HEALTH SELECT COMMISSION
15th June, 2017

Present:- Councillor Evans (in the Chair); Councillors Allcock, Bird, Elliott, Rushforth, Short and Whysall.

Apologies for absence were received from The Mayor (Councillor Eve Rose Keenan) and Councillors Andrews, Ellis, Jarvis, Keenan, Marriott, Williams and Victoria Farnsworth (SpeakUp).

1. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

3. COMMUNICATIONS

Members of the Select Commission were reminded about the demonstration of the Liquid Logic database and cohort data for Adult Social Care which was to take place on 4th July at 4.30 p.m.

4. MINUTES OF THE PREVIOUS MEETING HELD ON 13TH APRIL, 2017

Consideration was given to the minutes of the previous meetings of the Health Select Commission held on 13th April, 2017.

Members' attention was drawn to the supplementary information which had been supplied after the meeting with regard to domestic abuse training (Minute No. 92 RDaSH Quality Account).

With regard to Minute No. 93 (Whole School Approach to Prevention and Early Intervention), it was noted that former Select Commission Member Councillor Cusworth had volunteered to attend the final meeting of the whole steering group as she had attended previous ones. The Select Commission would receive feedback in due course.

Resolved:- That the minutes of the previous meeting held on 13th April, 2017, be approved as a correct record.

5. EVALUATION OF THE INTEGRATED LOCALITY PILOT

Dominic Blaydon, Associate Director of Transformation, and Melanie Simmonds, Strategy and Transformation Manager, presented an evaluation of one of the existing transformational initiatives that was currently underway – The Health Village Integrated Locality Pilot. The report was supplemented by the following powerpoint presentation:-

Key Challenges
- Funding challenges in Health and Social Care
- Increase in older population
- Difference between actual and healthy life expectancy
- Development of new care models
- Early intervention and prevention
- Self-management
- Public expectation
- Fragmentation of services
- Strengthening leadership at all levels

Key Elements of new Service Model
- Multi-disciplinary team
- Breaks down professional and organisational boundaries
- Team supports GP practice populations (Clifton and St. Ann's)
- Designated care homes
- New technology supports interface between locality and acute care
- All workers are co-located
- New leadership model evolving
- Operates a Virtual Ward
- Referral management service

Team Composition
- Community Nurses, Rotherham FT
- Physiotherapists, Rotherham FT
- Occupational Therapists, Rotherham FT
- Social Workers, Rotherham MBC
- Mental Health Workers, RDaSH
- Social Prescribing, VAR
- Community Link Workers, Rotherham MBC

A New Approach
- Community Reablement
- Management of Long Term Conditions
- Community Nursing
- Parity of Esteem
- Assessment and Care Management
- Community Development

Outcomes
- Reduction in unscheduled hospital admissions
- Reduction in admissions to hospital for assessment
- Non-elective bed days
- Average length of stay in hospital

Roll Out
- November 2017-March, 2018 Scoping and Design
- March 2018 Designed and agreed contracting model

- April 2018-2020 Phased implementation
- October 2020 Evaluation, conclusion and conference

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

- The regulatory responsibility for care homes rested with the CQC. Local Authorities had a duty, as did other public services, to ensure safeguarding and there were powers within their contracts to carry out visits. Rotherham had a dedicated Care Homes Team involved in the Locality Pilot which had reached out to care homes and supporting staff

- The Care Home Support and Locality Teams within the new structure would assist in spotting any issues in care homes

- An away day had been held earlier in the year to allow staff to come together and discuss the difficulties they were experiencing and to agree a joint vision. A staff evaluation before and after the event showed an increase in their satisfaction levels. A further evaluation would be conducted in July to ascertain if they were still engaged, motivated and empowered which reflected on how well the project performed

- There were national issues regarding computer systems linking together with no plans to introduce one system across Acute, Primary and Community Care. However, Rotherham was way ahead of other local authority areas in terms of developing the links and creating a system which increased visibility and then facilitating the interface between Primary, Community and Acute Care. It would continue to be an ongoing challenge until there was single system across the NHS

- Liquid Logic used a client's NHS number enabling the system to read across as to where the person was in the health and care system

- The Village had been chosen for the pilot as there were higher admission rates from the area which was also one with higher deprivation

- Bed blocking was not only an issue in the Winter, however, integrated localities should start to relieve the impact especially when it was rolled out to all localities

- Work was taking place with the Team and Heads of Service looking at the resources needed to roll the Pilot out. If the Health Foundation bid was successful it would provide additional resources to support the work and alleviate those pressures on the individuals allowing

them to concentrate on development. However, the funding was not being relied upon with a clear plan for development of the locality

- Work was also taking place on the impact and pressures in the system and mitigating the risk on other parts of the system

- There had been a lot of interest from other parts of the country in what Rotherham was developing and the interface between Acute and Primary Care

- IT, sharing of information across organisations and having a single care record were major barriers. The next challenge would be a single integrated recording system and care plan

- There would be a full evaluation of the Pilot in December, 2017

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

(2) That the results of the full evaluation be submitted to the Select Commission in December.

6. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2015-16

Giles Ratcliffe, Public Health Consultant, introduced the 2015/16 independent report which highlighted some of the successes in Rotherham as well as a frank assessment of some of the challenges faced as a community. A powerpoint presentation was given on healthy ageing living well and living longer as follows:-

Why focus on healthy ageing?
"Provides the opportunity to shine the light on the rich asset that older people are within our society and also to consider the changes that are developing within our older population"
Considerations include:-

- Ageing population
- Changing communities
- Older people as local asset
- Value of focussing on prevention
- Improving quality of later life

Local data highlights

- Rotherham's over 65s population is growing the fastest. By 2025:-
  21.7% of population will be over 65
  Over 85s population will rise by over 40%
- Rotherham has lower life expectancy than England (men and women)
- Life expectancy and healthy life expectancy gap is greater than England average (men and women)
- Poor perception of "their own health" reported in Census surveys by older people in Rotherham

Healthy Ageing Framework Structure
Four sections

- Healthy behaviours and lifestyles
- Age friendly environment and community support health
- Encouraging social inclusion
- Quality integrated services and prevention interventions

Healthy behaviours and lifestyles – adding life to years and years to life
Includes

- Obesity
- Fruit and veg
- Inactivity
- Alcohol
- Tobacco
- Sexual health
- Living with long term conditions (LTCs)
- Making Every Contact Count (MECC)

Key messages

- To promote the 5 a day and balanced diet messages and their importance in later life including hydration
- Older adults to be more active and meet CMO guidelines of 150 minutes per week including strength and balance activities
- It is never too late to stop smoking
- Alcohol misuse in later life leads to increased hospital admissions
- Older people are made aware of the health risks of regular and excessive alcohol use

Recommendation 1

- All services should encourage lifestyle behaviour change in older people where appropriate particularly in the most disadvantaged communities. This could be achieved through taking a systematic approach to MECC

Age friendly environment and community supporting health
The impact of where we live on our health in later life and includes

- Role older people play in their communities (e.g. volunteering)
- WHO Age friendly cities and communities
- Excess winter deaths
- Poor quality housing impact
- Cold homes and fuel poverty
- Falls prevention and support

Key messages are to:

- Plan together
  Use a Framework or plan to join activity and work towards a common goal for Healthy Ageing
  Housing need to plan adequately for the ageing population, considering account of tenure changes and promoting independence

Preventing falls and providing early intervention for those who have fell is an important factor in maintaining independence

- Work together
  A wide range of people can identify vulnerable people who may be at increased risk (e.g. cold weather, falls)

Recommendation 2

- Rotherham's Health and Wellbeing Board considers implementing the WHO 'Age Friendly Cities and Communities' and become the first area in South Yorkshire to achieve this accreditation, learning from other UK cities that have already begun this work. This would be complimentary to the Borough's aspiration to be young people and dementia friendly

Encouraging social inclusion

Challenges and opportunities that have an impact in later life includes:-

- Maintaining independence
- Carer responsibilities – for partners, friends, grandchildren
- Income, work, benefits and volunteering (giving back)
- Education and literacy
- Discrimination
- Mental health
- Dementia
- Loneliness and social isolation

Key messages

- Maintaining independence requires all stakeholders to work together and with individuals
- Older people play a significant role as car givers
- Opportunities for over 65s to remain in work are greater
- Volunteering is important as a social activity to combat social isolation and loneliness
- Health literacy is an important factor to support self-management
- Age discrimination needs to continue to be in policy developments
- Dementia prevention and support agenda needs to continue to be considered
- Mental health within later life needs to be responsibility of all organisations across the system

Recommendation 3

- The social inclusion of older people in Rotherham needs to be at the heart of policy and delivery across the Rotherham Partnership, addressing issues such as maintaining independence, income and participation, mental health, loneliness and isolation. To achieve this goal, older people must experience proactive involvement and participation in life and society as a whole

Quality integrated services and preventative interventions
Working together to commission and deliver the best services for older people in Rotherham. Includes:-

- Health and social care integration
- Asset based approaches
- Screening and immunisations
- NHS Healthchecks
- Personalised End of Life Care planning
- Integrated Wellness Services

Key Messages

- Health and social care integration is underway
- Screening programmes identify and treat individuals early
- People 65+ have higher health risks from flu, pneumococcal and shingles
- NHS Health checks detect early signs of illness and disease
- Personalised end of life care planning will increase in importance as our population ages
- Integrated wellness service will target communities and individuals of the greatest need providing a comprehensive behaviour change pathway

Recommendation 4

- All partners to deliver against the aspirations and commitments within the Rotherham Integrated Health and Social Care Place Plan and to continue to strive for the highest quality services for older people. This is to include an increased focus on prevention, early identification and self-management, with clear pathways for lifestyle behaviour change for older people that support individuals to make changes when the time is right for them

Next Steps

- Sharing the report with key stakeholders
- Facilitating the development of key actions
- Developing an action plan
- Monitoring and reporting on progress

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

- Rotherham suffered from legacies of its past heavy industries both in terms of individuals in those jobs and a cultural legacy

- Behaviour change was very challenging i.e. how do you change the culture of someone for whom it was tradition e.g. portion size

- The health literacy function was related to overall levels of literacy and what the public's understanding was of health and wellbeing, wellness and fitness. The services and routes into them were not easy to

navigate – the single point of access/single digital offer for lifestyle services was out to tender with the contract to commence in April, 2018

- The rate of smoking in young people had reduced year on year and, although high rates of smoking in adults, Rotherham was better than most areas for quitting smoking. There were issues with alcohol use with the area being one of the highest in terms of admissions to hospital and similarly with substance misuse

- MECC (or Healthy Chats) were part of the Health and Wellbeing Strategy. The commitment from partners had been developed over the past 4 months to train frontline staff to be sufficiently confident to offer advice and signposting to any member of the public they came into contact with and the conversation led into issues of healthy living

- The approach to smoking and nicotine consumption was old fashioned. "Vaping" was something that had progressed far quicker than anticipated and had taken tobacco companies and the Government by surprise. Presently the science had not caught up with the increasing trend and there was no evidence as to its impact. It was not licensed in the same way as tobacco and there were fewer controls on production methods and contents. There was a reluctance on the Department of Health to make any clear statements in support or otherwise of vaping and the Local Authority was limited by national guidance due to there being no evidence base to support an alternative and no guidance as to desired message to young people with regard to e-cigarettes

- Many of the functions the Authority provided were mandatory functions that had to be provided through the Public Health Grant. However, that limited the approach to people who wanted to reduce or cut down smoking with Stop Smoking only allowed to support quitting

- Manchester had done a lot of work on WHO Age Friendly environment taking a whole place view. It was about everybody at every level thinking and reflecting on every decision/policy and whether it helped or hindered older people and hopefully contributed to it being a better place to live. Manchester had used its local communities to develop plans and ideas to develop their own areas to make it age friendly and a more inclusive place for all people to reduce cost and barriers. Some of the things that mattered to young people were the same as to the elderly

- The Local Authority had a good understanding of Health and service assets, however, there were others that were harder to define and measure such as which of the communities were resilient, which had good social networks. Work had/was taking place with regard to Ward profiles and Ward Plans but there was a need to look at it in further detail and understand the full depth of assets

- The Warm Homes funding had focussed on improving housing conditions via installing updated boilers to make properties fit for purpose and fuel efficient. Obviously this was not the whole story with regard to excess winter deaths and still work required on isolation in communities and family finances

- The newly established Financial Inclusion Team within Housing Services focussed on vulnerable peoples' finances

- How RMBC made services such as parks accessible

- The risk factor for social isolation and loneliness was the same as smoking 15 cigarettes a day

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

(2) That a further progress report be submitted on the detailed action plan.

(3) That the previous spotlight review on urinary incontinence be considered in developing the action plan.

7. HSC WORK PROGRAMME 2017-18

Janet Spurling, Scrutiny Officer, gave the following presentation on issues for possible inclusion within the Select Commission's 2017/18 work programme:-

The big five issues
- Rotherham Place Plan (Health and Social Care integration)
  - Prevention, self-management, education and early intervention
  - Rolling out integrated locality working model – 'The Village' pilot
  - New Integrated Urgent and Emergency Care Centre (July 2017)
  - Further development 24/7 Care Co-ordination Centre
  - Building a Specialist Re-ablement Centre
- Adult Social Care (development programme and performance)
- Learning Disability
- Mental Health (child and adolescent)
- Regional Scrutiny – NHS reconfiguration

Continuing from 2016/17
- Big Five
- Public Health – annual report
- Carers – links Adult Social Care Programme
- Access to GPs
- Autism

Each year

- NHS Trust Quality Accounts and provider performance including progress on Care Quality Commission action plans following inspections
- Rotherham NHS Foundation Trust (hospital)
- Rotherham, Doncaster and South Yorkshire NHS Foundation Trust (RDaSH)
- Yorkshire Ambulance Service

Other Suggestions

- Dementia (from discussions in April)
- Suicide Prevention Plans – Parliamentary Select Committee
- Health and Wellbeing Strategy implementation

Methods – for example

- Reports – initial and Select Commission to decide if more work needed and information/progress/monitoring
- Presentations
- Reviews – spotlight or full
- Sub-groups
- Visits
- Service user/patient experience – case study or direct

Select Commission Members were asked to submit any suggestions to Janet.

Resolved:- (1) That the Scrutiny Officer work with the Director of Public Health and Assistant Director of Strategic Commissioning to draw up a draft work programme.

(2) That a draft membership of the Quality Account Sub-Groups be submitted to the next meeting for consideration.

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

The Health Select Commission received an update from the Scrutiny Officer concerning the Joint Health Overview and Scrutiny Committee (JHOSC) for the Commissioners Working Together Programme. The issues highlighted:-

- The decision on the reconfiguration proposals for Hyper Acute Stroke and Children's Surgery and Anaesthesia had been postponed from May until 28th June. However, the Joint Committee of Clinical Commissioning Groups would only be making the decision on the Children's Surgery and Anaesthesia on that date as there was further work taking place with regard to Hyper Acute Stroke. The new date had not been announced for that decision.

- There would be another meeting of the JHOSC in July. This would provide an opportunity to discuss the final decision for Children's Surgery and Anaesthesia and to discuss future scrutiny following any changes.

Resolved:- That the information be noted.

9. HEALTHWATCH ROTHERHAM - ISSUES

- No issues had been raised.

10. HEALTH AND WELLBEING BOARD

The minutes of the meeting of the Health and Wellbeing Board held on 8th March, 2017, were noted.

11. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 20th July, 2017, commencing at 9.30 a.m.