.

**4. Options considered and recommended proposal**

4.1 Partnership commissioning with CCG would make some health services exempt from open tender; this was the initial situation on transfer. This model did not enable Public Health to performance manage contracts or to make any changes – including making efficiency savings.

4.2 Consideration of not extending or decommissioning services -The Local Authorities (Public Health Functions and Entry to Premises by Local Health-watch Representatives) Regulations 2013 provide for the statutory duties of:

(a) Weighing and measurement of children
(b) Conduct of health checks
(c) Sexual health services
(d) Public Health advice services

The services described in this paper include (a) (b) and (c) as elements of the services but the scope is broader than the statutory function; (d) is provided by the Public Health team in RMBC.

The services that are in place now are deemed by Public Health to be essential to meet the health needs of the local population and part of this exercise is to review delivery against need. Any intentions to commission or to change services significantly would require a different process.

4.3 Complete review of services, followed by open transparent procurement with involvement for stakeholders as discussed in this paper. The recommendations within the paper are that extensions are needed to enable this to take place.

**5. Consultation**

5.1 Stakeholder and service users (current and potential) will be involved in the development of any new service models, or changes to existing services.

5.2 Potential providers will be engaged via a series of consultation/market stimulation events.

**6. Timetable and Accountability for Implementing this Decision**

6.1 Public Health will produce service specifications for consultation with stakeholders including RMBC and CCG colleagues, and begin market stimulation within 3 months of this paper being agreed.

The existing contracts terminate on 31st March 2016 and require extension until 31st March 2017, For Sexual Health, Children's Health Services (including oral health) and Substance Misuse Recovery Services. The remaining services, Secondary Care, Drugs and Alcohol, require extension until 31st March 2018 to allow for the final redesign to take place. This allows 18 months for the tender process to be completed, which includes 12 weeks of potential staff consultation if services transfer to a new provider.

## 7. Financial and Procurement Implications

7.1 The values of the 3 major service pathways currently are as follows;

| | | 15-16 | 16-17 Reduction | Budget Year | 17-18 | Budget Year | 18-19 Reduction | 18-19 Budget |
|---|---|---|---|---|---|---|---|---|
| 0-19 Children's Health Includes Health Visiting from 2016 full cost | TRFT | 5,449,205 With extrapolated full year effect of Health Visiting transfer | -104,000 | 5,345,205 | -102,000 | 5,243,205 | -100,000 | 5143,205 |
| Sexual Health | TRFT | 2,116,132 | -39,000 | 2,077,132 | -38,000 | 2,039,132 | -38,000 | 2,001,132 |
| Substance Misuse | RDaSH<br>TRFT | 2552,789<br>90,000. This may also be subject to the 1.8% | -48,000 | * 2,111,376<br>90,000 | -47,000 | 2,064,376<br>90,000 | -46,000 | 2,018,376 |

***** *This includes the reduction of the DIP grant from the Police & Crime Commissioner and full year effect of last year's commissioning and saving decisions.*

Efficiency savings of 1.8% have been proposed for all the services which are currently commissioned from TRFT and RDASH over the next 3 years which delivers on the £1 million of savings requested from the Public Health budget. Some of the figures above have been adjusted due to the additional funding coming from NHS England, The savings highlighted equate to 1.8% at the Sept 2015 position , but the contract values have changed slightly but it is not intended to increase the savings quoted to the Provider ( TRFT )

The process of service review may also offer opportunities for further savings by the identification of services that could be done differently, or by other services.

## 8. Legal Implications

8.1 The existing contracts terminate on 31st March 2016. In common with most local authorities, the transfer of Public Health to the RMBC on 21st April 2013 meant that existing NHS and other contracts were novated to the council. Since that time the council has continued to operate in accordance with the terms and conditions of these contracts. While an extension of the contracts beyond March 2016 pending completion of a full procurement exercise may not be the ideal way forward, this must be balanced against the risk to the council of not having appropriate contracts in place, which could mean that the proper delivery of essential Public Health services in Rotherham would be jeopardised.

## 9. Human Resources Implications

9.1 If contracts are awarded to new providers TUPE will apply. If the new provider is non NHS it will be necessary to utilise the full 12 weeks transfer period to establish any changes to Terms and Conditions.

## 10. Implications for Children and Young People and Vulnerable Adults

10.1 Children's 0-19 health services will be re-commissioned in partnership with RMBC children's services.

10.2 Sexual Health and drugs and alcohol services include provision to children and vulnerable adults and will be re-commissioned in partnership with RMBC children's and adult services.

## 11 Equalities and Human Rights Implications

11.1 Any proposed changes to services will have equality impact assessments conducted.

## 12. Implications for Partners and Other Directorates

12.1 Public Health contracts with TRFT and RDASH comprise a relatively small amount of their overall budget; however the potential for a number of current NHS jobs to be moved outside of the NHS as a result of procurement is likely to cause concern for the provider, the CCG and the affected staff.

12.2 Changes to current services and service providers could impact on partners e.g. Police and Probation. Stakeholder consultation will be important to help mitigate any negative impact. Closer working with partners should ensure improved efficiency and more joined up services.

## 13. Risks and Mitigation

13.1 Although the separation of funding for the Public Health transfer to Local Authorities was overseen by the Department of Health, it has become clear that this task was more complex than the time allowed to complete it. Numerous examples have come to light, nationally and locally, which demonstrate that funding, and sometimes services, have been put in the wrong place within the new commissioning architecture. There have been significant moves of funding and responsibilities, e.g. Children and Adolescent Mental Health Services, teenage vaccinations and tier 3 obesity services, since the transfer. It is likely that the process will reveal these types of anomalies for services where the easily identifiable services were transferred but that some elements, e.g. clinical testing or prescribing is still embedded in other NHS budgets. This may have cost implications for the services, and require negotiations with the CCG and NHSE.

13.2 Risk of challenge from potential service providers will be the mitigated by the publication of a timetable for open procurement and the involvement of providers and stakeholders in marketplace events.

**14. Accountable Officer(s)**
Anne Charlesworth

Approvals Obtained from:-

Finance and Corporate Services - Mark Scarrott Finance Manager

Finance and Corporate Services - Ian Gledhill Principal Officer

Procurement Senior Category Manager – Helen Chambers

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Rotherham Metropolitan Borough Council

Public/Private Report
Council/or Other Formal Meeting

**Summary Sheet**

**Council Report; Public Health Report to Health Select Commission 21st January 2016.**
**Detail of Public Health proposed efficiency savings to Public Health service providers.**

**Title**
Detail of Public Health proposed efficiency savings of 1.8% across commissioned services;
Stop smoking support – South West Yorkshire Partnership NHS Trust (SWYFT)
Sexual health and contraception services - The Rotherham Foundation Trust (TRFT)
Drugs and alcohol treatment services - Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH)
0-19's Children's health services - TRFT.

**Is this a Key Decision and has it been included on the Forward Plan?**
Yes

**Strategic Director Approving Submission of the Report;**
Terri Roche, Director of Public Health

**Report Author(s)**
Anne Charlesworth, Public Health Commissioning and Quality Manager.
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**Ward(s) Affected**
All

**Summary**
Public Health has worked effectively with South West Yorkshire Partnership NHS Trust (SWYFT) and Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH) to identify the detail of the 1.8% savings. The Rotherham Foundation NHS Trust (TRFT) have provided a high level response but are still working on the details requested by Public Health.

Public Health has been asked by Senior Leadership Team to make £1,000,000 savings from a budget of £14,176,400 over the next 3 years to support Rotherham Metropolitan Borough Council's (RMBC) financial challenge. This budget will then need to be reallocated across RMBC to areas of work that are identified as supporting the Public Health agenda.

This 'ask' was made prior to the announcement that the Chancellor requested an 'in year' saving from the national Public Health allocation amounting to a further £1,000,000 from the Rotherham Public Health Grant.
Subsequent to both of these decisions has been the autumn spending review and the announcement of further reductions to the Public Health Grant allocation over the next 5 years. The exact level of savings for Rotherham cannot be calculated until the results of the new funding formula exercise is completed but will require more savings from the Public Health budget.

This paper is accompanied to Health Select Commission by a paper which outlines the functions of Public Health as defined in the Health and Social Care Act; explains the statutory functions and aligns the remaining budget to those priorities.

**Recommendations**
That the savings for SWYFT and RDASH (outlined in section 1) are implemented in the contracts from 1st April 2016.

That the savings for TRFT (outlined in section 1) are also made with the understanding that as the TRFT service are to be recommissioned and procured in 2016/17, any changes to the service provision will be part of that exercise.

That there is increased recognition of the serious Public Health challenges facing the Rotherham population and of the relatively small (compared with the overall Health and Social Care budget) level of the Public Health Grant.

That the commitment is made for this grant to be utilised to support the work of the Health and Wellbeing Board and the prevention agenda in the borough.

**List of Appendices Included**

**Background Papers**

SLT paper on Procurement Proposals
Duncan Selbie letter.
Public Health risk assessments.
TRFT Correspondence**.**

**Consideration by any other Council Committee, Scrutiny or Advisory Panel**

**Council Approval Required**

**Exempt from the Press and Public**
No

**Public Health Report to Health Select Commission 21st January 2016.**
**Detail of Public Health proposed efficiency savings to Public Health service providers.**

## 1. Recommendations

1.1 the efficiency savings are made by effecting the following service changes;

1.2 Stop Smoking support – savings made by reducing the value to the provider (SWYFT) of the quality premium on the contract which allowed them to attract additional funding for achieving stretch targets. SWYFT will see the same numbers of patients but more in group settings, and the medications budget will be reduced, bringing it closer to the level of actual spend in previous years.

1.3 Sexual health and contraception services – TRFT propose to assess the numbers of patients accessing all clinics and close the 2 with least footfall. The precise detail in terms of days of the week won't be known until the Sexual Health Services have fully completed the survey.

1.4 Drugs and alcohol treatment services - The number of patients being referred into specialist alcohol services has declined over previous years, and in addition it has now become possible for non-medical prescribers to prescribe controlled drugs. The proposal is that the 2016/ 17 savings will be made by a reduction of the Full time Consultant psychiatrist post to 3 days from 5 (enabling this post to cover 2 geographical areas for RDASH) and that the doctors will be supported by non-medical prescribers in the future, releasing efficiency savings.

1.5 The RDASH savings for 2017/18 would be made by ceasing the enhanced drug service delivery for Criminal justice clients, in effect to making the service for them the same as for everyone else, after a proper process of impact assessment and mitigation for our partner agencies.

1.6 That TRFT review the Health Visiting service to identify efficiency savings.

1.7 That TRFT make efficiency savings from the oral Health promotion by reducing the amount of equipment that is given to the community, as per the background proposal.

1.8 That TRFT reduce the value of the dietetics service after clarifying with Public Health any changes they propose to the service.

## 2. Background

2.1 The 'All service review' (ASR) process was undertaken by Public Health during June and July of 2015 and identified a savings programme to deliver the requested £1 Million from the Public Health budget over 3 years from April 2016 – 2019. Part of this savings programme included a cost efficiency reduction from the large NHS contracts held as follows:

| | | 15-16 | 16-17 Reduction | Budget Year | 17-18 | Budget Year | 18-19 Reduction | 18-19 Budget |
|---|---|---|---|---|---|---|---|---|
| 0-19 Children's Health Includes Health Visiting from 2016 full cost | TRFT | 5,449,205 With extrapolated full year effect of Health Visiting transfer | -104,000 | 5,345,205 | -102,000 | 5,243,205 | -100,000 | 5143,205 |
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In addition it was proposed that 1.8% efficiencies could be delivered across the stop smoking support programme area.

The service providers were then asked to identify how this could be achieved with minimal impact to patients, and to work with leads in Public Health for each area to identify any areas of service that needed to vary from the service specification that is in place.

Timely and helpful responses were received from SWYFT and RDASH.
At the time of writing this report a late and less detailed response has been obtained from TRFT in respect of how the savings will be made, however they have indicated that they recognise that the efficiencies will need to be delivered but need longer to work out the detail. This is included in the background papers. To support the process Public Health has considered the service profile against Public Health statutory functions and indicated to the TRFT the areas that could be included for efficiencies savings: namely – Management costs in the 0- 19s programme, Oral Health Promotion and to control vacancies and spend on some additional areas of work that transferred from NHS England with the Health Visiting transfer which are not yet started.

## 3. Key Issues

3.1 Public Health has considered the proposals against the following criteria:

1. Impact on patient care
2. Impact on staffing,
3. Impact on partners and
4. 'Deliverability' in relation to timescales and resources.

3.2. The proposals are ranked as follows in terms of the considered risk, and the potential implications that Public Health will continue to work through with providers to mitigate impact. These may change as more information from TRFT becomes available.

| Service Area | 1-4 (4 high) Risk Score Patient Care | Staffing Impact – Frontline? | Impact on Partners | Deliverability within Timescales 1-4 of increasing challenge. | Total |
|---|---|---|---|---|---|
| Drugs & Alcohol RDASH Reduction of enhanced offer to Criminal justice system | 2 | 3 | 3 | 2 | 10 |
| TRFT Review of Health Visiting Service | 2 | 2 | 2 | 2 | 8 |
| TRFT Reduction in Community Dietetic Service | 2 | 1 | 3 | 1 | 7 |
| Drugs & Alcohol RDASH Reduction in medical staffing budget | 2 | 2 | 1 | 1 | 6 |
| TRFT Reduction in number of sexual health clinics | 2 | 1 | 1 | 1 | 5 |
| TRFT Reduction in Oral Health Promotion Programme | 2 | 1 | 1 | 1 | 5 |
| Smoking – SWYFT | 1 | 1 | 1 | 1 | 4 |

3.3 With the exception of the stop smoking support services which were procured in 2014 all of these services form part of the procurement proposals for Public health and as such the current providers may not be the contract incumbents for the entire savings period.

## 4. Options considered and recommended proposal

4.1 Public health recommends all the year 1 savings to be progressed and implemented from the 1st April 2016.

4.2 At this time Public Health do not have other proposals for meeting the savings requirement.

## 5. Consultation

5.1 That due process re notification should take place with the Criminal justice agencies (South Yorkshire Police and National Probation Service on the proposals from RDASH to reduce the enhanced level of service to those in the Criminal Justice system but that this should be implemented from 2017 at the latest.

5.2 Public Health has recently been consulting on the proposals for savings made from the 2015/16 budget. The changes to the recovery services will be implemented as per the proposal. The conclusions to the proposals to reduce the number of GP practices is that to continue the high quality shared care service the savings will be made in a different way to enable as many practices as are prepared to offer this service to stay in the scheme.

## 6. Timetable and Accountability for Implementing this Decision

6.1 The outline proposals, following initial consideration by Commissioners and Advisory Cabinet Members, were subject to Commissioner Manzie Decision Making on 20th November 2015, where they were formally referred to Overview & Scrutiny Management Board for consideration at a meeting on 26th November. A further Commissioner Manzie Decision Making meeting on 30th November provided a “minded to” approval decision for the proposals to take effect from 2016/17, providing Public Health further time to work with service providers on the plans for implementation reporting back to OSMB in January.

6.2 That the efficiency savings proposals should begin to be implemented immediately with savings to be made by the dates indicated in the initial plan at the latest.

## 7. Financial and Procurement Implications

7.1 The Procurement implications for these services in described in the paper that went to SLT on 24th November 2015 and to Commissioner Manzies decision making meeting on 14th December 2015. This is included in the referenced background papers.

## 8. Legal Implications.

8.1 **Legal** Department consider there to be no implications from this paper.

## 9. Human Resources Implications

9.1 There are redundancy implications for RDASH under option 4.2, their proposal paper included as background details the redundancies already made by RDASH in respect of savings through the Public Health reductions to this service. (£350,000) These proposals will incur additional cost to RDASH in respect of redundancies.

9.2 The review of Health Visiting by TRFT will have HR implications once it is undertaken during 2016. So far no implications for staffing have been identified by TRFT.

9.3 No staffing implications have been identified for the Stop Smoking Service.

## 10. Implications for Children and Young People and Vulnerable Adults

10.1 The 0-19 Children's health service area is a significant proportion of the overall Public Health budget and as such it would not be possible to deliver all the efficiencies without affecting this area – the proposals made are of minimal impact. Equally, the Drugs and alcohol area delivers services for some of the boroughs most vulnerable adults, but is again a major Public health programme. For drugs and alcohol in particular , where considerable savings were made last year Public health recognise that to identify the third year of savings more work will need to be done on assessing the options as part of the service procurement before this can be finally agreed. The programme spend has now reduced by 33% in 3 years and is now at the point where clinical safety and service quality may be affected.

## 11 Equalities and Human Rights Implications

11.1 Equality impact assessments are still being completed by Public Health on these changes; these have not been possible without some more of the detail being available from the provider services.

## 12. Implications for Partners and Other Directorates

12.1 The Police and Probation Service have become accustomed to a level of enhanced response from drugs services which will need to be reduced.

12.2 The other efficiencies proposed by the providers will be discussed in detail with the Clinical Commissioning Group (CCG)

## 13. Risks and Mitigation

13.1 The risks and mitigations for each proposal have been examined by Public Health which has generated more questions to the services. The key areas are:

13.2 Ensuring time for further impact assessment for the changes to the enhanced drugs services for criminal justice clients.

13.3 Reviewing the medical system for drugs and alcohol users as a whole, including the recent consultation and its potential impact on patient flows to make sure these changes do not adversely affect waiting times.

13.4 To work with TRFT on the details of their plans for both sexual health and health visiting service changes to ensure the detailed proposals are transparent and fully consulted with Children's Services.

Accountable Officer(s**) Teresa Roche, Director of Public Health.**

Approvals Obtained from:-

Strategic Director of Finance and Corporate Services:-Mark Scarrott

Principle Officer Legal and Democratic Services - Ian Gledhill

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**PROPOSAL TO REDUCE RMBC CONTRA**

**Level of savings during 2016/17 equat**

| Ref | Service Line |
|---|---|
| 1 | Health Visitors |
| 2 | Integrated Sexual Health - GUM/CASH |
| 3 | Oral Dental Health Promotion |
| 4 | Community Dietetics |

**ACT BY 1.8%**

**tes to £143k**

| Proposal |
| --- |
| TRFT will undertake a reconfiguration of the HV service. This will require a significant lead in time to ensure due process is adhered to. It is likely to require a 30 day staff consultantion followed by initerviews, appointments etc etc. |
| Reduction of 2 sessions per week, one in Acute, one in Community. A review of footfall will be undertaken during Q4 to identify the most appropriate time. There may be potential, based on current knowledge of times patients access the services (partiuclarly acute) to examine deferring daily opening times to later in the morning. This would be instead of a whole session closure. Further work is required to determine the best possible solution. A similar model is in place within Sheffield Sexual Health Services. Review the whole of integrated sexual health service provision around health promotion including use of social media and other alternative mechanisms for communicating with younger people |

Reduction in non pay i.e. loan resource items and a review of brushing clubs

| |
| --- |
| Service model under review. Require clarity from commissioners re future service specification. Potential to reduce level of service delivery but requires further discussion with commissioners in relation to which services they wish TRFT to cease delivering |

| Risk |
| --- |
| Unable to proceed with planned re-structure due to unforeseen circumstances. |
| Reduced access to Sexual Health Services. |
| • No additional resource boxes will be developed for loan to all agencies that have had oral health training and we will not be able to replace damaged or lost resources<br>• We anticipate that we may still be able to set up new brushing clubs but the numbers of new clubs may be less. The main impact will be that the running costs for the existing and new brushing clubs can no longer be provided by the OHP Service so replacement of resources for the clubs will need to be provided by the schools themselves<br>• Currently the OHP service provides feeder cups to vulnerable families and leaflets on the use of feeder cups to all families. The impact of the CIP is that the provision of feeder cups will cease for vulnerable families and instead they will receive a leaflet on the use of feeder cups. Leaflets on feeder cups for all other families will cease completely<br>• When providing training, training packages are provided by the OHP team to participants. This will not be provided in the way we have been doing but all the training resources will be emailed to the participants to print out their own |
| Unknown at this stage |

| Mitigation | Timeline |
|---|---|
| None at this stage | With effect from 1st April 2016 subject to HR consultation processes |
| Times of reduced capacity will be aligned to current demand patterns. The acute and community services will be closed on different days to ensure there is continuity of service. Posts will be lost through natural wastage. | With effect from 1st April 2016 |
| | With effect from 1st April 2016 |
| Unknown at this stage | With effect from 1st April 2016 subject to the outcome of commissioner/provider discussions during Quarter 4 |

| Savings |
| --- |
| £ 50,000 |
| £ 80,000 |
| £3,513 |
| £ 15,000 |
| **£ 148,513** |

Public Health England

Protecting and improving the nation's health

*Duncan Selbie*
*Chief Executive*
*Wellington House*
*133 – 155 Waterloo Road*
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*Tel: 020 7654 8090*
www.gov.uk/phe

To: Local Authority Chief Executives
Cc: Directors of Public Health

PHE Gateway Number: 2015-502

27 November 2015

Dear everyone

**Spending Review**

I wanted to write to you following Wednesday's Spending Review announcement about the public health grant to share my thoughts on what this means for the next five years.

First, as anticipated, there will be a reduction. The Chancellor talked about savings in the public health grant, which will be an average real terms saving of 3.9% each year to 2020/21. This translates into a further cash reduction of 9.6% in addition to the £200 million of savings that were announced earlier this year. From the baseline of £3,461m (which includes 0-5 commissioning and takes account of the £200m savings) the savings will be phased in at 2.2% in 16/17, 2.5% in 17/18, 2.6% in each of the two following years, and flat cash in 20/21.

Cuts are never welcome, and this is by no means the only challenge that local authorities face. However, you and your colleagues have already proved that you are capable of managing reductions on this scale. I am confident that you will find ways of continuing the very real progress of the past three years in protecting and improving the public's health and in working to reduce health inequalities.

We do not yet know the implications for individual local authorities. This will depend on decisions about the funding formula, on which the Department of Health has consulted on behalf of ACRA and the political decision on pace of change (how fast we move from historic spend to the formula based target shares). My advice to the Government throughout has been to prioritise stability and certainty for the next two years and concentrate on getting the arrangements right for the transition to full funding through business rates. I believe this reflects what your colleagues have told me on my visits to local authorities across the country.

The Spending Review made a number of further commitments including:

- a commitment to retain the public health grant for 16/17 and 17/18 in order to complete the transition of 0-5s and to work through what we will all need in a world without a ringfence.

- a clear signal that the public health grant will be replaced as we move to a model based on retained business rates. The detail of how this will work needs to be worked through and will be subject to full consultation. We will obviously be keen to ensure that any redistribution mechanism reflects health need and does not exacerbate health inequalities.

- the Government is not proposing to change the statutory prescribed functions for local authorities for 16/17. It is right that local government is trusted to make the best decisions about how to use the resources available.

As you know, improving the public's health is about so much more than services secured through the public health grant – it is about jobs, decent housing, a safe environment and companionship. Following the Spending Review, we can work together to build a far wider programme of action on prevention and improving health and wellbeing, including:

- the settlement for the NHS fully funds the Five Year Forward View, and its commitment to getting serious about prevention.

- understanding how we can best use the additional £1.5 billion invested in the Better Care Fund to maximise system-wide efforts to prevent the preventable.

- the importance of Government action, and in particular action on childhood obesity, is signalled. As you know, PHE have provided clear evidence on how we could reduce sugar consumption. We are now working with the Department of Health to produce an effective Childhood Obesity Strategy.

- the importance of work to health. The provision of new national funds to develop approaches to help people with health problems get back to work speaks to an agenda that I know is important to all of you.

- developing a place-based approach to NHS planning; the planning round for 16/17 and beyond will move to a place-based approach and properly engage local authorities in the decisions about future health services.

- the Government's commitment to real and meaningful devolution provides opportunities for local authorities to join up public services to address the real problems in our communities.

You will be considering the impact of the Spending Review for your authority. I am clear that we have the basis for making a real difference to the public's health in the coming years. I do not underestimate the challenges, but they are nothing to what you have already shown you are capable of.

PHE stands ready to help in whatever way we can.

Best wishes

Yours sincerely

Duncan Selbie
Chief Executive

SWYFT Stop Smoking Service;

2016/17 proposal:

- 2% reduction to total service cost budget (£403,107 – saving would be £8,062)
- 15% reduction to the total medication budget (RMBC contribution to medication budget £92,000 – saving to RMBC would be £13,800. The remainder of the budget is funded by Rotherham CCG, and this reduction would generate a saving for them of £25,950). The medication budget was underspent in 14/15 and is expected to be so again in 15/16, so this reduction is bringing the budget closer into line with expected spend.

To achieve these savings the service will need to demonstrate revised delivery models, such as the increased use of stop smoking groups and telephone support and reduced one-to-one support. Commissioners have proposed thresholds for activity targets that reflect the national decline in attendance at stop smoking services seen since the service specification and targets were drawn up. There is no final agreement to these proposals as yet but the aim is to reach agreement at the contract review meeting on 19 January 2016.

| | **1 low impact** | **2** | **3** | **4 high impact** |
|---|---|---|---|---|
| Patient Care | X The service offers a flexible delivery model that can adapt as required for example reduced one-to-one interventions and increased group delivery. This minimises the impact on direct patient care. | | | |
| Staff Impact (frontline) | X As above. The service currently uses some bank staff and those numbers could be reduced in the first instance to minimise impact on permanently employed staff. | | | |
| Impact on partners (e.g. pushing cost elsewhere) | X If impact on frontline delivery is minimised then cost should not be pushed to other parts of the health and social care system | | | |
| Deliverability Time & Resource | X Proposals not yet agreed however discussions have been underway for some time. | | | |

# HEALTH AND WELLBEING BOARD
## 25th November, 2015

**Present:-**

| | |
|---|---|
| Councillor David Roche | Advisory Cabinet Member, Adult Social Care and Health **(in the Chair)** |
| Louise Barnett | Rotherham Foundation Trust |
| Graeme Betts | Interim Director Adult Care and Housing |
| Tony Clabby | Healthwatch Rotherham |
| Dr. Richard Cullen | Clinical Executive, Rotherham CCG |
| Chris Edwards | Chief Officer, Rotherham CCG |
| Ruth Fletcher Brown | Public Health Specialist, RMBC |
| Kate Green | Policy Officer, RMBC |
| Michael Holmes | Policy Officer, RMBC |
| Tracy Holmes | Communications and Marketing, RMBC |
| Alison Iliff | Public Health Specialist, RMBC |
| Stella Manzie | Commissioner and Managing Director, RMBC |
| Paul McCurry | South Yorkshire Police (representing Jason Harwin) |
| Tracey McErlain-Burns | Chief Nurse, Rotherham Foundation Trust |
| Zena Robertson | NHS England (Yorkshire and Humber) |
| Councillor Stuart Sansome | Chair, Health Select Commission |
| Kathryn Singh | RDaSH |
| Jon Tomlinson | Better Care Fund, RMBC |
| Councillor Gordon Watson | Deputy Leader |
| Janet Wheatley | Chief Executive, Voluntary Action Rotherham |
| Sue Wilson | Performance and Planning, RMBC |
| Councillor Taiba Yasseen | |

**Observers:-**

| | |
|---|---|
| Chris Bland | |
| Sandi Keene | Chair, Adult Safeguarding Board |
| Councillor John Turner | |

Apologies for absence for absence were received from Jason Harwin, (South Yorkshire Police), Julie Kitlowski (Rotherham CCG), Ian Thomas (RMBC).

### 31. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

### 32. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no questions from members of the press and public present.

### 33. MINUTES OF THE PREVIOUS MEETING

Resolved:- That the minutes of the meetings held on 26th August and 30th September, 2015, be approved as a correct record subject to the correction of Conrad Woreham to Conrad Wareham.

Further to Minute No. 16(b), it was reported that confirmation had been received from NHS England that the CaMHS Transformation Plan had been fully signed off.

## 34. FOR INFORMATION

**CAMHS Transformation Plan**
As reported at Minute No. 33, the Plan had been signed off.

**Communications**
A new Twitter account was now active and would be used during the meeting to tweet updates and share information on what the Board was discussing. Any further suggestions on how to effectively engage with the public would be welcomed.

The Board's website was out of date and need a refresh. Consideration was being given as to how best to do this ensuring it was useful and engaging for the public and stakeholders.

Discussions were taking place with regard to the development of a local newsletter to share work of the Board with the public and stakeholders.

**Physical Activity Event**
Physical activity in Rotherham had recently received financial support from Sport England to develop a range of partnership projects.

There had been a wide range of regional sessions/literature referencing the positive approaches and outcomes achieved by local authorities who had focussed on increasing physical activity. As a result it was hoped to hold a local event to share good practice with support and funding from the LGA.

**Health and Wellbeing Board Member Survey**
The LGA had produced a survey for Health and Wellbeing Board members.

It was not felt appropriate at the current time given the development the Board had just undergone but could be used in 6 months' time.

**Additional Health and Wellbeing Board**
An additional meeting was to be held on 13th January, 2016 and would have a Children and Young People focus.

**Health and Wellbeing Board Chairs**
A network of Board Chairs was to be set up for the Yorkshire region.

**Healthwatch Rotherham**
Tony Clabby reported concerns with regard to CaMHS and the eligibility threshold for Learning Disability Services in Rotherham. These issues would be picked up outside of the meeting.

## 35. HEALTH AND WELLBEING STRATEGY

Further to the meeting on 30th September, 2015, Alison Iliff, Public Health, reported that discussions had taken place with regard to the mechanism for implementation of the Strategy ensuring a commitment across all partner organisations and maximised use of existing partnerships to deliver the Strategy aims.

The report highlighted:-

- Development of the Strategy action plan
  The Children's Partnership Board action plan would also form the action plan for Aims 1 and 2 of the Strategy. The Board sponsor for the two aims (who would likely to also sit on the Children's Trust Board) would use the wider Children's Partnership to help deliver the Strategy action plans

  Work would take place to identify any existing partnership actions relating to Aims 3, 4 and 5 and, to help identify where the Health and Wellbeing Board could add value to specific actions and consider what was already in place locally, a series of one-off development workshops were proposed. Aim 3: Mental and Emotional Health and Wellbeing would be trialled first.

- Role of Board members
  A Board sponsor to be nominated for each of the Strategy aims who would champion the topic, work at a strategic level to raise the profile of the work being done, drive local delivery, address barriers and ensure strategic links/connections were made and exploited. The sponsor would retain ultimate responsibility for the delivery of their aim(s).

  Board sponsors would be asked to nominate a representative on the Steering Group for their aim.

- Health and Wellbeing Steering Group
  Would support and steer the work of the Board, co-ordinate the work of the Strategy and action plans and inform the Board's future work programme.

  Healthwatch Rotherham would also be represented to ensure connection with local people and it would be chaired by the Director of Public Health.

  It was proposed that the Steering Group be divided into two, the first as above and the second being a much smaller group to develop the work programme.

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

- Ian Thomas, Interim Strategic Director, Children and Young People's Services, would be the link between the Children and Young People's Partnership Board and the Health and Wellbeing Board
- Should the nominated representative come from a different organisation than the Board Sponsor?
- Ensure that reports submitted were specifically for the Board only and not being discussed on multiple occasions by other meetings

Resolved:- (1) That the implementation plan and governance arrangements for the Health and Wellbeing Board 2015-18 be approved.

(2) That nominations for Board sponsors and nominated person be forwarded to Kate Green by Friday, 4th December, 2015.

(3) That the first development workshop be held on Aim 3: Mental and Emotional Health and Wellbeing.

(4) That the Health and Wellbeing Strategy be circulated with any comments thereon submitted to Kate Green by Friday, 4th December, 2015.

## 36. BETTER CARE FUND

Chris Edwards, Rotherham CCG, submitted the second quarterly Better Care Fund report which was due for submission to NHS England on or before 27th November, 2015.

Following the submission of the first quarter information, NHS England had completed a regional feedback on BCF performance. This showed that Rotherham was not an outlier in any areas of the BCF and, in line with just under half the localities, were still working towards two of the national conditions i.e. implementing seven day working and using the NHS identifier.

The quarterly return showed that Rotherham's plans to meet the two outstanding national conditions were on track and that performance on most metrics (where data was available) were on target. However, performance on preventing non-elective emergency admissions (target of 7,382) had not been to plan and there had been an increase (7,503) rather than the planned decrease. As a result no performance related pay had been awarded. However, it was a reduction on the previous quarter's performance (7,745).

Resolved:- (1) That the second quarter report be approved for submission to NHS England in accordance with the 27th November, 2015, deadline.

(2) That the regional feedback from NHS England on quarter one be noted.

## 37. SUICIDE PREVENTION AND SELF-HARM ACTION PLAN UPDATE

Further to Minute No. 81 of the meeting held on 18th May, 2015, Ruth Fletcher-Brown, Public Health Specialist, presented a progress report on the actions detailed in the Rotherham Suicide Prevention and Self Harm Action Plan.

The report set out the actions/areas of development undertaken under each of the eight areas:-

- Increase local level of understanding suicide and establish reporting mechanisms to strategic partners
- Reduce risk in high risk groups – children and young people
- Tailor approaches to improve mental health in specific groups
- Reduce access to medication
- Better information and support to those bereaved by suicide
- Support media in delivering sensitive approaches to suicide and suicidal behaviour
- Data collection and monitoring
- Workforce development

Discussion ensued with the following highlighted/raised:-

- A meeting with Head Teachers was still awaited to discuss the response plan – information had been sent to Safeguarding leads

- The social marketing campaign for young people had been developed and was awaiting graphics

- The Rotherham Self-Harm Practice Guidance 2015 was ready for circulation

- Mental Health First Aid was a nationally recognised course for anyone working with adults or young people. Funding had been received from the CCG and Public Health for 2015/16 but no commitment going forward

- Training and workforce development was an issue - there were only 2 Youth trainers and 3 Adult trainers in the whole of Rotherham. Part of the CaMHS work was to look at workforce learning and a more robust co-ordinated approach to training. It was very important to get youth trainers in place

- Promotion of the training to employers

- Samaritans were used as a support organisation but there were resource issues

- Publicity campaigns were with the Graphic Team for finalisation and once complete would have a scheduled timetable against them

- Death by suicide was a long term issue for families who needed long term support. The pathway for adults needed to be looked at as it was quite often a year after the death that an inquest was held. A leaflet had been drafted which contained all the detail of the services available as well as discussions with South Yorkshire Police who were looking at services Force-wide.

- Information available to support witnesses/bystanders

- Consideration should be given to the many other opportunities for offering advice including Councillors

- National resource, "Help is at Hand", had been sent to all GP surgeries

- When there had been a self-harm incident/suspected suicide within a school and the Community Response Plan activated, partners had worked together very effectively and a multi-agency meeting held. The feedback from the schools involved had been really appreciative and they had felt fully supported and equipped to deal with the incident

Resolved:- (1) That the actions taken by the Rotherham Suicide Prevention and Self Harm Group be noted.

(2) That the Office of National Statistics data on suicides and undetermined deaths from 2009-2014 be noted.

(3) That the recommendations for future activity be endorsed.

(4) That the Suicide and Self-Harm Community Response Plan be included on the agenda for the next available Head Teachers' meeting.

(5) That discussion take place on promotion of the training available to employers with a report back to the next Board meeting.

(6) That an All Member seminar be held on Mental Health.

## 38. CQC INSPECTION ACTION PLAN FOR ROTHERHAM NHS FOUNDATION TRUST

Tracey McErlain-Burns, Chief Nurse, gave a powerpoint presentation on the CQC Improvement Plan as follows:-

Inspection Ratings

- Overall rating – requirements improvement
- Safe – requires improvement
- Effective – requires improvement
- Caring – good
- Responsive – requires improvement
- Well-led – requires improvement
- Overview of ratings:-
  26 Good
  33 Requires improvement
  5 Inadequate

Detailing ratings: Core Service Level

- Community Care Services
  Community Health Services for Adults – overall requires improvement
  Community Health Services for Children, Young People and Families – overall requires improvement
  Community End of Life Care – Overall requires improvement
  Community Dental Services – overall good
  Community Health Inpatient Services – overall requires improvement
- Acute Core Services
  Urgent and Emergency Services – overall requirements improvement
  Medical Care – overall requires improvement
  Surgery – overall requires improvement
  Critical Care – overall requirement
  Maternity and Gynaecology – overall requires improvement
  Services for Children and Young People – overall inadequate
  End of Life Care – overall good
  Outpatients and Diagnostic Imaging – overall good

Improvement Action Plan

- Approved at Board of Directors in July 2015
- 'Must Do' actions from Requirement Notices
- 'Should Do' actions as advised by the CQC
- 17 'Must Do' sections with 101 actions
- 12 'Should Do' actions with 126 actions
- Each section has an Executive Lead and an Operational Lead responsible for delivering all actions in that section
- A Corporate Committee has oversight of all sections of the action plan

JSNA and CQC actions

- Starting Well
  M7: Children's Environments
  M13: Infection Control in short break service
  M14: medicines Management in short break service
- Developing Well
  M15: Liaison between Contraception and Sexual Health Service and School Nursing Service

- Living and Working Well
  M5: Elimination of Mixed Sex Accommodation
- Ageing Well
  M2: Mental Capacity Act and Deprivation of Liberty Safeguards
  M4: Do not attempt cardio-pulmonary resuscitation

Reporting Arrangements
- Monthly monitoring of all actions
- Updates against actions and evidence of completion of actions required from all Operational Leads monthly
- Board of Directors receives a monthly exception report of progress
- Corporate Committees monitor the progress against the sections for which they have oversight, escalating when required
- Progress is also tracked at the monthly Divisional Performance Meetings
- Weekly steering group meetings attended by all Operational Leads designed to assure the evidence of completion of actions and test that the outcome descriptors have been achieved
- Monthly progress updates on internet and intranet

Preparing for Re-inspection
- Mock inspections: 1 completed in November, another shortly
- 2 page staff briefings: pre-inspection briefings evaluated well so have been reintroduced highlighting the progress made since February 2015
- Challenging available evidence: via mock inspections, dip samples and the weekly steering group meetings
- Ensuring that completed actions deliver the outcomes required by CQC: via 1-2-1 meetings with Chief Nurse, mock inspections and dip samples
- Raising awareness: targeted communications campaign ensuring staff are mindful that CQC could re-inspect at any time

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

- The Trust overall faced capacity issues. There were shortages in certain occupation groups and a particular expertise set to lead the change that was expected

- Additional financial resources were being sought but the Trust was very committed and continually using innovative ways of working

- Volunteers from outside of the organisation were drawn upon for the mock inspections

Kathryn Singh, RDaSH, reported that the draft CQC report had been received. Due to the CQC's new working practice, the report would become a public document before the Quality Summit was held and an action plan produced. All partners would be briefed in advance.

Resolved:- (1) That the CQC Inspection Action Plan for the Rotherham NHS Foundation Trust be noted.

(2) That an update be submitted in 6 months dependent upon the timing of the re-inspection.

## 39. ADULT SOCIAL CARE VISION AND STRATEGY

Professor Graeme Betts, Interim Director of Adult Services, gave a presentation on the Vision and Strategy for Adult Social Care in Rotherham.

Adult Social Care

- Provision of Social Care for adults had undergone enormous change over the past generation with the pace of change accelerating over recent years as the demand for more personalised services continued to grow and traditional models of care seem to be outdated

- The approach was increasingly based on an asset model i.e. identifying with the person what they could do, what they had, who they knew and which community groups they were linked into, what their family and friends could do as carers and what the wider communities could offer

- Improving the help and support for individuals who needed it at any specific time benefited the whole community as they were likely to be family and friends of people requiring support or who may come to need it

- The changes had been reinforced by the introduction of the Care Act. There had been an increasing development of care based on a personalised model with people enabled to live in their own homes and to access services, facilities and buildings as part of the wider community

- The role of Adult Social Care had accordingly had to change and develop a strong partnership and influencing role.

Vision

- The ambition in Rotherham was that adults with disabilities, older people and their carers were supported to be independent and resilient with the desired outcomes, that they lived good quality lives and their health and wellbeing was maximised

- It was essential to recognise that during the course of someone's live there may be times when they required support and care and health services needed to be prepared to intervene on those occasions

- The aim should be to intervene appropriately to provide minimal support to enable the client to maintain their independence.

Strategy

- In order to achieve the vision it was fundamental that a network of support be created including Council services, health services, private and third sector services and voluntary, community and faith groups, as well as friends, family and neighbours

- Must recognise that the network of community resources needed development and investment and best delivered through a partnership with the third sector

- Need to ensure that there was a "front door" which listened and addressed what people were requesting in a way which would support them to take control of the situation for themselves e.g. provision of information/advice, equipment or undertaking of a self-assessment

- Aim of assessment to support the client to develop a solution which maximised them taking control and minimised interventions from the formal care sector

- Focus on building prevention, rehabilitation and enablement throughout the system as well as one-off interventions such as telecare to give people back control and independence

- Develop alternatives to traditional services e.g. promotion of Shared Lives, supported living, extracare schemes, homes suitable for older people, key ring schemes

- Seek to minimise the use of residential and nursing care whilst recognising that there was a place for it in a care and health economy

- Promote personalised services as alternatives to day services

- Promote the development of integrated commissioning and delivery of services

- Wide range of preventative services to reduce the need for intensive services plus investment in extra care and shared lives

Delivering the Strategy

- Need for a series of inter-related commissioning strategies to be developed involving Council services (especially Adults, Children's, Housing as well as Community Development and Community Safety), Health Services and other organisations where appropriate such as the Police

- The Health and Wellbeing and Adult Safeguarding Boards would own the Strategy and delivered through a range of Boards and groups

- The Department of Adult Social Services, as Statutory Office, would have responsibility for developing the Strategy and ensuring its delivery

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

- No decision had been made as yet but exploring different options for the service transformation

- The move to a locality model had started 18 months ago. Work was taking place with RDaSH who were configuring with the localities work

- There were 7/8 localities

- Role of the Safeguarding Adults Board to be extended

Resolved:- That the report be noted.

**40. DATE, TIME AND VENUE OF THE NEXT MEETING**

Resolved:- That a further meeting be held on Wednesday, 13th January, 2016, commencing at 2.00 p.m. at Oak House, Bramley.