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

Date:- **Thursday, 19 January 2017** **Venue:-** **Town Hall, Moorgate Street, Rotherham S60 2TH**
Time:- **9.30 a.m.**

HEALTH SELECT COMMISSION AGENDA

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

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

3. Apologies for Absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Communications

7. Minutes of the Previous Meetings held on 27th October and 1st December 2016 (Pages 1 - 40)

For Discussion

8. Overview of the Adult Care Development Programme/Better Care Fund (Pages 41 - 52)
   Nathan Atkinson, Assistant Director Strategic Commissioning, RMBC and Keely Firth, Chief Finance Officer, RCCG to present (report attached)

9. Transformation of Acute and Community Care (Pages 53 - 65)
   Louise Barnett, Chief Executive and Dominic Blaydon, Associate Director of Transformation, TRFT to present (paper attached)

For Information/Discussion

10. Briefing on Schools Mental Health Pilot (Pages 66 - 69)

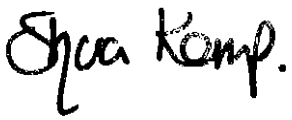
11. Health Select Commission Sub-Group: Older People's Housing (Pages 70 - 78)

12. Improving Lives Select Commission Update

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

14. Healthwatch Rotherham - Issues

15. Date of Next Meeting
Thursday, 2nd March at 9.30 a.m.



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.

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Vice-Chairman:- Councillor Short
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Co-opted Members:
Vicky Farnsworth and Robert Parkin (Rotherham Speak Up) and Peter Scholey.

HEALTH SELECT COMMISSION
Thursday, 27th October, 2016

Present:- Councillor Sansome (in the Chair); Councillors Albiston, Andrews, Brookes, Cusworth, Elliot, Elliott, Ellis, Fenwick-Green, Marriott, John Turner, Williams and Short.

Apologies were received from Ireland and Marles.

39. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

40. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

41. COMMUNICATIONS

(1) Information requested from Foundation Trust at quarterly briefing

- A&E 4 hour target performance
  - This remained a challenge nationally but in August the trust had exceeded the 95% target. Over the last year, bar one month, performance had exceeded the national average.
- Where the Hospital was in terms of staff shortages for emergency consultants.
  - There were currently 5.7 WTE in post and still some use of agency staffing. This position was set to improve by December and there will be further work around rotas and staffing from January 2017.
- If meeting targets for agency staff use/spend
  - For the five month period to August the trust had spent £393,000 less than the planned spend on agency staff.

(2) Information Pack
The pack contained:-

- Outstanding issues with regard to the Director of Public Health's annual report
- Sustainability and Transformation Plan presentation
- Quarterly briefing notes from meeting with Health partners
- Locality Working presentation

The presentation on the STP had been included to set the context for the agenda item in December. The integrated locality pilot, discussed at the last meeting, was also in the work programme.

(3) An all-day training session concerning prevention to be held on 24 January with HSC Members encouraged to attend.

(4) Scrutinising Performance Information with Confidence
Working session for the Select Commission, facilitated by Dianne Thomas (Centre for Public Scrutiny) to be held on Tuesday 22 November 2016 from
1.00pm – 3.00pm. This linked with the Commission looking at Adult Social Care performance on 1 December when the Yorkshire and Humber benchmarking data 2015/16 would be scrutinised.

42. MINUTES OF THE PREVIOUS MEETING HELD ON 22ND SEPTEMBER, 2016

The minutes of the previous meeting of the Health Select Commission held on 22nd September, 2016, were noted.

Arising from Minute No. 32 (Commissioners Working Together Programme) it was noted that the third paragraph should read “options appraisals ….” and not “operations appraisals”.

Arising from Minute No. 30 (previous meeting), the additional information provided after the meeting was noted regarding performance clinics

Arising from Minute No. 31 (Rotherham’s Integrated Health and Social Care Place Plan), it was noted that Councillor Short, Vice-Chair, would be joining the visit to the new Urgent and Emergency Care Centre on 11th November, 2016. The visit was now fully booked. New dates would be supplied for further visits in the New Year.

Members could keep up-to-date on developments through the dedicated website http://www.rotherhamemergencycentre.nhs.uk/. This included a short video giving a virtual tour of the Centre and the Trust were developing some characters and patient stories to add.

It was also noted that issues raised on the Rotherham Place Plan had been fed back to Nathan Atkinson, Assistant Director Strategic Commissioning, and colleagues at the Rotherham Clinical Commissioning Group.

Arising from Minute No. 34 (Health and Wellbeing Board), the additional information provided after the meeting was noted regarding digital roadmap.

Resolved:- That the minutes of the previous meeting held on 22nd September, 2016, be approved subject to the above clerical corrections.

43. RESPONSE TO SCRUTINY REVIEW: CHILD AND ADOLESCENT MENTAL HEALTH SERVICES - MONITORING OF PROGRESS

In accordance with Minute No. 96 of the meeting held on 14th April, 2016, Paul Theaker, Operational Commissioner, Children and Young People's Service, reported on the current progress of the Scrutiny Review's 12 recommendations.

The RDASH CAMHS Service reconfiguration had been completed at the end of June, 2016 with a new single point of access and locality workers in place. There had been positive feedback from partners on the changes made. However, a small number of posts were not recruited to until after that date due to a difficulty in recruiting appropriate staff to those posts. This had had an impact on the delivery of a number of the actions within the response to the Scrutiny review (detailed within Appendix 1 of the report submitted)

Consideration was given to the Appendix which contained the progress to the recommendations as at October, 2016. Discussion ensued with the following issues raised/highlighted:-

- The draft refreshed needs analysis would be going the following week to the partnership group.
- The performance framework would be for the full mental health system, so not only RDaSH but also other services including counselling in schools and Early Help counselling, formerly Youthstart. It was also being adapted and refined to meet national reporting requirements and would be tested fully in the new year.
- It was recognised that some of the timescales had been ambitious given the scale of the reconfiguration, consultation and recruitment but partners had really gone back to unpick the information and fully understand what services were doing.
- As some of the data was out of date, what impact did that have further down the line for partner agencies? – In terms of RDaSH CAMHS there was detailed information about young people who are in treatment. So there was good high level information but a need to unpick and get consistency in what was provided from partners.
- RDaSH provided more detail regarding training and awareness raising activities – revamped and more informal letters, meetings with schools to consider how they could work together better, refreshing the "top tips" documents, information packs distributed to all secondary and primary schools, working with South Yorkshire Eating Disorder Association, asking what training people want rather than assuming what they want.
- Had the CAMHS workforce development strategy been written? – Although a draft had been produced to the timescale it was still a draft. The plan had considered training needs at each level across the wider workforce e.g. from a playground supervisor needing

basic awareness through to a mental health practitioner, looking at where services' plans sit in the framework and then directing people to the training packages.

Schools mental health pilot

- Monitoring reports from the visits to the schools in the mental health pilot could be shared with Members.
- There seemed to be a low number of secondaries engaged in the pilot, so how were academies encouraged to have a certain level of staff training when there was no requirement for them to do so? – The need to get academies on board was appreciated which is why there was the approach to roll out from pilot schools to their peers and through the headteacher network. The schools involved were very engaged, including with training.
- Were we able to add schools to the pilot or would they have to wait until the next batch? There would be a meeting in December and schools were talking in terms of the network, but there was a need to start having that dialogue with the other schools.
- Would the full evaluation of the pilot in July be by an independent person, not someone involved in the work? – We need to take that forward and look at who will undertake the evaluation. In terms of the monitoring that is led by Public Health and Commissioning.
- Councillor Roche echoed concerns over the lack of influence over academies and the length of time it had taken to get suicide prevention on the agenda for the headteachers' meeting.
- What level of training did school staff have to have to be part of this initiative, as if they were not trained to a set level could they be doing more harm than good? If there is not a mandate to say staff must be trained to this level how would we mitigate against that? – As part of the pilot each school would identify a mental health champion and that tends to be the SEN or Safeguarding lead who would then roll the work out, as it is not directed by Council staff. In terms of training specifically this linked back to the action on workforce development and who could provide training at those levels.
- How many people in the pilot schools had been trained as the number who needed training would vary with the size of the school? Had they already been trained before the pilot started? – This information was not available but could be requested from schools as part of the monitoring. Schools and academies could not be directed regarding what training they undertook but could be made aware of what was available through the workforce plan.
- Are schools devising their own training? – Each pilot school undertook a mini needs analysis which led to them identifying their three priorities for this academic year, but not necessarily training. For example it could be peer mentoring with young people or staff wellbeing. The programmes are led by the identified mental health champion within the school.
- Are we saying there are possibly people working in schools with no mental health training? - It was understood that all the school

mental health champions had undergone mental first aid training but this would be checked. There is a school counselling service which could be provided by Rotherham and Barnsley MIND, MAST or by people directly employed by schools. So within schools there is a counsellor or a mental health professional or practitioner who is used to help develop these approaches in schools. As reassurance certainly in secondaries it is about those services such as counselling taking that lead alongside the mental health champion. In terms of primaries, for example in Maltby, that school is working proactively with the cluster around the mental health agenda, almost in a hub and spoke.

- So to clarify, all secondaries have some sort of counselling or mental health specialist in their schools but not primaries? Yes in secondaries. Within primaries there is a lead or designated person.
- Do those services than have priority access to second tier mental health services if those people then identify a child with greater need? – Access would be through the counselling service or through the designated lead contacting the Single Point of Access (SPA) and outlining concerns. Locality workers are coming into schools and they would be able to pick up those issues and advise and support - bespoke training/information.
- Regarding school lunch time staff it is more about raising awareness, taking a bit more time to notice but also knowing who in school to go to and say I've noticed this and could they watch out for it, rather than them going and doing some early intervention work themselves.
- Is responsibility for mental health being delegated to people working in schools? - It is about all the C&YP's workforce having responsibility, be that at a very basic level of awareness regarding who to speak to or refer on to. The role of CAMHS Locality Workers is to provide support, not just for schools but also for GPs, Early Help teams etc. so that is about supporting schools about techniques and enabling smoother referrals into CAMHS.

It was suggested that mental health teams needed to provide more support to work with schools on their plans.

Members emphasised the importance of the quality of the referral and were concerned that if people are not trained children could slip through the net. - Pathways to CAMHS had changed since the development of the SPA and this was enabling smoother access. RDaSH workers were alongside Early Help triage and schools and other workers could refer young people in to the SPA, where they would have a wider, more holistic assessment of their needs.

- Can parents or a young person still self refer and how is it publicised? – Yes they can although the joint sessions at Eric Manns had now ceased. Marketing is an area we need to work on, tied in with access through the Early Help hub once fully co-located.

- How many posts have not yet been recruited to and where are they? – Only one, based within the CSE team, even with three advertisements so RDaSH were now looking at this in a different way to recruit a locality worker who will be a CSE lead. Because of "*Future in Mind*" all trusts were trying to recruit mental health practitioners so RDaSH thought they would struggle but had a very successful recruitment campaign and recruited 12 really good calibre people. There are four additional staff in anticipation of work with unaccompanied asylum seekers, who are waiting to start following DBS checks. Recruitment started in January but it often takes three months for people to start with DBS checks and serving notice.

Waiting times

- Do we have a long waiting list given that people have not been able to access CAMHS successfully? Do we have targets about how quickly those young people will be seen? Do we have any threshold data or benchmarking with other similar LAs around anticipated numbers and access at the different tiered levels? Do we match staffing to identified need? – In the past there was a problem with long waits for assessment but that has improved. In May 2016 240 children were on the waiting list for an assessment appointment but that was now down to 50. The most that children were waiting now for an appointment date was four weeks and the average was 8 weeks to be seen for assessment against a target of 3 weeks, although we expect that to reduce significantly now staff are in place. Regular meetings have been held between RDaSH and RCCG regarding the waiting list and other issues arising from reconfiguration. Regarding C&YP starting treatment, we target 8 weeks but the national target is 18 weeks. Exact figures were not available and were requested.
- Four weeks might seem a long time but once a referral was made RDaSH were gathering information in advance e.g. from schools. A lot of people Do Not Attend (DNA) for their first appointment because people have not filled in the form. There were problems on information sharing between partners i.e. system error, which had to be sorted out. Because of the long waiting lists RDaSH had two teams, one working on the three week waiting list and the other bigger team bringing down the waiting list.
- Locality Workers see children at an earlier stage. Children with the right criteria are coming in to CAMHS and others are getting earlier support through Early Help, as before children might have waited for a few weeks but then not met RDaSH criteria once assessed. Our target, set by the CCG, is three weeks and nowhere else has this target and it is a problem. RDaSH would like it to be six weeks, as in the NICE guidance, so there is more time to gather the information. Reporting on both three and six weeks has been in place for some time.
- Is it time to review the three week target if it presents such difficulties? – This target was set to recognise the issue and to

recognise that radical change was needed to address it, so it probably was the right thing to do. Members' original scrutiny review recommendation was to retain the three week target in light of positive changes that were happening in RDaSH and then to review it. The CCG accepted that it was a challenging target but why not keep a challenging target if that was the right thing to do and system improvements allowed you to see people more quickly.

- Are we prepared for unaccompanied asylum seeking children coming, such as specialist training to deal with more complex needs? Has RDaSH now got the staffing in place to mitigate against surges in demand? We are taking on extra staff in preparation. Not 100% sure yet but as it is a new configuration we are still trying to respond to things as they emerge, for example there is greater demand in the South locality.

- Urgent cases are based on level of risk and mental health presentation and would be people expressing suicidal ideas, significant self harming, people on paediatric wards admitted from A&E or people with an acute psychotic presentation. RDaSH confirmed that children with an urgent need were seen within 24 hours and that they had met this target over the last three years, although this was questioned by Healthwatch on the basis of feedback from parents and young people. This is linked to awareness raising with referrers around criteria as they may make referrals saying they are urgent cases but as RDaSH gather information and through the early help triage that might be why there is misunderstanding. Long waiting times for assessment are around ASD and ADHD which RDaSH are working on alongside the other pathways. It also reflects differing perceptions of what is an urgent case and who makes the assessment.

- What types of referrals are we talking about? – RDaSH provides a broad range of services so it includes: diagnostics for ASD and ADHD for over 5s (which are neuro-developmental) and mental health ranging from low level anxiety and low mood, depression, eating disorder through to other common mental health conditions as in adults. Staff all have some level of professional qualification e.g. social workers, nurses, occupational therapists, psychologists and a bespoke CAMHS learning disability service, plus access to psychiatry as that is not normally the initial contact a patient has. RDaSH were developing a specialist eating disorder service.

The Parent/Carer Forum were doing a very good job leading the Family Support Service. They were facing a high level of demand: by quarter 2 they had supported 38 families and 50+ children, mainly aged 5-11, and a significant number with issues around ASD. Earlier in the week a news story highlighted the benefits of interacting with families and parents at an early age with children with suspected ASD. We were ahead of the curve and there was evidence of helping to avoid admission to CAMHS, in what was a positive example of true prevention and early intervention. Support

was not just around CAMHS but also with Education, Health and Care plans and school and home as well. The CCG was proposing to increase funding for 2017-18 by £15k. Contact was available via phone, email, facebook or face-to-face.

Discussions took place at RDaSH regarding what was meant by a SPA and as the local authority was also developing its own SPA that seemed the right option through a partnership agreement with staff going there and sitting with the Early Help team. This has produced a lot of learning about what is or is not CAMHS. There are still details to sort out in terms of networking, infrastructure and cover for annual leave but that will not stop the work taking place.

- How will you measure ease of access to the SPA and will the criteria be visible to all partners? It is not yet fully in place but we are trying to get to having one phone number for Rotherham for all to use into Early Help and from there it would be decided who is the best person to meet needs. Top tips documents for GPs and for universal services, plus the directory of services, set out the criteria and where to refer e.g. low level anxiety to school nurse.
- Are there financial contributions to Early Help? Can we be assured that people will meet criteria and receive a service? – Locality workers were aligned to the Early Help localities and the intention was not for others to undertake RDaSH's business for them but to prevent people bouncing around the system as had happened in the past. Looking at referrals together and having access to local authority information means it will be easier to know if other workers were already involved with a family and so the Locality Workers can support those other workers, so services are more streamlined. Work was also underway to look at the overall skill set within localities.
- Is the SPA now live? - RDaSH duty team members have been working at Rotherham on Thursdays, almost "testing out" what has been developed in terms of the SPA pathway and looking at going live from November. That will be reviewed, including if any bottlenecks appear.
- My Mind Matters web hits – over the last 6 months average of 341 hits per month, 57 of whom were new users, so some repeat visitors. 57% hits from YP, 25% from carers and 18% from practitioners. There is ongoing work to raise the profile and keep promoting it.
- IYSS Young Inspectors were involved with an unannounced inspection of CAMHS and were very positive regarding a "Rotherhamised" website rather than only the generic sites. A very detailed review has been done of the My Mind Matters website recently – review of every page in all three sections with extensive notes made regarding the wording and to ensure up-to-date statistics.
- National work will affect how services are paid for by commissioners. At present it was a block contract, but for a few

years now work has been done looking at a currency, which was already in place in adults and older people's with 21 clusters designated around types of medical condition e.g. cluster 5 is non-psychotic (very severe), 14 is psychotic (crisis). This was a way of monitoring activity and understanding where patients were going. Proposals for CAMHS were a bit different, still clusters but based on level of need, for example "getting help for ADHD" or "getting more help for eating disorders" which is more severe.

- CAMHS was overspent and there were a lot of agency staff that were costing more but now the trust has recruited permanent staff it is coming in at break even. Some of the work with the new pathways will be to see what each pathway is costing but how do you define value for money? Is it early help or is it preventing someone going in a Tier 4 bed if we can put in intensive support instead, which is costlier but more quality support for the child and their family, so it is a balance.

As general points for future reports Members requested:

- If time delays were indicated reports should say what action was being taken to get back some of that lost time, or similarly if budgets were not on track. If there were issues at national level that had affected timescales for work locally, this should also be covered.
- That clear demonstrable evidence and facts/data be built into the response template in future reports.
- More detailed narrative as this would be helpful for new Commission members to understand the context for the review recommendations.
- That as there has been concern over the number of actions rated as red more explicit narrative could also replace the RAG ratings.
- Revised clear dates and timescales for actions to be completed by.

Further information requested:

- Numbers of people trained in each pilot school and when they were trained.
- To check if school mental health champions have all undergone MHFA training and if there are any gaps how these will be filled.
- Validated figures for waiting and assessment times for both routine and urgent cases.
- Effective outcomes and seeing the impact of the work being done

Officers and partners were thanked for their attendance and responses.

Resolved:-

1. That the monitoring of progress against the responses to the Scrutiny review of Child and Adolescent Mental Health Services be noted.

2. That clear demonstrable evidence and data be built into the response template in future reports.

3. That mental health workers should be more involved with the schools in the mental health pilot on their plans.

4. That the regular monthly performance reports for waiting and assessment times for both routine and urgent cases be submitted to the Commission and performance data validated.

5. That the stretching 3 week target for assessment following referral should remain.

6. Future progress updates to include more evidence of improved outcomes for C&YP following the interventions put in place.

7. Following discussions, new dates to be agreed for actions in the recommendations.

8. That there should be independent evaluation of the whole school approach mental health pilot.

9. That the next progress update would be in March 2017.

44. ROTHERHAM CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) - REVIEW OF CHILDREN AND YOUNG PEOPLE'S VOICE AND INFLUENCE

Nigel Parkes, Rotherham Clinical Commissioning Group, presented a briefing note on the independent review of the nature and extent of children and young people's voice and influence in Rotherham CAMHS.

The independent review had been commissioned by the Rotherham Clinical Commissioning Group, using non-recurrent funding for CAMHS transformation, with the aim of:-

- Strengthening children and young people's voice and influence
- Increase the responsiveness of services
- Improve mental health outcomes

The first stage of the review had scoped what children and young people had said about their experiences of Mental Health Services, of being listened to and about their participation priorities. The second stage had drawn on the findings to frame guided conversations with 4 focus groups and some individual interviews with children and young people all of whom had personal experience of Mental Health Services. Members of the Parents and Carers Forum had participated jointly with the children and young people in 1 focus group.

The review had considered 9 participation priorities covering experience,

personal care and public involvement:-

- Feeling good – personal experience of being listened to and involved in decisions about own care
  1. Assessment
  2. Routine outcome monitoring
  3. Complaints procedure and advocacy
- Doing the job right – being able to take part in helping develop the Service (contributing to management)
  4. Staff training
  5. Supervision and appraisal
  6. Recruitment and selection
- Running the Service well - having a voice and influence with the leadership of the organisation
  7. Involvement in commissioning
  8. Influencing senior managers
  9. Mission statement

Both positives and concerns had been raised in the focus groups with most participants not having been involved in helping to develop the Service or influence the leadership of the organisation.

The review had made 1 overall recommendation: to embed the use of the mapping and planning tool of participation priorities in order to integrated participation more systematically as part of wider organisational and cultural change.

RDaSH had been tasked by the CCG with taking the recommendations forward by undertaking a baseline study to assess the work they did with different groups, such as the Youth Cabinet and the Young Ambassadors. This linked with the review of the Public and Patient Engagement Strategy by RDaSH.

The report author had visited RDaSH to talk with staff about the findings in the report and also about the tacit information from young people, with discussion focused on what could be done. RDaSH had found the report very insightful and the fact that it was independent gave it extra weight. It generated a lot of reflection on what it was like for people using RDaSH services.

Actions being taken forward included:

- Monthly training in place that included record keeping and safeguarding but also used “in their shoes type training” i.e. What is it like for a family coming into our services? What is our welcome like?
- Youth tube
- Work at Rotherham Show
- Improved supervision and percentage of staff having had an appraisal now nearly 90%
- Recruitment and selection

The following issues were raised:-
Where were RDaSH in terms of completing the template and how was this now being taken forward? - RDaSH were undertaking their self-assessment and would welcome some challenge with that, so they suggested taking it to the Youth Cabinet meeting on 17th November to see how robust the self-assessment was from a young person's perspective.

The Chair requested that the template be shared with the Commission so that Members could see how this would be taken forward and to gauge its success.

Resolved:-

(1) It was noted how the recommendations from the Voice and Influence review would be taken forward and in particular how this would support the recommendations from the Children's Commissioner Takeover Challenge review.

(2) That the completed self-assessment template be shared with the Commission.

45. RESPONSE TO CHILDREN'S COMMISSIONER'S TAKEOVER CHALLENGE REVIEW BY ROTHERHAM YOUTH CABINET

Janet Spurling, Scrutiny Officer, presented a report containing the response from partner agencies to the 11 recommendations arising from the spotlight review undertaken by the Youth Cabinet regarding Child and Adolescent Mental Health Services in Rotherham. The Youth Cabinet were also keen to scrutinise wider working and links between partner agencies especially through the School Nursing Service.

The review was carried out under the Children's Commissioner's Takeover Challenge initiative with the young people taking over a meeting of the Overview and Scrutiny Management Board.

The 11 recommendations were set out in full in Appendix 1 of the report submitted together with the detailed responses from partner agencies. The recommendations covered the following areas:-

- Involvement of young people – to inform practice and service development
- Reporting progress – on implementation of the new models/services
- Improving information – promoting and maintaining websites and addressing stigma
- Closer multi-agency working – in localities and with schools
- School Nursing Service – higher profile and accessibility

- Enabling informed choices by young people – regarding their treatment

Consideration was given to the Appendix which contained the initial responses to the recommendations. Discussion ensued with the following issues raised/highlighted:-

A detailed plan was needed with dates and times plus clarity over reporting routes from partners back to RYC and then to HSC if necessary. When would agencies be reporting back to RYC on the actions or with an explanation if there has been no action? – Some will take time, some are easy or already done such as the waiting area – music channels or tv and putting iPads in on stands. RDaSH will liaise with RYC and their input would be welcomed into action plan. This also linked with recommendation 5 for an annual update to RYC which could be more frequent if required.

Opening hours for the Single Point of Access (SPA)? – RDaSH want to move to an 8am to 8pm service so that it does not affect young people's school time and so they can be seen after school. As much as the trust wants to provide services in schools that is not always acceptable to all young people, so appointments will not always be in schools and it is important to talk to young people about where they want to be seen. 10-12 noon on Wednesdays seemed to be a popular slot for some reason. Families did say they wanted to be seen on weekends and between 4-6pm. Views on preferred locations for appointments differed but in general Rotherham town centre was seen as better than Kimberworth Place or people wanted an appointment in a locality base, but not always in a school. Again some were happy to be seen in the home and others not. The consultation report could be shared with HSC. Details around staffing were still to be worked out if parents want 8am appointments as usually mornings are more for people who have been admitted to hospital the previous night.

Out of hours will be through working with the Adult Mental Health out of hours service on call to cover 8pm-8am. Work and training with adults' services would ensure safe transfer. This would be cost effective and reduced demand for services has been seen in other areas with an 8am-8pm model.

TRFT confirmed that they had been successful in being awarded the 0-19 health services contract and thanked RYC for their participation in the commissioning process. Official feedback to the group by Public Health would be on 17 November.

Draft principles for the new RDaSH CAMHS web site were going out for discussion with young people. Much of the information on the current website would move across. The delay had been due to the reconfiguration into place based care groups and all children's coming together. A completion date would be forwarded to the commission for the

website and for the voice and influence policy.

Now the 0-19 contract has been awarded there is some work to do in rolling out locality working and there is the willingness and commitment to do that. Meeting dates have been set and a joint communications pathway will be developed between RDaSH and the SNS.

The importance of the monthly provider to provider meetings was emphasised. These had taken place for several months and were well attended by TRFT and RDaSH colleagues and had led to some of improvements seen, particularly the A&E response by RDaSH and the children's ward response by RDaSH.

Juliette Penney, TRFT attends the secondary headteachers meetings so she will be leading on raising the profile of the SNS in schools and involving headteachers in how to market the SNS. HSC agreed to maintain a watching brief and to receive information on any outstanding issues.

Part of the work on marketing the SNS will also be going out to young people to encourage them to work with the service and contact has been made with a RYC member to get their input as well.

Can academies opt out of the School Nursing Service? – No as it is a universal service available to everybody. Some academies are more open to partnership working than others but they cannot opt out

The School Nursing Service was locality based and RDaSH had been reconfigured around the same localities so that would enable joint working from there. Although there were some anomalies in the number of localities used by different agencies, for example adult health and social care based on seven and Early Help based on nine there is an overlap so areas are covered.

The Family Support Services work on stigma was important and it was agreed the update to RYC on 17 November would include this to capture the wider range of activities.

Concerns were raised regarding transition from CAMHS to AMHS and Cllr Roche informed the commission that a new transition board was being set up chaired by the Director of Adult Services and he was confident this would lead to improvements.

Could young people be involved in the work on transition, as it is happening to them so they are the best ones to talk about what needs to be put in place? – The new board was officer led and the date of the first meeting would be forwarded to the commission. The terms of reference may include details of plans to engage with young people but communication with young people to ask them how the service could be improved could be arranged.

Was the transition tool kit that was recently launched in Leeds being used? – RDaSH had carried out an initial draft of scoping against the toolkit which had been shared with CCG. This is a CQUIN target.

Members requested that RDaSH and partner agencies discuss the concerns regarding transition following the meeting to ensure young people receive support even if they do not meet thresholds for AMHS.

Recommendations 1, 3, 4, 8 and 11 from this review also linked to the Voice and Influence review recommendations and priorities for participation being taken forward in minute 45 below.

Resolved:-

1. That the response to the review undertaken by Rotherham Youth Cabinet be considered and noted.

2. That all dates be finalised for the actions in the response template.

3. That partner agencies discuss issues regarding improving transition from CAMHS.

4. That future progress updates include clear evidence and data, especially with regard to involvement of young people and improved outcomes.

5. That HSC would maintain a watching brief on progress in raising the profile of the School Nursing Service in schools.

6. That the next progress update would be in March 2017.

46. IMPROVING LIVES SELECT COMMISSION UPDATE

Councillor Cusworth gave the following update where the workstreams of Improving Lives linked to health:

Domestic Abuse sub-group was looking at support available in Rotherham:

- In the past referrals had not really been forthcoming from GPs and dentists and it was hoped this situation had improved since the last data was reported from 2013.
- Health visitors and GPs were required to provide support within 24 hours for children who witness high risk domestic violence.

Post abuse services for CSE – this involves health partners, including as commissioners

National transfer of unaccompanied asylum-seeking children:

- health assessments for the children might need interpretation services
- there was a regional approach across Yorkshire and Humber to health care as very specialised

Councillor Cusworth was thanked for her report.

It was noted that the next meeting of the Improving Lives Select Commission was to be held on 2 November, 2016 and all HSC members were invited to attend by Councillor Clark.

47. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR THE COMMISSIONERS WORKING TOGETHER PROGRAMME

Janet Spurling, Scrutiny Officer, reported the following:-

- Consultation had now commenced on the proposed changes to the Hyper Acute Stroke Care and non-specialised Children's Surgery and Anaesthesia
- The final consultation documents had reflected some but not all of the feedback from the Joint Committee and Health Select Commission
- A Frequently Asked Questions document had been produced which answered some of the concerns and questions raised
- The Rotherham Foundation Trust needed to do things differently to be sustainable and had realised a few years ago the need for collaboration even as a standalone Trust.
- Proposed model for Stroke Care reflected that for Coronary Care which was a recognised as a good model. Manchester and London also had a centralised model of Hyper Acute Care
- No Rotherham patients would go to Chesterfield for Hyper Acute Stroke Care
- Children and young people would go to the nearest hospital to where they lived
- Discussions with staff would take place if changes took place and, due to shortages of skilled staff, the NHS would be looking to match expertise across the region to provide the services
- Planning and managing bed capacity for the extra numbers of patients in the proposed 3 hospitals were currently being discussed

The next meeting of the JHOSC was to be held on 21st November when there would be an update on how the consultation was progressing and the business cases for change. The Yorkshire Ambulance Service were to be invited to discuss the issues raised with them.

The Chairman would feed back at the next Health Select Commission.

Resolved:- That the report be noted.

48. HEALTHWATCH ROTHERHAM - ISSUES

It was reported that no issues had been raised.

The Chair requested that in future any issues or concerns from Healthwatch be raised prior to the meeting.

49. DATE OF FUTURE MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 1st December, 2016, commencing at 9.30 a.m.

HEALTH SELECT COMMISSION
1st December, 2016

Present:- Councillor Sansome (in the Chair); Councillors Andrews, Brookes, Cusworth, Elliot, R. Elliott, Ellis, Marles, Marriott, Williams and Short and Mr. R. Parkin (Speak-Up).

Councillors Mallinder and Sheppard were in attendance for Minute No. 54 at the invitation of the Chairman.

Councillor Roche, Cabinet Member for Adult Social Care and Health, was in attendance.

Apologies for absence:- Apologies were received from Councillors Albiston and Fenwick-Green and Vicky Farnsworth (Speak-Up).

50. DECLARATIONS OF INTEREST

Robert Parkin, Co-opted Member made a Personal Declaration of Interest at the meeting (involved in the Learning Disability Offer consultation) – Minute Nos. 58 and 59.

51. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

52. COMMUNICATIONS

(1) Information Pack
The pack contained:-

- Rotherham Clinical Commissioning Group Clinical Thresholds paper (raised with Members in draft Clinical Commissioning Group Commissioning Plan)
- Latest version of the Rotherham Place Plan which had taken account of the Select Commission's feedback
- Notes from the Learning Disability Offer Sub-Group
- September Health and Wellbeing Board minutes

(2) Update from visit to the new Emergency Centre
The Vice-Chairman reported that he had visited the new Emergency Centre on 11th November. The size and scope of the new unit was very impressive and would be a wonderful asset for the town once open. He had been assured that the facility would open on time and be on budget.

(3) RDaSH had confirmed dates for actions from the CCTOC response:-

- Consultation was taking place with young people on the website and a functioning website for young people would be in place in February, 2017
- The first meeting of the new collaborative network would be arranged for March 2017 and then quarterly

53. MINUTES OF THE PREVIOUS MEETING HELD ON 27TH OCTOBER, 2016

The minutes of the previous meeting of the Health Select Commission held on 27th October, 2016, would be considered at the January meeting.

54. SOUTH YORKSHIRE AND BASSETLAW SUSTAINABILITY AND TRANSFORMATION PLAN

Chris Edwards (Chief Officer, Rotherham Clinical Commissioning Group), Louise Barnett (Chief Executive, The Rotherham Foundation Trust) and Sharon Kemp (Chief Executive) gave the following powerpoint presentation:-

Our Ambition:-
"We want everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to stay healthy and live longer"

Why we need to change
- People are living longer – and their needs are changing
- New treatments are emerging
- Quality, experience and outcomes are variable
- Health and care services are not joined up
- Preventable illness is widespread
- Shortage of clinical staff in some areas
- We have inequalities, unhealthy lifestyles and high levels of deprivation in South Yorkshire and Bassetlaw
- There are significant financial pressures on health and care services with an estimated gap of £571M in the next 4 years

Health in its wider context
- Being healthy is about more than just health services
- 80% of health problems could be prevented
- 60% are caused by other factors:
  Socio-economic status
  Employment
  Housing
  'non-decent' homes
  Access to green space
  Social relationships/communities
- Public service reform
  Personalised support to get people into work
  Support young people facing issues

Develop wraparound services
Structure ourselves better
Make money work better to achieve outcomes

Reforming our services
- We have a history of strong partnership working
- We want to work together in new ways
- Key to our success will be:
  Developing accountable models of care
  Building on the work of the Working Together Partnership Acute Care Vanguard
  Joint CCG Committee
  Local Authorities working together

Developing and Delivering the Plan
- £3.9Bn total Health and Social Care budget
- 1.5M population
- 72,000 staff across Health and Social Care
- 37,000 non-medical staff
- 3,200 medical staff
- 835 GPs/208 practices
- 6 Acute Hospital and Community Trusts
- 5 Local Authorities
- 5 Clinical Commissioning Groups
- 4 Care/Mental Health Trusts

Developing the Plan
- Built from 5 'place' based plans – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield
- 8 workstream plans (now our priorities)
- Chief Executive and Chief Officer led

Our Priorities
- Healthy lives, living well and prevention
- Primary and Community Care
- Mental Health and Learning Disabilities
- Urgent and Emergency Care
- Elective and Diagnostic Services
- Children's and Maternity Services
- Cancer
- Spreading best practice and collaborating on support office functions

Shadow Governance – Strategic Oversight Group
- Collaborative Partnership Board – membership includes
  5 Clinical Commissioning Groups
  5 Local Authorities
  5 Foundation Trusts
  4 Mental Health Trusts
  NHS England

Voluntary Sector
Healthwatch
- Executive Partnership Board
- Joint Committee CCGs
- Provider Trust Federation
- STP Delivery Unit

Reshaping and rethinking Health and Care
Our focus will be
- Putting prevention at the heart of what we do
- Reshaping and rethinking primary and community-based care
- Standardising hospital care

Putting prevention at the heart
- Drive a step change in employment and employability
- Help people to manage their health in their community with joined up services
- Invest in a region-wide Healthy Lives programme – focussing on smoking cessation, weight loss and alcohol interventions

Reshaping Primary and Community Care
- Improving self-care and long term conditions management
- Social Prescribing
- Early detection and intervention
- Urgent care intervention and treatment closer to home
- Care co-ordination

Standardising hospital care
- Reshaping services
- Managing referrals
- Managing follow-up appointments
- Diagnostics and treatment
- Reviewing local and out-of-area placement in Mental Health Services
- Specialised services

Early Implementation
- Spreading best practice and collaborating on support office functions
- Children's surgery and anaesthesia
- Hyper Acute Stroke Services
- Acute gastrointestinal bleeds
- Radiology
- Smaller medical and surgical specialties

Financial Challenge
- We currently invest £3.9Bn on Health and Social Care in South Yorkshire and Bassetlaw
- If we do nothing we estimate a £571M gap by 2020/21:
  £464M Health gap

£107M Social Care gap

Putting the Plan into action - Our Objectives
We will:-

- Reduce inequalities
- Join up Health and Care Services
- Invest and grow Primary and Community Care
- Treat the whole person, mental and physical
- Standardise Acute Hospital care
- Simplify Urgent and Emergency Care
- Develop our workforce
- Use the best technology
- Create financial sustainability
- Work with patients and the public

Engagement
We will:

- Connect and talk with our communities
- Connect and talk with our staff
- Foundation is in place with:
  Partners' communications and engagement group already set up
  Strategy in development
  Local conversations in 'place' already happening

Our Timeline

- Collaborating on support office functions – 2016-2019
- Develop network approach to services – 2016-2021
- Review Hospital Services and resources – 2016-2017
- Develop accountable care systems – 2016-2020
- Implement GP Forward View – 2016-2020
- Improve self-care and long term management of conditions – 2016-2021
- Focus on employment and Health – 2017-2020
- Invest in Primary Care and Social Prescribing – 2017-2020
- Develop and invest in Healthy Lives Programme 2017-2021
- New model of Hyper Acute Stroke Services – 2016-2019
- New model of Children's Surgery and Anaesthesia Services – 2016-2019
- New model of Vascular Services – 2016-2019
- New model of specialist Mental Health Services – 2017-2020
- New model of Chemotherapy Services – 2016-2018

Discussion ensued with the following issues raised/clarified:-

- There had been a lot of the concern regarding the decision by NHS England to keep the STPs confidential. Some other areas had gone against NHSE advice and published their STPs early. Would it have been better for South Yorkshire and Bassetlaw if it had been

published early? All Plans would be available in the public domain by Christmas; Rotherham's had been published in November. Everything going forward would be in the public domain. With hindsight it was a misjudgement to have kept it private.

- What was the aim of the consultation or was it an information sharing exercise? The Plan contained a set of aspirations. Working together across South Yorkshire was something everyone would want with increased prevention, joined up services and integration across Health and Social Care. However, the devil would be in the detail as during the course of the next 4 years when the business cases that underpinned the Plan were submitted there would be deeper discussions.

- Would the consultation change anything? The Plan was an aspiration and if people thought the aspiration was wrong then it needed to be known. It was an evolving document.

- Was the "80% of health problems could be prevented" a snapshot of South Yorkshire and Bassetlaw or a national figure? It was a national statistic.

- With regard to governance, Sir Andrew Cash had recently stated to all the Chairs of Yorkshire Health and Wellbeing Boards that there would be an Accountability and Commissioning Board where any resources, be it staff or otherwise, would go. The Board would be Chaired by him and it would make decisions as to where the funding would go. The model set up did not take into account the key accountability of Members of any Council who were accountable to the electorate for any resources they spent. Currently there was very little information being communicated with regard to the key accountability of Members and that was a real concern – The only governance the 3 Chief Officers were aware of was that contained within the presentation i.e. the Collaborative Partnership Board whose membership included the 4 Chief Executives who were very clear that they had no mandate to make any actions/decisions through the Board and that they had to go through each of their organisation's decision making processes. That feedback had been consistent. The 4 Chief Executives needed to be part of the Partnership Board to influence and ensure key local issues were taken into account and make sure that whatever came out of the STP delivered the Rotherham Place Plan as that was what would make a difference to Rotherham residents.

  The Cabinet Member would receive briefings. However, there was a need to get complete clarity with regard to the governance and where the decision making rested. The 3 Chief Officers were firmly of the view that the Partnership Board was an officer working group that would feed back into the respective decision making processes.

- Children's and Maternity Services had been included as 1 of the Plan's priorities and mentioned how a particular challenge was staffing it 24/7. Was this solely down to the lack of workforce and if so what had led to that shortage? Was it national or just a challenge for Rotherham and South Yorkshire? There were a number of factors for The Foundation Trust but workforce was always a significant challenge and there were national workforce challenges. You also had to be cognisant of the size of services, the level of demand and complexity of need. As an organisation, the Trust was very clear and committed to the delivery of high quality Children's and Maternity Services. They were provided 24/7 and consideration was being given as to how to better provide those services going forward.

  A key part of the Place Plan would start developing around Children and working with all the partners across Rotherham to work through how to meet their needs well. From that basis the Trust would then be contributing into the STP to ensure that where the Trust may need collaboration with other acute organisations to perhaps improve on clinical input which could be delivered to support services for Rotherham, this would be secured to deliver the Place Plan.

  Staff shortages were not particular to Rotherham. Like many organisations, the Trust struggled to recruit and was trying very hard currently to ensure that it created an environment where it could retain the staff it had and reduce turnover whilst at the same time creating an attractive place to work for other colleagues. The Trust had recently recruited some quite exceptional individuals to help lead elements of those but continued to have vacancies in some areas.

- Rotherham should not dilute the great services it had to its detriment for the wellbeing of other places – If done correctly, the STP should be a huge opportunity for Rotherham. The Foundation Trust was very self-aware but there were several specialities that needed collaboration to be sustainable. Hopefully the process would allow hospitals to collaborate with Rotherham patients treated in Rotherham unless there were good reasons, clinical or financial. The default position was work behind the scenes to manage the workforce and the patient being offered treatment on the same site. The majority of services should be provided from the same site.

- The interim governance arrangements would remain in place until April 2017 during which time a review would take place. What was currently operating? Where was the review and what was it moving to? What we have now was the arrangement on the slide with the 17 organisations having met once as the Collaborative Partnership Board. The review was to take place by April, 2017. It would be the expectation that the Collaborative Partnership Board would receive the review. The questions posed would be raised at the Partnership Board.

- Had work taken place on the specialist areas possibly being brought together with regard to patients' families travelling to visit and the associated costs? Work was commencing on the 8 workstreams and would result in business cases and proposals for change. If there were major changes it would have to go to full consultation and mapping of the impact for patients and family but had not reached that stage as yet.

- In the recent Autumn budget the Chancellor had stated that there was no monies for prevention. How was it intended to be able to deliver the standards desired and to meet the challenges when there was no extra funding? Realistically there was no funding and making prevention part of everyone's day job was essential. Making Every Contact Count should not cost anything; if every health professional made a smoker aware of the Smoking Cessation Services on offer that intervention could make a big difference. The Healthy Lives Programme, focusing on the "big three" of smoking cessation, weight loss and alcohol, and trying to measure how all Rotherham professionals could communicate that and ensure that the Rotherham population had the best access and made informed choices. Rotherham partners were trying to ensure that prevention would be one of the early workstreams.

- Would the increase in GP budgets be for increased Health Checks? In the plan there were 2 areas that received investment – GP and Mental Health Services. In terms of GP Services it was 2-3% investment which would tackle the management of patients with Long Term Conditions and access to GP services. However, there were not as many GPs so Primary Care would be looked at to provide, for instance, a pharmacist in the practice or more trained nurses to allow the GPs to spend more time with those patients with complex needs. Prevention would be core to everything they did.

- Are you looking at providing more training for staff who worked in GP surgeries? It was expected that every professional who came into contact with a patient to train them in the priorities.

- If members of the public will be able to speak to other professionals at GP surgeries would anyone be refused to see a GP? Every practice worked differently but patients would always be directed to someone who could meet their need. The practice would judge that – it may be the pharmacist, physiotherapist etc. If patients, after seeing those professionals, were not getting what they needed, they would need to see the GP. It was about trying to get the maximum benefit from the GP appointment and saving people's time.

- How confident are you that GPs with the pressures that were on them and other clinicians for timescales and the time spent with patients that they could Make Every Contact Count? GPs were a tiny portion of MECC. It was hoped that people would get the message 2/3 times every time they came into contact with a health professional, Council Officer etc.

- There was a complexity with the partnership working within and outside the South Yorkshire and Bassetlaw footprint. The Transforming Care Plan for Learning Disability and Autism included 3 of the 4 South Yorkshire CCGs and North Lincolnshire. Was there some train of thought as to how it would be tackled and how the Select Commission would be able to scrutinise it or would it be done on a singular basis? The rationale for North Lincolnshire being in the cluster for learning disability clients was that RDaSH provided services there. The 2 areas that you would normally see partnership with were North Derbyshire and Wakefield because of patient flow. Although there was the STP boundary there would have to be partnership work with a number of STPs.

The Chairman thanked Chris, Louise and Sharon for the presentation.

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

(2) That Rotherham Clinical Commissioning Group discuss with Public Health the possibility of providing local statistics regarding health problems.

(3) That the Chief Executive of Rotherham Foundation Trust would raise the issues regarding the formal governance process with Sir Andrew Cash.

(4) That the Rotherham Foundation Trust submit their action plan to the quarterly briefing.

(5) That consideration be given as to how the Transforming Care Plan for Learning Disability and Autism would be monitored/scrutinised.

(6) That it be noted that reports would be submitted to the Select Commission on a regular basis with regard to STP priorities reaching decision phase.

(7) That if Members had any further questions on the presentation these should be forwarded to be raised at the next Health and Wellbeing Board.

(8) That the comments made at the Select Commission be communicated to the Health and Wellbeing Board for inclusion in the formal consultation feedback.

55. ADULT SOCIAL CARE PERFORMANCE - YORKSHIRE AND HUMBER YEAR END BENCHMARKING

In accordance with Minute No. 6 of 16th June, 2016, Nathan Atkinson, Assistant Director Strategic Commissioning, and Scott Clayton, Performance and Quality Team Manager, presented the final published year end performance report for 2015/16.

The Council had seen continued improvements across the range of 22 national Adult Social Care Outcomes Framework (ASCOF) measures reported in 2015/16. 19 out of 22 comparable measures were recording an improvement since 2014/15.

The direction of travel was beginning to evidence that implementation of new Service delivery models led to better outcomes for people and increasing satisfaction levels sustained over the year:-

13 measures had improved their Yorkshire and Humber and national rankings
4 measures had retained their Yorkshire and Humber rankings
4 measures Yorkshire and Humber rankings declined and 8 measures national rankings declined
1 measure was not able to be ranked in 2014/15 so no comparison was applicable.

However, it should be recognised that some of the areas of improvement when compared to the now published national data, showed that the Council had either not always in the transitional year kept pace with other councils' performance or the improvement had been from a low baseline. Possible reasons identified that may have contributed to the negative shifts seen in some rankings were detailed in the report submitted.

Current 2016/17 performance update on the 8 declined national ranking measures were shown in Appendix 1 but in the main had improved since year end or an additional comment had been added.

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

- The information for customers needed to be presented in a way that all understood – This was the challenge and had to ensure that the advice offer was good, met the needs and able to answer what the customer was enquiring about so they could find the services that met their needs. That would not always be by the Council.

- Did the Service consult with other authorities that were performing better than Rotherham to see what they were doing differently? There was already a range of networks where officers met and could tie in with other colleagues to check out what they were doing differently to ascertain if it was a genuine difference and what steps they had taken.

- How did the Mental Health performance impact on the overall score? In terms of No. 3 (Proportion of adults receiving long term community support who receive services via Self-Directed Support), through the Care Act everybody could approach the Council to be assessed and see how their needs could be best met. That experience was across the board. What was found that, if look at activity across the Directorate, excluding Mental Health, almost 98% of Service users were able to have their needs met through a Self-Directed Support. Similarly, what was found on the Mental Health parts of the Service was that, because of some of the challenges, that some people with Mental Health issues have may chosen not to take that particular path.

  It was a similar story in terms of the carers. Historically there had always been a zero score because the nature of the services and provision offered to carers in Rotherham was predominantly badged up as information and advice which did not count to the score whereas the actual services went to the cared for person. This had now changed and was the reason for an increase from zero to 29%. In terms of the impact on Mental Health data they actually had a net reduction of bringing the score down as they were always offered services via the Direct Payment methodology, therefore, the current performance score was 100%. That would change by year end as it did not contain any RDaSH data who offered commissioned services.

- Performance showed that Direct Payments were good but also stated that they were flagged as 1 of the major budget pressures? It was due to how the data was collated. In terms of the statistics and measures, technically the more people in receipt of Direct Payments the better but it was about how you operated them. There had been many discussions regarding the applications and interpretation of Direct Payments which had created anomalies which in turn had financial implications. The data had to be reported to the Government but there was recognition at local level that this was an area for improvement.

  The total number of customers that benefited from Direct Payments was larger than the numbers accounted for in the figures. This was due to the majority being on Managed Accounts and did not count towards the Measure. When those customers had been revisited this year and asked if they wanted a full Direct Payment and take full control of their package they would move into a process that allowed that and increase the figures. Alternatively they could move into a more commissioned service and the cost element associated with Direct Payment would decrease.

- Was there an action plan as to how the situation would be improved? The Managed Accounts issue was part of the Budget Recovery Plan where there was significant activity attempting to rectify the situation.

Managed Accounts historically had been used as a way of finding alternative home care. There were standard home care rates i.e. 8 contracted providers to provide competitive prices but unfortunately the Managed Accounts process was individually negotiated with some of the prices being significantly higher.

- What would the future reporting process be through Liquid Logic? It was anticipated that there would be some issues with a dip in performance as operators became familiar with the new way of working.

- How would the information gathered from Liquid Logic be used? Were we confident about the quality of the data? It would be key to the validity of the data being reported mid-December and that the historical records had been transferred to the new system correctly. Liquid Logic was more structured than the current system and an increased number of mandatory fields that officers had to complete which would help with better quality data.

- Would there be question marks with regard to the end of year figures? A new reporting suite had to be developed which would allow the information to be transferred across specifically and capture Q4 activity correctly to facilitate the completion of national reporting and have confidence in the data.

- How was work progressing to secure and sustain NHS Continuing Health Care (CHC) funding where there was eligible need? It formed part of the Budget Recovery activity. Some of the care packages where it was believed the eligibility applied would be looked at.

- If the CHC funding was reduced was that because the NHS criteria changed or due to a change in the person's state of health? It would be due to a change in the person's needs.

- Why was CHC lost to a customer classified as a new admission? That particular Measure's definition of who counted as a new admission was centred around who funded the placement. Somebody who was in receipt of 24 hour provision but at the initial stage was fully funded by CHC the Council did not contribute to that placement and, therefore, would not be counted as a new admission. However if a person's needs changed and it became a jointly supported placement and, therefore, the Council began to pay a proportion of the costs, at that point it would be classified as a new admission in that financial year.

  In 2011/12 there had been a general decline in the number of admissions – down from 40 to 20. However, last year it had increased to 31. On examination, it appeared that the particular cohort of customers that now had to be taken account of was due to the loss of CHC funding. The current data for Q2 had seen

admissions increase from 7 to 10 and forecasting approximately 20 to year end.

The improvements made since the last report were welcomed.

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

(2) That future reports identify holistic improvements

(3) That the Select Commission receive written quarterly reports to have better visibility of how the action plans are addressing areas for improvement.

(4) That the Select Commission receive six monthly verbal reports on progress to see how the plans are moving forward on a gradual basis.

56. ADULT SOCIAL CARE PERFORMANCE - LOCAL MEASURES

Further to Minute No. 20 of 28th July, 2016, Nathan Atkinson, Assistant Director Strategic Commissioning, presented the Q2 Local Measures performance together with the 4 existing Corporate Plan measures.

The report set out the current performance challenges as at 30th September, 2016, which included:-

LM01 – Reviews
LM02 – Support plans % issued
LM03 – Waiting times assessments
LM04 – Waiting times care packages
LM05-07 – commissioning KLOE's
LM08 (CP2.B3) – Number of people provided with information and advice first point of contact (to prevent service need)
LM09 (CP2.B5) – Number of carers assessments (only adult carers and not including young carers)
LM10 (CP2.B7) – Number of admissions to residential rehabilitation beds (intermediate care)
LM11 (CPS.B9c) - % spend on residential and community placements new measure 2016/17

Discussion ensued with the following issues raised/highlighted:-

- How would the model currently being put together link into budget pressures and budget savings? If the performance improved what kind of budget savings would that give against requiring the same amount of investment? If so, would you be able to re-direct that investment across Adult Social Care or would it have to be shared across all the portfolios? In terms of re-investment, a purpose of the consultation was to look at where finances needed to be realigned. Investment would need to be moved around but there was not much slack in the system. The savings were challenging but were

deliverable, therefore, it had to be ensured that the intelligence and knowledge arising from the Performance Team and Liquid Logic were used to ensure that any issues were addressed quickly.

- If performance was falling where would that sit against the budget pressures within the model and into 2017/18 and beyond? The key for performance was improved assessments/re-assessments. In order to make any change in Social Care it was reliant upon re-assessment and the review process formed part of that. The Service needed to ensure there were good quality assessments that were strength based, considered all the options, and not just statutory services, and ensure that they had longevity and were of good quality. In the past there had been a tendency to look at numbers rather than quality.

  Care Act assessments were a much longer process than previously, if done properly, looking at the person centred approach with long conversations with the individual about what they required, what the person could do rather than what they could not do as well as a built-in time period for reflection. There was a need, from a workforce point of view, for considerable development in embracing and embedding the principles. Online Care Act training had been purchased as well as further workforce development initiatives.

  There also had to be good solutions and services for people. Some of the work being doing around the strategies was developmental but the challenge was that in some areas there was not a great amount of choice. There were things out there that may be a more community focussed than perhaps a statutory service.

- What was LM04 (waiting times care packages)? It was tracking those customers who were on a package of care and whether they had been reviewed at least once in a year. Currently it was tracking at just below 21% opposed to the target set of a minimum of 75%. Ordinarily there would be approximately 6,000 people on service during a year. LM04 looked at the sub-set of those 6,000 which had been on service for longer than 12 months and asked how many had been reviewed. The figures revealed that the Service was not getting through the pace of those numbers as it had been in the past some of which was due to the process of the Care Act and the length of time that took but also the changes in the Service and having the Teams and resources in the right place at the right time which had not happened as quickly as anticipated. Liquid Logic had also had an impact with staff having time out to learn the new systems.

- Was there an action plan in place for LM04? It was clear that the Service would not reach the 75% aspiration target but it was hoped to achieve 40% by year end. It was hoped that some of the improvements being put into place referred to earlier, better demand management and meeting needs in other ways, would result in a

reduction in numbers. It was hoped 2017/18, when Liquid Logic had been embedded and the new structure settled, would see improved performance.

- We need to be assured it would happen and when it would happen? In terms of the slippage, there was now improved project management by the Adult Social Care Development Board where the majority of the data would be scrutinised. It did not mean that customers were not getting services but not ensuring people received the right service through the assessment.

- What was LM10 (number of admissions to residential rehabilitation beds (intermediate care)? It was a measure that looked at the activity throughput of intermediate care as a joint service with the CCG. The numbers were increasing but in line with what had been provided in the past. It would suggest that the provision rate was right for meeting the current level of demand.

- It had been stated that with regard to meeting assessment targets that there may be other ways used to conduct an assessment other than face-to-face. In the days of more and more people using Services that were not inhouse, using Direct Payment to employ someone or even reliant upon family to provide care, if there was not that face-to-face contact some quite serious safeguarding issues might be missed. What exactly was being done to address that? For clarity any opportunity for remodelling some of the delivery and not being face-to-face contact would primarily refer to people on review. For a new person coming into the Service it would almost certainly come from the single point of assessment, contact be made and be seen by a worker face-to-face. If moves were made to discontinue face-to-face contact, it would have to be ensured that the relevant safeguards were in place to avoid the situations highlighted.

- There were times when a person they might be able to say something to a Social Worker in a private context or a Social Worker might see something. The lack of face-to-face contact would take that away that opportunity – The Service would devise a range of different models to actually undertake the number of reviews. They would have to carefully select which target groups were suitable for that range of different models and also put in place the fallback positions of when people felt that they needed to refer back into Service that they were seen, followed up and receive face-to-face contact. Previously, when consideration had been given to options, the Service put mechanisms in place whereby sometimes either provider reviews or telephone reviews had been done. The next step would always be that the next year the person would be seen face-to-face so there was not a continuum of that particular model of delivery. It may have to be included in the quality assurance side of any model proposed if moving away from face-to-face 100%.

- That would be more acceptable if the person had a telephone review in November/December and was then seen face-to-face at the beginning of the new financial year rather than waiting a full year without seeing anyone. This would be fed into the Service as a suggested model for consideration.

- LM05 and 6 (commissioning KLOEs) – how were these measured and what evidence supported the improvements? It was a self-assessment so open to interpretation. In terms of the standards there were 3 themes and within that a number of domains:-

  (1) Person centred and outcome focussed provision
  - Is the work you are doing starting with your outcome and working backwards and is it person centred?
  - Is it being co-produced with Service users, carers and the wider community?
  In the past a lot of the focus had been devising a specification with a small select group of officers, not spending time co-producing it with those in receipt of services and interested parties and losing sight of the outcomes. Some of the recent activity around Learning Disability and the work embarked on Autism, Carers and start of discussions with Older Peoples' Groups about developing an Older Person's Strategy, all pointed towards a move to co-produced models and very much part of the mission within Commissioning to ensure that it was embedded in everything it did.

  The person centred approach was not only mandatory through the Care Act but also a moral duty.

  (2) Well-led
  The direction of travel on leadership was coming from Elected Members, the Chief Executive through the SLT, the Strategic Director of Adult Services and Housing, Assistant Director of Commissioning and the Head of Health and Wellbeing, and staff appreciated that there was a lot more clarity about what the Services was trying to do. Commissioning was more prominent in people's knowledge in terms of the role it played and what was required to get good quality services for people. It was a whole system approach about how it interacted with other services.

  Evidence bases – As funding became tighter it had to be invested wisely so consideration was being given to developing new services. If other authorities had something working well in their area, with evidence behind it, it would be considered.

  (3) Promotes sustainable and diverse market
  At the moment Rotherham did not have a diverse market and in some areas the sustainability was questionable.

Developing and providing for value for money. It was known that some of the Authority's legacy services did not offer value for money and needed to renegotiate prices and think about what to/what not to invest in.

The Authority had historically been good at engaging with providers and had been embedded within the Commissioning function for some time. However, it had been limited to certain disciplines and cohorts, mainly learning disability and older people. It would be looked to widening it out to all the people supported in the Borough.

- Concern that the Leadership Team in 2015 judged itself practically as being in the "red" and the Leadership Team in place as of now judged itself as being in the "green". It did not seem to be the best measure. – When the Assistant Director for Commissioning had first come into post, a self-assessment had taken place. At that time there had not been any current commissioning strategies, no market position statement and very limited information on the people it supported. Within the proceeding period quite significant progress had been made. It was a matter of debate whether "amber" or "green" but certainly in a much better place than when the initial assessment was conducted in June/July, 2016.

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

(2) That quarterly reports are submitted to the Commission for information and decision as to whether any immediate further scrutiny was necessary.

(3) That performance on measures LM01-04 for October to December be reported to the Commission in January as part of the update on the Adult Social Care transformation.

(4) That the minutes of the performance clinic held in July be circulated to Select Commission Members.

57. DEVELOPMENT OF A ROTHERHAM ALL AGE AUTISM STRATEGY

Nathan Atkinson, Assistant Strategic Director Commissioning, reported that Commissioner Sir Derek Myers on 10th October, 2016, had approved a proposal to implement a strategic approach to the commissioning and delivery of services for people with Autism within Rotherham. The approach sought to develop a set of strategic commissioning intentions that promoted independent, choice and control for people with Autism.

The Strategy would strengthen Rotherham's statutory commitments and the approach positively added to the direction of the Adult Care Development Programme and the Children and Young People's Special Educational Needs and Disabilities (SEND) agenda.

Since the proposal was approved:-

- Initial consultation event held to launch activity attended by a range of stakeholders from public services, the voluntary sector, users and carers. The timeline for further consultation was currently being devised
- The event had focussed on mapping current provision across all sectors and identified gaps in some Services areas including training for staff working in Social Care, lack of specialist accommodation and access to information regarding local support
- Presentation to Learning Disability Partnership Board where the approach was strongly supported
- Completion of the Public Health England Autism Self-Assessment Framework which enabled the Council to benchmark progression towards meeting the quality standard goals outlined in the Government's 2014 Adult "Think Autism" Strategy
- Grant awarded to SpeakUp for Autism to assist with strategy development and co-production using users by experience
- Submission of funding bid to the Housing and Care Technology Fund to support the development of specialist housing and assistive technology for people with Learning Disabilities and Autism in Rotherham

The consultation plan was currently being devised with full consultation commencing in January 2017.

Resolved:- That the report be noted with an update to come in the future.

58. LEARNING DISABILITY - SHAPING THE FUTURE UPDATE

Nathan Atkinson, Assistant Director Strategic Commission, referred to the report, 'Learning Disability Commissioning – Shaping the Future', approved by Commissioner Sir Derek Myers on 10th October, 2016, to implement a strategic approach to the commissioning and delivery of services for people with Learning Disabilities within Rotherham through a market position statement. The approach sought to adopt a set of strategic commissioning intentions that strengthened independence, choice and control and supported the wider Audit Care Development programme.

Since approval of the report, the market position statement had been updated with the final version to be published on the Council's website in December. Speak Up had been awarded a £50,000 grant and had commenced a programme of work which would support the overall direction of travel for Learning Disability Services.

Two meetings had now been held with Sheffield City Council to progress activity on a Supported Living Framework which would lead to a formal work programme to facilitate the required tender activity and provider

selection process during 2017. A draft specification would be available for consultation in January with feedback from the Commission invited.

A bid had been submitted to the Housing and Care Technology Fund administered by the Department of Health on 28th October. The bid was to support the development of specialist housing and assistive technology for people with Learning Disabilities and Autism in Rotherham.

The tender for John Street and Oak Close had been published on YOURtender. It was envisaged that the Service provision would be awarded to a new provider in February, 2017, with a view to the transition taking place in March and handover on 1st April. Customers, carers and families would be actively involved in the provider selection process.

Sally from SpeakUp gave a verbal update on the Learning Disability offer consultation and the work they had undertaken:-

- Work had taken place with the Council as well as with people with Learning Disabilities and family carers with regard to how the consultation would work for people
- Development of a range and variety of methods in which people with Learning Disabilities, family carers, members of the public and staff across the Clinical Commissioning Group, RDaSH and the Council could have their say
- 4 different questionnaires that would be available through the Council's website along with an easy read version for people with Learning Disabilities and Autism
- Range of sessions that people could attend - 1:1 and drop-in sessions and focus groups for members of the public and family carers to have their say on the Learning Disability offer
- Made sure that carers have had their say in terms of thinking about some the questions that would be going into the consultation and making sure that people with Learning Disabilities across the Borough had the options to have their say
- Look to working with REMA and BME communities because conscious that very few BME communities access Learning Disabilities Services in Rotherham as well as organisations such as KeyRing and NASS to make sure people with Autism have their say on the Learning Disability offer
- The last Peoples' Parliament had focussed on road safety and hate crime. The Hate Crime reporting officer came to that session and took back peoples' views and voices to the Vulnerable Person's Unit

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

- When undertaking the consultation were you able to look at location bases? If there was a particular location where there was no response it may not be effective to go to the Borough-wide organisation but location-based community projects - Work was

taking place on ensuring all the information was available e.g. GP practices, across community services, posters displayed for the general public to know about the consultation. The information that would come back in through the online questionnaire would specifically ask for the location so it could be mapped across the Borough. Any issues in certain areas of the Borough would be picked up on a weekly basis. It was proposed that short reports be prepared for Members to update on progress with the consultation.

- A lot of people did not view such consultation work as a Service paid for by the Council. With all the funding being put forward it was important that people saw how the Council spent the money and who gained from it.

- Communications Team need to explain what was trying to be achieved, how it would be funded and the quality of the service.

- Were the drop-in sessions just in Rotherham or certain areas of the Borough? They were across Rotherham. Anyone could attend the drop-ins but there was a dedicated telephone line to book in on the 1:1 sessions or focus groups.

Resolved:- That the report be noted.

59. LEARNING DISABILITY - THE TRANSFORMING CARE PARTNERSHIP

Kate Tuffnell, Rotherham Clinical Commissioning group, presented a report on the South Yorkshire and North Lincolnshire Transforming Care Partnership (TCP) which comprised Rotherham, Doncaster, Sheffield and North Lincolnshire Clinical Commissioning Groups. The Partnership would transform care for people with a learning disability and Autism by working collaboratively to deliver the key principles from the national Building The Right Support Framework.

The TCP had been set the challenge to remove the need for permanent hospital care for people with a Learning Disability, people with complex and challenging care needs and/or Autism by March 2019. The plan set out how the Partnership aimed to achieve reducing the need for hospital beds whilst moving to a more proactive community-based care model which was in line with Building The Right Support core values and principles.

In 3 years the TCP would have:-

- Lowered the number of inpatient hospital beds for people with Learning Disabilities and Autism to between 10-15 beds
- Re-invested in new models of care such as expanded care teams, greater use of personal health budgets and a more coherent response to offender and forensic health

- Developed a coherent engagement strategy to ensure that Service users -and their families were genuine co-producers of models of care
- Development of the workforce, not just for statutory services, but also supporting the independent and private sector to access training across the system

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

- When someone who had been in hospital for a lot of years and was going to live in the community, it was essential that local Ward Councillors were notified to help ease other residents' concerns, prevent rumours getting out of hand and engaging the community in a positive manner - This was happening nationally. A challenge for Rotherham was that a lot of the homes that supported people with a Learning Disability did not always notify agencies. The CCG was working with providers across the Rotherham footprint and talking to them about their plans and how they worked locally. There had been instances where people had been placed locally, not known to the Services, and that was where things went wrong. It was also noted that in a number of the homes there were no Rotherham people in them.

- The public were concerned about the changes that were taking place for example support following the death of a family carer – It was really important that people fed into the consultation (Minute No. 58) and put their views forward because it would influence how the Council would take it forward. The work through the Transformation affected a very small number of people. Work was commencing to talk to them and find out where they wanted to live, what they wanted to do and it was hoped to do a piece of work with Speakup regarding Person Centred Planning for those individuals.

- Important to note that although the consultation was badged for Learning Disability it was for anyone in the Borough.

- If someone who lived in the community required a secure bed did we have the capacity to provide that person with a secure bed? If someone needed a hospital bed because they required treatment they would not be denied a bed. There was a staged approach; people who were working with someone in hospital to support them to move out of hospital. Then there was an At Risk of Admission Register which was an early warning and flagged where it was thought they may be problems with an individual and who may need additional support. Workers would meet as a team and provide that additional support and hopefully, with that support, stay in the community. If needed the individual would be admitted to hospital.

- If someone had to access Mental Health Services as an alternative was there capacity to support that person so they could access the Services that would help? A lot of work had been carried out over the last couple of years to look at the Mental Health Hospital and to make sure if someone with a Learning Disability needed to be admitted it was appropriate. Speak Up have done a lot of work with the hospital and training to ensure they understand the needs of a person with learning disability or autism. If somebody who needed to be admitted into Rotherham Mental Health Hospital that would happen if that required and the staff had had additional training to enable that to happen.

Resolved:- (1) That the work of the Transforming Care Partnership to transfer care for people with a Learning Disability or with Autism be noted.

(2) That future reports on Learning Disability – Shaping the Future and the Transforming Care Partnership, be submitted at the same time.

60. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR THE COMMISSIONERS WORKING TOGETHER PROGRAMME

The following verbal report was given on the above Programme:-

Consultation

- 900 hits on the website and interest via Twitter but these were not being converted into consultation responses as yet even though the information was getting out to the public
- As at 21st November there had been:-
  78 responses on the Hyper Acute Stroke proposals with 46 disagreeing with the proposals
  60 responses on Children's with 30 disagreeing with the proposals
- Very low attendance at public meetings with no-one attending the 18th November meeting at MyPlace in Rotherham or the meeting at the Source in Sheffield the following week
- NHS England were now looking at a gap analysis across all the communities and engagement so far to ensure they were reaching into communities and welcomed any suggestions from Members
- There had been feedback from all areas on both Services, Hyper Acute Stroke and Children's, but mainly from Barnsley (49 Stroke/26 Children)

Ambulance Service

- East Midlands – already had the specialist centre model in place for Stroke Care, Coronary Care and major Trauma and were achieving better outcomes and reduced mortality
- Yorkshire Ambulance Service Staff Training – all frontline staff (Paramedics and Technicians, call handlers for 999 and 111 as well as Community First Responders), were taught to assess the patient suspected of Stroke using the FASt. Patients at point of call had a fast assessment which was repeated at the time of the face-to-face

assessment. If it was a suspected Stroke staff followed the Yorkshire Stroke Pathway and referred the patient to the nearest Hyper Acute Stroke Unit

Children

- Data to come on the number affected by the proposals on the 6 sub-specialities

The Chairman and Vice-Chairman would continue to be involved, feeding in Members' issues and concerns and reporting back from the JHOSC.

61. IMPROVING LIVES SELECT COMMISSION UPDATE

Councillor Cusworth gave the following update from the 2nd November Improving Lives Select Commission meeting:-

- Post Abuse Services – significant investment put into the development and commissioning of Child Sexual Exploitation support Services by both Council and the Clinical Commissioning Group. They identified that this investment had resulted in a very different support offer both for victims and survivors to that identified in the Jay report. There was now a very comprehensive range of services existed.

- Unaccompanied Asylum Seeking Children that Rotherham committed to welcoming – the main concern expressed by the Select Commission was the possibility of an extra burden on services particularly CAMHS. The Clinical Commissioning Group did say they were fully prepared for this and appreciated there may be some extra service required. They did see the more locality plans and joint working as prepared to alleviate that and did commit to Looked After Children being prioritised as part of the assessment process.

Councillor Cusworth was thanked for her report.

62. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

63. DATE OF FUTURE MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 19th January, 2016, commencing at 9.30 a.m.

Rotherham Metropolitan Borough Council

Public
Health Select Commission Meeting

Summary Sheet

Council Report
Health Select Commission 19 January 2017

Title
Overview of the Adult Care Development Programme / Better Care Fund (BCF)

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

Strategic Director Approving Submission of the Report
Anne Marie Lubanski, Strategic Director of Adult Care and Housing

Report Author(s)
Nathan Atkinson, Assistant Director Strategic Commissioning, Adult Care and Housing

Sam Newton, Assistant Director Independent Living and Support, Adult Care and Housing

Ward(s) Affected
All

Executive Summary

This report provides an Overview of the Adult Care Development Programme and the Better Care Fund (BCF).

The Adult Care Development Programme is the overarching strategy to transform Adult Care. The aim of the programme is to embed Care Act 2014 principles and to build upon them in terms of a focus on strengths based assessments, investing in prevention and early intervention and maximising community assets. In order to achieve these aims, there is a need to review and develop existing services, both directly delivered and externally commissioned.

The strategy is enshrined within the Adult Care Development Programme and it is delivered through a governance route overseen by the Chief Executive and Cabinet Member for Adult Care via the Adult Care Improvement Board. Ultimately, the Strategic Director of Adult Care as the Statutory Officer has responsibility for developing the strategy and ensuring it is being delivered.

The activity is being programme managed using the guiding principles of project management. Products are currently being developed to support progress against set milestones and to ensure delivery.

This report provides an overview as to progress against current activity.

The Better Care Fund (BCF) is a programme spanning both the NHS and local government. It aims to improve the lives of some of the most vulnerable people in placing them at the centre of their care and support, and providing them with 'wraparound' fully integrated health and social care.

The Better Care Fund is co-produced and managed by the Council and the Rotherham Clinical Commissioning Group and includes risk share arrangements covered by a contract known as a Section 75 agreement. The investments have mutual benefits for both parties and help forge an approach to integrated health and care solutions. The submission for 2016/17 has been approved by NHS England.

Officers are awaiting further guidance from NHS England in order to develop the Better Care Fund submission for 2017-19. The submission will require full agreement between the Council and the Rotherham Clinical Commissioning Group as to content.

Recommendations

Members of Health Select Commission note the contents of the report.

List of Appendices Included

None

Background Papers

None

Council Approval Required

No

Exempt from the Press and Public

No

Title: Overview of the Adult Care Development Programme / Better Care Fund (BCF)

1.0 Recommendations

1.1 Members of Health Select Commission note the contents of the report.

2.0 Background

2.1 Nationally, the provision of social care for adults has undergone enormous change over the past generation. The pace of change has accelerated over the past few years as the demand for more personalised services continues to grow, traditional models of care are seen to be outdated and not delivering independence, choice and control and pressure on the system grows from more demand and less resources. These changes have now been reinforced with the introduction of the Care Act.

2.2 The focus within adult care has to be on outcomes – both for individuals and their carers and families but also for the wider community and residents. Improving the information and advice, help and support for individuals who need it at any specific time benefits the whole community as they are likely to be family and friends of people requiring support or who may come to need it.

2.3 Linked to this, the approach in Adult Care is increasingly based on an assets model – identifying what peoples' strengths are, what they do have, who they know and which community groups they are linked into, what their family and friends can do as carers and what the wider communities can offer and what they can offer them also.

2.4 The importance of prevention and early intervention is well-recognised and this cuts across social care, physical and mental health. Further, the principle should be employed in whatever situation people live. It is essential that the person is seen in the whole – that their health and wellbeing are addressed – and that this is done in at every stage of people's journey through life – whether they are outside of the formal care system or whether they are receiving high levels of formal care and health services. The opportunity must be taken at all times to maximise people's independence and ability to make choices and take control of their lives.

2.5 For many years, care was based on a building based model. There has been increasing development of care based on a personalised model with people enabled to live in their own homes and to access services, facilities and buildings as part of the wider community. Consequently, the role of Adult Care has changed – rather than being focused on delivering a range of services, it has had to develop a strong partnership and influencing role.

2.6 Beyond the Council, Adult Care has become a key partner with health services and this partnership has been enshrined in different ways – e.g. through the Health and Wellbeing Board, Rotherham Place Plan and the Better Care Fund. Increasingly, integrated services are seen as the way forward in delivering more personalised and holistic care.

2.7 The Better Care Fund (BCF) is a programme spanning both the NHS and local government. It aims to improve the lives of some of the most vulnerable people in placing them at the centre of their care and support, and providing them with 'wraparound' fully integrated health and social care.

2.8 The Better Care Fund is co-produced and managed by the Council and the Rotherham Clinical Commissioning Group and includes risk share arrangements covered by a contract known as a Section 75 agreement. The investments have mutual benefits for both parties and help forge an approach to integrated health and care solutions. The submission for 2016/17 has been approved by NHS England. This is two parts – a Narrative Plan and a Planning Template.

2.9 Officers are awaiting further guidance from NHS England in order to develop the Better Care Fund submission for 2017-19.

3.0 Adult Care Development Programme

3.1 The Council's ambition is that adults with disabilities and older people and their carers in Rotherham are supported to be independent and resilient so that they can live good quality lives and enjoy good health and wellbeing. This vision also supports the Council's financial challenge, in terms of mitigating rising demand for statutory services within the context of reducing budgets.

3.2 The strategy which will enable these outcomes to be delivered contains seven key elements and these define the Adult Care Development Programme. The Council must:

- ensure that information, advice and guidance is readily available (e.g. by increasing self-assessment) and there are a wide range of community assets which are accessible
- invest in services that embed prevention and early intervention. These reduce and delay entry into more expensive .statutory services
- focus on maintaining independence through reablement and rehabilitation
- improve our approach to personalised services – always putting users and carers at the centre of everything we do
- develop integrated services with partners and where feasible single points of access
- ensure we "make safeguarding personal"
- commission services effectively working in partnership and co-producing with users and carers
- use our resources effectively

3.3 The strategy is enshrined within the Adult Care Development Programme and it is delivered through a governance route overseen by the Chief Executive and Cabinet Member for Adult Care via the Adult Care Improvement Board. Ultimately, the Strategic Director of Adult Care as the Statutory Officer has responsibility for developing the strategy and ensuring it is being delivered.

3.4 The activity is being programme managed using the guiding principles of project management. Products are currently being developed to support

progress against set milestones and to ensure transparency of delivery. The programme activity has been divided into four key areas:

- Prevention
- Integration
- Care Co-ordination
- Maximising Independence and Reablement

3.5 This report primarily provides an overview as to progress against current activity as of Quarter 3, December 2016.

3.6 *Prevention*

- A not for profit organisation, Community Catalysts recently won a tender to provide expertise as to the development of community groups to deliver preventative services and supplement the wider Adult Care offer. They will work closely with the Adult Care Community Link Workers to identify areas for development and to provide guidance as to how to best stimulate local groups.

3.7 *Integration*

- The Village integrated health and care locality pilot has been running since July 2016 based out of the Clifton/St. Anne's Medical practice. The remit of the pilot has been kept intentionally flexible to allow creativity in relation to what can be achieved. The high level intentions remain to reduce duplication, avoid hospital and residential care admissions and help shape the thinking for a potential wide Rotherham roll out of integrated locality working. The Key Performance Indicator (KPI) suite is being developed to enable practical comparisons to be made with other localities in terms of performance and impact.

- The positives with the pilot have been closer working relationships and co-location with social workers, therapists and nursing staff. There has been some success in discharging patients from hospital through in-reach. However, a number of practical issues have hampered progress in this area, though these are now being addressed, including:

  - staffing levels and devolving of budgets to enable the teams to work differently
  - IT and access issues, including but not limited to interoperability
  - different views across the organisations regarding information governance
  - implementation of an agreed leadership model.

- In order to refocus The Village activity, an event is to be held on the 24 January 2017. Staff working in the pilot will lead the session with the aim to identify solutions to improve on the current approach, ensure that there is a full understanding across organisations of the remit of the pilot and to encourage a true multidisciplinary model.

- Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) provide statutory mental health services within Rotherham. They are currently implementing a major transformation programme. The realignment of mental health services to embrace the principles of the

Adult Care Development Programme is essential to the future of integrated service delivery. Officers are working with RDaSH to understand the work streams, timelines and interdependencies of the RDaSH transformation and how the Adult Care requirements can be built in.

3.8 *Care Co-ordination*

- Training is being commissioned to support operational workers with understanding and delivering a strengths based approach to assessment. This will also focus on an asset based approach to meet the support needs of customers. This will ensure that future practice is in line with the Care Act requirements, whilst maximising alternatives to more costly statutory services.

- A Practice Challenge group is in operation to ensure that the principles of the Care Act are being adhered to in assessing and meeting support needs. This will ensure consistency and practice challenge where appropriate.

3.9 *Maximising Independence and Reablement*

- Formal consultation on the future offer in Rotherham for people with a Learning Disability commenced on the 5 December 2016 and will end on the 2 February 2017. There are a range of opportunities for the residents of Rotherham to contribute to the consultation in a range of formats. Letters to the existing cohort of customers accessing internal services were sent at the end of November with the online questionnaire hosted on the Council's website going live just before Christmas.

- The aim of the consultation is to reach as many people as possible; therefore a range of advertising will take place over the next few weeks, with a press release also expected.

- All 84 customers (primarily older people, but some people with a learning disability) attending Charnwood Day Care resource have been reviewed and moved to more appropriate support. The staff skills will be utilised in other service areas and this will also assist in reducing the transport costs for this financial year.

- A desk top analysis was commissioned to review the current offer by the Shared Lives team with a view to the development of an effective expansion plan based on national best practice. The recommendations are currently being considered and a full Action Plan expected to be rolled out in January 2017.

- The Community Opportunity Pathway Programme (COPP) continues to work with 10 customers and their families. Support for the programme ended in December and a report into the work and its findings is currently being produced. This will support the next phase of the COPP work, which is to review all those customers with a learning disability who access internal day care provision.

- The employment support services within the Council for people with a Learning Disability (Ad-pro and Lite Bites café) are currently being reviewed. The purpose of the review is to improve outcomes for moving people into paid employment, maximise the reach of the services and to ensure that there is the best possible return on investment.

4.0 Update on the Better Care Fund (BCF)

4.1 The most recent submission to NHS England was the BCF Quarter Two Template submitted on 25th November 2016. This highlighted that Rotherham is fully meeting seven out of the eight national conditions. Rotherham is currently partly meeting the remaining national condition which comprises of two elements as follows:

- The first element (which is fully met) includes better data sharing between health and social care, based on the NHS Number (NHSN). This is being used as primary identifier for health and social care services. Work has now been completed to ensure better sharing between health and social care. There are 5,495 adults who were in the scope of the NHSN matching project and all BCF records now have an NHS number assigned. The new Adult Care social care system – Liquid Logic went "live" on 13th December 2016. This includes the facility to integrate with the NHS 'Patient Demographic Service' (PDS) – which will deliver the ability to quickly look up NHS numbers on the NHS spine. We will begin using the NHSN on Council correspondence now that the Liquid Logic system is "live".

- The second element (which is partly met) around better data sharing includes whether Adult Care can ensure that patients/service users have clarity about how data about them is used, who may have access and how they can exercise their legal rights. This second element of the national condition has recently been introduced since August 2016. Significant progress is under way, with an expected full implementation date of 31 January, 2017 to ensure that we fully meet the national condition.

4.2 Seven day social care working (which is another BCF national condition) is now in place and embedded at the hospital with on-site social care assessment available to support patients. This has become "business as usual" from 3 October 2016 following the implementation of the social work staffing Phase 2 restructure.

4.3 BCF Performance Metrics

- Permanent admissions of older people (aged 65+) to residential and nursing care homes: Quarter 2 admissions total 110 as at 30 September, 2016 which equates to a performance rate of (224.81) and is below target (399).

- Non-Elective admissions are performing within the planned levels in the Better Care Fund. Short stay assessments have increased significantly but these are not part of the Better Care Fund metrics.

- Delayed Transfers of Care (DTOC) targets are set nationally by the BCF programme. Performance during Quarter Two (1102.6) is below target (1241.3) and is currently on track to meet the target in this financial year.

- The emergency re-admissions within 30 days of hospital discharge (all ages) indicator is currently above target, i.e. more re-admissions than planned for. A piece of work is to be undertaken to review how this indicator is calculated, which groups of patients have the higher re-admissions and how the target has been set. Given that the indicator has been discontinued nationally and appears at odds to contractual positions, it is recommended that when local indicators are selected for the coming financial year, this indicator is no longer used.

4.4 **BCF Service Review Programme**

- A review of the Home Enabling services has recently been completed and reconfiguration of the service has taken place. The management is currently in the final stages of recruitment. A full training programme is in place to ensure that all staff working consistently and effectively in meeting customer outcomes. The set-up of the new service is designed to provide the maximum customer contact time. All available staff time will be utilised for the benefit of the customer or to work alongside therapists to enhance skills. There will be regular progress reviews to ensure that the service is operating effectively.

- A review of the Community Neurological Rehabilitation service has recently been undertaken. The narrative including an action plan is currently being developed.

- A review considering the benefits to patients and health outcomes of Breathing Space is now in progress.

- There have been performance issues for the Community Occupational Therapy service around waiting times for assessment due to increasing referral rates. The Occupational Therapy Backlog group has been set up and this has reduced the numbers from 599 in June 2016 to 165 in December 2016. The agreed rectification actions include:

    - The Single Point of Access Team can issue equipment at first point of contact.
    - Housing Repairs are able to directly issue lever taps, half step, grab rails and key safes.
    - Commissioners are in negotiation with the Home Improvement Agency to pick up on toileting assessments and tubular path rails.
    - Support staff to start assessing for level access showers.
    - The Adult Care Performance & Quality Team are currently reviewing the business processes followed by the Occupational Therapists to complete assessments in order to identify potential efficiencies.

- The Intermediate Care pooled budget review is ongoing and is multifaceted. Options to inform the future intermediate care offer are currently in development.

- Rotherham's approach to social prescribing has been signalled as good practice in the NHS Five Year Forward View. Rotherham Clinical Commissioning Group invests £0.8m in the Social Prescribing service hosted by Voluntary Action Rotherham – this is in place until 2018. This includes a Mental Health Social prescribing pilot which has been in place for a year and has created opportunities for mental health service users to sustain their health and wellbeing outside secondary Mental Health Services. The pilot has also created more capacity within secondary Mental Health services in addition to generating wider efficiencies.

4.5 **Better Care Fund 2017-19**

- The Council and the Rotherham Clinical Commissioning Group are waiting for the Government's Integration and Better Care Fund Policy Framework, Planning Guidance and Planning Template (an Excel document containing financial and performance data) to be released. These were all due to be published by NHS England in December but has now been delayed into the New Year.

- The submission date for Better Care Fund Plans for 2017-19 (Narrative Plan) was originally set for 5 January 2017, but this was dependent on the release of the 3 documents highlighted above. Officers are awaiting further instructions from NHS England.

4.6 **Next Steps**

- The final submission of the BCF Narrative Plan for 2017-19 is anticipated to be submitted to NHS England by 31 March, 2017. This will include what we have achieved in 2016/17 and what we plan to achieve (key priorities) in 2017/18 and 2018/19. The development of the draft Narrative plan and first draft Planning Template submissions are currently work in progress.

- The BCF Planning Templates are to be submitted to NHS England in January 2017 – one template to be completed for each financial year.

- There will be wider consultation with key partners on the Health and Wellbeing Board, including the Adult Care Cabinet Member, once the first draft of the Narrative plan and excel Planning template has been completed in January 2017.

- The final approval of the BCF Plan and Planning Template will be sought at the March 2017 Health and Well-Being Board to enable returns to be made in line with the NHS England deadline.

- Officers from the Council and Rotherham Clinical Commissioning Group will continue to complete service reviews financed by the Better Care

Fund to identify best models of provision, promote value for money and improve outcomes as this is ongoing activity.

5.0 Options considered and recommended proposal

5.1 None

6.0 Consultation

6.1 There is a current live consultation on the on the future offer in Rotherham for people with a Learning Disability. This commenced on 5 December 2016 and is due to conclude on 2 February 2017. It is anticipated that further consultations will take place on various elements of the Adult Care Development Plan driven by emergent activity regarding commissioning / decommissioning or remodelling of services.

6.2 There is no planned formal consultation for the development of the Better Care Fund 2017-19 submissions.

7. Timetable and Accountability for Implementing this Decision

7.1 None

8.0 Financial and Procurement Implications

8.1 The Adult Care Development Programme will contribute towards the wider savings requirements for the Council driven by the Medium Term Financial Strategy budget set in 2016/17 and also in the budget for 2017/18 currently being developed. There will be future requirements to procure services driven by the need to commission new models of care and these will become more explicit as the programme matures.

8.2 There maybe future requirements to procure services under the Better Care Fund 2017-19 and these will become more explicit as the submissions are developed.

9.0 Legal Implications

9.1 The Adult Care Development Programme proactively supports the delivery of the requirements of the Care Act 2014.

9.2 The Better Care Fund enables the Council to discharge a range of statutory duties under the legislation.

10.0 Human Resources Implications

10.1 There are likely to be future Human Resource implications for Adult Care and externally commissioned service personnel and these will become more explicit as the Adult Care Development Programme matures.

10.2 There are no Human Resource implications for the Better Care Fund.

11.0 Implications for Children and Young People and Vulnerable Adults

11.1 The Adult Care Development Programme and the Better Care Fund are primarily for adults – people aged over 18. However, there will be positive implications for young people transitioning to Adult Care services as new pathways are developed and an improved menu of choice is made available under the Maximising Independence and Reablement work-stream.

12.0 Equalities and Human Rights Implications

12.1 The overarching Equality Assessment for the Adult Care Development Programme has been recently updated and will be subject to regular refresh driven by activity and potential impacts. Each major work stream area has a specific Equality Assessment with review dates set.

12.2 There is no requirement for an Equality Assessment for the Better Care Fund.

13.0 Implications for Partners and Other Directorates

13.1 The Adult Care Development Programme will compliment and provide benefit to external health partners in terms of increased integration and coordinated multiagency working. The investment in prevention and early intervention, strengths based approaches to assessment and the development of community assets should keep people more independent and therefore delay escalation into higher cost, complex provision.

13.2 The Better Care Fund is co-produced and managed by the Council and the Rotherham Clinical Commissioning Group and includes risk share arrangements. The investments have mutual benefits for both parties and help forge an approach to integrated health and care solutions.

14.0 Risks and Mitigation

14.1 The Adult Care Development Programme has a comprehensive risk register that is linked to the four key areas. This includes strategies to provide mitigations. These risk registers inform the wider Adult Care Directorate risk register, which in turn feeds into the Corporate risk register for any high level risks. The primary risks for the Adult Care Development Programme are:

- financial - in terms of budget savings not potentially being realised in full
- reputational – in terms of transformational change may be negatively perceived by the press and public
- late or none delivery of anticipated transformational change – may have negative impacts on customers, carers and Council staff

14.2 The risk for the Better Care Fund is against the agreed financial framework. Part of the governance processes include the in-year assessment of expenditure against the schemes and highlights risks emerging in-year as set out in the risk share section of the Section 75 agreement between the Council and the Rotherham Clinical Commissioning Group. The anticipated forecast outturn against the original budget is currently showing overspend of £62,000 for 2016/17 – out of a total budget of £24.2 million per annum.

15.0 Accountable Officer(s)

15.1 Anne Marie Lubanski, Strategic Director Adult Care and Housing in her statutory DASS role will be the Accountable Officer for the Adult Care Development Programme and the Better Care Fund investment plan.

The Rotherham NHS
NHS Foundation Trust

Health Select Commission

Transformation of Acute and Community Care

A progress report on Acute and Community Transformation Programmes. Highlights specific transformational initiatives that will support integration, promote independence and improve the quality of care.

Author: **Dominic Blaydon, Associate Director of Transformation**

Recommendations: **It is recommended that the report be noted**

1. Introduction

Ambitions for the future of health and care in South Yorkshire and Bassetlaw have been published in the region's Sustainability and Transformation Plan (STP). This plan sets out the future vision for health and social care services across all partner organisations. The STP is underpinned by The Rotherham Place Plan, which provides a local respective on how the Rotherham MBC, Rotherham CCG and The Rotherham Foundation Trust will work together in the future.

This document highlights some of the exciting transformational initiatives that are already underway. They are an illustration of the strong partnership arrangements that already exist in Rotherham and a reminder of how local health and social care communities can improve the quality of care to vulnerable people.

2. The Community Transformation Programme

Rotherham's Community Transformation Programme is leading the development of integrated health and social care services. The Rotherham Place Plan includes an ambitious programme of transformation that focuses on integration, early intervention and self-management. The following projects are already underway.

2.1 Integrated Health and Social Care Teams

Rotherham's Community Transformation Programme is leading the development of integrated health and social care teams. The first pilot integrated team started in July. It brings together community nurses, therapists, social workers, mental health workers and the voluntary sector into a single team. The team will have a single point of access for all referrals. It incorporates named care coordinators responsible for supporting people with complex needs. The team is supported by an IT system called the Rotherham Health Record that provides full visibility of all patients from the pilot locality who are currently in hospital. This system enables the team to support discharge and reduce the likelihood of readmission. The Rotherham Health Record recently won a national Health and Social Care Journal award for innovation in IT Services. The team is serves the practice populations of two large GP practices and is co-located alongside these GPs

2.2. The Development of a Reablement Centre

With an ageing population, people living longer with more long term conditions and a significant efficiency challenge we want to develop a more integrated approach to the provision of intermediate care services. A fully integrated team of health and social care professionals will provide a mix of community rehabilitation services and residential intermediate care. This model will allow Rotherham people to remain in the community longer. We anticipate the Reablement Centre will deliver quality and drive efficiencies by creating economies of scale. It will reduce travel times, remove duplication and lower running costs. Reablement is one of council's main tools in managing the costs of service provision for an ageing population and has proved an important area where integration can improve quality of care.

2.3. A Multi-Disciplinary Integrated Rapid Response Service (IRR)

Over the last year the Transformation Board has combined a range of community health teams which provide reactive health care interventions. The service incorporates the following legacy services:

- Care Home Support Advance Nurse Practitioners
- The Fast Response Service
- The District Nursing Twilight Service and Night Sister

The IRR service now supports patients who are medically for discharge, can be cared for at home but are waiting for the appropriate health or social care package to be assessed and put in place. It also supports patients who are at immediate risk of hospital admission. The service is accessed through the Care Coordination Centre. The main interventions carried out by the IRR service include; rapid MDT assessment, nursing intervention, IV therapy, falls risk assessment, community rehabilitation and respite care e.g. due to carer breakdown. The Transformation Board is now working on extending the IRR Service so that it incorporates social care. If successful the new service will be able to support people with an urgent health and social care need. There will be a significantly stronger link between the out-of-hours social care services with additional enablement support

2.4 A Joint Approach to Care Home Support

There are presently around 1,800 older people living in residential and nursing care homes in Rotherham. The number of residents is predicted to increase to 2,100 by 2020. Rotherham has a Care Home Support Service, funded through the Better Care Fund. The main aims of the Care Home Support Service are to:

- Ensure that the appropriate quality of care is provided in our residential and nursing homes
- Reduce A&E referrals, ambulance journeys and hospital admissions from care homes
- Meet the mental health needs of residents (via agreed Mental Health pathways)
- Develop personalised care plans for residents at high risk of hospital admission

The Care Home Support service works closely alongside the GP Care Homes Local Enhanced Service. This ensures that each care home in Rotherham has a dedicated GP practice. The practice will review patients at high risk of hospital admission, ensure appropriate care plans are put in place and ensure that end of life care is optimised.

2.5 An Enhanced Care Coordination Centre (CCC)

The CCC is a central point of access for health professionals into community and hospital based urgent care services. Our aim is to expand the scope of the CCC to include mental health, voluntary and social care sector services, improving access through a comprehensive directory of services, driving efficiency and cutting down waste. Through managing system capacity, carrying out an telephone triage the CCC can identify the appropriate level of care, and deploy the right services and reduce the number of avoidable admissions. The CCC relieves pressure on GPs by streamlining the referral process into urgent care services and ensuring that GPs are able to make informed choices about the most appropriate level of care for people. The CCC is crucial to The Rotherham Foundation Trust (TRFT) vision of developing a whole system integrated service approach where people receive the appropriate care at the appropriate time in the appropriate place provided by the appropriate professional.

Over the next two or three years we expect our CCC to develop information sharing among all health and social care professionals. We intend to maintain a register of patients who are medically fit for discharge and use the CCC to ensure that they are placed on the correct care pathway. In addition to being the single point of access for community nursing referrals, the CCC will start to support GPs in the case management of people with long term conditions. The CCC will also help support the integrated locality teams in providing advice and support on care pathways.

3. Transformation of Children's Services

The Rotherham Foundation Trust has recently launched its Children's Transformation Programme. The programme is reviewing the current service model for children's health care. It has identified the key issues that need to be addressed to ensure that children's health services in Rotherham remain relevant and sustainable. The programme has also outlined proposals for a new sustainable service model which is aligned to the regional and national strategic framework.

Rotherham has a range of acute and community health services, a committed workforce and strong partnership arrangements. However it is clear that the current service model is not sustainable, nor does it align with the national and regional strategic framework. Rotherham requires a new service model with greater focus on prevention and early intervention. There is evidence that children who are currently being admitted to hospital can be supported more effectively in the community. Also, there is potential for discharging children from inpatient beds earlier if enhanced community support is available. National strategies support a new approach, based on building capacity and capability in the community. There is an emphasis on developing integrated teams, combining health and social care functions within a locality framework. This approach would make community health services more accessible, reduce levels of fragmentation across the health economy, remove duplication and support self-management.

As well as enhancing the quality of community health services, there is a need to create an acute care model which manages its bed base more effective. Currently there is a shortage of paediatric medical and nursing staff and a need to combine resources across a broader footprint. The STP supports collaboration with other health providers on the delivery of acute care. The Trust is located close to the Sheffield Children's Hospital Foundation Trust, which is already supporting Rotherham children. It is therefore important for The Rotherham NHS Foundation Trust to strengthen this relationship and to do this in the context of a fully integrated care pathway from home to hospital. This could also enable us to make more effective use of resources and deliver better quality care.

3.1 Integrated Locality Teams

The Rotherham Foundation Trust is currently consulting on developing fully integrated health and social care hubs based on a locality footprint. We envisage 3 hubs within Rotherham encompassing all 0-19 year services, which mirrors the current social care delivery model and has the ability to facilitate smoother multi-agency integration.

Each hub will incorporate:

- GPs with special interest working with paediatricians, nurses, social workers, mental health professionals and Allied Health Professionals
- Supported discharge and admission prevention pathways

- Enhanced outpatient support
- Rapid access clinics for urgent specialist help
- Specialist paediatric clinics on safeguarding and specific conditions

3.2 Reconfiguration of Inpatient Beds

The Rotherham Foundation Trust intends to reconfigure its inpatient bed base so that it is more effective and sustainable. We will deliver ambulatory care through a new short-stay assessment unit. We will explore the potential for developing an integrated pathway with Sheffield Children's Hospital for inpatients services. Paediatric Day Surgery will continue to take place at the Rotherham Foundation Trust. The partnership agreement will also explore the potential for a new workforce model, which supports both medical and nursing staff across the pathway.

4. Acute Care Collaborations

A key element of the Sustainable Transformation Plan is supporting joint working between acute care providers. There is a strong argument for combining resources where appropriate to support hospitals to specialise in specific care pathways and delivering across a sub-regional footprint. For some conditions this could mean that Rotherham patients have to travel out of the borough to access treatment. In others Rotherham could act as a hub supporting patients across the sub-region. The aim is to address some of the resource issues currently being faced by the local health economy whilst at the same time developing Centres of Excellence for specific disease types. Two examples of where this type of collaboration could be beneficial are set out below.

4.1 Hyper-acute Stroke Services

The Rotherham Stroke Pathway is currently being reviewed as part of the Working Together Programme. The proposal is to deliver Hyper Acute Stroke care at two sites in South Yorkshire & Bassetlaw; Sheffield and Doncaster. Patients who suffer a stroke will be taken to one of these sites for their first 72 hours of care after which time they will be repatriated back to their local hospital. This proposal is out to public consultation until 20th January 2016. If agreed it would mean significant changes to the Trust's service model.

Partner organisations in Rotherham support the general direction of limiting the number of centres doing high complexity interventions. If successful it will deliver a sustainable workforce with the right skills to support stroke patients during the most vulnerable time of their care. This approach has been successfully implemented in London and Manchester with improved clinical outcomes for patients.

However the Rotherham health community has expressed concern over the proposals to move Hyper Acute Services out of Rotherham. The Rotherham Foundation Trust is actually one of the better performing Trusts on stroke. It is unclear whether the new care pathway will improve the quality of stroke care to Rotherham patients. There are concerns over the impact of additional travel time and the potential increase in travel costs. Splitting the current pathway could potentially increase costs and potentially affect the viability of running an acute-only Stroke Unit. Finally the proposed service model does not adequately address the issue of what happens with patients who have stroke symptoms but are not actually having a stroke.

4.2 Breathing Space

In 2013 the Rotherham Commission Group (CCG) challenged Breathing Space to develop into a centre of respiratory excellence not only in the delivery of respiratory care but also in the domains of research and education.

Breathing Space delivers pulmonary rehabilitation for patients with COPD and other respiratory conditions. It also incorporates 20 specialist intermediate care beds for patients with respiratory conditions who do not require hospital care but cannot return home. Breathing Space runs emergency assessment clinics and a telephone support service 24 hours a day. It is unique in that it is the only centre in the UK where patients with an exacerbation of COPD can be admitted directly without medical assessment. In terms of impact The standardised hospital mortality index (SHMI) for Rotherham has been consistently 30% below the national average for the last 3 years and one of the lowest in the country.
Breathing Space has established a collaboration with Rotherham Respiratory Group and the University of Sheffield, securing over £1,000,000 to deliver training to healthcare professionals. It has achieved accreditation of a Respiratory Masters and Degree Module commissioned by the University of Sheffield. The first cohort of 32 students commenced their studies in October 2015.

In terms of Acute Care Collaborations Breathing Space is in a great position to develop as a Sub-Regional Centre of Excellence for Respiratory Care. It remains the only nurse-led model of care for respiratory patients in Europe. It can demonstrate impact through key quality indicators, such as mortality trends. The service has been recognised as excellent by the Care Quality Commission. Patient feedback is consistently excellent. The Centre is recognised as a training centre for respiratory nurses, with Education for Health and University of Sheffield commissioned courses supported by a strong working relationship with the Rotherham Respiratory Group.

Health Select Commission

Transformation of Acute and Community Care

Louise Barnett Chief Executive

Dominic Blaydon Associate Director – Transformation

Purpose of Paper

- Overview of The Trust's vision for the next 5 years
- Community Transformation Programme
- Acute Care Collaborations
- Transformation of Children's Services

Five Year Strategy

- We will continue as a stand-alone district general hospital
- We will build a reputation for innovation and quality care
- We will achieve a CQC rating of “good” or better
- We will deliver financial sustainability.
- We will have a strong emergency and urgent care function
- We will develop sub-regional specialist care centres
- We will provide a strong community health service offer
- We will integrate with health and social care partners

Community Transformation Programme

- Integrated Health and Social Care Teams
- The Development of a Reablement Village
- A Multi-Disciplinary Integrated Rapid Response Service
- A Joint Approach to Care Home Support
- An Enhanced Care Coordination Centre

Acute Care Collaborations

The Rotherham NHS
NHS Foundation Trust

Hyper-Acute Stroke Services

Breathing Space

Children's Transformation

- Integrated Locality Teams
- Review of Children's Assessment Unit
- Rapid Access to a Community Paediatrician
- Reconfiguration of Inpatient Bed Base
- A Joint Approach to Workforce Development

The Rotherham NHS
NHS Foundation Trust

Any questions?

Briefing paper for Health Select Commission 19 January 2017

Whole school approach to prevention and early intervention

Introduction

In May 2015 the Government produced a report called Future in Mind Report (FiM) which set out a clear national ambition to transform the design and delivery of a local offer of services for children and young people with mental health needs. FiM describes an integrated whole system approach to driving further improvements in children and young people's mental health outcomes with the NHS, Public Health, Local Authority Children's Services, Education and Youth Justice working together. One of the themes focuses on building resilience and prevention and early intervention.

In Rotherham non recurrent funding from the Child and Adolescent Mental Health Services (CAMHS) Transformation monies was designated to piloting a whole school approach to promoting mental health and wellbeing. Six schools in Rotherham were invited to take part in the scheme, representing each of the Social and Emotional Mental Health (SEMH) school cluster areas of north, south and central.

Aims and ambitions of the delivery plan

The whole school pilot in Rotherham is based on principles outlined in a national guidance document produced by Public Health England and the Children and Young People's Mental Health Consortium (2015). The guidance looks at a whole school approach to mental health following eight principles;

- leadership and management
- school ethos and environment
- curriculum teaching and learning
- student voice
- staff health, development and wellbeing
- identifying need and monitoring impact
- working with parents/carers
- targeted support

Each of the six schools were encouraged to benchmark themselves against all 8 principles and then pick at least two to progress. Their chosen principles were written up into an action plan. The schools began planning their work in the spring term of 2016 with the project commencing in September 2016. The schools have until July 2017 to deliver their actions. The project is being led in each school by a senior member of the school staff team; Assistant Head, Safe Guarding Lead or SENCO. All schools have committed to reporting progress once a term and must met with Officers to talk through their action plan. In addition all schools attend a steering group to share good practice. All schools are encouraged to share their learning within the school cluster group they are part of.

For more information visit the website:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414908/Final_EHWB_draft_20_03_15.pdf

Recommendations for HSC

Members of Health Select Commission are asked to:

- Consider accompanying Officers on the one to one update meetings with schools
- Consider nominating a member to sit on the Whole School Steering Group.

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

Appendix A

Participating schools:

Rawmarsh Community School

1. To build resilience with a targeted group of pupils at the earliest stage to enable them to deal with emotional health and mental wellbeing needs.

2. Deliver Social Studies lessons to Y7 and Y10 pupils, focusing on understanding how people behave, why people get angry or feel differently. Empathising with peers experiencing personal, social and emotional issues.
3. Engaging the hard to reach parents/carers.

Wingfield Academy

1. Enable student voice to influence decisions: Redevelop Student led Voice and Influence activities from strategic to operational within the Academy - Student Ambassador Programme.
2. Targeted support and appropriate referral- Provision of support services for children and young people. To develop an enhanced Early Help offer to further support emotional wellbeing for students and parents / carers through a therapeutic offer that is not currently available through the Core Early Help offer.

Newman School

1. To review and improve staff resilience and emotional health and mental wellbeing needs in the workplace.
2. To review the impact of current emotional resilience interventions and develop the whole school SEMH offer.

Wales High School

1. To improve staff resilience and enable them to deal with students' emotional health and mental wellbeing needs.
2. To improve identification of students who require mental health support and design clear thresholds of targeted support and appropriate referral.

Maltby Academy

1. To work with senior leaders in MLT schools to ensure that mental health is given due priority and that mental health awareness among wider workforce is raised, thus enabling staff to identify and seek support for students and colleagues at earlier opportunity.
2. To raise awareness among the wider community by implementing workshops for parents/carers and by providing a half-day mental health raising event for the wider Maltby Community**.**
3. To ensure that Pastoral Managers, as Mental Health Champions for their schools, have the requisite skills, knowledge and support mechanisms embedded in order to meet the needs of rising numbers of children with complex mental health needs while also safeguarding their own mental health and well-being. This will be facilitated by implementing a clinical supervision model, local and pilot-wide networking and regular links to multi-agency partners e.g. Educational Psychologists, Early Help teams and

CAMHS.

Oakwood High School

1. To develop information to baseline and assess for SEMH and resilience.
2. Build the skillset of staff to develop and build resilience in pupils.

Rotherham Metropolitan Borough Council

Public Report

Overview and Scrutiny Management Board

Summary Sheet

Council Report
Overview and Scrutiny Management Board 13 January 2017

Title
Health Select Commission sub-group: Older People's Housing

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

Strategic Director Approving Submission of the Report
Shokat Lal, Assistant Chief Executive

Report Author(s)
Janet Spurling, Scrutiny Officer, Assistant Chief Executive's Directorate
janet.spurling@rotherham.gov.uk 01709 254421

Ward(s) Affected
All

Executive Summary
A sub-group of the Health Select Commission undertook a scrutiny session regarding housing for older people in Rotherham. Members wished to carry out this work given the close links between housing, adult social care and health in terms of maintaining people's independence and enabling them to live in their own home. This report outlines the recommendations and includes the response from Housing and Neighbourhood Services.

Recommendations

That the Overview and Scrutiny Management Board:

1 Considers and comments on the report.
2 Agrees that as Improving Places Select Commission scrutinises delivery of the Housing Strategy this will incorporate progress on delivery of older people's housing.

Appendices Included
Appendix 1 – Response to HSC sub-group recommendations

Background Papers
- Rotherham's Housing Strategy 2016-19
- Presentation and notes from sub-group meeting 24 November 2016

Consideration by any other Council Committee, Scrutiny or Advisory Panel
No

Council Approval Required
No

Exempt from the Press and Public
No

Health Select Commission sub-group: Older People's Housing

1. Recommendations

That the Overview and Scrutiny Management Board:

1.1 Considers and comments on the report.

1.2 Agrees that as Improving Places Select Commission scrutinises delivery of the Housing Strategy this will incorporate progress on delivery of older people's housing.

2. Background

2.1 Central to the work programme for the Health Select Commission (HSC) is transformation and integration of health and adult care services. Members also wished to include older people's housing in the programme, given the close links between housing, adult social care and health in terms of maintaining people's independence and enabling people to live in their own home with the right care and support in place.

2.2 On 24 November 2016 a sub-group of the Health Select Commission (HSC) undertook a scrutiny workshop session regarding increasing the number of homes that are suitable for older people in the borough. At the workshop Members received a presentation from Housing and Neighbourhood Services, followed by a detailed question and answer session.

2.3 The purpose of the session was for HSC members to develop a clear understanding of the key issues involved in increasing the number of homes suitable for older people and to make recommendations to inform future plans for older people's housing.

2.4 Members identified a number of important matters to be considered in the planning and delivery of housing for older people, summarised below, and formulated ten recommendations following the workshop (see section 4).

3. Key Issues

3.1 **Rotherham context**

The borough has an ageing population, including significant increases in people aged over 65 and also over 85, plus growing demand for health and social care. Consultation and the recent strategic housing market assessment indicate insufficient specialist housing for older people and there is a growing waiting list for extra care housing. Therefore housing growth plans need to take account of the demographic needs of the community.

3.2 **Mixed communities**

It was clarified that older people tend to prefer to live in mixed communities and to be part of the wider community rather than only living near to or with other older people. Most prefer to remain in their current property with their care needs met through aids and adaptations, Rothercare and/or assistive technology, but around 25% want or need to move. Options for developing

small pockets of specialist housing for older people within wider communities are explored by the Housing Team in addition to larger scale initiatives.

3.3 **Features of housing and housing schemes for older people**
The presentation outlined a number of factors identified as important for older people, including:

- One level – bungalows or apartments
- Two bedrooms and adaptable spaces
- Transport, shops, services and green spaces
- Parking space
- Safe and secure location with good road and pedestrian access
- Easy and inexpensive to heat and run
- Communal space (including outdoor) for socialising and activities
- Guest units for relatives to stay (in housing schemes)
- Play facilities in communal areas for when children visit

3.4 **Housing design**
The concept of developing more “life time housing” was discussed i.e. housing designed to be more adaptable to changing needs as people get older, which would also widen the scope of where people could live, but this has to be considered in the context of price and viability.

3.5 **Bungalows**
Bungalows are a popular choice with older people but are relatively expensive and also “land hungry”. Under the allocation policy they are not allocated solely to older people, although a percentage are for people aged 60+ with another percentage for people with a medical priority need who may be younger. Members agreed that the public might not be aware of this policy and therefore might not recognise why younger people had been allocated such housing.

3.6 **Extra care housing**
This may consist of blocks of low rise flats and/or bungalows, or as elsewhere in the country, retirement villages. It differs from sheltered housing in that people have access to personal care and it may also be a viable alternative to residential care. Tenure may be mixed, including shared ownership as well as rented property.

The benefits of extra care housing highlighted in the session were:

- Enabling people to downsize from homes that were too large, unaffordable or unsuitable for their needs
- Enabling people to be independent and live in the community
- Communal facilities help people to be socially and physically active, reducing isolation and improving health and wellbeing
- Supporting people to feel safe
- Aiding the hospital discharge process
- Efficiency savings for health and social care budgets
- Freeing up family accommodation and stimulating the wider housing market
- Maintaining balanced and sustainable communities

Ideally any 60-80 unit extra care housing scheme would be divided into three groups ranging from people with lower care needs through to high care needs, allowing people to move within a scheme as their needs might change.

3.7 **Branding and marketing schemes**

This links in with 3.2 in terms of attracting younger older people to schemes, which can be difficult, through well-presented show flats and good interior design. Members recommended that if schemes were for mixed age ranges it was important that the housing did not look as though it was purely housing for older people and this might also make it less of a target, for example for fraudsters.

It was also agreed that a positive approach to branding and marketing housing options for older people should be adopted, such as promoting the third age. Older people should be consulted on branding and also on the use of the term “extra care” and what that meant to people as it could potentially be misleading.

3.8 **Public transport**

Reflecting the importance of transport links for older people, HSC were keen to ensure dialogue took place with transport providers, including Community Transport, regarding services to any proposed new sites at an early stage.

4. Options considered and recommended proposal

4.1 Following the issues identified in the scrutiny workshop, which are summarised in section 3 above, ten recommendations resulted and the response from Housing and Neighbourhood Services to each of these has been included in Appendix A.

4.2 Recommendations:

1) That an article be included in the tenant newsletter explaining how bungalows are allocated to different groups of people, not only older people, based on need.

2) That discussion takes place with transport providers, including Community Transport, regarding:
   - services for proposed sites before building commences;
   - maintaining transport links to those sites in the future.

3) That the importance of family pets for older people’s health and wellbeing is considered in developing housing options.

4) That consultation is undertaken with older people currently living in three storey buildings to capture their views on how suitable this housing is for their needs, to feed in to decisions about future models.

5) That consultation is undertaken with older people to ascertain their views on the term extra care and how housing schemes should be branded.

6) That the approach to branding and marketing housing options for older people should be a positive one such as promoting the third age rather than one of moving towards the end of a person's life.

7) That new housing schemes are designed to look more generic, rather than looking like they are only for older people:
   - to reduce the risk of older people being targeted;
   - to reflect mixed communities and reduce negative perceptions.

8) That Shaftesbury House undergoes external renovation and is made more secure for residents.

9) That action is taken to maintain high quality in current older people's housing to avoid the development of a "two tier" system with differences in quality and experience between current and new provision.

10) That all multiple storey buildings for extra care housing should have lifts.

5. Consultation

5.1 Rotherham's 30 year vision for housing was established in December 2012 following extensive consultation with residents. Further consultation was carried out in 2015 during the development of the Housing Strategy 2016-19.

5.2 HSC made two specific recommendations regarding consultation, 4 and 5 above.

6. Timetable and Accountability for Implementing this Decision

6.1 The recommendations from the sub-group will inform a report from Housing and Neighbourhood Services to the Cabinet and Commissioners Decision Making meeting in February 2017 regarding increasing older people's housing in the borough. That report will be shared with the HSC sub-group for final comments as part of pre-decision scrutiny.

7. Financial and Procurement Implications

7.1 As options for older people's housing are developed the recommendations may require further exploration by Commissioners, Cabinet, the Strategic Leadership Team and partner agencies on the financial or procurement implications of implementation.

8. Legal Implications

8.1 There are no legal implications arising from this report.

9. Human Resources Implications

9.1 There are no human resources implications.

10. Implications for Children and Young People and Vulnerable Adults

10.1 Safety and security has been raised as a concern by older people during consultation, which is one of the reasons for trying to maintain mixed communities and also prompted recommendations 7 and 8.

10.2 Extra care housing has a 24:7 staff presence on site which may make older people feel more safe and secure.

10.3 Important factors are ensuring the suitability of older people's housing for children to visit family members and including play facilities on sites to support being a child-centred borough.

11. Equalities and Human Rights Implications

11.1 The Housing Strategy focuses on ensuring the availability of a range of specialist housing suitable for older people and other groups with particular housing needs.

11.2 The Decent Homes programme is in place to refresh housing stock.

12. Implications for Partners and Other Directorates

12.1 Housing, social care and health services are closely linked together in maintaining older people's health and wellbeing and enabling people to remain independent and involved in their local community.

12.2 The voluntary and community sector also plays an important role, for example through the social prescribing initiative.

12.3 Housing and Neighbourhood Services are likely to work with a range of developers and housing providers in delivering the Housing Strategy.

13. Risks and Mitigation

13.1 It is a challenge to provide sufficient housing to meet the needs of Rotherham's growing ageing population, enabling people to live independently as long as possible, and reducing the number of people having to move into expensive residential care placements.

13.2 Closer links between health and care services with housing; increased partnership working between agencies; and proactive work with developers and providers such as the summit in 2016 and strategic housing market assessment ensures a focused and integrated approach in Rotherham.

14. Accountable Officer(s)

James McLaughlin, Democratic Services Manager

Approvals Obtained from:
Strategic Director of Finance and Corporate Services: N/A
Director of Legal Services: N/A
Head of Procurement: N/A

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Response to Health Select Commission subgroup - Older People's Housing

	Recommendation	**Decision** *(Accepted/ Rejected/ Deferred)*	**Response** *(detailing proposed action if accepted, rationale for rejection, and why and when issue will be reconsidered if deferred)*	**Officer Responsible**	**Action by** ***(Date)***
1.	That an article be included in the tenant newsletter explaining how bungalows are allocated to different groups of people, not only older people, based on need.	Accepted	This will be included in the Spring edition of *Home Matters*, tenants newsletter.	Jane Davies	March 17
2.	That discussions take place with transport providers, including Community Transport, regarding services for proposed sites before building commences and maintaining transport links to those sites in the future.	Accepted	This has been discussed at the Specialist Housing Group meeting and once Cabinet have considered the forthcoming older people housing report, a meeting will be arranged with Ian Ashmore – Transportation Highways and Design Manager to ensure appropriate public transport links are in place.	Jane Davies	March 17
3.	That the importance of family pets for older people's health and wellbeing is considered in developing housing options.	Accepted	We will adopt a pet friendly strategy when designing and developing new housing for older people. There are local examples, which can be adopted as examples of good practise.	Jane Davies	July 17

4.	That consultation is undertaken with older people currently living in three storey buildings to capture their views on how suitable this is for their needs, to feed in to decisions about future models.	Accepted	This will be included in the consultation plan – we will talk to residents and providers of sheltered and supported housing in 3+storey blocks to share their experience and offer visits / provide virtual tours.	Jane Davies	April 17
5.	That consultation is undertaken with older people to ascertain their views on the term extra care and how housing schemes should be branded.	Accepted	This will be included in the detailed consultation plan.	Jane Davies	April 17
6.	That the approach to branding and marketing housing options for older people should be a positive one such as promoting the third age rather than one of moving towards the end of a person's life.	Accepted	This will be included in the detailed consultation plan.	Jane Davies	April 17
7.	That new housing schemes are designed to look more generic, rather than looking like they are only for older people: - to reduce the risk of older people being targeted - to reflect mixed communities and reduce negative perceptions	Accepted	We will ensure high quality design and appearance is integral to all design specifications, and that older people's housing is complementary to existing housing in the locality. Excellent security will be an important aspect of the specification.	Jane Davies	Ongoing
8.	That Shaftesbury House undergoes external renovation and is made more secure for residents.	Accepted	Following Cabinet's consideration of the report – detailed plans will be developed to improve Shaftesbury House.	Jane Davies	Mar 18
9.	That action is taken to maintain high quality in current older people's housing to avoid the development of a "two tier" system with differences in quality and experience between current and new provision.	Accepted	The local authority owned older peoples schemes are under review and through the HRA Capital Programme, existing schemes will be updated and improved.	Jane Davies	Ongoing
10.	That all multiple storey buildings for extra care housing should have lifts.	Accepted	All multi-storey extra care housing will have lifts, this will be an automatic requirement in any design brief.	Jane Davies	Ongoing