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

Date:-	**Thursday, 28th July, 2016**	**Venue:-**	**Town Hall, Moorgate Street, Rotherham S60 2TH**
Time:-	**9.30 a.m.**		

HEALTH SELECT COMMISSION AGENDA

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

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

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

4. Apologies for Absence

5. Declarations of Interest

6. Questions from members of the public and the press

7. Communications

8. Minutes of the Previous Meeting held on 16th June, 2016 (Pages 1 - 22)

For Discussion

9. Transforming Rotherham Adult (18+) Mental Health Services (Pages 23 - 40)
   Alison Lancaster and Kerri Booker, RDaSH, to present

10. Adult Social Care Provisional Year End Performance Report 2015/16 - Follow-up Response (Pages 41 - 80)
    Nathan Atkinson, Assistant Director Strategic Commissioning, and Scott Clayton, Performance Officer, to present

11. Adult Social Care - Local Measures Performance (Pages 81 - 88)
Nathan Atkinson, Assistant Director Strategic Commissioning, and Scott Clayton, Performance Officer, to present

12. Carers Together Strategy Carers in Rotherham (Pages 89 - 107)

For Information/Discussion

13. Health and Wellbeing Board (Pages 108 - 129)
Minutes of meetings held on 20th April and 1st June, 2016

14. Improving Lives Select Commission Update

15. Joint Health Overview and Scrutiny Committee for the Commissioners Working Together Programme

16. Healthwatch Rotherham - Issues

17. Date of Future Meeting
Thursday, 22nd September at 9.30 a.m.

Sharon Kemp.

SHARON KEMP,
Chief Executive.

Membership 2016/17:-

Chairman:- Councillor Sansome
Vice-Chairman:- Councillor Short
Councillors Albiston, Andrews, Brookes, Cusworth, Elliot, R. Elliott, Ellis, Evans, Fenwick-Green, Ireland, Marles, Marriott, Roddison, John Turner, Williams and Wilson.

HEALTH SELECT COMMISSION
Thursday, 16th June, 2016

Present:- Councillor Sansome (in the Chair); Councillors Andrews, Brookes, Cusworth, Elliott, Ellis, Fenwick-Green, Ireland, Marles, Marriott and Williams.

Councillor Jarvis attended the meeting as an observer.

Apologies for absence:- Apologies were received from Councillors Albiston, Elliot and John Turner.

1. DECLARATIONS OF INTEREST

The following Declarations of Interest were made at the meeting:-

Councillor Andrews (non-pecuniary) – Mental Health Nurse working in the private sector

Councillor Cusworth (non-pecuniary) – Volunteer Teaching Assistant at Swinton Brookfield School

Councillor R. Elliott (non-pecuniary) – Volunteer at Rockingham J. and I. School

Councillor Marles (non-pecuniary) – relative works in Adult Social Care

2. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no members of the public or the press in attendance.

3. COMMUNICATIONS

Children's Surgery and Anaesthesia Services and Hyper-Acute Stroke Services

The Chairman reported that at the Joint Health Overview and Health Scrutiny Committee (OSC) held in Sheffield on 23rd May, the Terms of Reference for the OSC were agreed. Members had received a presentation from NHS England on the outcomes of their pre-consultation work with the public and the communications and engagement plans for when the options were out for consultation from September.

There was a further meeting on 8th August when the OSC would receive detailed information on the possible options for both Services.

Resolved:- That the Commissioners Working Together Programme (CWTP) be included as a standard agenda item.

Improving Lives Select Commission
Due to the crossover in work between this Select Commission and Improving Lives, a standard agenda item of "updates" would be included on future agendas to enable feedback from the Members who sat on both Commissions (Councillors Albiston, Cusworth, J. Elliot and Marriott). The Improving Lives Select Commission had not met since the last meeting of this Commission.

4. MINUTES OF THE PREVIOUS MEETING

Consideration was given to the previous meeting held on 14th April, 2016.

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

(2). That with regard to the Access to GPs Review:-

(a) that the action taken, with the majority of the actions either now completed or incorporated within the Interim GP Strategy, be noted;

(b) that a further update be received from the Clinical Commissioning Group in 2017 on the outcomes measures once the GP Strategy had had time to embed.

(3) That with regard to the Urinary Incontinence Review:-

(a) the response to the Review and progress to date be noted;

(b) that information be submitted regarding the training roll out and when the website had been completed so that the Review could be signed off as complete.

(4) That with regard to the draft Carers Strategy:-

(a) the monitoring of the implementation of the action plan be included in the work programme of this Select Commission;

(b) that the Select Commission have the opportunity to comment on the final draft including the action plan prior to sign off.

(5) That with regard to the CAMHS Review:-

(a) that a further progress report be submitted in 6 months;

(b) that the outcomes of the Voice and Influence Review be submitted to this Select Commission and the Youth Cabinet.

Arising from Minute No.9 (CAMHS Review), it was reported that the staff recruitment was due to be completed by the end of June. There would then be further work and consultation on developing the care pathways which would involve consultation with stakeholders.

Within the Public Health Annual Report there were sections on CAMHS going forward and emphasis for the future which required the restructuring to take place and, therefore, implications if it slowed down. It was important that the Select Commission were kept up-to-date with progress.

5. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

Terri Roche, Director of Public Health, and Anna Clack, Public Health Specialist, gave the following powerpoint presentation:-

Starting and Growing Well
Introduction/Background

- Independent annual report – statutory requirement
- Focus - pre-natal, childhood and young people's health
- Tackles key health issues
- Highlights areas to improve outcomes
- First report in a series planned to look at the life course

Aim

- To raise awareness and seek Directorate support to harness everyone's role in delivering a 'child centred Borough' by achieving the ambitions set out in the report

Children's Health in Rotherham

- Life expectancy at birth for a baby born in the 10 least deprived areas was 9.5 years longer than for a baby born in the most deprived areas
- Children in the most deprived areas were twice as likely to be disabled and more than twice as likely to live in a home where someone smoked
- http:/fingertips.phe.org.uk/profile/child-health:profies/data#pages/1/gid/1938132948/pat/6/E12000003/att/102/are/E08000018

Children's Voice

- We value the contribution of children and young people to our work and this report has been informed by a range of local consultations and surveys including:-
  The Rotherham Lifestyle Survey 2015
  Rotherham Post-16 Survey 2014
  Rotherham Youth Cabinet and Rotherham Youth Parliament Consultations

Key Recommendations

- 8 key recommendations that focus on
  - Integrated services and care pathways to maximise health outcomes
  - Partners working together to maximise opportunities for training
  - Improving mental health and wellbeing including timely access to Mental Health Services

- Tackling overweight and obesity
- Integrating the Health and Wellbeing Board and Children and Young People's Board
- Review the need for a poverty strategy

Our Ambition

- The report is a call to action for all stakeholders in Rotherham to share our knowledge, skills and expertise in a commitment to working in partnership to improve the health of our children and young people
- The report sets out ambitions to be achieved over the next year

Chapter 1 – Pregnancy, Birth and the Early Years

- Healthy Pregnancy – reducing the number of low birth weight babies (less than 2.5kg) and babies born pre-term (before 37 weeks)
- Maternal Nutrition and Vitamin D – enhancing the Healthy Start Scheme vitamin distribution to eligible mothers and children
- Smoking in Pregnancy – working with the CCG to mandate carbon monoxide screening for all pregnant women and to ensure access to specialist Stop Smoking support
- Alcohol in Pregnancy – a single consistent message 'no alcohol equals no risk'
- Sudden Infant Death Syndrome – development of Rotherham Joint Safe Sleeping Guidelines to reduce the risk of SIDS
- Breastfeeding – the Rotherham Foundation Trust achieving Stage 3 Unicef Baby Friendly Initiative by 2017

So What Factor?

- Smoking in pregnancy
- Working with the Rotherham CCG to mandate carbon monoxide testing for all pregnant women
  - The use of carbon monoxide testing at 36 weeks gestation provided a much more accurate picture of local rates of smoking during pregnancy
  - Having more accurate data would enable services to target interventions and tailor advice to reduce Venous Thromboembolism (VTE), still births and Sudden Unexpected Death in Infancy

Chapter 2 – Support for more vulnerable families

- Perinatal Mental Health – specialist perinatal mental health clinician and health visiting identification following a robust care pathway
- Domestic Abuse – commissioned services to have robust training, raising the issue/asking the question to be mandated as part of anti-natal care contracts, creating environments so people can disclose
- Teenage Pregnancy – ensuring teenage parents are registered and accessing children's centres (Early Help Support)
- Unintentional and Deliberate Injury – in-depth review and analysis of data and trends to target preventative advice, support and equipment

- Early Years and School Readiness – Early Years and Child Care Services work together to ensure the assessment completed by Health Visiting Teams and the 2 year old progress check were integrated

So What Factor

- Unintentional and Deliberate Injury
  - Early investigations looking at local trend data in 2014/15 showed:-
    A high number of accidental poisoning incidents among 0-4 year olds in Rotherham
    A concerning number of incidents involving contact with heat and hot substance among 0-4 year olds
    A significant proportion of children falling down stairs
- Rotherham Public Health are going to work with the Early Help Service and Health Visiting Teams to prioritise accident prevention and scope access to home safety equipment

Chapter 3 – Primary School Years

- Nutrition (food and drink) – reducing sugar
- Overweight and obesity – development of a Healthy Weight Action Plan
- Physical activity – increasing participation for young people aged over 5 through partnership initiatives and the Rotherham Get Active campaign
- Oral Health – Health practitioners and frontline staff promoting fluoride varnish and dental attendance
- Immunisation – to ensure the benefits of the HPV vaccine were communicated and to ensure a high uptake

So What Factor?

- Overweight and obesity
  - Development of a Healthy Weight Action Plan would ensure:-
    A whole system approach making being a healthy weight 'everyone's' business
    All services fully engaging with the healthy weight agenda
    Cross cutting priority delivery interventions including more walking to school initiatives, accessible green space and reducing the number of takeaways around Rotherham schools

Chapter 4 – Secondary School Years

- Emotional Health and Wellbeing – development of a workforce development strategy and partners to support Rotherham Youth Cabinet to address mental and emotional health and wellbeing
- Self-Harm – Rotherham self-harm guidance to be distributed and in use in schools, colleges, health centres and youth centres and training to be provided to frontline staff
- Health related behaviours: Tobacco – Rotherham schools to review smokefree policies to ensure they were in line with current Legislation

- Health-related Behaviours: Drugs and alcohol – every school and college to provide consistent substance misuse education that promotes resilience. Improving intelligence from young people and frontline agencies on emerging drug trends
- Health-related Behaviours – Sexual Health – Head Teachers and School Governing Bodies to fully support a 'gold standard' delivery of sexual health initiatives and education in schools. Review Sexual Health Service provision across Rotherham

So What Factor?

- Sexual Health
- 'Gold standard' sexual health initiatives in Schools
  Create opportunities for young people to learn how to identify and be part of a 'healthy' relationship(s). They should also be more aware of what constitutes good sexual health and have increased knowledge about contraception and sexually transmitted infections (STI) testing
- Review of Sexual Health Services
  Better and more efficient access to services for our young people. Opening times to better fit when young people want to use the clinics and making sure they were east to get to

Chapter 5 – Late Adolescence

- Employment and Training – partners to strengthen the universal offer to support children and young people at transitions. Information sharing with partners and Job Centre Plus must by more systematic
- Road Safety – continued rolling introduction of 20 mph zones across Rotherham and the Crucial Crew programme to be delivered to all Key Stage 2 children across Rotherham
- Suicide – implementation of the actions in the Rotherham Suicide Prevention and Self-Harm Action Plan. Suicide prevention training will form part of the emerging Workforce Development Strategy

So What Factor?

- Suicide
  Rotherham Suicide and Self-Ham Action Plan – The Rotherham Suicide and Self Harm Community Response Plan (2015) provided a co-ordinated approach to postvention support
- Suicide prevention training as part of Workforce Development Strategy
  Staff felt better equipped to support young people who may be in distress and/or expressing thoughts of suicide
  Children and young people received timely and appropriate support when bereaved by suicide or sudden death
- Social market campaign
  Comprehensive and reliable information on a variety of mental/emotional health topics including self-help guidance for young people, parents/carers and practitioners (My Mind Matters)

Chapter 6 – Cross cutting projects/transformation

- Child and Adolescent Mental Health Services - Schools taking part in a 'whole school' pilot approach to emotional health and wellbeing and mental health to share their learning with their school cluster group. Further CAMHS Transformation funding to have a strong focus on early intervention and prevention
- Special Educational Needs and Disabilities - The development of a joint SEND Education, Health and Social Care Assessment Hub

So What Factor?

- Public Health were supporting the Child and Adolescent Mental Health Services (CAMHS) Transformation and were leading the area of work relating to early intervention and prevention and workforce development
- The 'whole School' project to improve the emotional wellbeing and mental health of children
  Improve resilience, took a holistic approach to welfare and enabled children and young people to manage their emotional wellbeing and mental health in order to allow them to learn, develop and fulfil their potential

Update on the 2014 Director of Public Health Annual Report

- A full breakdown on the achievement following last year's Director of Public Health Annual Report were included at the back of the report including:-
  The published 2015 Health and Wellbeing Strategy
  The continued commissioning of NHS Health Checks

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

- How was Public Health engaging with schools? The Authority should be proactive with the schools that had indicated they were to transfer to academies and discussing with the Governing Bodies
  Engaging schools in a systematic way was extremely challenging. Meetings had taken place with Early Help and with CYPS Directorate Leadership Team as to how to engage further with schools. Work was taking place through the Healthy Schools Lead. Health issues could be explored at the CYP Partnership (which had Head Teachers' representatives) and at Head Teachers meetings. There were some great relationships and examples of good practice drawn from other areas and within the Borough but creating consistency was challenging

  A discussion was also to take place with the Strategic Director about the 0-19's and how to move forward with a systematic approach between Public Health/CYPS/schools. It may be the Elected Members who were School Governors could influence their Governing Bodies to understand the schools' role in health improvement with the community they served.

- Was Public Health able to access the information contained within the schools?
  Public Health attended meetings within schools for a range of issues some of which were discussed in the annual report. In the past the local level data has been provided to schools on the key health issues and interventions that schools could engage with or put in place to contribute to improved health outcomes. Specific data either came from local data that was submitted to Public Health or national data

  The national Public Health Outcomes Framework (PHOF) provided health data relating to specific health targets/measures. This data could be used and analysed to provide schools with an overview of the health issues related to their communities. Local data also came from GPs/Health Visiting/Midwifery/School Nurse records and the Lifestyle Survey

Chapter 1

- Do we know the impact E-smoking has to babies in pregnancy?
  This was an area being researched and further evidence was emerging all the time. Many people were using e-cigarettes as a safer alternative to smoking yet little was known about how safe e-cigarettes were

- It states that the number of deaths from SIDS had increased from 2012/13. What had the figure gone up to?
  The number of deaths were small and prone to fluctuation (five or six cases p.a.) so an increase by one or two cases meant a large percentage change. What had been noticed was that when there had been safer sleep interventions and a training programme for frontline staff, the number of deaths reduced in the following year. However, over time those interventions and messages got lost and the death rates appeared to increase again. The plan was to provide a rolling programme of sleep safe training to Health, Social Care, Early Help Teams. It was hoped to also offer awareness sessions to other key frontline services including South Yorkshire Police, South Yorkshire Fire and Rescue to ensure a consistent message was given to families across the Borough.

  The Child Death Overview Panel reviewed all child deaths in the Borough and part of the SIDs and safe sleep work was a key action plan to roll out and ensure the message remained on people's radar. It was not just a case of doing a paper assessment but for agencies to go into the homes and see where people put babies to sleep to ensure a full assessment. It was quite a simple but important and effective checklist. It was key to some of the work that would be carried out going forward

- There was a perception amongst health professionals of the increase of Vitamin D deficiency in Rotherham. How would the robust pathway be implemented when there was no data and why was there no data?
  Public Health used proxy measures from other areas such as Bradford who had received funding to carry out additional research and also from talking to health professionals. Additional blood tests could be carried out in order to obtain a baseline but the focus should be on increasing Vitamin D across the population rather than carrying out blood testing. Rotherham midwives would be proactive and talk about the importance of maternal vitamins, including Vitamin D. It was hoped to find ways of working more proactively with Children Centres particularly targeted work on maternal vitamin D on and promoting that at every opportunity. Midwives would be discussing it face-to-face with Mums

- Rotherham was significantly adrift from the national breastfeeding average statistics. What was Rotherham's approach to improve the situation?
  Rotherham had historically struggled to increase breastfeeding rates in line with national average as there was a prevalent bottle feeding culture. Areas that had improved their breastfeeding rates had adopted the Unicef Baby Friendly Initiative (BFI), a low level criteria, evidence based approach to make sure that everyone was skilled-up e.g. Health professionals to support women, and that women were aware and fully informed about the benefits of breastfeeding to make an informed choice. Rotherham had struggled adopting the initiative in the past. There was now a Community Breastfeeding Co-ordinator to deliver this agenda (available to all Community Health Nursing Teams and Children's Centres) as well as a Hospital Breastfeeding Co-ordinator. Rotherham did have a heavy bottle feeding culture and that had to be addressed by all partners. There was also Rotherham Breast Buddy Peer Support Service, a volunteer service that operated very effectively in Rotherham doing a significant amount of work in raising awareness of breastfeeding

- The Authority needed to be much more proactive and opportunistic of anything happening nationally with regard to breastfeeding
  There was a much more proactive approach between the Council and Health Communications Teams particularly when there were national campaigns

- Rotherham was to take the consistent approach of 'No Alcohol equals No Risk" message with regard to alcohol in pregnancy. Was there any evidence/arguments that you relied upon to make it the better advice you followed?
  It was felt that the safest message was to say 'no alcohol equals no risk' as some people were more susceptible to FASD than others and there was no way of testing or measuring the risk. From a foetal developmental point of view, it was much safer to advise no alcohol. Areas that had adopted this approach had found it much clearer for all

women to adopt this message rather than thinking they could have the odd drink. There were cases where just a small amount a week had resulted in harm.

- Was there any specific data in Rotherham on how the Authority compared with the national average with regard to Foetal Alcohol Syndrome Disorder (FASD)?
  FASD was very difficult to diagnose as like many syndromes and disorders there was a spectrum of severity from mild to more pronounced/severe and in some cases it was difficult to distinguish FASD from other conditions and disorders. FASD testing was a complex process

- What measures were required to make breastfeeding more acceptable in public places?
  Public Health had historically run some promotional campaigns about breastfeeding in public and there was a breastfeeding friendly award that a number of local businesses and cafes had signed up to. Women could find out via the Council's website all the public places that had signed up to the scheme. However, there was still work to be done, to be picked up through the Rotherham Breast Buddies Service

- Was there a clear definition of the situation with breastfeeding in areas of deprivation across the Borough and whether that coincided with health problems later in life?

  The PHOF could provide health profiles that identified the top key health issues that affected different areas in the Borough. Health profiles had been used in school catchment areas and Children's Centres. Equally the Public Health analyst could provide information based on the specific super output areas and areas of inequality across the Borough. These provided a guide to the main health concerns and could be shared with the Select Commission together with a number of websites that could provide very specific health data by area

  After the meeting further information was provided:
  We have not tracked locally to see if low levels of breastfeeding have impacted on health. However national data on the benefits of breastfeeding in the long term has a very strong evidence base. Breast feeding has many benefits for mother and baby. It is known that breastfeeding reduces the risk of some breast cancers and ovarian cancer. For baby it protects against SIDS, gastroenteritis, Type I and Type II diabetes and obesity.

Chapter 2

- What work has been done in the local area with regard to pornography and its damaging impact on young people and on their views of a sexual relationship?
  There had been a number of national campaigns and TV advertising that had raised this issue and provided advice and helplines. There had also been local school initiatives that had aimed to educate young people about healthy relationships as part of local school education provision around healthy relationships and sexual relationships. National data had been aggregated to the local population to give an idea of what the situation looks like locally. There were a number of organisations, including the NSPCC, that went into schools to educate on this issue as well as a local volunteer group

- With regard to domestic abuse within couples, did the prosecution have to be taken by the person who had been abused or could the Hospital/Police prosecute without their consent?
  A prosecution would be based on the evidence to the Crown Prosecution Service but it was possible that if Services had their suspicions it could potentially contribute to a decision whether to prosecute. There were occasions when the Police had sufficient evidence despite the fact that a woman did not feel confident to proceed with prosecution

- How can you encourage primary schools to deliver sexual education to Y5 and Y6 aged children?
  It was not mandated nationally that schools provide sexual and relationships education. It was a case of working with schools and the CYPS Service to persuade them of its importance. The influences that the Local Authority had over schools had changed. The desire would be for the Government to revisit the issue and make certain key areas mandatory that needed be covered. Currently some schools held a couple of awareness days a year which was probably not the most effective way of engaging with children young people

  Primary schools were still very good at their offer; obviously there were still inconsistencies across the Borough but a lot of that was with regard to training need and confidence of staff in getting the message across. Recently the issue had been put back to the Education Department stating that they needed to mandate this issue. The Personal Social and Health Education Union had submitted to say that this subject area needed to be mandated but it had been refused again and similarly for Sexual Relation and Health Education

  Video gaming was a huge problematic issue with regard to explicit content. Significant work had been undertaken by RMBC officers ~~on~~ working with parents and educating them on what was involved in the computer games as they were not aware of the sexual and violent content of the games. A fantastic video clip had been produced that really got the message over which was being promoted to

parents/families and community groups and school were embracing it as well

- What was the future of the Family Nursing programme in Rotherham? It was understood it was being decommissioned in Doncaster, Barnsley and Sheffield
  The 0-19 programme was out to tender at the moment. Rotherham had included the objectives of the Family Nurse Partnership within the tender but the tender did not tie in providers so that they had to buy the licence for the Family Nurse Partnership. The outcomes and learning were still included as requirements of the specification. This approach attempted to address the key advantages of the Partnership within the specification but to free the provider up, from the point of view of efficiencies, of not having to buy the licence. This was different to what other areas had done

- Do you think that would impact on the good results that it had been having?
  At this stage it was too early to say. It may provide an opportunity for bigger caseloads but may enable groups that perhaps did not meet the FNP threshold criteria. It could offer better support for a larger proportion of the population and it might mean freeing up Health staff from other Health teams to offer that level of support

- What work had been done to try and close the gaps between boys and girls in the development stages when leaving Foundation and going into Y1 and the children in receipt of free school meals and priorities to improve that?
  Feedback would be provided

Chapter 3

- Given the levels of deprivation within the Borough it was disappointing that there was not 100% take up of Free School Meals in Primary schools

- Children were allowed to choose what they ate for their School meal. Did any monitoring take place of the children's choices?
  The School Meals Service would be able to provide the information. The children did have a choice and often would choose the same meal as their friends.

  In terms of the take up of Free School Meals, there was a stigma attached to accessing them. In secondary schools it was less of a problem as they tended to operate a card system

- Was it not time cooking from scratch was introduced to secondary aged children?
  It was again a case of whether it was a mandated part of the curriculum. There were also issues for the schools regarding resources and space in schools with some not having a kitchen and

having the meals brought in. There had been a number of rolling skills interventions delivered across the Borough e.g. 'Let's Get Cooking' adopted by some schools. For the more vulnerable families, Family Support Workers had provided cooking skills support as part of their support interventions

- What was being done to improve uptake of Free School Meals especially at the universal level? Was there anything where people went into school and told the children about the nutritional value of food and to encourage them to make healthy choices?
  There was nothing universal but there were trainers in the Dietetics Service that conducted training for teaching and support staff in schools; to go out to all schools would be quite a challenge for any professional group so this work was mainly targeted. The Healthy Schools Service did have a resource pack for schools on healthy eating that could be delivered as part of the curriculum and there were resources that schools could access and that were promoted. It was acknowledged that there could be closer working with the School Meals Service

- There were some excellent examples of good practice. A local school promoted healthy eating and had a cooking club. They invited parents to school dinners. All the menus were sent home every week so parents could be involved with influencing choice
  Anston Greenlands had a "Let's get Cooking" programme and had received funding through this national initiative to deliver it. The funding had ended but the School had maintained the legacy. A number of schools offered taster days as quite often parents remembered schools meals from their own school days and assumed that they were still the same

- Sugar labelling was incredibly important. People's food habits had changed and people had less time. There was a national campaign to introduce really clear labelling. Could Rotherham get behind the national campaign?
  Across the Yorkshire and Humber region this was something that was being looked at as a partnership and having local action plans to address this very specific issue

  The Public Health Responsibility Deal – the Government had decided to make this voluntary rather than statutory and something that Directors of Public Health were still pushing i.e. did some need to be made mandatory. Debate was still taking place within Central Government and on the agenda when discussions were held with Ministers

- Was there any information as to whether Academies met the national school food standards?
  The information included Academies as it related to who was providing the service for School Meals and generally many local

Academies had continued to choose the services provided by the Local Authority

- If a pizza restaurant closed would it be able to re-open as a fast food takeaway?
  This was considered by the Licensing Section. It was hoped to prevent further approvals but it was difficult

- Who was the Primary School/PE Officer?
  This was a new post with the postholder newly recruited. Details would be forwarded

- It was very sad to see the statistic of Rotherham being 10 times worse than the national average for its 5 year olds with regard to decay and missing fillings
  Recent figures showed an improved picture of a decrease from 44% to 28.9% for 2014/15 of children (aged under 5 years) with 1 or more decayed/missing teeth/filled teeth. This brought Rotherham more in line with the national average. The validity of the data was being investigated to ascertain why it was significantly different from previous years. It could be the fact that a lot of schools and Early Help providers (namely Children's Centres) had done significant work on sugars in food and drink with families. Also the Oral Health Team had done a significant amount of staff training and rolling out interventions such as tooth brushing clubs

  Public Health had a new Oral Health Strategy and the Service Specification for the Oral Health Team been refreshed. Due to capacity, work had had to be targeted and this had meant that the Service was not universally promoted. Universal Health Services such as the Health Visiting Service had tooth brushing packs which were distributed as part of the early weaning contacts and parents were given a toothbrush and toothpaste suitable for their child's age

- Was there still a relationship with RUFC and the Rugby Club in terms of sport?
  There was a co-ordinated approach with the Rugby Club which had a range of interventions and initiatives. The Rugby and Football Clubs had some really fantastic facilities and alternative education programmes

  Could the School Dentist be reintroduced?
  It would be quite difficult to do that on a local level. Families were encouraged to visit dentists with the onus upon them to access the services on the high street

Chapter 4

- The report stated that Rotherham was making good progress on the delivery of CAMHS Transformation Plan. When was it expected to see the waiting list reduce?
  Part of the review was to look at the whole provision i.e. from the universal offer provided by Health Visiting and School Nurses Services. There was a lot of work to do across the pathway to make sure children and young people are identified as early as possible to ensure support was put in place that was robust and effective. Waiting lists remained a concern and RDaSH CAMHS were working on this issue

- How many years of funding did the Theatre in Education initiative have?
  Potential funding pots would become available which the Service could access

  58% of young people were obtaining alcohol from family with their knowledge. Did that include the legal amounts of ½ lager with a meal?
  Feedback from families indicated that they would rather provide their children with alcohol (in some instances) to have influence over what and how much they were drinking. It would be a combination of whether children accessed it from family with consent and also inclusion of legal consumption at family meal times. The information was from the Lifestyle Survey so it was not unpicked to provide this level of detail. It was not thought the question of how much alcohol they obtained without parents' knowledge was asked within the Survey

Chapter 5

- There had been a number of suicides/attempted suicides in the Wickersley area. CAMHS had been found to be lacking and there was concern about the restructure and what it would deliver; when you had someone who was self-harming and suicidal a 3 week delay in accessing help was not acceptable. It was felt that the Select Commission should be kept updated/monitor progress

  After trying to talk to Rotherham School Heads about their response to suicide for approximately two years, Rotherham Public Health and Educational Psychology have run one training session informing them of Rotherham Suicide and Self Harm Community Response Plan, the support which was available and their responsibilities. Only one-third of schools attended the session in April and another session had been scheduled for September 2016

  The majority of people who died by suicide in Rotherham and nationally were middle aged men and a new programme was to commence shortly.

After the meeting further information was provided:
During the period 2011 to 2014 there were two deaths of young people to suicide in the Wickersley area and a serious suicide attempt as highlighted in 'An Independent Review of Actions Taken Following a Group of Suicide Events in Rotherham' 2015. Partners who worked together on this at the time had to do so in the absence of any national guidance. Local guidance was written at this time. This guidance document was called the Rotherham Suicide and Self Harm Community Response Plan

RDaSH CAMHS were involved in providing support. Those people interviewed for the Independent report felt that the response given by CAMHS and Social Workers at the time was excellent. However, there have been concerns generally about the waiting times for young people to be seen by RDaSH CAMHS

RDaSH CAMHS were now at the end of their re-organisation process and had had a recruitment drive with most staff now in post. The new structure had Locality Workers who would be responsible for a number of secondary and primary schools. They would be a point of contact for schools providing support and consultation

- Concerns were raised about self-harm. Did a Mental Health Nurse go into school very regularly to support the School Nurse? What assessments did they use and what treatments did they receive when they progressed forward for treatment?
  It would depend upon the individual case presented but it would be a combination of cognitive behavioural therapy and counselling. Young people through the CAMHS Services would have a designated Mental Health Worker who would provide key work and may support the School Nurse if a partnership approach was taken and agreed. School Nurses were generally there to support young people but to refer them on and support them while waiting for more specialised services

  It was important that communities, the public and all partners learned about early warning signs. There was Mental Health first aid training and youth mental health first aid training to train community lay members, Health staff as well and other stakeholders

- Did they look at family history and higher risk of suicide and mental health problems?
  Yes it was included in the assessment process. A pathway had been put in place, in the cases of someone who had been bereaved by suicide, there was a significant action partnership approach in place to ensure that person received ongoing monitoring

  It was also noted that with many people there were no advance signs that they were at risk of dying by suicide. It was important that young people and children were encouraged to express their feelings

Chapter 6
Written questions had been received from a Select Commission Member who had submitted their apologies. These would be forwarded to Terri Roche and Anna Clack and ensure that the answers be circulated.

Members made a number of suggestions, summarised below:

- Links with Area Assemblies, including on good practice
- Focus on outcome reporting not processes/actions
- Capitalise on national campaigns and TV advertisements to get key messages out locally, including in The Advertiser, and by tailoring materials to Rotherham e.g. re breastfeeding, impact of pornography
- Being more proactive with schools when they are first talking about becoming academies, getting in early to influence their governing bodies and maintaining an ongoing relationship once they had left LA control
- Checking what schools did to encourage students to make healthy choices for meals/challenge what they select
- Success stories from young people to share with their peers e.g. weight loss
- Share good practice from Anston Greenlands regarding school meals
- Food labelling for sugar and spoons of sugar – scope for a possible local initiative? (Members made the link to the oral health statistics)
- Focus on issues where Rotherham is significantly below national averages
- Raise awareness with targeted schools on available resources for oral health
- Try to achieve 100% take up of free school meals in primaries

Resolved:- (1) That the Select Commission note the report.

(2) That the Select Commission support the recommendations in the report and seek further feedback on the progress made in the detailed action plan.

(3) That a response be supplied to the outstanding issues raised at the meeting.

(4) That the Council lobby the Government regarding mandatory PHSE/sex and relationships education and seek to influence the South Yorkshire and Humber Directors of Public Health Forum to lobby the Government on these issues.

6. ADULT SOCIAL CARE - PROVISIONAL YEAR END PERFORMANCE REPORT FOR 2015/16

Nathan Atkinson, Assistant Director Strategic Commissioning, and Scott Clayton, Interim Performance and Quality Team Manager, presented the Adult Social Care provisional year end performance report for 2015/16.

It was important to note that 2015/16 had been a transitional year where the Directorate had been seeking to change the existing customer journey and business processes in order to improve the customer experience and deliver better personalised outcomes. The results over the performance areas included in the report to date had been positive showing improvements in many Indicator areas.

19 of the 22 ASCOF measures were showing improvement which included 100% (7 of 7) User Survey measure results. 50% (11 of 22) 2015/16 targets were being met including 71% (5 of 7) User Survey.

2015/16 was also the second year of the new national Short and Long Term (SALT) reporting annual return and the Council's initial draft year-end figures provided a useful first insight to Adult Social Care performance. However, they were subject to change following national ratification of local partner data (RDaSH Mental Health performance) and Health partner submissions.

Discussion ensued on the report and appendix. The following issues were raised/clarified:-

- There had been a lot of Senior Management change. What was your approach and how were you going to manage the basic performance during the change that was only half way through?
  It had been made clear that the programme of change had been set and any new appointment would have to follow that direction of travel. The strategic direction that had been set was very sound and a sensible approach. The development plan was an operational model so it was imperative that the 2 were brought together and ensure there was continued performance. The measures contained within the report were national measures and there was a mandatory requirement to provide that information which tended to focus on the basics of the business that could not be lost sight of

  The report compared last year's performance with the previous year's and showed that 86% of the measures had showed some improvement. Although some of the improvement was very small it was reflective of what the programme acknowledged in terms of change and the need to be able to sustain performance. Whilst showing improvement, only 50% had managed to hit their target. This would be fed into this year's target setting

- What is your top priority?
  The top priorities were the safety and quality of services for Rotherham residents. In terms of performance measures, the priority would be permanent admissions to residential care for people aged 18-64. There was a much higher number of people in residential settings in Rotherham than other parts of the country where there was more focus on supported living community/based setting. It was a big challenge for the Service to maintain the direction of travel contained within the Strategy to move people away from the very traditional model of provision which was not always appropriate for everybody

- What had been the main services which had seen an increase in requests and how had the increased demand been met?
  There was no information but it would be forwarded.

  However, it was indicative of what the Service area were saying. Historically there had been very high numbers of people contacting the Service and, once they went through into the assessment and referral process, had a support package and at that point became long term and stayed with the Service. It was the intention to change that and where possible signpost/direct clients to other ways of having their needs met so that less people were brought into long term services or alternatively, in terms of trying the short term maximisation of independence e.g. enabling, being more successful to turn support for those people around quickly and negate the Council having to put long term packages of support in to maintain their independence

- What where the issues around funding for Continuing Health Care (CHC) and was it not something that could be addressed through the Better Care Fund and pooled budgets for Adult Social Care and Health?
  Whilst there had been a higher number of admissions than in recent years, it was still relatively low. The target had been 18 and there had been 29 but analysis had identified that when clients' funding streams were reviewed, the CHC was not being continued 100%; once that funding arrangement dropped below 100% the Council had to pick up some of the funding arrangement. From the Indicator point of view that person may well have been in that permanent admission for some time and not necessarily at the point that the funding ceased but had to be counted as a new admission

  The Service was now trying to ensure attendance at the reviews and where possible, if the need was still there, trying to secure the continued funding and, therefore, averting the need for the Council to contribute to the support package

- The rankings gave relative positions but how wide was the gap percentage wise for some Indicators where Rotherham was lowly ranked and where it was ranked first? It would be helpful to see both ranking and percentage score for each local authority?

Some of the annual returns had only just been submitted so, whilst Rotherham's performance was known, the performance of the other South Yorkshire and Humber (or the national picture) was not known. The information would be published around October/November and at that time there would be the ability to compare if Rotherham's relatively improved performance was mirrored, keeping pace or falling behind. Once that data had been received a further report would be submitted

- How would the Services manage poor performance as they continued to undergo transformation and change? It was important to be able to identify where poor performance was and how quickly the Service was able to react to make sure the measures were put in place which improved performance as well as communicating to the people within that as to what it was doing?
  Key Performance Indicators should not be relied solely upon but around the more granular intelligence and the information that came out of discussions with the end users of the services/carers/families linking in with the staff. The voluntary sector had a role to play as well in raising issues and challenging the Service. In terms of the performance approach, there was a need to capture as much real time information as possible which gave a retrospective perspective

- On the scoreboard (1) Adult Social Care 18.8% ranked 13, (9) Mental Health Services and Employment 5.27% ranked 14, (12) Service users having enough social care as they would like 46% ranked 13, 26% of services who felt safe 66% ranked 15. Could a response be provided as to how they would improve and what measures would be put in place?
  A written response would be provided

- Concern regarding the method of collating the data and the consultation
  The ASCOF measures were set nationally. It was survey based that all 152 councils were mandated to undertake and technically stipulated how it would be undertaken. In terms of the Council's annual user surveys, they had shown an upswing in terms of satisfaction and overall improvement in those areas but the user perception was a snapshot of that moment in time and did suffer a swing of opinion from the time the survey was conducted

- The Commission would appreciate an overview of the performance measures and targets set for 2016/17
  The priority set for the year end report had been around the national measures but the Service also undertook the setting of 2016/17 targets. Once agreed by the Directorate Leadership Team they would form part of the regular reporting which would run alongside Q1 and national Indicators

- Do you concentrate on the level of complaints that come in or go to Stage 2 as an Indicator?
  Under the current structure, Complaints was a separate team and had its own annual report and regular reporting mechanisms so would not necessarily be included in the Adult Social Care performance report. These were reported to the Overview and Scrutiny Management Board.

Councillor Roche, Cabinet Member, reported that at the last Health and Wellbeing Board there had been a presentation of a national initiative "Sustainability and Transformation Plan". In this area it included South Yorkshire and Bassetlaw. The key aim of the national funding was to reduce hospital admissions. The Select Commission may wish to receive a presentation on the Plan at some point. The Board was very conscious that the Plan did not sufficiently talk about intervention and prevention. The more transformational the Plan was, the more money that could be drawn down. Now was the time for the Council to become involved in persuading partners to put that stress on prevention and intervention to reduce hospital admissions.

Resolved:- (1) That the provisional year end performance results be noted.

(2) That a further report be submitted showing final submitted results and benchmark comparisons against regional and national data.

(3) That a report be submitted on the local measures for the Select Commission's next meeting.

(4) That a response be supplied to the outstanding issues raised at the meeting.

7. MEMBERSHIP OF QUALITY ACCOUNT SUB-GROUPS

Janet Spurling, Scrutiny Officer, reported that, as happened last year, Sub-Groups, to include all Health Select Commission Members, would be established to consider the Quality Accounts for the three NHS Trusts – The Rotherham Foundation Trust, RDaSH and Yorkshire Ambulance Service.

The Chair will lead on TRFT and RDaSH and the Vice-Chair on YAS.

Resolved:- That the Scrutiny Officer circulate an initial draft ensuring a balance of newly elected and longer standing Members, and political and gender balance, across all 3 sub-groups.

8. MEMBERSHIP OF THE HEALTH, WELFARE AND SAFETY PANEL 2016/17

Resolved:- (1) That Councillor Sansome represent the Health Select Commission on the Health, Welfare and Safety Panel for the 2016/17 Municipal Year.

(2) That the appointment of a substitute representative be deferred.

9. RDASH ADULT AND OLDER PEOPLE'S MENTAL HEALTH TRANSFORMATION UPDATE.

The Select Commission noted a report setting out RDaSH's Rotherham Transformation update.

Janet Spurling, Scrutiny Officer, reported that the final decision would probably be made in July and discussions would take place with RDaSH to ascertain which model had been agreed.

10. TIER 4 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES COMMISSIONING.

The Select Commission noted a letter received from NHS England dated 3rd June, 2016, regarding Child and Adolescent Mental Health (CAMHS) Tier 4 Services in Yorkshire and Humber.

11. HEALTH AND WELLBEING BOARD MINUTES

The minutes of the Health and Wellbeing Board held on 13th January and 24th February, 2016, were noted.

12. HEALTHWATCH ROTHERHAM ISSUES

No issues had been raised.

13. DATE, TIME AND VENUE OF THE NEXT MEETING AND FUTURE DATES FOR AGREEMENT

Resolved: - That future meeting dates take place on: -

- 28th July, 2016
- 22nd September
- 27th October
- 1st December

Briefing paper for Health Select Commission **28 July 2016**

Transforming Rotherham Adult (18+) Mental Health Services

Introduction
Rotherham, Doncaster and South Humberside NHS Trust (RDaSH) have worked closely with health and social care partners and stakeholders in Rotherham to review how Adult (18+) and Older People's mental health services are delivered, to improve the patient/service user experience and to achieve cost efficiencies.

Approach
The work has been carried out in two phases. Phase 1 has been completed and includes the following workstreams:

- Mental Health Hospital Liaison Service – between RDaSH and A&E
- New dementia pathway – to enable diagnosis in primary care
- IAPT – Improving Access to Psychological Therapies – Key performance indicators (KPIs) for waiting times now being met and further changes are being progressed
- Mental Health Social Prescribing
- *Carer Resilience (not an RDaSH project) – in GP practices*

Phase 2 is "Moving Forward Together: To work in partnership to provide an accessible and responsive mental health service." The Clinical Commissioning Group and RDaSH are working closely with RMBC and health professionals to explore the potential for shared services, such as a Rotherham Hub as an initial single point of contact, and co-location of services.

Engagement and evolution of the model
RDaSH have held a number of public engagement events during 2015-16 to discuss the proposals as they have evolved and been informed by consultation and feedback. This has culminated in the recommendations for the future service set out in the attached paper.

HSC received a paper and presentation outlining three initial options for the future service model (see below) at its meeting on 17 December 2015. Each had their own pros and cons but after discussion Members supported option 3, the needs-led community based approach.

1. Community Mental Health Teams - ageless (18+) locality based teams with borough wide front end and specialist services
2. Working Age Adult Locality Model with Centrally Based Older People's Team working into localities
3. Needs Led Community Based All-Age (18+) Pathway Model

Since then the model has developed further and HSC received an updated version in the agenda papers on 16 June 2016. Further work has resulted in the latest recommendations.

Recommendations
Members of the Health Select Commission are asked to:

1. Consider and discuss the recommendations for future services.
2. Submit any comments to inform the final model which will go to the RDaSH Trust Board for approval.

Briefing note: Janet Spurling, Scrutiny Officer janet.spurling@rotherham.gov.uk

Rotherham Doncaster and South Humber NHS Foundation Trust

Recommendations for Transforming Rotherham Adult (18+) Mental Health Services

Debbie Smith

Service Director Mental Health Services and Transformation

Version 2 July 2016

RDaSH leading the way with care

Corporate Services

Executive Summary

1. **Purpose**

The purpose of this paper is to outline the recommendations for the reconfiguration of Rotherham Adult (18+) Mental Health Services to inform commissioner governance processes and the RDaSH Trust Board decision making process.

2. The Case For Change

The case for change has been set out in previous transformation documents. It is based on the national and local direction of travel and specific feedback from stakeholder events captured in the Trust's change principles.

The case for change is based on three pillars:

i. **Good Practice** Clinical and research evidence in both mental health and social care increasingly supports a prevention, recovery and wellbeing approach, demonstrating the benefits to both patients and the wider system of supporting service users to live as full and independent lives as possible.

ii. **Stakeholder views** At an operational level stakeholders have expressed a consistent need for:

- a place based model where care is delivered closer to home
- timely access to services with clear routes in
- removal of artificial barriers such as age and narrow cluster based structures
- a reduced number of assessments
- named contacts

iii. **Efficiency and Effectiveness** it is no longer possible to deliver effective services whilst achieving the required efficiency savings by piecemeal change

Taken together, these factors require a fundamental change in how we approach and deliver our services. The recommendations set out in this paper aim to move us from patient care based on service models to a patient needs led model to enable patients to live as full and independent life as possible.

We recognise that efficiency savings are required across the system and that if each part of the system takes out costs independently there could be a negative impact on patients, carers and other providers. These recommendations have therefore been developed following extensive engagement with primary care, social care and the third sector as well as patients and carers to ensure we work together constructively to achieve the best possible outcomes for all our service users without 'passing the buck'.

3. What does this mean in practice?

3.1 **Change of mindset** a needs led patient centred approach needs a different relationship with patients, carers and providers. We need to re-think how we work together within RDaSH and the wider health and social care system. These changes will require cultural change as well as changes in practice.

3.2 **More flexible allocation of resources** to enable care to wrap around the patient

3.3 **Improved flow** freeing up capacity to provide a more robust front end service to reduce the overall numbers entering secondary services /being admitted and the length of treatment/stay.

3.4 **Specialisms** ensuring professionals work within their professional training, maintaining and continuing to develop expertise to meet patient needs and deliver the new ways of working

4. How will this be achieved?

4.1 **Pathway Framework** A new pathway framework is proposed, informed by NICE guidelines, with three clinical streams:

i. assessment and brief intervention at the front end to provide a rapid response and the capacity to offer a limited number of interventions for those in immediate need or who would benefit, reducing the numbers requiring secondary care

ii. an MDT approach to complex care management for higher intensity, higher risk patients

iii. a less medicalised model for longer term recovery and wellbeing for those with more enduring needs

4.2 **Multi-disciplinary working** across RDaSH specialisms and social care which can be extended to include physical care working closely with primary care

4.3 **Re-configuration of services** to include:

i. First point of contact and triage service, hosted by an established provider such as the Care Co-ordination Centre for economies of scale

ii. Crisis and rapid response

iii. Two balanced locality based teams, aligned with social care

iv. Borough wide teams, working and reporting into localities

v. Integrated social care, initially for working age adults, across all pathways with the aim of extending to older people and learning disabilities.

5. What will be different?

Patients will be encouraged and supported to live more independent lives. They will receive the care they need according to their individual circumstances, delivered closer to home where possible.

The system Over time there will be an overall reduction in those entering service and length of time spent in service. The improved flow will reduce waiting times, inefficiencies and cost.

Efficiency savings Targets have been set across a number of areas. This paper addresses clinical savings. It is projected that the 2016-17 clinical savings will be met from the management re-structure and some targeted savings. 2017-18 clinical savings will require closer integration of services across the care group including a review of clinical and administrative roles and responsibilities once the care group has been established. There is currently a critical dependency between mental health and social care funding of roles.

6. Transition

Transition will require strong clinical and operational leadership and management. If funding were available the transition period can be facilitated and speeded up. However, given the required saving requirements transition will need to be managed over a period of time and it will take longer to realise the benefits. A trajectory will be developed.

7. Future Development

Further development work is required with patients, carers, primary care and the voluntary sector to ensure there are clear, workable routes into service as well as robust routes back in for discharged patients who require specialist support.

The recommendations have been developed in parallel with and informed by the Integrated Locality pilot which RDaSH is a proactive part of. The approach outlined above could easily be built upon if the pilot is rolled out.

Recommendations for Transforming Rotherham Adult (18+) Mental Health Services: A More Detailed View

1. Purpose

The purpose of this paper is to outline recommendations for the transformation of Rotherham adult mental health services in line with the Trust transformation principles. This paper is for consideration by the Trust and Stakeholder transformation groups in order to inform service configuration recommendations to the Trust Transformation Board in July 2016. The outcome from this phase will inform the management and operational structure. A formal consultation process will be held with the affected staff group in the autumn, according to the Trust's change policy.

The proposals have been developed through three rounds of engagement activity in Rotherham. This has included over 20 stakeholder events including patients, carers, commissioners, multi-professional RDaSH, RMBC and TRFT groups and the voluntary sector. RDaSH have carried out two rounds of conversations with GPs through locality meetings as well as on-line surveys. Discussions have also taken place across the wider Trust, the CCG's Systems Resilience Group, NHS England and RMBCs Scrutiny Committee. More detailed work is on-going, with further activity planned using Listening into Action methodology.

2. Scope

This paper relates to the Rotherham Working Age Adult (WAA) and Older Peoples (OP) Mental Health Services. Transformational change is in progress in Learning Disabilities and CAMHS with Drug and Alcohol Services coming up for re-commissioning. These various threads will be pulled together into a coherent approach under the new care group structure. All areas are represented within current governance arrangements to ensure proposed changes are aligned and join up where appropriate.

3. Aims and objectives

The Trust's transformation vision is to provide all age care (18+) which is delivered in an integrated way, ensuring patients receive care close to the community in which they live and empowering our staff to work innovatively to deliver quality services

The key themes that have consistently emerged from internal and whole system engagement events are:

- **Access to services**: clear routes in, with named contacts and services that are close to home
- **Assessment**: effective (including timely) assessment and signposting (utilising the whole system, i.e. the patient's own networks, health, social care and voluntary & community sector), reducing the number of assessment points
- **Removal of structural barriers**: patients are currently fitted into existing services rather than care being provided according to patient need. Services based on age and cluster re-enforce this
- **More effective use of resources** across the whole system, including developing opportunities to utilise professional specialisms through multi-disciplinary working and more effective partnerships with the primary sector, social care and voluntary and community assets

4. Rationale for the Proposed Changes

Currently both health and social care are largely based on the premise of what services can provide for service users, channelling the person down particular cluster based pathways, rather than formulating a response based on the needs of the person seeking help. There is clear evidence that patients are being brought into secondary services when more appropriate alternatives exist and that many are staying in service for long durations, creating dependency. As a result services have become log jammed. New people in need are not getting help in a timely way and long term service users are not being supported to live the best life they can. This is costly for both patients and commissioners.

The proposed changes therefore aim to:

1. work in partnership within the Trust and wider system to provide care which is patient focussed and needs led, to improve the patient experience and outcomes
2. deliver a prevention, recovery and well-being approach which enables service users to live as full and independent life as possible
3. provide a clear framework for pathways which wrap care around the patient supporting their needs, and enabling them to access the support they require as close to home as possible
4. improve access to services, with an integrated approach to assessment, reducing duplication
5. enable service users to move through services and into recovery/wellbeing without being blocked or delayed by structural boundaries
6. ensure our mental health provision is safe, effective and delivers the required efficiency savings

5. Pathway Framework

5.1 Aims

A new pathway framework is proposed to address the issues outlined above and improve flow through the system. The framework provides:

i. a means to wrap care around the patient, utilising a prevention, recovery and wellbeing ethos
ii. a formulation tool for use by all professional specialisms which facilitates patient ownership and follows the patient through their journey
iii. an MDT approach, including social care, which removes age and cluster divisions, whilst defining specialist roles and responsibilities, knowledge and expertise

5.2 All-age in Practice

Whilst there is a commitment to removing artificial age barriers it is important to recognise specific needs of older people. The Faculty of Old Age Psychiatry developed guidance in 2014 for old age psychiatry services for the Royal College of Psychiatry. Noting that 'Restricting access to a service by age alone is not logical and now probably unlawful in the UK' they developed the following needs based criteria:

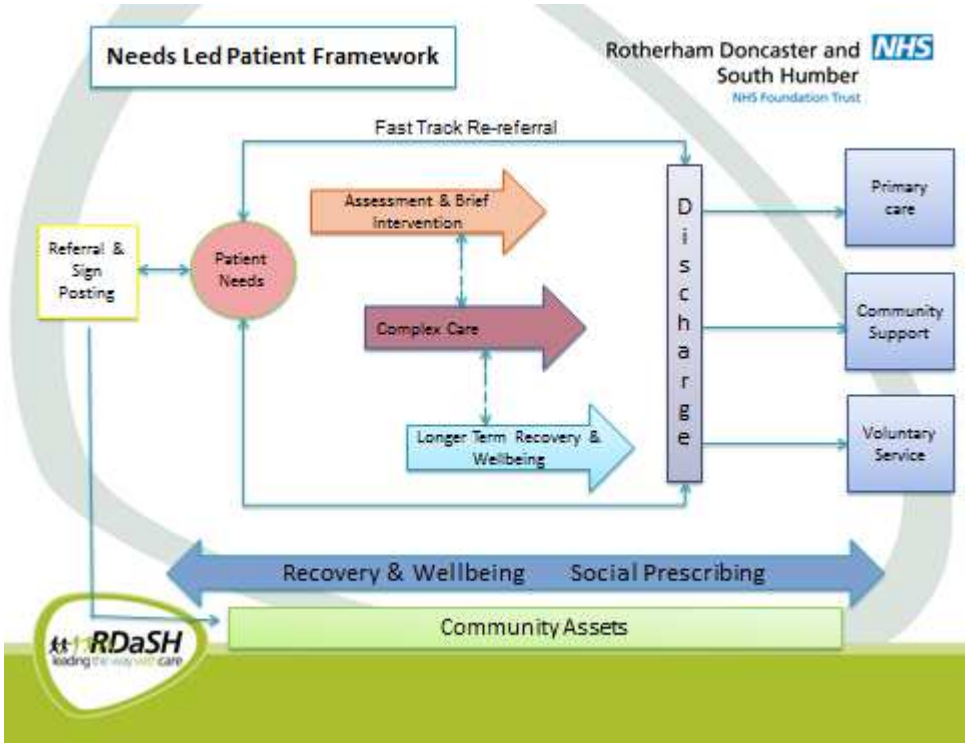
i. People of any age with a primary dementia
ii. People with mental disorder and physical illness or frailty which contribute(s) to, or complicate(s) the management of their mental illness. This may include people under 65
iii. People with psychological or social difficulties related to the ageing process, or end of life issues, or who feel their needs may be best met by a service for older people. This would normally include people over the age of 70.

They noted that:

- In all cases the patient's choice should be considered when deciding the most appropriate service. Patients should generally be transferred between different psychiatric services when stable. Patients should only move services in a crisis in exceptional circumstances due to patient safety.
- For those patients with severe co-morbidity, conjoint management should be explored. The principles of conjoint management are that one team takes responsibility for the overall care and treatment of the patient, but draws upon support in addition to consultation from other services.

These principles are a useful guide for developing an-all age framework whilst recognising age related need.

There are three clinical streams within the proposed framework:



1. **Assessment and Brief Intervention**: providing rapid intervention where either the patient requires some short term, specific support to enable them to return to independent living (ie supporting them through a 'blip' or specific targeted activity to address a particular need) or an intervention to prevent further deterioration which could escalate to a crisis / hospitalisation. The interventions may be social, practical or psychological.
2. **Complex Care:** for patients who have multiple needs, are higher risk, require high intensity support or may have frequent relapses. Established treatment pathways, for example

depression, will continue to operate within the framework, providing a clear overview of what will be provided, where appropriate for the patient.

3. **Longer Term Recovery and Wellbeing:** Lower intensity patients who are more stable but have enduring needs or need a longer/slower recovery period. This steam will require less medical intervention and will include social care.

A menu of NICE based treatment pathways will sit within the framework.

Targeted activity will be developed to improve the flow through services including:

i. reviewing referral criteria with GPs for greater transparency
ii. strengthening the knowledge of front line mental health services to ensure patients are signposted to the right place first time
iii. increasing the level of resource at the front end for rapid, brief interventions
iv. working with staff to strengthen the prevention, recovery and wellbeing approach for more patient centred care and discharge, using professional based formulations, co-produced with patients
v. developing alternatives to long term secondary care treatment interventions, where patients are no longer benefitting, including models such as the successful mental health social prescribing pilot delivered by the voluntary sector
vi. ensuring that there are rapid routes back into specialist support for discharged patients who may relapse

A more detailed summary of the framework is set out at appendix 1. An example patient journey is set out at Appendix 2 illustrating how the patient may move within the framework according to their need and how the framework provides flexible options to enable this.

6. Implications for Service Design

The pathway framework and service design work together to enable a more flexible, personalised approach to care. The framework determines what is needed for the individual and who will provide it. The service design is about how we organise ourselves to deliver care in an efficient and effective way. Appendix 3 overlays the proposed service configuration on the pathway framework. There are three elements:

i. Initial point of contact and triage
ii. Crisis and Rapid Response
iii. Locality Teams (which will have some borough wide services working into them)

It is proposed to move more resources into front end to provide short term interventions to those in crisis or for those who could benefit from this approach, without the need for longer term treatment. However, treatment teams may also adopt this approach.

Set out below is a summary of what this means in practice.

6.1 Initial Point of Contact and Triage

Purpose: A 24/7, 365 day service for crisis and new referrals to assess need and signpost the individual to the appropriate place. Discussions are taking place with the Care Co-ordination Centre to host this service providing an initial point of contact for both physical and mental health and a single all age (including Children's) contact number for the Mental Health Hospital Liaison Service. This is seen as an initial stepping stone to developing a wider Rotherham Hub including social care.

Role	Profession
Initial point of contact • capture and record core patient information (building on data already known) • initial screening and signposting where appropriate • initial prioritisation	Administrative
Triage • assess need • signpost service users (patients, carers and professionals) to the most appropriate place for their need (which may be the wider system rather than RDaSH services)	Clinical
Scope: Phase 1: Mental Health (and LD tbd) adult new and crisis referrals in core hours. Out of hours MH, LD, Drug and Alcohol and children 16 and over Phase 2: may include Drug and Alcohol and Children's Services Phase 3: to develop into wider Rotherham Hub including social care	

Anticipated Benefits

Benefit	By	Measure
Patient Care	Directing the person in need to the right place, first time Fast tracking re-referrals	Service user satisfaction Reduction in number of referrals / re-referrals [1] Reduction in inappropriate numbers coming into service
Efficiency/ effectiveness	To join 4 MH and LD entry points into a combined physical and mental health service to: **i.** provide a specialist gateway into services **ii.** with a bigger critical mass of staff for 24/7 coverage **iii.** Streamline processes and systems iv. Make more effective use of infrastructure costs (eg telephony)	Reduction in entry points Reduction in staffing Streamlining: Single process / systems solution interfacing with external systems to avoid duplicate data entry Improved management information for service delivery

Note:

i. Discussion are taking place with the CCC, an alternative option may be to work with the Doncaster SPA, whilst this would be a simpler solution in the short term, it would not provide the same stepping stone to a Rotherham hub

ii. Access to IAPT and Drug and Alcohol Services will remain separate in phase one

6.2 Crisis and Rapid Response

Purpose: To provide a rapid response to those in Crisis or in need of a rapid response, with provision for brief interventions to support specific short term needs for all adults. This service will

[1] This will require working with primary care and social care around referral criteria

incorporate functions such as assessment, crisis, hospital liaison and home treatment. There will be an integrated approach with social care (see below).

Role	Profession
To receive referrals from those in crisis / referring those in crisis,	Medics Nurses Social Workers AMHPs Admin
To assess referrals and provide time /session limited (tbd) short term interventions	
To provide home treatment to prevent hospital admissions or facilitate discharge	
Gatekeeping admissions to inpatients extended to all adults with intensive home support to facilitate discharge	

Anticipated Benefits

Benefit	By	Measure
Patient Care	To provide more timely interventions to reduce the need for secondary service or prevent a downward spiral	Service user satisfaction Waiting times Average duration of treatment Numbers entering secondary services Gatekeeping: reduced admissions/ length of stay
Efficiency/ effectiveness	More timely interventions to improve flow and reduce the overall demand on secondary services and the wider system	

6.3 Locality Teams

Purpose:

i. To provide treatment for those requiring secondary services closer to home
ii. To provide flexible care according to patient need
iii. To strengthen relationships with primary and social care and third sector / community assets
iv. Provide a named contact

Whilst it is recognised that Rotherham GPs have seven localities there is not enough resource within mental health or social care to mirror this. The mental health localities will therefore be divided into two: north and south to mirror social care provision and provide a simple and integrated model. Services will work into the localities, as is the practice with current older people's services and GPs will have named contacts within the locality for when specialist advice is needed. The locality boundaries are being set based on demand and demographics to provide balance across the two sectors and resource will be allocated accordingly. Discussions are taking place with the CCG and RMBC for co-located premises, although this is unlikely to be realised until 2017-18 at the earliest.

The mental health services will include Older Peoples Community mental health functions; memory services; community therapies, intensive community therapies, social inclusion and recovery.

Role	Profession
Designated assessments referred direct from triage	Medics

Brief, complex and longer term interventions, with treatment pathways informed by NICE guidelines	Nurses OTs Physios Psychologists Social Workers AMHPs Care Co-ordinators Admin

Anticipated Benefits:

Benefit	By	Measure
Patient Care	To remove artificial age and structural boundaries to meet the needs of the individual	Patient satisfaction Patient Flow Average Length of treatment time Waiting times
Efficiency/ effectiveness	To reduce the length of time spent in secondary services by use of patient formulation, elective, time limited interventions and proactive discharge management and use of community resources	

6.4 Specialist Borough Wide Services

It is recommended that some services are borough wide either because of their specialist nature (Early Intervention and Assertive Outreach) or because they are too small to be viable if split across localities (Young Onset Dementia and Korsakoffs). The teams will work into the localities and will be line managed through the locality structure.

6.5 Social Care

Purpose: To provide integrated health and social care to support service users ensure statutory requirements are met and that staff work to their professional expertise.

Principles: Mental Health and Social Care staff will work together to:

- support a strengths based prevention, recovery and wellbeing approach which:
  - is needs led
  - develops the resilience of the individual through maximising personal resources, close support networks (family, friends etc) and community assets
  - meets the requirements of the Care Act 2014 and Mental Health Act
- support service user needs with roles and responsibilities based on professional expertise
- staff will be co-located sharing office space
- working to a profession based line management structure with social care staff reporting to an RMBC manager and mental health staff to an RDaSH manager
- professional supervision will be provided by RMBC and RDaSH for social care and mental health respectively, with an overarching mechanism to manage and review cases
- Processes and systems will be streamlined according to agreed protocols including Care Act Compliance and Safeguarding
- There will be a single point of access for mental health and related social care issues

- There will be a single assessment with one assessment form which meets the needs of health and social care wherever possible
- Staff will have shared access to information across IT systems within information governance protocols

Key social care activities have been identified as:

i. Provision of services that are Care Act compliant
ii. 24 hour AMHP service: covering all aspect of work under MH act and any RMBC out of hours crisis issues.
iii. Assessment and short term centred intervention: including full needs assessment, working into the wards and re-referrals from treatment teams
iv. Social care activity in relation to safeguarding, BIA assessment, 117, management and review of residential care placements / direct payments and professional issues

Scope RMBC staff are currently embedded in mental health working age adult teams, but are separate for older peoples and learning disability services. The initial scope is therefore for working age adults, with the aim of extending this to older people and learning disabilities.

Anticipated Benefits

Benefit	**By**	**Measure**
Patient Care	To reduce the number of assessments and provide integrated support to address both mental health and social care needs in one place/process where possible	Service user experience Numbers entering service Number of assessments
Efficiency/ effectiveness	Utilise specialist expertise ensuring staff work to their professional training Streamline processes and systems Reduce duplication and cost	Efficiency savings

IAPT services currently work into localities and will continue to do so. They are part of the care group and will be more closely integrated with other services including more effective internal referrals. In the short term the IAPT service will continue to build on the gains made in reducing waiting times following non recurrent investment from NHS England to embed sustainable change.

Timescales

The proposed changes are transformational requiring changes in how we work with patients and carers, within RDaSH and with partners, as well as what we do and how we organise ourselves. This will also require cultural change as well as process and systems change. Due to the scale of change required a pragmatic, phased approach is being taken. RDaSH are developing the next phase of the programme plan which will also identify interdependencies with the Unity (patient record system) programme. Summarised below are the high level milestones of the next phase.

Phase 2

Governance Approval Process	
i. Service configuration	July 2016
ii. Confirmed clinical team design and	October 2016 (with formal HR consultation

management structure	process for affected staff, aligned with other care groups to manage redeployment opportunities)
Pathway design and development	On going
Admin review	November 2016
Phased transition (new referrals)	From December 2016
Implementation	By 1 April 2017*

***** Implementation will be phased, teams may initially be virtual as changes to estate will take longer to realise. Interdependencies with Unity and agile working will be realised in 2017-18.

8.QIPP Savings

It is anticipated that the service re-design will meet the required QIPP savings for this financial year through the senior and middle management re-structure and some targeted savings.

However, the 2017-18 target is more challenging and will require:

i. A reduction in numbers in service (realisation of the benefits outlined above)
ii. A review of clinical and administrative staffing
iii. The outcome of discussions with RMBC regarding funding of social care roles

9. Risks

The main risks are that:

i. There is a negative impact on patients during the transition period
Mitigation: to work together across the system to manage this
ii. Colleagues across the system do not work together to reduce the number of referrals and increase discharges so flow through the system is not improved. This will create blockages at the front end and increase waiting times
Mitigation: To work together to communicate the benefits and develop and deliver a transition and training plan
iii. Staff, colleagues and / or service users do not make the necessary cultural change to achieve new ways of working.
Mitigation: clear, timely and consistent communication as to what, why, how and when changes will happen, with ongoing dialogue to monitor, respond and adapt to circumstances where required
iv. There is a critical interdependency between mental health and social care funding of roles, this is to be reviewed by RMBC in 2017-18 and could have a negative impact on service provision and meeting the required savings
Mitigation: to acknowledge the cost pressures on commissioners and providers and work together to find a pragmatic solution which supports the new shared principles and the needs of the whole system

Future development In the short term, further work is required:

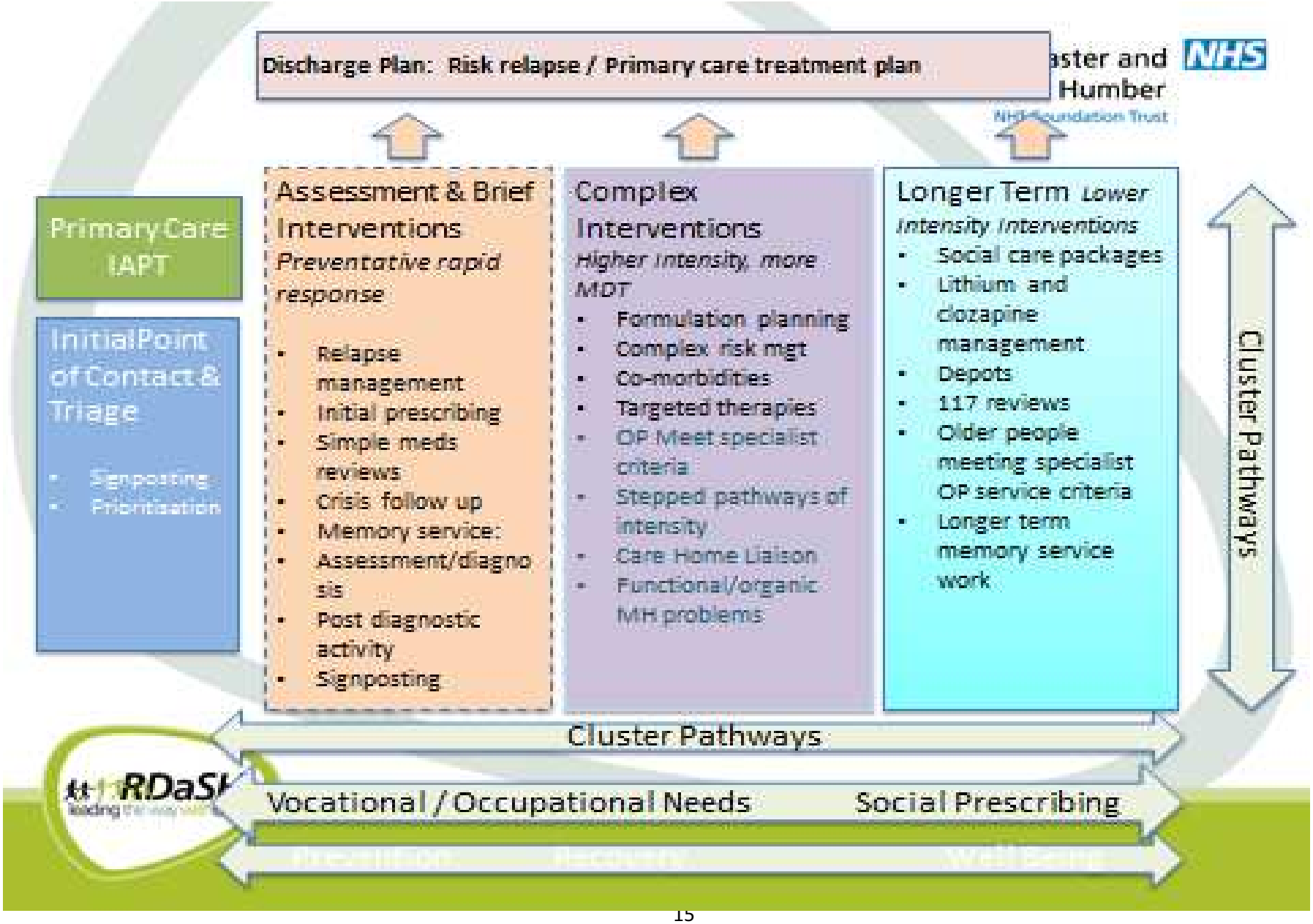
- To model services and trajectories to reduce numbers in service
- To work with primary care on referrals, discharge and re-referrals
- Develop alternative models with the voluntary sector in relation to bridging routes, such as social prescribing, to increase independent living and reduce isolation

For the longer term, these recommendations have been developed alongside the CCG's integrated locality pilot, which RDaSH is proud to be a member of. The recommendations can be further developed if the locality model is rolled out, extending the concept to whole system integration particularly in relation to a Rotherham wide health and social care first point of contact hub; physical health and mental health; all-age integration with social care and extended working with the voluntary sector.

10. Action

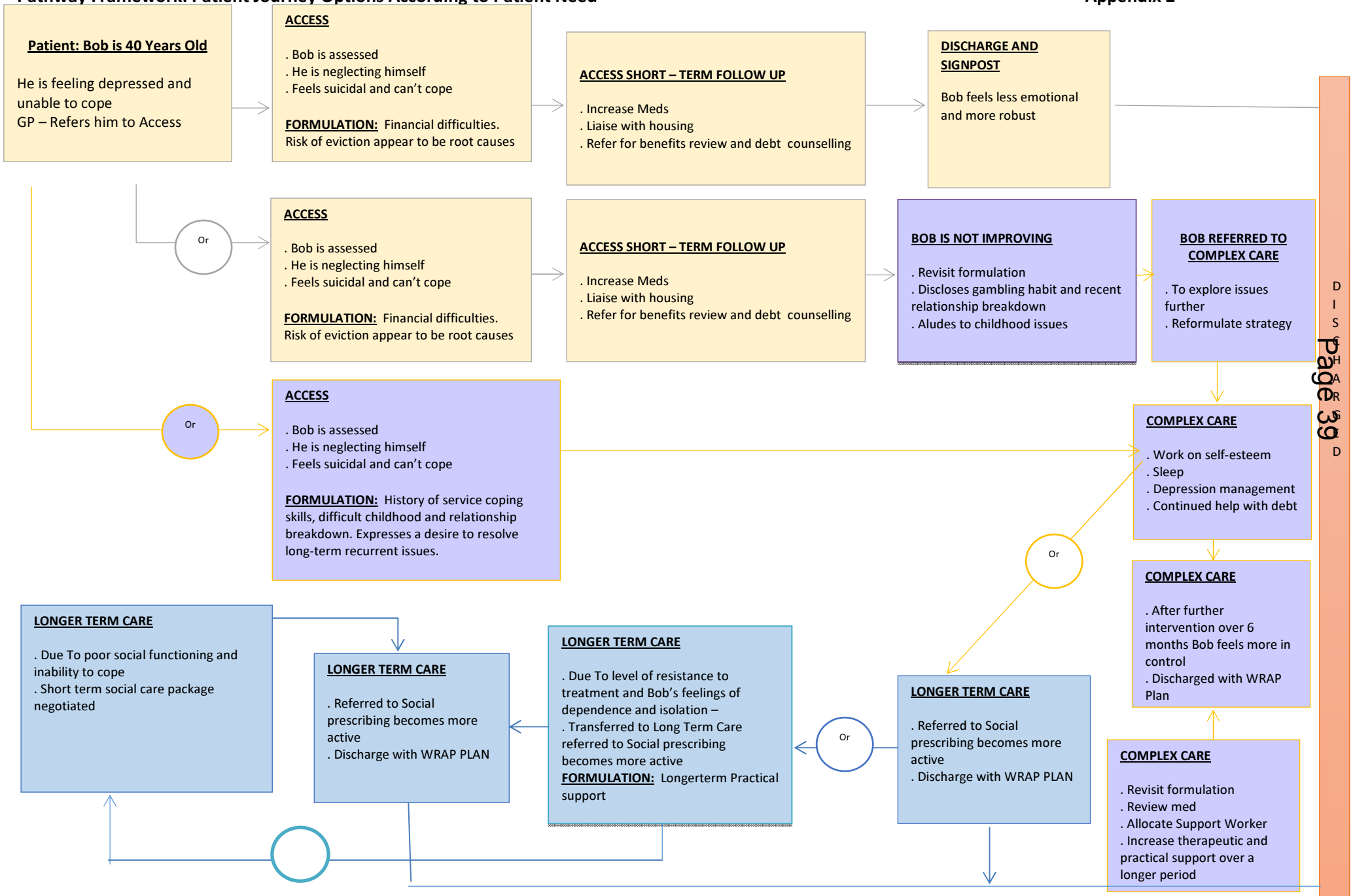
Members are asked to comment on the proposals outlined above in relation to:

i. Approach
ii. Pathway framework
iii. Service configuration
iv. Partnership working with primary care and social care

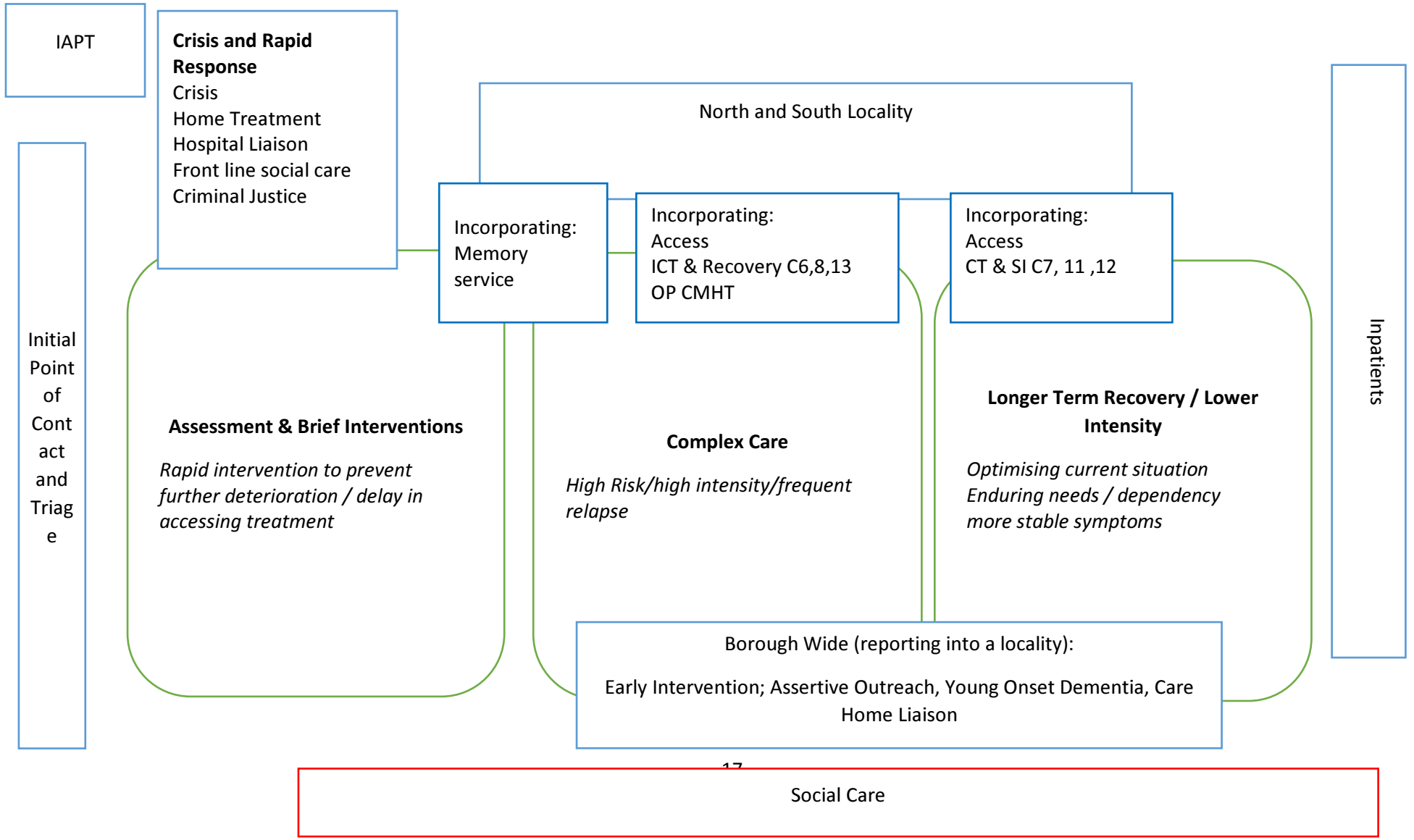

Discharge Plan: Risk relapse / Primary care treatment plan
aster and Humber
NHS
Foundation Trust
Primary Care IAPT
Initial Point of Contact & Triage
• Signposting
• Prioritisation
Assessment & Brief Interventions
Preventative rapid response
• Relapse management
• Initial prescribing
• Simple meds reviews
• Crisis follow up
• Memory service:
• Assessment/diagnosis
• Post diagnostic activity
• Signposting
Complex Interventions
Higher intensity, more MDT
• Formulation planning
• Complex risk mgt
• Co-morbidities
• Targeted therapies
• OP Meet specialist criteria
• Stepped pathways of intensity
• Care Home Liaison
• Functional/organic MH problems
Longer Term Lower Intensity Interventions
• Social care packages
• Lithium and clozapine management
• Depots
• 117 reviews
• Older people meeting specialist OP service criteria
• Longer term memory service work
Cluster Pathways
Cluster Pathways
RDaSH
Vocational / Occupational Needs
Social Prescribing

Pathway Framework: Patient Journey Options According to Patient Need

Appendix 2



PATHWAY FRAMEWORK and SERVICE CONFIGURATION **Appendix 3**



Rotherham Metropolitan Borough Council

Public
Health Select Commission Meeting

Summary Sheet

Council Report
Health Select Commission 28th July 2016

Title
Adult Social Care – Provisional Year End Performance Report for 2015/16 – follow up response to the outstanding issues raised at the 16th June 2016 meeting.

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

Strategic Director Approving Submission of the Report
Graeme Betts, Interim Strategic Director of Adult Care and Housing

Report Author(s)
Scott Clayton, Interim Performance & Quality Team Manager

Ward(s) Affected
All

1. Summary

This report provides the additional information that was requested following the consideration of the provisional year end 2015/16 performance report at the Health Select Commission, held on 16th June. 2016. The content addresses the requests that were made and recorded in the minutes as resolved actions (as copied below) with the exception of the (3rd) resolved action which is being presented as a separate report to the July 28th 2016 HSC meeting.

Resolved:-
(1) That the provisional year end performance results be noted.

(2) That a further report be submitted showing final submitted results and benchmark comparisons against regional and national data.

(3) That a report be submitted on the local measures for the Select Commission's next meeting.

(4) That a response be supplied to the outstanding issues raised at the meeting.-

2. Recommendations

It is recommended that Members note:

2.1 That a further report be submitted to the 1st December, 2016 Health Select Commission meeting, showing final 2015/16 submitted results and benchmark comparisons against regional and national data - resolved action (2)

2.2 That a further report has been submitted to the 28th July 2016 meeting of the HSC on the local measures and complaints data- resolved action (3).

2.3 The content of responses regarding the outstanding issues raised in the 16th June 2016 HSC meeting - resolved action (4).

List of Appendices Included

Appendix A - Adult Social Services Performance benchmarking data for all ASCOF Measures 2014/15 (latest available published data).

Appendix B – Sample Service User Questionnaire ('full' Community Based Service example template) – showing all questions raised in national survey.

Appendix C shows the relevant data tables from 2015/16 SALT national return, adapted to also show % increase.

Background Papers

No background papers

Consideration by any other Council Committee, Scrutiny or Advisory Panel

None

Council Approval Required

No

Exempt from the Press and Public

No

Title: Adult Social Care – Provisional Year End Performance Report for 2015/16 – follow up response to the outstanding issues raised at the 16th June 2016 meeting.

1. Recommendations

It is recommended that Members note:

1.1 That a further report be submitted to the 1st December, 2016 Health Select Commission meeting, showing final 2015/16 submitted results and benchmark comparisons against regional and national data - resolved action (2)

1.2 That a further report has been submitted to the 28th July 2016 meeting of the HSC on the local measures and complaints data- resolved action (3).

1.3 The content of responses regarding the outstanding issues raised in the 16th June 2016 HSC meeting - resolved action (4).

2. Background

2.1 Actions resolved

(1) That the provisional year end performance results be noted.

(2) That a further report be submitted showing final submitted results and benchmark comparisons against regional and national data.

(3) That a report be submitted on the local measures for the Select Commission's next meeting.

(4) That a response be supplied to the outstanding issues raised at the meeting (highlighted yellow below)

3. Revised summary text from initial report and minutes with additional follow up text for each item raised as per resolved action (4)

3.1. The SALT tables' highlights include:

- **Short Term** shows a 14% increase in request for service, over 5650 requests were made – almost 700 more than 2014/15 from **new** clients aged 18-64.

Further analysis of the almost 700 (nett) increase in requests for services showed that the biggest customer outcome category increase (cells highlighted blue in Appendix C) was for those customers who's request could be met either by existing available universal services or by being able to sign post them to other services.

- **Short Term** shows a 5.9% increase in request for service, over 9000 requests were made – almost 500 more than 2014/15 from **new** clients aged over 65.

Similar to findings of customers aged 18-64, the nett 500 increase in request from customers over 65 also showed most could be met from universal services or signposting.

Both aged groups increases could be an early indicator that the service re-modelling of front-end services was beginning to show that customer's needs could be met without requiring the Council to complete full assessments and provide low level traditional services.

3.2 What were the issues around funding for Continuing Health Care (CHC) and was it not something that could be addressed through the Better Care Fund and pooled budgets for Adult Social Care and Health?

Whilst there had been a higher number of new admissions of adults aged 18-64 than in recent years (20 new admissions in 2014/15), it was still relatively low. The target had been 18 for 2015/16 and there were 29 new admissions. Analysis had identified that when clients' funding streams were reviewed, the CHC funding was not being continued at 100% for a number of clients. For the purposes of ASCOF, once that funding arrangement dropped below 100% the Council had to pick up some of the funding arrangement and record accordingly as a 'new' admission. From the Indicator point of view that person may well have been in that 24 hour care home provision as a permanent admission for some time.

The Service is now ensuring attendance at CHC meeting reviews and where possible, if the need is still there, trying to secure the continued funding. This averts the need for the Council to contribute to the support package and does not count as a new admission.

In addition to the initial Continuing Health Care (CHC) funding response the service has recruited to a CHC lead post, re-configured teams to create a specific CHC team and is working with Children and Young Peoples Services to ensure that eligible CHC funding is maximised across all areas including for transition service users.

3.3. The rankings gave relative positions but how wide was the gap percentage wise for some Indicators where Rotherham was lowly ranked and where it was ranked first? It would be helpful to see both ranking and percentage score for each local authority?

Some of the annual returns had only just been submitted so, whilst Rotherham's performance was known, the performance of the other local authorities in Yorkshire and Humber (or the national picture) was not known. The information is usually published around October/November and on receipt there will be the ability to compare if Rotherham's relatively improved performance was mirrored, keeping pace or falling behind. Once that data had been received a further report can be submitted to the Health Select Commission.

3.4 How would the Services manage poor performance as they continued to undergo transformation and change? It was important to be able to identify where poor performance was and how quickly the Service was able to react to make sure the measures were put in place which improved performance as well as communicating to the people within that as to what it was doing?

Key Performance Indicators should not be relied solely upon but build a picture of performance when aligned to the more granular intelligence. Information that comes out of discussions with the end users of the services/carers/families linking in with care staff is of great value in evaluating performance. The voluntary sector has a role to play as well in terms of raising issues and challenging poor quality provision. There is a need to capture as much real time information as possible in addition to a retrospective snap shot.

3.5 On the scoreboard (1) Adult Social Care 18.8% ranked 13, (9) Mental Health Services and Employment 5.27% ranked 14, (12) Service users having enough social care as they linked 46% ranked 13, 26% of services who felt safe 66% ranked 15. Could a response be provided as to how they would improve and what measures would be put in place? -A written response would be provided.

To provide additional comparative context the 2014/15 benchmarked score range regionally is shown for each of the 15 Yorkshire & Humber Councils in appendix A. For each of the individual measure responses below, we have headlined Rotherham's 2015/16 provisional performance, 2014/15 ranking information and also referenced the 2014/15 national and regional average values.

Where applicable, performance data trends will inform 2016/17 improvement plans and actions.

3.6 (1) Adult Social Care related quality of life
- 2015/16 reported score value was 18.8 (improved from 18.5 and ranked 13th in 2014/15).

The national average value was 19.1 and regional average value was 19.2, if 'no change values' are reported from other council scores in 2015/16, then Rotherham's relative ranking would improve to 12th.

This measure is an average quality of life score based on responses to the annual Adult Social Care Survey. It is a composite measure using responses to survey questions covering the eight domains identified in the Adult Social Care Outcomes Toolkit (ASCOT); control, dignity, personal care, food and nutrition, safety, occupation, social participation and accommodation. The relevant questions are listed below (and a sample full questionnaire is attached as Append B):

- Control - Q3a: Which of the following statements best describes how much control you have over your daily life?

- Personal care - Q4a: Thinking about keeping clean and presentable in appearance, which of the following statements best describes your situation?
- Food and Nutrition - Q5a: Thinking about the food and drink you get, which of the following statements best describes your situation?
- Accommodation - Q6a: Which of the following statements best describes how clean and comfortable your home/care home is?
- Safety - Q7a: Which of the following statements best describes how safe you feel?
- Social participation - Q8a: Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?
- Occupation - Q9a: Which of the following statements best describes how you spend your time?
- Dignity - Q11: Which of these statements best describes how the way you are helped and treated makes you think and feel about yourself?

Each of the questions has four possible answers, which are equated with having:

- no unmet needs in a specific life area or domain (the ideal state);
- needs adequately met;
- some needs met, and;
- no needs met.

We will also seek to positively influence service user's perceptions for future surveys by proactively engaging them in the co-production of new service models and during service re-design. In addition there will be much greater focus on outcome based commissioning of services and embedding personalisation.

(9) Mental Health Services and Employment
- 2015/16 reported score was 5.27% (improved from 4.9% and ranked 14th in 2014/15).

The national average value was 6.2% and regional average value was 7.4%, if 'no change values' are reported from other council scores in 2015/16, then Rotherham's relative ranking would improve to 12th.

In Rotherham the cohort of Mental Health service users include those at the more severe end of the scale and further from the job market. We recognise that greater personal resilience leads to improved health and wellbeing that impacts positively on this measure. RMBC continue to work with our Mental Health Trust partner - RDaSH and we also note that reported RDaSH Doncaster MBC performance was also lower 4.4% and ranked 15th.

(12) % of Service users who reported that they had as much social contact as they would like
- 2015/16 reported score was 45.5% (improved from 40.2% and ranked 13th in 2014/15).

The national average value was 44.5% and regional average value was 46.4%, if 'no change values' are reported from other council scores in 2015/16, then Rotherham's relative ranking would improve to 9th

The Council's Adult Social Care Development Programme emphasises providing more personalised care including strategies that develop community assets as an alternative to provision of traditional services. This approach has an increased social contact element as well as contributing to improved health and wellbeing. The Public Health team are also developing a wellbeing strategy that will complement the work of the Rotherham CCG and RDaSH with regard to social prescribing for people with mental ill health.

26) % of Services Users who felt safe
- 2015/16 reported score was 66% (improved from 61.5% and ranked 15th in 2014/15).

The national average value was 68.1% and regional average value was 67.9%, if 'no change values' are reported from other council scores in 2015/16, then Rotherham's relative ranking would improve to 11th

27) % of people who use services who say that those services have made them feel safe and secure
- 2015/16 reported score was 84.5% (improved from 81.6% and ranked 8th in 2014/15).

The national average value was 85.6% and regional average value was 81.6%, if 'no change values' are reported from other council scores in 2015/16, then Rotherham's relative ranking would improve to 6th

These are two User Survey perception measures. When any service user responds by selecting any of the least positive options ("I feel less than adequately safe" or "I don't feel at all") the Council or RDaSH for Mental Health Service Users, follow up and make enquiries to ensure the safety of the service user. We have found through this process that most users' perception is reflecting a more generic community safety issue, covering examples of anti-social behaviour or presence of groups of youths on street corners, rather than specific aspects of social care provision or support. In 2015/16 we asked Service User's to tell us more, to help us better understand reasons why. We will complete our analysis during the summer and use the feedback to inform any service improvements during 2016/17.

3.7 **Complaints and Customer enquiries 2015-16**

In response to the HSC request for information on the above service area and ahead of the formal presentation of the Annual Complaints Report, the RMBC Complaints Team has provided a bulleted summary of activity findings, plus some headline commentary below.

3.7.1 **NB**. It should be noted that this data is still being finalised and is subject to change before published actuals are reported.

- Number of complaints, **76**, increase from **73** received 2014-15.
- The number of complaints (at all stages) upheld, **18** (24%), decrease from **21** (28%) upheld in 2014-15.
- The number of complaints escalating, (10%), **7** Stage 1 complaints escalating to Stage 2, from **69** Stage 1 complaints. Decrease from 12% in 2014-15. (**8** Stage 2 complaints and **63** Stage 1 complaints)
- Complaints about quality of service, 34, increase from **22** received in 2014-15.
- Complaints about actions of staff **9** decrease from **16** in 2014-15.
- **2** Upheld Ombudsman complaints from **6** decisions. **3** Upheld from **7** decisions in 2014-15.
- Total compensation awards made £500, £0 in 2014-15.
- External complaint investigation costs, £0
- Number of Councillor Surgery's received was **27**, decrease from **28** in 2014-15.
- Number of Compliments received was **59**, decrease from **104** in 2014-15.
- Number of informal complaints received, **35** decrease from **43** received in 2014-15.

3.7.2 Over the last 12 months the total number of complaints received for Adult Social Services was **76** (Total received in 2014-15 - **73**) and **91% of all complaints were responded to within the statutory timescales**. (**100%** in 2014-15). Common themes in terms of the types of complaints received were regarding communication, information, attitude of staff and cost of service.

3.73 A continuing trend in the Directorate is that the majority of complaints were received by dealt with by Independence & Support Planning. They received **36** out of **76** complaints, with the majority being dealt with by Locality Teams ,**16** complaints. Maximising Independence received the second highest number of complaints, **9** complaints, with the majority of complaints regarding Rothercare, and Direct Payments Team. The Community Occupation Therapy service received the third highest number of complaints, **8** complaint received.

3.74 In terms the types of complaints received the highest number of complaints were regarding the Quality of Service provided, **34** complaints received. Customers complained when their expectations of service were not met or they had experienced continuing problems on separate occasions. **17** complaints were received relating to Cost of Service; these were regarding the

cost of care and financial procedures. Customers complained if they felt there were not given enough information about the cost of care or if there were delays in processing financial assessments or disagreements over contributions. **9** complaints were received relating the Actions of Staff; these were regarding specific allegations about the conduct of a staff member. Examples include how they had addressed a customer, how they had failed to communicate correctly or how they had been an incorrect decision.

3.75 For all complaints, including those that are not upheld, there is consideration applied for any learning and service improvement. This means that there is either immediate action taken to remedy the complaint or work is completed by the service to improve procedures and processes to the benefit of all customers. These are reported to the Directorate Management Team for further consideration which allows opportunity for learning across all Services within the Directorate.

4. Options considered and recommended proposal

4.1 To note the content of the report.

5. Consultation

5.1 None

6. Timetable and Accountability for Implementing this Decision

6.1 None

7. Financial and Procurement Implications

7.1 None

8. Legal Implications

8.1 None

9. Human Resources Implications

9.1 None

10. Implications for Children and Young People and Vulnerable Adults

10.1 None

11 Equalities and Human Rights Implications

11.1 None

12. Implications for Partners and Other Directorates

12.1 None

13. Risks and Mitigation

13.1 None

14. Accountable Officer(s)

Approvals Obtained from:-

Graeme Betts, Interim Strategic Director Adult Care and Housing

Nathan Atkinson, Assistant Director Strategic Commissioning

Scott Clayton, Interim Performance & Quality Team Manager

This report is published on the Council's website or can be found at:-

http://moderngov.rotherham.gov.uk/ieDocHome.aspx?Categories=

Adult Care and Housing
Performance and Quality
Contact: Scott Clayton
Tel: (01709) 255949
Email: Scott.Clayton@rotherham.gov.uk

Rotherham Metropolitan Borough Council
Where Everyone Matters

Our ref: SP/CBS/410 - 1155016

Date: 01/02/2016

Appendix B – Council Report
Health Select Commission 28th July 2016

Title : Adult Social Care – Provisional Year End Performance Report for 2015/16 – follow up response to the outstanding issues raised at the 16th June 2016 meeting.

Dear xxxxxxx

Your Social Care and Support Services

Introduction

I am contacting you because you receive, or have received, care and support services that are paid for (at least in part) by Rotherham Metropolitan Borough Council. I want to improve and develop our services so I would like to get your views on the services you receive in the enclosed questionnaire. In particular, I would greatly appreciate hearing about your quality of life and how services have affected the quality of your life.

Confidentiality

Your answers will be treated as confidential: they will not be passed on to your social worker, care manager, care and support worker or anyone providing you with services. You will not be personally identified and your answers will not affect the services you receive.

The code found on the top of this form is used only to make sure that when you return the questionnaire we do not send you another one. However, if you say on the questionnaire that you are being hurt or harmed by anybody or your safety or health is at risk at question 7a, then we will use this code to identify you so that someone (but not your care and support worker) will contact you initially to talk about it. This is the only circumstance under which this code will be used to identify you.

What we would like you to do

We would like you to help us by completing the questionnaire attached. Full instructions are given with the questionnaire including what to do if you need help to fill it in. If you choose not to take part then it will not affect the services you receive.

It is standard practice as part of the survey's administration to issue one reminder letter. Every effort is made to ensure that you are not sent a reminder letter if you've already responded or opted out by returning a blank questionnaire to us.

What to do if you have queries

If you, or your friend or relative, have questions you would like to ask about the survey, or if you would like the questionnaire in another language or different format like large print or easy read then please ring **01709 255949** between 9.00 am and 17.00 pm Monday to Friday

Sending back the completed questionnaire

Once you have completed the questionnaire please return it in the envelope provided by **4th March 2016**. You don't need to put a stamp on the envelope.

Thank you for helping us by taking part in this survey.

Yours sincerely

Sam Newton
Assistant Director for Independent Living and Support

Arabic:

لطلب هذه الرسالة باللغة العربية، الرجاء كتابة اسمك وعنوانك هنا وإعادة هذه الإستمارة بالظرف المرفق. شكراً لك.

الإسم :

العنوان:

Bengali:

বাংলা ভাষায় এই পত্রটির জন্য, অনুগ্রহ করে এখানে আপনার নাম এবং ঠিকানা লিখুন এবং এই ফর্মটি প্রদত্ত খামে ভরে ফেরত পাঠান।

ধন্যবাদ।

নাম :

ঠিকানা :

English (large print):

To request this letter in English (large print), please write your name and address here and return this form in the envelope provided. Thank you.

Name:

Address:

Greek:

Για να ζητήσετε τη συγκεκριμένη επιστολή στην ελληνική γλώσσα, παρακαλούμε συμπληρώσετε εδώ το όνομα και τη διεύθυνσή σας και επιστρέψετε το έντυπο στον συνοδευτικό φάκελο. Ευχαριστούμε.

Όνομα:

Διεύθυνση:

Gujarati:

આ પત્રને ગુજરાતીમાં મેળવવા માટે, કૃપા કરીને આપનું નામ અને સરનામું અહીં લખો અને આ ફૉર્મને આ સાથે આપેલ એન્વલપમાં પરત કરો. આભાર.

નામ:

સરનામું:

Hindi:

इस पत्र की हिन्दी प्रति का अनुरोध करने के लिए कृपया यहाँ अपना नाम एवं पता लिखें और इस प्रपत्र को, दिए गए लिफ़ाफे में रखकर वापस भेज दें।

धन्यवाद।

नाम :

पता :

Mandarin:

如您想要本信件的中文版本，请在这里写下你的姓名和地址并将本表格置于我们提供的信封内寄回。谢谢！

姓名：

地址：

Punjabi:
ਪੰਜਾਬੀ 'ਚ ਇਹ ਪੱਤਰ ਪ੍ਰਾਪਤ ਕਰਨ ਦੀ ਬੇਨਤੀ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਇੱਥੇ ਆਪਣਾ ਨਾਂ ਅਤੇ ਪਤਾ ਲਿੱਖੋ ਅਤੇ ਦਿੱਤੇ ਗਏ ਲਿਫ਼ਾਫ਼ੇ 'ਚ ਇਹ ਫ਼ਾਰਮ ਵਾਪਸ ਭੇਜ ਦਿਓ। ਧੰਨਵਾਦ।
ਨਾਂ :
ਪਤਾ :

Somali:
Si aad warqaddan ugu hesho af Soomaali, fadlan magacaaga iyo cinwaankaaga halkan ku qor oo foomkan ku soo celi bokhshadda u diyaar ah. Mahadsanid.
Magaca:
Cinwaanka:

Turkish:
Bu mektubu türkçe olarak temin etmek için isim ve adresiniz buraya yazıp, formu verilen zarfa koyarak gönderin. Teşekkürler.
İsim:
Adres:

Urdu:
اس خط کو اُردو میں حاصل کرنے کے لیے برائے مہربانی یہاں اپنا نام اور پتہ لکھیں اور یہ فارم ساتھ فراہم کیے گئے لفافے میں ڈال کر واپس بھیج دیں شکریہ ۔
نام:
پتہ:

Vietnamese:
Để yêu cầu thư này bằng tiếng Việt, hãy viết tên và địa chỉ quý vị ở đây và gởi lại biểu mẫu này trong phong bì được cung cấp. Xin cám ơn.
Tên:
Địa chỉ:

Your Social Care and Support Services

Introduction

We are contacting you because you receive, or have received, care and support services that are paid for (at least in part) by Rotherham Metropolitan Borough Council. By care and support services we mean you may be living in a care home, receiving a Personal Budget, home care, equipment, meals services, Direct Payments, or attending a day centre. We want to improve and develop our services so we want to get your views on the services you receive. In particular, we want to hear about your quality of life and how services have affected the quality of your life.

If you are unable to complete this questionnaire either on your own, or by giving answers for someone else to record, such as a friend or relative, then please either discard it or if you are able, return it uncompleted in the envelope enclosed.

Why you were selected

You have been selected at random along with lots of other people from Social Care records of people who are receiving social care and support services.

What we would like you to do

We would like you to help us by taking about twenty minutes to give us your views about the care and support services you receive. If you choose not to answer this questionnaire this will not affect the services you receive.

What to do if you need help to give your views

You can ask a friend, relative or an advocate to help you complete the questionnaire, but please remember that it is your views and your experiences that are important to us, rather than the views of anyone that helps you. If you are having help from someone else then please remove the last page from this questionnaire and pass it to them as it contains some guidance.

If you prefer, you can also get in touch on 01709 255949 to ask for someone independent from social services and your care provider to help you to complete the questionnaire. Staff from Social Services involved in the provision of your care, or anyone that you pay to care for you should not help you to fill it in.

What to do if you have queries

If you, or your friend or relative, have questions you would like to ask about the survey, or if you would like the questionnaire in another language or different format such as large print or easy read then please ring 01709 255949 between 9.00 am and 17.00 pm Monday to Friday

What will be done with the results of the survey

The results of the survey will be used by the Care Quality Commission, the Department of Health and your Social services department to see how happy people are with their care and support services and assess their experiences of local care services. The results will also be used for further research or analysis.

Confidentiality

Your answers will be treated as confidential: they will not be passed on to your social worker, care manager, care and support worker or anyone providing you with services. You will not be personally identified and your answers will not affect the services you receive.

The code found on the top of this form is used only to make sure that when you return this questionnaire we do not send you another one. However, if you say on the form that you are being hurt or harmed by anybody or your safety or health is at risk at question 7a, then we will use this code to identify you so that someone (but not your care and support worker) will contact you initially to talk about it. This is the only circumstance under which this code will be used to identify you.

Reminder Letters

If you do not return this questionnaire then you may be sent reminder letters. If you do not wish to receive reminders then please send back an uncompleted questionnaire in the envelope provided.

Sending back the completed questionnaire

Once you have completed the questionnaire please return it in the envelope provided by **4th March 2016**. You don't need to put a stamp on the envelope.

Thank you for helping us by completing this questionnaire.

«Printing_Client_Id»

Section 1: Overall satisfaction with your social care and support

1. Overall, how satisfied or dissatisfied are you with the care and support services you receive?

By 'care and support services' we mean any equipment or care provided by staff who are paid to help you. The staff could be from the council, an agency, a care home or bought by you using money from Social Services through a Direct Payment.

Please tick (✓) one box

- ☐ I am extremely satisfied 1
- ☐ I am very satisfied 2
- ☐ I am quite satisfied 3
- ☐ I am neither satisfied nor dissatisfied 4
- ☐ I am quite dissatisfied 5
- ☐ I am very dissatisfied 6
- ☐ I am extremely dissatisfied 7

Section 2: Your quality of life

When answering the following questions please think about the quality of your life as a whole, including the help you get from others as well as Social Services.

2. Thinking about the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole?

Please tick (✓) one box

- ☐ So good, it could not be better 1
- ☐ Very good 2
- ☐ Good 3
- ☐ Alright 4
- ☐ Bad 5
- ☐ Very bad 6
- ☐ So bad, it could not be worse 7

2b. Do care and support services help you to have a better quality of life?

Please tick (✓) one box

- ☐ Yes 1
- ☐ No 2

3a. Which of the following statements best describes how much control you have over your daily life?

By 'control over daily life' we mean having the choice to do things or have things done for you as you like and when you want.

Please tick (✓) one box

- ☐ I have as much control over my daily life as I want 1
- ☐ I have adequate control over my daily life 2
- ☐ I have some control over my daily life but not enough 3
- ☐ I have no control over my daily life 4

3b. Do care and support services help you in having control over your daily life?

By 'care and support services' we mean any equipment or care provided by staff who are paid to help you. The staff could be from Social Services, an agency or bought by you using money you receive from Social Services, using a Direct Payment.

Please tick (✓) one box

- ☐ Yes 1
- ☐ No 2

4a. Thinking about keeping clean and presentable in appearance, which of the following statements best describes your situation?

Please tick (✓) one box

- ☐ I feel clean and am able to present myself the way I like 1
- ☐ I feel adequately clean and presentable 2
- ☐ I feel less than adequately clean or presentable 3
- ☐ I don't feel at all clean or presentable 4

4b. Do care and support services help you in keeping clean and presentable in appearance?

Please tick (✓) one box

- ☐ Yes 1
- ☐ No 2

5a. Thinking about the food and drink you get, which of the following statements best describes your situation?

Please tick (✓) one box

- ☐ I get all the food and drink I like when I want 1
- ☐ I get adequate food and drink at OK times 2
- ☐ I don't always get adequate or timely food and drink 3
- ☐ I don't always get adequate or timely food and drink, and I think there is a risk to my health 4

5b. Do care and support services help you to get food and drink?

Please tick (✓) one box

- ☐ Yes 1
- ☐ No 2

6a. Which of the following statements best describes how clean and comfortable your home is?

Please tick (✓) one box

- ☐ My home is as clean and comfortable as I want 1
- ☐ My home is adequately clean and comfortable 2
- ☐ My home is not quite clean or comfortable enough 3
- ☐ My home is not at all clean or comfortable 4

6b. Do care and support services help you in keeping your home clean and comfortable?

Please tick (✓) one box

- ☐ Yes 1
- ☐ No 2

7a. Which of the following statements best describes how safe you feel?

By feeling safe we mean how safe you feel both inside and outside the home. This includes fear of abuse, falling or other physical harm.

Please tick (✓) one box

- ☐ I feel as safe as I want 1
- ☐ Generally I feel adequately safe, but not as safe as I would like 2
- ☐ I feel less than adequately safe 3
- ☐ I don't feel at all safe 4

7a ii. If you don't feel safe, please tell us the reason (s) why

Please tick (✓) <u>as many</u> boxes as apply

- ☐ Fear of abuse (physical, psychological, financial, sexual)
- ☐ Fear of falling (within or outside your home)
- ☐ Fear of going out alone
- ☐ Other, Please provide more information in the box below

7b. Do care and support services help you in feeling safe?

Please tick (✓) one box

- ☐ Yes 1
- ☐ No 2

8a. Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?

Please tick (✓) one box

- ☐ I have as much social contact as I want with people I like 1
- ☐ I have adequate social contact with people 2
- ☐ I have some social contact with people, but not enough 3
- ☐ I have little social contact with people and feel socially isolated 4

8b. Do care and support services help you in having social contact with people?

Please tick (✓) one box

- ☐ Yes 1
- ☐ No 2

9a. Which of the following statements best describes how you spend your time?

When you are thinking about how you spend your time, please include anything you value or enjoy including leisure activities, formal employment, voluntary or unpaid work and caring for others.

Please tick (✓) one box

- ☐ I'm able to spend my time as I want, doing things I value or enjoy 1
- ☐ I'm able to do enough of the things I value or enjoy with my time 2
- ☐ I do some of the things I value or enjoy with my time but not enough 3
- ☐ I don't do anything I value or enjoy with my time 4

9b. Do care and support services help you in the way you spend your time?

Please tick (✓) one box

- ☐ Yes 1
- ☐ No 2

10. Which of these statements best describes how <u>having help to do things</u> makes you think and feel about yourself?

Please tick (✓) one box

- ☐ Having help makes me think and feel better about myself — 1
- ☐ Having help does not affect the way I think or feel about myself — 2
- ☐ Having help sometimes undermines the way I think and feel about myself — 3
- ☐ Having help completely undermines the way I think and feel about myself — 4

11. Which of these statements best describes how <u>the way you are helped and treated</u> makes you think and feel about yourself?

Please tick (✓) one box

- ☐ The way I'm helped and treated makes me think and feel better about myself — 1
- ☐ The way I'm helped and treated does not affect the way I think or feel about myself — 2
- ☐ The way I'm helped and treated sometimes undermines the way I think and feel about myself — 3
- ☐ The way I'm helped and treated completely undermines the way I think and feel about myself — 4

Section 3: Knowledge and information

12. In the past year, have you generally found it easy or difficult to find information and advice about support, services or benefits?

Please include information from different sources, such as voluntary organisations, and private agencies as well as Social Services.

Please tick (✓) one box

- ☐ Very easy to find 1
- ☐ Fairly easy to find 2
- ☐ Fairly difficult to find 3
- ☐ Very difficult to find 4
- ☐ I've never tried to find information or advice 5

If you found it very difficult to find information and advice, please tell us why and what we can do to make it easier for you.

Section 4: Your health

13. How is your health in general?

Please tick (✓) one box

- ☐ Very good 1
- ☐ Good 2
- ☐ Fair 3
- ☐ Bad 4
- ☐ Very bad 5

14. By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

a. Pain or discomfort

Please tick (✓) one box

- ☐ I have no pain or discomfort 1
- ☐ I have moderate pain or discomfort 2
- ☐ I have extreme pain or discomfort 3

b. Anxiety or depression

Please tick (✓) one box

- ☐ I am not anxious or depressed 1
- ☐ I am moderately anxious or depressed 2
- ☐ I am extremely anxious or depressed 3

15. Please place a tick (✓) in the box that best describes your abilities for each of the following questions.

	I can do this easily by myself	I have difficulty doing this myself	I can't do this by myself
a. Do you usually manage to get around indoors (except steps) by yourself?	☐ 1	☐ 2	☐ 3
b. Do you usually manage to get in and out of a bed (or chair) by yourself?	☐ 1	☐ 2	☐ 3
c. Do you usually manage to feed yourself?	☐ 1	☐ 2	☐ 3
d. Do you usually deal with finances and paperwork - for example, paying bills, writing letters – by yourself?	☐ 1	☐ 2	☐ 3

16. Please place a tick (✓) in the box that best describes your abilities for each of the following questions.

	I can do this easily by myself	I have difficulty doing this myself	I can't do this by myself
a. Do you usually manage to wash all over by yourself, using either a bath or shower?	☐ 1	☐ 2	☐ 3
b. Do you usually manage to get dressed and undressed by yourself?	☐ 1	☐ 2	☐ 3
c. Do you usually manage to use the WC/toilet by yourself?	☐ 1	☐ 2	☐ 3
d. Do you usually manage to wash your face and hands by yourself?	☐ 1	☐ 2	☐ 3

Section 5: About your surroundings

17. How well do you think your home is designed to meet your needs?

Please tick (✓) one box

- ☐ My home meets my needs very well 1
- ☐ My home meets most of my needs 2
- ☐ My home meets some of my needs 3
- ☐ My home is totally inappropriate for my needs 4

18. Thinking about getting around outside of your home, which of the following statements best describes your present situation?

You can include getting around by yourself or with help from someone else

Please tick (✓) one box

- ☐ I can get to all the places in my local area that I want 1
- ☐ At times I find it difficult to get to all the places in my local area that I want 2
- ☐ I am unable to get to all the places in my local area that I want 3
- ☐ I do not leave my home 4

Section 6: About yourself, the service user
The answers to the next group of questions will be used to get a picture of who took part in this survey. For example, we will use these questions to help us make sure that services are delivered equally to people with different backgrounds.

19. Do you receive any practical help on a regular basis from your husband/wife, partner, friends, neighbours or family members?

Please tick (✓) as many boxes as apply

- ☐ Yes, from someone living in my household a (1)
- ☐ Yes, from someone living in another household b (1)
- ☐ No c (1)

20. Do you buy any additional care or support privately or pay more to 'top up' your care and support?

Please tick (✓) as many boxes as apply

- ☐ Yes, I buy some more care and support with my own money a (1)
- ☐ Yes, my family pays for some more care and support for me b (1)
- ☐ No c (1)

21. Did you have any help from someone else to complete this questionnaire?

Please tick (✓) <u>one</u> box

- ☐ No, I did not have help 1
- ☐ I had help from a care worker 2
- ☐ I had help from someone living in my household 3
- ☐ I had help from someone living outside my household 4

22. What type of help did you have?

Please tick (✓) <u>as many</u> boxes as apply

- ☐ I didn't have any help a(1)

- ☐ Someone else read the questions to me b(1)
- ☐ Someone else translated the questions for me c(1)
- ☐ Someone else wrote down the answers for me d(1)
- ☐ I talked through the questions with someone else e(1)
- ☐ Someone answered for me, without asking me the questions f(1)

23. Please use the space provided below to describe any other experiences you would like to tell us about, or to write any other comments you would like to make?

24. We may be asking some people to take part in follow-up research for this study in the next year or so.

Would you be happy to be invited to take part in more research?

Note that even if you say "yes" there will be no obligation to take part in the future.

Please tick (✓) one box

☐ Yes, I have written my name, address and phone number in the space below

☐ No

If you would be happy to be contacted for this purpose please provide your contact details here:

Name:
Address:

Telephone number:
Email address (optional):

Please tick (✓) this box if you would like to receive a copy of the report of this survey ☐

Thank you for helping us by filling in this questionnaire.

Please post it back to us in the envelope provided.
You don't need to put a stamp on the envelope.

For your views to count please return this form by 4th March 2016

Guidance for People Helping Somebody to Complete the Questionnaire

Thank you for helping your family member or friend to fill out this form. It is important for us to get their views. Please try not to influence their responses. Please read below how best you can help them.

First, would the person prefer to have a Large Print version of the form or an Easy Read version or perhaps one that's written in their preferred language? If any of those would be better, contact the person named on the covering letter using the phone number provided.

If you are helping the person by reading out the questions aloud…

1) Please read them out exactly as they are written. If they don't understand the question read the words out aloud again. If they still don't understand it may be that they would be better off with the easy-read version. If so, contact the person named on the covering letter using the phone number provided.
2) Please ask the person to listen to all of the response choices before deciding which one is their answer.
3) Some questions require more than one option to be chosen. For these, please pause after reading each option and prompt the person for a response.
4) You should read the text illustrated in grey out aloud. It signals that the questions refer to a different area.
5) Similarly you should read the text *in italics* out aloud because it explains what things mean.

If you are helping the person by translating the questions…

1) Please contact the person named in the covering letter. It may be possible for a translated version to be sent to your family member or friend. They could then complete it without any help.
2) If you are helping by translating out aloud, then please read out the questions exactly as they are written.
3) You should also translate the text in grey which describes that the following set of questions cover a different area.
4) You should also translate the *italicised* definitions which appear in some questions.

Thank you for helping to complete our survey

HSC - 28/7/2016

Appendix A

2014/15 benchmarking

	TOTAL 1A		TOTAL 1B		TOTAL 1C(1A)		TOTAL 1C(1B)		TOTAL 1C(2A)		TOTAL 1C(2B)		TOTAL 1D		TOTAL 1E		TOTAL 1F		TOTAL 1G		TOTAL 1H		TOTAL 1I1		TOTAL 1I2		TOTAL 2A(1)		TOTAL 2A(2)		TOTAL 2B(1)		TOTAL 2B(2)		TOTAL 2C(1)		TOTAL 2C(2)		TOTAL 2D		TOTAL 3A		TOTAL 3B		TOTAL 3C		TOTAL 3D1		3D2		TOTAL 4A		TOTAL 4B	
	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank	Outcome	Rank
Shire Counties	19.3		79.3		83.8		80.7		29		71.5		7.8		5.8		8		71		49.8		45.7		37.6		14.4		642		81.2		2.8		12.7		4		77.2		66		40.7		73.3		74.5		64.4		69.8		85.3	
Unitary Authorities	19.2		78.8		87		66.1		25.6		51.5		8.1		6.7		7.9		74.1		61.2		44.8		40.7		16.3		701.6		83.2		2.9		11.4		3.5		75.4		66.2		44.5		74.4		75.8		68.7		69		86.3	
Metropolitan Districts	19		76.2		82.4		78.9		23.4		70.5		8		4.6		5.6		78.9		62.6		45		39.7		14		784.1		80.8		3.4		10.6		4.1		71.4		64.4		41.7		71.9		74.4		66.4		68.9		83.6	
Inner London	18.4		73.2		80.4		90.7		21.5		79.7		7.5		6.1		5		69.8		76.5		41.1		34.1		14.9		638.7		89.1		4.8		6.2		2.5		70.9		59.7		34.7		64.2		71.8		61.3		62.9		79.5	
Outer London	18.5		70.4		81.6		79.1		29		68.5		7.6		8.6		5.9		68.7		78.8		42.3		36.4		8.7		431.8		83.4		3.8		7.3		2.4		69.3		59.4		35.5		65.7		72.9		62.7		64.8		82.3	
North East	19.4		79.1		91.9		81		24.1		48.1		8.5		4.7		5.1		78.1		53.3		47.6		47.4		16.2		835.8		86.4		3.2		7.4		1.6		79.7		66.6		49.3		80.3		79.7		73.2		71.9		88.8	
North West	19.2		78.1		78.7		75.6		22.8		67.3		8		4.2		6.7		87.9		58.9		45.5		39.5		16.8		848.3		80.9		3.2		9.4		2.5		72.3		66.8		42.9		71.6		74.6		68.2		70		84.5	
Yorkshire and the Humber	19.1		78.1		81.1		63.1		24.4		59.9		8.1		6.6		8.3		81.4		67.2		45.7		40.5		11.5		726.9		83.2		2.6		9.6		3		70.5		65.9		43		74.6		74.4		68.3		67.7		81.8	
East Midlands	19		76.6		95.6		87.3		35.9		86		7.6		3.2		4.7		73.2		33.5		41.7		35.1		15.8		679.9		82.1		2.3		14.3		3		80.1		64.4		42.9		68.9		72		61.6		67.4		87.7	
West Midlands	19		76.3		83.9		64		24.7		61.3		7.8		4.3		9.5		62.6		71.2		44.2		38.4		12.4		656.6		80		3		15.4		7		67.3		64.3		38.7		71.3		73.6		63.4		69.5		86.1	
Eastern	19		77.7		84.7		85.3		28.3		75.8		8.1		7.3		6.8		69.2		56		43.6		42.2		17.4		610		79.7		2.9		11.6		3.1		80.9		63.6		39		76.3		72.9		63.6		69		82.6	
London	18.5		71.6		81.1		84.6		26		73.8		7.6		7.7		5.5		69.1		77.8		41.8		35.5		11.1		491.7		85.3		4.1		6.9		2.4		69.9		59.5		35.2		65.1		72.5		62.1		64		81.2	
South East	19.4		80.1		86.2		91.5		28.3		87.8		7.7		7.5		6.7		68.5		51		47.1		35.5		13.1		587.5		79.4		3.1		11		4		74.5		65.6		41.2		72.7		75.9		65		70.7		85.5	
South West	19.3		79.9		79.2		71		24.7		47.7		7.9		6.3		8.4		69.5		53.8		45.7		36.4		16.8		678.2		84		3.5		15		5.9		76		67.4		41.9		72.1		76.6		66.4		68.3		86.9	
ENGLAND	19.1		77.3		83.7		77.4		26.3		66.9		7.9		6		6.8		73.3		59.7		44.8		38.5		14.2		668.8		82.1		3.1		11.1		3.7		74.6		64.7		41.2		72.3		74.5		65.5		68.5		84.5	
HSC 16/6/2016 Scorecard ref number	#1																#9						#12																												#26		#27	
Barnsley	19.4	3	74.1	12	79.9	9	100	1	31.8	5	100	1	8.3	2	2.5	13	5	12	82.9	7	67.2	11	46.4	8	45.3	5	14.6	14	697.5	7	81.8	8	2.5	4	1.4	1	0.2	1	81	3	72.7	2	46.8	4	82.5	1	77.8	5	74.3	1	71.9	3	88.5	4
Doncaster	18.8	12	77	10	88.9	5	89.9	8	17	13	80.6	6	8.3	2	9.4	4	4.4	15	77.6	10	75.5	2	38.9	15	45.5	3	23.4	15	1084.6	15	81.8	8	2	8	5.5	4	3.8	12	75.8	6	64.7	10	41.9	12	76	7	72.1	13	71.9	5	67.6	9	80.9	12
Rotherham	18.5	13	74	13	76.4	12	0	14	17.4	12	0	14	8.3	2	6	8	4.9	14	78	9	73.1	5	40.2	13	45.5	3	12	10	958.5	14	84	7	1.5	11	9.5	9	2.3	8	85	2	65	9	49	2	75.3	8	77	6	71.6	6	61.5	15	81.6	8
Sheffield	18.5	13	73.9	14	71.6	13	68.5	11	22.3	8	50.5	10	7.3	15	3.6	12	5.6	11	86.3	4	74.4	3	41.5	11	27.6	15	14	13	730.4	9	76.5	15	4.9	1	15.2	13	7.4	15	78.5	5	59.8	14	26	15	59.9	15	65.7	15	52.5	15	63.6	12	81.5	9
Bradford	19.4	3	77.8	8	79.4	10	100	1	14.8	15	100	1	8.4	1	4.9	11	7	9	84.4	5	66.5	13	52.2	2	47.4	1	7	2	717.7	8	88.8	4	2.1	6	3.7	2	0.6	2	54.4	13	62.5	13	40.4	14	77.6	4	73.3	10	67.4	12	70.7	5	82.3	7
Calderdale	19.4	3	80.7	4	98.7	1	100	1	30.1	6	36.4	11	7.9	12	8	5	8	6	91.7	2	69.3	7	52.6	1	38.3	11	8.8	3	613.3	5	79.7	13	1.1	14	16.2	14	1.6	5	59.3	12	66.5	8	45.2	7	74.9	10	76.1	8	64.3	14	68.9	6	81.5	9
Kirklees	18.2	15	72.7	15	88.9	5	0	14	40.7	1	0	14	8.3	2	10.4	3	8.1	5	83.2	6	67	12	39.7	14	45.8	2	11.1	8	503	1	94.1	1	1.8	10	9.8	10	1.2	3	73.2	7	59.3	15	41.2	13	71.3	14	72.6	11	69.1	10	61.7	14	75.3	13
Leeds	18.9	11	77.3	9	82.3	7	73.1	9	16.9	14	68.8	8	7.9	12	7	6	10.7	4	79.8	8	54.2	15	44.3	10	38.7	9	11.1	8	763.7	11	81.3	12	4.6	2	12.7	12	3.9	13	64.4	11	63.2	12	42	11	76.1	6	70.4	14	67.5	11	67.3	10	86.5	5
Wakefield	19.1	9	75.6	11	66.7	14	72.5	10	21.2	10	72.5	7	7.9	12	5.3	9	6.7	10	76.7	12	69	8	44.7	9	34.6	14	10.9	6	748.3	10	81.6	10	2.2	5	17.9	15	2.7	9	65.6	10	68.2	6	47.8	3	77.7	3	72.4	12	65.4	13	67.9	8	82.9	6
East Riding of Yorkshire	20.1	1	91.4	1	98	2	100	1	33.9	2	97.8	5	8.2	7	6.5	7	16.3	1	69.7	14	78.1	1	48.8	5	39.7	8	6.2	1	519.8	2	77.1	14	1.2	12	5	3	1.3	4	68.3	8	76.2	1	45.9	6	76.4	5	80.6	2	72.9	3	78.9	1	94.4	2
Kingston upon Hull	19.3	6	78.7	6	82	8	100	1	32.6	3	100	1	8.1	9	0.8	15	5	12	73.8	13	68.5	9	47.1	6	38.5	10	11	7	938.1	13	91.1	2	1.9	9	9.2	8	1.7	6	42	14	68.6	5	50.4	1	73.8	11	76.5	7	69.7	8	70.8	4	95.9	1
North East Lincolnshire	19.2	8	82.4	3	91.8	4	91.1	7	24	7	28.7	13	8.1	9	1.9	14	8	6	66.6	15	74.2	4	40.4	12	43.8	7	13.7	11	553.2	3	88.7	5	1.2	12	7.1	6	2.1	7	67.7	9	64	11	46.5	5	75.2	9	79.7	4	74.3	1	65.7	11	92.3	3
North Lincolnshire	19.6	2	83.5	2	60.1	15	44.5	13	31.9	4	35.4	12	8.2	7	5.2	10	7.4	8	77.3	11	67.7	10	50.1	4	38.1	12	13.9	12	560.4	4	90.3	3	2.1	6	6.3	5	2.7	9	85.3	1	71.7	3	44.6	8	72.5	13	84.4	1	72.6	4	74.6	2	81.5	9
North Yorkshire	19.3	6	80.3	5	76.9	11	53.8	12	19.1	11	53.8	9	8.1	9	10.7	2	13.9	2	86.5	3	69.6	6	51.6	3	37.8	13	9.5	4	785.5	12	87.8	6	3.1	3	7.7	7	2.9	11	79.3	4	69	4	44.1	9	78.7	2	75.8	9	69.4	9	68.7	7	74.8	14
York	19	10	78	7	95.8	3	100	1	21.6	9	100	1	8.3	2	13.7	1	10.9	3	91.8	1	55.1	14	46.6	7	44.7	6	9.9	5	630.8	6	81.5	11	0.9	15	11.6	11	6.3	14	33.8	15	67.1	7	43.4	10	73.2	12	79.8	3	70.3	7	62.3	13	67.4	15
2015/16 score and rank	18.8	12															5.2	12					45.5	9																											66	11	84.5	6
YORKSHIRE & HUMBER																																																					
Quatile for Y&H	18.9		74.9		76.7		61.2		18.3		35.9		8.0		4.3		5.3		77.0		67.1		41.0		38.2		9.7		586.9		81.4		1.4		5.9		1.5		61.9		63.6		42.0		73.5		72.5		67.5		64.7		81.2	
	19.2		77.8		82.0		89.9		22.3		68.8		8.2		6.0		7.4		79.8		69.0		46.4		39.7		11.1		717.7		81.8		2.0		9.2		2.3		68.3		66.5		44.6		75.3		76.1		69.7		67.9		81.6	
	19.4		80.5		90.4		100.0		31.9		98.9		8.3		8.7		9.4		85.4		73.7		49.5		45.4		13.8		774.6		88.8		2.4		12.2		3.4		78.9		68.8		46.7		77.0		78.8		72.3		70.8		87.5	
ENGLAND																																																					
Quatile for England	18.7		73.8		79.0		70.7		19.3		39.1		7.5		3.1		4.4		67.6		54.5		41.9		33.0		17.2		790.5		78.6		2.0		12.7		4.2		62.8		61.1		37.9		67.6		72.1		61.7		65.3		81.2	
	19.1		77.4		89.0		97.6		25.1		90.6		7.9		5.5		6.2		74.2		68.4		44.5		38.2		12.6		641.9		83.8		3.0		9.6		2.5		72.6		64.6		41.5		71.9		74.9		66.8		68.1		85.6	
	19.4		80.1		96.4		100.0		31.8		100.0		8.2		8.3		8.4		82.4		77.9		47.8		43.1		8.8		539.6		88.8		4.0		6.7		1.4		82.2		67.8		45.2		75.1		77.9		69.9		72.0		88.9	

Appendix C - HSC 28/7/16

Table 1a Age Band 18 to 64	Short Term Support to Maximise Independence	Long Term Support (Eligible Services)	Long Term Support (Eligible Services)	Long Term Support (Eligible Services)	End of Life	Ongoing Low Level Support	Short Term Support (Other)	Universal Services / Signposted to Other Services	No Services Provided - Any Reason	TOTAL
	Sequel to Request for Support (and Support Setting)									
SUPPORT SETTING (if relevant)		NURSING CARE	RESIDENTIAL CARE	COMMUNITY						
2014-15 TOTAL	45	1	5	208	0	667	16	3937	81	4960
2015-16 TOTAL	54	9	9	212	0	588	22	4686	76	5656
no's Changed	9	8	4	4	0	-79	6	749	-5	696
%age Change	20.0%	800.0%	80.0%	1.9%	-	-11.8%	37.5%	19.0%	-6.2%	14.0%

Table 1b Age Band 65 and over	Short Term Support to Maximise Independence	Long Term Support (Eligible Services)	Long Term Support (Eligible Services)	Long Term Support (Eligible Services)	End of Life	Ongoing Low Level Support	Short Term Support (Other)	Universal Services / Signposted to Other Services	No Services Provided - Any Reason	TOTAL
	Sequel to Request for Support (and Support Setting)									
SUPPORT SETTING (if relevant)		NURSING CARE	RESIDENTIAL CARE	COMMUNITY						
2014-15 TOTAL	570	45	121	889	0	2909	225	3307	432	8498
2015-16 TOTAL	698	70	98	882	0	1929	263	4695	365	9000
no's Changed	128	25	-23	-7	0	-980	38	1388	-67	502
%age Change	22.5%	55.6%	-19.0%	-0.8%	-	-33.7%	16.9%	42.0%	-15.5%	5.9%

Originator : Scott Clayton

Rotherham Metropolitan Borough Council

Public
Health Select Commission Meeting

Summary Sheet

Council Report
Health Select Commission 28th July 2016

Title
Adult Social Care – Local Measures Performance Report

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

Strategic Director Approving Submission of the Report
Graeme Betts, Interim Strategic Director of Adult Care and Housing

Report Author(s)
Scott Clayton, Interim Performance & Quality Team Manager

Ward(s) Affected
All

1. Summary

This Local Measures Performance report was requested to be submitted to the HSC following the consideration of the provisional year end 2015/16 performance report, held on 16th June. 2016. The content addresses the request that was made and recorded in the minutes as resolved actions (as copied below)

Resolved:-

(3) That a report be submitted on the local measures for the Select Commission's next meeting.

2. Recommendations

It is recommended that Members note:

2.1 The contents of the report.

List of Appendices Included

Appendix A - Adult Social Services Local Measures Performance Scorecard

Background Papers

Agenda and minutes of HSC meeting held 16/6/2016 provide additional information that has informed this report.

Consideration by any other Council Committee, Scrutiny or Advisory Panel

None

Council Approval Required

No

Exempt from the Press and Public

No

Title: Adult Social Care – Local Measures Performance Report

1. Recommendations

It is recommended that Members note:

1.1 The contents of the report.

2. Background

2.1 As part of the continued performance management framework and to support the business needs of the Adult Social Care Directorate Leadership Team, a number of key local measures have been developed. These measures contain performance targets for 2016/17 and are designed to complement the statutory ASCOF measures referenced in the June 16 report to the Health Select Commission. The specific measures are referenced in the Local Measures Scorecard attached as Appendix A.

The local measures have been prioritised to ensure that they reflect areas of Adult Social Care service activity and that they link back to the Council's overarching strategic policies and strategies e.g. Improvement Plan, Corporate Plan plus delivery flows from the key work streams of the Adult Social Care Development Programme. A number of the Local Measures were formerly national measures which are no longer reported, but they retain local value in providing assurance on service responsiveness and outcomes for customers.

The management teams within the Directorate receive regular (usually monthly but this can be refreshed more frequently when required) updates of the current performance of the Local Measures alongside the National ASCOF measures reporting. Local Measure in-year performance will be included routinely in future Cabinet Member reporting arrangements commencing with quarter 2. This will align and run parallel to the agreed Corporate Plan and Improvement plan reporting schedules.

In addition to the Local Measures included in the scorecard, it should also be noted that a range of other measures of activity are also performance managed and reported via alternative reporting streams, for example Safeguarding Adults Board performance measures. Service level management information measures are also regularly reported internally to Senior Management Teams.

The reporting arrangements on the range of Local Measures included in the scorecard and compilation of the data from within existing ASC reporting systems also enable any necessary and agreed, new in-year prioritised local measures to be incorporated and performance monitored readily.

3. Key Issues

3.1. The targets for 2016/17 reflect the progress and expectation of the Adult Care & Housing Directorates Development Programme actions and key delivery milestones. The measures provide an assurance opportunity to gauge the pace, impact and effectiveness of changes being implemented. This is particularly important as more traditional service offers are re-modelled, alternatives to traditional service delivery are developed and personalisation is further rolled out. These provide insight into the customer journey experience.

3.2 Current Performance challenges as at 31st May 2016 data

LM01 – Reviews

This measure accumulatively counts the number of customers in receipt of long term services (over 12 months), who have had a review of their care packages and received on-going support in the financial year.

The minimum target of 75% of good quality reviews has been set for 2016/17. If this is to be achieved by year end, then the current pace of reviews needs to increase to enable quicker throughput of activity. A performance clinic will be held in July to identify how the re-modelled service can project a work programme to achieve the target and provide the impetus to attain 100%.This 'clinic' will also explore with services how to undertake alternative approaches to conducting reviews but will still meet good practice and deliver good outcomes/experiences for customers.

LM02 - Support plans % Issued

This tracks that customers support plans are updated in line with their assessment so that they are informed of the outcome and aware of the level of care/support required to meet their needs.

Current activity data demonstrates attainment of 83% of assessments being accompanied by an up to date Support Plan.

LM03 – Waiting times assessments

This measure tracks the time to complete new customer's assessment so that they are undertaken in a timely manner. The service aims to complete within 28 days from date of first contact.

Current activity demonstrates attainment of 76% being completed within 28 days. Service re-modelling impact should positively impact in year and continued monitoring will inform decisions as to if any further remedial actions are required.

LM04 – Waiting times care packages

This measure tracks the time to put in place a customer's support plan services. The measure tracks the time from the date the assessment is completed until all services have been set up. The service aims to complete within 28 days from the date of the completed assessment.

Current activity demonstrates attainment of 76% being completed within 28 days. Service re-modelling impact should positively impact in year and continued monitoring will inform decisions as to if any further remedial actions are required.

LM05-07 – Commissioning KLOE's

Achieving effective commissioning approaches is one of the key measures in The Improvement Plan for Rotherham and therefore the Local Government Association's *Commissioning for Better Outcomes* measures are deemed to be best practice for Adult Social Care. Further, these measures are regularly benchmarked across the Yorkshire and Humber region, enabling Rotherham's progress to be effectively measured. There is also the potential for a peer review, facilitated by ADASS,[1] from best in class local authorities across the region to provide independent feedback on current approaches, share best practice and assist in propelling the Council towards achieving commissioning excellence.

Effective commissioning cannot be achieved in isolation. It needs to be co-produced with people who are using or likely to use adult social care and will be best achieved by close collaboration with other key services – children's services, public health, housing and NHS partners.

The core principles of the best practice guidance support the development of a common focus and purpose, driven by shared values and behaviours. This includes commissioning for prevention; for both the care and support for people with assessed care needs, and for the overall health and wellbeing of all, thereby preventing, reducing or delaying the need for services in the future.

4. Options considered and recommended proposal

4.1 None

5. Consultation

5.1 None

6. Timetable and Accountability for Implementing this Decision

6.1 None

[1] Association of Directors of Adult Social Services

7. Financial and Procurement Implications

7.1 Commissioning activity in line with the recommendations of *Commissioning for Better Outcomes* should inform procurement approaches and ensure best value is attained.

8. Legal Implications

8.1 Compliance with statutory requirements under the Care Act 2014

9. Human Resources Implications

9.1 None

10. Implications for Children and Young People and Vulnerable Adults

10.1 Adult Social Care primarily provides services to vulnerable adults and therefore the attainment of local measures demonstrates a higher quality of service being offered to customers.

11 Equalities and Human Rights Implications

11.1 The *Commissioning for Better Outcomes* standards ensure compliance with the Human Rights Act (2004) and duties under the Equality Act (2010)

12. Implications for Partners and Other Directorates

12.1 Improved Adult Social Care services have positive benefits for health partners and young people transitioning into Adult Care from Children's services.

13. Risks and Mitigation

13.1 Non-compliance with the Care Act requirements, mitigated by implementing the Adult Care & Housing Directorates Development Programme

14. Accountable Officer(s)

Approvals Obtained from:-

Graeme Betts, Interim Strategic Director Adult Care and Housing

Nathan Atkinson, Assistant Director Strategic Commissioning

Scott Clayton, Interim Performance & Quality Team Manager

This report is published on the Council's website or can be found at:-

http://moderngov.rotherham.gov.uk/ieDocHome.aspx?Categories

Adult Social Care Local Performance Measures 2016/17 (Appendix A)

Direction of Travel Key

⇧	Indicator has improved
⇔	Indicator shows no change
⇩	Indicator has deteriorated

Indicator Ref						Indicator Title	RAG	Freq.	2015/16 Performance	16/17 Target	DOT (15/16 - 16/17)	16/17 Performance as 31/5/16	Head of Service	Accountable Officer	Comments / Remedial Actions
LM01	SALT 1					Proportion of Adults on service over 12 months as at 31st March who received a review in year	High	Monthly	49.23%	75% min 100% max	⇩	9.38%	Sam Newton	TBC	
LM02	NAS 18 (PAF D39)					Percentage of people issued a support plan	High	Monthly	79.33%	90.00%	⇧	82.71%	Sam Newton	TBC	
LM03	NI 132					New - Social Care assessments only (excludes OT/Sensory activity) completed within 28 days from first contact.	High	Monthly	76.13%	90.00%	⇧	76.42%	Sam Newton	TBC	
LM04	NI 133					New - Social Care packages of care only (excludes OT activity) in place within 28 days of assessment (Adults)	High	Monthly	84.00%	95.00%	⇩	75.93%	Sam Newton	TBC	
Commissioning KLOE - Self Assessment Ratings * 3															
LM05	C_Kloe1					Person-centred and outcomes-focused	RAG	Quarterly	RED Qtr 1				Nathan Atkinson	TBC	
LM06	C_Kloe2					Well led	RAG	Quarterly	RED Qtr 1				Nathan Atkinson	TBC	
LM07	C_Kloe3					Promotes a sustainable and diverse market place	RAG	Quarterly	RED Qtr 1				Nathan Atkinson	TBC	

Briefing paper for Health Select Commission 28 July 2016

Caring Together Supporting Carers in Rotherham

Introduction

At its meeting on 3 December 2015 the Health Select Commission received a presentation covering the development of a new Carers Strategy for Rotherham. This has been a partnership approach through a multi-agency group comprising RMBC officers, members of the Carers Forum and health and voluntary sector partners. A further draft was presented at the April meeting of the Commission, together with an update on the Carers Forum.

Draft Strategy and Action Plan

Attached is an updated draft strategy which emphasises the need to identify and support all carers, including hidden carers and young carers. It focuses on three outcomes:

- Outcome One: Carers in Rotherham are more resilient and empowered.
- Outcome Two: The caring role is manageable and sustainable.
- Outcome Three: Carers in Rotherham have their needs understood and their well-being promoted.

The strategy includes:

- An introduction that defines who a carer is and includes a five-point pledge
- Statistics about informal care and carers
- Carers' rights
- Support for carers from partners
- Feedback from carers, including young carers
- "We will …." statements for each of the three overarching outcomes

Also attached is a draft of "Making it Happen – Caring Together Delivery Plan", the implementation plan that will form part of the strategy document once completed. This sets out the actions to be taken to meet the "we will" statements and includes measures to demonstrate how the strategy is making a difference.

Recommendations

Members of Health Select Commission are asked to:

- Consider and comment on the draft strategy and delivery plan.
- Agree an appropriate timescale with the Delivery Group to receive a progress update on implementation.

Briefing note: Janet Spurling, Scrutiny Officer janet.spurling@rotherham.gov.uk

Making it Happen – Caring Together Delivery Plan

	What actions are we going to take to ensure we meet the "we will" outcome statements	Who is going to lead / support and by when	How we will know it is making a difference
1	Develop a quality assurance framework to capture carers outcomes across the health and social care economy	Caring Together Delivery Group	✓ We will have a baseline to measure the action plan against ✓ carers will not be continually "surveyed" for different purposes ✓ we will have a system for capturing qualitative and quantitative measures
2	Targeting hard to reach carers through the integrated locality team and a joined up approach between Children's and Adults services	Integrated Locality Team Caring together delivery group	✓ increase in the number of carers assessments ✓ Feedback from carers ✓ profile of "known carers".
2	Continued promotion and encouragement of GP Carers registers and carers clinics within GP surgeries (ensure these lists are used to routinely involve carers)	RCCG (Julie Abbotts) / Crossroads (Liz Bent) On-going	✓ Every GP Practice in Rotherham has a register ✓ registered is shared with wider health and social care economy (subject to consent) ✓ carers champion in every GP surgery

	What actions are we going to take to ensure we meet the "we will" outcome statements	Who is going to lead / support and by when	How we will know it is making a difference
3	Development of joint funded carers support service through the Better Care Fund to include: • breaks for carers • information, advice and support • rebrand / refresh of Carers Centre (Carers Corner) model • utilises community based support • targeted action around hard to reach groups	Better Care Fund Operational Group agreed in BCF plan for 2016	✓ Increased numbers of carers assessments, carers linked into support services ✓ number of carers getting a break ✓ outcomes from carers resilience measurements ✓ levels of carers benefit achieved across the Borough
4	Review of all the carers needs assessments, forms and methods of assessments to ensure this becomes more personalised	RMBC (Sarah Farragher) to lead in partnership with the Caring Together By December 2016 (Development of family assessment within the new social care assessment system (Liquid Logic) December 2016	✓ Feedback from Carers in relation to their experiences of the assessment process ✓ Increase in the number of carers receiving an assessment ✓ Strong carers forum ✓ on-going involvement of carers in the caring together implementation group

	What actions are we going to take to ensure we meet the "we will" outcome statements	Who is going to lead / support and by when	How we will know it is making a difference
5	Review the way that social care resources are allocated for carers in line with the requirements of the Care Act	RMBC (Sarah Farragher) to lead in partnership with the Caring Together By September 2016 (within the new Social Care Assessment System (Liquid Logic) December 2016	✓ No of carers in receipt of a personal budget / well-being budget
6	Develop an on-line / self- assessment for carers linked to resources	RMBC Debbie Beaumont	✓ No of people using the assessment tool ✓ No of carers in receipt of a carers budget
7	Review and develop information, advice and guidance offer in conjunction with Carers	Caring Together Delivery Group Supported by information, advice and guidance officers September 2016	✓ Feedback from carers and support agencies ✓ Increase in identification of Hard to reach carers ✓ Feedback from mystery shopping

	What actions are we going to take to ensure we meet the "we will" outcome statements	Who is going to lead / support and by when	How we will know it is making a difference
8	Undertake an awareness campaign to promote Carer friendly communities	Caring Together Delivery Group supported by the information advice and guidance officers	✓ Increase in identification of hard to reach carers ✓ increase in number of carers who report to access flexibly working ✓ increase in Carers being involved in service planning
9	Development of a memorandum of understanding with relation to young carers	RMBC commissioning (adults and children's)	✓ Carers routinely have a voice in service development and changes
10	Development of carers pathway that looks at all ages caring and whole family approaches	Caring Together delivery group TO BE AGREED	✓ Feedback from Carers regarding
11	Ensure that Carers Forum receives appropriate support to represent the "voice" of carers and is utilised as a co-production partner Procure appropriate advocacy for carers through the advocacy framework	Carers Forum Management Committee / Crossroads (Liz Bent / RMBC commissioning) RMBC (Jaqui Clarke) August 2016	✓ Success and growth of carers forum ✓ Carers routinely have a voice in service development and changes

12	Development and roll out of an enhanced training offer that provides training for carers and about carers	RMBC Learning and development in conjunction with the Caring Together Group	✓ Number of professionals accessing training on carers ✓ Numbers of carers accessing training

2016–2018

Caring Together

Supporting Carers in Rotherham

Rotherham Metropolitan Borough Council

Contents

The Care Act has a strong focus on carers. It acknowledges the value of the support provided by unpaid carers which underpins the whole adult social care system. It also recognises a carer's right to choose to care, and to a life outside caring. The Act gives increased rights to assessments and support and ensures carers will be recognised in law in the same way as the person they care for.

1. Introduction

Who is a carer?

A carer is anyone who provides unpaid support to a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support

In Rotherham we recognise that informal carers are the backbone of the health and social care economy, and that enabling them to continue this role is vital.

It is important that we identify and support all carers, including young and hidden carers.

Our Ambitions are:

To achieve this pledge we need to build stronger collaboration between carers, and other partners in Rotherham, and recognise the importance of whole family relationships.

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. Co-production means services working together with people who use services and carers.

2016 marks the start of a renewed partnership to support carers in the Borough. This document sets out our commitment to working together so that collectively over the next 2 years we can work towards the following agreed outcomes:

- **Outcome One:**- Carers in Rotherham are more resilient and empowered
- **Outcome Two:**- The caring role is manageable and sustainable
- **Outcome Three:**- Carers in Rotherham have their needs understood and their well-being promoted

Our pledge…….

- **That every carer in Rotherham is recognised and supported to maintain their health, wellbeing and personal outcomes**
- **That carers in Rotherham are not financially disadvantaged as a result of their caring role**
- **That carers in Rotherham are recognised and respected as partners in care**
- **That carers can enjoy a life outside caring**
- **That young carers in Rotherham are identified, supported, nurtured to forward plan for their own lives**

2. What do we know about Carers?

Nationally

5.8 million people nationally are providing informal care, with 24% of these people providing in excess of 50 hours per week.

The estimated financial value of this care annually is £119billion and this has risen by 37% since 2007 (Buckner & Yeadle, 2011).

35% rise in the number of older carers between 2001, and 2011 and evidence that many of these carers are providing over 60 hours a week of care.

Mutual caring is a way of life for many older couples but also in families where there is a family member who has a disability. It is estimated that 1 in 4 people with a learning disability live with a parent over the age of 70 and the mutual caring remains hidden until the family experiences a crisis.

In Rotherham there are around 31,000 unpaid carers, of which 1,619 (5.2%) are BME. 12% of the total population are carers, compared to the national average of 10.3%. 7.8% of all BME residents are carers (reflecting a younger age profile). The highest proportion by ethnicity is in the Irish community where 14.6% are carers (reflecting an older age profile). 42% of BME carers are Pakistani. 28% of Rotherham carers are providing 50+ hours of care per week which is, again, slightly higher than the national average. (Information from the 2011 Census)

Figure 1 below shows a breakdown of the amount care provided by Rotherham carers:

- Provides 1-19 hours of unpaid care a week
- Provides 20-49 hours of unpaid care a week
- Provides 50 or more hours of unpaid care a week

Carers in Rotherham receive similar levels of benefits, assessments and reviews to other local areas.

In 2013/2014 2,375 assessments of carers' needs were undertaken, with 72% of these taking place jointly as part of the cared for persons' assessments. 105 carers assessments are recorded as refused during this period. Estimates for 2015/2016 are for 2,378 carer assessments to be completed with a further 2,404 carers offered information advice and signposting.

Young Carers undertake a full range of care tasks on a regular and sustained basis which can seriously impact on mental well-being. (Abraham & Aldridge

Four key priorities for supporting carers:

✔ Identification & recognition ✔ Realising & releasing potential
✔ A life alongside caring ✔ Supporting carers to stay healthy

National Carers Strategy (DOH, 2014)

Black & Minority Ethnic Groups:

Once the Black & Minority Ethnic Groups (BME) community had a younger profile but are now becoming an ageing population, especially the Pakistani and Yemeni community.

The current statistics on BME carers in Rotherham show only those carers who have registered as a carer or are already known to services.

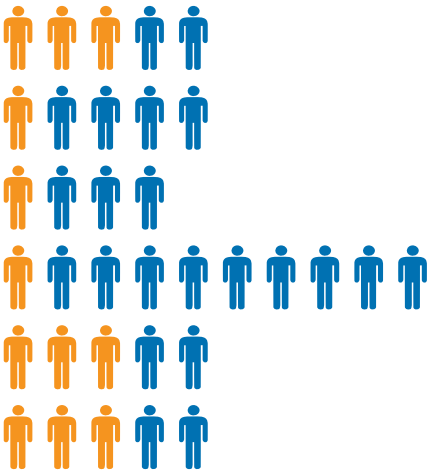
There is a significant number of hidden carers who due to their cultural background do not see themselves as carers. They see it as their duty to look after their elderly, along with parents/carers of children with disabilities who are adults now, There is a culture amongst certain communities not to ask for help, which is having a long term impact on the health of carers trying to do it alone.

Impact of Caring:

Research findings show that caring can have impact on the physical health and mental wellbeing of carers. Caring can:

- Make you physically exhausted – if you need to get up in the night as well as caring in the day, if you have to lift or support someone, if you are also looking after your family and have a job.
- Leave you emotionally exhausted - stressed, depressed or with another mental health issue.
- Affect relationships - with your partner or other family members.
- Lead to isolation – difficulties in keeping or developing friendships, keeping up interests and hobbies, leaving the house.
- Lead to financial difficulties – giving up work to care, managing on benefits, cost of aids and equipment to help care, not having enough money to do "normal" things such as buying new/warm clothes, heating the house, house repairs, holidays, etc.

Carers need to be able to balance their caring roles with other parts of their lives – such as jobs and educational opportunities. They need time to keep up relationships and pursue their own hobbies and interests. Young carers can find it difficult to manage education, training or employment if they also have a caring role.



Nationally Add stats:

3 in 5 people will be carers at some point in their lives

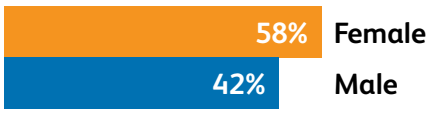
1 in 5 people aged 50-64 are carers in the UK

1 in 4 carers are caring for someone with a mental health need up to 1.5 million carers, of which 50,000 are children/young people

1 in 10 carers are caring for someone with dementia – this is 11% of all UK's carers

3 in 5 people will be carers at some point in their lives

3 in 5 people will be carers at some point in their lives



Care Gender

(Source: Carers Trust)

It is estimated there could be around 166,000+ young carers in the UK, with 13,000 caring for 50+ hours per week

There are around 350,000 young adult carers aged 16-25, with 56,000 caring for 20+ hours per week and 27,000 providing 50+ hours care each week 65% of older carers (60-94) have long-term health problems / disability themselves

By 2030 the number of carers will increase by 3.4 million (around 60%)

3. Carers' rights

Changes in policy and law over the last few years have meant that carers have more rights than they did in the past.

The Care Act (2014)

The Care Act has a strong focus on carers. Local Authorities now have a responsibility to assess a carer's need for support, which includes considering the impact of caring on the carer. The Act also contains new rules about working with young carers or adult carers of disabled children to plan an effective and timely move to adult care and support.

Children and Family Act (2014)

The Act introduces new rights for young carers to improve how they and their families are identified and supported. All young carers are entitled to have an assessment of their needs from the Local Authority. This can be requested by the young carer or their parent. This Act links to the Care Act 2014 which states Local Authorities are required to take "reasonable steps" to identify young carers in their area.

The introduction of the "family test" (DOH, 2014)

Brings the need to consider impact on family life when making policy decisions.

Practical guidance on planning which considers the needs of the whole family. This includes looking at natural support networks in place and the outcomes that the family want to achieve. This whole - family approach moves away from the traditional split between carers and the person they care for.

Equalities

In preparing the Carers' Strategy we have ensured that the strategy complies with Section 149 of the Equality Act 2010. This is about protecting and promoting the welfare and interests of carers who share a relevant protected characteristic - such as age; disability; gender re-assignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

Changes in employment law, under the Work and Family Act, mean that since 2007 carers have the right to request flexible working.

4. Partnership contributions to supporting carers in Rotherham

NHS Rotherham Clinical Commissioning Group commission a range of dedicated carer services

Carers' resilience work is now taking place in all GP practices across the Borough, with 7 surgeries now having carer clinics

Rotherham Metropolitan Borough Council spends approximately £2million a year on services and support which are specifically targeted at carers (this includes support for young carers).

The Carers Forum has recently been re-launched. It is a carer-led organisation, completely independent of statutory services. It aims to provide a "single voice" for Rotherham carers

The partners in Rotherham all contribute to supporting carers, however we need to get better at working together and reaching more carers.
A full list of services available in Rotherham is at Appendix 1

Rotherham Doncaster and South Humber NHS Foundation Trust (RDASH) was one of six pilot sites to sign up for the Triangle of Care.

In addition to Council and NHS funded services, the voluntary sector offer a range of support for carers

Rotherham Hospice offers a 24 hour a day advice line for carers using the service. It also has targeted support for carers and wellbeing support

5. What carers have told us?

As part of developing this plan we asked carers to tell us what things would make a positive difference to their caring role. Some of these where extremely personal examples, however, most of this feedback can be grouped into a number of themes:

We also had responses from a group of young carers, and the feedback from Barnardos is that these responses are reflective of other young carers.

6. The outcomes

Outcome One:

Carers in Rotherham are more able to withstand or recover quickly from difficult conditions and feel empowered.

Carers need to be enabled to continue in their caring role for as long as they choose to, or are able to do so. At times carers may need support to build, maintain or regain their caring role. Carers' ability to cope can be challenged in times of changes and, therefore, any changes need to be made in partnership with carers

What we plan to do to support this outcome:

We (the partners) need to develop a culture and reality of collaboration and co–production to deliver:

- Co-produced and delivered training package for agencies on carers' issues
- Integration of current carers' support services
- Partnership support for developing fundraising and match funding opportunities to build carers' resilience within Rotherham

We will:

- ✔ Raise the profile of carers within the wider health and social care economy
- ✔ Offer opportunities for support and a voice within the Council for carers and self-advocacy groups
- ✔ Involve carers in the planning of services
- ✔ Develop a family assessment that focuses on whole family approaches that can be used interchangeably with individual assessments as appropriate
- ✔ Enable carers' assessments to be undertaken in more flexible ways, e.g. online or through carers support services
- ✔ Ensure young carers' assessments are age appropriate and the process is meaningful to them. The assessment should focus on the IMPACT caring can have on the individual child, as this may be different from one child to another
- ✔ Promote carers' right to have an assessment
- ✔ Create and maintain strong links between Children's and Adult services, and ensure that there are systems in place to identify young carers
- ✔ Strive to ensure carers can access proportionate advice, in the right way at the right time.

Outcome Two:

The caring role is manageable and sustainable

Carers may at times need support to manage their current caring role. If we achieve the first outcome and carers are more resilient then this will help, but carers may also need breaks from their caring role. The amount and intensity of this support will vary and needs to work for both the carer and the person they care for.

Carers need to be assured that there are good plans in place to continue the caring role if they are unable to do so. This could be an emergency plan or a longer term plan.

We will:

- ✔ Treat carers as equal partners with professionals when supporting the cared for person
- ✔ Develop "shared care" models for people with the most complex needs as an alternative to traditional care models
- ✔ Increase the amount of community based, local support and networking opportunities for provision of support
- ✔ Improve the information, advice and guidance offer for carers, and link this up to immediate support during periods of crisis
- ✔ Review the Carers' Emergency Scheme to make sure that it works for carers of all people with support needs in Rotherham
- ✔ Develop a Supporting Families Planning Project that enables early planning to take place in families where an adult with support needs is living with older family carers
- ✔ Undertake a review of the transition of young carers into adult provision
- ✔ Develop a carers' pathway

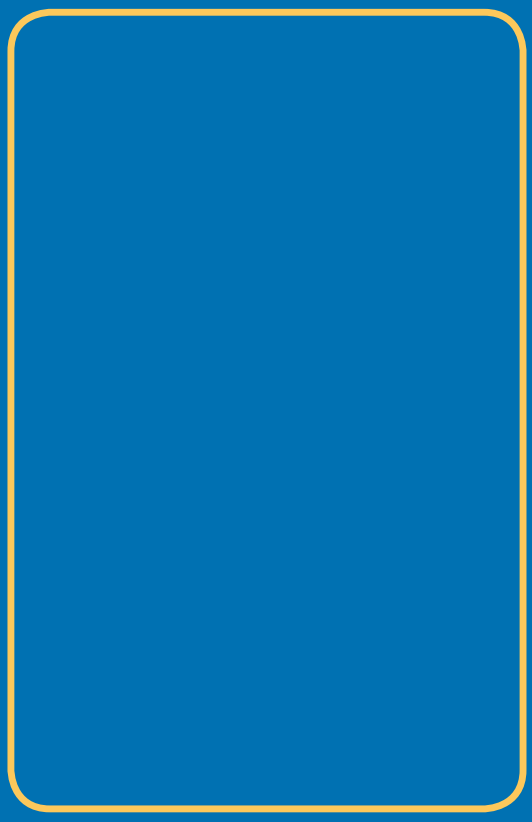
Outcome Three:

Carers in Rotherham have their needs understood and their well-being promoted.

The steps identified to achieving the first two outcomes will support with making the caring role more manageable. In addition to this carers in Rotherham need to be recognised outside of their caring role.

There needs to be a recognition that:

- **Some carers do not recognise or accept this label and see the caring relationship as part of family life**
- **Not all carers want to be carers**
- **Trust needs to be fostered between carers and statutory services**



We will:

- ✔ Develop a well-being budget and resource allocation system that supports carers independently of the support for the cared for person
- ✔ Develop carers' assessments and devolved carers' budgets to voluntary sector support services
- ✔ Encourage the development of a range of circles of support around carers within their community, including hard to reach communities - support people where they live
- ✔ Work proactively with the carers of young people in relation to their care and support needs whilst transitioning to adulthood.
- ✔ Ensure information and advice is available in appropriate formats and venues, that is sensitive to the diverse range of needs in Rotherham
- ✔ Ensure carers are supported to maximise their financial resources by:
- ✔ Working with partners to encourage Rotherham employers to become carer friendly
- ✔ Ensuring benefit advice is available to support carers
- ✔ Strive to work closely with parent carers

7. Making it happen – Caring Together Delivery Plan

Changes in policy and law over the last few years means that carers have more rights

What actions are we going to take?	Who is going to lead / support and by when?	Outcome(s)	"We wills" are we meeting	How we will know it is making a difference?

HEALTH AND WELLBEING BOARD
20th April, 2016

Present:-

Members

Councillor David Roche	Cabinet Member for Adult Social Care and Health **(in the Chair)**
Louise Barnett	Rotherham Foundation Trust
Graeme Betts	Acting Strategic Director, Adult Social Care and Housing
Karen Borthwick	Children and Young Peoples Services, RMBC
Tony Clabby	Healthwatch Rotherham
Richard Cullen	Governance Lead, Rotherham CCG
Chris Edwards	Chief Officer, Rotherham CCG
Sharon Kemp	Chief Executive, RMBC
Julie Kitlowski	Clinical Chair, Rotherham CCG
Rob Odell	South Yorkshire Police
Teresa Roche	Director of Public Health, RMBC
Debbie Smith	RDaSH
Janet Wheatley	Voluntary Action Rotherham
Councillor Taiba Yasseen	Cabinet Member, Neighbourhood Working and Cultural Services

Report Presenters:-

Steve Helps	South Yorkshire Fire and Rescue Service
Gill Harrison	Public Health, RMBC
Richard Hart	Public Health, RMBC
Sally Jenks	Public Health, RMBC

Officers

Dominic Blaydon	Rotherham CCG
Kate Green	Policy Officer, Chief Executive's Office
Gordon Laidlaw	Communications, Rotherham CCG
Dawn Mitchell	Democratic Services, Assistant Chief Executive

Observers

Chris Bland	Rotherham Pharmaceutical Committee
Councillor Mallinder	Vice-Chair, Health Select Commission

Apologies for absence were received from Carole Lavelles, Councillor Sansome, Kathryn Singh, Ian Thomas and Councillor Watson.

67. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

68. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

69. MINUTES OF THE PREVIOUS MEETING

Resolved:- That the minutes of the meeting held on 24th February, 2016, be approved as a correct record subject to the following clerical amendments:-

Minute No. 56 (Update on the Health and Wellbeing Strategy Implementation)
"It was noted that a lead officer from Voluntary Action Rotherham had now been identified for aim 2 by Ian Thomas as the Board sponsor and Janet Wheatley"

Arising from Minute No. 63 (Transforming Services for People with a Learning Disability and/or Autism), it was noted that discussions had taken place between the CCG and the Council. As from 1st April, 2016, the threshold had changed and the diagnostic tool adjusted the IQ to 70 rather than 50.

Arising from Minute No. 62 (Adult Safeguarding Strategy), Julie Kitlowski reported that GP practices were aligning themselves to care homes which would improve the Health input and be more alert to any possible issues.

A meeting had taken place to discuss the issue and ensure that the CCG had early warnings of any concerns.

Arising from Minute No. 65 (Rotherham Get Active Event), it was noted that so far 50 had registered for the event. There were 10 further places available and anyone interested should contact Kate Green as soon as possible.

Tony Clabby also raised the possibility of receiving the minutes as soon as possible following a Board meeting rather than waiting for the next agenda.

Resolved:- That the draft minutes be circulated to Board members as soon as possible after a meeting.
Action:- Democratic Services

70. SOUTH YORKSHIRE FIRE AND RESCUE

Steve Helps, Area Manager, gave a powerpoint presentation and a video of the work of the South Yorkshire Fire and Rescue Service Safe and Well initiative:-

Change of Fire and Rescue Service Business Model

- Change to Fire Service Act 2004 to introduce statutory duty to provide Community Fire Safety Advice
- UK Fire and Rescue Service business model amended from a reactive lead service to one of proactive

- The introduction of Home Safety Checks – approximately 670,000 completed annually across the United Kingdom – around 20,000 across South Yorkshire

Targeting the most vulnerable
- Are over 65 years of age
- Live alone
- Have a physical or learning disability
- Have a cognitive impairment including dementia or memory loss
- Have a mental health issue
- Have a substance or alcohol dependency
- Have Adult Social Care needs
- Are a smoker
- Are unable to protect themselves from harm for any reason

Safe and Well Visits
- In support of the 5 year forward plan CFOA, RSPH, NHS and Age UK published the consensus statement in 2015
- Move towards Safe and Well visits
- Doncaster pilot – Ageing Well, Falls questions, crime prevention, fire safety and crime private information
- Steering Group in Barnsley – work was progressing in Rotherham and Sheffield

Delivering a range of prevention initiatives
- Comprehensive schools educational programme
- Lifewise Centre introduced CPR awareness
- 7 Cadets Units routes4you
- Achieving Respect Confidence (ARC) courses
- Princes Trust Team Programme
- Eyesight tests RNIB Sheffield
- Boxing Clubs – Thorne and Moorend
- Age UK Barnsley and Rotherham
- Eastwood in Rotherham and Great Places in Sheffield – cooking courses
- Rotherham Hospice
- Hotspots referral scheme
- Over 100 Safe and Well Referral Partnerships
- Investment in £1.7m through SSCR across over 30 community-based projects
- Winter warm packs
- Midwife lead prevention work through SSCR project
- Troubled Families Programme
- Supporting food banks
- Dementia Alliance funding/project
- Alzheimer's Memory Café

Fire Health Conference 2016
Recommendations

- The introduction of Safe and Well visits across South Yorkshire
- Partnership supporting and becoming Safe and Well referral partners allowing the most vulnerable within our communities to receive early interventions
- A mature conversation with partners to identify opportunities for data sharing to ensure limited resources are targeted at the most vulnerable through early intervention activities
- South Yorkshire Fire and Rescue Service to support the priorities of the Health and Wellbeing Boards and for Boards to recognise the varied activities that the Service undertake in support of the Health and Wellbeing agenda
- Commissioners and South Yorkshire Fire and Rescue Service to identify activities which the Service's assets could contribute to support early intervention or reduce demand on existing services

Safe and Well Referral Partnership
How you can assist

- To sign up to become a Safe and Well Partner please follow the links below
  Website www.syfire.gov.uk/safe-well
  Email
  Safe&well@syfire.gov.uk
  Once you have made contact with us an Officer will follow up your enquiry to discuss further and process your application

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

- The fact that the Fire Service was a trusted service going into a property was very useful. For elderly people who were isolated and lonely, and by definition not engaging with services, the opportunity of Safe and Well visits linked up with social prescribing

- One of the biggest referrals from outside agencies was to the Fire Service
  We see the benefits of working with the 3rd sector agencies and Age UK with the engagement programme

- The Service was doing this work but most of the agencies did not see/aware of it; the challenge was how to make that connection. Was a Safe and Well visit communicated to partners?
  The referral pathway would enable the Service to report back the outcome and the number of visits made. If the visit resolved the issue that was the end of the matter but if it was more challenging and the resident was someone who had long term issues it would be escalated to a specialist Community Safety Officer. There would be a multi-agency approach with the right people around the table and

discuss the resident and every endeavour would be made to ensure that the resident was safe

- Were the red referral cards that a professional had to fill in still used? *The system had been found to be quite bureaucratic. A new simpler system was used for Safe and Well as well as a web portal*

- If the Service was able to find a way of looking at/achieving risk reduction it would be helpful to the Foundation Trust

- The Trust was to start its next stage of community setting work which would include the Fire Service so there would be an opportunity to educate the Health side

Steve was thanked for his very informative presentation.

71. HEALTH AND WELLBEING STRATEGY

Julie Kitlowski report on the workshop held on 16th March to address health inequalities and healthy life expectancy. Key themes that were felt to make a difference if all partners were aware of the commitments were pulled together:-

Making Every Contact Counts issues – which should include encouraging the most deprived and hard to reach to go for Healthchecks and have Champions in the community who would be able to give their stories about how they had managed to make significant life changes by personal testimony

Community Champions – there were some really good stories of people from hard to reach communities standing up and being prepared to say how they had made a difference. The aim was to have health champions/more health ambassadors

Keeping Active – All partners knew exactly what was available so it was incumbent on them to pass that information onto their clients and staff and attempt to try and link up the education of what was available

It was important that employers, businesses, volunteers etc. worked together with the Partnership Group and business community or it would not progress in the way needed to make a difference in health inequalities. It was key to engage better with partners and businesses

Measure Outcomes – the number of patients having Healthchecks could be measured as well as the number of Community Champions and those that signed up the various activity events

Terri Roche reflected that the notes from the workshop did not have a strong emphasis on NHS Healthcheck but agreed that it was important that harder to reach communities had support had access to the right

health care services in a timely manner. This could include improving the uptake of national screening and vaccinations programmes and early presentation of symptoms at Primary Care.

Discussion ensued on employment and business and linking in with the discussions taking place around the Sheffield City Region (SCR). The most effective way of tackling inequalities was money and that usually came from employment. There was a danger if the Board did not influence the SCR agenda, access to employment for those who experienced barriers could make the inequalities worse.

Terri Roche reported that the working group for Theme 5 had not met as yet. There was an outcome based accountability Safer Rotherham Partnership workshop taking place on 26th April, 2016, and it was felt that some of the actions that needed to be in Health and Wellbeing Strategy would "fall" out of that. The group would then look at the gaps and who else needed to be pulled in

Chris Edwards and Louise Barnett gave a brief report on the Sustainability and Transformation Plan (South Yorkshire and Bassetlaw Equality Plan). Chris, Louise and Sharon Kemp were meeting on a weekly basis to pull the Plan together. It covered health and wellbeing and had links through the whole Sheffield City Region. There were very tight timescales for its submission which would not coincide with the meetings of the Board. A submission had been made on 15th April with a further submission required by the end of June. There was to be an engagement event on 25th April.

Resolved:- (1) That the update on the Health and Wellbeing Strategy be noted.

(2) That an update on the Sustainability and Transformation Plan be submitted to the next meeting of the Board.
Action: Chris Edwards, CCG

72. THE HEALTH PROTECTION COMMITTEE'S ANNUAL REPORT

Richard Hart, Health Protection Principal, presented the Health Protection Committee's 2015 annual report.

The Committee had made considerable progress in seeking assurance from organisations across the Borough on a range of controls associated with health protection. The report outlined the responsibilities of the Council, NHS England, the Clinical Commissioning Group, Public Health England, Foundation Trust and RDaSH. It also highlighted the work that had been done over the year and areas where further development was needed.

The following areas of progress were highlighted:-

- Clarifying health protection roles and responsibilities and the line of accountability between the Health Protection Committee and the Health and Wellbeing Board
- Maintaining effective working relationships and communications with Council staff, external agencies/professionals and the public
- Controlling the spread of TB and HIV through multi-agency incident meetings
- Providing local advice on national and local alerts on environmental hazards such as high level air pollution episodes
- Managing Health Care Associated Infections, MRSA bacteraemia and Clostridium Difficile Infections and engagement of the Hospital and Community Trusts
- Implementing the national childhood immunisation and seasonal flu programme across Rotherham
- Facilitation of training and simulation exercises run by the Emergency Planning Shared Service
- Local planning and response to Ebola and other emerging infections

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

- The CCG had employed an excellent Infection Prevention and Control Lead Nurse

- Was it appropriate to include issues that were pertinent to Rotherham e.g. poor air quality and how that impacted on respiratory indicators, the real improvements in antibiotic resistance and the supporting work carried out on Ebola

- Shade provision and reducing skin cancers – this did not come under the scope of Health Protection Committee but there was a need to revisit where that might fit particularly working with Children and Young Peoples Services

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

(2) That a report be submitted annually and exception reports as appropriate.

73. PHARMACEUTICAL NEEDS ASSESSMENT (PNA) UPDATE 2016-17

Sally Jenks, Public Health Specialist, presented the refresh of the Pharmaceutical Needs Assessment (PNA) which had been subject to consultation with all the key stakeholders involved in the process of developing the PNA.

Producing and publishing a PNA fulfilled the legal requirements laid down in National Health Service (NHS) (Pharmaceutical Services) (Amendment) Regulations 2010.

The PNA would guide the opportunities for pharmacists to make a significant contribution to the health of the population of Rotherham.

The document linked to a number of other key Borough-wide strategies and plans including the Rotherham Joint Needs Assessment which provided the local data set used for informing pharmacy applications and pharmaceutical service commissioning.

The document would be reviewed in a year or sooner if necessary to ensure progress was being taken or should there be any significant changes in Legislation or commissioning intentions.

Resolved:- (1) That the Pharmaceutical Needs Assessment be approved.

(2) That it be noted that the process had been conducted within the regulatory framework.

(3) That it be noted that the key stakeholders who contributed to the development of the PNA had been involved in the review process as per the regulatory framework.

(4) That, unless a significant change occurred locally which would trigger a re-write of the document, a new PNA would need to be published on 1st April, 2018.

74. ROTHERHAM SEXUAL HEALTH STRATEGY 2015-17 UPDATE

Gill Harrison, Public Health Specialist, presented a progress report on the multi-agency Sexual Health Strategy and action plan.

In May 2013 the Health and Wellbeing Board had recommended the reconvening of a multi-agency Sexual Health Strategy Group to produce an updated comprehensive Strategy for Rotherham. The final Strategy was agreed in December, 2014.

One year into the delivery phase of the Strategy the following had been achieved:-

- The mapping of the provision of Sex and Relationship Education across Rotherham
  An audit by the School Effectiveness Team had revealed that the provision varied but the majority of schools felt that it was an improving picture regarding time on the curriculum for Personal, Sexual and Health Education which was where relationships and Sexual Health Education would be taught

- CSE Theatre in Education (TiE)
  The TiE 'Chelsea's Choice' had been funded by the Clinical Commissioning Group and Public Health and aimed at Y8 or Y9 pupils. All secondary and special schools and Pupil Referral Units engaged and there were a further two evening sessions for vulnerable young people (60 capacity) and parents/carers and siblings of vulnerable young people (126 booked, 117 attended). All performances received excellent evaluations

- Review of Sexual Health for Looked After Children (LAC) and Children Leaving Care
  The multi-agency LAC Physical and Emotional Health Group now had a regular focus on sexual health with new training for carers being considered. A review of pathways into services was being undertaken

- Review of Youth Clinic Provision
  The Rotherham Foundation Trust and Early Help and Family Engagement had undertaken a comprehensive review of all youth clinic provision and there had been a realignment of services to provide consistent delivery of services to young people on sites that were accessible by all within the community/locality and extended beyond the restrictions of term time only. Staffing provision had improved in each clinic and the partners were marketing the services and had developed stronger links and pathways between other areas such as family Nurse Partnership and School Nursing. Where footfall was poor and the more vulnerable were not engaging with the services, plans had been put into place for outreach work. Embedded into the core of the clinics were robust assessments for CSE and Safeguard and partner notification or sexually transmitted infections such as Chlamydia

- Review of delivery of Emergency Hormonal Contraception in the Community
  Following a review, the CSE referral pathways had been updated and all pharmacists were undergoing extra training. An audit of activity had been undertaken and provision across Rotherham mapped. Data showed that the majority of women accessing this service were over the age of 20; this information would now help in the future commissioning processes

- Development of the Integrated Sexual Health Services
  In line with national recommendations, the Council had commissioned an Integrated Sexual Health Service from the Foundation Trust to provide a full range of STI testing, HIV testing (not treatment) and comprehensive contraceptive services. At present, NHS England also commissioned HIV treatment from the Trust. The Trust had been working to an integration plan and developing their services. CSE referral pathways had been strengthened and the Service would be going out to tender during 2016 which would further strengthen the

process of integration to offer Rotherham residents a comprehensive sexual health offer

- Review of Primary Care Sexual Health Services
  Existing provision had been mapped. Public Health and GP providers had been working towards ensuring that competencies were maintained and that there was a good service in place for all users. Audit of the Services had shown that they were mainly used by women over the age of 20

- New Service for HIV Prevention and Support
  +Me had been commissioned to provide HIV education, awareness raising and prevention in the community as well as support with a regular drop-in service for people living with HIV. The third sector was actively promoting HIV testing and working closely with the Trust to help people access services. Although Rotherham did not score well on the Public Health Outcomes Framework measure for late diagnosis of HIV, it did score highly on uptake of testing within the Sexual Health Services. The newly commissioned Service should help improve diagnosis by promoting the Services and HIV testing

Proposed future activity was:-

- Although the audit of schools was positive, it was felt that the promotion of good practice should be continued. Many schools were providing excellent Relationship and Sex Education and this should be the 'gold standard' for all Rotherham schools

- The audit of primary care contraception provision showed that a few young people were accessing these services. More work needs to be done to ensure that our young people had the best possible access to contraception. This is especially important as, there was an increase in teenage conception rate in 2014 taking Rotherham once again above the rate for England. However, Rotherham still has the lowest rate among its closest statistical neighbours and the last two quarters of 2014 had rates well below those in England

- Among NHS funded abortions in Rotherham, the proportion of those under 10 weeks gestation was considerably lower than in England. The earlier abortions were performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, was also cost effective and an indicator of service quality and increased choices around procedure. There was considerable room for improvement in earlier access to terminations in Rotherham. The commissioners (CCG), abortion providers and all referrers into the service needed to work to ensure earlier access

- Because of the complexity of the commissioning of Sexual Health Services, more work needed to be done to ensure that services provided were effective and provided services that were relevant to the needs of the population

Discussion ensued with the following issues raised/clarified:-

- The Group had felt there was a need to develop a specialist service to work with hard to reach vulnerable groups such as the Roma community and young people in care and adopt specific, evidence based targeted interventions but not necessarily to introduce a new service.

- Linking in with the locality theme work would be a good way of finding out what work was already taking place and ascertaining if there were any gaps

- There was a clearly defined action plan which was a living document used by the Strategy Group to monitor progress. This report was a summary of the things that had been achieved over the past year

- Teenage pregnancies had considerably decreased; the numbers had been slightly up at the beginning of last year but had reduced again and measured quite well with statistical neighbours. There were certain aspects of STI infection reports which were higher. However, the Chlamydia detection rate was good and providers of service were able to identify infection within the community

- In comparison with its statistical neighbours, Rotherham was the 3rd highest in Yorkshire and Humber with a tremendous difference between Rotherham and Wakefield and Doncaster

- How did diversity fit into the picture particularly in relation to commissioning?

- How was the work linked to deprivation particularly the effect of the Welfare Reforms?

- The Team participated in the work of the Health Protection Committee and did “deep dive” into infection. The Team tried to look at it from a Health Protection point of view of what was working well and how to address some of the issues

- The main provider of Sexual Health Services (Specialist Service) were required to report how many referrals they had made to the MASH

- Public Health England was looking at the early monitoring and early detection of STIs as a much earlier indication was required against what would normally be expected

- The report showed that there was progress of early testing of HIV but a high number of late diagnosis. HIV figures came out retrospectively so this was what had happened previously. Once patients were into the service, it was very good at offering the test and it being accepted. There was a need to get potential patients into the service and be tested earlier and was the reason why there was a group promoting HIV testing. A recent meeting had revealed that the measure of late diagnosis was reducing but more awareness raising was needed

Resolved:- (1) That the progress made against the suggested actions within the Sexual Health Strategy be endorsed.

(2) That the proposed future activity be endorsed.

75. ANY OTHER BUSINESS

(a) Self-Assessment
The Board would be undertaking a self-assessment which was being developed by the Local Government Association. A questionnaire would be sent to all Board members around 10th May with a return date of the end of May.

All responses would be anonymous and collated by the LGA. A facilitated session would be held on 13th July.

(b) Local Government Association Pilot
The LGA would be undertaking a pilot which would look at Health and Wellbeing Boards' transformation; Rotherham had been selected as a pilot area. The self-assessment (see (a) above) would take place and then look at how the Board could be best placed in terms of transformation. The LGA were looking at potentially holding workshops in September/October.

Resolved:- That a working group, consisting of the Chair, Terri Roche, Louise Barnett, Julie Kitlowski, meet to discuss integration.
Action: Kate Green

(c) Tony Clabby reported that he had recently attended the Health and Wellbeing Boards network event in York where the strategic transformation plans and devolution were discussed.

He has also attended the South Yorkshire and Bassetlaw Urgent and Emergency Care Network.

(d) Better Care Fund
Feedback on the recent BCF submission had been "assured with support" which was the best anyone had received in the South Yorkshire and Bassetlaw area.

76. DATE, TIME AND VENUE OF THE NEXT MEETING

Resolved:- That a further meeting be held on Wednesday, 24th February, 2016, commencing at 9.00 a.m. to be held at the Rotherham Town Hall.

HEALTH AND WELLBEING BOARD
1st June, 2016

Present:-

Members:-

Dr. Julie Kitlowski	Clinical Chair, Rotherham CCG **In the Chair**
Louise Barnett	Chief Executive, Rotherham Foundation Trust
Chris Edwards	Chief Officer, Rotherham CCG
Ian Thomas	Strategic Director, Children and Young People's Services
Terri Roche	Director of Public Health
Janet Wheatley	Chief Executive, Voluntary Action Rotherham
Councillor Yasseen	Cabinet Member, Neighbourhood Working and Cultural Services

Report Presenters:-

Anna Clack	Public Health Specialist, RMBC
Miles Crompton	Policy and Partnerships Officer, RMBC
Ruth Fletcher-Brown	Public Health Specialist, RMBC
Claire Smith	Rotherham CCG

Officers:-

Nathan Atkinson	Assistant Director of Commissioning, RMBC
Richard Bellamy	Democratic Services, RMBC
Kate Green	Policy Officer, RMBC

Observers:-

Chris Bland	Rotherham Pharmaceutical Committee
Councillor Sansome	Chair, Health Select Commission
Councillor R.A.J. Turner	

Apologies for absence were received from Sharon Kemp, Tracy Holmes, G. Parkinson, Councillor Roche and Councillor Watson.

1. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at this meeting. It was agreed that the Members' register of interests should be reviewed.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no members of the public or the press in attendance.

3. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting of the Health and Wellbeing Board, held on 20th April, 2016, were considered.

Matters arising updates were provided in relation to the following items -

(i) Minute No. 69 (reference to previous minutes) – the 'Let's get Rotherham Active' event had taken place on 11th May, 2016, at which 68 people had attended. Feedback had been positive. The outcome of the event and next steps were being considered by an officer meeting on 14th June and would be shared with the Board at a later date.

(ii) Minute No. 71 (Health and Wellbeing Strategy) – there was steady progress being made with the preparation of the Strategy with the Health and Wellbeing Steering Group meeting monthly since March to support the progress. There was, however, an urgent need for a lead officer to be identified to work alongside Richard Cullen GP on aim 1 of the Strategy.

(iii) Minute No. 75(a) (Health and Wellbeing Board Self-Assessment) – the self-assessment event would be taking place on the day of this Board's next meeting, Wednesday 13th July 2016;

It was noted that the Board meeting would be an extended meeting to 12.00 Noon. The first part of the meeting, 9.00-9.30 a.m. was to conduct normal business and open to the public and observers; from 9.30 a.m. the meeting would be a closed facilitated session.

Resolved:- That the minutes of the previous meeting of the Board, held on 20th April, 2016, be approved as a correct record.

4. SOUTH YORKSHIRE AND BASSETLAW SUSTAINABILITY AND TRANSFORMATION PLAN/DRAFT INTEGRATED HEALTH AND SOCIAL CARE PLACE PLAN

Consideration was given to a report, presented by Chris Edwards, concerning the NHS Shared Planning Guidance, which asked every local health and care system in England to come together to create its own ambitious local plan for accelerating the implementation of the Five Year Forward View (5YFV). These blueprints, called Sustainability and Transformation Plans (STPs), will be place-based, multi-year plans built around the needs of local populations.

To deliver STPs, local health and care systems have come together to form 44 footprints, which collectively cover the whole of England. These geographic footprints are of a scale which should enable transformative change and the implementation of the 'Five Year Forward View' vision of better health and wellbeing; improved quality of care, and stronger NHS finance and efficiency by 2020/21.

It was noted that Rotherham sits within the South Yorkshire and Bassetlaw footprint which is led by Sir Andrew Cash (Chief Executive of Sheffield Teaching Hospitals).

A copy of the South Yorkshire and Bassetlaw Plan was included with the agenda and supporting documents for this meeting.

A comment was made as to whether there was adequate reference (within the local plan) to preventative work.

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

(2) That the Health and Wellbeing Board places on record that it feels appropriately engaged in the local plan (Sustainability and Transformation Plans) process and notes that the South Yorkshire and Bassetlaw Plan has to be submitted to NHS England by the due date of Thursday 30th June, 2016.

5. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE

Consideration was given to a report, presented by Miles Crompton (Policy and Partnerships Officer, RMBC) concerning the Joint Strategic Needs Assessment (JSNA). The report stated that the Health and Wellbeing Board has a statutory duty to evidence the needs of people in Rotherham and the JSNA assessment underpins health and social care commissioning, service development and the Health and Wellbeing Strategy.

The JSNA was refreshed as a new online resource in 2013, replacing the former fixed document format of 2011. After a period of consultation, the Health and Wellbeing Board had approved the final version of the JSNA in February 2014. The revised JSNA was used to inform the new Health and Wellbeing Strategy 2015-18.

The new JSNA format allows for updates of information so that the content is continually evolving in response to new data becoming available, or additional content being required. Contributors from a range of service areas have been asked to provide any updates required, on a quarterly basis.

The JSNA was subject to a review in 2015/16 which added a new overview of issues identified in the JSNA and made presentational changes to make it easier to find information about children and adults, and better understand the JSNA process.

The presentation and subsequent discussion about the Joint Strategic Needs Assessment highlighted the following salient issues:-

- implications of the Health and Social Care Act 2012;

- noting that the Joint Strategic Intelligence Assessment is an entirely separate process, prepared by the South Yorkshire Police and the Safer Rotherham Partnership;

- the early JSNA format had concentrated upon adult social care, although the revised document now encompasses a much wider range of issues (e.g.: domestic violence; transport, etc.);

- the JSNA includes 82 separate issues, catalogued into seven different categories;

- the emphasis upon issues affecting children and young people (eg: teenage pregnancy; smoking in pregnancy; Children in Need and living in poverty; disability and mental health);

- the specific issue of the oral health of young children (including tooth decay) – the Board noted that the statistics appeared to be in need of updating, as there was now evidence of an improving pattern being made in terms of children's oral health; it was also noted that there is no fluoridation of the water supply in the Rotherham Borough area);

- the prevalence of long-term sickness absence amongst the adult working population;

- the current life expectancy of women (81 years) and men (78 years) living in the Rotherham Borough area; the population aged over 80 years is increasing by 4% per year; the consequent demand on adult social care services;

- ethnic diversity in the Rotherham Borough area;

- the demand for food banks is increasing; some supermarkets are donating food to the food banks, in order to try and reduce the amount of food waste where the food is still fit for consumption.

It was agreed that copies of the presentation will be distributed to members of the Health and Wellbeing Board.

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

(2) That the Health and Wellbeing Board:-

(a) acknowledges that service-based contributors are being asked to provide any updates to the Joint Strategic Needs Assessment on a quarterly basis; and

(b) agrees that the Joint Strategic Needs Assessment will be subject to further review during 2016/17.

6. HEALTHY AGEING FRAMEWORK - A CO-ORDINATED WHOLE SYSTEM APPROACH TO HEALTHY AGEING FOR ROTHERHAM

Consideration was given to a report, presented by the Director of Public Health, stating that an initial draft of a Healthy Ageing Framework has been developed to raise the profile of the needs of the Rotherham Borough's ageing community and improve the coordination of the healthy ageing initiatives across Rotherham. Further stakeholder engagement will be sought to agree a vision that will drive activity forwards and improve the health and wellbeing of the Rotherham Borough's ageing population.

The report included the initial draft of the vision : "to improve the health and wellbeing of the ageing community of Rotherham. Rotherham services work together seamlessly to develop healthy, independent and resilient citizens, who live good quality lives".

The principles and desired outcomes of the Framework were also listed in the report. The next steps include a stakeholder engagement event, during July 2016, to shape the vision and framework and ensure that the Healthy Ageing Framework meets the needs and expectations of all stakeholders.

Discussion took place on the transport requirements of elderly people, many of whom will rely upon public transport (especially buses and trains). The need for a continuing dialogue with the South Yorkshire Passenger Transport Executive, about this specific issue, was acknowledged by the Board.

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

(2) That a further report about the Healthy Ageing Framework be submitted to a future meeting of the Health and Wellbeing Board, during the Autumn 2016, after completion of the stakeholder engagement event and consultation.

7. BETTER CARE FUND

Consideration was given to a report of the Head of Long Term Conditions and Urgent Care (Rotherham Clinical Commissioning Group) and the Assistant Director of Commissioning (RMBC Adult Social Care) containing an overview of the Better Care Fund Plan 2016/17 which would be submitted to NHS England.

The report stated that, in early March 2016, NHS England had issued the Better Care Fund planning requirements for 2016/17, which included the completion of a financial planning template and a narrative plan with a comprehensive set of Key Lines of Enquiry. There are eight conditions, which local areas have to meet through the planning process, in order to

access funding which is included in the Key Lines of Enquiry. These eight conditions were listed within the submitted report.

The Better Care Fund Plan had been jointly developed between the Rotherham Clinical Commissioning Group (CCG) and the Borough Council and is well aligned to the priorities within the Joint Health and Wellbeing Strategy 2015-18, the CCG Commissioning 2015-19, CCG Operating Plans 2016-17 and Provider Plans.

The Health and Wellbeing Board noted that Rotherham's Better Care Fund Plan 2016/17 had been cited as an exemplar Plan within the Yorkshire and Humberside region. The Board thanked the team of officers for their work.

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

(2) That the Better Care Fund Plan 2016/17, as now submitted, be approved and submitted to NHS England.

8. BETTER CARE FUND SECTION 75 AGREEMENT 2016-17

Consideration was given to a report submitted by the Head of Long Term Conditions and Urgent Care (Rotherham Clinical Commissioning Group) and the Assistant Director of Commissioning (RMBC Adult Social Care) containing the Framework Partnership Agreement relating to the Commissioning of Health and Social Care Services from the Better Care Fund in 2016/17 (Section 75 of the NHS Act 2006 refers). It was noted that this Agreement had been approved by the Government-appointed Commissioners to the Borough Council.

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

(2) That the 'Section 75' Framework Partnership Agreement, as now submitted, be approved and submitted to NHS England by the due date of Thursday, 30th June, 2016.

9. BETTER CARE FUND QUARTER 4 SUBMISSION

Consideration was given to a report submitted by the Chief Finance Officer (Rotherham Clinical Commissioning Group) and the Assistant Director of Commissioning (RMBC Adult Social Care) containing the fourth quarterly report to NHS England regarding the performance of Rotherham's Better Care Fund.

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

(2) That the contents of this fourth quarterly report be ratified and it be noted that the report had been submitted to NHS England by the due date of Friday, 27th May, 2016.

10. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2015-16

Consideration was given to the Director of Public Health's Annual Report 2015/16 as submitted.

The Director of Public Health has a statutory responsibility to produce an Annual Report and the Council has a statutory duty to publish it.

This report focused on an analysis of some of the key issues affecting the health and wellbeing of Rotherham's Children and Young People and explored the health inequalities that exist for children between Rotherham and the rest of England. The Report described Children and Young People's health through a life-course approach, from pregnancy and birth, through school years into young adulthood.

The Annual Report aimed to engage with professional stakeholders across the Rotherham Borough, in order to work together and deliver on a clear set of recommendations that will help improve the health and wellbeing of the Borough's Children and Young People. The recommendations are aimed at all statutory and voluntary partners across the Rotherham Borough area.

The recommendations evolved from sections in the report which highlight 'our ambitions for Rotherham'. The intention of the Public Health Annual Report is to sit alongside the Health and Wellbeing Strategy and to help inform the actions taken by the Health and Wellbeing Board. It also offers some practical interventions which will improve child health and contribute to reducing the health inequalities across the Borough. Future reports will describe progress against the recommendations and the associated action plan.

The Public Health Annual Report contained seven recommendations. The report also explained the action taken in response to the recommendations of the previous (2014) Public Health Annual Report.

The presentation and subsequent discussion highlighted the following salient issues:-

- life expectancy in the Rotherham Borough area and the impact of poverty;

- infant mortality rates; still-births and sudden infant deaths;

- accidents affecting very young children;

- physical activity and obesity amongst children and young people;

- the oral health of young children (also discussed at Minute No. 5 above);

- educating young people about positive and healthy relationships and good sexual health;

- mental health issues (including self-harm and suicide);

- the importance of the accurate recording of health data and statistics.

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

(2) That the recommendations contained within the Director of Public Health Annual Report 2015/16, as now submitted, be supported and progress on the actions taken on the recommendations be reviewed at future meetings of the Health and Wellbeing Board.

11. SUICIDE PREVENTION AND SELF-HARM ACTION PLAN UPDATE 2015-16

Consideration was given to a report, presented by Ruth Fletcher-Brown (Public Health Specialist, RMBC) providing a six months' progress report on the actions detailed in the Rotherham Suicide Prevention and Self-Harm Action Plan 2015/16. The report stated that the delivery of the Rotherham Suicide Prevention and Self-Harm Action Plan is an action within the Rotherham Health and Well Being Strategy.

Listed within the submitted report were details of the progress, as monitored by the Rotherham Suicide Prevention and Self-Harm Group, of the various actions being taken based on the six national areas for action and an additional two which are Rotherham specific.

The Board's discussion of this report highlighted the following salient issues:-

- the real-time surveillance pilot scheme in the Rotherham Borough area (with partner organisations, including the South Yorkshire Police);

- identification of any 'hot-spots' of increased rates of suicide;

- continuing partnership working with the Rotherham Youth Cabinet about mental health issues affecting children and young people;

- the value of the social marketing campaign work;

- support for bereaved families and sign-posting to appropriate services (e.g.: the Samaritans; CAMHS, etc).

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

(2) That the Health and Wellbeing Board:-

(a) accepts and endorses the report on actions taken by the Rotherham Suicide Prevention and Self Harm Group for 2015/2016;

(b) endorses the areas for future activity, including a commitment to continue Rotherham's Real Time Surveillance work and the social marketing campaign work; and

(c) receives an update report on the work of the Rotherham Suicide Prevention and Self Harm Group once per year and exception reports more frequently, as appropriate.

12. DATE, TIME AND VENUE OF THE NEXT MEETING

Resolved:- (1) That the next meeting of the Health and Wellbeing Board be held on Wednesday 13th July, 2016, at the Town Hall, Rotherham. This meeting shall be extended from 9.00 a.m.-12.00 Noon to include a developmental session for members of the Board. From 9.30 a.m. the meeting will be closed to the public and observers.

(2) That future meetings take place on: -

- extraordinary meeting in August 2016 (if deemed necessary)
- 21st September, 2016 (agenda to include a report about the Children and Young People's Services Partnership Board)
- 16th November, 2016;
- 11th January, 2017;
- 8th March, 2017.